

John F Roatch Global Lecture Series on Social Policy and Practice

2007

Is There Still A Place For Traditional Values

In Family Medicine?

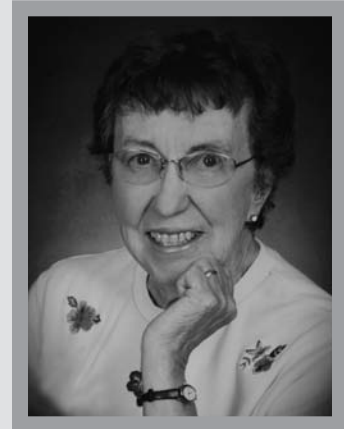
Confronting Managed Care

Presented by
John Wynn-Jones, M.D.

March 30, 2007



*With gratitude
to Mary Roatch
The present*



The John and Mary Roatch Endowment was created by gifts made to the university by John and Mary Roatch. The endowment provides support for the Global Lecture Series, which are organized through the office of the John F. Roatch Distinguished Professor at University College.

John Roatch was born in Ellsworth, Wisconsin, on May 3, 1921 and died in Phoenix, Arizona, on July 2, 1997. Mary was born to missionary parents in Darjeeling, India, and resides in Phoenix. The Roatches have four children, Virginia, Thomas, David, and Joseph. Both Mary and John met and graduated from Hamline University in St. Paul, Minnesota.

John received a master of social work from Washington University in St. Louis, Missouri. He practiced social work and was director of the social work department at the Clinical Center of the National Institute of Health in Bethesda Maryland, from 1965 to 1972. Mary was a teacher, a cottage-parent, and a tutor, but her real love was being a librarian and a consultant on libraries for persons with special needs. She worked at the Phoenix Public Library where she organized the first Special Needs Center in 1983. We continue to be indebted to John and Mary for their vision and to all the family for their continued support of the Lecture Series.

The John F. Roatch Global Lecture Series has always been at the forefront in covering timely topics. In January 2007, the *Arizona Republic* published an editorial by the president of the Arizona Medical Society in which he addressed the vanishing family doctor. When this editorial appeared, we had already invited Dr. John Wynn-Jones who had accepted our invitation to speak on a similar topic. Our foresight brought forth great results, for the 2007 lecture was a resounding success. Dr. Wynn-Jones, as keynote speaker and Drs. Weisbuch and Bradshaw, as respondents, provided an enlightening discourse on what is one of the most important keys to good health—a well-prepared and caring primary physician.

We are indebted to these generous professionals for their time, their wisdom, most of all, for their willingness to share their gifts with our audience.

Emilia E. Martinez-Brawley
John F. Roatch Distinguished Professor and
Professor of Social Work
2007



Celebrating
John F. Roatch's
The memory
Legacy

“When I first practiced family practice, we provided a fully comprehensive level of care to our patients. This included obstetric care and in-patient care for our patients with serious illnesses in our small community hospitals. We also visited many of our patients at home. Sadly, our visiting rates have reduced by at least 80 percent and there is a danger that we may become hermetically sealed within our own surgery or office environment. It is surprising what you can learn about somebody by visiting their home environment.”

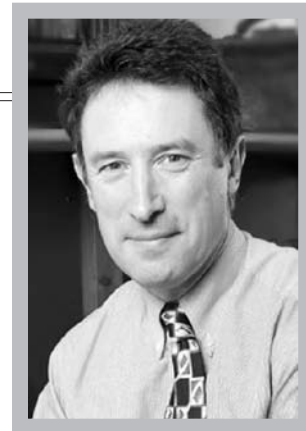


“Today, I aim to discuss the importance of human contact and communication in the delivery of effective patient-centred health care. How can we as physicians, working in health systems that are becoming increasingly process driven and disease-focused, maintain human dignity and a patient sensitive approach? I will argue that traditional values in family practice still offer us the opportunity to meet and focus on the modern needs of individuals and communities rather than on the needs of the health care industry.”

John Wynn-Jones, MD

University of Wales, College of Medicine

DR. JOHN WYNN-JONES is a practicing general practitioner in Montgomery, Powys, Wales. John is well known nationally and internationally for his pioneering work in e-health and for his special interest in education, having held a post with the University of Wales College of Medicine for many years. John is also Life President of the Institute of Rural Health, President of Euripa (European Rural and Isolated Practitioners Association), a member Institute of Learning and Teaching (ILTM), and a Fellow of the Royal College of General Practitioners. He has been a speaker on a variety of health topics and family practice issues in Spain, Germany, Norway, and the U.S.



Dr. Wynn-Jones' practice in Wales is carried out in a team with four full-time and one part-time doctor serving 7,300 patients. The team includes a nurse practitioner, a practice nurse, a triage nurse, a chiropodist, three district nurses, two health visitors, seven receptionists, and a practice manager. Recent regulatory changes for general practice in the United Kingdom established a coordinated out-of-hours service in response to the need to permit general practitioners to balance work and family. The new medical contract also provides general practitioners sophisticated IT support, which is owned and maintained by the primary care organization.

In the European Union, which recently increased to close to 30 independent states, there are as many different models of health care delivery, language and culture. There are large inequalities in health and poverty. Dr. Wynn-Jones has been a student of accessibility and quality issues, but, most of all, has been concerned with maintaining the commitment to caring for people, which initially inspired so many family practitioners to go into medicine.

As an interesting aside, he is the medical adviser to the "Archers," a radio program in the U.K.

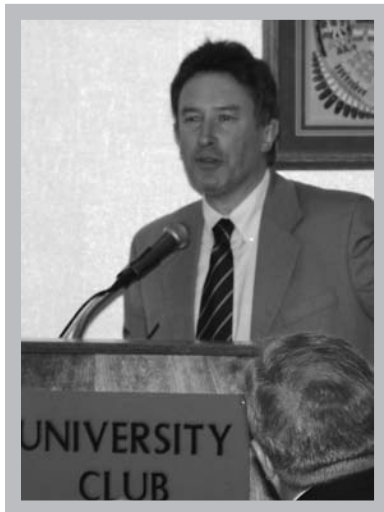
Scenes from the Lecture



Is There Still A Place For Traditional Values In Family Medicine?

*Confronting
Managed Care*

March 30, 2007



“I would like to draw your attention to one of the most seminal books on family practice/general practice, A Fortunate Man, by John Berger. It is about a man called Sassall who is a country doctor. Berger says he is a fortunate man because his work occupies him and fulfills him. His work and his life are not separate, but are closely intertwined.”

INTRODUCTION

I would like to give special thanks to my sponsor, Mrs. Mary Roatch, and host, Emilia Martinez-Brawley, for inviting me to join you today.

You may ask yourselves how a rural family practitioner from Wales came to be giving such a prestigious lecture in Phoenix, Arizona. I had the good fortune to meet my host, Emilia, at a rural and remote health conference in Norway. We found ourselves giving keynotes back-to-back and hit it off from the start. Twelve months later, I was delighted when my long-lost speaking partner phoned me up and invited me to join you today.

As we start the 21st century, I do not know of a nation that can afford to fund comprehensive health care for its people. Countries throughout the developed world are finding it increasingly difficult to meet the rising costs of health and social care in the climate of health cost inflation, greater inequalities, and an aging population. Health systems evolve to meet national demography, political aspirations, and the national psyche. One size does not fit all and one country's solution is not transferable to another, but we can learn from each other and share views, ideas, and initiatives in order to improve the health of our own populations.

I am not an academic. My main role is as a rural practitioner working in family medicine (or general practice as we call it in the United Kingdom), in rural Wales. I have seen major changes in medicine, society, and government during the 27 years that I have served my community and the 20 years I have been a tutor and lecturer. I have witnessed major advances in the technology of health care, changes in the way that society views physicians and the expectations that are placed on us. These changes have had an impact on my working life. As the rate of change accelerates, we find it harder to keep our heads above water, thus increasing our stress and reducing our capacity. I am not a health economist or a strategic planner. I will, however, give a “bottom up” view, emphasizing the importance and value of primary care, family practice, and the “human effect” in the development of cost effective, equitable, and accessible health care.

Today, I aim to discuss the importance of human contact and communication in the delivery of effective patient-centred health care. How can we, as physicians working in health systems that are becoming increasingly process driven and disease-focused, maintain human dignity and a patient sensitive approach? I will argue that traditional values in family practice still offer us the opportunity to meet and focus on the modern needs of individuals and communities rather than

on the needs of the health care industry. I will start by giving you a personal perspective of my work, my experiences, and my family practice. I need to explain why I chose this title. What were my driving passions in taking on this arduous task? I will then spend some time arguing the need for effective primary care and, especially, accessible and responsive family practice. The presentation will describe how today's family physicians have evolved into the "new generalists" who have become the lynchpin of modern and effective health systems. We will discuss the birth and growth of managed care and what impacts that might have on the values of traditional family practice. The presentation will explain more about the "human effect" and the therapeutic benefits of the consultation, effective communication, and an enduring relationship between practitioner and patient.

I will try to put these issues in the context of both our health systems in the United Kingdom and the United States. We will explore the differences and identify how we can learn from each other. I want to emphasize that I do not intend to criticize the American system in comparison with the United Kingdom. Both countries have similar life expectancies and health outcomes, which are often worse than some of the other developed nations. The changes that have taken place in the U.K. with a new family medicine contract have the potential for major impact on the health of our nation and I will illustrate these changes with data from my own practice. I wonder whether the concept of a single-payer, accessible, free-at-the-point-of-contact primary care service may have a certain resonance in states such as Arizona, especially in light of recent articles published in the *Arizona Republic* in January this year, which have many equivalents in the British press.

I intend to conclude by offering some suggestions on how we can make compromises by incorporating what is best in managed care and traditional care and use it to shape our new health services in the 21st century.

WHY I CHOSE THIS SUBJECT

I chose this subject for a number of reasons. Some of this emanates from my own personal frustrations and experiences in practice. I have to ask myself whether it is just one of those age things! Do all doctors feel like this when they get past 55 years old? I can remember my ex-partners feeling similar concerns about the direction of their profession in the past. I have, however, had the good fortune to travel extensively and experience good family practice around the world. I believe that crucial elements of traditional practice are being lost in the U.K., and I grasped the opportunity to confront the march of "managed care" and critically argue the case for traditional values to remain. It is clear, however, that a more managed care program can provide the opportunity to handle the 21st century challenge of an aging population with chronic disease in need of high levels of care. I felt that by comparing the strengths and weaknesses of both health systems I could identify what we both do well and what we can learn from each other.

Finally, I have a specific interest in how we train the next generation of health care practitioners. We must use the best practice to build an image of what our future doctors should look like and accordingly shape the undergraduate and postgraduate curricula in order to produce a workforce "fit for purpose".

A PERSONAL PERSPECTIVE

I would like to draw your attention to one of the most seminal books on family practice/general practice, *A Fortunate Man* (1967), by John Burger. It is about a man called Sassall who is a country doctor. Burger says he is a fortunate man because his work occupies him and fulfills him. His work and his life are not separate, but are closely intertwined.

Sassall is my hero and at the same time represents an age gone by. Burger describes the transition by which a scientifically orientated, disease-focused doctor begins to change in the new environment in which he works. He describes how he learns the language of his patients. He learns the importance of that unique enduring relationship with his patient, the spontaneity of that moment when all may be revealed. He feels inadequate when he doesn't know what to do and how to behave. He struggles with the expectations that doctors and patients place on each other. His role as a family physician is that of a universal man. He describes the birth of the "new physician" or the "new generalist" that began to appear in 1960s. More than anything else, however, he tells us that Sassall's most important role is in the management of "anguish" in his patients.

When I first practiced family practice, we provided a fully comprehensive level of care to our patients. This included obstetric care and in-patient care for our patients with serious illnesses in our small community hospitals. We also visited many of our patients at home. Sadly, our visiting rates have reduced by at least 80 percent and there is a danger that we may become hermetically sealed within our own surgery or office environment. It is surprising what you can learn about somebody by visiting their home environment.

But, I have seen major changes during my 27 years in practice. The most significant have been due the advances in medical technology. We can now do more for our patients, we have more treatment options, we have more information at our finger tips, our patients expect more from us, and they live longer. No longer does a patient tell us "don't worry, doctor, but you did all that you could". Expectations are greater and are often unachievable. Our patients are also more informed, and our relationships have changed. Health care is now based on partnerships rather than the traditional parent-child relationships.

Workload and stress have grown exponentially. The aging of our practice population has made the management of chronic diseases, and especially the problems associated with co-morbidity of multiple complex chronic diseases, our biggest challenge to date. One-fifth of the U.K. population is over 60 years old. Within 30 years, the numbers over 65 will rise from 18 percent to 22 percent while those under 20 will drop from 25 percent to 22

percent. The elderly already consume a large proportion of the NHS budget with 40 percent spent on the over 65-year-olds (while over 50 percent of the social services budget is spent on this age group). In order to cope, much of the chronic disease management is now undertaken by nurses and nurse practitioners working to protocols. The nature of family practice has changed, with care being provided through complex horizontally integrated multidisciplinary primary health care teams.

The quality/safety/governance agenda has also impacted our work. Patients, understandably, expect high levels of quality and governance. Many of the procedures and treatments that we regularly provided are now deemed to be specialist only. We are told that we no longer have the competencies to practice procedures that were once the domain of the family practitioner. We are increasingly becoming de-skilled and this, in turn, increases work for secondary care and causes a reduction in job satisfaction.

The dynamics of our practices have also changed. Practices have become bigger and more complex. Time involved in management, paperwork, and administration impinges on clinical time and patient contact. In Britain, family physicians were given the option of relinquishing 24-hour responsibility for their patients three years ago. This has clearly improved our work-life balance, however, as a result, I feel GPs have lost status and have lost credulity. We interact less and less with our community and our role as community leaders is disappearing all the time. We are becoming less relevant as agents of change.

Attitudes in society are also changing and our community sees us in a very different light. Society is less forgiving and more demanding. As we share less and less of our patients' anguish, we become just another professional group who are well paid, protectionist, and look after their own self interests.

Care has become increasingly more disease-focused rather than patient-centred. We are in danger of providing a mechanistic type of care based on things that we can measure rather than the suffering that we can alleviate.

MY MEDICAL PRACTICE IN MONTGOMERY, WALES

My practice in Montgomery, Wales is not just a team but a complex organisation. We have five doctors and the team cares for 7,300 patients. We work out of two surgeries. We have one nurse practitioner and four practice nurses, and their main role is the management of minor illnesses and chronic disease in the practice. We have a counsellor, a psychiatric nurse. We provide telephone nurse triage throughout the day. We have a chiropodist, two health care assistants, four district visiting nurses, two health visitors who work as public health children's nurses. We have access to specialist nurses who join us for our weekly multi-disciplinary meeting, such as a palliative care nurse, urology incontinence nurse, etc. We have a practice manager who manages this organisation. She is helped by twelve receptionists and dispensers. Five doctors still provide "out of hours" services on a shift basis, working

for a local emergency care company. We no longer provide maternity services or look after patients in hospital. We have established a patients group, which meets on a regular basis and advises us on our patient services.

THE STRENGTHS OF PRIMARY CARE

Barbara Starfield and other authors have conducted extensive research into the impact of effective primary care. In a Health Policy document, Starfield and Shi (2002) state health care costs are directly related to the strength of primary care. Countries with weak primary care infrastructures have poorer performance on major aspects of health, although countries that are intermediate in the strength of their primary care generally have levels of health at least as good as those with high levels of primary care. This is not the case in early life when the impact of strong primary care is greatest. Equitable distribution of resources, publicly accountable universal health and financial coverage, and comprehensive and family-orientated social services distinguish countries with overall good health from those with poor health at all ages. Neither income inequalities nor smoking status accurately identify those countries with consistently high or consistently poor performance on health indicators. A certain level of health care expenditures may be required to achieve overall good health levels, even in the presence of strong primary health care infrastructures. Very low costs may interfere with the achievement of good health, particularly at older ages, although higher levels of costs may signal excesses and potentially health compromising care. The policy-relevant characteristics aforementioned appear to be related to better population health levels. Studies showed that mortality levels in countries with high quality primary care consistently outperformed those with low-quality primary care. These comparisons are also applicable across American states with stroke mortality and post neo-natal mortality.

Starfield (1985 & 2002) has consistently championed the importance of strong and comprehensive primary care as a basis for a nation's health, and her evidence has indicated that this relationship remains true irrespective of a nation's GDP or the proportion of its GDP spent on health.

FAMILY PRACTICE: THE HISTORICAL PERSPECTIVE

Family practice is placed at the core of strong primary care and remains one of the most important elements. The family physician provides the interface between the patient and the health service by providing care when necessary, referring horizontally to other members of the team when appropriate, and acting as the gatekeeper to secondary care when needed. The majority of care will be provided through primary care without any need to refer on.

Family practice is in a period of change, but change in medicine is not new. Medicine as we know it developed as a profession in the 19th century. Before then, there were a small number of elite physicians and a whole array of unregulated healers, surgeons, apothecaries, midwives, etc. providing care to the majority of the population.

The 19th century was the age of regulation. Both the government and the profession gradually regulated and controlled medicine in order to safeguard the public. Examples were the Apothecary's Act, 1815; the 1st Bill for The Regulation of the Medical Profession, 1840; the Charter for the Formation of the Royal College of Surgeons, 1843; and the National Association of General Practitioners, 1845. It was out of this period of regulation and evolution that the first general practitioner developed. A general practitioner was considered to be a physician who was trained in and able to provide surgical, medical, and midwifery practice.

The 20th century saw the birth of specialisation in medicine. The great majority of physicians at the end of the 19th century were generalists. For the first time, scientific advance was linked to the practice of medicine. Johns Hopkins University, in particular, was formed by specialists to place medical education on a firm scientific foundation. As a result, medical education became increasingly laboratory orientated.

Through the early part of the 20th century, the family practitioner was overshadowed by the hospital orientated specialist. By the 1960s, there were three recognized levels of care: primary care, provided by generalists practicing personal and comprehensive care; secondary care, provided by specialists; and tertiary care, provided at highly specialized centres.

General Practice/Family Medicine has constantly evolved as a discipline and responded to the changing health environment and economy. By the 1970s, we began to see the need for a "new generalist" working in primary care. This new type of family physician developed as a response to the expansion of primary care. This new physician provided generalist patient-centred care. Around them grew a need for an academic infrastructure, and this led to the establishment of colleges, associations, and university departments. This new discipline led to the setting up of specialist training programmes and the establishment of Family Medicine/General Practice as a specialist discipline.

The growing research base began to look at how doctors performed and behaved, how patients sought help, and the importance of patient-centred care. This led to the incorporation of behavioural and social sciences into medical education and research. Primary care/family practice research has grown considerably and now accounts for a significant proportion of the biomedical academic output. Modern research has needed to embrace qualitative as well as quantitative research methodologies.

This era also saw the changing face of hospitals, with the growth of care outside the hospital environment and expanded community services. Economists realised that community care was cheaper, and strategic planning aimed to reduce hospital admissions when possible. Hospital stays became short and time spent in hospital was highly intensive. It is during this time that the concept of managed care arose in an attempt to rationalise and contain the costs and the use of resources.

The evolution of family medicine/general practice has had an impact on medical education. Students were traditionally trained in hospital because hospitals were places that patients went to. The realisation that the majority of sick people are treated in primary care and the shift of care into the community has meant that undergraduate training needed to be re-orientated to family and community practice. Students not only learn about family practice from family practitioners, but the change in hospital practice means they now also need to learn their basic skills and medical knowledge in the community. New and innovative medical schools in countries such as Australia see medical students spending between six and 12 months in family and community practice.

FAMILY PRACTICE DEFINITION AND ROLES

Ian McWinney, in his *Textbook of Family Medicine* (1981), stresses the importance of being different and having a different role to other disciplines. He described Family Practice as the only discipline which defines itself in terms of relationships, thinks in terms of individuals rather than diseases, and transcends the gulf between mind and body. He goes on to list the nine principles of family practice:

- 1) Family physicians are committed to the person rather than a particular body of knowledge, group of diseases, or special techniques.
- 2) The family physician seeks to understand the context of the illness.
- 3) The family physician sees every contact with his patient as an opportunity for prevention or health education.
- 4) The family physician views his or her practice as a population at risk.
- 5) The family physician sees himself or herself as part of a countrywide network of supportive and health care agencies.
- 6) Ideally, family physicians should share the same habitus as their patients.
- 7) The family physician sees patients in their own homes.
- 8) The family physician attaches importance to subjective aspects of medicine.
- 9) The family physician is a manager of resources.

The family physician is also the key to the horizontal and vertical integration of health care delivery. The concept of an enduring relationship which spans a period of time is a crucial element in the management of individuals and communities allowing the physician the opportunity to use experience and personal knowledge to solve problems as they arise. Self reflection, critical thinking, and lifelong learning ensures that the physician is always striving to improve care and incorporate advances in science and medicine into their individual practice. McWhinney also recognises that there are potential conflicts between a family physician's role and his/her responsibilities. These challenges are often associated with achieving the balance between science, experience, and the subjective; learning who defines the problem, the patient or the doctor; resolving potential conflicts between the needs of an individual and that of the group; deciding how much time

should be spent in management and away from patient care; investigating how the quality agenda impacts traditional care and values; discovering conflicts that might occur between the needs of government and the needs of the patient; and finally, ensuring that the family physician achieves a work-life balance, a balance that will benefit the physicians, their families and their patients.

CONTINUITY OF CARE

Modern health care often means that patients are seen by many practitioners and professionals. It is conceivable that care may, as a result, become fragmented. Continuity of care must, therefore, remain a prerequisite of modern family practice. Attlinger & Freeman (British Medical Journal, 1981) stated: "Continuity of care improves both patient satisfaction within a general practice service, but also, more importantly, improves compliance with medical advice. It seems that patients who get to know their GP (and by implication are able to develop a good relationship with the doctor) are more likely to take pills as advised."

But, authors suggest, continuity of care must be also looked at from the patient's point of view. There is some evidence that personal continuity, as opposed to organisational continuity, brings forth greater patient satisfaction with care and more efficient use of resources. It has also been proposed that a service needs to provide: continuity of information—excellent information transfer following the patient; cross-boundary and team continuity—effective communication between professionals and services and with patients; flexible continuity—adjust to the needs of the individual over time; longitudinal continuity—patient follow up across time; and relational continuity—a named individual professional with whom the patient can establish and maintain a therapeutic relationship.

McWhinney (1981) summarizes that continuity of care is built on an enduring relationship between patient and physician, based on the four principles of responsibility, trust, relationships, and accumulated knowledge.

ARE THERE WEAKNESSES IN TRADITIONAL FAMILY PRACTICE?

Do we need a generalist in this modern world? Clearly, the patient needs a trusted and informed physician who can support, steer, and protect them through the growing labyrinth of modern health care. The trusted family physician needs to protect against over-medicalisation, acting as the patient's advocate, and translator. Sceptics may argue whether the family physician can keep up with growing body of scientific knowledge. The new generalist is a specialist in generalism. Their knowledge is extensive and it allows them to transcend the various barriers that often arise between individual medical specialties and sub-specialities. I understand that the term "gatekeeper" is perceived in the USA as a barrier, which may restrict freedoms and a patient's options. Gatekeepers can also welcome and protect individuals, help them choose the most appropriate option, and guide them along on their journey.

It may be argued that the family practitioner can act as a barrier between the smooth integration of primary and secondary care. Family physicians need to communicate effectively with their specialist colleagues. This communication can, on one hand, ensure that patient information flows easily across the border between primary and secondary care and, on the other, that they work together to create pathways of care in order to guide the patient on their journey effectively, efficiently, and safely.

THE UNITED KINGDOM NATIONAL HEALTH SERVICE

The National Health Service (NHS) in the United Kingdom was established in 1948. It aimed to provide a service "from the cradle to the grave". The wartime government, in 1942, commissioned William Beveridge to write a report which would lay the foundations for a "modern welfare state" and provide a "society

"We must improve the patient experience by adopting patient-centred rather than disease-focused approaches. Doctors must forge therapeutic relationships and contracts with their patients and families. These relationships must maintain patient autonomy, foster self care, and avoid dependence on the physician."

fit for the soldiers to come home to at the end of hostilities". Lord Beveridge said that the object of government is not the glory of rulers or of races but the happiness of the common man. There was a time when the NHS was the envy of the world. I cannot say that it is the case now but we can still maintain some pride in a system that provides comprehensive care irrespective of wealth and free at the point of entry with a single payer. In 1990, a similar time to when managed care organisations in the United States were expanding, Margaret Thatcher introduced the market economy into health care in the United Kingdom in an attempt to make it more efficient, more effective, and produce value for money.

GENERAL PRACTICE IN THE UNITED KINGDOM

You will need to know more about the nature of general practice in the United Kingdom. The NHS is a centrally co-ordinated service. It has a single payer in the U.K. government and is free at the point of delivery. GPs act as gatekeepers, co-ordinating referral to secondary care and at the same time identifying the appropriate care for their patients. GPs work as independent contractors; they are not government employees, although they have the benefits of the NHS pension scheme. Their pay structure is complex and consists of a mixture of capitation, item for service, and target base payments. Premises and staff are subsidised. General practitioners work in teams with an array of other primary health care professionals.

The Health Service has gone through a considerable amount of change over the last two decades and this has been a de-stabilizing factor on general practice. The new GP or General Medical Services Contract has radically altered the service. Roland, describing the new contract in the *New England Journal of Medicine*, (2005) said, "The 1990s were the years of evidence-based medicine, when health professionals gradually came to accept that there were better and worse ways of doing things and there were justifiable limits to individual freedom in the clinical setting". The 1990's was also a decade when researchers in health care on both sides of the Atlantic demonstrated that there were widespread variations in the practice of medicine and that many patients were receiving care that fell short of what could be provided. The combined effect of these developments was that it became increasingly possible both to define high-quality care and to provide methods that could be used to measure some aspects of the quality of care". The change in the culture of the profession that occurred during this decade was enormous, and it stemmed in large part from research in the health services that was carried out in the United States and the United Kingdom. A recent editorial in the *BMJ*, describing the new GMS contract, commented that the proposed new contract between the NHS and the general practitioners aims to improve the quality of primary care in the boldest, large scale proposal ever attempted anywhere in the world.

THE NEW GMS CONTRACT

The new GP or General Medical Services Contract introduced in 2004 has radically altered the service. The new contract originated as a result of a survey of general practitioners carried out in 2001. Over half the GP respondents felt so overworked and stressed that they had considered leaving the health service, and it became clear that doctors wished to achieve a better work-life balance.

A new formula for funding was developed. It broke down general medical services into core services, additional services (such as child surveillance, immunisations, cervical cytology), and enhanced services that could be commissioned on a local or national basis (anticoagulation, minor injuries, minor surgery etc.). The revolutionary development was what became known as the "Quality and Outcomes Framework". This identified a number of chronic disease areas (cardiac disease, hypertension, diabetes, asthma, COPD, mental health etc.) and outlined a set of targets with which to measure their management. Each chronic disease area was allocated points. GPs were remunerated with "new money" for each point achieved. Points were also allocated for management targets such as the quality of records, information for patients, practice services, the patient experience, etc. The new contract also gave general practitioners the opportunity to opt out of 24-hour care for the first time. In addition, the government took over the responsibility of providing sophisticated information technology systems in general practice.

Some GPs have mixed feelings about this contract. Incomes have risen and workloads have expanded, but there is no doubt that it has succeeded in improving the management of chronic diseases. It is too early to look at the health outcomes, but anecdotal evidence appears to suggest a reduction in certain presenting conditions. Incidentally, the abandonment of 24-hour care has increased hospital admissions and placed undue stress on the hospital services. The NHS drugs budget has also soared with the aggressive use of expensive drugs such as statins to reduce cholesterol.

In an attempt to meet the targets, practices have increased the number of practice nurses. The contract has led to an expansion in primary care teams and more traditional medical tasks being undertaken by nurses.

The data presented (slides) from my practice shows a range of patient health parameters which have consistently risen over the last three years as a result of our intensive and coordinated programme of chronic disease management. Our practice has achieved maximum points every year. No other practice in our Health Board has managed to achieve these results.

Sceptics will suggest that this is a form of managed care which has pushed GPs in the U.K. into the area of disease management and has possibly compromised holistic patient-centred health care.

THE HUMAN EFFECT IN MEDICINE

Does quality family practice have more to it than just the management of chronic diseases? Does the relationship between two human beings have a positive impact in its own right? Michael Dixon, (2002) in his book, *The Human Effect in Medicine*, refers to “a therapeutic outcome to the relationship between doctor and patient.” He goes on to say that “For centuries, medical writers and thinkers have debated the importance of relationships in medicine, of good communication, and of trust as the basis of the clinical interaction”. He further states that we should “forge to aim a new balance between evidence and philosophy and between professional responsibility and self care”. The consultation between doctor and patient lies as the core of this relationship. The bulk of research in the medical science still lies in the area of bio-mechanics rather than in relationships between people. Hypocrites said, “Make frequent visits and enquire into all particulars, cultivate prognosis that men will have the confidence to entrust themselves to a physician”. Plato stressed that the emphasis must be on good communication.

Writers during the renaissance began to stress the importance of taking histories and listening to the patient, linking spirituality with human suffering. Alessandro Beneditti, a physician in Venice in the 17th century, said that “the human body was created for the sake of a soul”. The Enlightenment philosophers such as Descartes introduced the concept of mechanistic thinking through “Cognito ergo sum”. In the 19th and 20th centuries, Freud’s contribution developed a vocabulary for the inter-relationship between doctors and patients and saw the therapeutic benefits of the doctor. Michael Ballant, in the 1950s, stressed the importance of listening as a skill, the awareness of self as a doctor, and the understanding of the doctor’s emotional reaction to the patient. While discovering in himself an ability to listen to things in his patients that are barely spoken, the doctor soon experiences changes within himself”.

The last decades of the 20th century saw a growth in the importance of relationships in health care. Deveriche demonstrated how the death of a loved one impacted personal care. Other research showed the importance of stable marriages, happy childhoods, a positive fruitful relationship with the doctor, and the importance of managing life events. There was a change in the medical metaphor. Iona Heath (1995) reported that the three roles of a general practitioner are interpreting the patient’s story, guarding against over medication, and witnessing suffering.

Can we define what healing is, or is it just the “placebo effect”? Hypocrites described the healing capacity of the patient. Various researchers have tried to quantify the effect of the placebo. Estimates varied, but some have reported that it may have an impact as great as up to 30 percent on health. Any pharmaceutical therapeutic intervention having a 30 percent benefit would be hailed as a significant medical tool. Do we know the benefits of alternative therapies? Do we understand self-limiting

diseases and what is the impact of the loss of empowerment and self healing?

So where have we gone wrong and why is this human effect so often missing from modern medicine? Michael Dixon says, “Our intention is to challenge the dogma of modern technological medicine that ignores the therapeutic effect of the doctor and the self healing powers of the patient.” So, we might ask, should we endlessly fight disease by throwing technology at it, especially when we are unable to deliver the technology without frustrating and stressful delays? Perhaps we should concentrate more on maintaining health and resistance to disease in the first place. Ballant, in his *Utopia* (1957), said of the future, “The General Practitioner will no longer be able to disappear behind the strong and the impenetrable façade of a bored, overworked, but not very responsible dispenser of drugs and writer of innumerable letters, certificates, and requests for examinations; instead, he will have to shoulder the privilege of undivided responsibility for people’s health and well-being and, partly, for their future happiness.”

MANAGED CARE

Healthline defines managed care as “a system of health of care delivery that aims to control costs by signing set fees for services, monitoring the needs for procedures such as tests and surgical operations, and stressing preventative care. *The Encyclopaedia of Public Health* (2001) says that “managed care is the enrolment of patients into a plan that makes capitated payments to health care providers on behalf of its members, thus shifting the financial risk for health care from patients and payers to providers.” The intent of this shift is to provide incentives to health care professionals to reduce their utilization of services, ideally through measures such as health promotion and disease prevention among the group’s members.

Managed care grew as a result of the re-organization of health care in response to economic forces. The rapid growth of managed care in the USA occurred during the Reagan presidency. Managed care was provided by nonprofit organisations, which strove to integrate services across the three sectors (primary, secondary, and tertiary), to conserve resources and eliminate waste, encouraging team work and removing barriers between the levels of care. It saw the primary care physician as a gatekeeper. These physicians, however, complained of a loss of independence and autonomy. Involvement in and responsibility for financial management could also lead to possible conflicts of interest.

Managed care has significant strengths. It facilitates the vertical and horizontal integration of care leading to the efficient and effective use of resources. It can easily establish mechanisms within its structure to control governance, quality, and safety. Physicians and other clinicians are involved in management and planning. Managed care’s major weakness is that financial drivers predominate. Schemes are disease- and

population-orientated. There is often a lack of holistic, patient-centred care, leaving health care professionals often feeling dis-empowered. So, how can we incorporate the "human factor" into managed care to ensure that the traditional values of patient-centred family practice are not lost? It is my belief that merging the principles of managed care and traditional family practice can, together, contribute to better and more effective health care.

AMERICA'S ILLS

In a recent paper in the *British Medical Journal (BMJ)*, Davies (2007) said that "failure to ensure access to health care for all lies at the heart of the US failure to achieve value for money". The United States is the only major industrialised country in the world without universal health insurance. Rather than getting better, the situation is getting worse. You have a confusing mix of health programmes and funding options. Major inequalities exist in mortality, morbidity, access to health, and the quality of care.

Sixteen percent of your population is uninsured and considerably more is under-insured. This percentage is rising, mainly in the 18-to-64 year old age group. It is estimated, according to Davies, that 18,000 deaths per year are due to lack of adequate health care coverage. The uninsured are further disadvantaged as health care costs for them are higher because there is no discounting. They get poor quality care, poor chronic disease management, and no regular care. A larger percentage of their care is accessed through the ER room (35 percent for uninsured, 16 percent for insured) and, finally, significant ill health can lead to financial difficulty or even ruin.

The cost of care in the United States is increasing. It is perverse to think that the cost of filling the gaps in the US system would be less than the national lost productivity due to illness and poor insurance coverage. Costs are continuing to rise. If we look at health care expenditure, the United States spends twice that of other industrialised countries yet life expectancy is the lowest of the eight industrialised nations, in Davis' study. When we look at deaths amenable to medical care, only the United Kingdom seems to have a worse record. Access problems again show the USA with the worst record and this is even more stark when we compare access with an open-ended free service such as in the United Kingdom. Despite the money spent on health care in the USA, health outcomes are woeful. Breast cancer survival rates are considerably worse than the rest of the developed world, as are myocardial infarction mortality rates. What is equally worrying is that in a country that boasts the most sophisticated medical care in the world, deaths from surgical and medical mishaps are the greatest.

There is considerable discussion as to how Britain and the United States can share experiences. Chris Ham, in a 2005 BMJ issue said, "The NHS performs as well or better than the US health care system on many objective indicators. Yet the United Kingdom shows great interest in

learning from the United States and not vice versa. Is this paradox a consequence of American insularity, British credulity, or some other factor, and is there any prospect of the balance of trade in health policy ideas being reversed? If so, what aspects of health care in the United Kingdom should the United States be studying and seeking help from"? He goes on to say, "In a world where trade barriers are tumbling, the borders are opening up. A special relationship between the United States and the United Kingdom should not blind these two countries to the opportunities of learning from elsewhere".

If we look at a simple table comparing the United States and the United Kingdom, life expectancy is virtually the same. Yet the United Kingdom spends eight percent of GDP on health care, whereas the United States spends 15 percent. Satisfaction with the health care system is greater in the United Kingdom than it is in America despite the public's unhappiness with the deficiency of the NHS. In the U.K., fifty percent of the doctors work in primary care, yet only 30 percent do so in the United States. The number of young doctors wanting to become GPs in the U.K. is stable whereas those applying for family practice residences in the United States continues to drop. There are no cost barriers to health care in the United Kingdom as there is in the United States.

What, therefore, can we learn from each other, and can experiences from other countries fundamentally change the American system? In the *Journal of the American Medical Association (JAMA)*, Robinson (2001) said, "Change at that stage was a long way away. American people wanted to direct their own health care with clinical advice from their physician, financial subsidy from employers and public programmes, information from the internet and off-line sources, and the support of their families and friends. Public health initiatives will expand to the extent that private initiatives contract but the likelihood of a national, one-size-fits-all programme becomes more remote with every passing year".

Speaking with American colleagues, you do get a feeling that there may be some change in the air. But I remember being in Seattle when the Hillary Clinton's reforms were expected, and there was excitement and expectancy in the air. That was soon dashed by disappointment. I fear that we will have great difficulty learning from each other because our values and our politics are different. Europeans value a strong central government while in the United States citizens mistrust central government. Changes in funding to develop models similar to those seen in the U.K. would be far too radical in the United States. Wholesale change is unlikely, but this does not stop us "cherry picking" from each other. Each country can be a potential laboratory where we can learn from each other. Learning, as Chris Ham suggests, is, at present, only one way. There is an appetite in the U.K. for managed care programmes such as Evercare, Kaiser Permanente, Group Health etc.

If we are to persuade the USA to look elsewhere, then what can you learn from the U.K.? Whereas the U.K. can learn from secondary care in the USA, the strength of the United Kingdom's primary care must have some attraction, especially in the light of the new GMS contract. Initiatives such as National Service Frameworks for chronic diseases and vulnerable sectors of the population which promote quality and safety through the incorporation of evidence-based care must also attract attention. Other organisations such as the National Patient Safety Agency and the National Institute of Clinical Excellence aim to provide an ongoing clinical effectiveness assessment of treatments and technologies. Finally, primary care computing has seen significant investment and advances in technology and it continues to underpin the success of general practice in meeting the needs of the U.K. population.

HOW CAN WE INCORPORATE PASTORAL VALUES INTO MANAGED CARE?

To conclude, I have given you a personal perspective of my practice and my work. I have given the case for strong primary care and patient-centred family practice. I have explained how general practice in the U.K. has incorporated elements of managed care but still, at the same time, maintains the fundamental principles of comprehensive, open access, free health care. I have also discussed the values of the human effect in medicine and its ability to provide pastoral patient-focused care. Finally, I have compared our two health systems and extracted what we can learn from each other.

Is it possible to incorporate pastoral care and values into managed care? Managed care clearly does have its strengths. If we can introduce that human effect or pastoral element, we can deliver effective, efficient, economic, and humanitarian care into both countries.

We must continue to champion the importance of the generalist in health care. Only generalists, as McWinney suggests, can genuinely see and understand the big picture. By enabling and empowering family physicians, we can introduce a "bottom up" approach ensuring that management is never too far away from the patient and the primary doctor-patient interface. We must improve the patient experience by adopting patient-centred rather than disease-focused approaches. Doctors must forge therapeutic relationships and contracts with their patients and families. These relationships must maintain patient autonomy, foster self care, and avoid dependence on the physician.

We need to develop a workforce fit for purpose. The majority of medical students and other health professionals will spend their working lives out of hospital and, as a result, we need to train them in the community when we can. Learning about the basic biosciences will not be enough. They will need to learn more about the context of illness and the impact of social and behavioural pressures on their patients. The one certainty that I can pass on to

you is that medical technologies, treatments, and health policy will change, but the values passed on by Hypocrites stay the same. This is something that we can pass on from generation to generation. Family medicine will probably be the best place to do it.

Family practice will also need to change. More care will need to be provided by bigger and more comprehensive primary care teams. The family physician will be even more important as the linchpin that will coordinate care horizontally and vertically in the future. The family physician will need to break down the vertical barriers and work with specialist colleagues to develop integrated care pathways and protocols. The patient journey must be a seamless and confident experience. Crucial to this, we need to establish mechanisms for maintaining quality and safety for our patients. We will need to work in a "joined-up" way, working closely with other agencies and services in local government and the voluntary sector.

We will need to expand academic endeavours in primary care. It is well developed in some areas but not in others. Academic growth brings credibility within the profession. It also fosters critical thinking and research. Research in medicine has predominantly been quantitative. The science of caring, relationships, and suffering needs a qualitative approach borrowing from the research methodologies of the humanities and social sciences.

Finally, we must not be seduced by technology. Technology is often merely a tool and has its limitations. I would like to finish by quoting Michael Dixon. "Our intention is to challenge the dogma of modern technological medicine that ignores the therapeutic effect of the doctor and the self-healing powers of the patient."

Dr John Wynn-Jones
March 2007



Respondent Mary Ellen Bradshaw, MD



Mary Ellen Bradshaw, MD

Consultant, Public Health Administration, Child, Adolescent & School Health

Mary Ellen Bradshaw, a native of New York City, attended SUNY Downstate Medical Center College of Medicine and completed her pediatric internship, residency and fellowship at Bronx Municipal/Jacobi Hospital Medical Center. She served as a clinic and school physician in the District of Columbia Department of Public Health, eventually becoming chief of the Bureau of School Health Services, a position she held until moving to Phoenix, Arizona, in 1997. Dr. Bradshaw taught School Health and Policy in the Masters of Public Health Program at George Washington University. She was a delegate to the AMA from the D.C. chapter for many years. As a delegate, she introduced resolutions regarding the health of children, adolescents, and women and the practice of medicine. Most of her resolutions were passed and became AMA policy. Of particular interest is "Towards Preserving the Soul of Medicine," a subject close to Mary Ellen's heart. Less successful were those resolutions directed to the consideration of a universal health/single payer system. Locally, she has been active in the Arizona Medical Association House of Delegates and has chaired the Task Force on Child Abuse and Family Violence Prevention of the Arizona Public Health Association. She has been a member of the Smoke Free Arizona Coalition. Currently, she is a consultant.



I am pleased to have this opportunity to respond to Dr. Wynn-Jones' impressive presentation on the intricacies of the medical care system in the U.K.

My remarks will focus on the human factor in the doctor-patient relationship. In doing so, I will share my thoughts on what medicine is about; my own experiences with the practice of medicine in the US over several decades; and the issue of relationships, primary care practice, and community.

A few years ago, when I served as a Delegate to the AMA from the Medical Society of D.C., I introduced a resolution, "On Saving the Soul of Medicine", reflecting that medicine has traditionally been "an art and a science" and that we now are in the process of substituting business for art. The resolution, which was passed, stressed the need for all physicians to reflect on the essence of the Hippocratic Oath and to present a patient-centered, ethical model to young physicians who are being trained in times of HMOs, when salaries are dependent on the number of "clients/customers" seen and other economies of scale, but when they all have huge medical school debts.



I have always thought of the practice of medicine as a sacred trust between two human beings, where individuals place their innermost self and bodies, their very life, in the care of another human being, who is sworn to do no harm but to heal and comfort. In days of yore, before many more treatments were available, one of the compassionate functions of the physician was to sit by the patients and offer succor to them and their families.

So much has changed regarding treatment that what often falls by the wayside is that still critical component of the doctor-patient relationship, the trust, the X-factor in healing and comforting, the knowledge that someone is there for you, with your interest at heart. I believe that it is still the most powerful medicine at our command.

Managed Care, alluded to in the presentation, as I originally understood it, was to assist in the overall coordination of care for patients—to assist them in traversing an increasingly complex medical system and bring greater satisfaction to both physician and patient. Instead, it has devolved into Managed Cost with recognizable benefits to neither.

When there is no time to spend with patients, when we become more absorbed with the business aspects of keeping a practice going (fighting insurance companies for reimbursement, having patients change from one provider to another when insurance coverage changes), we lose that connection, that ongoing trust, that continuity and familiarity that is so essential to the X-factor of healing and patient care and to the satisfaction of being a physician. This is one reason so many good doctors are leaving the profession. The practice of medicine has become another world, estranged from the reasons we went into what we considered a vocation, a calling to care for others in their

most vulnerable moments and to stand with them through illness and the end of life.

There are at least three, perhaps uniquely American, phenomena that were briefly mentioned by Dr. Wynn-Jones. One is the huge problem of lack of access to routine medical care due to no or insufficient health insurance faced by about 47 million people in the US. When care is finally sought, usually in the far more expensive and overwhelmed hospital ERs, there has been an increase in the severity of illness. In these cases, there is essentially no patient-physician bond, much to the chagrin of both doctor and patient.

The second is the problem of patients with insurance—the multitude of different policies with menus of coverage, differing co-pays and deductibles, physicians being “in or out of plan”, the confusion and frustration of the patient, and the necessity of a solo or group practitioner having to hire from two to six administrative staff just to handle the paperwork with all the attendant excess costs to the health care system! The mandatory introductory question of “What type of insurance do you carry?” does not engender that warm fuzzy feeling of entering a caring environment.

The third is the ever present and growing threat of malpractice lawsuits which in the US increases the cost of liability insurance for practitioners and necessitates the ordering of every possible test to cover all the potential bases, which in turn raises the cost of health care. US health care is the most expensive in the world, but without the compensatory increases in healthy outcomes, i.e., life expectancy (40th) and infant mortality (28th), to mention a few. This tendency to “sue the doctor” stems partly from the expectation of perfection, whether it is a baby without defects or a procedure without complications. But I believe the tendency is also based, at least partly, on the current disruption of the patient-physician relationship and patient anger over the lack of time and attention paid by the over-scheduled physician. Years ago, one rarely even thought of suing one’s doctor, not because mistakes were not made or complications were absent but because there was a feeling that the doctor cared and was doing everything possible in the interest of the patient. Doctors may have been regarded in some ways as gods, but they were also excused from fault because of their humanity.

My family doctor was a GP, who took overall care of our family, including relatives from abroad. His brother, a pediatrician, made house calls when I was ill, asked about the pictures on the mantel, knew the names of our cousins in the war—he knew us. Healing was through knowledge, understanding, reassurance and the gentle hand on the shoulder.

One July when I was 15, I worked as a receptionist in his office and learned of his and his brother’s early history, their love of medicine and devotion to patients. I learned that re-imburement was of secondary importance: When patients could pay, they would pay. People from all walks of life came to his office and loved

him. He encouraged me to enter medicine, extolling it as the most satisfying of all professions.

I attended medical school in Brooklyn, New York in the 1960s, and was fortunate to have professors who exemplified integrity, commitment to excellence in care and respect for patients, who were always to be treated with dignity, addressed as Mr., Mrs. or Miss, and never considered as “diseases” or “cases”. I was taught that taking a complete history was critical—it makes up 85 to 90 percent of the diagnosis. The answer is in the patient. History came first, then a thorough physical exam, the formation of a differential diagnosis, and then, finally, the appropriate lab work to confirm or rule out diagnosis. All this interaction takes time and communication with the patient! How far we have strayed from these concepts!!

One of the most impressive courses in med school was Environmental Medicine and Community Health, where I went to a community health center (public health) in one of the poorer areas of Brooklyn, saw a family of four, and followed them clinically doing both a family and community diagnosis. I visited them in their home and took note of their living circumstances which, of course, had an impact on their health and well-being. I still believe that this type of experience should be part of every medical student’s training—placing the patients in their context.

My medical school classmates went primarily into internal medicine, pediatrics, ob-gyn, psychiatry, surgery and radiology. Many eventually sub-specialized. About three of 115 went into general practice. Throughout future years, the areas of sub-specialization increased with fewer and fewer physicians even considering general practice. In the late 60s, the specialty of family practice started emerging in certain areas of the country and departments of family and community medicine were developed. I chose pediatrics. Other members of my family went into the private practice of psychiatry and internal medicine and into preventive medicine and public health, in which the community is the patient.

After training, I moved to D.C. and became a clinic and school physician and eventually a public health administrator as chief of the Bureau of School Health Services in the D.C. health department. In all of these primary care and secondary specialties, relationships with patients and their families proved essential. Further, in pediatrics and public health, relationships and involvement with the community (schools, other agencies and organizations serving children and their parents) are part and parcel of the job.

Developing legislation, fighting for budget allocations, testifying before Councils and Boards are par for the course. Active participation in a variety of professional associations and enlisting colleagues in support of child- and family-centered initiatives are essential to success. These are on-the-job lessons learned, not necessarily skills taught in medical school, although I believe they should be.

In sum, there are many primary care specialties whose core practice is based on physician-patient relationships and community involvement, but these, and the basic trust inherent in continuity of care, are being severely disrupted by the current practices of the US health care system. Medicine as "a business" is destroying the soul of medicine and rupturing the sacred bond of the physician-patient relationship, sabotaging the X-factor so essential to healing, and disheartening physicians who entered medicine with the expectation of a satisfying profession dedicated to the long term care of their patients.

In spite of the problems in the health care system in the U.K., I think we in the U.S. can take some inspiration and lessons from the model of universal access, continuity of care and humanity of the patient-physician relationship more easily preserved through a national health/single payer system that removes several barriers to caring and healing.



Respondent Jonathan B. Weisbuch, MD, MPH



Jonathan B. Weisbuch, MD, MPH, FACPM

Adjunct Professor, Global Health and Biodesign Institute, Arizona State University

Jonathan Weisbuch received his medical degree from New York University, his Master's in Public Health from Harvard, and his Bachelor's of Science from the Massachusetts Institute of Technology. He is a Diplomat of the American Board and a Fellow in the American College of Preventive Medicine. Between 1989 and 2005, he was the director of Maricopa County Department of Public Health and chief county health officer. Prior to coming to Arizona, he had been the medical director in the Los Angeles County Department of Health Services, director of the Department of Health and Social Services of the State of Wyoming, and state health officer in North Dakota. Currently, Dr. Weisbuch is an adjunct professor at the Global Health and Biodesign Institute at ASU.

Dr. Weisbuch has had extensive experience as a health officer in environmental health, a health director in the corrections field and a health resource analyst. He has been the recipient of the Ben Freedman Award for Excellence in Public Health in 2003 and the Andrew Nichols Award for Public Health Service in 2002.



Thank you, Dr. Martinez- Brawley, for the opportunity to respond to Dr. Wynn-Jones and Dr. Bradshaw. Each has addressed significant facets of our troubled healthcare system. Dr. Wynn-Jones has shown how the British National Health Service can provide quality primary care, incorporating traditional medical values—the doctor-patient relationship, caring and curing, doing no harm—even though care is more managed, more technical, and more impersonal than in the past. He suggests that America can learn from the British experience, which has improved the health status of Britons under a single payer structure and, very importantly, preserve the valuable holistic perspectives that family doctors or GPs can provide.

Dr. Bradshaw expanded upon that theme, urging a return to "The Soul of Medicine," that trusting relationship between a patient and a physician whose professional commitment to alleviate pain, repair injury, rehabilitate disability, lessen fear, and treat illness is the central focus of the craft. Medical practice as a production line designed to reduce costs at all costs is anathema. Both speakers support human factors in practice that may not be in concert with the efficient economic management of resources. The "business of medicine" is caring for individuals, drawing upon family and community resources as a chief complaint becomes a diagnosis, and then a therapeutic drama engaging the patient, family, friends and community providers.



Dr. Wynn-Jones has emphasized what we all know: Our excessive costs, high technology and array of medical specialists have failed to achieve the national health status that every other advanced nation has reached at much lower cost. The decline in primary providers in America to 25 percent of graduates as compared to 35 to 40 percent in other Western nations further exacerbates higher costs, reducing prevention and public health.

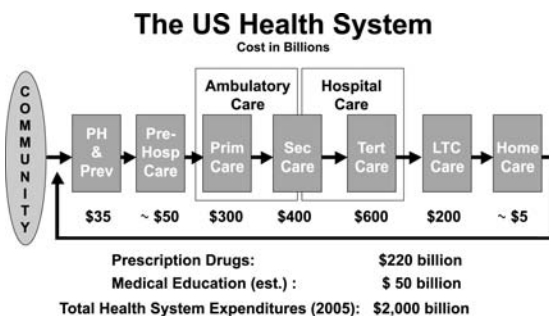
While alluded to, but not discussed in detail by either speaker, the decline in public health resource is ironic, since nearly all improvements in community health status (lowered infant and maternal mortality, longer life expectancy, improved food and drug safety, and declines in occupational and highway trauma, dental caries, heart disease, stroke, and now lung cancer) are due to public health interventions in the past century. And gaps in these data between America and other developed nations will continue unless major investments in public health and primary care occur.

To return to a compassionate system, the "soul of medicine," described by Drs. Wynn-Jones and Bradshaw, public policy must change. Our focus on cost containment in clinical practice must evolve toward a policy of reducing the total social cost of poor health by increasing access to care for everyone. We must also address eliminating the factors in the environment, our culture, and our biology that promote disease, disability and death. Raising the health status of the nation benefits everyone. But tweaking the current system to encourage "better consumer choices," tighter controls over medical practitioners, and the further expansion of private insurance benefits only a few. The



strategy I recommend would increase resources allocated to public health and create a single payer reimbursement system akin to those in Western Europe, Japan, or Canada.

Figure 1 depicts the costs and relationships associated with various elements in the US health care system. Public Health (PH) serves virtually everyone in the population. Pre-hospital care provides emergency transport about 15 million patient trips annually. Annually, one billion primary care visits generate another 300 million referrals to secondary care specialists. Secondary care, both ambulatory and in-patient, consumes 20 percent of medical resources; tertiary care another 30 percent. Long term care, nursing homes, and specialty hospitals (rehab, mental health, etc.) serve the critical needs of a relatively small number (2 to 3 percent of the population); home care and other community-based services constitute a small, but important, part of the system. Nearly 40 percent of costs occur in the hospital setting; 23 percent reimburse physician visits (primary and secondary care). In the United States, prescription drugs consume 11 percent of the total. In 2005, an estimated \$2 trillion was spent in the health system, 30 percent being administrative overhead. Increases in public health and prevention will reduce risk factors that promote disease. A shift from the employer-based, pluralistic clinical reimbursement system will reduce overhead expenses to the 5 percent consumed by Medicare (excluding Part D).



Strengthening public health and changing the reimbursement system for clinical care will improve health status and reduce costs, provided the plan includes several items:

- Funding must support public health infrastructure expansion, not just preparation for bioterrorism attacks.
- The system must assure access to clinical care for everyone irrespective of income, race, employment, or immigrant status.
- It must provide adequate reimbursement for primary providers, encouraging their increase through incentives.
- It must balance the economic value of specialty care against the necessity for primary care for everyone, a principle that may require increasing the fees for family physicians, internists and pediatricians, and diminishing reimbursement for super-specialists.
- And, last, hospital compensation must assure an adequate supply of beds, nursing coverage, a reduction in nosocomial and iatrogenic illness, technologic improvement and capital investment, while limiting non-clinical administrative overhead.

Radical change of this type may not occur at the federal level, but innovation among states is possible. Several bills pending in State Houses across the nation may initiate this trend. The California Kuehl Bill will grant everyone in California access to medical care, reimbursing all private sector costs through one public agency. In Arizona, a similar bill has been introduced. Vermont and New York are developing similar plans. When any of these bills become law, overhead in that state will decline, as will the cost of drugs. As primary care expands to serve everyone, excessive emergency room use for non-emergent problems will diminish and preventable problems will be identified and treated. Practitioners will no longer need to ask, "Who is your insurance provider?"

In summary, Dr. Wynn-Jones recommends that America examine delivery systems in the United Kingdom and in Europe, and incorporate into our managed health system the principles of expanded primary care, an enhanced family and community orientation, and a focus on preventing disease rather than high-tech treatment. Dr. Bradshaw urges the return to the art and science of medicine as a caring profession, not a business that buys and sells technical services. These recommendations will not be achieved, however, unless we expand our investment in the public's health, guarantee the right of health and health care for all, and reorganize reimbursement so that our pluralistic system with its complex administrative bureaucracy is eliminated.

Winston Churchill once quipped, "America always does the right thing, after it has tried everything else." Now is the time for us to do the right thing.