Is prevention unbalancing general practice?

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ABSTRACT

- Australia has begun to encourage and financially reward general practitioners for implementing preventive activities.
- While an expanding preventive agenda for general practice remains attractive, there is a real potential for opportunity costs, especially in the absence of realistic practice-based support for preventive care. These costs may include a shift from the needs of individual patients to those of the community.
- It is crucial not to neglect the concept of relationship-centred primary care (which may actually enhance preventive activities), as well as enhancing the preventive environment of the practice, when considering strategies to improve preventive uptake.

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Susan had been feeling strangely exhausted since turning 40. She hadn't been overly busy at work and, if anything, her three children had been less of a handful than usual. She decided after a month or so to visit Anne, her family's GP for over a decade.

Something about Susan worried Anne even before she found the tiny posterior triangle cervical lymph node. Further examination and routine blood test results were normal, but the node was unchanged at follow-up a couple of weeks later. Anne was vaguely surprised at how readily Susan agreed to a plan for a fine needle aspiration. As it turned out, the node was the only clinical sign of what turned out to be a stage-4 lymphoblastic lymphoma. Susan visited Anne regularly throughout her months of chemotherapy. They spoke of how the disease affected her children, the pressures on her marriage, and of her attempts to reconcile medical technology with her belief in natural therapies.

And that's what general practice is all about — stories, intuition, relationships, serendipity. When general practitioners get together in tea rooms, corridors or in the small hospitals of our nation, they tend to speak of their work, not in terms of tests, trials and outcomes, but in stories of their experiences with patients.[1] There is substantial evidence that the durable primary-care relationships valued by GPs[2] and patients[3] are important influences on health care outcomes.[4]

However, it seems that care characterised by enduring relationships has become increasingly peripheral to the current policy domain of Australian general practice. Joining an international trend,[5] Australia has begun to embrace a population health model for general practice. The Health Insurance Commission (HIC) now provides targeted payments for GPs to deliver and document the increasingly complex childhood vaccination schedule, as well as for specific preventive tasks associated with asthma, diabetes, cervical cancer and aged care.[6] Divisions of General Practice are also measured by preventive yardsticks. Recent draft outcome indicators for Divisions were strongly weighted towards prevention and the early, mainly expectant management of chronic disease.[7]

All of this implies that a preventive-minded (and financially aware) GP could also see Susan's presentation with tiredness as a great opportunity for prevention — the perfect time to double check lipid or blood sugar levels, offer a delayed Pap smear, advise about osteoporosis risk or review body mass index.

The preventive care agenda

Public health medicine has struggled for over a century to implement preventive activities into clinical practice.[8] Early concepts of opportunistic prevention within the general practice consultation[9] have evolved to a situation where GPs are encouraged to use clinical guidelines to promote healthy lifestyles and to detect the early signs of chronic disease in a patient group framed as a population at risk.

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Opportunistic prevention was first advocated at a time when few primary-care based interventions were likely to achieve positive outcomes.[10] The recent explosion of information in the prevention of chronic disease has produced a situation in which a typical family practice patient requires an average of 25 separate preventive interventions, the diligent completion of which has been estimated to take up to 7.4 hours of a full-time family doctor's working day.[11] Despite this, there has been widespread use of preventive targets as a proxy for quality primary care.[12] Ninety-seven per cent of the studies in a recent systematic review of quality in primary care evaluated either chronic disease management or prevention; only 2% examined management of acute illness.[13] Resulting perceptions of low-quality care have spurred numerous GP educational efforts — few of which have had even moderate success.[14]

The evidence suggests that the greatest barrier to optimal prevention in general practice is not lack of knowledge but the lack of a systematic and integrated approach.[15] It is no surprise that many of the studies supporting preventive initiatives originated in the tightly controlled world of British general practice. In the United Kingdom, patient registration, fully-funded practice nurses and integrated care[16] mean disease registers and recall systems are easier to implement. By contrast, Australia leaves its GPs to fend for themselves in trying to construct systems for dealing with the preventive load.

At a deeper level, a preventive agenda implies an evolution from a viewpoint of medicine oriented towards individuality and autonomy to one oriented towards the needs of the community.[17] This has its own problems, with even the British Medical Association questioning the ethics of offering financial inducements to GPs to encourage patient participation in preventive activities for which the benefits are at a population level rather than an individual level.[18]

Regaining the balance

While I doubt we will ever see a debate on the ethical framework of the Australian health care system, there may be a couple of preventive debates worth having.

The first would be whether we should replace the HIC's complex system of preventive rewards with broader strategies to strengthen the *environment* for preventive care. As with mammography and Pap smears, community-based registers for priority diseases could make patient recall less reliant on the fragile enthusiasm of individual general practices. At the practice level, I doubt that prevention (or general practice) would be harmed by realistic support for longer consultations, quality information technology and an expansion of fledgling initiatives to make practice-based nursing a reality. More controversially, with nobody predicting early solutions to our workforce problems, has the time arrived for us to begin to delegate some of the preventive agenda to pharmacists, nurse practitioners and others?

The second debate could address the fundamental aims of clinical practice. Should generalists focus primarily on the needs of the patient sitting before them, or on the needs of the community? Could there be an opportunity cost if GPs become even more directed towards preventing future disease? One could reflect on situations like Susan's and speculate as to whether a preoccupation with an expansive preventive agenda could just have been enough to distract Anne from seeking the core reason for Susan's visit. It may be an even more critical issue at times where communication is difficult for reasons of language, culture or just lack of time.

Part of the answer to questions surrounding the balance between the needs of the individual and the needs of the community may lie in the complexities of the patient–doctor relationship. Ironically, several studies have found that preventive activities increase with increasing continuity of primary care.[19] Such a realisation has encouraged the intensely mechanistic US health care system to acknowledge that a sustained personal relationship between patient and clinician should be a cornerstone of health care reform.[20] Could such a realisation in Australia improve the delivery of preventive care with less red tape, additional downstream benefits and greater relevance to the world of general practice?

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Competing interests

None identified.

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