

Making primary care people-centred: a 21st century blueprint

Not since the Alma-Ata definition of primary care in 1978 has there been so much soul searching on how best to provide a first-contact system that is fair, equitable, accessible, cost effective, sustainable, and above all improves the health and wellbeing of the population it serves. Part of this renewed attention on primary care is the widespread feeling, in high-income countries in particular, that there is an impending crisis with not enough general practitioners, an increasingly unsustainable workload, underfunding by governments, fragmentation between primary and secondary or tertiary services, and a changing burden of disease and risk factor profile in populations. So, how should a primary care system operate in the 21st century?

In their final opinion, published on July 15, an independent expert panel set up by the European Commission argued strongly for a primary-care system that is “universally accessible, integrated, person-centred, comprehensive...and provided by a team of professionals accountable for addressing a large majority of personal health needs”. The panel stresses that primary care needs to continuously evolve. It examines the role of primary care in coordination of care, the question of accessibility versus continuity of care, the collaborative nature of primary care and implications for workforce development, and its function as a referrer or gatekeeper.

Coordination clearly is a key function, and one that is likely to become more complex as populations get older and have an increasing number of comorbidities. Yet, without an electronic patient record system that provides readily accessible information about patients' history, treatment, and care plans, coordination remains administratively cumbersome and inefficient. On the need for continuity of care the panel acknowledges that it might be important for some people at a certain time in their lives, but is not always paramount for everyone. Rapid and easy access might be more important for many people. However, a continuum of health records is extremely important. For rapid access, new models, such as online, email, and phone access or consultations should be explored and expanded. Electronic transmission of test results and electronic health monitoring could work in certain circumstances. Access to health advice and services needs to be offered beyond weekdays and normal working hours.

The collaborative way of working in primary care is to be encouraged. The time of the lone general practitioner is over and outdated. The current primary-care system in England is a long way away from such collaboration. In a somewhat plaintive report *We are Primary Care*, Pharmacy Voice, the body that represents community pharmacies, has argued that pharmacists are in an excellent position and should be used more to provide advice for many long-term conditions and minor ailments, and could help relieve the strain on general practice in a patient-friendly way with easy access. If anything, collaboration should be expanded beyond an obvious and much needed collaboration between general practitioners, nurses, dentists, pharmacists, psychologists, occupational therapists, optometrists, and social workers.

The boundaries between primary and secondary care need to be rethought. Specialists working in hospitals should provide advice, teaching, and specialised patient care within the primary-care setting, to the benefit of patients who will not have to wait for, and travel to, oversubscribed hospital outpatient appointments. For children and the elderly, it would be excellent if all primary care centres had paediatricians and geriatricians to deliver appropriate care. Hospital-based clinics should be reserved for those with rare and complex diseases that need special expertise and equipment for management and diagnosis.

Primary care's function as a gatekeeper to more specialised care is dependent on a division between care levels. If there were closer collaboration between primary and secondary care, physically and through management and financing structures, with the patient as the central and most important focus, cost-saving attempts through delayed referrals might become an anachronism of the past. The divisions as they currently exist, in England in particular, are highlighted by the ill-conceived discussions on whether there is enough money for general practice and whether general practitioners should be working in accident and emergency departments to relieve the strain. The Royal College of General Practitioners should look hard and critically at its own role in perpetuating a trench war of specialties. Primary care needs to be reshaped to truly function as the most important pillar for people-centred health and wellbeing in the 21st century. Primary care leadership needs to wake up and start a revolution. ■ *The Lancet*



See *World Report* page 295

For more on the **European Commission independent expert group opinion** see http://ec.europa.eu/health/expert_panel/opinions/docs/004_definitionprimary-care_en.pdf

For the **We are primary care report** see <http://www.nhsalliance.org/wp-content/uploads/2014/07/We-Are-Primary-Care-FINAL-14-07-14.pdf>