

## Workforce substitution and primary care

David P Weller

*We must preserve the elements of our health care system that work well*

All the signals in health care in the Western world point towards increasing demand and limitations on supply — a development driven by ageing populations, ever-increasing and sophisticated technologies and treatments, and a workforce that is less inclined to work the long hours of years gone by. There have been calls from governments for more flexibility in health care delivery. In the case of primary care, the arguments for substituting “traditional” general practitioner roles seem compelling — primary care in the United Kingdom and Australia is struggling to provide adequate access to care for a population with increasing needs. Surely we must expand our workforce to meet this need — especially if this can be achieved by employing less expensive health care providers?

In this issue of the Journal, Sibbald and colleagues (*page 10*) review the current status of workforce substitution between nurses and GPs.<sup>1</sup> They point to the variety of roles that nurses have adopted in primary care settings: there seems compelling evidence that nurses can, with a great deal of autonomy, effectively deliver routine management of chronic conditions, such as asthma, diabetes and coronary heart disease. Indeed, further roles for nurses, such as cognitive behavioural therapy for psychological problems, are continually being explored.<sup>2</sup> The new contract between GPs and the UK National Health Service (NHS), while rewarding GPs for meeting quality targets, underpins nurse-led management with specific chronic disease targets and a strong focus on clinical audit.<sup>3</sup> There seems no doubt that nurses can take the lead on these processes effectively and produce favourable clinical outcomes — acknowledging that successful GP–nurse work substitution is, indeed, context dependent, and accepting that issues such as continuity of care, legal liability and practicalities of prescribing are paramount.<sup>1</sup>

Also in this issue, Parle et al (*page 13*) discuss the development of a “medical care practitioner” curriculum in the West Midlands<sup>4</sup> — there is considerable interest in bringing this North American model to the UK. On the whole, the pilot study by investigators at the University of Birmingham of the impact of US-trained “physician assistants” on the NHS indicated that introducing this new kind of health care provider into primary care can ease demand.<sup>4,5</sup> Further, they have generally been met with positive responses from both their practice colleagues and patients. However, can we assume that because primary care capacity is insufficient there is an “overwhelming need for a mid level clinician working under the supervision of a qualified doctor”?<sup>3</sup>

The need for extra capacity is being met in part by new doctors. In common with Australia, the UK has chosen to increase student numbers to meet projected future requirements,<sup>6</sup> and to reduce to a large extent the dependence on international medical graduates to fill both training scheme places and service posts. The number of places at UK medical schools increased by almost 60% between 1998 (when there were about 3750 places) and 2005, as a result of introducing new 4-year graduate entry programs, establishing four new medical schools, and adding places to existing schools. These new

doctors are yet to have an impact on the workforce, but this greater capacity must inevitably influence access.

A legitimate role for medical care practitioners seems apparent in secondary care settings, where the arguments of fluctuating skills of junior doctors and trends towards increased specialisation have more salience. In primary care it's more complex: in Australia and the UK, primary care has been much more central to health service provision than in North America, and we know that a strong primary care focus within health systems can produce favourable health outcomes.<sup>7</sup> The US physician assistants (the equivalent of medical care practitioners) have had a significant effect on primary care services,<sup>8</sup> but it's a different environment to ours. While there is something to be said for a mixed economy of approaches to workforce in primary care, there are inherent dangers in drifting towards a system in which primary care is seen as a “second tier” in the health service. A great deal of effort has been invested in trying to promote integration between primary and secondary care, and there are many efficiencies and health gains that can be achieved in doing so. A growing gap between primary and secondary care, in which the two workforces develop fundamental structural differences, can only inhibit this process.<sup>9</sup>

Hence, we need to approach with caution any new innovation that potentially marginalises primary care. While investigating the potential of new layers of health professionals, primary care needs to diversify to meet changing needs. A great deal of diversification is already underway, much of it aimed at improving access, albeit with its own “health warnings”. For example, the development of “GPs with special interests” can improve access to much-needed specialist services. However, it needs to happen in a way that preserves continuity, and the universal, comprehensive nature of primary care.<sup>10</sup> Similarly, in Australia, the development of primary care clinics for skin cancer, women's health and travel medicine has both benefits for access and threats — some argue it undermines the fundamental principles of general practice.<sup>11</sup>

Developments in informatics and e-health hold further potential for improving access. Increasingly, we are looking at different models of consultation — email and telephone consulting, and greater, quality-assured use of the web hold great promise.<sup>12</sup> The UK government's recent White Paper, *Our health, our care, our say: a new direction for community services*, while provoking some controversy, has highlighted the importance government places on access to primary care, and points the way towards redesign of referral and treatment pathways, and better use of information technology — diversification of providers is highlighted as one of several options (Box).<sup>13</sup>

There is a need to keep an open mind about diversification and workforce substitution. While examining the potential of new kinds of health care providers, we should exercise caution before committing significant resources, and ensure we preserve the elements of our health care systems that work well. In the case of primary care, many innovations, which may have equal potential

**UK government White Paper, *Our health, our care, our say: a new direction for community services*<sup>13</sup> — key features**

- There is a strong focus on patient involvement in planning and decision making
- There is an emphasis on partnerships; for example, between health services and local authorities
- Care is to be moved out of hospitals and “nearer to patients’ homes”
- Encouragement is given to new entrants, including the private sector, as primary care providers ◆

to improve access, are already underway (so we shouldn’t “throw out the baby with the bath water”!). So far, the detailed studies comparing these different approaches to improving access are still to be done.

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