

The Vital Link: generalist clinical discipline in a world of health care markets and strategic planning* – Prof Nigel C H Stott



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Curriculum Vitae

Following a three year period at Cape Town University, Prof Stott transferred to Edinburgh University where he obtained the BSc and MBChB degrees, as well as the FRCP (Edinburgh) and the FRCGP. His internship was done at King Edward VIII Hospital (Durban) and he also spent a period at St Lucy's Hospital in the Transkei. Prof Stott has been in Cardiff since 1973: a lecturer in General Practice, then in private practice and since 1986 as Professor of General Practice. He has read papers at numerous conferences, published extensively and held major research grants in the fields of health promotion, respiratory disease, chronic disease care systems in family medicine and cervical cytology screening. He was instrumental in the establishment of a Palliative Care Unit in Cardiff, a rural Primary Care development project for the Welsh Mining Valleys and active planning towards a post graduate Masters Degree in Family Medicine. He has also been instrumental in developing a framework for primary health care which is used in many teaching and other practices internationally.

Summary

Most countries have no clear, strategic vision of their health services despite the massive budget involved; only poorly controlled and unplanned growth. In Wales for the first time an attempt is being made to tackle the problem of strategic planning. They identified priorities and spelled out what they want to achieve for the people of Wales in health terms. This has become a field trial on a national scale to change the face of health service by using explicit strategic planning methods motivated by managers. This has to be implemented in a flexible way into the practical world of clinicians and patient needs. They are using the concept of "overall-health-gained" to aim at adding years to life and life to years. As a vital link and gatekeeper, the GP also needs to be involved in strategic planning where he can guide decisions into the direction where they will deliver people-centred health gain. He can be the advocate and helper for the patient who is lost in a maze of specialities and all kinds of health therapies offering themselves to the patient. Translating these underlying methods and principles of the Welsh trial into a less developed South Africa, promises far more, far quicker and far more dramatic gains than the equivalent in Europe.

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Introduction

In a mechanical chain every link is vital because it is a linear system. The situation in ecology is different because, although all parts of an ecosystem are inter-related and inter-dependent, a sudden discontinuity/change at one level does not usually lead to a collapse of the whole system. Instead, compensatory changes tend to occur at other levels in the system to localise or reduce the overall effects of change. This process depends on the presence of a hierarchy of inter-dependent and inter-related structures which link in a complex, non-linear way to provide a network of support and homeostatic control. Every cell, organ or whole body has well regulated relationships with the other parts of the total system. A change in one area always causes other areas of the system to change. Overgrowth or over dominance in one part due to breakdown in local homeostatic controls, can often be tolerated to a limited extent, but eventually a major crisis will occur when the imbalance can no longer be compensated for by the rest of the system. Cancer is the obvious medical example, but environmental or social issues can be studied in the same way. General Systems Theory is often used to explain the properties of such systems¹.

The growth of health care systems has been jokingly compared with a breakdown of homeostatic mechanisms in society because such a proliferation of health professionals has occurred internationally. The exponential growth has not always been in response to population health needs because local power struggles and ambitions have sometimes operated in a market place atmosphere. In UK, for example, the

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National Health Service is the biggest single employer in the country and yet the British spend nearly 80% less per capita on health care than the Americans or Germans where free enterprise has dominated health care to a greater extent.

Despite this massive expenditure, most countries have no clear strategic vision for their health services which have grown 'like Topsy' and begin to consume ever increasing numbers of

The GP can only be the Vital Link if he adopts a consistently, disciplined approach to every consultation

staff, technology and energy. It is a scenario of poorly controlled growth which is aided by an increasingly fearful public who are educated by the media and the school of life, to be aware of an infinite number of hazards to health, despite falling infant mortality and rising longevity. Abstract 'risk awareness' causes fear which fuels health service demands and expectations. Indeed, the concept of epidemic distress has begun to replace the infectious epidemics of yester-year² yet our understanding of why people seek so much help from professionals is still quite primitive.

The Health Service in Wales is no exception. Cardiologists, paediatricians, thoracic surgeons, oncologists, public health doctors and others have fought for a bigger slice of the cake. General practice has less than 20% of the total budget yet delivers 90% of the health care and 99% of prevention. Yet the proportion spent in the community

sector is growing progressively smaller despite the aging population with its dominance of chronic disorder and disability.

The incremental growth of our health service only bears a partial relationship to the more obvious needs of the population. In this paper I describe an attempt in Wales to tackle the problem of *Strategic Planning* for the NHS so priorities can be identified and considered against a background of informed choice.

It is the principles underlying Strategic Planning that are important rather than the detailed data. The framework presented is not unique but the method has been little applied to health services and even less used by doctors and nurses themselves. The gains to be achieved in the less developed world using similar

Never before has the patient been in such a need of an advocate and helper in the maze of specialities and therapies offered to him

methods would be far quicker and more dramatic than the equivalent gains in Europe. However I will use illustrative data from Europe because this is the material that is familiar in our current exercise.

Strategic Planning and the Welsh Health Planning Forum^{2,3}

For the first time in the history of the NHS a group of individuals,

appointed by the Secretary of State, have spelled out what we want to achieve *in health terms* for the people of Wales as we move into the 21st century. The NHS in Wales is expected to be in the forefront of the drive for better health in Wales.

"Working with others, the NHS should aim to take the people of Wales into the 21st century with a level of health on course to compare with the best in Europe."

This Strategic intent can only be achieved if there is an equally clear

Add years to life, and life to years (John F Kennedy)

statement of strategic direction and the Planning Forum has pointed out that in order to make the Strategic Intent a reality there must be advances in three directions simultaneously.

The Strategic Direction must be:

- i. *Health Gain Focused:* The NHS in Wales seeks to add years to life through a reduction in premature deaths, and life to years through improvement in the well-being of both patients and the population at large.
- ii. *People Centred:* The NHS in Wales should value people as individuals and manage its services to this end.
- iii. *Resource Effective:* The NHS in Wales should strive to achieve the most cost effective balance in its use of available resources.

RIGHT NOW, FALLING ILL WOULD BE A COMPLETE DISASTER

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These strategic principles challenge clinicians and managers to review their services because every organisation needs a strategy to map out the path ahead and how to commit resources to the direction set.

The small private sector of medicine in UK will continue to provide the care it finds commercially attractive, but all health authorities and family practitioner services are expected to adopt the Strategic Intent and Direction for Wales. The channelling of resources to Health Authorities will eventually be linked to these broad principles of strategic direction.

The Priorities

The next stage in the work of the Planning Forum has been to establish priority areas for the health gain dimension because, without health gain, the other two components of the strategy would be comfortable but less relevant.

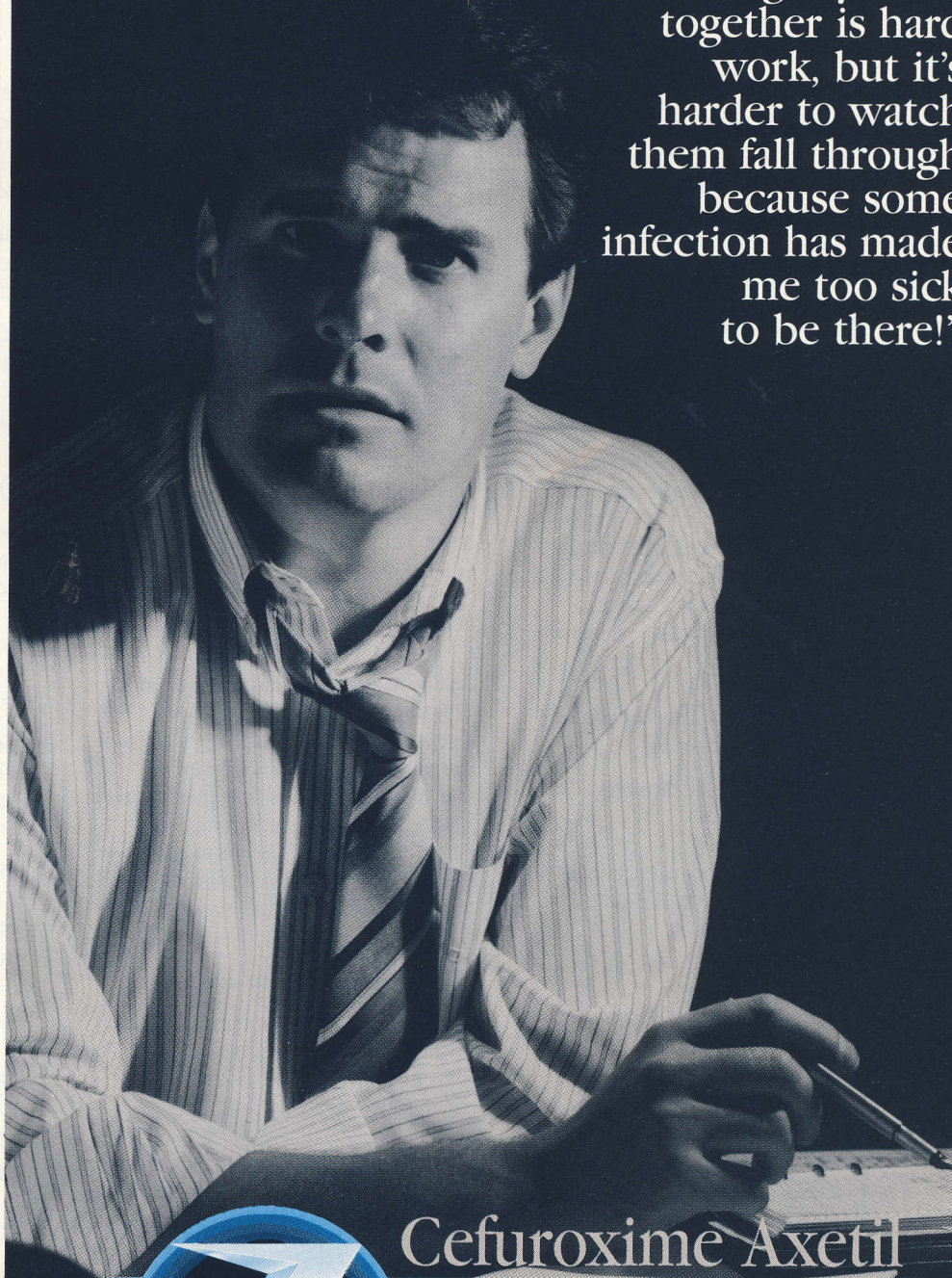
The health gain concept of adding years to life and life to years is a phrase attributed to the late John F Kennedy. It rolls off the tongue easily but contains two important ideas:

- reducing premature deaths from birth onwards;
- an improved quality of life for those who are patients as well as the population at large.

The relative balance of these two notions does of course change as people advance through life, but death rates are a poor proxy measure of both.

With infant mortality at less than 10 per 1 000 live births, Wales lies fourteenth out of eighteen in the

"Putting my deals together is hard work, but it's harder to watch them fall through because some infection has made me too sick to be there!"



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European league (best is Finland with an IMR = 6,5; worst is Portugal with an IMR of 14,2). Survivors' life expectancy is quite good. The average Welsh man lives 71,4 years and woman 77,3 years both lying at mid point in the European league table (70 - 73 years for men, and 71 - 80 for women).

Heart disease is the number-one killer of adults in Wales where there are between 500 and 600 deaths per 100 000 per year. Wales is nearly worst in the European league.

The Planning Forum has identified ten priority areas because they make a significant impact on years of potential life lost, quality of life lost or NHS cost.

The ten priority areas arising from the strategic direction are:

- Maternal and child health
- Mental handicap
- Injuries
- Emotional health and relationships
- Mental distress and illness
- Respiratory disease
- Cardiovascular disease
- Cancers
- Physical disability and discomfort
- Healthy environments.

General Practice in UK has less than 20% of the total health budget, yet delivers 90% of the health care and 99% of prevention

Each of these is to be the subject of an expert appraisal document. The appraisal document will then be studied by a multi-disciplinary panel

of practicing Welsh health professionals and lay people to establish the priorities for action and ways to recruit fellow health professionals to support the inevitable targeting of resources that will follow.

The list is extensive and all aspects of each area cannot be tackled at once, but content analysis of each leads to a substantial narrowing of priorities

The era of the Health Fayre and Health Care supermarket is upon us!

and a balance between diagnosis, treatment, rehabilitation and prevention. The Planning Forum arrived at the priority areas by studying the available evidence and then producing an aim and justifications for each aim. For example in cardiovascular disease and injuries the following were produced:

i.) *Cardiovascular diseases*

Aim: To reduce the incidence and impact of cardiovascular diseases by decreasing disease, disability and premature death.

Justification: Cardiovascular diseases account for half the deaths in Wales.

Premature deaths in Wales due to cardiovascular diseases are amongst the highest in the world.

The prevalence of disability post heart attack, angina etc is very high in later life.

Cardiovascular disease accounts for 41% of the lost years of potential life for men and 39% of women. This is

even higher for those aged 45 - 64 years.

Rehabilitation post-heart attack is poorly developed in Wales.

There is reasonable expectation that prevention and treatment could reduce deaths by a third.

Cardiovascular disease is a major reason for GP consultation and accounts for nearly 25% of the drug bill.

ii.) *Injuries*

Aim: To reduce premature death and disability from accidents, poisoning and other injuries.

Justification: Injuries account for 5% of the lost years of potential life for males and 2% for females.

For those aged 15 - 29 years deaths due to injuries account for 31% of the lost years of potential life - 40% for males and 14% for females.

There is considerable scope for gain in the area of road and domestic accidents, particularly among lower socio-economic groups.

Increased public awareness does not reduce demands on health services; expectations tend to rise!

This area has a large impact on hospital use, GP and ambulance services. Under the age of 4 years 25% of children suffer significant injury⁴.

Each of the ten areas is subjected to an appraisal by an external expert and

THIS WINTER, I REALLY DON'T WANT TO SPEND HALF MY TIME IN BED

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then a report sent to a multi-disciplinary panel of Welsh health professionals and lay representatives for detailed analysis and priority ordering before coming back to the Forum.

Health Gain is the dominant theme in the strategic planning process but it is supported by two other major emphases: 'a people centre service' and a 'resource effective service'.

A People Centred Service

A people centred service responds sensitively to peoples' needs and maintains autonomy and dignity. It is a service which is available to all because it is concerned with health promotion and prevention as well as caring/curative functions.

The Forum has identified a number of priority areas for achieving such a service:

- Participation in planning
- Quality service delivery
- Appropriate facilities
- Responsive staff
- Informed choice

Each priority area has been analysed into aims and justifications as demonstrated for health gain. For example in quality service delivery and responsive staff the following were decided:

i.) *Quality Service Delivery*

Aim: To provide the right type of service, by the right provider at the right time and place.

Justification: Services should be:

Appropriate: for the particular condition and person ranging from encouraging self-help to

"At my age, infection can really take its toll. But this year it won't stop me seeing my grand-children!"



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supplying treatment and rehabilitation.

Available: with a balance between prevention and treatment services.

Accessible: as close to a person's home or work as is reasonable for their condition, and at convenient times.

Timely: provided within an appropriate time scale.

Co-ordinated: a managed package of care involving all the relevant agencies.

Informative: providing adequate information about health conditions.

Those who work in primary health care will recognise how closely these justifications fit with the widely accepted characteristics of our discipline. Indeed, one of the interesting aspects of the Forum's work has been the way the principles of Alma Ata have become incorporated into a strategic statement for the health service as a whole.

Do we understand the help-seeking patterns of our patients?

ii.) *Responsive Staff*

Aim: To ensure that all health care staff are committed to meeting social, physical and emotional needs of clients and patients.

Justification: High quality care depends upon all staff being aware of the individual needs of patients.

When these are taken into account the healing process can be improved. Such emphasis is likely to result in people being:

engaged more actively in health promotion;

feeling encouraged to become more involved in their treatment;

having an enhanced sense of dignity and self worth;

having an increased willingness to participate in the affairs of the Health Service.

Never before have GPs had such an opportunity to show how health care can be delivered by the primary sector

Those who have struggled to improve health services will recognise the ethical, practical and economic importance of a health service administration signing up to such primary principles. However, there are in these assertions a number of assumptions about how logically people approach health and illness in themselves. Much research in health education/promotion has been based on the assumption that human beings are basically rational, and, if given sensible information about the desirability of change, will follow it. Evidence from Cardiff⁵, USA⁶ and elsewhere shows that neither experience, nor history of experiment supports those premises. Each person functions within a set of contextual constraints and values which will often over-rule otherwise logical health-related decisions. For example, a mother is likely to value peace and harmony far more than running

battles with her husband or children over chips in their diet. Indeed the short-term pleasures of high-risk living also may outweigh any consideration of longevity or a healthy old-age, particularly in the young whose need to be different and zest for excitement and new experience is often highly risky; for example, 6 in every 1 000 young adults in UK will die from accidents but 250 per 1 000 will die from smoking related diseases.

'Person-centredness' may therefore, conflict with the aims of health gain in some sectors of society, so health services will always be needed to mop-up the tragic results of people's autonomy. The ethics of health care must of necessity, reflect a non-judgemental, unconditional acceptance of the people's right to damage or destroy themselves.

Effective Use of Resources

This third strategic theme reflects how our Health service is being driven in the 1990s following major legislative changes. In this brave new world Health Authorities and budget holding general practitioners will become purchasers of services for patients. The providers of those services will only win contracts if

Empower people to feel free of clinical supervision

their standards are good. This new "internal market" is viewed as a prerequisite to the natural weeding out of the less efficient hospitals or practices or services.

WHAT WOULD MY PATIENTS THINK IF I WAS ILL FOR WEEKS?

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Six priority areas were identified as a focus for achieving improvements in the effective use of resources:

- Balance of appropriate responses.
- Balance of appropriate providers.
- Motivation of staff.
- Managing of client contact.
- Quality service.
- Information management.

Two illustrative examples will reveal the general thrust of this approach:

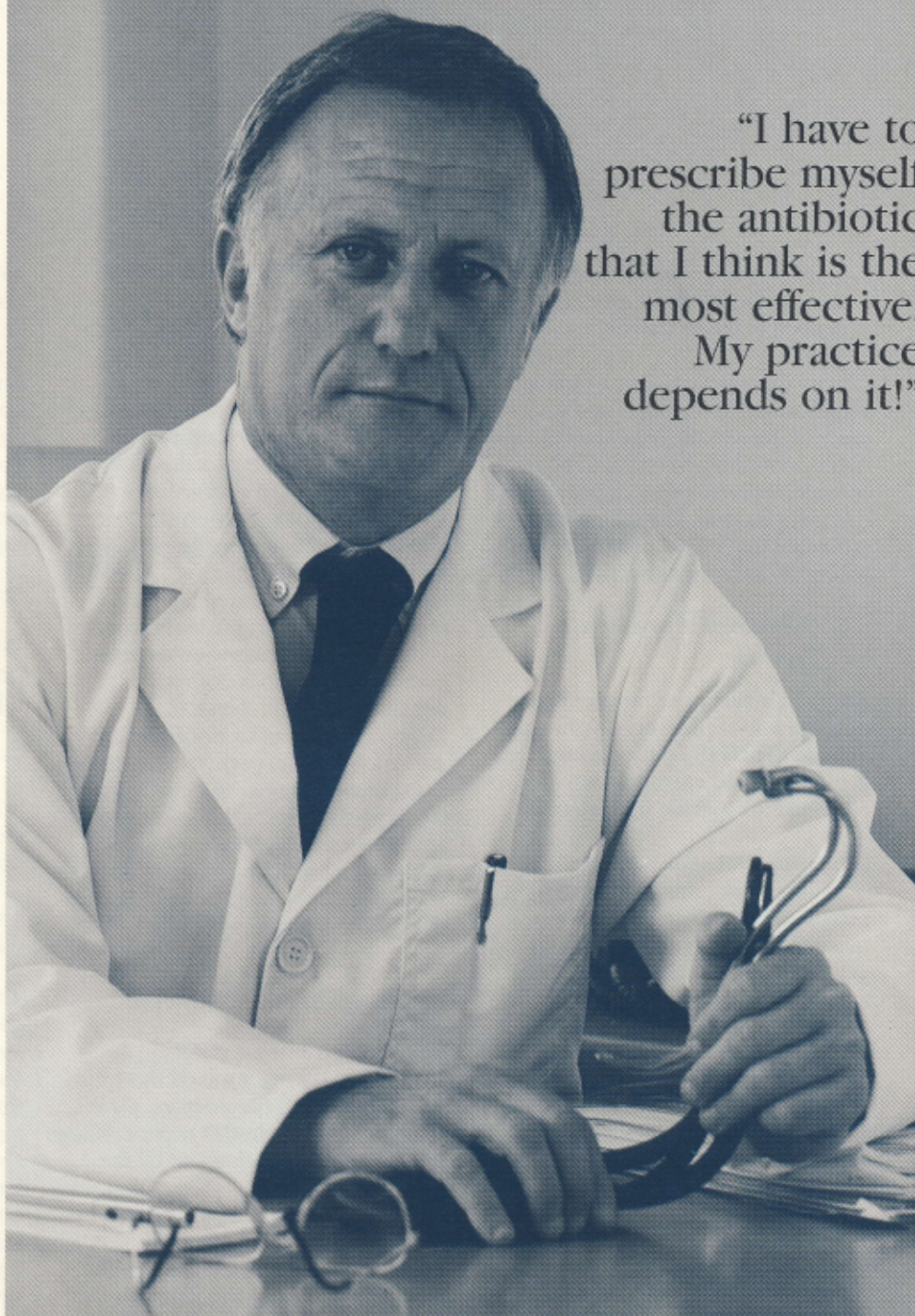
i.) *Balance of Appropriate responses*

Aim: To secure the most effective response, blending prevention and promotion, diagnosis and assessment, treatment and care, and rehabilitation and monitoring - for each health gain area, and to review the balance regularly.

Justification: To date, decision making in the Health Service has tended to focus on choices between provision rather than response options. Achieving the scale of health gain required by the Strategic Intent demands a better understanding of the cost-effectiveness of different types of response and intervention, for example:

- the proportion of day and minimally invasive surgery could be increased significantly;
- expensive acute beds are often occupied by non-acute patients;
- rehabilitation and discharge care require further development;
- greater emphasis could be given to preventive and promotive activities, yielding substantial health gains in the medium to long term;

"I have to prescribe myself the antibiotic that I think is the most effective. My practice depends on it!"



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more people could be treated outside DGHs through changes to general practice activity.

Clearly this emphasis has a profound significance for hospitals and general practitioners because the shift of work to the community sector will be considerable and many clinical sacred cows will be slain. For example, it is estimated that 60% of all cold surgery will be on a day-basis by 2000.

ii.) *Balance of Appropriate Providers*

Aim: To achieve the most effective mix and use of providers within and outside the NHS by procuring, supporting and encouraging responses to specific health needs.

Justification: to date, services have been largely determined by existing provision, and often shaped by inherited facilities and an established pattern of specialities. The central and continuing contribution of the National Health Service could be

People themselves should adopt satisfied responsibility for their own health and the health of their environment

enhanced by drawing upon a wide range of possible providers. This could be achieved by:

- stimulating and supporting the involvement of patients, families and communities in developing partnerships for care;

- building on the existing network of voluntary and patient support groups;

using non-NHS providers when they are better placed geographically and technically to meet service demands.

The pluralistic health care provision implied in this statement unlocks many old restrictive practices. Indeed the undoing of laws regarding advertising in medicine in the UK is also likely to have a profound impact on the pattern of provision. The shift to self-care is controversial but topical because our evidence to date is that increased public awareness of complex issues does not reduce demands on health services. Expectations tend to rise in better informed people, particularly when they are encouraged to be consumers rather than patients. Furthermore, an ageing society can be very expensive: it has been estimated that 50% of the NHS budget is spent on people who will be dead within 6 months!

Implications for Clinician

The Welsh Strategic planning initiative is having a mixed reception among rank-and-file doctors, nurses and others in the health service. Many are still somewhat shocked by the extraordinary New Contract that was imposed on general practitioners by the Government on 1st April 1990/91⁷. This has left them with little time to digest the Planning Forum's early documents and few have grasped the wider significance of the strategic planning process because they are too busy devising ways to cope with the new bureaucracy.

In the international scene the WHPF work is important because it is a field trial on a national scale to change the face of a health service by use of explicit strategic planning methods,

motivated by managers more than clinicians.

The theory is appealing and logical. The steps towards achieving statements of strategic intent, direction and priorities have also been taken. The next sensitive and important stage is to create implementation plans which will marry the top-down strategic

Health is not a matter of perfection: it is to do with wholeness

'concepts' to the practical world of clinicians in the field without destroying local flexibility.

The vital link between strategic planning and relevant developments in community care remains unproven. The greatest danger is that resource allocation which is directed at strategic priorities may lead to a focussed service which then cuts through the principles of integrated generalist care and fragments it into specialised components. This is already happening in some sectors eg obstetrics and mental health and it may proliferate if managers fail to understand the dynamics of primary health care.

We now have good evidence that human behaviour and choices are not necessarily rational and consistent with a thoughtful weighing up of available evidence. Even in highly intelligent circles there is much evidence that human decisions are often the product of a mix of emotion, habit, impulse, bloody mindedness and lack of forethought which is so characteristically human⁶.

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No branch of the medical profession is more aware of the ambiguities of human nature than GPs. In the front-lines of care we are a paradoxical group, trained in reductionist methodology but immersed in highly unpredictable human behaviour. A pragmatism and benign acceptance of human failings is essential for anyone who wishes to spend more than a year-or-two in these front lines of medicine.

What is the vital link?

The general practitioner still views him/herself as the vital link in the Health Service in UK because the referral process ensures that specialists see few patients except through general practitioner referral. Moreover in the future specialists will lose their contractual security with the NHS and depend even more on private practice and NHS budget-holding GPs for their survival. The professions allied to medicine do not have the same constraints.

The Planning Forum's priority areas will place heavy pressure on every general practitioner, community nurse or health care worker because for the first time every decision will begin to be judged for its potential health gain, people centredness and resource effectiveness. The bottom line will be resource allocation to priority areas with the decisions being based on the strategic plans. Clinicians need to develop clinically meaningful audits which match the strategy and link its directions to the way we can plan integrated patient care.

An Example

Clinicians tend to work from the patient outwards rather than from an

abstract strategy inwards. A patient who dies with cardiovascular disease is an illustrative starting point, using the technique for critical event analysis:

Mr G a 56 year old male plasterer happily married with wife and 3 children:

1985-6: 9 consultations for retrosternal burning pain partly relieved by antacids. Made worse by stress/exertion. Normal ECG, Barium meal and Chest X-ray. BP 140/90. Smokes 20.

1986-9: No consultations.

1990: One consultation for abdominal pain (surgeon seen).

Sudden death 3 months later. Atherosclerosis at post mortem. Wife reports he had 2 years of unreported dyspnoea on exertion and very high levels of anxiety over financial issues.

Disease is not The Enemy which can be pushed back to unrealistic levels – it is part of life!

The critical events appear to lie in the 11 consultations in three and a half years including one with a specialist. This is a high help-seeking rate for a 56 year old man. What could have made a difference?

- i. an explicit record of attempts to help with smoking/diet is associated with greater success⁸;
- ii. his lipids and exercise ECG were never checked;
- iii. the single pre-morbid

consultation after a 2-year absence was episodic and focussed on his abdominal pain rather than his continuing problems or risk factors;

- iv. a patient who accepted moderate dyspnoea on exertion as a 'fact of life' for over 2 years before his demise (= expectations).

The general practitioner appears to have failed to be comprehensive in acute care, continuing care, health promotion and his understanding of help seeking behaviour². Some of the omissions may have been due to pressure of time, some were probably due to poor resourcing of cardiology services, and some were attributable to the patient's apparent lack of motivation to modify his lifestyle and seek help for persisting symptoms. The summation of events illustrates how the clinician can try to tackle the strategic priority for 600 per 100 000 cardiovascular deaths pa at grass-roots level by analysing each individual tragedy and asking searching questions of self and others. This event left a young widow with huge debts, a distraught family and social dependency due to premature loss of a bread winner.

We know that Mr C was treated in a person centred way with dignity and gentleness by kind and responsive staff because his wife expressed her appreciation for the care given. Yet his potential health gain was never achieved for other reasons, some personal and some professional. The scenario does not reflect an efficient use of resources.

If the GP is to be the vital link then s/he will have to adopt a consistently disciplined approach to every consultation. A discipline which reveals a more predictable integration

... the Vital Link

of physical and psycho-social elements with continuing care, prevention and an understanding of help seeking patterns. S/he will have to be vigorously self-critical without being self-destructive so the pursuit of excellence within areas of relevance to national priorities can be achieved by the doctor and the staff.

Outside an area of strategic priority the clinicians' task will become more difficult because resources will be withdrawn from one sector to give priority to another. Managers of the health service may, for example, decide that the resources for surgical removal of gastric malignancy or resection for small cell carcinoma of lung do not achieve sufficient health gain to justify the expenditure. All such surgery would then be conducted on a research basis only and the strategy would be interfering directly in clinical decision making.

The general practitioner is unlikely to use expensive investigations if patient management is not going to be modified by them. For example, a 65 year old man with dyspepsia will not necessarily have an endoscopy to diagnose his malignant gastric ulcer if it will be managed symptomatically in a health service which refuses to pay for surgery due to lack of evidence for health gain (*hypothetical example*).

As 'gate keepers' to the health care system in the UK general practitioners have also found that the 'gates' are becoming besieged by other professionals who claim to be better skilled at assessing or educating or treating or empowering the public. Psychologists, nurses, social workers, counsellors, physiotherapists and others are establishing their professional

autonomy and independence. As the burden of front line care increases the general practitioner may well be content to collude with those who say:

"The physician is not the vital link. S/he is one link in a multidimensional health care system."

A pluralistic multi-disciplinary health service in which each professional works alongside other professionals and in which medical dominance is reduced has great attractions to the professions allied to medicine. Government perceive this as a cheaper option than medical

Why do well-informed people still seek so much help from professionals?

dominance and strategic planners are as reductionist in their thinking as most specialists. What they have forgotten is the gate-keeper role and its relevance to cost containment.

The challenge to the generalist is whether s/he can sell skills to the public who expect to get what they want (= consumer). The era of the Health Fayre and Health Care Supermarket is upon us where the consumers (patients) can choose their therapist or adviser and trade one off against the other.

The marketing of health and disease through the media represents a new dimension in the orientation of public attitudes. It is also associated with rising distress levels as revealed in:

suicide rates;
divorce rates;
infidelity in up to 60% of marriages;
single parent families;
violence in sport;
violence against the elderly;
non-accidental child abuse;
litigation and disillusion with services.

The experience of most people is that fear, loneliness and hurt are still with us and our consumer society has not removed the need for a refuge when the cruelty of society isolates the individual¹. Never before has the hurt, lost, ill or injured person been in such need for an advocate and helper in the maze of specialties, alternative therapies and witchcraft which are on offer. These are not primary care teams but competing players in a market place of health care, all feeding on public distress.

The marketing of health runs the risk of equating health with superficial performance or with youth, good looks, clever deals and buying what you want. A new breed of salesmen now markets components of the healthy life in a way that suggests that eternal life may be obtainable from the Health Shop. This is very alienating for the less able, ageing or unattractive members of society who may be made to feel marginalised by their apparent cost and lesser productivity.

The censoring of public information about health and illness is as unacceptable as the permissive abuse of its marketing for commercial gain. Somewhere between these two is the middle ground which allows professionalism to empower and team-work to grow at its best. A disciplined approach to every PHC

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consultation by doctor or nurse is still an undervalued component of our discipline and a vital link between 'strategy' and the individual.

Visionary-thinkers in our discipline and others have pioneered many of the principles now propounded by strategic planners. Furthermore our discipline is the VITAL link that enables top down strategy (and priorities) to be matched to bottom up reality and humanity. Never before have we had such opportunity to

show how health gain, person centred and resource efficient care can be delivered by the primary sector. Not in fragmented, competing parts but as teams of complementary professional workers who enjoy working together with common aims but different methods.

The vital link embodies a conceptual leap which gives the doctors permission to step down from the high ground and to recognise that health is not a medical preserve. In

chronic illness care and prevention we are increasingly dependent on the patients themselves, their families and co-workers from different disciplines. Population health gain can only be achieved as the people themselves adopt satisfied responsibility for their own health and the health of their environment. This is only possible when professionals are willing to provide a refuge in a crisis and hand the responsibility back when the crisis is over or in danger of becoming a chronic response to stress.^(2,9,10)



JANSSEN
PHARMACEUTICA

**Committed to progress
through research
Toegewy aan vooruitgang
deur navorsing**

"There are still many severe problems for which there is no cure at all and for which effective drugs have to be found quickly in the interests of all those who are suffering. This is the way we see our duty here and we would like to think that we have contributed to the solution to some of those problems. And we will continue..."

**...because there is so much
more that needs to be done."**

Dr. Paul Janssen, Chairman. Director of Research.

"Daar is nog talle ernstige probleme waarvoor daar hoegenaamd geen genesing bestaan nie en waarvoor effektiewe middels spoedig gevind sal moet word in belang van al diegene wat lyding verduur. Dit is die wyse waarop ons ons plig hier vertolk en ons sal graag die wete wil hê dat ons 'n bydrae kan lewer in die oplossing van sommige van hierdie probleme. En ons sal aanhou..."

**...aangesien daar nog só baie
is wat gedoen moet word."**

Dr. Paul Janssen, Voorsitter. Direkteur van Navorsing.

'ROHYPNOL' ROCHE**Components:**

Flunitrazepam

Indications:

Tablets: sleep disturbances, whether occurring as an isolated functional disturbance or as a symptom of an underlying chronic disease.

Ampoules: pre-anaesthetic medication; induction of anaesthesia; maintenance of anaesthesia.

Dosage/Administration:

Treatment of insomnia. Adults: 1 – 2 mg; elderly patients: 0.5 – 1 mg, immediately before going to bed.

Anaesthesia:

Adults:

Premedication: 1 – 2 mg i.m.

Induction of anaesthesia: 1 – 2 mg by slow i.v. injection.

Maintenance of anaesthesia: if the amount used for inducing anaesthesia is inadequate, further small doses may be injected slowly. Children:

For premedication and induction of anaesthesia: 0.015 – 0.030 mg per kg by i.m. or slow i.v. injection.

Contra-indications:

Severe chronic hypercapnia.

Hypersensitivity to benzodiazepines.

Precautions:

General: elderly patients with organic cerebral changes. Avoid alcohol during treatment. Pregnancy.

Discontinue breast feeding.

Packs:

Tablets 2 mg: 30's, 100's.

Ampoule pack containing:

5 ampoules with 2 mg of active ingredient in 1 ml solution;

5 ampoules with 1 ml of sterile water for injections as diluent,

to be added prior to i.v. or i.m. injection.

... the Vital Link

The general practitioner has 90% more opportunities than any specialist to function with such disciplined integration which empowers people to feel free of clinical supervision. If we fail to use this potential we fail the public. Sadly it is the public who pay the price because the specialised alternative is more expensive and less readily available and more interventionist.

There is a grave danger that strategic planners will begin to over-simplify disease as 'the enemy' which can be beaten or pushed back to unrealisable levels. Disease is part of life and health is not a matter of perfection, it is to do with wholeness:

being real to self with all the ambiguity this embraces;
recognising one's failures;
accepting help in our broken moments;
admitting to our unity with others;
admitting our basic human needs;
accepting that illness is an inevitable part of our human experience.

References

1. McWhinney J.R. A Textbook of Family Medicine. Oxford University Press, 1989.
2. Stott N.C.H. Primary Health Care: bridging the gap between theory and practice. Berlin: Springer Verlag, 1983.
3. Welsh Health Planning Forum. Strategic Intent and Direction for the NHS in Wales. Welsh Office, 1989.
4. Agass M, Mant D, Fuller A, Coulter L, Jones L. Childhood accidents: a practice survey using general practitioners' records and parental reports. Br J Gen Pract 1990; 40: 202-5.
5. Stott N.C.H, Pill R.M. The Health of lower social class women: a 5 year follow-up study. University of Wales College of Medicine 1990.
6. Research Unit in Health and Behavioural Change. Changing the Public Health. United Kingdom: John Wiley & Sons Ltd, 1989.
7. General Practice in the National Health Service. The 1990 Contract. Department of Health. UK, 1989.
8. Pill R.M, Jones Elwyn G, Stott N.C.H. Opportunistic Health promotion: quantity or quality? J Roy Coll Gen Pract 1989; 39: 196-200.
9. Turk J, Marks I.M, Horder J. Obsessive - compulsive disorder: case study and review. Br J Gen Pract 1990; 40: 210-13.
10. Greist J, Marks I.M, Berlin F, Noshirvani. Avoidance versus confrontation of fear. Behavioural Therapy 1980; 11: 1-14.