GP-hospital interface must be strengthened

No single group in the health service should have a monopoly on deciding what is best for the service, writes Mel Bates

GPS COULD MAKE A DIFFERENCE to the nation’s health if properly resourced to do so. We put a paramount value on the continuing personal care of the patient.

We GPs see 66% of our practice population in any one year and 95% in five years. We are chosen and trusted health advisors with an understanding of the personal context of the patient, be it family, cultural or employment. We have access to a comprehensive medical record.

This exposure to our practice population puts us in the ideal position to provide programmes of prevention in a community setting. Heartwatch is a working example of this fact and there is a long list of initiatives, shared care in diabetes being just one, where we can make a real difference.

Defining our area of expertise is important. We GPs have a wide breadth of knowledge which is not as deep as that of our sub-specialist colleagues in hospitals. Indeed, general physicians and surgeons are something of a rarity nowadays and GPs may soon be the last of the ‘generalists’ in the health services.

The problem of the elderly patient with co-morbidity doesn’t always support this emphasis on specialisation; something which is continuing to be promoted in the Hanly Report. The balance between generalists and specialists is a delicate one.

Hospital staff have a distorted view of the overall morbidity in society, dealing as they do with the sickest of the population. Kerr White’s work (see Figure 1) is helpful in explaining to non-GPs what the role of the GP as gatekeeper of the health services really means and how hospital staff should be aware of its value to them. This study was first done 30 years ago. He is now in his 80s, and with Larry Green, he repeated the study recently. It is amazing that the numbers have remained almost identical over that time.

The Inverse Care Law refers to the fact that those who need healthcare most are the least likely to get it. The well-off private patient and those with medical cards are by and large well served in general practice. Those just above the medical card limits are deterred from attending to their health needs by the cost of the GP visit and prescription charges. While the soon-to-be introduced ‘GP-only’ medical card will help to cater for some patients over the previous eligibility limits, they will still have the considerable burden of drug costs to cope with.

Changes in the budget have increased the limits for the existing medical card by 7.5%.

Hospitals are no strangers to manpower shortages but are largely unaware of the crisis in GP manpower. The situation is particularly acute in north Dublin. North Dublin GP Stan Natin’s study with the Northern Area Health Board gave helpful figures to illustrate this. There is one GP per 2,500 of the population in north Dublin and, with a few exceptions, one GP per 1,800 of the population in the rest of the country.

A very large number of north Dublin GPs are within 10 years of retiring, so moves to increase the number of trainees from the current 84 to 150 over the next few years will be particularly important for the future development of primary care.

No single group in the health services should have a monopoly on deciding what is best for those services. The fact that secondary care competes for resources with primary care means that there will always be a tension between our needs and theirs.

However, our hospital colleagues have far more in common with us GPs than we have differences, and it is to be hoped the GP/hospital interface will be a closer one as we face into the future and embrace whatever is in store in the health reform process.

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References
1. American Health Behaviour During One Month, Kerr White and Larry Green.