

Repositioning the General Practitioner

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The Government of India has recognised the importance of primary health care. The High Level Expert Group on Universal Health Coverage for India, set up by the Planning Commission, has stressed in its report the importance of patient management and the gate-keeping functions of primary care doctors. Unfortunately, it has not diagnosed the reasons for the failure of primary care. This article points out that general practitioners are the only ones who can provide patient-oriented holistic care at the primary level. It argues for the introduction of a market-based incentive for general practitioners and give them pride of place in public health policy.

Views are personal.

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India, today, faces an unenviable double burden of disease as traditional communicable diseases like tuberculosis (TB) jostle with a rising epidemic of non-communicable diseases (NCDs) like diabetes, hypertension and cardiovascular disease. In 2010, the country had an estimated 50 million diabetics and 250 million patients with hypertension. According to the World Health Organisation (WHO), India could account for 79.4 million diabetics, almost 22% of the worldwide diabetic population by 2030.¹ Add to this the rising incidence of hypertension and cardiovascular disease and it is clear that India's healthcare system needs a strategy to cope with the coming epidemic of lifestyle diseases.

Personalised Approach

As the Indian middle class increases in affluence, so will the incidence of lifestyle diseases. These chronic illnesses need to be managed – through changes in the way of life and coordinated, holistic care – sustained over a long period, as they cannot be cured. This approach, by definition, is costly and difficult to implement, and one that the public as well as private health systems of India, with their emphasis on secondary and tertiary care are ill-equipped to handle. Management of chronic care requires a personalised approach, including support and guidance for self-management – it entails a change of perspective from healthcare providers from looking at

someone with diabetes to working with someone who has diabetes.

This change cannot happen at hospitals, as their cost structure cannot sustain a personalised approach. It is simply unviable to have coaching and training sessions in the high-cost space of the hospital. The rising incidence of chronic illness points to the need for an effective primary health care delivery system. Only a system at the primary level can work effectively to both prevent lifestyle diseases through regular screening and timely advice, as well as manage them through personalised treatment and care. So far, however, primary care has been treated as a handout from the government. As a result the market has not provided any incentives for the development of a robust, primary health care delivery system. This article argues for introducing a market-based incentive to enable general practitioners, who are the only ones who can provide patient-centred, holistic care at the primary level, to get pride of place.

High Level Expert Group

The good news is that the Government of India has recognised the importance of primary health care. The High Level Expert Group (HLEG) on Universal Health Coverage for India, set up by the Planning Commission, in its report has stressed the importance of patient management and gatekeeping functions of primary care doctors. The bad news, however, is that their headline solution – allocating 70% of the total healthcare budget to primary care amounts to just throwing money at the problem.² They have correctly identified a need for quantitative expansion of the primary health care system. But the moot question is at what cost? Unfortunately, the HLEG report has not made an attempt to

diagnose the reasons for failure of primary care in the country. The focus, instead, is merely on increasing the inputs (such as more primary care physicians and more nurses) into the primary care process along with an enormous wish list of additional institutions (viz, district health knowledge institutes). These, however, will only add to the exchequer's burden. Not just that, they will pose the usual challenges of governance and sustainability, which have, unfortunately, dogged our healthcare institutions so far. Instead, can the market be developed to provide incentives for a robust, patient-centred primary health care delivery system? It is imperative that this be thought-through.

Much deeper probing is needed to seek answers to certain uncomfortable questions. Without resolving these, additional financial outlays would not create a lasting solution. Let us start with the doctor. Why does almost every doctor seek to become a specialist? Why do even educated patients self-select specialists? The answers are not far to seek. Today, primary care is regarded as a stopgap career, something to do while preparing for postgraduate exams or the United States Medical Licensing Examination. Doctors who choose family practice are regarded as failures both by the public and the peer group. The assumption being that they could not get a postgraduate seat, and hence, were left with no option. The financial rewards are similarly skewed – surgeons get paid a percentage of their high cost surgery. Primary doctors can barely charge Rs 200 per consultation. With the future in primary care so bleak, why would anyone choose to be a family doctor? Unfortunately, the HLEG is silent on this problem.

A New Approach

Behavioural economics provides valuable lessons on the power of incentives that can be used to advantage in this case. The government can make a large impact by changing the existing incentives for primary care. The focus of the government policy should be on creating the right incentives for healthcare so that the government pays for results rather than effort.

To start with, there is a need to create a marketable qualification in family medicine. The current approach to introduce a doctor of medicine (MD) in family medicine is a good idea. However, with the limited number of seats available, it will take a generation to train the number of family doctors required. We need a faster mechanism – let us call it the certified family physician (CFP). Only practising primary care doctors with a minimum Bachelor of Medicine, Bachelor of Surgery (MBBS) or Bachelor of Ayurveda, Medicine and Surgery (BAMS) degree would be eligible to enrol, and much like the study courses for financial qualifications such as those of a chartered accountant or certified financial advisor, the CFP course would have a large “practical” component to be completed by the doctor over a period of two years, while she continues with her practice. As a self-study programme, the CFP would negate the need for expensive institutes and costly mid-career breaks; and by requiring a minimum of two years to complete would ensure that it remains challenging yet achievable. The qualification itself would be granted on the basis of a combined assessment of performance in exams as well as patient feedback. To retain the qualification, the CFP would require rigorous continuous professional education and would need to meet outcome measures which would include both patient satisfaction and success in rigorous tests.

Benefits of Qualification

To really benefit from creating such a qualification and to cement the standing of the CFP as a new speciality, the government would also have to launch a public health campaign educating the masses about the benefits of the new qualification. The campaign would need to highlight the ability of the CFP to diagnose and manage the broad, underlying condition that may be responsible for a range of symptoms – making the CFP synonymous with holistic, patient-centred care. Such a programme would go a long way in changing the image of primary care practitioners. With increased peer recognition, we would expect to see fewer doctors reflexively applying

to postgraduate programmes. A well-supported and publicised qualification would also change the financial incentives of primary care. As patients understand the value of holistic healthcare, their willingness to pay will increase. Furthermore, CFPs will be trained and able to offer long-term lifestyle support programmes that will create a regular stream of income.

The main benefit, however, will come from linking results to financial incentives. The government could offer the CFP a “no claims” bonus based on the number of patients empanelled with CFP who do not use a hospital in a given year. Such a payment could be adjusted based on the age mix and population-based parameters of the empanelled patients. The CFP would be free to share these payments with their patients – enabling them to create behaviour change programmes with real financial incentives. Such a structure would unleash creativity in managing chronic diseases, which is the need of the hour.

Some may argue that such a market-based incentive structure would not work for the poor, but evidence from the Rashtriya Swasthya Bima Yojana and the proposed Direct Cash Benefit Transfer Scheme suggests that the poor are more efficiently reached through targeted subsidies.

For long years the primary health delivery system has languished. It has been perceived as a handout from the state. It is now time for transformative change. Only by building a trusting and long-term relationship between the doctor and the patient can such transformative change be brought about. For this to happen, the family doctor or general physician has to be restored to her original place of confidence and first consultant to the family – a place she enjoyed before specialisation became the buzzword.

NOTES

- 1 World Health Organisation, Country and Regional data on Diabetes http://www.who.int/diabetes/facts/world_figures/en/index5.html, accessed on 20 March 2013.
- 2 High Level Expert Group Report on Universal Health Coverage for India, November 2011, p 12, http://planningcommission.nic.in/reports/genrep/rep_uhco812.pdf, accessed on 20 March 2013.