GENERAL PRACTICE / FAMILY PRACTICE AS THE GLOBAL STANDARD – EXPERIENCE AND WORLDVIEW FROM SIX COUNTRIES

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INTRODUCTION

The invited symposium "Family Practice/General Practice as a Global Standard" was a highlight of the Wonca Asia Pacific Regional Conference 2005 held in Kyoto. Four speakers from the Asia Pacific Region – Hong Kong, Korea, Japan, and Australia, and two others outside the region, namely, the United States and the United Kingdom shared their experience and worldviews.

Around the world, family physicians are increasingly being recognized within the health care systems of their countries as essential elements in the delivery of cost-effective and patient-centered care.

THE REAL POTENTIAL OF FAMILY MEDICINE

The real potential of General Practice/Family Practice is only beginning to be recognized. Starfield[1], in her cross-sectional study of ten industrialized countries in the later 1980s and early 1990s, concluded that there was general concordance for primary care, the health indicators, and the satisfaction-expense ratio in nine of the 10 countries. Ratings for the United States were low on all three measures. West Germany also had low ratings. In contrast, Canada, Sweden, and the Netherlands had generally high ratings for all three measures. The lack of concordance in the ratings in the United Kingdom may be a result of relatively low expenditures for other social services and public education in that country.

The discipline of general practice/family medicine has gone further ahead since then. The Vancouver statement "Family doctors working to meet the needs of people" in 1992 and towards unity for health collaboration with WHO further clarified the role of the general practitioner/family physician.

At the system and micro-levels, the synergy of family doctors, patients and families to prevent disease and promote health, to deal with acute medical problems quickly, and to capitalize on chronic disease management programmes will no doubt make sizeable reductions to the prevailing disease burdens.

METHODOLOGY OF ANALYSIS

Each country has its unique history, culture, and therefore unique healthcare system. An analysis is made in this paper, in the six countries presented, of the presence of environmental factors that must be present for family practice health care delivery to be of quality. If the factor is present in most or all of the countries, the factor can be regarded as a global standard.

The environmental factors of financing, regulation, accreditation, and training identified by the Institute of Medicine in its Chain of Effect model in its publication, *Crossing the Quality Chasm*, appear to be relevant. (Figure 1)[2,3]. Hence, these were selected as indicators of quality and sustainability.

The abstracts in the Conference Handbook were scrutinized for the presence of these factors. Additionally, the acceptance of family practice and the involvement of the family physician are also considered indicators of sustainability.

Figure 1. Crossing the Quality Chasm

The Chain of Effect in Improving Health Care Quality

Patient and Community	Experience	Aims (safe, effective, patient-centered, timely, efficient, equitable
Micro-system	Process	Simple rules / Design Concepts (knowledge-based, customized, cooperative)
Organizational Context	Facilitator of Processes	Design Concepts (HR, IT, finance, leadership)
Environmental Context	Facilitator of Facilitators	Design Concepts (financing, regulation, accreditation, education)

Berwick, 2003

RESULTS OF ANALYSIS: EXPERIENCE AND WORLD VIEW OF THE SIX COUNTRIES

The information in this section was taken from the abstracts, with the exception of missing items where the information is available elsewhere or known by the author.

(1) Place of Family Medicine and Family Doctors In the Health Care Delivery System

Australia. The majority of Australians have their own general practitioner. Each year, 85% of all Australians visit a general practitioner at least once[4].

Korea. When Korea established the National Health Insurance System in 1977, many major hospitals soon found themselves to be overwhelmed with patients of which primary care patients were predominant. This made health care authorities come to the thought that many primary care patients should be screened and filtered by qualified generalists before being seen at tertiary care centres. To accomplish this, it was concluded that the

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Table 1. Average rankings* for health indicators in infancy, for countries grouped by primary care oruientation

	Low Birth Weight (1993)	Neonatal Mortality (1993)	Postneonatal Mortality (1993)	Infant Mortality (1996)
Low Primary Care	9.5	7.8	14.5	8.8
Belgium				
France				
Germany				
US				
Intermediate Primary Care	7.3 – 5.0	5.3 – 6.7	5.5 – 6.0	6.0 – 6.2
Australia				
Canada				
Japan				
Sweden				
High Primary Care	4.8	7.8	4.6	6.4
Denmark				
Finland				
Netherlands				
Spain				
UK**				

Source: Starfield & Shi, 2002
*Footnote: *Best level of health indicator is ranked 1; worst is ranked 13. Thus, lower average ranks indicate better performance. The ranks for each of the countries in each group represen the average rank for the countries in the group;*
*** England and Wales only.*

nation needed to nurture well-trained primary care physicians in a well-defined health care delivery system. Thus, Korea set up the Family Medicine specialty within the infrastructure of the health care system. In 1985, Family Medicine was recognized as the 23rd specialty by the national government[5].

Hong Kong. After many years of lobbying by family physicians, the Hong Kong Government has finally recognized the importance of general practice/family medicine in the overall provision of health care to its citizens. The Western-trained private medical practitioners provide 75% of primary care while public doctors provide 15% and the rest are provided by other health care providers like traditional Chinese medicine practitioners. Over 90% of specialist and hospital care is provided by the public system[6].

Japan. Japan's primary care has been managed by "specialists" who are self trained to be generalists. There is now a decline in the need for paediatricians and a growth in the number of elderly people. The Japanese view is elderly people need well trained family physicians rather than numerous specialists[7] .

United Kingdom. Family physicians are the primary care providers in the National Health Service and are the gatekeepers to higher levels of care. Every individual has a registered family practitioner.

United States. Family physicians provide the primary health care and are gatekeepers in the health care delivery system. "Advanced or open" access and disease management programmes are catching on and these sometimes do not involve family physicians[8].

(2) Financing

Australia. National health care funding by Government.

Korea. National health insurance system.

Hong Kong. Primary care is mostly private. Hospital care is mostly public.

Japan. National health insurance system mainly.

United Kingdom. National health insurance system mainly. Payment for quality is now in the Government's New Contract with family practitioners[11].

United States. American health care is largely private. The health care schemes are contracted with managed care organizations individually or as corporate accounts. Family Medicine in recent years has found itself with a public backlash against the managed care model of gatekeeping[8]. Paying for quality is advocated by the Institute of Medicine[12].

(3) Regulation

Australia. General practitioners are the gatekeepers to the rest of the healthcare system. They ensure that the people of Australia have access to high quality general practice care. The RACGP is responsible for setting and maintaining the standards for quality clinical practice, education and training, and research in Australian general practice[4].

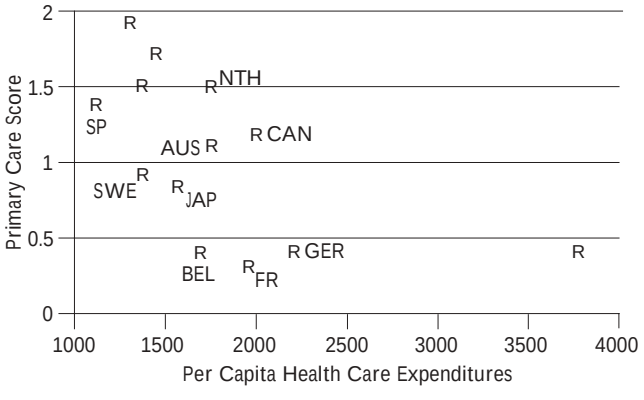
Korea. Primary care physicians are the gatekeepers to higher levels of care. Major hospitals have Family Medicine Departments for easy access of primary care problems[5].

Hong Kong. Referral to attend a private specialist by a family physician is not necessary in many instances. This may make the gatekeeping role of family physicians less necessary when compared to other countries[6].

Japan. There is presently no regulation. Primary care is managed by doctors who are organ specialists.

United Kingdom. General practitioners are the gatekeepers to the rest of the healthcare system.

Figure 2. Primary care score vs. health care expenditures, 1997



Source: Starfield & Shi, 2002

United States. Regulation is based on the gatekeeping policies of the health care programmers provided by managed care organizations.

(4) Accreditation

Australia. The Fellowship examination of the RACGP (FRACGP) is the exit end point of training for general practice trainees.

Hong Kong. The exit end point for the family practice trainee is the Fellowship of the Hong Kong Academy of Medicine (FHKAM).

Korea. A Board certification Examination for those completing the 3-year residency was started in 1977.

Japan. There is at the moment no national accreditation programme in Family Practice in the country.

United Kingdom. The exit end point is the RCGP Diploma. More than 70% of all trainees sit for this examination. Trainees can complete the vocational training programme only and be given an completion of vocational training certification.

United States. The exit end point is the Ameican Board Certification Examination in Family Medicine. Recertification every 7 years is required.

(5) Training

Australia. Australia has the Royal College of General Practitioners (RACGP). The Diploma of the RACGP is the end point of training for general practitioner trainees. Those trainees planning to work in rural general practice may also choose to undertake training to further support aspects of their future work by completing the RACGP Graduate Diploma in Rural General Practice, or other qualifications offered by other medical colleges. The RACGP s developing a developing a quality framework for Australian general practice with the following precursors to ensure safe and sustainable high quality general practice: attracting The "brightest and the best"; support for lifelong learning; providing excellent practices; ready access to the best available evidence; valuing the generalist tradition; and maintaining morale and a yearning for excellence[4].

Korea. Korea has the Korean Academy of Family Medicine. A 3-year training period after a 1-year mandatory rotating internship. Faculty development programmes usually consist of a 2-year Family Medicine Fellowship course after board certification[5].

Hong Kong. Hong Kong has the Hong Kong Academy of Family Medicine. The interest in the family physician has resulted in the Family Medicine vocational training scheme now being the largest training scheme among all specialties in the public health care system. Hong Kong is a place where the Western culture mixes with Oriental culture. This has influenced the way how general practice/family medicine is practiced in Hong Kong. This is particularly so because of local patients' expectations of medical consultations and their understanding of their illnesses. Hong Kong will probably need to develop its general practice/family medicine with its own characteristics while the core values of the discipline are maintained, namely, primary, continuing, comprehensive, and whole- person[6].

Japan. Although there is the Japanese Society of Family Medicine, there is no national post-graduate training system of family medicine in Japan. Several pilot family medicine training centres have however been initiated as for example the Hokkaido Family Medicine Centre by Dr Kasai and his colleagues. Japan is trying to establish its residency training system in family medicine. In 2004, the Ministry of Health, Labour and Welfare of Japan started a mandatory 2-year rotating internship, which may stimulate an interest in primary care among specialist oriented trainees[7].

United Kingdom. The United Kingdom has the Royal College of General Practitioners (RCGP). A structured 3-year vocational training programme has been in place for the last 30 years. Additionally, the RCGP promotes excellence and high standards in family medicine by offering a variety of guidelines, frameworks and tools to help individual family practitioners and primary care teams to maintain and develop their practices, thus ensuring a quality service to their patients.

United States. The American Academy of Family Physicians provides the leadership in the training and development of family medicine. Vocational training for family practice is provided by a 3-year residency system across the country. There is a Board Certification Examination for family medicine as well as a Board Recertification Programme.

DISCUSSION

From the analysis of the six countries, several observations can be made.

Place of family medicine and family doctors in the health care delivery system. With the exception of Japan, family practice is an established component of the health care delivery system. Japan is likely to be following suit, as shown by the shifts towards family medicine training and family practice delivery.

Primary care orientation. From Starfield's study in 1991 and again in 2002, some observations can be made. From Table 1 and Figure 2, taken from Starfield's study in 2002, the ranking by primary care orientation will place United Kingdom in the high primary care group and the United States in the low primary care group, with Australia and Japan in the intermediate primary care group. By extrapolation, Hong Kong and Korea, countries which were not studied by Starfield, would be in the intermediate group. As primary care orientation has been confirmed by Starfield to be cost-effective, the global standard for primary care should be towards the United Kingdom model and away from the United States model[10].

Financing. Four out of the six countries have national health insurance systems. Hong Kong has highly subsidized hospital care. The United States has a predominantly privately funded system. In whichever system of funding, there must be pairing of cost containment and quality. The American financing system demonstrates the backlash that the public and practitioners may experience if there is cost containment without quality assurance.

Starfield has also pointed out in her paper in 2002 that a certain level of health care expenditure may be required to achieve overall good health levels, even in the presence of strong primary care infrastructures. Very low costs may interfere with achievement of good health, particularly at older ages, although very high levels of costs may signal excessive and potentially health-compromising care[10].

Regulation. Gatekeeping is the mechanism of control of utilization of higher level services in all the countries studied except in perhaps Hong Kong and Japan. The ability to do sensible gatekeeping will be a global standard. This sensible gatekeeping will be based on evidence based medicine, safety considerations, and perhaps uncertainty of risk in some situations.

Accreditation. A national standard for accreditation of who is a trained general practitioner or family physician is available for the 5 countries where family practice is an accepted component of the health care delivery system.

Training. From the standpoint of training, there is commonality of training directions and curriculum in the five countries with established family medicine vocational training programmes. The free cross-sharing of experiences and availability of training materials have no doubt contributed to the common standard that is seen across the countries. The global standard of training structure, process and outcomes can therefore be easily established.

CONCLUSIONS

The fact that there is a relationship between presence of primary care infrastructure and health status places the presence of primary care infrastructure and primary care orientation as global standards for any health care delivery system. The other standards are the presence of an accreditation standard, and a family medicine vocational training programme with the requisite objectives and content. Cost containment without quality assurance is an unacceptable standard of health care provision. Paying-for-quality will be an important driving force for good health care. Until payment policies reward quality improvement, providers will not place it at the core of their business strategy[13] .

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