Organisation and design of healthcare for generalism

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 Organisation and design of healthcare for generalism
Stewart Mercer, John Gillies and Clare MacRae

Introduction
This chapter examines how traditional, existing and future healthcare systems can support or undermine generalism in practice. We discuss current issues within UK general practice, although our reflections and suggestions on the crucial contribution of generalism to healthcare systems are by no means limited to this context. The relevance of generalism within all healthcare systems is emphasised. We provide historical examples from medicine with relevance to generalist clinical learning and practice today and beyond.

Drawing on Don Berwick's seminal paper published in 2016 ‘Era 3 for Medicine and Health Care’ (1), we describe how the ‘epic collision of two eras with incompatible beliefs’ has undermined generalism, and emphasise the achievable changes required in the organisation and delivery of care to make ‘Era 3’ a reality with generalism at its core. We highlight the importance of generalism and Era 3 approaches now and in the future, as healthcare systems worldwide face the increasing challenges posed by mobile and ageing populations, isolation, multimorbidity and frailty. We describe how and why the organisation and design of healthcare systems, and their surrounding social, political and physical environments, are crucial to enabling effective and efficient generalist care.

Generalism is not a panacea for poverty, poor housing, unemployment, insecurity, abuse or injustice and will never fully mitigate health inequalities. However, generalism can help work towards ensuring health services work best where they are needed most. We highlight the key partnerships required – between health and social care providers and
between care providers, care users and the general public – for generalism to flourish in the interests of the people that need it, now and in the future.

The value of generalism

Man is the measure of all things.
Protagoras the Sophist (c.490–c.420 BCE)

Protagoras’s epigram suggests that, in much of what we (‘man’) do and decide to do, there are few truly objective truths. We have the freedom and the responsibility to decide what we measure and therefore what we regard as important. This is relevant because, for the organisation and design of healthcare to reflect generalist principles, it must embrace and balance different ways of seeing, knowing and understanding the world by integrating statistical evidence with a deep understanding of patient, community and population perspectives. For generalism to be valued, research should therefore reflect the science of qualities as well as the science of quantities. It should also include what has been described as the ‘tacit knowledge’ that experienced clinicians and patients acquire over years of engagement with individual patients, including their knowledge and understanding of what has worked well and less well in the organisation and delivery of healthcare (see Chapters 4 and 5).

Joanne Reeve has defined generalism as:

a philosophy of practice which is person, not disease centred; continuous, not episodic; integrates biotechnical and biographical perspectives; and views health as a resource for living and not an end in itself.

Reeve 2010 (2)

This ‘way of looking at the world’ is similarly reflected in what Launer describes as ‘attentiveness’ or paying close attention to every aspect of the patient’s story (see Chapter 10). This attentiveness relies on the perceptual capacity of the clinician (3). Perceptual capacity is founded on phronesis: the ability to read or assess a situation correctly, in depth and breadth. Wiggins called this ‘aisthesis’ or ‘situational appreciation’ (4), and Nussbaum ‘some sort of complex responsiveness to the salient features of one’s situation’ (5). It is based on sound clinical knowledge, the exercise of empathy and compassion and the judicious use of imagination.
and finely tuned emotional responses. To achieve this, health professionals should aim while consulting to become ‘a person on whom nothing is lost’ (Henry James as paraphrased in 6,7).

This perceptual capacity or situational appreciation also applies to the organisation, structure and delivery of healthcare. This must reflect a broader understanding, contained within the above definitions, of individual health and ill health in the context of families, communities and cultures, how these constrain or enhance physical and mental health from both biographical and biotechnical perspectives.

An economic argument for generalism

All countries are eager to contain the costs of healthcare, and this has become especially important with the growing costs associated with ageing, mobile and multimorbid societies. Indeed, the challenge of ageing has been defined as one of the grand challenges facing modern society. Secondary care consumes most healthcare costs, relating largely to hospital admission and length of stay. As specialists become increasingly super-specialised, the complexity of care increases and costs escalate further. Delivery of generalist care is a key method of mitigating these spiralling costs, as well as reducing fragmentation of care which leads to treatment burden for the patient as well as harmful effects from polypharmacy. Thus, developing generalism across healthcare systems will be an important way to make care more rational and sustainable, to reduce waste and duplication, and to reduce harm to the patient.

At the population level, a strong primary care system based on generalism is key to cost containment and the provision of high-quality care. The groundbreaking work of Barbara Starfield (8) showed clearly that countries with strong primary care systems deliver higher quality care and are more cost-effective than countries without strong primary care (Figure 8.1).

Generalism: past, present and future

Effective healthcare is one of the huge successes of the post-Enlightenment age. The evolution of healthcare, however, has been a long journey with periods of stasis punctuated by episodic rapid advances. Aseptic surgical techniques, anaesthetics, immunisation against infectious disease, joint replacements and antibiotics, are only some of these advances. However, not all progress has been based on ‘medical’ advances. In addition, public
health measures, such as housing and sanitation, have arguably made a much greater contribution to people’s health than any of the previous examples. Florence Nightingale’s ‘proper use of fresh air, light, warmth, cleanliness, quiet and proper diet’ in 1854 dramatically reduced deaths among casualties during the Crimean War. Infectious diseases, such as tuberculosis, scarlet fever, diphtheria, pertussis and measles, were common and led to the building of hundreds of isolation hospitals usually with a focus on Nightingale’s principles, as no specific treatments were generally available.

In the UK, the National Health Service (NHS) was established in 1948 on the principles that it should be comprehensive (meet the needs of everyone); that it should be universal (free to all at the point of delivery to access GP consultations or hospital treatment); and that it be based on clinical need, not ability to pay (9).
and functioning of the NHS were dependent on medical cadres adopting a generalist approach. The surgical techniques and therapeutic advances that have subsequently led to increased specialisation and super-specialisation were not yet developed. So, most doctors had, by necessity, to be clinical generalists managing the widest range of clinical problems and presentations with a limited range of equipment and therapies. The founding of the Royal College of General Practitioners (RCGP) in the UK in 1952 included a commitment to an approach to generalism that embraced science and compassion as ‘cum scientia caritas’. That broad approach to the care of patients is at heart a generalist one and necessitates a way of looking at the organisation and delivery of care that goes far beyond the immediate clinical problem. Although central to the philosophy of good general practice, it is not necessarily unique to general practice (2,10).

Berwick describes Era 1 as the establishment and ascendancy of the power of the medical profession (dating back to the time of Hippocrates) in which the doctor is regarded as noble, beneficent, with knowledge that is inaccessible to everyday people (and patients), and thus all-powerful. Many of the advances described above occurred during this Era 1, an era of professional autonomy. The ‘doctor as God’ construct led to the profession being exempt from external scrutiny, and able to judge the quality of its own work and to self-regulate. This model of medicine, based on prerogative and blind trust, continued well after the establishment of the NHS in 1948, and only began to be challenged when researchers studying healthcare systems uncovered issues such as enormous unexplained variation in practices, high rates of clinical errors, and inequities in care relating to sex, race and social class, together with evidence that the soaring costs of healthcare were not always related to better patient outcomes.

This heralded the birth of Era 2 medicine, characterised by accountability, governance, scrutiny, measurement, targets, incentives and (in many countries) marketisation. In the UK, the evolution of Era 2 can be traced back to the rising influence and power of managerialism within the NHS, including the separation of health and social care, and the introduction of the provider–purchaser split by the UK’s Thatcher government in 1998. Berwick contends that the inherent tensions between these two eras continue to play out. In his own words, ‘this conflict impedes the pursuit of the social goals of fundamentally better care, better health, and lower cost’ (1).

One of the developments of Era 2 healthcare has been the enormous growth of specialist and super-specialist care and the single-disease
paradigm that has come to dominate clinical care and evidence-based medicine (discussed also in Chapters 2 and 5). However, recent concerns around the wastes and harms of overdiagnosis and overtreatment have led to an increased focus on a generalist approach which uses a much wider view of the patient and their life as part of a community to complement a disease-focused approach (11). A related development has been a vision of clinical care in the future being delivered through ‘realistic medicine’. Championed by the Chief Medical Officer (CMO) in Scotland in 2015, this concept aims to reduce the burdens of overdiagnosis and overtreatment, reduce waste and harm, increase patient involvement in decision-making, and encourage innovation (12). Arguably this is only possible by adopting a generalist approach to the organisation and delivery of care (11) and can be seen as part of a broader move to Era 3 medicine.

Era 3 medicine is guided by reduced measurement, improvement science, transparency, and co-production with patients. Achieving this requires a paradigm shift to an approach to medicine that has realistic and proportionate, high-quality, high-value care as its aim and collaboration at its core.

Smith et al. 2017 (13) referencing Berwick 2016 (1)

Both the philosophy of generalism described in Chapter 1, and the day-to-day practices of health professionals, support a shift from Era 2 to Era 3: reduced mandatory measurement and incentivisation; complete transparency; shifting the business model from forefronting revenue to quality; embracing improvement science; replacing individual professional prerogative with a team identity; working collaboratively in the interests of patients and populations through co-production, co-design and person-centred approaches; protecting civility; and rejecting greed.

A common question, given that an Era 3 approach is inherently responsive to local needs, is how the success or otherwise of local approaches should be assessed or assured; and given reduced incentivisation, how healthcare systems can be organised to encourage excellence. Letting go of Era 2 thinking and embracing Era 3 requires moving from a culture of measurement and incentivised targets (that are often poorly, or at best crudely, aligned to people’s needs) towards a culture of transparency and collaborative engagement in continuous improvement. We argue that Era 3 approaches are necessary to realise the key
advantages of generalism as outlined by the Essence of General Practice group (14):

- **Trust** in both professional intentions and competence.
- **Coordination** between people, community and hospital services.
- **Continuity** of care with attention to both current and future needs.
- **Flexibility** of thinking and approach.
- **Coverage** for all, including disadvantaged and marginalised people.
- **Leadership** based on situated and multidisciplinary knowledge.

**General practice and generalism**

Generalism, as explored in Chapters 1 and 2, is applicable in all aspects of healthcare. General practice, however, is where the philosophy of generalism, its practical application and evolution are currently most clearly reflected. General practice is underpinned by a holistic, biopsychosocial approach to care that combines the biomedical with the biographical. This is one of the reasons why the consultation between clinician and patient is such a key feature of general practice training and research. The rise of specialism and super-specialism has to some extent endangered generalist learning by focusing on narrowly biomedical rather than more holistic approaches, a trend that must be reversed if the needs of patients and populations are to be met in ways that are both person-centred and future-proof. The role of general practice in the delivery of generalism remains central to the functioning of universal healthcare systems. The WHO estimates that effective public health and primary care could prevent up to 70 per cent of the disease burden through primary prevention, supported self-care, and health in all policies (15).

General practice plays a key role in the enactment of generalism within healthcare systems for the reasons set out in Figure 8.2. General practice is the central hub of effective healthcare systems, providing people with contact (the average person in the UK consults a GP approximately six times a year), coverage (almost the entire population is registered with a single GP practice in the UK), continuity (both informational and relational), comprehensive (there is no condition or population group that GPs will not consult with or manage as an initial presentation), coordinated care (GPs are the gatekeepers of the NHS, and refer fewer than 10 per cent of the patients who consult them to secondary care services) built on historically good relationships and high levels of trust.
Example 8.1: Current threats to UK general practice

In 2008, Don Berwick described UK general practice as the ‘jewel in the crown’ of the NHS (16). However, there is, at the time of writing, a crippling workforce crisis in UK general practice. This is driven by rising patient demand and complexity, insufficient numbers of general practitioners, unsustainable workloads, insufficient resources, political scapegoating and outdated infrastructure (17). A focus on Era 2 approaches has increased the compartmentalisation and commodification of general practice work, reducing opportunities for relational expertise and continuity (18). General practice delivers approximately 90 per cent of healthcare activity in the UK, using only approximately 10 per cent of NHS funding – which has only returned to this level recently after falling as low as 8 per cent in 2013 (19,20). Between 2008 and 2018, there was a rapid rise in new hospital NHS consultants compared with either
very small increases, or actual decreases, in GP numbers across the four nations of the UK (Figure 8.3).

The delivery of generalist care to the population is only possible through a strong general practice foundation that provides continuous cradle-to-grave care for all citizens. Precisely the opposite has been encouraged under successive UK governments. An ideological belief in market forces has neither improved efficiency nor increased capacity. Instead, it has created a fragmented, supply-driven system that has catastrophically failed to address the demand side of healthcare (21). Resource allocation towards hospitals rather than primary care has increased costs without reducing demand (22) and financial cuts to public health and social care may actually be increasing demand (23). Accompanying this is the influence of industry and pharmaceutical companies, and the ‘industrialisation’ of medicine – which thrives on demand and treats advanced healthcare as a
commodity to be bought and sold, irrespective of the detrimental implications for patients and populations (24).

Secondary care, with its focus on super-specialism and biomedicine, thus continues to dominate the UK’s healthcare system, and, largely, clinical education. Unfortunately, part of this culture is to denigrate general practice as a career (‘just a GP’) – the so-called ‘hidden agenda’ or ‘hidden curriculum’, which, for many young doctors in training, is not so hidden. So, although generalism is still present in UK general practice, it is clearly under threat (25,26).

Improving access to generalist healthcare

Ensuring that people who need care have access to it is one of the foundational principles of an equitable healthcare system. Generalism is central to universal health coverage and equitable access to healthcare internationally. As part of the United Nations’ Sustainable Development Goals, member states have agreed to work toward worldwide universal health coverage by 2030, and the WHO has specified that good primary care is fundamental to universal health coverage (15,27). ‘Healthcare as a universal human right’ is also an important aspect of Era 3 medicine. Universal health coverage is defined by the World Health Organization (WHO) as follows:

Universal health coverage is defined as ensuring that all people have access to needed health services (including prevention, promotion, treatment, rehabilitation, and palliation) of sufficient quality to be effective while also ensuring that the use of these services does not expose the user to financial hardship. Universal health coverage has therefore become a major goal for health reform in many countries and a priority objective of WHO.

World Health Organization 2022 (28)

Gulliford and colleagues conceptualise improving access to healthcare across four domains (29): increasing supply (building capacity), removing barriers (personal, financial and systems-based), optimising utility (the right service at the right time and place) and ensuring equity (priority access for those with the greatest need). Each domain will have different impacts on health service availability, utilisation and outcomes,
and each domain indirectly impacts the others. For example, reducing barriers through online booking systems may reduce equitable access for those without online access, and increasing supply without attention to quality might reduce utility. No single strategy is likely to be effective, rather a judicious combination of all four.

Attention to authenticity when building capacity

The role of generalism internationally varies widely due to variations in the structure of healthcare systems. The World Health Organization (WHO) describes how, in developed countries, future emphasis is likely to be on quality and sustainability, whereas in developing countries, priorities include building capacity and improving access (15). The WHO warns against fragmentation, unregulated commercialisation and hospital centrisms, and argues instead for systems that are based on health equity, that put the care of people first, that secure the health of both communities and individuals, that invite participation and that provide reliable, responsive care.

The WHO also warns against oversimplification of generalism when building capacity in developing countries. Generalism is not one-way delivery of a small range of priority health interventions, nor is it isolated community health workers, nor community clinics for common ailments, nor cheap, low-tech, non-professional care for the rural poor who cannot afford any better. Instead, they argue for attention to the core attributes of generalism: comprehensive care for all people and all health problems; collaborative care, referring and guiding people through a range of services; relationship-based care that involves people, families and communities in the decisions that affect them; care that opens opportunities for health promotion, disease prevention and early detection of disease; and care that combines sophisticated biomedical and social skills through adequate resources and investment in education and training. Countries with developed general practice have generalism as a core tenet within postgraduate training, and qualifications that are specific to this role.

Many developed countries are also seeking to extend existing models of working with allied healthcare professionals and creating additional roles to address challenges with primary care capacity. Such expansion may well be warranted, given the key role of primary care in healthcare systems, and the global shortage of GPs. It is not, however, clear to what extent allied health professionals are trained in, or indeed practise, generalism. If the expansion of allied health professionals into the primary care team is to be effective, then all practitioners need to
understand the vital role of generalism, their role in it, and how to best put it into practice. The implications for generalism of expanding capacity in this way are not yet clear. Simply co-locating healthcare professionals who are specialists in a specific area of healthcare, such as physiotherapists, pharmacists, mental health nurses and so on, will not in itself lead to the integration of care (see Chapters 2 and 9) and may indeed simply replicate the fragmentation of care that is seen in specialist services in secondary care.

Good primary care requires GPs and other healthcare staff to be trained to a high standard in the core aspects of holistic care, and hence generalism (30). True integration of the multidisciplinary team into primary care will therefore require training and education in generalist approaches. This is likely to require mentorship and leadership from experienced generalists, potentially adding to the workload of already overstretched general practitioners (31). In Scotland, the new GP contract aims to engage generalists in training allied health professions, but recent evaluation suggests problems exist with its implementation (32) most of which were predicted (33) but not acted upon. Internationally, barriers to effective transformation of primary care identified poor leadership, resistance to change, inadequate resources, and a lack of clear targets or outcomes as key themes (32). Challenges integrating multi-disciplinary health workers into primary care are likely to be similar to those encountered when integrating teams across health and social care (see below).

Influences on the quality of generalism

Funding models

Funding and payment mechanisms have important impacts on both patients and clinicians. Relying on out-of-pocket payments at the point of service can lead to catastrophic expenditure that pushes people into poverty or bankruptcy (34). Point-of-care payments are also a barrier for people on low to medium incomes where they do not qualify for free care, further exacerbating health inequalities (35). These inequalities can also be driven at a national level, for example the affordability of cancer treatments in low- to middle-income countries driving global health inequalities (36). Incentivisation systems have consistent impacts on physician behaviour, but mixed or limited impacts on patient outcomes (37). Incentives can subvert the intrinsic motivations of clinicians to provide personalised holistic care and influence decision-making through
micro-incentives to over- or under-treat people (38). They can also cause a focus on the incentive (for example, waiting time) to the detriment of overall quality (39). Fee-for-service, for example, incentivises clinicians to provide as many (short) consultations as possible and may disadvantage people with more complex problems requiring longer consultations compared to capitation-based funding systems (40). A US study comparing fee-for-service to managed care found preventive screening was lower, hospital admission rates higher, and health outcomes virtually identical (41).

Consultation length

Studies have shown wide variations in consultation length in general practice (where longer consultation times are assumed to correlate to a more generalist approach), ranging from a mean of under one minute in Bangladesh to 23 minutes in Sweden (42). It is inconceivable that a generalist approach, that combines the biomedical with the biographical, and includes shared decision-making, collaborative planning and opportunistic health promotion, can take place in a very short consultation. Indeed, a study in a general outpatient clinic in the public healthcare sector in Hong Kong, in which three-quarters of consultations were shorter than five minutes in duration, found that 99 per cent of patients were consulting about physical problems, mostly about one problem (despite being a largely elderly multimorbid population), with reported low rates of continuity of care, GP empathy, and patient enablement (43,44). As discussed in Chapter 11, using interactional knowledge well, may make for a more efficient use of time within consultations and thus the ‘ideal’ consultation length will depend on multiple factors including continuity of care and the therapeutic relationship (45). There is some evidence that longer consultations result in more patient enablement, lower GP stress and better patient outcomes, as well as being highly cost-effective (46). Increasing the duration of generalist consultations might also reduce the use of unnecessary investigations and downstream referrals, thereby improving care, avoiding iatrogenic harm and improving the patient experience.

Continuity of care

Continuity of care has been threatened by incentives to operate in larger practices, increases in remote healthcare, and systems that do not give people the choice of a named doctor. Other threats include mobile populations, multidisciplinary working, part-time working, portfolio careers, shift-working and the commoditisation of patient needs into discrete
components. Many people, however, still prefer to see a known, regular GP, and evidence suggests that older people, those with multimorbidity and those with mental health conditions are most likely to benefit from continuity of care (18). Continuity of care could be prioritised for people most likely to benefit (18); however, identifying those most likely to benefit in advance of an appointment is challenging, and patients may prefer to prioritise speed over continuity for different problems. Patient-led strategies include giving people clear information about how and when to get an appointment with their chosen doctor, how to request a longer appointment, and how and when to contact their chosen doctor between face-to-face appointments (47).

Empathy and compassion

Regardless of financial resource constraints, care providers must be able to interact with compassion and empathy alongside technical clinical expertise, because a care provider must first understand the situation from the person’s perspective to effectively propose suitable solutions (48). Empathy is the ability to understand and share someone else’s feelings or experiences by imagining what it would be like to be them, and includes three domains: emotional; cognitive; and behavioural (49). Empathy in the consultation is beneficial for both the care user, in terms of improved satisfaction and treatment adherence, and for the care provider, where empathy can protect against stress (48). Nevertheless, it is challenging for individual care providers to engage cognitively and emotionally or to behave with empathy when they are not supported by the systems in which they work. Policymakers need to be aware of structural aspects such as relational continuity that affect how clinicians empathise with patients’ needs (48).

Integrated care

Fragmented healthcare systems tend to focus clinicians’ attention on small and local ‘ savings’, rather than focusing on the bigger ecosystem and ultimate cost-effective strategies for patients across the health and social care system. People with complex problems can find themselves pushed from service to service. Strengthening the delivery of generalist care needs to combine integrative approaches (where there is effective coordination both between primary and secondary care, and across multidisciplinary teams) and interpretive approaches (where clinical decision-making involves careful consideration of the needs of the individual in addition to guidelines) (50). The United Model of Generalism, devised by Reeve et al. in 2017 (Figure 8.4), describes types of care
Figure 8.4  United model of generalism. Reproduced from Reeve et al. 2017 (50) with permission
provision suitable for meeting the needs of the whole person (50). The goals of integrating health and social care include the reduction of this fragmentation and the improvement of health and wellbeing of the people who require these services (51). Another driver for integrating across sectors is to reduce cost and improve efficiencies. Although integration in the UK does not appear to have reduced emergency hospital use, there is some evidence that it has improved user outcomes and experience (51).

Commodification and marketisation

Julian Tudor Hart, in his essay on the inverse care law (52) over half a century ago, warned of the negative impacts of market forces on disadvantaged groups:

This inverse care law operates more completely where medical care is most exposed to market forces, and less so where such exposure is reduced. The market distribution of medical care is a primitive and historically outdated social form, and any return to it would further exaggerate the maldistribution of medical resources.

Hart 1971 (52)

Since then, there has been a steady move towards privatisation of the NHS, especially in England, under consecutive governments. One way in which this has been done is to ‘commodify’ care by cutting comprehensive generalist services into individual bits that can be delivered by the private sector. Such segmentation of care damages possibilities for generalism and often increases rather than decreases costs. Furthermore, it often allows ‘cherry-picking’ by the private sector of ‘easier’ patients and problems, leaving public services to support people with complex needs (53).

Where generalism is needed most

Ageing populations

People are living longer, and the world’s population is ageing. It is anticipated that one in six people globally will be aged 60 years or over by the year 2030 (54). There will be a substantial increase in people with complex care needs, including higher levels of dementia, multimorbidity and frailty, with associated dependence on health and social care services (55). When the process of ageing and the experience of longevity are accompanied by good health this brings opportunities for people to contribute to their families and communities. However, multimorbidity
increases with age and brings many health and care challenges, and this stage of life can also be associated with social life transitions such as the death of a partner, with associated loss of support (54). Application of generalism to clinical practice, using approaches such as more widespread training in geriatric medicine for hospital-based clinicians, could improve generalist care for such patients within secondary care (56). However, if future healthcare needs of ageing populations with complex needs are to be met holistically and cost-effectively, countries must invest in growing general practice as well as supporting generalism in hospital specialties.

Complex needs

As discussed in Chapter 1, the term ‘complex’ can be used to mean ‘atypical’ or ‘technically difficult’. Here, however, we use the term to mean multiple and potentially interrelated factors where the outcome can be unclear and/or the process continuous or ongoing. People with complex needs, such as those with learning disabilities and long-term health problems, or people with complex childhood trauma combined with substance misuse, have additional health- and social-care requirements while also experiencing illness and treatment burden (57). They also have additional challenges negotiating the complexities of a fragmented health- and social care system (58). Inadequate social support and poverty further contribute to ill health (see Chapter 10). The co-existence of mental and physical multimorbidity is more common and occurs up to 40–45 years younger in people living in areas of high deprivation compared with those living in affluent areas in the UK (57). This adds to the existing challenges facing both the people living in, and the clinicians working in, areas of deprivation (59,60). Generalism is of crucial importance in the delivery of integrated health and social care, particularly for a population with rising needs and where inequalities are marked (51). Multimorbidity and personalised approaches to care are discussed further in Chapter 18.

Marginalised communities

Special attention to marginalised groups is central to Era 3 medicine. With generalism at the core of organisational structures and culture, healthcare systems can maximise their inclusivity and adaptability to meet the needs of people in need. There are many marginalised communities requiring expert generalist care. Perhaps the largest and most pressing relates to people affected by conflict, famine, trafficking, persecution and environmental threats. The United Nations estimates that 1 in 74 people on earth has been forced to flee (61). The UK’s Equality
and Human Rights Commission points out that forced migrants may have fled traumatic circumstances, had traumatic journeys, and arrived with little or no resources or support, leaving them at risk of further exploitation (62). Dispersal on arrival may further disrupt supportive social networks, and people often fall outside formal asylum systems. These traumas are compounded by barriers to accessing health and social care. These include language barriers, discrimination, being unaware of their rights or entitlements, fear of arrest or detainment, as well as structural barriers such as the need to provide an address, or pay for services and medicines. Rights-based interventions are discussed in Chapter 10.

Health and social inequalities

Inequalities exist in the organisation and quality of care for people living in areas of high deprivation. These groups are less likely, for example, to receive good quality end-of-life care where they are less commonly consulted about advance care planning and decisions about their care (56). Patients living in areas of higher deprivation often have more problems to address during a single consultation, and these problems are often more complex (mental, physical and social) than for those people living in more affluent areas. However, due to the inequitable distribution of GPs relating to the allocation of funding, the consultations they receive are often shorter and less patient-centred than in affluent areas, and result in higher stress levels in the GPs, less patient enablement and poorer outcomes following clinical encounters (59, 62). Patients in deprived areas have lower patient satisfaction and GPs have lower job satisfaction compared with affluent areas (63). Structural approaches to address social inequalities (housing, education, employment, social security) are also needed in parallel to approaches that address health inequalities (64).

Addressing the ‘inverse care law’

Throughout this book it is argued that generalism is central to high quality, person-centred care. This is particularly important for patients with the largest burden of health and social care needs, who in practice often have the least access to good quality generalist care. Such inequity in care provision stems from the organisation of healthcare. Over 50 years ago, this mismatch between need and supply was coined the ‘inverse care law’ by GP and epidemiologist, Julian Tudor Hart, in a seminal essay in the Lancet (52). Tudor Hart explained the inverse care law as follows: ‘The
availability of good medical care tends to vary inversely with the need for it in the population served.’ A series of papers from Scotland over the last 20 years have shown how the inverse care law still operates within the NHS. The fundamental problem is a historical mismatch of need and supply – as Figure 8.5 shows, increasing levels of need in more deprived areas of Scotland (as reflected by higher levels of premature mortality, multimorbidity, and poor general health compared with more affluent areas) are not matched by the funding or distribution of GPs (65).

Recent research by the Health Foundation has confirmed the ongoing existence of the inverse care law in the English NHS (66). Ongoing research in Scotland on the new GP contract, which outlines how GP services are funded, also suggests that there has been little emphasis on the needs of older patients or those exposed to health inequalities (32).

The effect of the inverse care law is most apparent in patients with multimorbidity. In affluent areas, multimorbid patients get substantially longer consultations than non-multimorbid patients (on average 40 per cent longer), perceive their GPs as more empathic, and the GPs deliver more patient-centred care when measured objectively using video recorded consultations. In deprived areas, no such differences between multimorbid and non-multimorbid patients exist (67) (Table 8.1).
Table 8.1  Issues affecting communities and consultations in deprived areas.
Based on data from Mercer and Watt 2007 (59) and Mercer et al. 2012 (68), reproduced with permission from Graham Watt

<table>
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<th>Issues affecting clinical encounters</th>
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<td>Drugs and alcohol</td>
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Future policy must address the inverse care law. Generalism must be at the centre of care systems that support all patients, particularly for vulnerable groups such as those with multimorbidity who live in deprived areas. A holistic approach is needed, with continuity, integration of services and a patient-centred balance of approaches and priorities. Providing services for people with complex clinical and care needs requires them to be designed around people and populations rather than single diseases, and for there to be intelligent and adequate funding for health and social care that is targeted towards the most vulnerable so that care is responsive and personalised. High-quality generalist care for such patients requires several components: time, continuity, an empathic patient-centred approach, and (at least initially) support for practitioners in managing such complexity. The feasibility, effectiveness, and cost-effectiveness of such an approach has been demonstrated through the CARE Plus Study (69,70) meaning in the future it could be implemented at scale. However, this will require reinvestment in primary care in deprived areas with sufficient staff, training and funding to make it a reality, together with a shift in how generalist work is understood and valued by society and populations.

Major opportunities exist to effectively harness scientific and technological advances while maintaining the basic principles of generalism, and such innovations need to be rapidly developed, evaluated and implemented equitably and at scale within primary care. Future strategies in the UK include enhancing the use of digital infrastructure, integrated care records and responsive data tools such as risk-based screening, digital health checks, access to online peer support, virtual consultations, and at-home diagnostics to deliver ‘flexible, tailored services that promote people’s health, wellbeing, and independence’ (71).
To meet these increasing needs, systems and processes must become responsive to the needs of individuals and populations. Additionally, systemic participatory approaches such as engendering a culture that invites and welcomes feedback from people using services, involvement of people and carers in service design, and providing appropriate training for people who provide health and social care, could be used to make real-time changes to services and improve the generalist approach (56).

For changes of this nature to occur, the organisers of a healthcare system and the individuals working within it must share a common holistic view of healthcare provision (69). For people with complex care needs, effective provision of generalist care requires that clinicians working in all disciplines understand the specific needs of individuals, promote shared decision-making, and collaborate skilfully across teams of professions (50). For this to occur, healthcare systems at the population level must enable generalist systems to thrive.

A vision for the future: making generalism a reality

Quoting from the Health Foundation document on modern medical generalism: ‘the essential quality is that the generalist sees health and ill health in the context of people’s wider lives, recognising and accepting wide variation in the way those lives are lived, and in the context of the whole person’ (10). Implementing generalism at scale throughout the healthcare system must therefore overcome current barriers.

The well-known saying ‘culture eats strategy for breakfast’ has been attributed to the management expert Peter Drucker but is often quoted in healthcare management circles in relation to quality improvement. Thus, in the ambition to expand and enhance generalism, as argued for in this book, we must be mindful that any strategies will need to understand and address issues of culture within healthcare. Healthcare systems around the world remain dominated by the biomedical, reductionist model of disease and treatment, and the supremacy of secondary care specialties. It is also reflected in the single-disease paradigm that still dominates healthcare practice, education and systems. Implementing generalism, especially in secondary care, will require a change in culture amongst specialists, so that generalism is seen as everyone’s job and not just that of the geriatrician and the GP (see also Chapter 2). Delivering expert generalism at scale, as discussed earlier, will undoubtedly require a substantial investment in general practice, since hospital care is episodic and most care for most patients (especially those with multimorbidity) is, across
their life course, delivered in general practice (72). This is a political and practical challenge as there is a global shortage of trained GPs. Bold actions are required by governments to boost GP numbers by encouraging more trainee doctors to become GPs, help retain experienced GPs, and, above all, ensure the work of GPs is meaningful and sustainable for both professionals and patients.

The WHO suggests focusing on the following drivers of reform to ensure the future of generalism (15):

- **Mobilising the production of knowledge**: ensuring policy reviews stimulate organisational imagination, intelligence and ingenuity; address the technical and political obstacles to the advancement of generalist knowledge; and ensure that new knowledge is effectively shared and implemented.
- **Mobilising the commitment of the workforce**: ensuring generalist careers are more stimulating and gratifying, and more socially and economically rewarding than past models, and that generalist clinicians are attracted to the areas that need them most.
- **Mobilising the participation of people**: harnessing the dynamics of civil society so that the perspectives of people are included within policy debate; so that all people have reliable protection against health threats and equitable access to quality healthcare without fear of financial exploitation.

The facilitators to integrating generalism into the organisation and design of healthcare systems are summarised in Table 8.2. Because the quality of care is a combination of technical and interpersonal effectiveness, generalism – with its integration of the biomedical and the biographical – is important in all aspects of healthcare. Yet, as clinical care has become more specialised and super-specialised, the balance has inexorably shifted towards the biomedical. Generalism is the key to delivery of effective, sustainable and compassionate care. However, generalist services, especially UK general practice, currently suffer from financial under-investment, chronic workforce shortages and compartmentalisation. Healthcare challenges, including an ageing population, rising complexity, marginalised groups and health inequalities, mean that adoption of generalist approaches will become even more necessary. Organisational structures must support and encourage generalist ways of working, generalism must be a key theme in clinical and postgraduate training, together with a culture change within the clinical professions that challenges the dominant reductionist, overtly biomedical model to one that
Table 8.2 Facilitators of generalism in healthcare systems

- Universal coverage: a healthcare system free at the point of care, with a strong general practice-led primary care base
- A healthcare system that adequately responds to the needs of all patients, including those suffering health inequalities
- Widespread training in generalism for all medical students and doctors in training
- Putting generalism at the heart of the integration of health and social care
- Organisational support for the factors that enable generalism to flourish such as appropriate leadership training, supporting effective communication within and between teams and system interfaces, flexibility, continuity of care, relationship-centred care.

prioritises and rewards generalism. Politically, there is an urgent imperative to halt commodification and profit-based approaches to organising clinical care systems, in order to deliver the most cost-effective and clinically appropriate care to all members of society.

From the seminal publication on generalism by the Health Foundation in 2011 (10) to Berwick's moral prescription in 2016 (1) and since, the philosophical and empirical case for situating generalism at the heart of healthcare systems and their organisation and delivery has grown and developed. Urgent action is now required.

References


