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John Fry Fellowship Lecture

Primary Care in the Driver's Seat?

Professor Richard B. Saltman

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This Lecture by Professor Richard Saltman was delivered at the Royal Society of Arts, London, 30 October 2003. The book of the same title, described in this lecture, will be published in 2005 by Open University Press/McGraw Hill Education.

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Introduction

It is a great honour to be the John Fry fellow. I am grateful to John Wyn Owen and to the Nuffield Trust for their willingness to work in collaboration with the European Observatory on this primary care project and on the forthcoming volume from this study, to be published in early 2005[1] (Saltman et al, 2005 forthcoming).

I come to the topic of primary care from a broad health systems perspective. I also come as a beneficiary of the expert knowledge of one of my co-editors, Wienke Boerma, as well as many of the chapter contributors to the Observatory volume (see Appendices A and B). While I will draw on what they have written, these experts should be absolved of all responsibility for how I use their insights. In particular, they may not always agree with the way that I have re-configured their information into a broader policy picture.

Both the final volume itself and the overall Observatory project share some structural characteristics that may be useful to emphasise. First, the book focuses on primary care, not on primary health care. This was a controversial decision that reflects the considerable range and complexity of activities contained within primary health care. The editorial team found that it was not feasible to encapsulate all of the organisational reforms that have taken place, across the board, in such a widely diverse set of activities. We chose, therefore, to focus on primary care, and within it, on the GP as the central actor. Second, while we incorporated material from central and eastern Europe where available, the study mainly concentrates on western Europe.

Third, the study looks at a wide variety of organisational and structural factors. We look at the public and private mix, at issues of co-ordination, at the role of expanding task profiles, and at substitution and shared care issues; all of which are part of the emerging framework for general practice across Europe. We also look at a number of other additional factors which influence primary care, including finance issues; quality of care questions; changes in technology, particularly telemedicine and how that is going to influence the development of primary care; and issues of training and education.

This paper focuses on specifically structural and organisational issues,

1 This work will be published by Open University Press/McGraw Hill Education in 2005, entitled *Primary Care in the Driver's Seat?* Organizational reform in European Primary Care. Different chapters mentioned in the course of the lecture are referenced under their authors' names and the contents of the book is given in Appendix 1.

and does so in three parts. First, adopting the Swedish concept of mapping, the paper presents a broad overview of what appears to be changing in terms of primary care and general practice across western Europe. The second section considers the controversial topic of the credibility of GPs, an intriguing issue on which my observations may indeed depart from those of some colleagues from the book. Finally, drawing on the first two segments – on the mapping segment and the credibility issue – the paper then looks at the driver's seat question, considering whether general practitioners or primary care ought to be responsible for steering the broad health care system.

The role I will take is that of an interested academic, seeking to ask useful questions as well as suggest potential policy responses. I will try to stay out of the ideological potholes that run through the broader topic of primary health care. I will, however, still make some points that may be controversial – the John Fry lecture is an opportunity to raise some questions that may not often get considered – but I will try to be controversial in a neutral and balanced manner.

I. Mapping Recent Organisational Changes

Moving into the mapping section, GPs work in a variety of settings. They can be independent, which in classification terms means that they are small businessmen or women. That puts them in the private-for-profit sector, both for solo practice and group practice. They can also be salaried in the public sector, either as solo practitioners to municipalities (Norway) or, more typically, within primary health centres, whether municipally (Finland), regionally (Denmark, Spain, Sweden) or nationally (Portugal, UK), owned and operated.

Primary care has a number of different functions. It has clinical responsibilities as the first point of patient contact with the health care system; however, it also has co-ordination responsibilities which often include gatekeeping for specialist and hospital services as well as maintaining links with the rest of primary care. In recent years, primary care has increasingly taken on financial responsibilities in terms of holding part or all of the annual budget for secondary and tertiary level services but also in terms of fundholding, to use a UK term from a prior era. Primary care also can hold responsibility for overall primary

health care budgets as well. If one thinks about what has changed in western Europe over the past 30 years, if one looks at the broad panorama, there has been a general movement away from solo practice, toward various forms of group practice and also toward primary health centres. This began in the 1970s and 1980s in the Nordic region. By the end of the 1980s, most of Swedish primary care was delivered through multi-physician primary health centres which also include a nurse component, a health education component and a social care component. Finland started roughly at the same time and developed nearly as many primary health centres as Sweden, although private solo practitioners have a larger role and remain important in Finland, which is not the case in Sweden. And then in the 1980s and 1990s, Spain, and in the late 1990s, Portugal followed in a similar process of change. There also are some primary health centres in the UK, and in the 1990s group practices became increasingly important.

When one stitches these observations together, utilising the notion of public-private mix, one comes up with a very interesting framework (Figure 1).

The logic suggests that European experience with primary care circa 1990 can be captured in four categories. First, one can separate out those dimensions of primary care delivery that are controlled by the state directly, as an arm of a national government, in contrast to, second, health centres that are controlled by elected regional or municipal public sector actors but not by the national government. This distinction is important not only in the Nordic Region, but also in Spain where the regional governments – the 17 autonomous communities – have now

Figure 1 1990 Public/Private Paradigm in Primary Care

PUBLIC		PRIVATE	
State	**Public-but-not-state**	**Not-for-Profit/ Voluntary**	**For-Profit/ Commercial**
• Primary Care Centers (Greece, Germany, Portugal) • ?Policlinics (CEE/CS)	Regional/Municipal Health Centers (Finland, Spain, Sweden) (Norway – 19%)	?	• Solo practice (Denmark, UK) • Group Practice (Netherlands, UK)

Private GPs in municipal offices (Norway – 66%)?
Private GPs with state pensions (UK)?

taken complete responsibility for healthcare, including complete control over the financing of healthcare (although they do not raise this themselves). As a result, in Spain now as in the Nordic region, the national government does not play a role in the day-to-day operating decisions of how care is delivered. In fact, this is true in Spain even more than in the Nordic Region, with the Spanish regional governments often directly opposing what the national government would like to do. Similarly, in Italy, the 22 Regions have complete authority over health sector operations (although control over finance remains in some dispute).

Thus, this second category under public, with the somewhat clumsy label of public but not state, in fact exists in the real world, and in a number of countries in Europe this is an increasingly important distinction. In Portugal, conversely, this is not a meaningful distinction. The regions are not separate from the state, but rather simply de-concentrated offices operated directly by the national government. In an important sense, the Portuguese instance helps make the more general point about regions elsewhere that are in fact politically devolved and thus quite independent.

On the private side of Figure 1, the major distinction is between the third category, not-for-profit, as against the fourth, for-profit status. One interesting aspect of this chart is that there seem not to be examples of not-for-profit voluntary activity in primary care. That is quite different from what one finds in the hospital sector (Saltman, 2003), where religious institutions that are typically not-for-profit but mission driven fit in that box. In the for-profit commercial category, as noted earlier, one finds both solo practitioners as well as all private group practices.

The dilemma with this chart is that, even by 1990, this four-way breakdown does not adequately describe the full range of structural reforms that were underway. The two entries at the bottom that are without a home are two examples of this dilemma. One has to do with private GPs in Norway: they were small private businessmen yet two thirds of them worked directly in public clinics run by the municipalities. It is hard to find where to put them on this chart. And then there is a question that Walter Holland raised long ago in my mind about what one does with private GPs who are small for-profit businessmen who nonetheless get full state pensions. Where do they fit? These two anomalies raise some interesting questions about the usefulness of the paradigm.

During the 1990s, there was rapid growth in a whole variety of different

aspects of organising primary care. This passage from one of the chapters in the forthcoming book (Sheaff *et al*, 2005 forthcoming) captures the emerging complexity:

> *New forms included medical co-operatives, voluntary provision including informal and self-care; public firms, that is to say public corporations that are publicly owned but independently managed; new forms of commercial primary care provision; non-medicalised primary care including alternative as well as traditional methods; and four different types of network provision, each of which is a fairly complex structure.*

Some forms of these networks are virtual, further complicating the picture. All these different formats can lead to considerable pressure on the traditional understanding of how general practise and primary care function.

One key issue about future role of primary care concerns the degree to which, in this changing environment, gatekeeping is a sufficient tool to manage access to secondary and tertiary health services. Another contribution to the book (Calnan *et al*, 2005 forthcoming), suggests that gatekeeping itself is inadequate. The chapter contends that co-ordination ends once the patient is referred.

> *It might be argued that GPs control the access to the gate but that their co-ordination powers are ended after the patient passes the gate.*
>
> Calnan *et al.* (2005, forthcoming)

This author also questions the impact of ongoing organisational changes in the way that primary care is delivered, suggesting they appear to have eroded gatekeeping during the 1990s:

> *Maybe GP coordination is outmoded. Maybe we need to talk about new forms of coordination of care at organization level, not at doctor-patient level.*
>
> Calnan (2002)

Increased points of entry for patients create dilemmas in terms of co-ordination issues. Other examples of growing organisational pressure include the difficulty of establishing a single patient record that can follow a patient through the system, and the decreased likelihood that patients may not know the treating GP in larger practices or in health centres, particularly if there are part-time physicians working in the practice. The chapter also takes note of emerging specialist roles for GPs, for example dermatology, and use of nurse triage. Drawing these different factors together, the authors question how long gatekeeping can remain a

critical factor given the present rate and scope of change within primary care.

Going one step further, the lead author on this chapter, Michael Calnan, raised a question in the authors' workshop about the capacity of primary care to provide health service co-ordination overall. He wondered whether GP-led primary care is in fact outmoded: whether there needs to be a different understanding of co-ordination and whether it needs to be done, not at the patient-doctor level, but at the overall primary care organisational level. That question served as the first hint toward what might become a new future configuration for primary care. However, the main impact of Calnan *et al*'s work has been to reinforce the perception that the four-part public-private paradigm is no longer appropriate. This framework, which had taken form by 1990, appears to have eroded to the point where it does not now seem very analytically useful to talk about public, public but not state, and private-for-profit categories in the content of primary care. With apologies to Thomas Kuhn (1963), there is a sense that the prior organising paradigm is no longer suitable, but that as yet no new explanatory paradigm is on the horizon.

Several candidate paradigms can, however, be put forward in thinking about what a future analytic explanation might look like. Phrasing it in this way suggests that the available evidence to support these possible explanations may not be as strong as we might like. We could, for example, think about the organisation of primary care as a broad continuum, with many different individual points. But, of course, a continuum is linear and this new paradigm may in practice have to be two-dimensional or even three-dimensional, which suggests that the modelling process could get rather complicated.

Martin Pfaff, a professor of economics in Augsburg, Germany, has suggested that a possible solution may be to think about function, not structure (Pfaff, 2003). It is noteworthy that this reflects an economist raising an analytic framework put forward by a sociologist, Talcott Parsons (Parsons, 1960). By focussing on function rather than structure, there may be a way to develop a new perception of how the organisation of primary care is evolving in Europe. There also is the potential to use Williamson's work about hierarchy, markets and networks, and to think about how that might apply as well (Williamson, 1985).

There is in addition one further issue in terms of the changing organisation of primary care. This observation reflects materials published by my co-editor, Wienke Boerma, in his new book (Boerma, 2003). The research is based on almost 8,000 surveys of general practitioners in 32 countries in which Nivel, which is the centre for research and primary care in the Netherlands, set out in the mid-1990s to map a picture of primary care across Europe. The key point that Wienke raises is that there is tremendous diversity in what general practitioners actually do in different countries: there is a broad range of services, that vary not just on rural to urban parameters, but on a variety of additional parameters as well.

How then does one pull these diverse observations together? It appears appropriate to conclude that there is a profusion of new organisational models, with major diversity in how GPs actually work, in what they actually do, and in the range of their activities. The former public-private paradigm that made it relatively easy to classify the developments underway in different countries has begun to melt, and thus far we do not seem to have a suitable new paradigm to replace it.

II. The Credibility Conundrum

The second part of this paper presents some perspectives on the credibility of general practitioners. This topic was not formally part of the broader Observatory study, although the analysis here draws on work from a number of its contributors. The issue of GP credibility is one of the more complicated issues in terms of thinking about primary care. Is it true and when it is true, where is it true, that GPs have lower credibility than hospital specialists? What factors help explain this where it is correct? What policy responses are appropriate?

It may well be that this issue goes to the heart of both the past and the future of primary care. It is a sensitive, uncomfortable, and controversial question. While it may not be particularly relevant in some countries, it can be considerably relevant in others. Given that I personally have a longstanding relationship with the World Health Organisation, I also realise that the European regional office will not be entirely pleased to see questions being raised about the credibility of general practitioners, upon which the overall structure of primary health care depends and upon which WHO has structured much of its policymaking over the last two decades.

There would appear to be at least eight different dimensions that contribute to an overall assessment of this issue. Credibility is itself one of them, but there are also considerations of respect, of trust, prestige, and status, as well as questions of power, authority, and legitimacy. An overall assessment also would reflect how the general practitioner is perceived by at least four different sets of health actors: patients (who are a critical dimension here), hospital specialists, in some countries payers – where they are separate (in certain health insurance countries, for example) – and policy makers.

It would be rather tedious to assess all eight of these factors sequentially. It does seem useful, however, to comment on two of the most critical dimensions regarding GP credibility. One is trust. Trust self-evidently is at the core of how primary care works. As Mikko Vienonen noted at the authors' workshop, trust means having someone to bring your ailments to, and reflects a strong human need: "almost as strong a need as for religion." Trust is clearly a critical dimension for GPs, and it is something that runs at somewhat varying levels among patients in different countries. As Table 1 indicates, levels of trust appear to be in the 80% range – very high – in both social health insurance countries like Germany and the Netherlands, as well as in tax-funded countries like Sweden and the UK. The numbers likely trend considerably lower, however, in countries in Eastern Europe and the Former Soviet Republics.

The second of the eight dimensions that is of interest is credibility itself. How does one define credibility, and how is it conferred or withdrawn? Credibility exists when the exercise of power is seen to be justifiable and socially sanctioned (Pfeffer, 1981). Power itself cannot generate either credibility or legitimacy. Instead, if power is to be credible, it has to be seen as socially acceptable by those who it affects. Thus, credibility is conferred by those whom power (or its institutionalised face, authority) controls, not by those who actually exercise power.

Table 1 Patient trust in GPs

Country	Very much/*much trust*	Source
Germany	82%	Boecken et al. (2003)
Netherlands	86%	Friele (1998)
Sweden	75%	Socialstyrelsen (2002)
England & Wales	89%	Calnan and Sanford (2003)

A key element of the concept of credibility, then, as viewed from the perspective of trust and power, is that it reflects not the imposition of measures of control upon subscribers or patients, but rather the acceptance by patients of that control as both clinically appropriate and socially legitimate. A similar discussion could be held regarding the genesis of GP credibility in the eyes of the three other health system actors: specialist physicians, payers, and policymakers. Credibility thus appears to be conferred by the interaction between health system decisions and how those decisions are assessed within the broader confines of civil society. This perception could no doubt be deepened by further explorations into several of the other eight dimensions, in particular status and prestige.

Overall, it appears that GPs have relatively high trust and respect from patients in a number of western European countries. They may also have substantial power over hospital and primary health care budgets in the new emerging environment (again, depending on the country). However, GPs still seem to have somewhat lower prestige, lower status, and lower authority than hospital specialists. GPs also may still have somewhat lower credibility than specialists with policy makers and payers. And GPs often appear to have somewhat lower overall legitimacy in the eyes of patients.

There have been a number of efforts over the last 30 years to try to raise the overall position of general practitioners within the health sector. There have been educational efforts to create professorships of general practice, as well as programmes to create training rotations for GPs within key hospital clinics like obstetrics and internal medicine. There have been widespread initiatives to create specialisations in general practise and family medicine, as well as to introduce a process of continuing education. There also have been concerted financial efforts in some countries, including the introduction of higher incomes: at one point in the late 1980s in Finland, a primary care doctor in a rural area could earn a higher salary than a cardiac surgeon in a public hospital in Helsinki.

An additional dimension has come into play when GPs hold hospital and primary healthcare budgets, since these give GPs financial power over other sub-sectors in the health system. The academic shorthand for the impact of this type of initiative is sometimes framed in the UK as the issue of who sends Christmas cards to whom (Glennerster *et al.*, 1994). Lastly, there are targeted efforts to maintain and/or expand key

organisational efforts. Gatekeeping is the traditional one, along with patient lists, both of which have sometimes been utilised, for example in Spain and in Sweden, to try to increase the status and role of general practice.

One finds oneself forced to ask, however, why – despite all these efforts – does it still seem that GPs have lower credibility than do hospital specialists? Table 2 explores some of the factors that might contribute to an answer to this question. It employs question marks since these five different categories are only speculative contributions to a potential explanation as to why this might be the case.

The first, educational issue can be understood as one of legitimacy and the structure of authority (Weber, 1947). Higher levels of specialist legitimacy may in part reflect professional education and the specific set of clinical skills that a specialist has acquired. In particular, it may reflect the fact that a surgeon who operates on a particular organ does so in precisely the same manner regardless of which country they work in, in contrast to the GP, whose specific activities often are tied to their position in the broader healthcare system, and which often vary considerably (Boerma 2003; Jepson 2001). In this view, GP power is tied more to the organisation than to a specific set of skills, a perception which could be one component of the credibility gap.

A second factor may be politically incorrect but is a visible part of the changing clinical landscape in Europe: the increasing feminisation of the GP workforce. This has to do with the growing number of women who are becoming GPs, and reflects the unfortunate reality that women in Europe still are paid less for the same level of work as men, suggesting that they are not respected to the same degree by society. Wienke Boerma's new book draws upon NIVEL's survey research results to demonstrate that the proportion of female GPs is rising substantially (Boerma, 2003). The comprehensive data enable him to

Table 2 Why GPs have lower credibility than hospital specialists

Five potential explanations:

1)? Educational base of GP
2)? Increasing feminisation of GP work force
3)? Inherent nature of GP job
4)? Structure/organisation of primary care
5)? Growing GP role as state agent

draw several interesting observations about female GPs:

> *'The proportion of female GPs is growing rapidly in many countries, particularly western Europe.'*
> *'Female GPs … more often worked part-time in groups or partnerships … they made fewer home visits and did less work outside office hours ... lower involvement of female GPs in the application of medico-technical procedures and the treatment and follow-up of a range of specific diseases.'* Boerma (2003)

As the second quote suggests, female GPs often work part-time and make fewer home visits. They also do less work outside of office hours and use less medical technology. Boerma did note that female GPs tend to be more involved in health education. These observations should not be taken to suggest that there are not clear reasons why women choose to approach general practice in this manner, or that they are not legitimate in doing so. Rather, the intent here is to raise the uncomfortable question as to whether, given current attitudes in western European societies, the growing percentage of female GPs (Table 3) helps alter the calculus regarding the respect and credibility that all GPs receive from patients.

Moreover, in 2003, more than half of all medical students were women,

Table 3 Active female GPs, 1995 and 2002 (% of total active GPs)

	1995 (%)	2002 (%)	Change 1995–2002 (%-points)
Belgium	24.5	28.7[1]	+4.2
Denmark	21.8	30.5[2]	+8.7
England[3]	28.5	34.3	+5.8
France	35.8[4]	38.3	+2.5
Germany[5]	33.0[6]	34.4	+1.3
Netherlands	19.3[7]	28.3[6]	+9.0
Northern Ireland	26.5[8]	29.5	+3.0
Norway	25.8	30.3	+4.5
Wales[3,9]	24.3	29.4	+5.1
Scotland[3]	32.0	38.5	+6.4
Sweden[10]	36.8	41.3	+4.5
Unweighted average	28.0	33.0	+5.0

Notes: Comparison is complicated by internationally differing GP functions (Boerma 2003), GP definitions and relative rates of part time workers. [1]No statistics available after 1998, estimation based on % registered (1.6%-point more than in 1998). [2]2003. [3]Contrary to northern Ireland data: only unrestricted principals and equivalents. [4]1997. [5]Not including doctors of internal medicine working as GPs. [6]1999. [7]1996. [8]1994/5. [9]1 October 1995 and 31 March 2002. [10]Active members in the Swedish Medical Association (95% of all GPs in Sweden are members).

Sources: Belgium: SPF Santé Publique, Sécurité de la Chaîne Alimentaire et Environnement (2003): situation on 1 January next year; Denmark: Danish Medical Association (2003); France: Conseil national de l'ordre des médecins (2004); Germany: KBV (1999, 2002); Netherlands: NIVEL (2004); Norway: Norwegian Medical Association (2003); Sweden: Swedish Medical Association (2003); UK: Royal College of General Practitioners (2003), Health Statistics and Analysis Unit Welsh Assembly Government (2003), ISD Scotland (2003), Department of health (2003), Central Services Agency (2003).

and a high proportion of those women are expected to choose to become general practitioners.

The third contributory factor concerns the specific content of the GP's job. This comes back to the broad range of activities that GPs undertake, and the notable variance in those activities between countries. As indicated above, this raises questions as to whether GP work is context-defined or professionally-defined activity, and whether this difference influences how patients, hospital specialists, and policy makers choose to view GPs. Again there is considerable evidence that supports this assessment, indicating broad differences in different countries in terms of how GPs perform their work (Jepson, 2001; Boerma, 2003).

The fourth factor is a function of the structure and organisation of primary care itself. Two aspects are notable here. One is that a considerable degree of the variation observed in what GPs actually do appears to be closely related to specific structural characteristics of the healthcare system (Boerma, 2003). That is, the variation is tied to the broad framework of the health system itself, rather than based on individual decisions of individual GPs.

The second aspect may have to do with the way in which GPs have evolved as co-ordinators of services provided by others, including the primary sector, primary healthcare sector, and hospital sector. To the extent that the GP has a role as manager rather than a role as provider, that might make a considerable difference in their overall credibility, as viewed both by patients and others.

The last, fifth factor concerns the growing role of the general practitioner as an agent of the national government and of national policy. Gatekeeping has always involved cross-sector co-ordination, however, it also has traditionally had a cost containment dimension to it. Holding budgets for primary care, and especially for hospital care, has given the GP a clear role as an agent of the state within tax-funded health systems, like the United Kingdom. Similarly, in social health insurance countries like The Netherlands and Israel, GPs have gatekeeper roles and thusalso influence national cost containment (Rosen 2003; Den Exter *et al.* 2004, forthcoming).

All the above leads to a number of difficult questions. Is lower credibility of GPs in fact structural in nature? Does it reflect the inherent character and/or nature, of a GP's job? To what extent does it reflect a growing GP role in administrative co-ordination? Does it reflect the managerial dimension and/or the state agent

dimension of being a GP? How is it influenced by an increase in the number of female GPs? More pointedly, is this credibility dilemma likely to deepen in the future if GPs are increasingly seen to be managers and spend correspondingly less time as providers of care? And what happens, as some of the experts working on the Observatory project have suggested, if gatekeeping fades? There are, in short, a number of questions here that can usefully be brought to the discussion about the likely and/or appropriate future of GPs in primary care.

III. Should GPs be in the Driver's Seat?

With these questions in mind, we turn to the third part of this paper, which focuses on the 'driver's seat' issue. What role should primary care have in running healthcare systems? This topic has been discussed a number of different ways over the last ten years. It is a rather helpful metaphor and, as we learned in the workshop, people have different and often quite interesting ways of thinking about this issue. Josep Figueras, a research director of the Observatory and a former GP in Spain, asked: do we really want GPs in the driver's seat? Martin Marshall wondered whether or not the driver's seat has to feel comfortable before GPs will get into it. Peter Groenewegen, from NIVEL in the Netherlands, asked: exactly how are GPs going to drive – on the left or the right? This was followed by Diana Delnoij, a primary care expert in Amsterdam, who asked whether or not there should be different drivers for different parts of the primary care system or different parts of the healthcare system – one for acute care, another for elective care, a third for chronic care.

One can conjure a number of additional questions. If GPs sit in the driver's seat will they actually drive? Who is going to give them a driving test? Is the driver's seat clinical or managerial in character? If all roads lead to Rome, are all GP-driven vehicles expected to get there? Further, what is Rome in this? Where is it that primary care wants to go, and is it the same place that the healthcare system overall needs to go? There also are questions about whether we need to build a special highway. Do general practitioners need high speed lanes for a privileged position? Wienke Boerma, who has studied general practitioners for 20 years, concluded rather wryly (does this have to do with his long experience in working with general practitioners?) that people tend not to

show their best side when they are driving.

There are additional complications that reflect the profusion of models currently emerging across Europe, and particularly given the central but complex matter of credibility. If GPs were to take over the driver's seat, they would have a larger role in co-ordinating services, which in turn suggests they would have a larger role as state agents. They would, in short, be spending more time as managers. Inevitably, this enhanced managerial role will increase their organisational power, although not necessarily their authority (in that their power may not be fully sanctioned). In some countries, this increased organisational role might well be questioned by hospital specialists as well as by other primary health care professionals. But if GPs' managerial role grows, if their state agent role grows, what can be expected to happen to the level of trust and to GPs' overall credibility? In the United States, we learned that trust can erode rapidly if it becomes clear that primary care physicians represent first and foremost the best interests of the managed care organisation rather than of the patient. Once that agent relationship between the patient and the physician was undercut, the trust of patients in their general practitioner plummeted. Consequently, the likely impact on trust is an important issue for policymakers to take into consideration.

A further concern, raised at the authors' workshop by Jan Heyrman from Belgium, was that primary care had become so complex that gatekeeping will no longer suffice as an adequate steering mechanism. He compared the general practitioner to a spider trapped in its own cobweb. He was concerned that the general practitioner, even if responsible for steering others and co-ordinating other dimensions of the system, does not have the power to ensure compliance. This places the general practitioner in the unenviable position of having responsibility for multiple dimensions of healthcare activities but without having sufficient controllability to guarantee their performance. Such an unbalanced relationship would violate the first rule of a good management control system: that responsibility and controllability be linked so as not to require a manager to undertake an impossible task (Young, 1984).

What kind of alternative strategies are possible? At various points in the workshop, it was suggested that perhaps primary care can be in the driving seat but the GP can be in the back seat. This is more or less the model which has emerged in some of

the Nordic countries with local level, elected political boards, for example the municipal health and social boards in Finland. This general model suggests that primary care could hold major co-ordinating responsibilities, but at the system organisational rather than the GP level. It suggests that in the future, if this strategy were to be followed, GPs could well have fewer rather than increased co-ordination or state agent functions. This in turn implies that a growing number of health system management functions would have to be transferred to various alternative agents located within primary care, but who were not practising GPs with a patient panel. This is already the case in some countries, however in other countries it would be something very new. Based on the broad differences in organisational models of primary care between countries, one also wonders whether different balances might emerge between general practitioners, on the one hand, and these non-GP primary care managers – these other entities that would be responsible for running the system – on the other.

It may also be worth noting that these new entities need not necessarily be termed Primary Care Trusts (PCTs), although some in the UK may choose to use this as a generic label. Others may wish to consider other approaches, based on the multiple directions in which general practitioners are evolving, and the different models emerging across Europe. One can speculate that there perhaps may be room for a new consensus or even a new paradigm to form around this issue. Perhaps, in the final analysis, general practitioners will in fact be content to be driven around, once they know where the car is headed.

Acknowledgements

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Appendix A:

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Appendix B:

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