

Perspective

General Practice in Pakistan and UK: What We can Learn from Each other

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Abstract

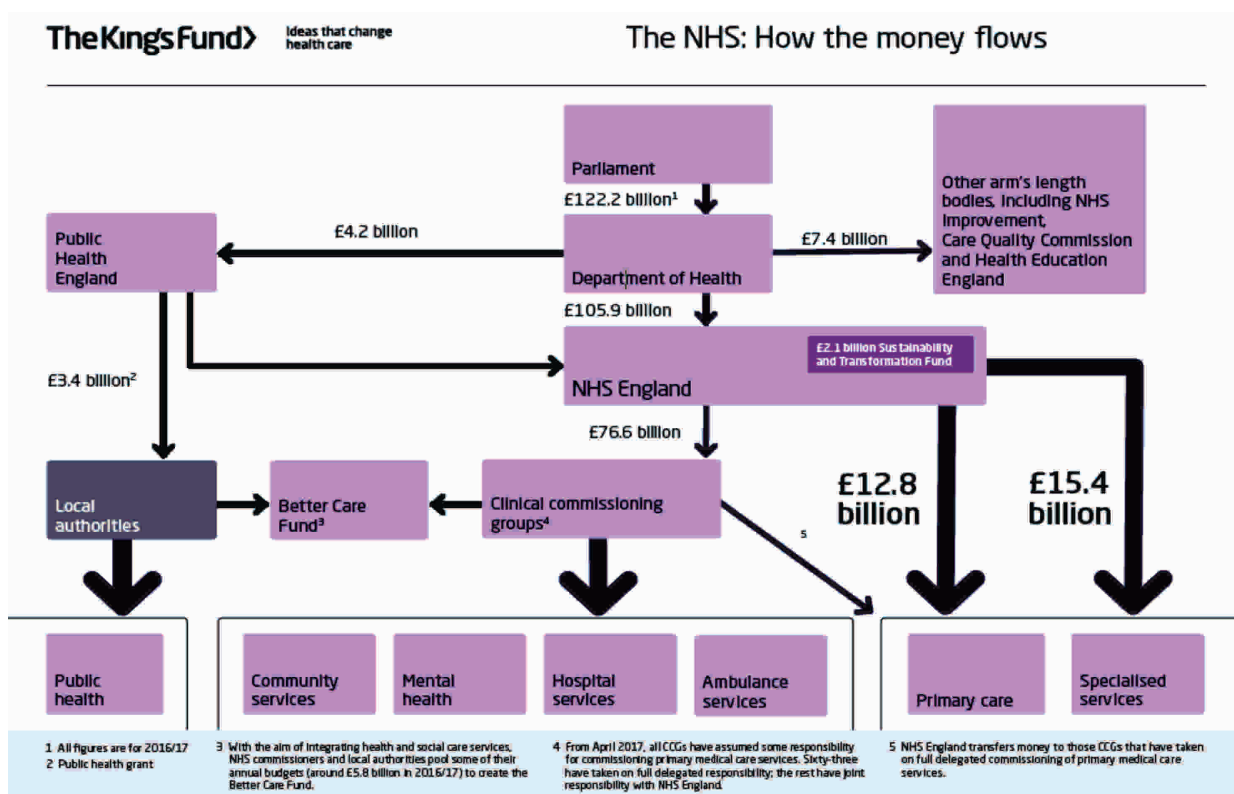
The National Health Service (NHS) came into being in 1948 in the wake of the nation's recovery after World War 2. This was the first true attempt at providing universal health care. This organisation has three core principles at its heart; that it meets the need of everyone, that it be based on clinical needs rather than the ability to pay and that it is free at the point of delivery. These three principles have guided the development of the NHS for the past 70 years and still remain the fundamental ethos despite many changes over the last few decades.

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Introduction

The NHS has massively grown since its inception. It now employs more than 1.5 million people making it by far the biggest employer in the UK and

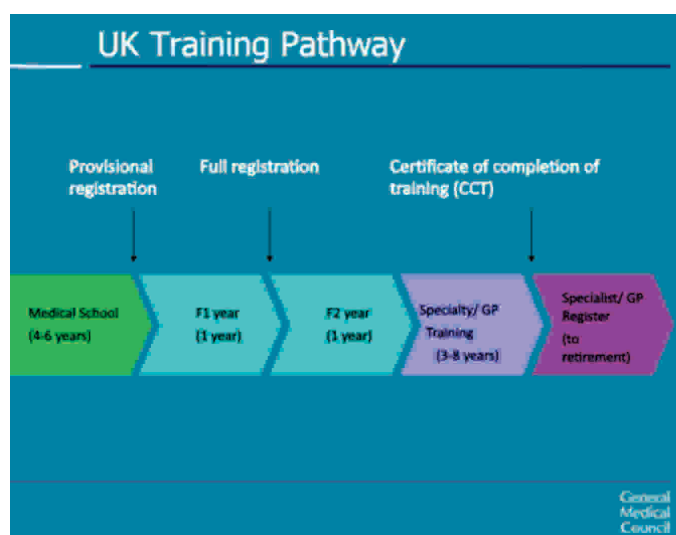
5th largest in the world. Doctors make about 12% of its work force out of which 2.8% are general practitioners¹. Primary care has always played a central role in the delivery of these core objectives.



98.8% of NHS funding comes from general taxation and national insurance while 1.2 % comes from patient charges². Workings of the NHS are best understood by tracking the flow of funding as depicted in this diagram by the King's Fund.¹⁰

It is quite evident that General Practitioners (GP) play an important role in the efficient and cost effective delivery of healthcare. They are technically self-employed but most of their work and income comes from the NHS. This is mainly in the form of capitation fee, where GP is provided certain amount of money for each patient who is registered with them. They provide most services as their core contract with the NHS. They provide some additional services which are periodically negotiated, commissioned and additionally funded. Most importantly, they work as a gateway to access virtually all of secondary care services. They are also involved in commissioning of various services including hospital services, mental health, community services and ambulance services via Clinical Commissioning Groups. Some of them provide training for future GPs and medical students if appropriately accredited. UK medical training pathway is summarised in following diagram.

Training structure for general practice comprises of two years of foundation training mostly in various



specialities in hospital followed by 3 years of GP registrar training, out of which 16 months are spent in hospitals and 20 months are spent in general practice. Registrars are usually trained under supervision of the same GP tutor throughout their training. They go through series of exams and rigorous work place based assessments. Upon successful completion of which they are given a certificate of completion of training and they are able to independently practise.

This training is partly funded by Health Education England (fully public funded) and partly by their service delivery (pay for the work that they do).

UK spent about 9.7% of its gross domestic product (GDP) on health care and ranked 13th in 2016 according to the World Bank figures³. Total health care costed a shade over 190 billion in 2016. Healthcare spending per person was just under £3000. Total healthcare expenditure in 2017 was £197.3 billion, an increase of 3.3% on spending in 2016. Total current healthcare expenditure in the UK accounted for 9.6% of gross domestic product (GDP) in 2017, compared with 9.7% in 2016. In real terms, adjusted for inflation, total healthcare spending increased by 1.1% in 2017, while real healthcare expenditure per person grew by 0.5%; these represented the lowest rates of growth since the start of the series in 2013⁴.

There are various models of universal health care delivery in developed world. In a single-payer system, the government taxes its citizens to pay for health care. The United Kingdom is an example of single-payer socialized medicine. Some countries enforce an insurance mandate. It requires everyone to buy insurance, either through their employer or the government. Germany is the best example of this system. Some countries use a two-tier approach. The government taxes its citizens to pay for basic government health services. Citizens can also opt for better services with supplemental private insurance. France is the best example for this approach⁵.

What is the best model of care? More importantly what is more likely to work in Pakistan? This will be difficult to determine as it depends on so many factors. We certainly need to probe following issues. What resources are available, how are these resources being generated, what proportion is allocated to healthcare, how efficient is the current health care model, and where are the main areas of improvement?

According to WHO data 2017, the UK spent 4,356 U.S dollars per capita on health and ranked 14th in the world. Same data suggested that Pakistan spent 38 U.S dollars per capita on health and ranked 170th.

It is interesting to note that IMF data ranks UK at 26th by way of GDP purchasing power parity (PPP) per capita while Pakistan is ranked at 135th. This suggests that Pakistan has considerably lower level of wealth, which is not surprising. However, it is quite worrying that Pakistan spends a lot lower percentage of that GDP on health in contrast to the UK. In other words developed countries have significantly higher GDP and they spend an even higher proportion of this wealth on their healthcare as compared to developing

countries. Most of the developed nations are spending around 10% of their GDP on health while Pakistan is spending mere 2.75% of its GDP on health³.

The Common Wealth Fund performed a study comparing quality of health care in 11 developed nations in 2014 and ranked UK at number one⁷. This suggests that the UK model of care is quite cost effective but it still involves spending a very large amount of money on health which is not a realistic prospect in Pakistan at this time. Therefore, I decided to explore our immediate neighbourhood where circumstances and resources are somewhat similar.

I am particularly impressed by the performance of the healthcare system in Sri Lanka and in the state of Kerala in India. Their health parameters have been steadily improving and becoming comparable to developed nations with relatively modest health spending. Sri Lanka is using a variation of a two-tier approach. Approximately 50% of outpatient care and 90% of inpatient care is funded by the government while rest is either covered by medical insurance or out of pocket⁸. Sri Lanka is still spending 3.89% of their GDP on health and their GDP per capita is \$13,397. While Pakistan spends 2.75% of GDP on health and its GDP per capita is \$5,680⁶.

Sri Lankan model is performing better, mainly due to their long term investment in improving education and primary care over a long period of time. This coincides with their improved GDP which allows them to put more resources into health care. They have elected to spend more money on primary care and smaller hospitals with essential equipment instead of developing big and expensive tertiary care institutions⁹. This has proven to be much more cost effective use of their relatively limited resources. I believe we can learn a lot from their model.

Suggestions and recommendations

Significant real term increase of investment in health and education

Strengthening basic health units focusing on maternal and child health, communicable diseases, prevention and health promotion strategies

Provision of access to some diagnostics at primary care level

To develop strategies to retain doctors in primary care by incentives e.g. increased salaries, private practice, and better career structure.

To train other health care professionals to provide some primary care services, e.g. nurses and pharmacists can be easily trained to deal with minor ailments in addition to their normal duties.

To allow only primary care doctors to refer to secondary care, thereby acting as gatekeepers and managing demand.

To introduce some form of structured training of GP's to prepare them for this role.

To develop curative services consisting of THQ/DHQ hospitals, providing both hospitalization and ambulatory services while basic Care units providing only ambulatory care which function with non-specialist medical doctors and other staff.

Conclusion

We need to take a bottom up approach which involves putting basic education and primary health care at the forefront of considerably increased expenditure of resources.

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