

Commentary – Alma Ata

Is the traditional family doctor an anachronism?

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Key Messages

The polyclinics debate should recognise the need to balance the benefits of long-term personal doctor–patient relationship with the broader improved health outcomes from evidence based inputs from multidisciplinary teams in primary care.

There is increasing evidence from the international health literature that a focus on integrated health systems is the key to better health outcomes both at the individual and population levels, in addition to being more cost effective.

Although there is some evidence that other healthcare professionals such as nurse practitioners can deliver equally high health outcomes for patients, the GP role is not an anachronism and even seems increasingly more important in the 21st century given the increasing complexity of primary care and long term conditions.

Keywords: continuity of patient care, family practice, health service research, holistic health, patient advocacy, policy making trust, professional practice

Introduction

In many developed countries, the traditional family doctor has acted as a point of first contact for medical matters (the 'medical home' or 'regular source of care'); provided continuity of care (sometimes 'from cradle to grave'); and acted as a care coordinator or guide to other parts of the system.¹ In optimal circumstances, the operationalisation of these roles has resulted in a positive relationship between patients and GPs characterised by trust, mutual respect and familiarity.² A long-term relationship with an individual family doctor is greatly valued by patients, especially those with long-term illness and co-morbidity, and is associated with better health outcomes and lower costs.^{3,4}

In some countries, the role of the family doctor has evolved into a highly structured profession – the General Practitioner (GP) or Family Physician (FP) – with

defined training, organised professional bodies and values (see Box 1).⁵ Elsewhere, particularly in low and middle income countries, there is no established family doctor role; primary care services are underdeveloped, and access to any medical care limited.⁶ When these countries have moved to set up general practice as a discipline, they have generally turned to the more established GP organisations in North America, Western Europe or Australasia as a model or for guidance.⁷ These differences in the structure and quality of primary care was condemned in the Alma Ata Declaration 30 years ago, which also advocated for a more integrated and responsive primary health care systems.

Many analysts will argue that globally, the observed changes in the structure and delivery of primary health care in the past few decades have been largely in

Box 1 Professional values in general practice²

The professional values of GP organisations in developed countries are very similar. These shared values of general practice have emerged through the cross-fertilisation of ideas, people, values and common professional and humanitarian principles and focus on providing:

- holistic patient-centred care
- patient advocacy
- continuity of care

response to changing disease patterns, diagnostic and therapeutic possibilities, and patient expectations, and to a lesser extent, a response to the vision articulated in the Alma Ata Declaration. So how relevant is Alma Ata to the 21st century GP?

The end of the road for general practice?

Recent trends

The introduction of new technologies (e.g. in diagnostics, therapeutics and information technology), structures for health care provision (e.g. walk-in-centres and poly-clinics), patient expectations (e.g. the rise of choice and consumerism) and expansion in the number and roles of other health care providers (e.g. nurse practitioners, physician assistants and an increasing number of alternative care providers) have led to a 'mixed economy' of primary health care provision and threatened the role of the traditional family doctor.^{6,8-10}

Despite these changes, we believe that the need for the type of the care offered by GPs is rising, not falling. The examples we have chosen are not exhaustive, but represent areas where there is evidence that general practice has a central role to play now and in the future.

'Gate-keeping' and the costs of health care

Every health care system faces the challenge of keeping within its allocated financial resources. In developed nations with well established general practice systems, GPs act (or are being encouraged to act) as gate-keepers to more expensive secondary care services. In the absence of a gatekeeper role, policy makers may impose obstacles to health care consumption, either on patients (in the form of co-payments) or on GPs (in the form of referral management systems).¹¹

The GP's gate-keeping role is not only one of cost containment. Having a trusted and familiar GP, who takes a holistic view of a patient's symptoms or illness assists patients in making more informed and appropriate choices by asking questions such as 'Is this operation really necessary?'.¹ Potentially there is a win-win situation: patients make informed choices about health care interventions and funders make savings from the judicious use of increasingly expensive health care services.

In countries (such France and Germany) where patients have a free choice of direct access to specialists, the role of GPs could be extended to guide patients towards the most appropriate actions when they are unwell. Building long term trust-based relationships may also help to counter one of the most unwelcomed aspects of such health systems, namely 'doctor-shopping', where patients consult multiple doctors until their wants are met.¹²

The gate-keeping role of the GP is being challenged by two important trends: greater information and reduced trust. The internet has opened up patient access to health information (and dis-information) – resulting (sometimes) in better-informed discussions and (at other times) in demands for inappropriate, costly or potentially hazardous interventions.⁸ Differences in health care practice within and across countries (for example in the frequency or cervical smear tests or PSA screening for prostate cancer) are readily discovered and may increase demand for health care.¹³ The future-proof GP needs to have the necessary skills in information mastery to find the right evidence at the right time to help patients make informed choices.¹⁴

Almost all aspects of the GP–patient relationship – advice, advocacy, guidance, and therapy – are built on trust. In the 21st century, 'blind' trust in the medical profession has been questioned, partly due to a number of scandals.¹⁵ Trust has now to be earned both on a personal and professional level and GPs increasingly need to demonstrate the necessary attitudes, knowledge, skills and commitment to earn the trust of patients. The trusted GPs is well placed to act as a counterweight to the growing tide of consumerism and commoditisation of health care and 'disease-mongering' that is occurring in all nations which threatens to bankrupt health systems.¹⁰

In less developed nations, where few have free access to health care, illness can have significant financial consequences for the individual and their family.¹⁶ Even when health care is free, access to health care is often limited as health care professionals tend to be clustered in urban areas, and long queues may mean that time has to be taken off from paid employment, adding greatly to patient-borne costs.¹⁷ In such circumstances, guidance and advice from a 'gate-keeping' professional on whether (and what sort of) healthcare is needed is even more crucial.

The potential deleterious financial impact of ill health is not restricted to developing nations. Illness is as a common cause of bankruptcy in the USA.¹⁸ Where health systems are organised in such a way as to potentially condemn patients to penury as a result of ill health, then the familiar and trusted GP has a doubly important role in helping to ensure the best use of the patient's resources – both psychological and financial (see Box 2).

Chronic and infectious diseases

The GP has a central role in the management and support of patients with chronic diseases and such a role will grow in importance as populations age and

the prevalence of chronic (and often multiple) health problems increases. This predicts a need for greater coordination of care as different generalist and specialist professionals are involved in the patient's multiple, complex and changing needs. In many developed countries, much chronic disease management is already undertaken by multidisciplinary teams.¹⁹

The assumed 'gold standard' for chronic disease management includes input from a wide mix of skills and expertise (rarely found in a single practitioner), educational support for self-care, sophisticated information systems to support coordination and prevent duplication of care, and (often) access to specialist investigations. However, whilst large multidisciplinary teams may offer a more appropriate skill mix, they are

Box 2 The need for general practice: a case example from China

China is a vast country with a population of approximately 1.3 billion (21% of the world's population). China spends approximately 4.7% of GDP on health care. Life expectancy for men and women is 69.6 and 73.7 respectively and rising. Overall the health of the population in China is improving, but at a much lower rate than the growth in health expenditure (approximately 16% per annum).

Over the past three decades or so, China's health care system has undergone a dramatic series of reforms. Decentralisation and market forces were introduced into a health care system which had been community based and state or collectively run. The Cooperative Medical System (CMS) in rural areas was staffed by local community members with limited training ('barefoot' doctors), who provided primary care to the local population. A significant contributor to the demise of the CMS was the collapse of the collective system and economy in rural communities as they formed the main source of finance for this system. In urban areas, reform of state owned industries led to the phasing out of clinics (linked to factories) and 'factory doctors'.

The focus of health care moved from the community and place of work to local and regional hospitals and health departments. Most hospitals were state-owned but were required to generate up to 90% of their income from user fees charged to patients and health insurance funds. Health care providers were thus encouraged to 'over-service' patients by increasing the use of diagnostics, procedures and medications. In 2005, user fees constituted 54% of total health expenditure with the government accounting for 17% and health insurance 29%.³⁷

The demise of the CMS has left the rural population of China with few health care options. Village clinics are predominantly privately run and poorly staffed and users had to pay for all the expenses themselves for the clinic's services. The majority of local hospitals are based in urban areas and user fees have erected a significant barrier to access to health care. For example, in 2005, a farmer can expect to earn 3255 RMB* per annum, an average outpatient appointment costs 127 RMB and an average inpatient episode is 4662 RMB. Poor health has been cited by 30–50% of the poor as the single largest cause of poverty. In a survey in eight provinces in China several years ago, 41.8% of rural households where a member had a catastrophic illness borrowed money for treatment. Average borrowing was 4360 RMB and money was borrowed from relatives (74.8%), credit union (9.4%) or friends (7.5%).

In response to the growing need for a more comprehensive health care provision for all (and especially rural populations), in 2003 the Chinese government launched its 'New Cooperative Medical System' (NCMS). This county (as opposed to local or village based) system is subsidised by the government and members pay an annual subscription to enrol in the NCMS. To further strengthen the provision of health care at a local level, Community Health Centres (CHCs) and Township Health Centres (THCs) were introduced into rural and urban areas, respectively. When staffed by fully trained General Practitioners, CHCs and THCs could make a significant contribution to the well being of the Chinese population. However, general practice is a new discipline in China and faces a range of challenges, from the need to build capacity to the societal devaluation and misunderstanding of general practice (for example, patients often prefer to bypass CHCs and THCs in order to see specialists in prestigious hospitals at much higher costs).

* RMB (Renminbi) 1RMB = approx. UK£0.07 or US\$0.14

not valued as much by patients because of the concomitant loss of access and continuity of care as provided by the single-handed (or small-practice) GP.²⁰ The right balance in service delivery between the continuity of a single, long-term personal relationship and evidence-based input from multiple experts has yet to be established for any chronic condition.

Non-infectious chronic diseases are set to become the main causes of morbidity and mortality in most low and middle income countries, putting additional strain on existing fragile health systems.²¹ India and China, for example, face growing epidemics of obesity, diabetes and cardiovascular disease. Furthermore, increasing affluence and health expectations are likely to drive the demand for a trusted source for advice, diagnosis and treatment.

With aging populations and the growing global burden of chronic diseases there is the potential for fragmentation of care as a patient develops more than one illness. In developed nations which lack a strong general practice system (e.g. USA), lack of coordination in the care of a patient with multiple health problems (the absence of what has been termed a 'medical home') is a significant contributor for poorer health outcomes despite high health care expenditure.¹ In middle-income and developing countries, a 'medical home' that allows for coordination of care for multiple diseases, and also provides the infrastructure for proactive surveillance, health education, and preventive care is equally important, as the middle classes develop 'diseases of affluence' and the poor face the double jeopardy of infectious diseases as well as increasing risk of non-infectious ones (e.g. related to smoking or obesity).

Traditionally, it has been physicians (such as GPs) who have acted as care coordinator and a source of advice, diagnosis and treatment. However, the attitudes, skills and knowledge for such a role are not confined to GPs and where there have been physician shortages, such roles have been successfully undertaken by other health care professionals (such as nurse practitioners).²²

Within developing nations, infectious diseases cause a significant burden of ill health and governments, non-governmental organisations and charities have focused on tackling these. However, many have been accused of focusing too narrowly on single conditions (e.g. HIV or TB) and ignoring the need for a more holistic approach to patient care.²³ This is especially important as infectious diseases often occur alongside other non-infectious chronic disorders (for example in tuberculosis and diabetes).²⁴ There has been a global call for a change in funding streams from disease-specific initiatives to capacity-building in primary care and GPs can make a contribution, alongside other primary care professionals, in this call for a more holistic approach.

Policy and research challenges

Measuring the 'real' value of general practice

To date the research evidence demonstrates that good general practice can improve population health outcomes but more work needs to be done to help us understand how and why this happens. The 'added value' of being trusted and familiar to patients is difficult to define or measure. Health services research tends to measure the measurable (for example, prescribing data, consultation rates or referral patterns)²⁵ while 'softer' (and often more patient-centred) outcomes are rendered invisible.²⁶ Balint highlighted that much of the added value of general practice comes from the interaction between the doctor and her or his patient (the consultation) and that the doctor herself/himself acts as a powerful medicine (the 'drug doctor').^{27–29} However, more research is still needed to help us understand the theoretical and practical steps that lead to the development of the trusting relationship that is so central to the care offered by general practice. For example, what factors help GPs to build up trust? How does this happen – i.e. what theories are in operation? Is being medically trained important or can other primary care professionals add similar value?

Building recognition and capacity

In many low and middle income countries, neither general practice nor primary health care are recognised as distinct specialties with their own body of knowledge. Even when there is such recognition, GPs are held in lower esteem, poorly remunerated compared to their specialist colleagues, and seen as adding little to patient care (see Box 2). Many GPs have no post-graduate training beyond medical school and work in conditions where, in order to make a living, must see large numbers of patients under time pressures. Such conditions have resulted in poor recruitment in to general practice and emigration or 'defection' to specialty training.⁶ The disadvantages and disincentives faced by GPs are often the result of multiple causes which are complex and unique to each health care system and involve the interplay within each country's historical, political and socio-economic make-up. There is no 'one-size-fits-all' solution to this daunting challenge worldwide. When general practice has managed to emerge as an increasingly important specialty, it has been as a result of deliberate increased resourcing and policy initiatives from national governments^{30,31} and international bodies (such as the World Health Organization).²⁵

Based on the current evidence on the contribution that health care systems with strong physician primary care provision improve population health outcomes and that values of general practice are well matched to the health challenges of the 21st century, it is not surprising that primary care and in particular general practice has gained increasing prominence on the world stage as a favoured policy device. However, in many rural communities in developed nations (for example in USA, Canada and Australia)³² and in middle-income and developing countries, the inability to recruit GPs has resulted in the provision of care independently and exclusively by other health professionals, such as nurse practitioners.^{6, 22, 33} There is some evidence that in primary care, nurse practitioners deliver equally high quality (if not sometimes better) care.³⁴ However, the expansion in the use of other primary care professionals has often been limited for a range of reasons (such as protectionism,³⁵ role misunderstanding and devaluation^{22, 33} and professionals' prevailing norms and expectations).³⁶ Whilst traditionally much primary care has been GP focussed and delivered, meeting the increasing health needs of patients will require all primary health care professionals to work together and research on how this might best be achieved is needed.

Conclusion

Far from the GP being an anachronism, we believe that there is strong evidence that the type of care traditionally provided by GPs is increasingly important and beneficial. The key inputs of personal care over time, coordination of care and guidance to the wider health-care system, built on familiarity, trust, and a long-term interpersonal relationship, have been shown to add value to healthcare systems globally. Where this can be done by specially trained doctors – GPs, the optimal use of resources will take place. When such doctors are not available, then consideration will need to be given to the utilisation of other health care professionals (such as nurse practitioners), though it is not clear if a health care professional with a different training background and professional ethos can simply act as a 'substitute'. However, good general practice depends on a motivated and professional workforce that is appropriately trained in the skills of holistic care, information management, and teamwork. The well-described benefits of general practice will not be reaped if the system is under-resourced and staffed by unmotivated physicians. Whether the quality features of general practice might be achieved by different professions (especially nurse practitioners) and/or by entirely new roles is an important research question for health

systems in the 21st century. The current shift in emphasis to integrated primary care health systems provides an opportunity to address these research questions in the current polyclinics debate and the policy recommendations arising from the Healthcare for London (HfL) report.

Summary points

- General practice (family medicine) is a distinct branch of medicine characterised by holistic, patient-centred care, patient advocacy, continuity of care, and judicious guidance to the wider health-care system. It has an established body of knowledge and (in some but not all countries) a well-developed system of training and self-regulation.
- Changes in disease patterns and population demographics in the 21st century will create a greater demand for the type of care provided by the traditional general practitioner.
- Whilst there is good evidence that high-quality general practice is associated with improved outcomes and lower costs of care, its added value is not universally recognised.
- Unanswered research questions include whether the 'added value' of general practice could be achieved by the input of different professionals, and how to build capacity in countries where the healthcare system is oriented to secondary care.

Literature links

Wonca (www.globalfamilydoctor.com/)

Wonca (World Organization of Family Doctors) represents and advocates for 119 general practice/family physician organisations across 99 countries. Its main functions are to represent general practice at an international level and also to promote, sustain and help member organisations to work together and share good practice.

15by2015 (www.15by2015.org)

The 15 by 2015 campaign was launched in 2008 by a partnership of professional and non-Governmental Organisations. The campaign is based on the evidence that primary care is, "... *the best and most affordable ways to save the most lives and improve overall health. And so should form the cornerstone of all health care systems. Its goal is to have, ... donor organizations allocate 15% of their vertical funding towards sustainable comprehensive primary health care that is accessible and affordable in all regions of the world.*"

The future direction of General Practice – a roadmap (www.rcgp.org.uk/PDF/Roadmap_embargoed%2011am%2013%20Sept.pdf)

GPs in the United Kingdom (UK) face many of the challenges raised by us in this article. In response to the potential fragmentation of care and devaluation of the unique contributions of GPs in the UK to patient care, the Royal College of General Practitioners worked to provide a vision of a way forward to challenge these potential threats.

Achieving a high-performance health care system with universal access: what the United States can learn from other countries

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This position statement was published by the American College of Physicians and highlights what this organisation believes are the challenges facing the American health care system. They make a number of recommendations which recognise the contributions that primary care can make to improve access, co-ordination and the quality of patient care for Americans. Furthermore, they call for an expansion of the primary care physician workforce by providing the necessary incentives for training in this specialty.

People-centred health care: a policy framework
WHO Western Pacific Region. Manila:WHO,2007 (www.wpro.who.int/NR/rdonlyres/55CBA47E-9B93-4EFB-A64E-21667D95D30E/0/PEOPLECENTREDHEALTHCAREPolicyFramework.pdf)

This report was endorsed by the member countries of the Western Pacific Region of the World Health Organization in 2007 and is the brainchild of the visionary Dr Shigeru Omi (Regional Director, WHO Western Pacific Region). This report highlights the problems that many national health systems face and then explains why the solution may come by focussing care on people and not just diseases. Of note is that fact that this report suggests a number of policy level reforms to that may realign health care systems to be more people centred, notably, that primary care must be developed and strengthened (Section 4.4 – page 13).

CONTRIBUTORS AND SOURCES

GW drafted the paper and LJW and NB both contributed significantly on the overall content, concepts and structure of subsequent drafts. GW is a GP Principal in an urban NHS practice and academic in the UK with expertise and teaching in international comparisons in primary care. LJW is an assistant research fellow in a think tank in China with expertise in health care reform and general social policy. NB is a GP and Professor of General Practice in Denmark and Norway and has been Chair of the Wonca International Classification Committee. His expertise is in teaching, medical audit and International Primary Care Classification. In writing this paper, all authors have drawn on their personal knowledge of primary care, general

practice and international health care system as well as their personal bibliographies and recent publications on this topic. GW is the guarantor of this paper.

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CONFLICTS OF INTEREST

None.

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