THE FIVE-STAR DOCTOR:
An asset to health care reform?

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Defining universal challenges in health reform is itself a challenge, let alone proposing appropriate responses to such challenges. We hope to avoid the risks inherent in such generalization by focusing on some major changes that would lead to the adequate provision of health care to all. Although the spectrum of causes of death, disease and disability that hinder an enjoyable and productive life varies considerably with environment, socioeconomic context and demography, we will try to identify determinants valid in any health care delivery system.

In much of the world, both health care beneficiaries and those who plan, finance and provide health care are increasingly aware of the need to reform health care systems but have very different priorities and expectations. For example, consumers primarily want high-quality health services in adequate quantity; health professionals want to expand their knowledge base and exercise independent judgment in providing the best possible care; and health care policy-makers want care for all citizens that is cost-effective.

SHARING VISION on CHALLENGES in HEALTH REFORM

For a health care system to make the necessary changes and run efficiently, however, the main stakeholders must decide to work together and must agree on a set of fundamental values. Relevance, quality, cost-effectiveness and equity are values implicit in the goal of health for all, endorsed by all nations and governments, which offers such a basis. The

stakeholders – policy-makers, health system managers, researchers, care providers, educators and consumers alike – must re-examine their position on the health chessboard and consider readjusting their expectations to ensure that these values are upheld and people's health needs are better met. It is in this context that the future role of health professionals, and in particular, the medical doctor, should be thought of.

Relevance: Relevance in health care can be defined as the degree to which the most important problems are tackled first. Although priorities may be interpreted in different ways in different societies or by different groups within the same society, primary attention should be given to those who suffer most, to ailments that are most prevalent, and to conditions that can be addressed with locally available means. It is fundamental that health policy reflect these priorities. Relevance also implies an organized effort to constantly update a plan to address the priority health needs. Certain aspects of relevance may be considered universal. As articulated in the Declaration of Alma-Ata[1], these include issues of universal access, primary health care services, essential public health services and availability of essential drugs.

Quality: High-quality health care uses evidence-based data and appropriate technology to deliver comprehensive health care to individuals and populations, taking into account their social, cultural and consumer expectations. WHO's definition of health as "a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity" should be a beacon for health care reformers and communities. The quest for high-quality care is universal, but the definition of quality may differ with sociocultural context. Also, what is good can no longer be determined solely by the professionals and institutions that deliver the goods and services. Consumers expect health services to be comprehensive, continuous and

[1] *Alma-Ata 1978: primary health care. Report of the International Conference on Primary Health Care, Alma-Ata, USSR, 6–12 September 1978. Jointly sponsored by the World Health Organization and the United Nations Children's Fund*. Geneva, World Health Organization, 1978 (WHO "Health for All" Series, No. 1).

personalized to respond to their specific needs for well-being. High quality in health care must therefore encompass the technical criteria set by health care providers and the comfort criteria set by health care consumers.

Cost-effectiveness: The rise in health care costs is due to universally observed phenomena: specialization in health care, which implies the use of costly procedures; increased access to health services due to sociodemographic changes; increased demand from individual consumers as expectations for a better quality of life result from wider access to information. As these phenomena will persist and even be amplified in the future in any society, all health policy-makers and health care providers concerned with the health reform process must give urgent attention to the containment of cost without compromising effectiveness in health care. This issue is all the more urgent as governments, under socioeconomic pressure to invest preferentially in more wealth-producing sectors, allot no increase in health budgets; in many countries, health budgets are decreasing even as the health status of the people is deteriorating.

Cost-effective health care systems are those that have the greatest positive impact on the health of a society while making the best use of its resources. Whatever the level of resources available, cost-effective care can be provided.

Equity: Equity, which is central to a socially accountable health care system, means striving towards making high-quality health care available to all. The central goal of the WHO Global Strategy for Health for All is that all people receive "at least such a level of health that they are capable of working productively and of participating actively in the social life of the community in which they live. To attain such a level of health, every individual should have access to primary health care and through it to all levels of a comprehensive health system."[2] Equity means that people's needs, rather than social privileges, guide the distribution of opportunities for well-being.[3]

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[2] *Global Strategy for Health for All by the Year 2000*. Geneva, World Health Organization, 1981.

[3] *Equity in health and health care: a WHO/SIDA initiative*. Geneva, World Health Organization, 1996 (unpublished document WHO/ARA/96.1; available on request from Division of Analysis, Research and Assessment, World Health Organization, 1211 Geneva 27,

The quest for relevance, quality, cost-effectiveness and equity is universal. Societies at every level of socioeconomic development seem to adhere to the same fundamental principles. Attaining each of these values is indeed a challenge for health reformers, but even more demanding is the need to address this challenge in a balanced way.

Figure 1 depicts these four values plotted on a diagram, analogous to a compass. The crossing of the axes is the lowest point and the extremities of the axes are the optimal points on the scale of values. This “health compass” represents an ideal health care system that is attempting to meet the needs of individuals and populations.

Switzerland).

Figure 1. "The health compass"

The compass analogy may not seem appropriate, as it implies the need to choose and maintain a direction, whereas in the case of health reform it should not be necessary to choose one value at the expense of others. But the compass analogy shows the tensions that exist in a health reform process that aims at finding technically appropriate and socially acceptable compromises among all values at the same time.

In our view, the essence of the responses to challenges in health reform lies in reducing the conflict of interests among the different stakeholders in each of the four principles, in order to release tension and find a *modus operandi* that permits approaches based on these principles to evolve to full bloom.

THE EMERGENCE of the FIVE-STAR DOCTOR

The optimal model of health service delivery may be one that contributes to the convergence of different inputs towards the satisfaction of the values of relevance, quality, cost-effectiveness and equity in health. Innovative thinking and courageous attempts must be made to counteract the galloping fragmentation of the health care delivery system, which is characterized by at least three splits (see figure 2): the first is the relative isolation of individual care from population-based care, or in other words, the split between medicine and public health (A); the second is the split between generalists and specialists (A') and the third is the split between the health sector and other sectors with a bearing on health (A"). Figure 2 shows how a reconciliation of the splits could be mapped[4].

[4] Boelen C. From fragmentation to unity in health care: a challenging journey. *Changing medical education and medical practice,* June 1996:2.

Figure 2

Priority should be accorded to reconciling activities geared towards the health of individuals and groups and research dedicated to the design of appropriate schemes, whereby both sets of activities could be carried out in coordination and in an acceptable and cost-effective balance, either in the same health care settings or by the same health professionals.

The concept of the "five-star doctor" is proposed as an ideal profile of a doctor possessing a mix of aptitudes to carry out the range of services that health settings must deliver to meet the requirements of relevance, quality, cost-effectiveness and equity in health. The five sets of attributes of the "five-star doctor" are summarized in Figure 3.

Figure 3

	The five-star doctor
*	Care provider
*	Decision-maker
*	Communicator
*	Community leader
*	Manager

Details of these attributes are given below

- **Care-provider**. Besides giving individual treatment "five-star doctors"must take into account the total (physical, mental and social) needs of the patient. They must ensure that a full range of treatment - curative, preventive or rehabilitative - will be

dispensed in ways that are complementary, integrated and continuous. And they must ensure that the treatment is of the highest quality.

- **Decision-maker.** In a climate of transparency "five-star doctors" will have to take decisions that can be justified in terms of efficacy and cost. From all the possible ways of treating a given health condition, the one that seems most appropriate in the given situation must be chosen. As regards expenditure, the limited resources available for health must be shared out fairly to the benefit of every individual in the community.

- **Communicator**. Lifestyle aspects such as a balanced diet, safety measures at work, type of leisure pursuits, respect for the environment and so on all have a determining influence on health. The involvement of the individual in protecting and restoring his or her own health is therefore vital, since exposure to a health risk is largely determined by one's behaviour. The doctors of tomorrow must be excellent communicators in order to persuade individuals, families and the communities in their charge to adopt healthy lifestyles and become partners in the health effort.

- **Community leader**. The needs and problems of the whole community - in a suburb or a district - must not be forgotten. By understanding the determinants of health inherent in the physical and social environment and by appreciating the breadth of each problem or health risk "five-star doctors" will not simply be treating individuals who seek help but will also take a positive interest in community health activities which will benefit large numbers of people.

- **Manager.** To carry out all these functions, it will be essential for "five-star doctors" to acquire managerial skills. This will enable them to initiate exchanges of information in order to make better decisions, and to work within a multidisciplinary team in close association with other partners for health and social development. Both old and new methods of dispensing care will have to be integrated with the totality of health and social services, whether destined for the individual or for the community.[5]

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[5]Boelen C. Frontline doctors of tomorrow. *World Health*, 1994, 47:4–5.

Although the five attributes described above may equally apply to any health professional, family doctors come close to fulfilling the concept of the “five-star doctor”, and it is fair to say that in an increasing number of contexts they are seen as playing important roles as primary care providers who can reconcile quality and cost-effectiveness in care. It should also be stressed that, where doctors are scarce or not available, these roles can be played by other health care providers.

Shaping the profile of the doctor of the future, such as the “five-star doctor”, offers a pragmatic opportunity for health care, medical practice and medical education interests to work together, with health for all as their common goal (see Figure 4). Such a profile could develop as a point of convergence of these interests and the expression of a common denominator for their work.

Figure 4

Optimal practice patterns could then develop to enable the "five-star doctor" to respond efficiently to challenges in the health sector. Optimal educational approaches should be in place to prepare future graduates and to reorient doctors already in practice to assume the new roles and responsibilities expected of them.[6]

Medical schools have an important role to play in this regard. In committing themselves to prepare future doctors of the kind of the "five-star doctor", they demonstrate their capacity in contributing proactively to shaping the future health system.

To fully respond to societal needs, medical schools must accept responsibility for the outcome of their deeds. Is there evidence that the graduates they produce optimally respond to priority health concerns? Do research results have a positive impact on the way health care services are delivered and address health priorities? Do delivered health care services optimally respond to needs?

Social accountability of medical schools is defined as the obligation to direct their education, research and service activities towards addressing the priority health concerns of the community, region, and/or nation they have a mandate to serve.

The four values used to assess progress in addressing social accountability - relevance, quality, cost-effectiveness and equity - must be emphasized by the medical school and the health care system alike.

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[6] *Priorities at the interface of health care, medical practice and medical education: report of the global conference on international collaboration on medical education and practice, 12-15 June 1994, Rockford, Illinois, USA*. Geneva, World Health Organization, 1995.

Figure 5 provides a schematic overview of the social accountability grid, which is a framework for assessing a medical school's progress towards social accountability in the three domains of education, research and service.[7]

Figure 5

It is proposed that in each domain and for each value a medical school provide evidence of its contribution through the three phases of "planning", "doing" and "impacting". By "planning", the school demonstrates its commitment. By "doing", it demonstrates its

[7]Boelen C, Heck J. *Defining and measuring the social accountability of medical schools*. Geneva, World Health Organization, 1995 (unpublished document WHO/HRH/95.7, available on request from Division of Organization and Management of Health Systems, World Health Organization, 1211 Geneva 27, Switzerland).

allocation of resources, time and energy to implement its commitment. By "impacting", the school stretches beyond the traditional boundaries of the medical school's sphere of activity and makes special efforts to develop partnerships with other entities – governments, communities, professional associations – to influence health in society. Users of the grid may decide to develop indicators for each cell and to modify those proposed in it to make them more meaningful to their context.

In applying the concept of social accountability to the "five-star doctor", a medical school should pay attention to the changes that are needed in its educational programmes but also to initiatives it should take to ensure that graduated "five-star doctors" can properly function in their future working environment, in consistency with requirements of health reform.

FUTURE TRENDS

In 1994, in the joint WHO and WONCA (World Organization of Family Doctors) conference, reference was made to the "five-star doctor" particularly when recommendation was made that "the family doctor (general practitioner/family physician) should have a central role in the achievement of quality, cost-effectiveness and equity in health care systems. To fulfil this responsibility the family doctor must be highly competent in patient care and must integrate individual and community health care"[8]

In 1995 the World Health Assembly, the principal governing body of the World Health Organization, in adopting Resolution WHA48.8, "Reorientation of medical education and medical practice for health for all", urged WHO and its Member States to undertake coordinated reform in health care and in health professions practice and education. It also called for a "Coordination of worldwide efforts to reform medical education and medical

[8] *Making medical practice and medical education more relevant to people's needs: The contribution of the family doctor*. Report of the WHO-WONCA (World Organization of Family Doctors) conference 6-8 November 1994, London, Ontario, Canada. Geneva and Hong Kong, 1995 (available on request from Division of Organization and Management of Health Systems, World Health Organization, 1211 Geneva 27, Switzerland).

practice in line with the principles of health for all, by cosponsoring consultative meetings and regional initiatives to put forward appropriate policies, strategies and guidelines".[9] The WHO global strategy for implementing this resolution, as articulated in the document *Doctors for health*, mentions that "Doctors of tomorrow may not be doctors of the day-after-tomorrow, as societies and health systems evolve and adaptation to current and anticipated needs continues. But certain universally essential skills characterize what WHO calls the "five-star doctor".[10]

[9] *Reorientation of medical education and medical practice for health for all*. World Health Assembly Resolution WHA48.8. Geneva, World Health Organization.

[10] *Doctors for health: a WHO global strategy for changing medical education and medical practice for health for all*. Geneva, World Health Organization, 1996 (unpublished document WHO/HRH/96.1, available on request from Division of Organization and Management of Health Systems, World Health Organization, 1211 Geneva 27, Switzerland).