the relationship between general practitioners and specialists. Secondly, and more importantly, the shift from secondary care to care in the community has led to the establishment of many specialist community posts, particularly in paediatrics and psychiatry.

Community specialists are increasingly making use of specialist outreach clinics, which are often more convenient for the patient and can lead to closer contact between the specialist and the general practitioner. These advantages would be negated if the clinics led to open access for the patient, as this would lead to a fragmentation of care. The referral process to an outreach clinic should be the same as that to a hospital outpatient clinic.

Much chronic care in future will be in the form of shared care, and already there are well established examples of this. The key factors that underpin good shared care are good communications, patient held records, clear lines of responsibility, locally agreed protocols, shared medical and clinical audit, and closer integration of training. Well organised shared care provides not only advantages in high standards of patient care but can also produce the opportunity for learning for all the professionals concerned.

Easy access to diagnostic tools, including newer ones, should be available to the general practitioner. The general practitioner must be prepared to discuss the use of newer procedures with specialist colleagues, conduct research on how to use them appropriately, be aware of the cost implications, and agree to audit the use of such equipment.

OTHER BODIES

General practitioners will continue to relate to many different organisations in the public, private, and voluntary sector.

Social services—Many difficulties remain, such as

lack of coterminosity, worries over confidentiality, different priorities, and understanding of degree of urgency. Examples of good practice where close cooperation is the norm should be highlighted so that others can benefit. At a minimum, each practice should have a named social worker and care manager.

FHSAs, health authorities, NHS trusts—Not many years ago few general practitioners felt that health authorities had anything more to do with their everyday lives than to provide administrative support. Now all general practitioners are aware of the potential influence of their family health services authority on their practice. In the future, closer cooperation, especially in deciding on local priorities for health gain, will benefit the population, but it must not compromise personal care. General practitioners are becoming increasingly involved in the commissioning; the greater voice that general practitioners (and through them their patients) are having in commissioning of health care services is something that needs to be fostered.

The voluntary sector—General practitioners will need to be aware of the increasing part that the voluntary sector plays in counselling, providing support for carers, self help groups, and so forth. Information technology could play a vital role in keeping general practitioners in touch with all the various groups in the area.

Members of the joint working party were: Welsh General Medical Services Committee: Dr A R Dearden, Dr G I Graham, Dr R B John, Dr J S Jones; Welsh Council of the Royal College of General Practitioners: Dr M H Herbert, Dr H P Joshi, Dr D H O Lloyd (chairman), Dr S A Smail, Professor N C H Stott; secretariat: Miss R Roberts, Miss K F Pope.

1 McWhinney IR. *A textbook of family medicine*. New York: Oxford University Press, 1989.

For Debate

Public health 2020

Stephen J Watkins

The aim of public health is to improve the health of people in communities and in populations (protection from environmental hazards and provision for health needs). The challenge for public health doctors is to re-establish public health leadership of communities, address social and environmental causes of ill health, and link with primary care (a) to improve the health of neighbourhoods and (b) to combine perspectives in commissioning services. Current threats derive from organisational philosophies. For example, focusing on market development does not allow for population based functions and so neglects the main influences on health. The way forward is a network model of organisation in which small teams collaborate with each other to the common good. For example, successful commissioning authorities would have the public health leadership of the director of public health and the support of the chief executive, treasurer, and representatives of primary care, including a medical adviser from the family health services authority.

Remit

Public health exists to improve the health of the people, firstly, by advising on the action communities

can take to improve their health; secondly, by protecting populations from environmental and biological hazards; and, thirdly, by assessing populations' needs for health services.

I use the terms "communities" and "populations" distinctly. It is possible to assess the needs and protect the environment of, say, the population living in a square of the National Grid. But a community shares an identity, has a culture shaped by common media, and operates through common institutions and organisations. Public health doctors work on that identity and culture and those media, organisations, and institutions. They cannot do this for arbitrarily defined populations.

Improving health is more complex than other aspects of commissioning health care because it entails persuading other organisations to commit their resources or change how they carry out their business. Time is needed to cultivate those who have local power and influence.

Environmental issues are of increasing importance. Protection from obvious environmental hazards is no longer enough—public health needs to have a positive influence on decisions about how land is used to address issues such as transport policy, industrial pollution, and open spaces in towns.

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In contrast, needs assessment is centred on commissioners of health services so must be organised around the same units, which range from fundholding practices to NHS regional offices. Needs assessment is not just solving technical equations. It identifies mismatches between need (services are "needed" if they bring proved benefit), demand, and supply.¹ If unneeded services are not supplied or demanded resources are found for needed services to be supplied and used. Such assessment takes account of issues of clinical practice and effectiveness. The challenge is to fund new services and demographic change with essentially static resources. To move from panic closures to rational priorities we need doctors round the contracting table.

Working in appropriate populations

ADVISING COMMUNITIES

The appropriate population in which to work to advise communities about health depends on what communities people identify with.

One well defined type of community is that which shares a local government organisation. Other bodies, such as chambers of commerce and voluntary organisations, tend to organise conterminously with local authorities. Council affairs create common media and political organisations. Natural communities figure prominently in the boundary plans of the Local Government Commission.

The single health goal of increasing opportunities for exercise can entail such diverse needs as protecting urban open spaces, developing cycleways, improving bus services from deprived areas to swimming pools, promoting cheap access to leisure facilities for poor people, developing community sports initiatives, and encouraging workplaces to install showers, as well as traditional health education. I spend about a third of my time relating to officers of the local authority, council for voluntary service, or chamber of commerce. I could not work so intensely for more than one community. Moreover, the legitimacy of the "doctor to the town" will not attach to a functionary of some remote entity.

People also identify with their neighbourhoods. Strengthening the relation between public health and primary care would help develop public health at this local level. *New Worlds, New Opportunities* saw this as part of the role of community nurses.²

There are also non-geographical communities, such as ethnic minority communities, schools, and workplaces.

PROTECTING POPULATIONS FROM ENVIRONMENTAL HAZARDS

Between 1948 and 1974 the tripartite NHS included local authority health departments, which included much of what we would now call social services and environmental health. A referee who read the first version of this paper reacted to my comment that slum clearance and smoke control were achievements of the tripartite NHS by saying that they could hardly be attributed to the NHS. In fact, the local authority departments that carried them out were indeed part of the NHS. This is a striking commentary on how much we have forgotten the breadth of vision that characterised the tripartite organisation with its idea that the NHS is the total of all the mechanisms by which society pursues health as a social goal.

ASSESSING POPULATIONS' HEALTH NEEDS

Several populations are important when addressing health needs.

- The areas of the new regional offices of the NHS
- Areas across which district health authorities will

merge or work together (a) to achieve a population with epidemiological stability of need for a full range of services and (b) to afford a full range of specialist skills

- Areas conterminous with social services authorities—and therefore of critical importance for commissioning community care services
- Areas across which general practitioners can identify with each other sufficiently to enable collaborative commissioning
- Practice populations.

Professional development

Public health is multidisciplinary. Certain roles within public health require public health doctors because a medical degree and training in public health are essential to perform them. These roles are:

- Public health leadership of major communities, where only a medical opinion carries sufficient weight with the public
- Overall responsibility for advice about public health in primary care. General practitioners expect such advice to come from expert professional colleagues.
- Needs assessment that takes account of clinical issues. Much needs assessment has these connotations so every unit engaged in needs assessment must include at least one public health doctor
- Environmental medicine and control of communicable diseases.

There are, however, many public health roles that do not require a medical degree. Firstly, in public health leadership of communities, support for the director of public health should include public health nurses, health promotion advisers, and environmental scientists.

Secondly, although advice about public health in primary care requires medical leadership, a system to reach into every practice will need to include public health nurses.

Thirdly, any unit engaged in needs assessment requires at least one public health doctor and one doctor with a background in primary care (either two different people or one person with mixed experience), but it should also include social scientists and epidemiologists.

There is also a need for the development of a new discipline of public health accountancy, with a focus on using resources in relation to need.³

There should be a clear distinction between consultant posts in public health that require a medical qualification and those quite different posts that can be held either by consultants or by non-medical specialists appointed as top grade scientists.

Public health and primary care

Geographical and practice populations consist of the same people, and the health of the population cannot be improved without improving the health of its individuals. Public health perspectives based on population need reinforce and are reinforced by primary care perspectives, which see need as the expressed problems of individuals.

Commissioning for populations can pool risks and has more leverage—or the power to move large sums of money from one purpose to shape a totally new kind of service. Commissioning by practices has more bite—or the capacity to meet the immediate problems of the patient and recognise deficiencies in quality.

Public health skills are needed in each general practice, perhaps in the form of a public health nurse, a partner with an epidemiological interest, or a fund

manager with a degree in public health. This needs to be supported by a public health doctor with experience of primary care and working in a geographical population that general practitioners will identify with.

Public health and primary care can work together to develop a neighbourhood base for promoting health. Health activity needs to be directed at communities rather than individuals (and must therefore be geographically rather than practice based) and yet needs to be local. Examples include health promotion in schools, identification of hazards, publicity campaigns to support health promotion programmes in general practices, and development of community spirit to enhance mutual help.

Such work must be organised through neighbourhood healthy alliances, led by public health nurses and supported and advised by the public health doctors (primary care).

Local practices have a key role if such alliances are to be part of an integrated primary care system. A neighbourhood is a group of practice populations as well as a geographical population.

Current threats

Public health doctors have faced threats to their existence for over 100 years and will face them for another 100. The current threats derive from rival organisational philosophies.

One model, focused on market development at all costs, sees super-funds, health commissions, and insurance companies competing for the business of small primary care based commissioning units, whether these are general practice fundholders or neighbourhood health committees. This model makes no provision for population based functions and therefore neglects the major influences on health.

A more serious challenge comes from anti-professionalism, which seeks objective measures of health gain, efficiency, and effectiveness as substitutes for professional judgment. This model, supported by many whose skills lie in bureaucratic corporate management and who do not want to work in devolved entrepreneurial organisations with a professional ethos, is flawed for four reasons.

- Not all human experience is measurable in numbers, and that which is not may be more important than that which is
- Even when human experience can be summarised by data, it is impossible to devise a data system to answer every question that arises so data are unlikely to be available in exactly the definitions, categories, and subcategories that are required
- Even if the required data are available in the form required they are likely to be wrong. The system is as accurate as its least competent coding clerk so larger and less specific systems are less accurate
- Even if the data are correct at the moment they will cease to be correct when used as a control mechanism.

This model destroyed the economy of the former Soviet Union and resulted in lightly laden goods trains running in large circles in Siberia as the cheapest way to achieve train mile targets.

Meeting the challenge

The benefits of working on a large scale can be combined with the realities of working on a small scale by a network model of organisation.

The skills required for commissioning are:

- Public health skills
- Primary care skills
- Management skills of empowerment, organisational development, and entrepreneurialism

- Accountancy skills which use money as an agent of change and focus on the use of resources.

There is almost no place for bureaucratic corporate management or for traditional public accountancy with its emphasis on control systems for the finances of large organisations—the traditional underpinning of NHS management.

Currently, the four core skills of the commissioning authority will come from different sources. Successful authorities will be those in which the public health leadership of an effective director of public health is supported by an entrepreneurial and facilitative chief executive, a dynamic treasurer, and primary care colleagues, including a medical adviser from the family health services authority who can embrace a broader role. The model of organisation required is that advocated by management experts such as Rosabeth Moss Kanter in which small teams collaborate with each other in the pursuit of common purposes.⁴

Within the area covered by a comprehensive purchasing structure there could be

- A central team assessing need for specialist services
- Central technical departments, such as contracting, information, and traditional organisational accountancy
- Teams conterminous with local authorities pursuing public health under the leadership of directors of public health
- Teams conterminous with local authorities pursuing community care
- Local teams drawing practices together for collaborative commissioning.

These small purposive teams will replace traditional functional unidisciplinary departments and traditional all inclusive authorities.

Back to the future

The referee of the first version of this paper made an extremely telling criticism of it. He or she said what it described as the future is in fact the past—that the model of an environmentally active “doctor to the town” is the old medical officer of health nostalgically reinvented.

There is much of the old medical officer of health that I would not wish to reinvent—especially the bureaucratic large department, the separation from general practice, and the dominance over other professional groups.

But I do believe that the tradition of a doctor responsible for the health of a real community is a distinctive strength of British public health. I also believe that the concept of an NHS which embraced social and environmental models of health as well as clinical models was wantonly squandered in the 1974 reorganisation and that it must be recovered along with the closer relationship to local authorities. I am confident that these values will be rediscovered. They are the values that the present government is groping for in the concept of “healthy alliances” and that the opposition is overtly committed to in *Health 2000*.

This paper is a personal statement issued with the support of the executive committee of the BMA Committee for Public Health Medicine and Community Health, of which I am chair.

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- 2 NHS Management Executive. *New worlds, new opportunities: report of a task group*. London: NHSME, 1993.
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- 4 Kanter RM. *When giants learn to dance*. London: Simon and Schuster, 1989.

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