The need for integrated working between public health and primary care

Can community-oriented primary care help GP commissioning?

Stephen Gillam

General Practitioner/Consultant in Public Health, Institute of Public Health, University of Cambridge, UK

A continuing challenge across all health systems is how to reconcile the individual and patient-centred perspective with a population perspective, as envisioned in the World Health Report 2008.¹ In an elegant monograph, Peter Toon described three domains of practice: the biomedical (management of disease), the humanitarian (patient-focused) and a public health tradition.² Perhaps inevitably, the march of medical science has unbalanced that tripod. The biomedical domain, as enshrined in the Quality and Outcomes Framework (QOF), with its laboured adherence to National Institute of Health and Clinical Excellence (NICE) guidance and the stuff of randomised trials is pushing persons and populations to the margins. In consequence, the divide between public health and general practice – with their own training, research and training programmes – is widening.³

Bridging this gulf is not helped by the contemporary belief that competition and markets are the mechanisms to achieve quality. In fact, the evidence that competition between hospitals does this remains astonishing flimsy.⁴ The bulk of it relates to systems as alien to our own as to be of questionable relevance. Two often-quoted papers examining our own quasi-market purport to show benefits from competition, but these are unremarkable.^{5,6} What is lacking are mechanisms that systematically facilitate collaboration, but understanding about how to do this is in short supply.

The late, much-lauded Barbara Starfield contributed immeasurably to our discipline's self-confidence. She is renowned for demonstrating the association of well-developed primary care with more efficient use of resources and better population health.⁷ The business of commissioning should begin with assessment of health and healthcare needs.⁸ General practice and public health have complementary insights into health need.

But many general practitioners (GPs) are quite parochial in their view of the world, with only a hazy grasp of the bigger picture. They may make good

businessmen, but few are experienced as corporate managers. Their views of local needs are coloured heavily by what they see in the sanctity of their surgeries. The neediest on their lists may seldom cross their portals.

Many recent developments have eroded the experience that builds up 'local knowledge': changing responsibilities for 24-hour and out-of-hours care, salaried provision, what I have elsewhere termed the 'clinicisation' of general practice,⁹ and the conflation of our discipline with chronic disease management. These are just some of those developments.

I may know my patients' needs but they may be unrepresentative of a large local practice, let alone of the wider local community. I have worked in the same town for over 20 years, during which time the number of consultants at the local hospital has trebled. How well can I know my younger hospital colleagues and the services they provide? How well do I know the local alternatives? The management of community and mental health services has changed hands at least three times in the last 10 years. How well do I know the third sector and voluntary organisations that flourish or fail in abundance?

What is needed now are models that stimulate creative interaction between public health and primary care, that bring together anecdotal insights about patient experience provided by GPs and public health information about services, morbidity, performance and inequalities. Also, collaborative projects need to be systematically encouraged, to facilitate greater understanding of the value of each others' contributions.

Community-oriented primary care (COPC) is one model that facilitates ongoing collaboration between those concerned with individual healthcare and those concerned with public health systems.¹⁰ COPC could strengthen the role of clinical commissioning groups in addressing upstream causes of social inequities in health – in collaboration, of course, with other agencies, as championed by Thomas and Nasir.¹¹

COPC integrates the practice of public health with primary care on the basis of the community's assessed health needs.¹² The principles of COPC were first formally delineated by Sydney Kark and colleagues working in rural South Africa.¹³ With his anticipatory approach to the management of cardiovascular disease, Julian Tudor Hart has been the most visible exponent of something akin to COPC in the UK context.¹⁴

A demonstration COPC project was established by the King's Fund in the early 1990s. Eleven primary healthcare teams worked with health authorities to assess a practice population's healthcare needs before devising and implementing strategies to meet them (e.g. doing outreach work in the community to tackle cardiovascular risk factors). COPC training workshops helped develop teamwork and collaboration, but yielded cost-effective benefits to patients too.¹⁵

COPC and Tudor Hart's model of 'anticipatory care' have been overtaken by the highly medicalised approach to prevention enshrined in the QOF. What is missing is any incentive to go beyond the surgery door to advance the health of practice populations.

COPC is no panacea¹⁶ but such programmes could be valuable for emerging clinical commissioning groups if and when they go beyond today's imperatives of demand management. Health and well-being boards need to find ways of engaging their local practices in tackling health inequalities.

At the very least, other approaches to primary care remind us that there are different ways of balancing Toon's tripod. If we are taking on the challenge of commissioning, we need the right blend of expertise to do it effectively.

REFERENCES

- 1 World Health Organization. *World Health Report, 2008. Primary Health Care: Now More Than Ever!* Geneva: WHO, 2008.
- 2 Toon P. *What is Good General Practice? Occasional Paper 65*. London: Royal College of General Practitioners, 1994.
- 3 Lancet van Weel C, Roberts R, De Maeseneer J *et al*. Public health: profession, health system, government control. *Lancet* 2011;378:468–9.
- 4 Mays N. Is there evidence that competition in healthcare is a good thing? No. *BMJ* 2011;343:d4205.
- 5 Cooper Z, Gibbons S, Jones S and McGuire A. Does hospital competition save lives? Evidence from the English NHS patient choice reforms. *Economy Journal* 2011;121. www.res.org.uk/journals/abstracts.asp?ref=0013-0133&vid=121&iid=554&aid=7&doi=10.1111/j.1468-0297.2011.02449.x
- 6 Bloom N, Propper C, Seiler S and van Reenan J. The impact of competition on management quality: evidence from public hospitals. Imperial College Business School discussion paper 2010/09. Imperial College, 2010.
- 7 Starfield B, Shi L and Macinko J. Contribution of primary care to health systems and health. *Millbank Quarterly* 2005;83:457–502.
- 8 Wright J and Kyle D. Assessing health needs. In: Pencheon D, Guest C, Melzer D and Muir Gray JA (eds), *Oxford Handbook of Public Health Practice* (2e). Oxford: Oxford University Press, 2006, pp. 20–31.
- 9 Gillam S. Should the quality and outcomes framework be abolished? Yes. *BMJ* 2010;340:c2794.
- 10 Gillam S and Schamroth A. Community-oriented primary care experience in the United Kingdom. *American Journal of Public Health* 2002;92:1721–5.
- 11 Thomas P and Nasir L. Could GP commissioning enable collaboration throughout the NHS? *London Journal of Primary Care* 2011;4:1–4.
- 12 Institute of Medicine. *Community-Oriented Primary Care: A Practical Assessment, Volume 1*. Washington, DC: National Academic Press, 1984.
- 13 Kark S. *Community-Oriented Primary Health Care*. New York: Appleton-Century-Crofts, 1981.
- 14 Tudor Hart J. *A New Kind of Doctor*. London: Merlin Press, 1985.
- 15 Gillam S and Miller R. *A Public Health Experiment in Primary Care*. London: King's Fund, 1994.
- 16 Pollock A and Majeed A. Community-oriented primary care. *BMJ* 1995;310:481–2.

ADDRESS FOR CORRESPONDENCE

Stephen Gillam
General Practitioner/Consultant in Public Health,
Institute of Public Health,
University of Cambridge
Cambridge
UK