Editorial

A tale of two specialties: primary care and public health

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Two things shout loud and clear in this edition of *LJPC*. Firstly, primary care and public health partnerships are essential for high quality healthcare systems. In November 2008 *LJPC* (1.2) emphasised this when we revisited the 1978 Alma Ata consensus. One hundred and thirty four member states of the World Health Organisation and United Nations Children's Fund (UNICEF) and 67 international organisations agreed that primary medical care on its own would not produce a healthy society – public health, in its broadest sense, is an essential partner.¹ Authors in this edition of *LJPC* remind us of this inescapable fact.

Secondly, it is not easy. There are inevitable tensions between a discipline that considers individuals within the context of their family and community and a discipline that considers whole populations. This edition includes contributions from senior authors with a track record of resolving these tensions. They argue for mechanisms to facilitate ongoing collaborative projects, from which comes trusted relationships and integrated effort.

John Ashton authored the highly influential 1988 book *The New Public Health*² that made the case for local partnership between public health and primary care. In these pages he shows that his energy is undimmed. He writes: 'I'm as passionate about general practice as I am about public health and have spent the last 35 years trying to find the common ground between them'. He describes his recent work in Cumbria, working with GP leaders. He has wise words for clinical commissioning groups about establishing local leadership.

Another famous contributor to this discussion is Steve Gillam, who led the King's Fund initiative on Community Oriented Primary Care (COPC). He is now a GP in Cambridge. In this edition of *LJPC* he reminds us of the potential of COPC to help general practices to work closely with community development initiatives to improve health. He argues that

clinical commissioning needs to look again at this model.

Steve Field, chairman of the government appointed NHS Future Forum, emphasises that the most difficult task of the Forum is to advise on integration – 'this vast and complex problem'. He intends that the Forum proposes practical ways to integrate diverse contributions to health improvements, including public health.

Maha Saeed, head of public health intelligence in NHS Hounslow, continues the theme of integration. She summarises the planned public health reforms, and builds an argument about the best ways to integrate public health and primary care activities. As public health relocates to local authorities she warns of the dangers of fragmentation. For integration to succeed, clinical commissioning groups need to facilitate ongoing joint working that goes beyond the familiar *joint strategic needs assessment*.

Our own editors describe one mechanism to facilitate integration between primary care, public health and academia – '*university linked localities*'. Clusters of general practices that serve geographic areas of 20–30 000 population could resolve the personal care and population health tension by providing a geographic area inside which a '*community of practice*' could collaborate for health promotion, teaching and innovation.

The West London Consortium for Research and Innovation (a sponsor of *LJPC*), adds impetus to the *university linked localities* idea by proposing increased general practice recruitment into research projects. Resources flow when practices recruit into research projects. By sharing the role with neighbouring practices they could maintain a high level of activity, nurturing relationships between *those who think* and *those who do*.

Aungst, Ruhe and Stange move the debate about integration to a higher theoretical level, introducing

the concept of *boundary-spanning teams* to broker collaboration and coordination across institutional boundaries. They describe how a family practice discovered the need to collaborate across several intellectual and practical boundaries when developing personalised care for sick patients. They conclude that 'health services need high level skill at boundary spanning, including systems-thinking practitioners and managers, and mechanisms that support it, including relationship-building between disciplines and organisations through shared projects'. They invite readers of *LJPC* to engage in an international debate about these contested and difficult issues. They offer their facility – *Promoting health across boundaries (PHAB)* for such a conversation.

Nigel (Lord) Crisp, former chief executive of the NHS, also concludes that 'health professionals in their practice and education need to understand and operate within systems'. His paper brings together the results of reviews undertaken by the Global Health Workforce Alliance Taskforce on scaling up the education and training of the health workforce and the Lancet Commission on Health Professionals for a new Century. He calls for a change in our approach to professional medical education and learning from poorer countries from which 'we in richer countries have so much to learn'.

This edition picks up this challenge in three ways

First, two *LJPC* editors publish a response to Nigel's paper. They agree that *systems thinking and systems practice* are desperately needed in the NHS – and go on to propose ways in which this can be smuggled into existing curricula. But wholesale change will be difficult to achieve because medical curricula are already overcrowded and there is little appetite for such a huge change. Furthermore, the dominant ideology of the market discourages systems thinking. We need a long-term strategy.

Second, we asked Kurt Stange to write a review of Nigel's recently published book – *24 hours to save the NHS*. Kurt is co-author of the paper on boundary spanning and, as editor of the highly cited *Annals of Family Medicine* is very familiar with the debate on healthcare systems. His very thoughtful review welcomes the book, but also warns about the long-term harmful effects of market thinking. He writes: 'I still wonder about the potential longer-term unintended consequences that are not considered in the analysis, such as increasingly treating health care as a commodity rather than a relationship.'

Third, we publish three papers that bring to our attention learning from other countries about how to integrate public health and primary care efforts:

- Geoff Meads, well known for his magnificent review of 24 different healthcare systems,³ deduces six lessons for the UK from the *Latin American Community Development Agencies* and the *Macedonian Health Home*. 1) Primary care should facilitate local relationships that shape cultures nationwide and not simply be *compliant* with national requirements. 2) Modern primary care flourishes when it embraces the growing resources of civil society: in shared services, joint investments, community development and custodianship, and mechanisms for lay governance. 3) The primary care organisation is the natural home for public health leadership today... incorporating issues ranging from domestic welfare and dementia to environmental protection and global epidemics. 4) Primary care is about flexible practitioners and open networks, not closed professions and practice teams. 5) Primary care is a modern business operating in an international trading environment... offering the prospect ... of expanding beyond national borders, through new alliances and takeovers. 6) Primary care would benefit from learning from well beyond the traditional sources of North America – particularly if they wish Professor Ferlie's 'New Localism' to come true (a reference to *LJPC* 4.1).
- Matthew Harris gives a moving account of the Brazilian model of lay community health workers who span the boundary between primary care and public health by going door to door to help families and communities to improve health. The effect is jaw-dropping – infant mortality has declined from 48 per 1000 to only 15 per 1000 since the early 1990s; hospital admissions for diabetes and stroke have reduced by 25% since 2003; the proportion of children under 5 years of age that are underweight has reduced from 13% to 5% since 2003; nearly 60% of women receive over seven antenatal consultations; and DTP vaccine coverage is over 95% in most municipalities. Matthew argues that the NHS could save money by providing an integrated, universal package of services similar to this Brazilian model.
- Mark and Elizabeth Harris describe contemporary changes in Australia to provide new structures that will bring together primary care and public health to improve inequalities of healthcare access.

John Owens reflects on ethical and epistemological challenges of a 'patient-led NHS'. Patients and doctors don't mean the same thing by the term 'health' – another intellectual boundary that needs to be crossed.

This edition is the last of the eight scene setting editions of *LJPC*. The twice yearly themes have covered the intellectual and practical territories that underpin the vision for healthcare that is held by the editorial team and RCGP London. We believe in, and want to promote, broad-visioned, multidisciplinary, relationship-based healthcare. As *LJPC* moves into a new phase we want to continue to explore the practicalities of this vision, providing a resource for commissioners and providers.

It is poetic that John Horder's autobiography also comes to an end in this edition. He describes his retirement, when he set up the Centre for Advancement of Inter-professional Education (CAIPE). *LJPC*

owes him thanks for allowing us to print the autobiography of one of the greatest general practitioners of all time, a most humble and inspiring human being. Thank you John.

REFERENCES

- 1 Okoro C. Primary health care in London: onwards from Alma Ata. *London Journal of Primary Care* 2008;1:61–5.
- 2 Ashton J and Seamore H. *The New Public Health*. Open University Press; 1988.
- 3 Meads G. *Primary Care in the Twenty-first Century: an international perspective*. Oxford: Radcliffe Publishing; 2006.