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The capacity of primary care practitioners to undertake public health work: a broadbrush literature review.

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29 July, 1999

THE CAPACITY OF PRIMARY CARE PRACTITIONERS TO UNDERTAKE PUBLIC HEALTH WORK: A BROADBRUSH LITERATURE REVIEW

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1. METHODOLOGY

This review analyses selective UK literature from 1994 to the present day on the attitudes towards, experiences of and comments by and about the capabilities of primary care practitioners in undertaking public health work. The references were found by searching the four following databases: King's Fund Unicorn Database, DHdata, Helmis and Medline. The keywords used were: "PRIMARY", "GENERAL PRACTI$", "GP", "GPS", "PHYSICIANS-FAMILY", "FAMILY PRACTICE" and "PUBLIC HEALTH", "HEALTH PROMOTION", "NEED$", "NEEDS ASSESS$" and "POPULATION$". The results of the searches were analysed and the most relevant references located and read. The following report reviews the information they contained and amalgamates this into a series of themes.

2. INTRODUCTION

In recent years, many publications have investigated aspects of primary care and public health. Jordan, Wright, Wilkinson and Williams (1998) describe this situation:

> "Although many publications consider the theoretical, practical, and ethical issues associated with assessing health needs, little empirical evidence on understanding and uptake within primary care in the United Kingdom exists."

Two themes to have emerged from the extensive literature cited by Jordan *et al* are that the definition of primary care in the UK is currently very narrow, especially in relation to the World Health Organisation Alma Ata definition (World Health Organisation, 1978, David Colin-Thomé, 1999, Peckham, Taylor and Turton, 1998 and Busby *et al*, 1999) and, supporting the Chief Medical Officer's report on the project to strengthen public health (Calman, 1998), a wider understanding of health is becoming popular. This has been backed up by calls for the health service to consider concentrating on maintaining wellness rather than simply curing illness (Hunter, 1997 and Taylor, Peckham and Turton, 1998).

On top of this, there is an increasing awareness among primary care practitioners and researchers of the importance of introducing elements of public health into their work. David Colin-Thomé (1999) describes the current primary care agenda as containing "an opportunity, if not an imperative" to deliver a broader, more holistic type of health care via the primary care route. He implies that this should infuse all levels of care.

Ann Rowe (1998) explains how primary care is becoming more complex through increased responsibilities and through increased patient demands. She states that the Primary Health Care Team (PHCT) often has no time to assess population needs; but also asserts that "all primary care professionals have a responsibility...to weigh up their service provision alongside the needs of the practice population."

Rowe takes health profiling as one way in which they can do this. She describes the concept as something which is new to many but which is also gaining importance. The "new to many" part of this context is perhaps the most problematic. Not only are the responsibilities of the PHCT increasing, but the nature of the new roles they are being encouraged to take on are, in many ways, highly different from what they have been used to. This is not to say that

the fresh roles in primary care are impossible to fulfil. Colin-Thomé (1999) explains that although health gain is largely outside the remit of traditional NHS care, in fact it "can be funded or facilitated by the NHS and in particular primary care". This review will attempt to show how the literature analysed for this report explains how easy or problematic implementing this new part of primary care could be.

3. THE FIRST PROBLEM: WHAT IS PUBLIC HEALTH ORIENTED PRIMARY CARE?

There is very little agreement about what constitutes public health. Where consistency does appear is in the primary care practitioners' almost universal confusion about what public health involves. Jordan *et al* (1998) illustrate this. In their survey, all 35 practices interviewed could offer some sort of interpretation of assessing health needs, but, they say, "it is notable that 15 initially expressed confusion over its meaning, with 11 of these explicitly asking for clarification before providing a response". They go on to explain that only a few practices spontaneously associated health needs assessment with the identification specifically of current unmet need and of those practices which endorsed the idea of population-oriented, proactive assessment of health needs, most did so only after the idea had been introduced by a third party.

Ann Rowe (1998) describes a few attitudes she discovered towards health profiling from within primary care: it is described as a dry exercise unrelated to reality, as a vastly time-consuming task best left to public health experts and, in some cases, is dismissed as the latest in a long line of "good ideas". These descriptions do not add greatly to the definition of health profiling, but do illustrate the vague way in which the concept is perceived in primary care. Rowe states that others simply admitted to being mystified about what it is.

The situation is not simply as straightforward as understanding Health Needs Assessment (HNA) as one concept. Jill Farrington and Andrew Clapperton (1996) explain that there are in fact three different types of needs assessment and that GPs often do not grasp the meaning of any. The three types are: systematic HNA, which is carried out by all members of the team and which is based on a variety of information sources and used to inform practice planning and purchasing; practice profiles, which are produced by health authorities and which draw on a number of quantitative sources; and the practice of drawing out information from practices as a basis for locality or district-wide purchasing. They go on to explain that even the definitions of these three types of HNA are not solid as different approaches to undertaking each of them exist.

Health promotion seems to be no different, in that it enjoys a variety of definitions. As Norma Daykin and Jennie Naidoo (1997) put it, "health promotion means different things to different people". They go on to explain that even in the broad definition of health promotion in the UK a narrowness exists as it is often perceived as an attempt to reduce, through educational interventions, individuals' risk factors in relation to particular diseases in accordance with epidemiological evidence. Despite varying perceptions of the discipline, Rowe also suggests that as well as a lack of cohesion in the definition of profiling, there is also a lack of consistency in how it is currently being done. She states that various members of PHCTs may well be using different models of public health within their everyday practice, ranging from individualist bio-medical models to those which are community based and more social.

As the nature of public health differs in the perceptions of various practitioners, so do the values they attribute to the concept as a whole. In 1996 Yvonne Doyle and Paul Thomas reported on a nationwide survey of Family Health Services Authorities (FHSAs) which they undertook in order to identify current initiatives in health promotion in primary care. From

this, they discovered that a different value was attributed by public health staff and by primary care staff to the same health promotion initiatives even at the practice level. They used the OXCHECK study and the Family Heart Study Group to test these perceptions. The reactions to the follow up to the OXCHECK study (which reported that benefits from general health checks by nurses were sustained over three years) and to a commentary and a health economics paper published at the same time (both of which recommended caution about untargeted health promotion) were surprising. Doyle and Thomas found that the directors of public health involved concluded that a potentially respectable health gain at a population level was achieved using the OXCHECK and British Family Heart Study Group interventions and that therefore health promotion was essential to achieving national health targets. Primary care commentators, on the other hand, saw the results as a vindication of their argument for abandoning such methods of health promotion. Doyle and Thomas point out that to many GPs and staff, "health promotion" has been discredited, mainly due to its hasty introduction into the GP's Terms and Conditions and that many general practitioners delegated it to Practice Nurses very early on.

It is not only the attitudes of the staff in the health service which can cause public health to acquire varying definitions. Doyle and Thomas (1996) explain that the mis-match in expectations they found between public health directors and primary care practitioners was compounded by patient interactions with general practice. Those most likely to consult, they say, are the elderly and the ill, and these are the very people who place the least value on check-ups and preventative medicine. Public health specialists see a huge potential in GPs to take the lead role in the reduction of risk factors, such as smoking, in a population; however, underprivileged populations may be resistant to messages about risk-factor reduction when the risk factor, such as smoking, is seen as a relief. Doyle and Thomas highlight the importance of supporting individual health promotion plans in primary care with additional, population-wide schemes:

> "[I]nterventions which depend on individual behaviour change in deprived communities may not be sustainable in the absence of community development approaches as a back-up."

The nature of public health in primary care becomes a sort of amalgam of individual lifestyle advice coupled with population based initiatives. This is wider than either public health or primary care on their own and so the demarcations of the tasks and the professional roles involved in public health in primary care are broadened and broadened. If the views of the clients involved in some of the schemes are also taken into account, the concept becomes yet wider. Caroline Harding (1996) describes some community, client-driven schemes, such as a lunch club, which she established to try to achieve health gain in Sileby, a large village near Leicester. She found that the clients' views of health were much wider than those of health authority professionals, encompassing social, economic and environmental aspects of life as well as purely health related ones.

So, public health, it seems, encompasses the more traditional activities of HNA and health promotion, as well as perhaps a broad need to counter inequalities in socioeconomic circumstances; but what else do the commentators in the literature see as being part of it – at least in the primary care arena? David Hunter (1997) helpfully provides a list of key characteristics of primary care and of the new paradigm for (public) health. He states that the composition of primary care should include: the first point of contact for the individual seeking help or advice about a health-related condition, direct access for the individual, care for the whole person and not just the immediate problem, a continuing relationship (usually with intermittent contact) between the individual and provider, co-ordinated care, providing a gateway to a range of other services, care delivered by highly trained generalists backed up by a growing range of community-based specialists and a network of community-based

health services which is linked in turn to a much wider social care network. His new paradigm for health is made up of: a focus on health and not only on health care, a focus on outcomes and improvements in health status, an enabling role for the NHS, greater concern with accountability, user empowerment and a balance between collective and individual action.

He ends up by defining a new job description for the primary care practitioner which brings these two concepts together. This includes monitoring the state of health of the practice population, surveillance of local environmental hazards and infectious diseases, planning care, auditing the effectiveness of preventive programmes and evaluating the effect of the intervention on the population. He has not included individual, one-to-one consultations with patients, but perhaps this goes without saying.

Dennis Pereira Gray (1995) provides theoretical support for this new hybrid public health primary care practitioner. He states that as primary care is the best single source of data about the health of the population, there is a natural partnership between primary care and public health which he describes as "a new marriage". He describes general practice data as "living epidemiology" and states that scientific, statistical and probability-based approaches are increasingly governing primary care. Helen Busby *et al* (1999) also support this, saying that "the nature of the public health role within primary care may vary across different places and times but it will always be a necessary relationship." The two disciplines are often viewed as opposing, but seem, in several authors' views, to be inextricably intertwined.

One caveat to this new amalgam of public health and primary care is mentioned by Kilduff, McKeown and Crowther (1998) though. They point out potential difficulties which may arise in undertaking conventional public health in the primary care arena, as life in primary care is not quite as scientific as that in departments of public health can be. They say that the main lesson to be learnt is that "public health must not expect to plug into a rational and scientific process, primary care life is not usually like that."

Pat Taylor, Stephen Peckham and Pat Turton (1998) state that current, accepted definitions of public health, primary care and the community are unhelpful, as they are so vague. They ask whether primary care (which in the UK is often associated only with general practice) includes other community health staff, pharmacists, health promotion in schools and more general community activity? Is it constrained to a medical model? In their research, the PHCT was seen as being very important in medical care and in providing access to secondary services but other agencies, families, neighbours and community voluntary organisations were also strongly identified as contributing to primary care in its widest interpretation.

Public health is also a wide concept. Taylor, Peckham and Turton (1998) mention its origins as a vague and diffuse concept linked to past attempts to improve sanitation. They describe it now both as a resource (including information gathering (epidemiology) and actions to improve health status) and as an action (health promoting activities undertaken by anyone) (Peckham, Taylor and Turton, 1998). They conclude from the results of a literature search that both primary care and public health operate within a wide social context and that any complete understanding of them should include a community dimension. They say the public health model of primary care exists where these three sectors overlap. They suggest that the factors which intercut the three sectors, making this possible, are the concern to address inequality in public health, the recognition of the importance of collaboration in primary care and the wish of the community to participate in health and social care.

Elizabeth Gould (1998) suggests that, today, health visitors are already doing much that is involved with public health and, it seems, with a broad definition of public health:

"[W]hat is health visiting if it is not about empowering people, working in partnership and raising self-esteem?"

What Gould goes on to worry about is how the extension of this work might disconnect health visitors from individual relationships. This seems to be a key issue. In his report, Kenneth Calman (1998) mentions a variety of properties which make the public health function effective, one of which is crossing multidisciplinary boundaries. Public health in primary care encompasses two traditionally separate disciplines and bringing them together will always create some problems. The question is perhaps not how the two have been defined in the past, but how an amalgam of them can be defined in the future, taking perhaps just elements of each into a new, hybrid public health-primary care practitioner.

4. THE SECOND PROBLEM: BALANCING INDIVIDUAL- AND POPULATION-BASED CARE

The most dissonant chord seems to be chiming in the debate over whether primary care practitioners, used to individual relationships with patients, can or even should undertake population-based work. Jonathan Graffy and Bobbie Jacobson (1995) explain that some clinicians perceive a conflict between the "rational, evidence-based medicine that underpins public health medicine and the individualism of the doctor-patient relationship". Stephen Gillam *et al* (1998) found this through their work with Community Oriented Primary Care (COPC):

"For most, a conflict remained between the utilitarian values underpinning COPC and the traditionally individualistic doctor-patient relationship."

They state that few of the teams they worked with came to regard the principles of COPC as central to their way of working. A health visitor involved in one of the teams said:

"Population planning and general practice don't always go well together. The patient always comes first."

Pat Gordon (1995) explains the inherent tension in primary care, in that GPs have two potentially opposing core values in their roles: the first being to ensure the central importance of the one-to-one relationship with the patient and the second to improve the health of the populations they look after, on their practice list. She says that many doctors try to honour both without acknowledging the tensions there and this can be a mistake:

"Some practices have found ways of accommodating both without making them explicit. But this has taken much time and energy and probably represents a truce rather than a lasting equilibrium."

The most important tension, states Gordon, occurs in the need to ration spending, when a practice has to consider its financial constraints as a commissioner above the secondary care needs of individual patients. This brings the values of the practice into conflict with the values of its practitioners. She identifies some solutions to this problem, one of which is to separate GPs into clinical generalists and those who work more on the role of the practice and data collection and commissioning. Another solution she proposes calls for GPs to shed their caring, biographical (as in taking into account the whole individual over a series of years) and healing roles and concentrate only on the biomedical one. Both of these solutions seem, at least in part, to be coming into use with primary care practitioners more interested in public health perhaps joining PCG boards and with the introduction of walk-in surgeries and medicentres allowing those who wish to concentrate on the technical, biomedical aspects of their work, perhaps without the traditional aspects of continuity of care, to do so.

The inherent conflict in trying to combine two quite different – and potentially opposing – aspects of health care becomes even more difficult when faced with demanding patients. Stuart Little (1995) quotes Neville Davenport, the lead fundholder at the Total Purchasing Pilot in Saltash who is in favour of a needs led service:

> "When individual GPs sit down face to face with individual patients, it is often difficult to sort out needs from demands."

Ann Rowe (1998) reiterates that primary care practitioners are in a difficult position and are concerned about doing anything which might increase patient demands; she says that GPs and practice nurses often feel sceptical that health profiling, for example, will be of any help to them as "they perceive themselves as unable to move away from the demand led, open access appointment system". The issue of lack of control is important to this cynicism, states Rowe:

> "They feel they have very little control over their workload and often do not believe that anything can be achieved by further time spent on planning. Indeed, they are often fearful that the process will highlight needs they are currently not addressing and so increase their workload further!".

The problem appears to be one of combining the open-door ethos of general practice with the structured, planned and controlled environment which PCHTs perceive to be the domain of public health.

Howard Stoate MP (1998) relates the open door problem specifically to rationing:

> "Rationing of hospital treatment is a thorny issue, but there are good arguments for the careful management of hospital care. However, GPs and community nurses are not in a position to shut their doors if money runs out."

Kilduff, McKeown and Crowther (1998) expand this idea that PHCTs are constantly having to deal with demanding people, relating it not only to patients but also to pressure from above (from the health authority, the Department of Health and the Government); they describe the primary care climate as being one which is "typified by rapidly shifting agendas, priorities and demands, which tend to be addressed on a 'first come, first served' basis". This is reiterated by Peckham, Taylor and Turton (1998). This environment, say Kilduff, McKeown and Crowther (1998), rather than supporting development, "tends to breed a culture which favours immediate clinical action rather than long-term strategic thinking" – and so the quick wins of decisions taken for individuals are favoured over population-based planning.

Doyle and Thomas (1996) point out that a Survey of the Faculty of Public Health Medicine found that many health promotion workers who had moved beyond the medical, individualised model of health promotion had developed a broad vision of the determinants of health; however, the number GPs who were in this group was small. Kate Billingham (1997) puts the importance of understanding how the two forms of care impinge on each other very well:

> "We should not be too busy pulling people out of the river to go upstream to stop them falling in in the first place."

Although the differences between the two ways of delivering care are recognised by some practitioners, a further difficulty exists where primary care staff believe that their work with individuals adds up cumulatively to population-based work and that the information gained from one-to-one consultations is enough to define or satisfy an entire population's needs.

Farrington and Clapperton (1996) found these ideas in their survey of practices in one health authority area:

> "Many considered that they assessed health need every day but focused on the individual patient."

This is backed up by some of the comments added to the survey. Primary care practitioners said that "the need of the patient is the core of the GP's role" and that the "focus of any health needs carried out within the practice is very much on the individual". Another assured the researchers that public health work was carried out in their practice and that it was "done intuitively, focused on the individual (presenting problem) and expanding on that." That this way of undertaking needs assessment is, in fact, possible though is supported by a comment from John Robson, K Bloomla and A Livingstone (1994) who assert that the PHCT sees 90 per cent of their population, with each person having an average of 15 consultations over five years. If the data from these consultations is collected rigorously it would provide a rich resource. David Colin-Thomé (1999) implies that primary care is the best place for public health activities:

> "The primary healthcare team, with its frequent longitudinal contacts and registered population, is in a unique position to deliver both personal and population-based activities."

Indeed, public health work has been happening in primary care for some time. Even where primary care practitioners have succeeded in implementing public health initiatives though, much of their success relies on individual relationships they cultivate with the community. This can be especially true for health visitors. Daykin and Naidoo (1997) describe a range of practice based strategies in current use. They say that many practitioners subscribe to "a highly individualistic professional ethos endorsed by their training". This ethos seems particularly strong among practice nurses, many of whom spoke to Daykin and Naidoo of the need to tailor health promotion advice to the needs of individuals, which can cause problems in cases of poverty, where the lifestyle changes recommended are often fewer and less attractive to the individual than those suggested to the more affluent. Importantly, all outcomes recorded in Daykin and Naidoo's research were viewed in individual terms, such as an increase in psychological well-being of the one patient involved. Community development was not considered to be part of the work of the professionals they included:

> "Collective empowerment or the enabling of communities to change their circumstances and environments, including gaining more resources...was rarely seen as part of practitioners' health promotion remit."

Jenny Billings, quoted by Gould (1998) believes that this must change:

> "If health visitors really want to focus on public health they will have to concentrate more on the community and less on individual needs"

Gould herself, however, believes that the individual approach is vital for health visitors. She does not seem to class health visiting with public health, or even as coming from the same stable:

> "I would urge caution to health visitors who feel that they should forsake their focus on the individual and throw their lot in with public health. For public health, above all, is a population-based approach to health as opposed to an individual approach."

In fact, she associates health visiting with primary care:

> "Isn't health visiting about primary health care in its true sense, even more than it is about public health?"

She states that although health visitors have an understanding of public health factors, they do nothing that is population wide. She admits that they address the fundamental public health issues of our time (such as child protection, breast-feeding rates, child safety, postnatal depression) but that these issues are not addressed on a population basis, but rather, again, that health improvement builds up over time through these individual encounters. Gould implies that this is no bad thing. She believes that the cumulative effect of working with individuals and families over several years pays off:

> "I would argue that the foundation of health visiting is the working relationship that is developed over years with individuals. The work carried out by health visitors behind the closed doors of tens of thousands of homes across the UK has an effect on public health. Of course it does. But it does so as a cumulative effect, as the result of the individual programmes of care and intervention."

Kate Billingham (1994) supports this. She admits that it may be possible for some health visitors to combine family and child health work with public health work, but in very deprived areas this may well be infeasible:

> "for those working in disadvantaged areas and where public health work is an important mechanism for addressing inequalities in health it is probably impossible to fulfil both functions."

Gould (1998) describes a project in the Rhondda Valley in which health visitors on one housing estate found that 13% of their caseload took up 30% of their time. A project to improve the quality of life of the residents was initiated. Gould describes it as "something unique" for that community; she states that it was "spawned by the slow build-up of trust through the development of one-to-one relationships". She likens this to public health, as the project made use of needs assessment and small-scale epidemiology; she goes on however:

> "But scratch the surface and you will find that, at its heart, it is about the culmination of those personal and often long-term relationships that health visitors have built up as a result of their access to the population."

The problems appear when individuals on the professional side of the equation change. Gould describes what happened to the project once the health visitor involved had to leave through ill health:

> "the community withdrew from the clearly health-related aspects of the project, demonstrating that their links to the project were heavily dependent on individual trust."

The problems of solely individual-based care relate not only to the individuals who are being cared for but also to the professionals doing the caring or planning; when one-to-one relationships between professionals and patients or communities have built up over time, the possibility remains that without either party within that personal, subjective relationship (be that the patient or the professional), all the elements of the work which relate to public health could disappear. No matter how hard a health visitor, for example, may work with whole populations, the fact remains that fundamentally he or she also has one-to-one contact with individual members of that community and they may attribute more importance to that than to any planning which lies behind it. The question is how to balance these two ways of working (Busby, *et al*, 1999).

Lynda Carey (1999) picks up this theme. She states that nurses are facing a challenge: they have been using individualised models of care for some time and must now transfer that philosophy to a population, if this is possible. This may be difficult. Carey shows how individual comment is seen as more important than overall statistics by some. One of the criticisms primary care practitioners have made of health profiles, she says, is that there is a tendency for health authorities to collect quantitative, epidemiological data rather than

qualitative data derived from comments from users which could offer a far richer picture of health needs. Again, the individual wins as his or her views are felt to be more helpful than statistics on the whole community. One of the reasons given by Carey for this is that although community nurses are often the only point of contact for the vulnerable members of society, the data they supply is often extremely difficult to measure. For the needs of the vulnerable to be heard says Carey, it is crucial that nurses act as advocates for them when a population's health needs are being assessed to ensure a holistic approach is taken.

A holistic approach is advocated by Maggie Ioannou (1999?). She echoes Pereira Gray's (1995) desire for a medical view which takes into account the person not only as an individual but as a product of his or her environment. She says that the concepts underlying public health include the identification of health needs and the engagement of the community in developing services to meet them:

> "This work recognises that people are members of groups and cannot be viewed only as individuals. A public health perspective anchors clinical and non-clinical care in the social, organisational and policy aspects of health development."

The idea of combining the two disciplines into a hybrid one in order to facilitate some sort of holistic care is articulated. Dennis Pereira Gray (1995) stated in 1994 that a broader view of medicine was emerging which he called "whole person medicine". This is population based; he describes the hierarchy of medical science and how discrete parts of it, such as cells, individuals, communities and groups within society – or even society as a whole – form a chain. He points out that there is a gap in research which looks at this chain in its entirety, research which relates to the medicine of the whole person:

> "Medicine, it seems, is the only science in which the study of the whole has somehow come to be seen as less important than the study of its component parts."

Again, however, he associates the improvement of the health of one patient with the improvement of the health of a population (seemingly regardless of whether all patients even visit their GP) as he says that the clinical generalist knows the patient as a person and so can improve their health and so can improve the health of the population.

To take the whole person and their social context into account is essential and is supported by Robson, Bloomla and Livingstone (1994) who seem to see the need to care for communities as a whole almost as a moral obligation:

> "The main responsibility for change lies with the government. But a medical profession that fails to advise the whole population for which it is responsible of their multiple, simply quantifiable risks is no less culpable. We need to inform and advise all people (and their families) of their risk - more often and more intensely for those with most to gain."

The debate over whether or not PHCTs should undertake population based work is heated and long. It will no doubt continue to rage for some time to come. What will possibly become clearer sooner will not be whether primary care practitioners should do this sort of work but rather whether they can.

5. THE THIRD PROBLEM: CAN THE PHCTs DO IT?

There are several problems which mitigate against PHCTs being able to undertake public health work successfully; as Kate Billingham (1997) puts it:

> "Currently Primary Health Care Teams are not 'natural' public health organizations. Professional training, different managerial structures, contractual obligations and workload pressures all act as barriers to public health work."

All of these problems manifest themselves slightly differently in different parts of the country, geographically and socioeconomically; however, in all studies at least some enthusiasm was expressed by at least a few of the respondents questioned. The areas of concern fall into five broad topics: the attitudes of the professionals, their experiences, their reliance on the medical model of care, their broad collaborative abilities and training issues.

5.1 Attitude

Much of the resentment towards past attempts to introduce public health into primary care related to the GPs' fears that their independent contractor status was in danger of being eroded from above. Daykin and Naidoo (1997) cite Taylor and Bloor (1994) on this matter:

> "Research has indicated that GPs view recent policies as a form of government interference that undermines professional judgement and autonomy."

That GPs can be health promotion's most vehement opponents in primary care is borne out at least in part by Daykin and Naidoo's own assertion that "research has also indicated that nurses may be more welcoming and less cynical about health promotion" than doctors. Jill Farrington and Andrew Clapperton (1996) also found that GPs were antagonised by top-down pressure to undertake public health work and Terry Bradley and Agnes McKnight (1997) support the idea that this sort of top-down pressure on GPs does not generally work. They state that in Northern Ireland at least there is much resentment towards the PGEA system which could provide some (albeit not much) additional health promotion training for GPs, as GP involvement in these meetings is controlled by withholding salary if their attendances do not meet the government specified requirements.

Also in Northern Ireland, Anne Lazenbatt (1997) cites the attitudes and knowledge of other health care professionals, including GPs, as being one of the difficulties which had to be faced in attempting to raise awareness of the need to target health and social care need. She states that some professionals simply did not understand community development and the implications or challenges this held for professional practice. Others were suspicious about lay workers working on health issues and some even undervalued the nursing contribution.

Maggie Ioannou (1999?) supplies more information about these differences in professional opinion and attitude. She describes a project to improve the health of the population in a deprived and isolated estate in Croydon. This was undertaken by nurses who succeeded in starting to improve the area, using an agenda for improvement specified by the residents themselves and with the support of the local authority, housing association and sponsorship from local businesses. The main problems they encountered seem to relate to the attitudes of colleagues (both nurses and doctors) regarding the traditional role definitions of health visitors, district nurses, practice nurses, nurse practitioners and school nurses and the project's need to make these a little more fluid. Ioannou explains that the implicit threat of integration of philosophies and practice was found to be uncomfortable and challenging. She also highlights attitudinal differences between the project leaders and local GPs. Despite all the professionals theoretically working to the same ends, little support was gained from the LMC:

"The fact that all the clinicians are employed by the same organisation should facilitate the transition to a culture based on shared values and learning, particularly when accountability paths are also shared. However, setting this within the prevailing, begrudging, co-operation of the Local Medical Committee, the task becomes more difficult with the risk of isolating the pilot doctor from her peers."

Local community nurses were positive about extending and challenging current practice, but little support was forthcoming from other local GPs, due to fragile morale and increasing workloads, which Ioannou describes as "formidable barriers to innovation". The GPs were also highly suspicious that the new services could decrease their list sizes.

Kilduff, McKeown and Crowther (1998) provide some additional obstacles to the PHCT's acceptance of HNA: the tension between gathering information on the extent or pattern of a problem and gaining insights into solutions to the problem can prevent successful working; also, they say that "change fatigue" is perhaps occurring in general practice as a corollary to a time pressured and demanding environment. Steve Peckham (1998) reiterates this, stating that he found that primary care had "little energy to chart a new course" at the present time.

Bearing in mind the cynicism and downright opposition some primary care practitioners express in relation to population based planning, the question about the nature of incentives offered to induce them to take up their new roles might be asked. David Hunter (1997) affirms that none of the notions of PHCTs undertaking public health type work are new and admits that he finds that depressing:

"If implementing shared care and the rest has proved problematic in the past, then why should the future be any different? What incentives are required to modify behaviour and practice? Unless these questions are addressed seriously, it is no good relying on altruism and hoping for the best. The history of joint working is littered with failed attempts to bring about change."

The landscape of attitudes of GPs is not entirely bleak, however; the desire at least to try to make public health initiatives succeed within primary care exists. Ann Rowe (1998) states that as "more professionals are recognising the need for both a targeted and co-ordinated service they are increasingly willing to give profiling a try." Paul Hocking (1999) states that despite a policy shift towards public health oriented primary care, there is evidence of a limited commitment in general practice in the UK. He found that GPs in Wales showed strong agreement with public health oriented primary care (although only 7% agreed strongly). He also found a strong commitment to 'health' in its widest sense, that values of equity and collaboration appear strong (but also that the value of participation by the community is weaker and that GPs have strong resistance to the idea of accountability to local councillors). Much of this resistance to public health at least, Hocking implies, may be tied up with nomenclature. He says that GPs expressed a fairly strong interest in developing public health oriented primary care skills but had a less positive reaction when presented with the bald concept (using these words) of "public health". The potential problem of GP attitude to public health may lie more in their preconceptions about the words used to describe the concept, rather than the tasks involved. This may have more to do with the traditional boundaries - and, perhaps, barriers - between the two disciplines of public health and primary care than anything relating to primary care practitioners' abilities or interest in what constitutes public health.

Bradley and McKnight (1997) show the results of a questionnaire they undertook on GPs' attitudes to health promotion. Again, the resentment GPs felt towards the government's last health promotion initiatives was clear (60% agreed that the health promotion records they are required to complete are a waste of time and 78% disagreed with the statement "I am in sympathy with the approach to Health Promotion advocated by the government") and 61% agreed that the GP's role in health promotion should be limited to advice to patients when

they are consulting; nonetheless, 31%, agreed that GPs should play the widest possible role in promoting community health. Also, when asked to rank the duties of a GP as defined by WHO, although they placed "curative care" at the number one spot, health promotion did come second, despite their calls for evidence of its effectiveness.

Peter Mumford (1997), when running a King's Fund Management College Programme entitled *Choices in General Practice*, found that "there are a significant number of GPs, mid-career, who are willing and able to contribute to the wider health agenda beyond their own practice." One of the attendees described the course, which taught candidates to build a comprehensive picture of a population's needs using local and epidemiological data, as laying down a challenge which can be uncomfortable but which is ultimately positive as it allows the GPs to see the impact of wider social needs on the health of their communities.

So, it seems that GPs believe health promotion and other aspects of public health to be useful, but they can be confused about how to undertake the work itself and question whether they should do it. Encouraging views of the importance of needs assessment work were discovered by Jordan *et al* (1998) in their survey, carried out in 1996 in Leeds and Bradford, on the topic of needs assessment work undertaken in general practice, but, again, the appropriateness of doing this in primary care was questioned.

Although the authors state that assessing health needs is poorly understood and relatively untried in primary care, several of the respondents at least thought they were trying to do it. Of the respondents to their survey, 45% considered assessing health needs as being very important, 46% saw it as fairly important, only 7% though it was not important and 26% (usually the larger practices with five or more partners) said they had already carried out an assessment of need, usually via an audit with medical records, questionnaire research to investigate priorities within the practice (e.g. asthma) and other screening. Most of these said that this had led to tangible improvements in clinical or management practice. Of those whose success with public health was limited, eleven GPs said no needs assessment had been carried out either because it was considered irrelevant or subordinate to routine primary care activity or it was an inappropriate use of resources. Several practices highlighted the futility of such activity given the lack of resources available to provide an effective response. Few practices implemented any means of local consultation. This research identified that primary care practitioners do not feel that public health is really part of their remit. Overall, departments of public health were considered to be in an advantageous position to deliver population based assessment of needs, which could be based on aggregate primary care data. Some GPs were attempting to undertake HNA; however, as Jordan *et al* state, "it is clear that the concept is surrounded by considerable uncertainty and some ambivalence."

A large part of the attitudinal barriers are tied up with a lack of preparation. Daykin and Naidoo (1997) explain the "feeling of helplessness among health care professionals who feel ill equipped to address such issues or see such activities as falling beyond their remit." This, they say, is compounded by a lack of resources and a past training which "advocates pluralistic theoretical perspectives, leading to pragmatism rather than an overarching theoretical perspective which has a critique of poverty as its centre." Due to their original training, Daykin and Naidoo say that primary care professionals "are likely to adopt, maintain and revert to reactive and individualistic styles of work". In other words, without adequate resources and training, PHCTs are likely to fall back on what is familiar; and what is familiar is not likely to be a public health task. The fact remains though that GPs and other primary care practitioners will have to take on some new public health tasks and, as Jonathan Graffy and Bobbie Jacobson (1995) said, back in 1995, of the new way in which health care could be provided in the wider community, "if general practitioners are to play an effective part in

today's health service, they cannot afford to ignore this change in role or the way resources are rationed on ever more explicit criteria."

5.2 Experience

Certainly, some public health initiatives have been ongoing for some years in primary care. Often, the PHCTs doing this jump on the HNA bandwagon, as Kilduff, McKeown and Crowther (1998) describe:

> "Faced with the task of defining, measuring and prioritising population health needs, primary care managers and practitioners have been tempted to see health needs assessment as the methodology of first choice."

These authors state that PHCTs should be encouraged to use valid and reliable instruments, with the proviso that they are clear that HNA cannot replace decision making. They believe that the best way to start a public health project is to start small, to use a proxy area, just one aspect of service delivery, so that both sustainable enthusiasm and ownership are generated.

Ann Rowe (1998) explains that health visitors have been creating practice profiles for many years now and the experience they have is rich. The problem lies in whether anything is ever done with the profiles once they have been completed; Rowe states that health visitors are often sceptical these days as:

> "they have often been asked, or have undertaken themselves, to create profiles in the past, only to see them sit on a shelf gathering dust through lack of interest from colleagues or managers"

Lynda Carey (1999) highlights this problem as well. Using the skills and work of a lone person does not seem to be the most effective way to go about health profiling. Rowe (1998) also explains that, as with all adult learning, "the primary principle is that teams must choose to undertake this work themselves. A team coerced into taking part will not see it as a priority and consequently will not reap the benefits." Commitment from all team members is needed. This might mean that debates will be difficult as strongly held principles of practice will become obvious; nonetheless, these debates are essential. Once all team members are on board, the idea of a hybrid discipline, combining quantitative and qualitative research into the needs of a community may become a reality, as Rowe suggests:

> "Profiling in primary care is not the rational scientific activity it is in a Public Health department. In contrast it may be characterised as an art where the views and knowledge of the staff providing the service, along with the population receiving them, combine with population based data to provide evidence of need."

It is not only health visitors who have been undertaking this sort of work for some time though: Pat Gordon (1995) explains how, in recent history, general practice has been developing from "a GP working alone or with a small group of colleagues, to an organisation providing community-based health services"; Tony Hirst (1997) refers to fundholders who have been using waiting list information and practice profiles (among other tools) to identify need in order to commission services for their patients; and Daykin and Naidoo (1997) recount a series of projects they discovered during their research which show that primary care practitioners are, albeit individually and perhaps alone, including strains of public health in their work. Among the projects they identified were a project to train local mothers in counselling skills, another to establish a healthy eating group and one team made use of linkworkers and specialist voluntary services, especially in relation to the needs of black and ethnic minority groups. A key point raised by Daykin and Naidoo is that "the extent to which such initiatives are possible is also dependent on local support." In all of the successful

public health projects they relate, a lead was certainly taken by the health professionals, but an element of flexibility in how to tackle the issues was included.

David Colin-Thomé (1999) explains how primary care can deliver the public health agenda by separating public health work into three categories: anticipatory care (which would be evidence based); primary care (encompassing health promotion education); secondary care (involving screening); and tertiary care (which works to improve outcomes in chronic disease management). He explains that this model was followed successfully in the Castlefields practice in Runcorn, an area of considerable deprivation. Initially, HNA was undertaken by a public health nurse. The practice then concentrated on brief interventions and opportunistic screening in an antismoking programme which supplied free nicotine patches. They adopted a care management approach to inter agency working and funded a welfare rights worker. They also started an Exercise Co-operative and a Healthy Eating Initiative.

Another project which is recounted in the literature is that which took place in May 1995 in the four counties (Berkshire, Buckinghamshire, Oxfordshire and Northamptonshire, Editorial, *Purchasing in Practice*, 1996). Here, Directors of Public Health set up a one year project to establish ways in which public health skills could enhance primary care development. It was intended to be a two-way exercise, developing skills in both medical areas. The success which has been achieved includes population based support given to practice development plans, from which guidance will be developed, the resolution of complex purchasing issues, inpatient and outpatient referral data now being fed back to individual GPs and the development of a common approach to forming new guidelines and appraising existing ones.

Farrington and Clapperton (1996) found that some HNA work was being undertaken in Leeds. They also found that attitudes and approaches to this work did not differ between areas of deprivation and affluence or between fundholders and non-fundholders. Steve Peckham's (1998) research seems to refute this, however; he states that people working in primary care and public health recognise that inequity contributes significantly to ill health, but can lack confidence to address this, with not all professionals dealing with public health in the same way: inequity is often seen as someone else's issue. So, Peckham equates inequity not just with areas of deprivation and material resources but also with the ability to influence policy decisions. Inequalities exist around the country and relate to resources but also, importantly, in some cases, to the attitudes and abilities of the PHCT in addressing public health issues.

Despite this, of those who considered that they did some form of HNA, most did not seem to have a systematic approach to it. One of these based it on intuition ("a GP intuitively knows the need (of the patient and the practice)"), while another admitted to an *ad hoc* approach ("issues are taken on board as and when they arise or are learnt about"). Few in Farrington and Clapperton's (1996) study connected HNA with a change in service. It seems that most ideas which led to change emerged informally "over coffee", although one or two spoke positively of health promotion data collection as a useful catalyst for change. This view was not shared universally though; one respondent could not see the connection between this sort of work and planning services:

> "health promotion work does not inform the practice planning process – it ties up resources, it is a means to an end and is of no real benefit to the practice."

Workload and resourcing issues were found to be a big stumbling block to GPs' commitment. Another was a concern about the demarcation of responsibilities. Almost a third of practices were concerned that HNA would further blur the responsibilities of the GP between health and social care, individual and population health.

This was mentioned by several commentators in relation to health visitors, who were often cited as being ideal professionals to take up public health work. While exhorting health visitors to take up the opportunities to use their public health skills in HNA, Alison Summers and Kevin McKeown (1996) also warn that there may be a danger for these professionals from a demarcation of roles and a high reliance on health visitors to do more than they can:

> "One danger for the health visiting profession is that closer involvement with GPs in fundholding primary health care terms may encourage GPs to expect health visitors to assist more extensively with the tasks which are important in a market system, such as dealing with individual clinical demands and generating income for the practice."

They also voice the fear that as more health visitors become involved in primary care, these new pressures may begin to isolate them from the broader public health agenda, and from "their traditional public health allies in the NHS and local authority". Despite this, other commentators, such as Kilduff, McKeown and Crowther (1998) show that the demarcations of the role and function of the team within primary care is changing – or, at least, in need of change. They describe the PHCT as "a chimera in many ways." They explain that, as primary care is predominantly made up of individuals who do not tend to work together, there can be uncertainty and ignorance about the skills, perspectives and potential contributions of other members.

Despite the potential problems in understanding the borders of each member of the team's role, the abilities of health visitors to make vital contributions to the public health via primary care are mentioned more than once in the literature reviewed. Kate Billingham (1997) explains how they are ideally placed to make connections between individual stories and epidemiological evidence, individuals and social structures and practice populations and the local community. They bring people together for social support and to work together for change, as well as working across organisational and professional boundaries to meet community needs and promote policy changes that will improve health. Billingham goes on to say that health visitors' skills can increase the capacity of the community to care for itself, but in order for this to happen, team work, information sharing, a perspective detached from day to day demands and responsiveness to local needs are all vital.

Questions have been raised in the literature over the practicalities of primary care practitioners undertaking public health work. Scott Murray and Lesley Graham (1995) analyse four methods of HNA, used in primary care: rapid participatory appraisal, postal surveys, routinely available statistics and practice held information. Each method had benefits and disadvantages and each was good at highlighting different sorts of needs. This implies also though that none seemed to be completely satisfactory on its own. The authors conclude that a composite practice model of HNA in primary care should comprise the following: analysis of practice-held knowledge and experience of working in the local community; followed by a public health physician joining the team to draw up a practice profile including mortality, morbidity and demographic data; this to be followed by a rapid participatory appraisal to identify broad areas of perceived health need; a survey then to be carried out to clarify specific issues; and, finally, changes to be implemented and reviewed.

Much has been written in the literature about data collection, presentation and use in primary care and implied support of the notion that one set of information will not be enough is shown in the work of Spencer and Jones (1998). They sent a questionnaire to 64 practices in the North East of England asking them to pilot a minimum dataset over three months containing "data of potential significance for clinical care not collectable elsewhere." Of the nine who submitted a pilot dataset, none were able to capture all of the information requested. Doubts were expressed by the respondents over the accuracy and completeness of the data

and there was no systematic linkage with other providers' datasets. Spencer and Jones conclude that, despite the small size of their sample, "general practices cannot easily construct meaningful datasets concerning their activity...if data collection in presumably enthusiastic practices was problematic, the position would be even worse in a representative cohort."

Stuart Little (1995) provides information which supports the idea that the current data to which GPs have access is not necessarily the best for identifying health need. He quotes Dr Ian Mackenzie, Senior Registrar in public health at South and West Devon Health, who says that although GPs have access to plenty of data about their practice population's age and sex structure, morbidity and referral patterns "often the data tells them little about actual healthcare needs among their patients". Little also identifies problems with list sizes: some are so small that wild variations in statistics between practices and even between different years occur. It is often difficult to see whether quirky variations in referral patterns between practices – and individual GPs – are related to health needs or to other factors. The last inconsistency that Little illustrates is in the recording of data and this could be a problem of training in coding. He gives the example of chest pain, which one GP might classify as angina (using Read Codes) whereas another might put it under ischaemic heart disease. This was also found by Farrington and Clapperton (1996) in their study. They say:

> "From our discussions, data collected often appeared to be incomplete, inconsistent and, in some instances, technically flawed."

They voice concerns that practices should not be overwhelmed with more and more data without adequate interpretation skills. This could certainly be a problem. Ian Mackenzie, Rob Nelder and Gina Radford (1997) explain that the current ways in which data are presented in primary care are not necessarily the best:

> "Many data are collected at a local level, but are presented in a form that is not appropriate for, or understood by practice teams."

They describe a project to produce a set of practice-specific information sheets for every practice within the South and West Devon Health Authority using a computer model to manipulate routinely available local and national data. They too discovered inconsistencies in practice-to-practice information collection:

> "As with many aspects of general practice, there is considerable diversity amongst practices in the range and quality of practice-held information. Practices can only be expected to collect information which is perceived to be directly relevant to their work with patients."

Not only did they find diversity among practices but among public health specialists' knowledge about what sort of data was available. One thing which the GPs found very useful was information on hospital utilisation. This had not been presented to GPs before and in the past had only been used for contracting. Many clinicians were unaware even that this range of data could be produced for individual practices, but once it was, the benefits were appreciated by the primary care teams.

Mark Shaw (1995) also describes an innovative method of providing GPs with data which could be easily analysed. He says that it was found to be impractical to provide GPs with census results for combination with information derived from their own systems as their data were extremely difficult to interpret. Instead, data was collected from consultations in a standard and simple manner using a software package (unfortunately, the package used was slow and prone to error, but this could, theoretically, be resolved). The data was then indexed in relation to the person to whom it related so that values could be compared before and after

an intervention and benefits assessed. This also resulted in standardisation of the collection of data across many practices, which, as Newrick, Spencer and Jones (1996) state, practices are very willing to do, time and cost permitting.

Newrick, Spencer and Jones go on to emphasise the importance of the data collected and analysed, rather than the way it is collected. They say that despite expensive computerisation, their survey of practices in Northern Region in 1993 showed little vision about which data should be recorded and how it should be used. They admit that telecommunication technologies can help but say also that data collection needs more focus, agreed standards and consistent cross mapping so it can inform public health properly. The follow-on to this rationalisation of data collection would be that GP workloads may then decrease.

It seems that for every project which failed though there is at least one other (and often more than one) which succeeded. Helen Lloyd Jones and Christopher Dowrick (1996) used just one method of acquiring information in their project. They surveyed the health and social care needs of three client groups within one practice using questionnaires and interviews: older people (over the age of 75), those with severe and enduring mental illness, learning disabilities and physical disabilities. This resulted in unmet needs being successfully identified and referrals being made to other agencies, mostly via social services, as well as a series of 'in-house' assessments for people with complex social care needs. It has also resulted in closer cooperation between the PHCT and social services district teams.

Ruta *et al* (1997) took the research question, can information on health and health care needs, when used as the basis for a priority-setting exercise, provide a useful first step in planning primary care provision within a practice? They looked at Alyth Health Centre and answered the question with a yes. The data they collected was richer than that used in either Lloyd Jones and Dowrick's (1996) or indeed Spencer and Jones's (1998) work, in that it comprised patient contacts with GPs and practice nurses, health visitors and district nurses, a morbidity register, patients' views of their socioeconomic background and health status, gained via a postal survey, census information, Tayside Health Board statistics and existing practice based statistics. Nonetheless, the information certainly influenced the choice of priorities. It confirmed some perceptions of how well needs were being met (e.g. a district nurse with an appropriate skill adequately met many health care needs) and also showed that some perceptions of unmet need were unfounded (e.g. there was in fact a very low prevalence of single parents on low income). It also highlighted some needs of which the practice was unaware (e.g. a high proportion of patients with mental health scores on SF-36 indicative of major clinical depression). Although the data collected was satisfactory for planning purposes and thus indicates that such things can be done in primary care, some problems were encountered with primary care led planning. In particular, the funding arrangements made it difficult to implement many of the developments and the GPs did not have any protected time in which to do the work. Difficulties were also experienced through lack of management support from the health authority which suggests that the communication skills of both parties were not necessarily as good as they could have been.

5.3 Reliance on the medical model

One of the main barriers identified in the literature to GPs and other primary care practitioners successfully undertaking public health is their reliance on and adherence to a medical model of care. Stephen Peckham (1998) explains how public health was "highjacked" by the medical model since responsibility for it was moved from local authorities to the NHS in 1974. He says that the resulting organisational and professional structures within the internal market pose barriers to promoting a public health agenda which should involve a wide range of agencies and the community itself. In another publication, he,

Pat Taylor and Pat Turton (Taylor, Peckham and Turton, 1998) explain how the overwhelming influence of the medical model in defining public health raises problems in even developing a shared language for the topic when communicating with non public health professionals. Here, these authors also state that there is some concern that expanding primary care to include a social dimension may engender a more demanding practice population than at present. In today's general practice, where time seems to decrease as workloads rise, this could be a very real fear for some.

David Hunter (1997) sets the research context, explaining the medical domination of public health:

> "Research and development within the health service has been largely devoted to biomedical health care services at the expense of public health. Randomised control trials - the gold standard of biomedical research - have limited relevance in public health. The research and development programme is not supporting health promotion research because of its medical domination."

Daykin and Naidoo (1997) support this. They say that, often in primary care, the social aspects of public health are not considered (although they do admit that nurses are better than doctors in including the social context when considering patients and in supporting community based initiatives). They believe that the medically-dominated structure of primary care may well mitigate against successful public health work. They cite Blackburn (1993):

> "[A] strong professional ethos of one-to-one intervention is identified, in which the individuality of each client is highly valued. This again means that factors common to people's health problems, such as poverty, tend to be overlooked...[S]he argues that health professionals' training remains dominated by the medical model of health, with little health promotion input or expertise included in curricula or assessment. Health promotion tends to be interpreted as effective health education or getting people to accept expert messages couched in sensitive and appropriate language."

J Robson (1995) is slightly more optimistic. While discussing the problem of the distance some patients live from their GPs, Robson says that, despite the dispersed nature of some practice populations, "some measure of social planning is at least conceivable" within primary care. In fact, the picture could be even more positive than this. Anne Lazenbatt (1997) states that project staff working in Northern Ireland successfully raised an understanding of the holistic view of health and social care, poverty and deprivation. This resulted in new services being established, such as drop-in centres, parentcraft classes and counselling.

Geoff Meads *et al* (1999) found more examples of "really innovative practice in public health", moving away from medical dominance, in primary care than in fact in public health departments in health authorities. Examples of these are a primary care led health education programme in schools and a PCG wide community stroke programme. They say that a lot of joint learning still needs to be undertaken and that, contrary to some opinions (and especially to the opinions of some GPs highlighted elsewhere), both health authorities and primary care are at a very early stage in the work on the new form of public health. They are both having to leave behind the medicine and disease focus which they both had before and start with something new.

Taylor, Peckham and Turton (1998) explain some ways in which primary care practitioners can leave behind the medical model and successfully implement full public health care. Firstly, committed individuals are essential; however a danger exists that interagency collaboration – and other parts of the project – can be dependent on the enthusiasm of just one person working outside their official brief (this is also highlighted by Lazenbatt (1997)

who found that some individuals were so committed that they paid for resources using their own money). A mediating role, taken by individuals and/or projects bridging gaps between PHCTs and community groups could also be very useful. A neutral geographical base is also important in order to gain the enthusiasm and commitment of the local community. The project must not only have access to its funding and resources, but also control of them. A shared understanding of the community is important: primary care staff are more likely to be prepared to work collaboratively if they both live and work in the community, especially if they fulfil other non-medical functions in a local community (e.g. as local councillor or school governor). Lastly, supportive organisational strategies, such as designated jointly funded posts contribute significantly to success. Perhaps predictably, existing collaborative structures make life a lot easier; in their research, Taylor, Peckham and Turton (1998) found that:

> "The site that had achieved the highest level of joint working had a collaborative structure established for over ten years."

Not all PHCTs have this luxury, however, and will need to investigate ways in which interagency collaboration can be implemented.

5.4 Collaboration with others

One important aspect of the new role of PCGs is the need for the primary care practitioners to collaborate with other agencies and the public at large. The views of the commentators on the abilities of primary care practitioners to do this vary. It seems that, although GPs do not take to this naturally (Steve Peckham (1998) says that they are not known for their skills in collaboration or for their appreciation of the potential contribution of their patients), work has been ongoing to encourage this and GPs themselves have been trying to cultivate networks with other agencies.

Daykin and Naidoo (1997) report that some primary care respondents to their survey "asserted the view that basic material needs should be met before health promotion can be seen as a realistic goal". Importance was accorded to connections with social care and social services, in some cases over and above immediate health care needs. They say that current alliances do exist but are very specific in nature, focusing on topics such as accident prevention. One PHCT had piloted a successful scheme involving referrals to the environmental health department for patients whose poor housing was identified as a health risk. Daykin and Naidoo also quote one very enlightened GP who believes that carts can sometimes be put before horses in primary care:

> "The health of the nation will not improve unless the financial situation of many people improves. It is like suggesting immunizing everybody against cholera when they have not sorted out the drains."

Another was interested in looking at the motivation behind poor health behaviours:

> "[T]hey say...all that has to be done is that doctors or health visitors or somebody tell people to stop smoking. It takes no account of why people are smoking."

That GPs have been working on the collaboration issue for some time is highlighted by Peter Mumford (1997). He says that they have, over the last 20 years, learnt how to manage partnerships with varying degrees of success. They are in the ideal position to take a broad view of health, he says:

> "GPs are in a unique position to understand complex system-wide problems and to contribute to improvements in health and health services."

He also says however that a capacity to influence does not come naturally to most and needs to be learnt.

This implies a great deal of understanding on the part of primary care practitioners on the need to work with other agencies. The question is whether, as members of PCGs, they will be able to keep this up. Meads *et al* (1999) point out, worryingly, that the development and delivery of a public health strategy depends on a range of relationships which may be new and different or previously neglected or difficult, relationships which could be further complicated by having four different types of PCG. Smith, Regen and Shapiro (1999) believe that for the PCG board to work effectively, strengthened relationships between it and the stakeholder groups at a strategic level will be necessary so that PCG functions such as health improvement and commissioning can be fully implemented. They say that the practical realties entailed by involving health authorities, nurses and the public "will significantly test their enthusiasm for these new ways of organising and commissioning healthcare at a local level." Peter Mumford (1997) quotes a fundholder who explains how collaboration requires hard work and time commitments:

> "Dialogue is crucial to the development of understanding between health authorities and GPs, for each party has its own perspective, language, time frame and agenda. But dialogue requires a commitment to listen, to adjust plans and aspirations."

Peckham, Taylor and Turton (1998) agree; they say that collaboration does not automatically happen. It is clear that it is not something with a tick-box culture.

A question is also raised about whom the PCGs should be collaborating with. Maria Duggan, health policy analyst for the UK Public Health Association and lay member on West Haringey PCG is quoted by Marc Beishon (1999) as wondering whether the right stakeholders have been identified:

> "The strength of the PCG is that it can be focused on the needs of local communities...But questions remain as to how this approach can be developed, and whether PCGs have the structure, skills and capacity to address health improvement. There is no automatic public health expertise, and the health promoting role of local government is not reflected. There are other departments that can contribute more to health improvement than social services."

David Colin-Thomé (1999) also states that departments other than just social services, such as housing, leisure, youth services, environmental health services, education and transport should be included in the PCG's collaborative networks. Michael Dixon, chair of NHS Primary Group Alliance and a GP in mid-Devon PCG is more positive though and suggests that additional relationships will emerge from the first ones:

> "For the first time, GPs are actually sitting down with social services, local managers and lay people. It may seem a small step, but once these initial relationships start to gel, it will only be a short time before the PCG goes out to build proper relationships with other sectors such as education and housing." (Beishon, 1999)

Another area in which collaboration is vital is between practices in a locality. Jordan *et al* (1998) say that examples of successful collaboration between primary care and public health departments at a district level might usefully be applied to inter-practice collaboration. They say that, whatever the scale, a team approach which enables a sharing of workload and resources either within or between practices will help in achieving a feasible approach to assessing health needs within primary care.

One of the stakeholders with whom it is thought the most collaborative problems may occur is that with whom the most could potentially be shared: the departments of public health in

health authorities. Although Pereira Gray (1995) states that there is a "natural partnership" between public health and primary care, Graffy and Jacobson (1995) explain that the doctors in both these fields often miss opportunities to collaborate because of the way in which they have both evolved as separate academic disciplines, "each focusing on its own territory rather than developing a common ground." They also explain how the tensions between the two were exacerbated through fundholding; firstly, fundholders were asked to prove they could purchase health care better than health authorities and then more tensions were created when fundholders focused on their own patients' needs while public health doctors still had to consider those of the whole population. The health authorities will be taking a more strategic role in commissioning services in the future; Graffy and Jacobson see an educational need here:

> "For this to work well, health authorities and public health doctors will need to learn how to influence, rather than control, the purchasing decisions of general practitioners."

As well as starting out on a learning curve, Graffy and Jacobson give some examples of how public health doctors and GPs could practically work together better: these include sharing HNA and clinical audit work creatively; building closer links between academic departments of general practice and primary care and health authorities; and by GPs overcoming their mistrust of the corporate role of public health doctors.

The last vital aspect of collaboration which the PHCT must address is that which involves the public. Kenneth Calman (1998) gives some pointers on how to go about doing this: he says that the language used to talk about public health must be carefully analysed to ensure that it means the same thing to everyone; he recommends the development of a programme to raise public awareness and knowledge of specific public health issues; he identifies a need to provide education for health and active citizenship in schools, youth and adult education settings; he asks for public involvement to become a *mainstream* part of public health; and he also highlights the need to promote actively the participation of those least likely to be involved and in greatest need because of social exclusion, vulnerability or existing poor health. If lay involvement is successfully achieved, as Anne Lazenbatt (1997) explains, the results can include improvements in the quality of life, self-esteem and social wellbeing of individuals and communities as well as improvements in local communities through housing improvements, environmental schemes and increased income via local employment.

In practice, however, bringing together primary care professionals and members of the public does not always work. Colin-Thomé (1999) explains that community development can sometimes induce scepticism in biomedical PHCT members. Peckham, Taylor and Turton (1998) illustrate the difficulty some primary care practitioners find in communicating with non-medics, by quoting a lay volunteer:

> "Generally health professionals distrust volunteers – they are seen as encroaching on their territory of expertise and they feel threatened. Once they know you have a similar background, they are more relaxed and start to value your contribution."

In another publication (Taylor, Peckham and Turton, 1998) they explain that primary care professionals seem to have difficulty in relating to health activities based on collective self help or group models, but that if the community group was working for or in a recognised medical service or could offer a service to individuals, this appeared to have a better 'fit' with the medical model and was accepted more by the professionals. This can sometimes lead to fruitful levels of trust and understanding and sometimes to the medical agenda taking over. Taylor *et al* are keen for the power gap between professionals and lay people to be reduced – as well as that between different professional groups (such as lay councillors, as Paul

Hocking (1999) highlights) in order to attain an equal voice for all. One way in which such equality could be achieved could be in altering geographical boundaries:

> "Artificially contrived administrative boundaries which went against historical local groupings, and without compensatory activities to overcome this, were problematic, particularly when focusing around professional needs rather than the needs of local people." (Taylor, Peckham and Turton, 1998)

Calman (1998) also recommends that 'shared populations of interest' based on coterminosity of boundaries between local authorities and the NHS should be focused on to overcome this. The boundaries to interagency working are not merely geographical, however; Taylor, Peckham and Turton (1998) also include a very telling quotation from a senior lecture in public health:

> "GPs are more likely to recognise the importance of social support in relation to chronic illness, but their attachment as doctors to the 'real' medicine remains paramount. They mix with other doctors and perpetuate this culture together...projects and initiatives which attempt to draw doctors into community contacts, social care and social support will never be able to scale the walls of the citadel, however much they are welcomed into the outer courtyards of the castle. This kind of marginal activity includes all health promotion, public health prevention, community development and all collaboration including healthy city initiatives. Even doctors whose commitment to equity and the importance of community development is clear still frame their concerns within a medical interpretation of social problems."

Perhaps the introduction of PCGs with a duty to collaborate with others will go some way to breaking down the walls of this citadel? Or perhaps that is a naïve hope.

5.5 Skills and Training

One of the major problems for the GPs in having to undertake public health work is that they are coming to it under-prepared. Their traditional training does not include a vast amount of HNA work. Terry Bradley and Anne McKnight (1997) carried out some very interesting research in Northern Ireland, looking at the perceptions of GPs towards health promotion, at the education with which they had been provided and at their future training needs. One thing they did was to analyse the 1,285 postgraduate accredited meetings which were held in Northern Ireland in one year. Of these, disease management had the most sessions and health promotion the least. Examples of the elements of health promotion covered in the sessions which did take place are screening, immunisation and lifestyle education, while the care of the elderly, nutrition, prevention of accidents, prevention of disability, patient education, environmental health concerns and sexual health did not figure at all. The mean duration of health promotion education attended was one day compared with 2.8 days of disease management and 1.8 days of service management courses. Bradley and McKnight sum up the current provision and uptake of CME for GPs as a "hotch-potch whose content is often determined by vested interests."

The need for a change in GP education is echoed by Graffy and Jacobson (1995), who say that the training of both GPs and public health doctors needs to adapt to the NHS as it is now. They reported in 1995 that both the Royal College of General Practitioners and the National Association of Health Authorities and Trusts proposed supplementing vocational training with a further two years of higher professional training, partly to prepare future GPs for their roles as purchasers. They go on to say that "the public health doctors of the future will also need a clear understanding of primary care." Ironically, it seems that the opposite is true; however, the need for training in primary care and public health for both GPs and public health specialists is clear.

Doyle and Thomas (1996) support the need for changes in training as well. They imply that it is not just the curriculum which needs altering, but also that the methods in which the training is given may need to be analysed. Primary care is an isolated discipline and "team

work may not be well enough developed to allow for a 'democratic' strategy." Kilduff, McKeown and Crowther (1998) also highlight the need to introduce change carefully; they state that changes to primary care education should be incremental, dynamic and on-going, reducing a reliance on the 'one-off' solution which tends to be divorced from mainstream primary care activity.

The training required does not necessarily all have to be found outside the practice. Billingham (1997) provides two examples of health visitors transferring their own skills to others in their PHCT: in one practice described, it was found that there were high dependency scores and low breastfeeding rates for mothers. The health visitors researched the problem with statistics and evidence and found that inconsistent advice was being given in the practice. To counter this, they ran workshops with the midwife and practice nurse for all the practice staff, including receptionists and GPs on the sort of advice to give breastfeeding mothers. This then freed up their time to do some breastfeeding promotion work and focus on less confident women. This all resulted in a 25% increase in breastfeeding rates at six weeks. In the second example, a practice felt that it had a high proportion of older people with a lack of social opportunities and depression. The district nurse visited the public health department who provided some statistics which confirmed this. This nurse then met with social services and voluntary groups to assess their opinions, while a colleague, a practice nurse, visited older people to ask them what provision they would like to see. Following on from this, the nurses presented a series of workshops on detecting and managing depression in older people, while the health visitor set up a local multi-agency group that developed a volunteer home visiting scheme, an exercise session at the church hall and an information pack for workers on what is available for older people locally.

Tim Wilson, Fran Butler and Marion Watson (1998) agree that training in public health should be carried out at the PCG level like this – and that it is highly important (they state that training for PCGs should be prioritised in the short and medium term). They believe that a co-ordinated curriculum is needed and that each PCG will need to have the means to achieve this, that the training should be PCG led, multidisciplinary, use existing sources (from health authorities and trusts) and be based on an audit of existing skills. This implies that PCG ownership of the new ways of working could be then be encouraged from the very start of the training project. They also recommend that training should involve networking and cross fertilisation between PCGs to share ideas and experiences. Thus, not only is training important now, but it should also retain importance as PCGs get to grips with their new public health roles.

Lazenbatt (1997) also illustrates the need for training in networking skills. In the projects she evaluated, all of which attempted to target health and social care need, she found that there was insufficient contact and communication between them. She states that "networking is not an added extra" but rather an important component which is essential for efficient and comprehensive health cover.

Steptoe *et al* (1998) state that practice nurses, with the main responsibility for cardiovascular health promotion, generally have positive attitudes towards it but even they don't feel utterly confident in their education; they also feel that a lack of training in lifestyle counselling is a problem. Despite the enthusiasm for health promotion and the desire to keep it within the nursing field, a need for training in effective mechanisms about how to do this is clearly needed. Few responders to the survey thought they were effective or influential in getting people to change their lifestyles. Lazenbatt (1997) also bears this out. She states that nurses proactively targeting need in the community are essentially supposed to empower clients. This implies that contact with the nurse should be classified as education about one's lifestyle. The trainers themselves in this case need to be trained. Lazenbatt emphasises that

this sort of training should be made available to the nurses expected to carry this out as soon as possible.

One example given in the literature of how this training could manifest itself is via COPC. Steve Gillam et al (1998) explain how this helped to educate primary care practitioners in more population based needs assessment. COPC takes three stages: community diagnosis (what are the health problems?), prioritisation (which is the most important?) and detailed problem assessment (in which an exploration of the priority problem is made in the total practice population), after which intervention plans are made, implemented, evaluated and reassessed. Those on the training days felt that they all learnt a lot and it seemed to inspire some to re-look at the information they were holding in their practices:

> "We had some crude data, we'd been keeping a mortality register on all patients dying for a number of years...we also had morbidity registers for asthma, diabetes, hypertension...but we had never actually used them before in a meaningful way."

This certainly helped the primary care practitioners with public health type work; however, perhaps the training needs to be even broader than that. The CMO's report on the project to strengthen the public health function (Calman, 1998) states that:

> "Most professionals, including managers in the NHS, local authorities and elsewhere as e.g. teachers, would benefit from a better basic understanding of public health."

The need for additional training is all pervasive, covering many disciplines and types of student. The CMO says that a smaller group of "hands on" public health practitioners (e.g. public health nurses, health visitors, community development workers, environmental health officers and health promotion specialists) who further health by working with communities and groups also need more specialised knowledge and that a still smaller group of public health specialists need a core of knowledge, skills and experience to carry out their duties effectively. No-one escapes the need for more education.

6. A POSITIVE: TEAMWORK CAN BE ENHANCED

A side effect which seems to ensue from the successful implementation of some sort of population based work in primary care is that the PHCT then functions better as a whole. This is mentioned by several commentators in the literature, including Ann Rowe (1998). She explains that the process of analysing, prioritising and planning for the needs of the community and for the skills available in the team results in teams learning to share their work patterns and philosophies of care. As long as commitment is consistent across the team, this often then results in a more united and focused set of professionals working together.

This idea is seconded by Ruta *et al* (1997) who recount that, in their work, the roles and responsibilities of members of the team were openly discussed and debated and that all team members' views were accorded equal status. Peckham, Taylor and Turton (1998) explain that public health work undertaken in primary care can result in members of the PHCT working at the edges of their professional boundaries, but right at the centre of the public health model of work. Discussion over roles would seem to be a vital first step in taking on this sort of work. If done properly though, it seems that the very process of undertaking the public health work can resolve at least two of the problems identified as barriers, that is, hazy professional boundaries and the fact that, in some cases, some members of the team are more equal than others.

Tony Hirst (1997) concurs, but also highlights the need for consistent commitment. He says that consultation should take place across the PHCT to ensure ownership of the process by the practice as a whole. This is supported by Bradley and McKnight (1997) who say:

> "It has been shown that involvement of practice staff including practice nurses is important for effective implementation of change, and the health promotion education needs of these other staff members should be taken into account."

Summers and McKeown (1996) point out the possible difficulties in ensuring consistent commitment across the board:

> "Different team members will approach health needs assessment from very different starting points, due to their previous training and experience."

They explain that some will have read a lot, others very little and that differences in training, professional perspective, skills and general understanding mean that "the early stages of health needs assessment may require considerable time to develop a common view of what the exercise might involve."

Despite this caveat, simply talking about one another's roles in the course of planning for public health not only assists the team but also exposes some surprising misconceptions. Gillam *et al* (1998) reveal that, during their work with COPC it became clear that:

> "Many participants were surprisingly ignorant of one another's roles, expertise and special knowledge."

Working together in COPC helped the teams to function more smoothly. It is no bad thing to expose such ignorance in order to counter it and facilitate better teamworking. Without a team which works well in the practice, one could ask how is the work which that team is about to undertake in the community going to succeed?

7. WHAT IS NEEDED: ORGANISATIONAL SUPPORT AND EFFECTIVE ORGANISATIONAL STRUCTURES

Internal teamwork is important, but something else which is clearly needed for the effective implementation of new roles and responsibilities in primary care is organisational support (Ruta *et al*, 1997). This entails reliable back-up from the health authority, without which projects can suffer and enthusiastic individuals can end up taking on the burden of the entire initiative, only for it to fade and die once they have left the organisation (Peckham, 1998). This support is geographically variable and the quality of the information supplied differs widely (Rowe, 1998).

Judith Smith, Emma Regen and Jonathan Shapiro (1999) found that the pilots involved in their GP commissioning programme accorded great value to the quality management support they received:

> "Some sites felt that they needed a greater degree of management input: the crucial nature of this role was summed up by one interviewee as being 'the glue which holds the whole thing together'."

The problem with this is that, as J Robson (1995) put it in 1995, even forward thinking administrative authorities were "floundering" in establishing adequate structures and policies for dealing with coherent planning in primary care. Meads *et al* (1999) ask whether health authorities can fulfil objectively the dual role of PCG developers *and* monitors of the NHS. Taylor, Peckham and Turton (1998) also raise the issue of health authorities' reliance on the

medical model when approaching population based care, which may not be absolutely appropriate in primary care led public health. The primary care practitioners who received assistance from these health authorities undoubtedly found it helpful; however, they did question whether this reliance on medical evidence resulted in as much use being made of the available data as was possible. All this raises a question mark about some authorities' potential usefulness in assisting primary care practitioners.

The way in which primary care as an organisation is constructed was seen by some commentators as being unhelpful when it came to undertaking public health work. Daykin and Naidoo (1997) describe the clinic-driven organisational framework for health promotion as "stifling" local initiatives. They also believe that the inequity perpetuated by the banding system does not help those communities most in need:

> "The rigidity imposed by the banding structure was often seen as a barrier to community-based initiatives. These initiatives often revealed a gap between local peoples' perceptions of health need and the narrower set of priorities recognised by the funding arrangements."

J. Robson (1995) mentions this as well. He illustrates the problem of inequity in resources and funding among primary care services; he says the gaps are in fact widening:

> "Additional payments for deprivation have improved some unacceptably low medical incomes. But more substantial measures will be needed to prevent the widening divergence in access to and quality of primary care services, which is increasingly apparent both locally and regionally. Efficient distribution of resources is inextricably related to equity."

The organisational culture of primary care has pervaded the professional lives of practitioners for so long now that it is also difficult for some of them to change. This is something which needs to be altered at the organisational level. Daykin and Naidoo (1997) quote a practice nurse on this topic:

> "I think it's quite difficult asking people what they want when we've always had a model of not asking them, even asking people seems quite difficult bevause the structures are very rigid."

Another practice nurse they spoke to has similar problems in getting colleagues to use community initiatives in the same way as they would do medical interventions:

> "With our communtiy schemes it's difficult for the GPs to hold it in their minds to refer people, they're gettig there but it's just difficult thinking along those lines when you don't normally do so."

Daykin and Naidoo use these quotations to show how health professionals struggle to reconcile new professional issues with the day-to-day requirements of responding to clients, all of whom have their own priorities and perceptions of need. This tension becomes more acute, say Daykin and Naidoo, in relation to health promotion. Here, the government emphasis on individual lifestyle change as a strategy for health promotion overlooks the experiences of those in poverty; this then leads to frustration in the health professionals who then have to balance the need to respond to policy requirements with the actual needs of their clients.

Another problem which mitigates against an organisational culture appropriate for team working in public health is the isolation factor. That, more often than not, primary care practitioners work alone can cause difficulties in understanding each other's roles, in collaborating (Lazenbatt, 1997 and Taylor, Peckham and Turton, 1998) and also, as Lynda Carey (1999) states, can lead to information selfishness, with community nurses taking caseload profiles which are never looked at.

Sometimes too much talking goes on. Kilduff, McKeown and Crowther (1998) recount the experiences of the Ribblesdale Total Purchasing Pilot. The main obstacle to effective purchasing, they found, was organisational incoherence. The Pilot steering group was too unwieldy, met infrequently and was too bureaucratic. The lack of clear guidelines about fundholding led to much confusion, resistance and ineffective working:

> "Energies were consumed by the bureaucracy of the system and the complexities of large-scale budget setting and contracting."

The authors state that the Pilot was not a coherent corporate entity. They describe it as "a dynamic, emerging and consequently 'fragile' structure"; however, they also believe that any sort of organisational cohesion is missing from most PHCTs:

> "The majority of general practices are lacking in organisational coherence."

The lesson Kilduff, McKeown and Crowther draw from the Ribblesdale Total Purchasing Pilot is that the successful development of, in this case, HNA (but any new service delivery could be substituted) is dependent on the organisational context in which it is applied. They say that it is conceptually helpful to think of the development stages of the PHCT as being "spiral" in nature. Each loop of development activity depends on and expands from the previous one. There are five key loops: the ensuring of internal team consistency and appropriate organisation; maximisation of the team's potential for development; a shift from operational to strategic thinking and practice; the pursuit of focused and owned HNA; and finally the management of organisational and strategic change.

The stages of organisational development of primary care settings can depend on the type of primary care organisation to which each conforms. Geoff Meads *et al* (1999) define four types of primary care organisation: the defence organisation in which most of the practitioners subscribe to the medical model and may find a social model threatening and which may not desire to become a PCG, but is content to allow the health authority to retain control; the friendly society, which includes all the views of team members in its approach to strategy setting; the executive agency with a pragmatic, selective and focused strategy and which is full of action men; and the franchised public utility which has a strategy to improve the health and wellbeing of the population and reduce inequalities and social exclusion, using consensus building and learning from communities themselves.

Tim Wilson, Fran Butler and Marion Watson (1998) pulled together a list of skills which they identified as being needed by PCGs. Interestingly, the majority are managerial or organisational: team working; team building; understanding the role of others; working through co-operation and conflict; communication skills (both internal and external); influencing; operating as a corporation; understanding the PCG (including its decision making mechanisms and its organisation); strategic planning; commissioning; critical/analytical skills; project management; quality management; clinical governance; involvement of the public; and, of course, their public health role, incorporating the use of a population perspective and HNA.

All of this implies that one of the first tasks facing the new PCG is to create an effective organisational structure which will allow its new and unfamiliar responsibilities to be executed properly. This is supported by Smith, Regen and Shapiro (1999) who recount evidence from the GP commissioning pilot programme they evaluated:

> "The findings from this research suggest that in the early days, PCGs will tend to focus on issues of structure and process, as they seek to establish themselves as effective organisations."

To make matters potentially more complicated, their evaluation also found that "management arrangements are likely to be far more complex than the apparently simple PCG board structure."

8. WHAT IS NEEDED: MORE TIME

A fear which is repeated over and over again in the literature is that PHCTs simply will not have enough time to undertake this new work (Doyle and Thomas, 1996, Gillam *et al*, 1998, Jordan *et al*, 1998, Lazenbatt, 1997, Morris, 1996, Rowe, 1998, Spencer and Jones, 1998 and Busby *et al*, 1999). It seems that a lot of primary care time is already spent in data collection. Newrick, Spencer and Jones (1996) suggest that about 1,230,000 hours are spent every month collecting data in general practice in England and Wales. As well as being time-consuming, this may not be the most efficient use of PHCTs' time as much duplication exists in the data that is collected by different bodies.

Some solutions have been suggested in the literature. Spencer and Jones (1998) say that this duplication should be avoided and that, "provided that different data sources can be combined, general practitioners and their teams need only collect information that cannot be gleaned elsewhere". Tony Hirst (1997) says that whole process should be staggered so that at any one time, some projects are being planned, others are being developed or implemented while yet more are being evaluated. He goes on to advocate the appointment of another member of staff dedicated to undertaking HNA:

> "Few staff have the skills or protected time to gather the information needed for an HNA...A member of staff dedicated to HNA at practice or locality level will be essential in the future."

Kilduff, McKeown and Crowther (1998) believe that rather than necessarily employing a new body, time needs to be set aside for the PHCT to develop their new public health roles:

> "Development requires time, but there is very little protected time within general practice to focus on issues which fall outside the remit of day-to-day activity."

The Ribblesdale Total Purchasing Pilot (Kilduff, McKeown and Crowther, 1998) saved time by re-organising the structure of their HNA meetings: comprehensive progress reviews and global overviews were replaced with sound bites and summaries.

An additional time related fear was expressed over how long it would take for the results of public health work to be visible (Little, 1995). Daykin and Naidoo (1997) found that:

> "Some practitioners felt that fund holding GPs may be reluctant to support strategies which could not demonstrate tangible results, such as health promotion work addressing poverty and deprivation, which was seen as long-term"

This gives the impression that the current primary care arena is one where quick wins are afforded most value. This is given credence from Kilduff, McKeown and Crowther's (1998) assertion that the projects in the Ribblesdale Total Purchasing Pilot's which had wider implications and therefore would take longer to come to fruition (such as those relating to the health of young people and people with learning difficulties) were put on hold so that projects with more immediate results could take precedence. Steve Peckham (1998) broadens this idea out to the wider planning agenda which sometimes makes unreasonable time-related requests. He says that short-term funding and inappropriate time scales are unhelpful as good relationships and an understanding of communities take time to develop.

9. CONCLUDING COMMENTS

The literature examined in this review implies that, despite some obstacles, the past experiences of PHCTs in attempting to introduce public health initiatives into their work show that this certainly can be done and can be done successfully. As Ann Rowe (1998) puts it, few practitioners would disagree with the principles of delivering care according to need. The question is, how to get to this point, encountering the fewest problems along the way?

The Chief Medical Officer (Calman, 1998) paints a picture of the current public health world. He puts its strengths as being a diversity of sources of public health expertise, the fact that local authorities are increasingly addressing the quality of the environment and the social and economic wellbeing of local people (e.g. through Agenda 21), that health authorities are providing support and leadership through multidisciplinary and cross sectoral working and that national organisations with a focus on public health are collaborating more closely. The areas which need improvement, he says include the involvement of citizens, the need for more dedicated staff from a number of disciplines to deliver the current public health agenda, as the present public health specialists are over stretched, the need for joint work between health authorities and local authorities to drive strategic change, the need to recognise the contributions of the preventative work of GPs and dentists with individual patients, the wider community development work of other members of the PHCT and the fragmentation of public health research.

How these areas in need of improvement will change remains to be seen; however, the Institute of Health Sciences (date unknown) in Oxford presents a picture of how the health care system may develop in the next few years. They say that primary care will still be the first point of contact for care but will in future provide access to a multidisciplinary, multiagency team of health and social care professionals. The role of PHCTs will change; the independent contractor status of GPs will be called into question and nursing professions will have a greater part to play through better use and deployment of their skills. Patients will have more power, choice and information. In order for this to happen, PCGs will need to foster a 'healthy working environment' in true team working and workload sharing, skills shortages will need to be addressed (especially in commissioning, HNA, leadership and management, interagency collaboration, communication skills, team building skills and rationing skills) and multidisciplinary training and shared learning should take place at all levels.

The fact that the potential difficulties to achieving these things can already be identified goes some way to helping the PHCTs overcome them; however, other, currently hidden barriers may be lurking out of sight and may only appear once PCGs have been up and running for some time. Those primary care practitioners whose experiences are cited in the literature are usually among the most innovative ones in their areas. Once every primary care practitioner has taken on the new roles which being part of a PCG brings with it, the capacity of PHCTs to undertake this sort of work will become much clearer.

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