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Primary care groups

Can primary care groups and trusts improve health?

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The last of the core functions vested in primary care groups and trusts is to improve the health of the population and address inequalities in health; this is possibly their biggest challenge. The term health improvement has various meanings in government documents, reflecting the degree to which core NHS activity is or is not seen as central.¹ At one end of the spectrum the Commission for Health Improvement is concerned primarily with the quality of health service organisations. At the other end early guidance for primary care groups defined their function as being to "improve the health of, and address inequalities in, their community."² This is explicitly distinguished from developing primary care and community care and commissioning hospital services. Health improvement includes activities to promote health that occur outside the NHS (for example, in workplaces and schools) as well as activities that address social, economic, and environmental influences on health (for example, housing, transport, employment, and community development). In this paper, we use health improvement to indicate an approach to the health of a population rather than to illness, a perspective that is new to primary care.

Attempts to orient general practitioners towards the health of their registered populations have a long history in the United Kingdom.³ At the heart of the relation between general practice and public health is an ethical conflict between individual freedom and

Summary points

Primary care groups and trusts are charged with improving the health of their populations through activities that reach beyond the NHS

Groups and trusts must also address social, economic, and environmental determinants of inequalities in health

Groups and trusts have made progress in developing their organisational ability to undertake this role but face shortages of staff with skills in areas such as public health

They have begun to establish working relations with local authorities and voluntary organisations to support initiatives to promote health

Most groups and trusts are funding projects led by organisations outside the NHS

Groups and trusts will need to be persistent to ensure that the population's health, rather than the organisation of health care, remains a central focus of the new NHS

This is the last in a series of five articles

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collective good. For practitioners, the roles of patient's advocate and population planner may overlap and conflict with one another.⁴ General practitioners are often not trained as health educators, have a narrow view of health promotion, and limited experience of community development activities.⁵ Many primary care providers are politically antipathetic to social intervention disguised as health promotion,⁶ particularly if the opportunity costs of such activities compromise their traditional role as carer.

The forerunners of primary care groups—general practitioner commissioning groups and total purchasing pilots, as well as fundholding practices—were not imbued with a mission to address the social determinants of health. They focused on the purchasing of health services; their capacity, let alone enthusiasm, for assessing health needs, developing strategy, and working with other agencies to address the determinants of health was limited.⁷⁻⁸ General practitioners' reluctance to engage with the first national health strategy, *The Health of the Nation*, was one reason for its perceived failure.⁹ However, the welcome emphasis on developing partnerships to improve health in the 1997 white paper was no guarantee that these new primary care organisations would deliver more than health authorities had.¹⁰

The government's concern with social exclusion has spawned a diverse range of new collaborations designed to address health inequalities; these include health and education action zones, Sure Start (an initiative to support families with young children who live in deprived areas), and new deals for communities. In these circumstances, trying to integrate planning is challenging. The national strategy for neighbourhood renewal emphasised the importance of developing local strategic partnerships and listed 105 objectives, just nine of which are directly related to health services.¹¹ This reflects a recognition that many of the key determinants of health are socioeconomic rather than related to health care. The role of primary care groups and trusts in such partnerships is not self evident, particularly since there is a lack of evidence on which programmes are likely to be effective in tackling inequalities in health.¹²

This paper describes the progress made by primary care groups and trusts in developing their role in health improvement and the challenges they face.

National tracker survey

The national tracker survey is a longitudinal survey of 72 of the 481 primary care groups established in England in 1999.¹³ These annual surveys aim to evaluate their achievements and identify features associated with success in performing their core functions, including health improvement. The first survey was completed in December 1999 and the second in December 2000.¹³⁻¹⁴ By the time of the second survey two of the primary care groups had merged with each other and six had become trusts. Details of the survey were summarised in the first article in this series.¹⁵ The evidence cited in this article is derived from telephone interviews from the 2000 survey with 69 of 71 (97%) chairs of primary care groups and executive committees of trusts and 69 of 71 (97%) chief officers.

Clarity of purpose

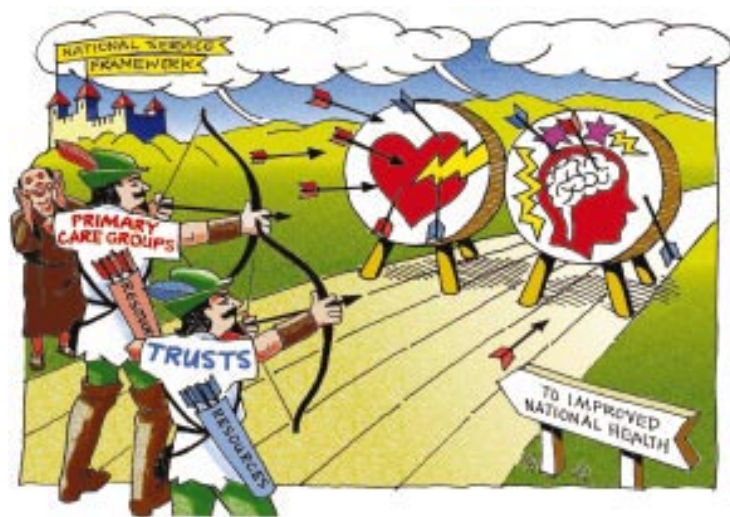
In 1999 the early views of chairs and chief officers on their key priorities for addressing the health of their populations were dominated by diseases and focused on inequalities in access to care. Their involvement in producing the first health improvement programmes was limited. Chairs perceived that local aspirations were being eclipsed by national priorities set by government.¹³⁻¹⁶ In 2000 a greater commitment to addressing poverty or deprivation as priorities for improving health was apparent. Chairs' understanding of the use of partnerships to improve health had broadened to embrace the public sector and the voluntary sector. Indeed, voluntary sector organisations were represented on more than three quarters of boards or executive groups. Their contribution to the health improvement programme was greater in 2000 than in 1999. Two thirds of chairs reported that their health improvement programmes now contained a separate section dealing specifically with their organisation; previously health improvement programmes made no mention of primary care groups or their priorities.

Unsurprisingly, coronary heart disease and mental health were the most common targets for health improvement. This is probably because they are central priorities of the national service frameworks and national performance indicators. As important causes of morbidity and mortality, they offer groups and trusts the opportunity to address several tasks at once. A fundamental part of primary care is managing and preventing these illnesses, and there is firm evidence to support most recommended interventions.

Setting targets for health improvement is challenging but without markers of progress it may be difficult for groups and trusts in future to engage those who work with them. Such targets may need to relate to outputs rather than health outcomes, since changes in outcomes are unlikely to be detectable in the short term and cannot be easily attributed to the efforts of these organisations alone.¹⁷ Forty four chairs (62%) reported that they had set targets, predominantly in relation to heart disease.

Organisational capacity

Meeting the objectives of health improvement programmes requires commitment and leadership. Two thirds of chairs said that their group or trust had a



subgroup that focused on health improvement. Only 6 of 69 (9%) groups reported having neither leader nor subgroup focusing on health improvement. The majority of chairs said that their organisation had a designated person responsible for health improvement but the nature of that leadership varied. About a third of those responsible for health improvement were general practitioners and a fifth were management staff. Only 10 (14%) leaders were public health specialists and only nine (13%) were nurses.

The ability to perform traditional public health functions is one measure of an organisation's "fitness for purpose." A shortage of people with public health skills was apparent on boards in 1999. The limited amount of needs assessment undertaken by groups was a reflection of this. In 2000, however, chairs reported a substantial increase in the number of health needs assessments carried out by groups and trusts. The new organisations are beginning to adapt and extend existing information sources to their current and emerging needs.¹⁸ Only 9 of 69 (13%) reported that they had engaged in no such activity at all. A range of activities were classed as needs assessment: about three quarters of those surveyed had analysed health authority datasets or collected practice data; two thirds had consulted health professionals; about half had consulted the community; and 41% had analysed local authority datasets.

Unsurprisingly, and as in other areas, respondents wanted more support from staff at health authorities to carry out this work. In particular they wanted more detailed data and data that were specific to their primary care group or trust.¹³ Altogether 1 in 3 chairs said that the only available data for planning were based on boundaries that differed from those of the primary care group or trust.¹⁶ In cases in which data were available, explaining primary care groups' highly variable patient and practice characteristics was found to be technically demanding.¹⁹

Implementing national service frameworks

Primary care groups and trusts seem to be working hard to implement the national service frameworks. Over two thirds of chairs reported undertaking needs assessments for coronary heart disease, although less than half reported that they had assessed mental health needs. Four fifths of those responsible for commissioning said that they had developed one or more integrated care pathways, most often for the management of coronary heart disease or stroke. Altogether, 49 of the 57 (86%) board members who had responsibility for clinical governance said that their organisation had developed strategies, such as protocols, guidelines, or service agreements, for implementing the national service framework on coronary heart disease, although less than half reported that they had developed such strategies for the national framework for mental health.

However, while groups and trusts have taken on more commissioning responsibilities during 2000 (particularly for secondary care and acute care), in many areas increases in responsibility have not been as great as anticipated. Little progress has been made in commissioning services for people with mental illness or learning disabilities, for example. Reasons given for this discrepancy include the lack of management

Table 1 Most common health improvement initiatives funded by primary care groups and trusts, 2000¹⁴

Health improvement initiative	No (%) groups or trusts funding initiative (n=69)
Community development project	32 (46)
Leisure, exercise, or recreation programme	32 (46)
Support for carers	27 (39)
Welfare benefits or advice	21 (30)
Accident prevention programme	19 (28)
Family support programme	16 (23)
Community transport programme	9 (13)

capacity, information, and budgetary discretion in the face of commitments to meet financial deficits at hospitals. Almost universally chief officers and chairs articulated a sense of being overwhelmed by the plethora of priorities set by government, of which the burgeoning number of national service frameworks form just one element.

Addressing inequalities in health

Tackling the root causes of ill health requires agencies to work together effectively across organisational boundaries. The imperative of working in partnership has been considered earlier in this series.²⁰ It is reassuring that those surveyed reported that liaisons between groups and trusts and departments at local authorities, other than social services, exist: for example, 44 (64%) reported that they have worked with departments of urban regeneration; 38 (55%) have worked with leisure services; 31 (45%) have worked with housing services; and 29 (42%) have worked with educational services. In contrast, only a quarter of groups or trusts reported that they had developed links with transport departments.

These links may be rudimentary, consisting only of formal arrangements, such as membership in multi-agency groups, rather than anything more active, strategic, or sustained. The formation of groups and trusts provides opportunities for such links to be made in a way in which individual practices did not. But are groups and trusts backing the rhetoric of partnership with resources? Fifty seven (83%) chief officers reported that they had allocated some of their budget to at least one health improvement initiative; the most common initiatives are shown in table 1. Though the scale of these investments was not specified, the symbolic importance of channelling even small sums towards health promotion should not be ignored.

In the 2000 survey 63 chairs (91%) reported that their organisation had implemented health promotion programmes relating to smoking; in the 1999 survey 38 (53%) had. Smoking cessation clinics provided in primary care or elsewhere were reported to be available in 51 (74%) groups or trusts and were planned in a further 16 (23%). Chairs also reported introducing local programmes for addressing a range of other health related behaviours (table 2). Only three (4%) had not implemented any programmes.

A central challenge

The extent to which trusts are able to increase their capacity in public health will be one determinant of success. Developing the public health workforce requires shared understanding about which functions

Table 2 Most common health promotion initiatives planned by primary care groups and trusts, 2000¹⁴

Health promotion initiative	No (%) groups and trusts
Smoking cessation programme (n=69)	63 (91)
Weight reduction programme (n=65)	26 (40)
Healthy eating initiative (n=64)	30 (47)
Physical activity programme (n=66)	53 (80)

can be undertaken locally and what needs to be supported centrally. Many public health functions cannot efficiently be delegated to trusts, for example surveillance to control communicable disease. Other core functions currently undertaken by health authorities also require population bases larger than that of a single primary care trust, for example those undertaken to support the commissioning of specialist services.²¹

The report on the Chief Medical Officer's project to strengthen public health across the NHS emphasises the need for better communication within the public health community as well as more coordination between organisations that contribute to the health of the population.²² There are particular opportunities to extend the role of nurses in public health.²³ The rest of the United Kingdom can learn from the implementation of the Scottish public health review which proposed extending the roles of public health nurses.²⁴

Those who champion health improvement in primary care groups feel isolated.²⁵ All local staff with relevant skills need to be identified and empowered to take on new roles. Primary care groups and trusts must support their training in order to develop a public health culture that spans these new organisations.²¹ One model advocated by the Faculty of Public Health Medicine is that of the "managed public health network" which would link and coordinate multidisciplinary professional groups across organisational boundaries for the common goal of improving health.²⁶

Conclusions

The view that improving the health of the population is a job too far for bodies that are dominated by doctors and that have no track record in this area is unduly pessimistic. Primary care groups and trusts have made more progress in laying the corporate foundations for delivering better services and improving health than some thought likely in 1998.²⁷ Their main achievements have been in organising and developing primary care; they have made limited progress on commissioning.

However, groups and trusts have taken some first steps in addressing health improvement: most have begun to acquire and use data for assessing health needs; they have established partnerships with other agencies; they have embraced national public health priorities; and they have contributed to the health improvement programmes of health authorities. Continued progress in implementing the national service framework for coronary heart disease should yield important health gains.

Some of the more ambitious aspirations for these new public health organisations, however, must be tempered after two years. A degree of "partnership fatigue" can be detected. The position of the minister for public health is less prominent, and health action

zones have drifted down the political agenda. Financial pressures in the acute sector remain the predominant concern. The multiplicity of changes in local NHS systems will ensure that there is a continued focus on structures such as mergers among primary care groups and their progression to becoming trusts, reconfigurations of community and mental health services, and changes in local government. In particular the imminent scaling down of health authorities will further limit their capacity to support primary care groups and trusts in this area. It will require persistence on the part of groups and trusts to ensure that the population's health, rather than the organisation of health care, remains a central focus of the new NHS.

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