

General practice should hold government to account on disease prevention

INTRODUCTION

As GPs, our fate is tied to the ever-increasing prevalence of chronic disease. We firefight these illnesses and encourage behaviour change but rarely think about the root causes of illness. The root causes are often very remote from us, but that makes them no less influential. The Global Burden of Disease 2013 estimated that, in England, an alarming 40% of morbidity and mortality was preventable, with smoking and poor diet alone accounting for half of this number.¹ Meanwhile, in the 10 years to 2018, the number of multimorbid people is estimated to increase by over 50% to 2.9 million, a rise identified by the King's Fund as a major driver of GP demand,² while ever-increasing workloads drive pressures.

Important drivers of preventable illness may be remote from our surgeries, but that doesn't mean we can't change them. It is the government's responsibility to design policies to improve the population's health, and we need to hold them to account on this. Obvious examples might be improving food or housing standards. The *Five Year Forward View* states: 'Twelve years ago Derek Wanless' health review warned that unless the country took prevention seriously we would be faced with a sharply rising burden of avoidable illness. That warning has not been heeded — and the NHS is on the hook for the consequences.'³

The NHS is on the hook despite inaction being on the government's part. As key stakeholders in controlling chronic disease, we should be among the loudest voices holding government to account, yet we are peripheral in the debate.

TACKLING CAUSES, NOT JUST CONSEQUENCES

Like cutting back a weed but leaving the roots, treating population health problems at the individual level may be a doomed strategy so long as the drivers persist. Smoking cessation is important, but we can't undo the damage of yesterday's smoking. Instead, tobacco regulation could prevent the same damage in 10 years' time by acting today.

There are many examples of effective preventive policies. For example, bread now contains 40% less salt than it did in the 1980s.⁴ More recently, plain-packaged cigarettes and sugary drinks taxation were eventually implemented despite government

inertia and industry resistance.^{5,6} Rather than wasting resources on protracted arguments, we could have moved on to evaluating the policies' impacts. Indeed, industry has obfuscated the evidence on the harms of sugar⁷ and tobacco,⁸ and the intellectual counterbalance to this has evidently been underpowered. The referenced summaries make for disturbing reading. However, these proximate causes must not overshadow less direct causes such as poor housing, education, and employment, largely driven by inequality. Prevention could also help us liberate capacity in general practice. As laid out in the *Five Year Forward View*,⁴ billions of pounds could be saved by treating preventable illness. Addressing root causes would also tackle the problem in general practice; it's very difficult to help people who don't attend — missing opportunities for early intervention, often for those with the greatest need.

COORDINATING ACTION

There is a notable mismatch between the importance of preventable illness in GPs' lives and how much attention our professional organisations dedicate to it. For instance, the RCGP rightly names workload as a policy priority, but prevention hasn't yet been linked to this. The College's broader policy areas include a small number of risk factors and it aims for GPs to improve their illness prevention activity. However, a coherent approach to tackling root causes would reinforce all these workstreams — without costing GPs more time.

It seems strange to lean back from this issue. GPs have become very comfortable criticising politicians' managerial choices over NHS services. Disease prevention has just as big an impact on us but we haven't yet got to grips with it. We must advocate for tomorrow's patients by arguing for disease prevention. Our influential professional organisations such as the College, the *BJGP*, and *WONCA* should be joining forces to take the lead on this change. We need a wider discussion on what our priorities are, and this should be followed up with programmes of research, commissioning, and lobbying. This would put a strong public health voice back into the NHS after the move to local authorities. We may not do anything differently in our practices, but petitioning the College to do more may be the single most important thing we do.

CONCLUSION

That 'prevention is better than cure' is a truism exported across many aspects of life, but neglected at home. In the medical profession, we should view increases in preventable risk factors in the 21st century as a social failure and we need to be much more assertive about that. It's not our sole responsibility to clean up the mess left by poor policy. As one of the big challenges that we, our patients, and health service are facing, it is incoherent not to take leadership on this key issue.

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