Community health initiatives and their relationship to general practice

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SUMMARY. This paper considers recent voluntary action in primary health care and focuses on community health initiatives, describes why they are important and how they may relate to general practice.

Introduction

A CONSIDERATION of the implications for general practice of community health initiatives is timely on two accounts. First, it is now known that thousands of such initiatives exist in the UK. Secondly, the present government is showing increasing interest in the role of the voluntary sector in primary health care services.

Philanthropic societies have provided welfare services for hundreds of years, and increasingly voluntary organizations work alongside or within statutory services. Norfolk's Glaven District Caring Scheme, a non-qualified nursing service created by Dr Allibone to give support to a community care scheme, and Paignton's Karing, a project which uses volunteers to provide support and services for the housebound and the elderly[1] are examples of the many schemes which have been developed. The integration of volunteers or independently funded voluntary organizations with certain aspects of the provision of health services has introduced the concept of non-professional care to general practice.

A more recent development is that of patient participation groups. These groups meet for many reasons, but one common concern is to have a say in the decision-making processes that affect the service provided by their doctor or health centre.[2] The emergence of patient participation groups demonstrates the willingness of many doctors to break from the traditional divide between the expert doctor and the non-expert patient. The two groups have much to offer each other, and doctors are being asked to take formal account of the services which patients feel should be provided by a practice.

Community health initiatives are a new element in voluntary sector activity in primary health care. A progression can be seen from the introduction of non-professional care, to accountability in delivery of care, to an attempt to exercise control over ill health produced by social factors. There is now considerable voluntary activity taking place within the community, which is neither alongside nor within general practice — 12 000 community health initiatives are known to exist in the UK.

The community health movement

Community health initiatives fall into three broad categories.

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Self-help groups

In self-help groups, people who either suffer from a condition or are relatives of a sufferer, meet together to give each other mutual support. They exchange experiences, methods of coping, and sometimes campaign for better services and for ways of overcoming the stigma about a particular condition. There are two sorts of self-help groups: those where the members are sharing a condition that is relatively well provided for by the National Health Service (NHS), and those where it is not. This simple division to a large extent determines whether the group regards itself as a supplement to NHS care, or as a challenge to it. The groups are often started by a sufferer or a relative and occasionally by a health worker, particularly if there is already a national organization for the condition. The groups often disappear as quickly as they emerge.

Community health groups

These groups are similar in origin and structure to self-help groups, with one important difference — the health concern that members share will be one that is regarded as being beyond the medical remit. Hence, while most physicians are now familiar with the importance of social factors to health, many do not regard poor housing, lack of safe play space, unemployment, and so on, as conditions that require a medical response. Hence, women on a housing estate who share a state of depression, and who identify its cause as isolation which in turn is caused by there being nowhere safe for their small children to play, decide to treat the depression by campaigning for play space. The chances are that a general practitioner would not have done this, but neither would he/she have been likely to cure the depression.

Community development health projects

These are rather different as they are normally based within a neighbourhood rather than on an issue, and they will usually have one or more paid workers. Funding for such projects comes either from a statutory source, such as the local authority, or from a trust or foundation. The aims of each project vary, but there is a shared commitment to the principle that people should have a far greater say in the conditions in which they live and which affect their health, including the nature and level of the statutory services provided. Community health workers, employed to work in such projects, assist people to decide collectively what their health needs are and to choose the appropriate action to attempt to get these needs met.

While community development health projects vary widely, one common element is the understanding that health is not an individual matter. Participants in community development health projects identify the causes of ill health in certain social factors over which individuals have little control.[3-5] Indeed, the mutual support gained from the sharing of experiences, and the subsequent lessening of the guilt associated with the illness of an individual are elements common to the community health movement as a whole and not only to community development health projects.

The majority of community health initiatives are to be found in the voluntary sector and have little if any contact with their local primary health care services. Is there scope for useful links to be formed between these initiatives and general practitioners? As one would expect in a movement of this size, there is considerable diversity of opinion. Some initiatives argue for autonomy from the NHS, for fear of being taken over and 'medicalized' while others argue in favour of working with, if not within, the NHS, as a means of influencing the service provided. So while there is no blueprint for the relationship a sympathetic doctor might attempt to develop, there are a number of ways in which he or she can support community health initiatives, if help is wanted.

How general practitioners can help

1. General practitioners can provide support by taking into consideration patients' experiences and perceptions of their health needs. The current professional definition of needs is often incomplete. Furthermore, a commitment to extending the concept of causality in ill-health to the wider social context will ultimately be of value to doctors, as well as to their patients.
2. Most general practitioners have little, if any, knowledge of the extent of local informal health networks, yet could be extremely useful to these networks if they became familiar with them and subsequently referred patients to them. The general practitioner should contact the local community health council, the council for voluntary service, the community action centre, the rural community council, and any other generic organization, in order to make contact with local networks. Meetings with these organizations could result in contact with the less readily available initiatives. Doctors could then advertise community health initiatives in surgery waiting rooms.
3. The doctor can then let it be known that he or she is willing to act as a resource for local health initiatives. Offering to give an informal talk on childhood illnesses or allergies for example, is one way of developing useful relationships. Similarly, doctors who are responsible for trainees might recommend that trainees also involve themselves with the local health networks.
4. A general practitioner may be instrumental in starting up a community health initiative. Patient participation groups have already been discussed but more recently some doctors have introduced group consultations. So, for example, rather than see a large number of individuals with back pain over the course of a week, a group consultation for patients with back pain is held once a week. This initiates the process of mutual support among the patients and the doctor benefits from a collection of experiences. This group consultation may provide the impetus for a subsequent self-help group.
5. Having developed community health initiatives within a practice, the doctor may then wish to consult them to determine whether the practice facilities are adequate. Issues, such as toys for children to play with, a pram shed, receptionists trained to deal sensitively with patients and a cheerful waiting room, may be raised. These issues can be dealt with simply and relatively cheaply.
6. The general practitioner could make surgery premises available, out of surgery hours, as meeting places for groups involved in health initiatives.

It can be seen that there are a number of ways in which general practitioners can support their local health networks. None of these proposals require substantial expenditure, yet if implemented they would provide a relevant service for patients and may even be cost effective.

Conclusion

Privatization of certain aspects of primary health care could contribute to an erosion of collectivity in health. Increasingly, however, evidence indicates that ill health is caused by social factors. Any challenge to such factors must be collective to be appropriate or effective. Moves towards individualism — an inevitable side effect of privatization — will therefore be unhealthy.

Measures that counter individualism and take account of the social systems responsible for peoples' health experiences, knowledge and needs, should be encouraged and reproduced. To this end, the provision of support and resources to community health initiatives by general practitioners will be one essential contribution.

References

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