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General practice or primary health care?

PRIMARY health care in the UK is undergoing a period of extensive review. The 1980s have seen the publication of the green[1] and white papers,[2] the Cumberlege review of community nursing[3] and the Griffiths report on community care.[4] Over the same period, the scope of primary medical care has widened, and with the setting up of independent family practitioner committees in 1985, a management framework for family practitioner services is now being created.

These recent reports have reflected, rather than resolved, three major tensions in primary care: between individual and population-based approaches, between employed staff and independent contractors and between broad and narrow definitions of primary health care. These tensions are maintained by the way primary care services are currently provided — by family practitioner committees, district health authorities, local authorities and voluntary organizations, each with different ways of working.

Recent policy documents have done little to promote a strategic policy for primary care as a whole.[5] In the green[1] and white papers,[2] primary care was reduced to the activities of those providing family practitioner and community nursing services, with the emphasis on the former, while the Cumberlege report[3] made community nursing the mainstay of primary care. Little attempt has been made to balance the management and area-based approach of the Cumberlege report with the 'financial incentives as a route to quality' approach of the green paper. How, for example, will planning for dispersed general practice populations relate to the populations served by neighbourhood nursing teams? What tensions may be created by the general practitioner receiving a financial incentive to reach targets for preventive services, when the health visitor may actually carry out the relevant procedures? How can the priorities of nurses attached to general practices, but employed by the health authority, be harmonized with those of the primary health care team or individual general practitioners?

While these anomalies are a result of primary health care being delivered by different organizations, developments within primary medical care also reflect changes in the balance between individual and population-based approaches. This is particularly evident in the changing boundaries between primary medical care and prevention/public health and care in the community for priority groups.

First, general practitioners are increasingly involved in providing population-based preventive services such as paediatric surveillance, cervical cytology and immunization. This trend will accelerate if the financial incentives proposed in the white paper become a reality. This type of care requires different management and monitoring procedures from individually-based anticipatory care and opportunistic forms of screening and, while some practices use age–sex registers to monitor uptake, this is far from the rule for general practice as a whole.

Secondly, the increasing number of elderly people and of those who are vulnerable through mental illness and learning disabilities living in the community has implications for the workload and composition of primary health care teams. The green paper confidently stated that 'the move towards the provision of care in the community has been assisted by the increasing involvement of a wider range of professional groups who with appropriate training are participating in the primary

health care team and by increases in the number of support staff.[1] Yet there is evidence that many general practitioners lack information on local services for priority groups, and that, in some cases they may assume that all medical care falls within the remit of the specialist.[6] Studies have demonstrated that the primary medical care needs of people with learning disabilities and the physically disabled are not always met.[7,8] Continuity of care means more than care by a single practitioner, although it is often defined in this way.[9] It may involve setting up monitoring systems (such as dependency registers) and ensuring coordinated care. For example, the Griffiths report advocates 'a more systematic approach by all GPs to identifying the potential community care needs of their patients'.[4] Moreover, it gives general practitioners responsibility for informing social services of the community care needs of their patients. While it is not essential for a general practitioner to act as a case manager, it is important that care provided by general practitioners and by district health authority and local authority services is properly coordinated.

Many have argued,[10,11] particularly in relation to prevention, that general practitioners should combine a public health and population-based approach with traditional clinical skills. Reports on the health of a practice could include social and environmental influences on health. Already, some family practitioner committees are working with community physicians to use information on the population of the family practitioner committee for planning purposes.

Planning for practice populations forms only part of the picture. Increasingly, general practitioners will be charged with improving their accountability to consumers and demonstrating value for money in the way services are delivered. As independent authorities directly accountable to the Secretary of State for Health, family practitioner committees are developing their planning role. Referral and prescribing patterns will come under scrutiny, surveys of consumer opinion are being carried out and more rigorous monitoring of practice premises is being undertaken. Targets for certain preventive services are likely to be set in conjunction with district health authorities. In particular, the Health and Medicines Bill makes provision for family practitioner committees to become budget holders for the ancillary staff reimbursement scheme and this represents a major extension of their planning responsibilities. General practitioners can either become active participants in the planning process or can retreat into a defensive position in the face of these developments.

The broad goals for primary health care set by the World Health Organization[12] emphasize that primary health care is more than the sum of the activities of professionals involved in delivering it. For the WHO, primary health care is the key to achieving health for all by the year 2000. Their definition of primary health care includes proper nutrition, sanitation, immunization and basic treatment for health problems, and requires joint working by all the agencies providing services. Despite criticisms of 'sloganeering'[13] and an over-simplistic approach to solving major health problems,[14] 'health for all' has reaffirmed the main determinants of a population's health status, firmly relegated primary medical care to one element in a much broader framework and encouraged action to make this broad definition of primary health care a reality. An indication of a country's success or failure to provide primary health care may be gauged by the extent to which inequalities in health are reduced — the number one target for the European region of the WHO.[15]

While general practice forms only part of this picture, changes in the organization and management of primary health care already demand that general practitioners become more population-based in their approach and more accountable to consumers and the public purse for the services they provide, and that they collect more information on social and environmental aspects of health. If general practice meets this challenge we can look forward to improvements in the health of the whole population based on a strong primary care system.

LINDA MARKS

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Training for hospice care

THE hospice movement has become well established within the UK to the extent that there are now recognized training courses for nurses and palliative medicine is beginning to be seen as a specialty in its own right. Initially, many hospice doctors were recruited from general practice, which they either maintained on a half-time basis or left to take up full-time medical appointments at their local hospice unit. Often these general practitioners have been instrumental in setting up and establishing the unit in which they have subsequently worked.

There has been much negotiation over proposed training for palliative medicine and the Royal College of Physicians has recognized that palliative medicine is emerging as a specialty.