

Reducing health inequalities: primary care organisations and public health

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Introduction

Attempts to strengthen the public health function in primary care organisations in the UK have a long history. At the heart of the relationship between general practice and public health is an ethical conflict between individual and collective freedom. For practitioners, the roles of patient's advocate, mediator and population planner may overlap and conflict with one another (1). General practitioners are often untrained as health educators, with a narrow view of health promotion and limited experience of community development activities (2). Many primary care providers are politically antipathetic to social intervention in the guise of health promotion, particularly if the opportunity costs of such activities compromise their traditional caring role (3). Primary care trusts' forerunners – general practitioner commissioning groups and total purchasing pilots as well as fundholders – were not infused with a mission to address social determinants of health (4,5).

Establishing the last of the core functions vested in primary care trusts – to improve population health and address inequalities – is therefore challenging. The term 'health improvement' has various shades of meaning in the government documents where it appears, reflecting the degree to which core NHS activity is or is not included (6). Early guidance for primary care groups defined the function as being to "improve the health of, and address inequalities in, their community" (7). This was explicitly distinguished from the development of primary and community care and the commissioning of hospital services. Health improvement is separated from NHS activities, and presumably includes health promotion outside the NHS (e.g. in workplaces and schools) as well as activities which address social, economic and environmental influences on health (e.g. housing, transport, employment, community development).

Many policy initiatives are impelling primary care organisations and those working in them to address health inequalities. 302 PCTs are now responsible for at least 75% of health service spending; inequalities in access to primary care are influencing their investment plans. At ground level, Personal Medical Services pilots have provided new flexibilities through which to address previously underserved needs and are, in turn, shaping the new GP contract. With the abolition of the Medical Practice Committee, PCTs are assuming a role in the equitable distribution of GPs themselves.

Shifting the Balance of Power and the advent of Local Strategic Partnerships underline the pivotal contribution of PCTs in, for example, tackling inequalities through neighbourhood renewal (8). National service frameworks are but one attempt to address variations in the level and quality of service provided.

But the very breadth of activities involved - from individual health advice to organisational forms of primary care organisation to complex community interventions - is in itself a stumbling block. The range of relevant “evidence” – different interventions, different settings, different end-points - makes any systematic compilation problematic. However, lack of evidence is only one factor limiting primary care organisations in their efforts to reduce inequalities in health (see below).

The purpose of this paper is to comment on the evidence for public health interventions likely to be promoted by the new primary care organisations as they develop their role in health improvement and tackling health inequalities. This does not claim to be a systematic review of all such evidence. “Recommendations for policy and practice” are framed in the form of key questions for discussants.

The determinants of health inequalities

There is an abundant body of evidence demonstrating the key determinants of health, and the social determinants which give rise to health inequalities. The health of individuals and populations is associated with a variety of factors, including socio-economic status, gender, age, ethnicity and locality. The interplay of these factors lead to variations such that some groups in society experience poorer health outcomes than others – increased mortality and morbidity - and are less likely to receive good health care. There is a substantial literature examining the social determinants of variations in the health of population sub-groups. Classifications include that suggested by Wilkinson and Marmot (9) (Table 1). While the evidence for most of these factors is widely accepted, there are some important gaps. There is uncertainty as to the precise effects of many factors and how they act. Large swathes of public policy - eg in education, transport, housing or employment - lack an evidence base and assessment of the health impact of initiatives in these areas is in its infancy.

What kind of interventions are we talking about?

Various reviews have summarised the areas of activity within primary care which are effective in reducing health inequalities (10-16). They can be divided into individual, organisational and community interventions.

The first are those which take place between **individual** health professionals and patients, eg classical preventive activities. Individual interventions are often classified into primary, secondary and tertiary prevention. This is a helpful distinction for two reasons. Firstly, in part for methodological reasons (see below), the evidence on effectiveness tends to be stronger in the areas of secondary and tertiary prevention (barring some exceptions such as immunisation). Secondly, secondary and tertiary prevention often accords more closely with the traditional view of clinical activity than does primary prevention and thus health professionals are readier to take on these tasks. There is plenty of evidence for an ‘inverse care’ effect in relation to preventive activities. Communities most at risk of ill health tend to experience the least satisfactory access to the full range of preventive services, the so-called “inverse prevention law” (17).

The reviews cited above demonstrate that there is much high quality evidence, often experimental, on effective individual preventive interventions, particularly secondary and tertiary. The national service framework for coronary heart disease (CHD) provides examples. There are, however, a number of persistent problems. Many effective interventions are not implemented, for reasons discussed below. In this as in other fields, there remain many gaps in the evidence, not always reflected in policy. Pursuing the example of CHD prevention, some individual interventions do not have a robust evidential base, eg the impact of lifestyle advice on diet and exercise, but remain enshrined in policy. Where evidence does exist, there is a need for prioritisation of policies.

The second important group of primary care interventions are **organisational**, particularly those concerned with improving the organisation of care and access to services for disadvantaged groups. Types of intervention in this category include changes within the organisation of primary care from practice level to whole system

changes. An example of the former might be changes to make cervical screening more accessible to certain ethnic groups by providing information in different languages and increasing the availability of female health professionals. More wide-ranging organisational changes could include the organisation of individual practices into PCTs or the establishment of 'managed public health networks' that are to link multidisciplinary professional groups across organisational boundaries for the common goal of health improvement (18). Evaluation of PMS pilots, for example, suggested that the provision of nurse-led PMS addressed previously unmet needs in deprived, under-doctored locations (19).

The evidence for these types of interventions is patchier than for individual preventive activities. There is much good quality evidence, often experimental, around interventions to improve access at practice level, and indeed about the negative effect of financial barriers at any level. User charges for primary care have been repeatedly shown to deter those most likely to benefit from preventive activities (17). But there is rarely experimental evidence on broader scale organisational changes and observational evidence comparing systems is limited. What evidence there is has not generally been compiled systematically, nor appropriately contextualised into the whole system within which organisational developments take place. The outputs of interest in primary care are diverse and organisational changes may have wide-reaching implications, making evaluation methodologically difficult. A full evaluation of organisational change for example would require assessment of trade-offs between a number of different dimensions – such as equity, effectiveness and continuity of care, and evaluation on this scale and in this detail is not widely available.

The third type of interventions are **community**-wide including community development initiatives. Primary care organisations have not been central to such interventions but have a potentially important role to play as partners with other agencies. Several recent policy changes have promoted this type of primary care activity and a number of evaluations have been carried out – including work on PCG/Ts and health improvement (Table 2) and on Health Action Zones (21). There is also a body of international research in this area but little experimental evidence. The

methodological problems described below apply particularly here. In their roles as employers, users of resources, procurers, producers of waste, deployers and vendors of land, PCTs have opportunities to enhance community health that have as yet been neglected by researchers and practitioners alike (22).

Methodological issues

The methodological problems applicable to evidence for primary care interventions to reduce inequalities may be summarised as follows:

- Study design

A well established protocol, especially for systematic reviews and meta-analyses, places experimental randomised control trials at the top of a hierarchy of evidence. Non-experimental designs and especially qualitative data are seen to provide weaker evidence. This excludes highly relevant evidence from many evaluations, particularly of organisational and community interventions which are not amenable to experimental designs. Progress has been made in designing studies to evaluate such interventions rigorously. The evaluation of Health Action Zones is a good example (21).

- Outcomes

Interventions with long-term and sometimes diffuse outcomes pose major methodological challenges, eg in attributing causation, particularly in non-experimental designs.

- “Black box” problems

It is difficult assessing the significance of complex interventions through quantitative experimental designs. These do not allow identification of exactly which components of complex interventions are or are not effective in which circumstances. This intelligence requires qualitative approaches which take context into account. Such work is increasing, again as in the evaluation of the Health Action Zones.

- Heterogeneity

Evidence for interventions is more powerful if it derives from several different studies. However, different studies are frequently too varied in terms of interventions and settings for their results to be pooled.

- Generalisability

It is therefore difficult generalising from one type of intervention in one setting to interventions in other settings. Work from countries where circumstances are very different may have uncertain significance for the NHS.

Why is the existing evidence not implemented?

Despite these methodological problems, evidence for effective interventions does exist. However, supportive evidence does not necessarily lead to implementation of interventions. The reasons for this go beyond the quality of the research and accumulating further technical evidence may not be the most useful response.

Barriers to implementation include:

- Gaps in technical knowledge regarding effective interventions.
- Partial understanding of the barriers to implementation by health professionals.
- Failure to synthesise the existing evidence – in part for methodological reasons.
- A consistent failure to address the opportunity costs of new or different activities in primary care. Increasing primary care's public health role means doing less of something else.
- Related to the above, a failure to address adequately and with all relevant stakeholders, the question of the role of primary care. This is not a technical agenda but one of achieving shared values as a starting point for any changes in professional roles.
- Resource constraints.

The contribution of PCTs

Primary Care Trusts' main achievements have been in the field of primary care and organisational development with limited progress on commissioning and health improvement. The three Tracker surveys have charted significant progress as PCTs establish an infrastructure for health improvement (23). They are using data for health needs assessment, addressing national population health priorities, and implementing local health improvement programmes. They are working with local authorities beyond social services departments and beginning to participate in local strategic partnerships. They have invested in a range of health promotion schemes (Table 3). The purpose of much primary care investment has been to address inequalities in access to services (e.g. legacies of fundholding). Over 60% per cent are giving financial support to community development activity.

Many PCTs have implemented health improvement initiatives in line with national targets and the national service frameworks (NSFs) which link clinical governance, commissioning and health improvement priorities. Continued progress in implementing the coronary heart disease NSF should in time yield significant health gains but PCTs are at the limits of their strategic planning capacity given the volume of existing central guidance.

However, there remain significant concerns. PCTs continue to report the need for more help with public health activities than they currently receive. The abolition of health authorities has reduced available support for PCTs in the short term. While public health specialists have made progress in establishing managed networks, Strategic Health Authorities (SHAs) themselves are in flux. They appear unlikely to be able to offer much developmental support to new PCTs. The latter will therefore be looking elsewhere, for example to the National Primary and Care Trust Development Programme, for help. Without continuing development of the public health workforce, PCTs may be unable to sustain and develop the health improvement activity which they have already initiated.

As they develop their performance management role, SHAs will need to give due weight to achievement in this area of the PCTs' brief. All too easily, as Chairs and chief officers testified, health improvement drops down the agenda when set against

'must do's' related to the acute sector (23). In particular, PCTs will need clear incentives to take an active role in furthering local strategic partnerships.

Questions for discussants:

- What are your views on the barriers to implementation we have identified? Are there others? What are their implications?
- What are the most effective ways of developing a public health workforce?
- What can be learnt and shared from the early experience of managed public health networks and local strategic partnerships?
- Can new flexibilities available to PCTs (eg PMS) be associated with measurable reduction in inequalities in access to health care?
- How can the performance of PCTs be managed to ensure priority is attached to health improvement and tackling health inequalities?

Table 1. The social determinants of health:

- The social gradient
- Stress
- Early life factors
- Social exclusion
- Work
- Unemployment
- Social support
- Addiction
- Food
- Transport

Table 2. Factors influencing PCG/Ts' progress on health improvement (20):

- Corporate board level commitment to addressing inequalities
- The quality of PCG/T leadership
- Adequate management support
- The availability of development money
- Collaboration with neighbouring PCGs/Ts
- The availability of specialist public health support
- The strength of local partnerships
- The relationships between PCG/T board and frontline staff, especially GPs

Table 3. Investments in specific initiatives.

<i>Service</i>	<i>Number</i>	<i>Percentage</i>
community development projects	32	45%
leisure/exercise/recreation	32	45%
support to carers	27	38%
welfare benefits/advice	22	32%
preventing accidents	19	27%
family support	17	24%
community transport	9	13%

References

1. Pratt J. Practitioners and practices. A conflict of values? Oxford: Radcliffe Medical Press, 1995.
2. MacDonald J. Primary health care: medicine in its place. London: Earthscan, 1993.
3. Fitzpatrick M. The Tyranny of Health. Doctors and the regulation of lifestyle. London: Routledge, 2001.
4. Mahon A, Stoddart H, Leese B, Baxter K. How do total purchasing projects inform themselves for purchasing? London: King's Fund, 1998.
5. Abbott S, Killoran A (2000) Did Total Purchasing help the advent of PCGs? British Journal of Health Care Management: 6, 202-6.
6. Abbott S, Gillam S. Health without a care. Health Services Journal 2000 2/11/00, p. 32.
7. Department of Health. Primary Care Groups. Delivering the Agenda. (HSC 1998/228: LAC (98)32). Leeds: Department of Health, 1998.
8. Social Exclusion Unit. A New Commitment to Neighbourhood Renewal: National Strategy Action Plan. London: Cabinet Office, 2001.
9. Wilkinson R, Marmot M, 1998. The Solid Facts. World Health Organisation.
10. NHS Centre for Reviews and Dissemination. Review of the Research on the Effectiveness of Health Service Interventions to Reduce Variations in Health. CRD Report 3. University of York, 1995.
11. Hulscher MEJL, Wensing M, van der Weijden T, Grol R. Interventions to implement prevention in primary care (Cochrane Review). In: The Cochrane Library, Issue 1, 2001. Oxford: Update Software.
12. Ebrahim S, Davey Smith G. Multiple risk factor interventions for primary prevention of coronary heart disease (Cochrane Review). In: The Cochrane Library, Issue 1, 2001. Oxford: Update Software.
13. A systematic review of the effectiveness of promoting lifestyle change in general practice. Ashenden R, Silagy C, Weller D. Family Practice 1997, 14(2), 160-175.
14. Interventions to reduce socioeconomic health differences: a review of the international literature. Gepkens A, Gunning-Schepers L J. European Journal of Public Health, 1996; 6(3), 218-226.
15. Review of the research on the effectiveness of health service interventions to reduce variations in health. University of York. NHS Centre for Reviews and Dissemination. 1995, 157 York: University of York, NHS Centre for Reviews and Dissemination. (CRD Report; 3)

16. Evidence from systematic reviews of the research relevant to implementing the 'wider public health' agenda. University of York. NHS Centre for Reviews and Dissemination. 2000. York: University of York, NHS Centre for Reviews and Dissemination.
17. Independent Inquiry into Inequalities in Health (Acheson Report) 1998. London: The Stationery Office.
18. Faculty of Public Health Medicine. Developing public health in Primary Care Trusts – a framework for discussion. London: FPHM, 2000.
19. Lewis R, Jenkins C, Gillam S (eds). Transforming Primary Care – PMS pilots in the new NHS. King's Fund, London, 2001.
20. Abbott S, Florin D, Fulop N, Gillam S. Primary Care Groups and Trusts: Improving Health. London: King's Fund, 2001.
21. <http://www.haznet.org.uk/>
22. Coote A (ed). Claiming The Health Dividend. King's Fund, London, 2002.
23. Wilkin D, Gillam S, Coleman A. The National Tracker Survey of Primary Care Groups and Trusts. Modernising the NHS 2000/2001. Manchester: National Primary Care Research and Development Centre and London: King's Fund, 2001.

