PRACTICE OBSERVED

Practice Research

Developing primary health care

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Abstract

Primary health care is best provided by a primary health care team of general practitioners, community nurses, and other staff working together from good premises and looking after the population registered with the practice. It encourages personal and continuing care of patients and good communication among the members of the team. Efforts should be made to foster this model of primary care where possible and also to evaluate its effectiveness. Community services that are not provided by primary care teams should be organised on a defined geographical basis, and the boundaries of these services should coincide as much as possible. Such arrangements would facilitate effective community care and health promotion and can be organised to work well with primary care teams.

The patient's right to freedom of choice of a doctor, however, should be retained, as it adds flexibility to the rigidity of fixed geographically based services.

Introduction

Many agencies provide health care and social services in the community, often overlapping considerably.[1] This can cause confusion and wastage of resources. Several of these services are provided to a geographically defined population, but the boundaries of the service provision by the different agencies do not always coincide. There would be considerable benefit in defining common boundaries for these areas now, while some are still in the early stages of development. This would enable information about the needs of the population, based on census and other data, to be shared. It would also avoid the unnecessary duplication of services, allowing decisions to be made about the most effective and efficient use of resources, and would allow the population of an area to have a say in the decisions that are made about the services provided for them.

The underlying theme of the two government reports on primary health care published last April[2,3] was the importance of the primary health care team. This was also the case with the two reports on the same subject that preceded them by five years[4,5] and the recently published report from the social services committee of the House of Commons.[6]

This paper is not concerned with those recommendations of the community nursing review which the government has decided not to implement.[3,6] We believe that primary care is best organised by a well functioning primary care team, with patients being registered, often for many years, with one general practitioner whom they choose and having access to the coordinated services of other members of the team. Though we believe that this model should be encouraged whenever possible, it should be borne in mind that, despite the agreement of all the reports mentioned above, this is to a certain extent an article of faith that should if possible be tested using as criteria satisfaction of the patients with the services provided and satisfaction of the health workers with their jobs, together with measures of outcome in terms of improved quality of care for patients. This applies equally to geographically organised community care, and we support attempts to evaluate different models of care.

The present position

The agencies providing community services are mostly under the control of the Department of Health and Social Security or the Department of the Environment. They include the following, which are provided almost entirely on a fixed geographical basis:

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The National Health Service provides hospital priority care services for mental illness, mental handicap, physical handicap, and the elderly; and day hospitals and day care. It also covers community medicine, health education, health visitors and district nurses (when working geographically), speech therapists, occupational therapists, domiciliary physiotherapists, chiropodists, and dentists; community diabetic nurses, midwives, and psychiatric nurses; outreach services for terminal care and incontinence, stoma nurses, special drug and alcohol services, and so on.

Local authorities provide home helps, meals, day centres, residential homes, social workers, occupational therapists and home aids and adaptations, housing, education, and other services. They deal particularly with children, the elderly, the mentally and physically handicapped, and the mentally ill.

Social security services pay attendance allowance, mobility allowance, invalid care allowance, disability benefits, sickness and invalidity benefits, retirement pension, unemployment benefit, child benefit, and income maintenance—that is, supplementary benefit (including board and lodging payments for people in hostels and residential and nursing homes), housing benefit, and family income supplement.

Voluntary and private organisations provide a very wide range of services.

The only services that are not geographically based are the NHS family practitioner services (general practitioners and attached health visitors, district nurses, and so on and ancillary staff, pharmacists, dentists, and opticians), the acute hospital services (because general practitioners are free to make referrals to any hospital in the country), and some of the voluntary and private services.

These different agencies provide interrelated services to groups of people living in the community, but the different structures within which the services are provided make it difficult for the providers to communicate with each other. The workers responsible have different training, different attitudes, different methods of employment, different management arrangements and accountability, and different geographical boundaries for their work.

Various agencies are currently developing new policies for community care because of factors such as the health service policy of transferring care to the community, the closure of large mental hospitals, the increasing numbers of elderly in the population needing care at home, and so on. Community psychiatric nurses, health visitors and district nurses, social workers, and some general practitioners have developed or are developing their own defined geographical areas that do not necessarily have the same boundaries. Local authority housing departments, hospital geriatric and psychiatric units, and social security offices have larger defined catchment areas that they cover, which also often do not coincide.

The cost of providing a service by one combination of agencies may be greater than the cost of another combination.[1] For instance, caring for ill elderly people by admitting them to a hospital or nursing home can be much more expensive than keeping them at home with the support of an attendance allowance (and possibly an invalid care allowance for the person in attendance) and home helps and district nurses and general practitioners from a primary care team visiting regularly. Usually patients want to stay in their own homes for as long as they can, and a move to a nursing home or hospital can be very unsettling for an elderly person, heightening confusion and accelerating physical deterioration. Coordinating these services and deciding on the most effective and efficient method of provision is difficult because of the complexity of community services and the fact that payments are made from different parts of the DHSS and other budgets. This leads to confusion—for patients and workers—and wastage. The increased mobility of people and the lack of common boundaries of health authority areas with local authority and family practitioner committee areas since the 1982 NHS restructuring of district health authorities and their boundaries have made things more difficult.

Positive features and new developments

The present system and recent developments in community care have some positive features that could be developed.

Firstly, many primary care teams offer a range of services under one roof. For instance, in the health centre in which one of us works there are general practitioners and their employed ancillary staff (general medical services); dentists, health visitors, and district nurses (some in the treatment room and others visiting in the district, mostly attached to practices), community psychiatric nurses, school nurses, a speech therapist, a midwife, a sex therapist, a dietitian, a health worker who speaks Bengali, and a community physiotherapist (district health authority); a full time social worker (local authority); counsellors provided by the Marriage Guidance Council (voluntary body); and someone giving advice about DHSS social security benefits.

At the centre staff from different disciplines meet regularly, both casually and at weekly practice meetings, at which there is no difficulty in deciding which group of workers is the most appropriate to deal with a particular problem. Usually there are common goals, and there is always a form of continuing mutual education when discussing the attitudes of different workers. There is no question of one person being in charge or of sectional interests in competing for patients, as can occur if the services work independently with poor communication. Each section does its own job as best it can and is glad of any help that can be provided by another member of the team. If a new social worker, nurse, or doctor is appointed several members of the team have a say in the choice. For people coming with a problem to the health centre it makes little difference how the services represented there are structured—they just pass easily from one to the other, as they are under the same roof. It is a system that works, and this has much to do with the services being in the same building and the staff meeting regularly.

Most general practitioners now work in group practices, and many have variants of this arrangement. The premises of the practice vary in standards—only one quarter of general practitioners work in health centres—and people have a continuing relationship with the doctors in the practice, whom they see three or four times a year. A lack of continuity of care is more a matter of the arrangements in the practice and the number of doctors in the group rather than whether the practice is located in a health centre or not.

Secondly, general practice in this country has evolved so that 94% of all doctor contacts in the community (NHS or private) are with NHS general practitioners.[7] The general household survey of 1982[7] showed the following breakdown of contacts made by 4079 elderly people in the month before the interview: doctor in surgery 938 people (23%), doctor at home 41 (10%), doctor at surgery and home 1264 (31%), district nurse or health visitor 245 (6%), chiropodist 326 (8%), home help 326 (8%), meals on wheels 82 (2%), lunch out at lunch club or day centre 122 (3%), and a visit to a day centre 163 (4%). General medical services account for 7% of the cost of the NHS,[8] not including the cost of the drugs prescribed by general practitioners, which is determined largely by agreements between the government and the pharmaceutical industry. Treatment in hospital normally results from referral by a general practitioner, and, in comparison with other developed countries, we have relatively low rates of admission to hospital and spend a low proportion of our gross national product on health services.

The system provides long term continuity of care and also a mechanism for transferring patients' medical notes when they move house. Throughout a patient's lifetime notes made by the general practitioner and letters between the practice and hospitals regarding referrals and admissions and so on move with the patient. As hospitals do not generally transfer patients' notes when they attend another hospital this is a valuable aspect of general practice in this country and enables a general practitioner, when referring a patient to a nurse or hospital, to give a summary of the relevant history.

Thirdly, in some areas different agencies have cooperated to define common boundaries and have set up local multidisciplinary teams to ensure coordinated services.

Finally, information technology can now help to give details of social conditions (and hence indicate the likely needs of the population) down to small areas such as postcode sectors, enumeration districts, electoral wards, or any combination of these. The location of different services and the boundaries of their normal working areas can also be charted and overlaid on maps of demographic and social factors to show the correspondence between services and local needs. Family practitioner committees are computerising all their records—which cover 97% of the population[3]—with one common, integrated system of software throughout the country. With postcoded addresses the distribution of general practitioners' practice populations can be mapped and the overlap with other services shown. This system could be linked with community child health systems and eventually with hospitals. Standardised mortality ratios, infant and perinatal mortality rates, and measures of morbidity such as self reported sickness or disability and the proportion of low birthweight babies can also be linked with the social and service data for small areas, enabling the relation among health indices, social factors, and services provided to be monitored.

It would be relatively straightforward to produce data and maps by computers and give the information to local workers.[9] This would allow local data to be compared with those of larger areas or national data. Services, particularly preventive services, could be targeted at social groups with the greatest need, with the aim of reducing morbidity and mortality.

Community care areas

The community nursing review pointed out the potential advantage to the community nursing services if they were managed on a neighbourhood basis.[2] As an extension of this principle local

community care areas with the same boundaries for community nurses, social workers, and others working geographically could be drawn up by the local authority and health authority acting together with local residents. Each area would cover 10 000-25 000 people, preferably comprising groups of electoral wards. Statistics about the social conditions of the population of each area (numbers of elderly people, homeless families, and so on) could be used to work out the levels of service needed. Each authority could set a local budget for the services it provided in the area and plan with the local residents how these resources should be deployed most effectively. Staff would have to be trained to adapt to this approach. Eventually it would be possible to integrate data about housing, social security payments, hospital usage, and so on even for small areas and so produce the information necessary for planning the most advantageous mix of services.

This raises the whole question of virement—transferring money from one budget to another. Theoretically this is possible at the moment through the machinery of the existing joint consultative committee at the health authority and local authority level, but there are several difficulties with this mechanism, and the money in question constitutes less than 1% of the NHS budget.[1] If there is a change in the balance between different community services the relevant financial resources need to be transferred. Eventually the switch of resources between social security, local authority, and health budgets in a budget of a common community care area could be envisaged, with the aim of providing better and cheaper services. Before this is possible, however, the data needed to make the budgeting decisions have to be gathered for each small area. Such data could also give information about the variation in the existing provision of resources among different community care areas in relation to their key social and demographic characteristics.

The efficiency of different services in an area could also be studied. A district nurse may have a total of 1500 visits to patients a year,[2] mostly in the home, whereas a general practitioner will have, on average, over 7000 consultations a year, of which about 900 will be in patients' homes.[10] General practitioners are usually requested to visit a patient at home, or they make an appointment to do so for a routine visit for a chronic condition. Health visitors and district nurses spend 16% and 24% of their time, respectively, travelling[2] and often find that patients are not at home when they arrive, a wasteful practice that rarely happens with general practitioners. General practitioners hold about 88% of their consultations in their surgeries,[10] and community nurses might also be able to do this if they had a base in which to do so—for example, in a health centre. This would enable them to make the maximum use of their skills and to develop the extended role of the nurse.

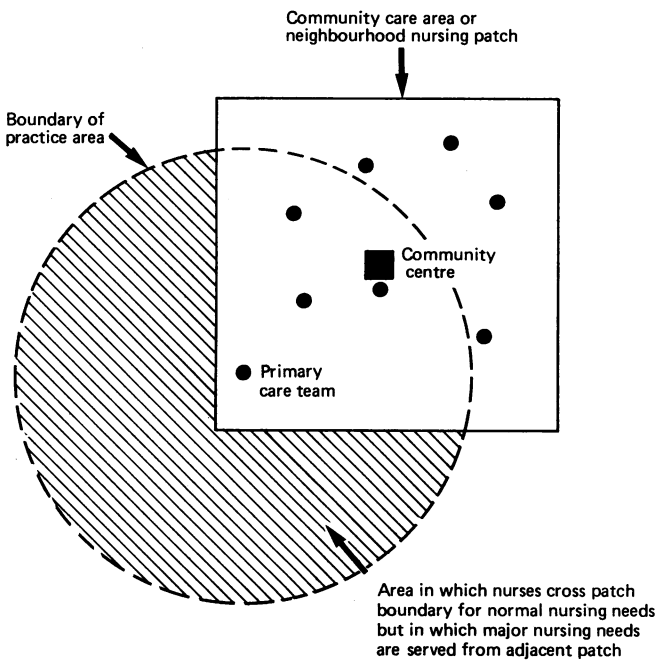
The community nursing review suggested that health care associations should be formed. Their structure could vary infinitely, from an antenatal group that can see a potential for improving their services or an ethnic minority who do not know how to use the services, to a more substantial group, under the auspices of the community health council, that covers more than one neighbourhood and will help to monitor and plan services with a view to maximising their effectiveness. Local residents would have some say in decisions about planning, allocating resources, and quality control of the services that they receive and ultimately pay for. Voluntary workers could help the professionals—for instance, with prevention campaigns and caring for the elderly. There could be close collaboration between people in the community and staff of the health and social services, allowing collective responsibility and collaboration at a local level, perhaps covering only a few thousand people. It is, however, important to ensure that the views put forward are representative of the local population and those directly using a particular service, not only those of a particular pressure group.

General practitioners working in primary care teams normally discuss with other members of the team in a confidential way the aspects of a patient's medical history that are relevant to the management of the patient by the team. Social workers' records, however, are held separately from the notes of the general practitioner and community nurse (and this will continue for legal and confidentiality reasons), but the possibility of these professionals working more closely together would allow relevant information held in different sets of records to be exchanged more easily when appropriate, such as in cases of suspected child abuse.

Primary care teams and community care areas

General practitioners' lists of patients are traditionally not based on a defined geographical zone other than the loose arrangement implied by the contract between the general practitioner and the family practitioner committee, in which the general practitioner agrees to visit patients at home if necessary and therefore can accept only patients living within visiting distance of the surgery. Fears have been expressed about how general practitioners' practice areas can be made to overlap with community care areas as described above and still retain the freedom of patients to choose which general practitioner they register with. The benefits of this freedom and the continuing doctor-patient relationship, which is a cornerstone of our general practice system, are very great.[2-6] So, also, in a geographical zoning system, are the benefits of knowing the exact area for which a service is responsible if the service does not have the advantage of a registered list of clients (as a general practice has). There would, however, be an advantage in general practitioners continuing to be able to take patients from over the boundaries of a community care area, as this would leave an element of consumer choice in what otherwise would be too inflexible a system.

It is obviously best for the community nurses working in a primary care team with general practitioners to remain with that team, but they could be responsible to the neighbourhood nurse manager for their training, sickness cover, weekend rota, and so on. The general practitioners and nurse manager would have to decide how best to cover registered patients who live in another area. Patients with few nursing needs should be covered by allowing flexibility in the system so that a nurse can cross the boundary. It would be only the very few patients who are highly dependent on nursing care (or living a long way away) who would be best covered by an arrangement in which the nurse manager contacts her neighbouring colleague to arrange for the patients' nursing needs to be dealt with by the neighbouring patch (figure). This arrangement must be clearly understood by all concerned so that nurses know that they are working with patients who are registered with the practice (though they could still decide among themselves to divide the practice population geographically if they wished).



Relation between neighbourhood nursing practices (community care areas) and primary care teams.

General practitioners might slowly decide to divide their patients geographically more in future if they see advantages in working with one group of workers, preferably based in the same building and covering a wide range of social and health services for their area. If the areas covered 10 000-25 000 people (two to five electoral wards, which are roughly the size of the area covered by a medical practices committee) and most general practitioners were limiting their lists to the community care area patients would still have a choice of between five and 12 general practitioners and could even go over the boundary to another general practitioner who was still taking patients from further afield if they preferred the services of that primary care team.

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100 YEARS AGO

No first week of October can ever pass by without exciting thoughts of the medical student in the minds of members of the profession and of the general public. In the case of the member of the profession, the thoughts are most probably of the pleasant yet melancholy type common to every kind of reflection on past days. In the case of the public it will be admitted that the medical student is far more popular and in better favour than he was even twenty years ago. The Ambulance Corps, the successful cultivation of the arts in hospitals, and the consequent excellence of social entertainments given at those institutions during times of public festival have raised the status of the student. He appears in print as having been reviewed at Lambeth, or as having sung solos or joined in duets at hospital concerts at Christmas. His detractors can only bring against him exploded objections in relation to his extinct prototype of forty years since.

We must all bear in mind the fact that the student of 1847 is a different being from the student of 1887, and we must not overlook matters of detail in relation to this distinction, else we cannot so readily defend the modern student against calumny. The old type began life in apprenticeship. He came up to town to "walk the hospitals," and it was then only that he began to be a medical student as popularly understood, though the deferring of the title till that stage of his career was illogical. The homologue of the modern "first year's man" was the youth commencing his apprenticeship. The old-school student too often looked upon his entry into hospital life as the beginning of a holiday, a relief at least from the restrictions of apprenticeship. He was a young man about twenty, often deteriorated by mouldering away his early youth in some remote district, where skittles and beer were his chief solace. It is not for us here to dwell on the advantages of apprenticeship properly managed. The practice of walking from one hospital to another, excellent in theory, worked badly; time was at least wasted, and covering space between hospitals often implied stoppages for refreshment. Already, forty years ago, it was becoming customary for the student to pursue his studies at one hospital. The evening amusements of the student were those of the time, and very rough they were. Supper rooms abounded, where comic, which generally meant vulgar, songs were sung, and too much alcohol taken. After a night spent in this kind of entertainment, the revellers often amused themselves by damaging public and private property. Medical students sometimes followed, but certainly did not set, the example to be found in places of nocturnal amusement. They simply participated in them in company with distinguished literary characters and members of another liberal profession. The student was apt to imbibe "half-and-half" at intervals throughout the day, but this was a habit not confined to medical schools. Lastly, Dickens and Albert Smith gave broad caricatures of the student, which many people still take in sober earnest.

The student of 1887 is brought up under different circumstances. He begins his study of the profession either at one of the universities or in a medical school, when quite a youth and very amenable to discipline. The school is his world, but as he knows that there are other hospitals, his local spirit is strong, and he fears to get a bad name for himself or his hospital. Outside the hospital walls the amusements for gentlemen, in London, are far less pernicious than was the case in 1847, and intemperance is seldom forgiven, and never looked upon as a joke.

The distinction between the old and new type of student being made evident, the still existing prejudices against the medical student may be considered. The theory that he is "not a gentleman," rests on the fact that a certain proportion of the students of any school are of humble social origin. How many of that proportion rise to be a credit to humanity! Again, the medical student is looked upon as a youth who is too much versed in delicate physiological arcana, but knowledge gained in the way of duty is seldom pernicious. The idea that frolicsome youth, unpleasant for the sick to contemplate, is nevertheless forced upon the patients, is based upon the erroneous impression that the students spend all their time in the wards. A well-known portion of the public, ever the first to discredit everything and anything medical, have an idea that the student amuses himself by vivisecting, but this assertion argues a total ignorance of his habits, ideas, and duties. A very prominent charge against the student is that he is advanced in religious ideas, and is encouraged in agnosticism by his teachers. This is a pure fiction, intended solely to discredit him at any cost. For obvious reasons, his teachers are not likely to encourage that which would injure him and them in the eyes of the public, and the alleged indiscretions of one or two "advanced" doctors are exceptions which prove the rule. Lastly, but not least, come the purely sentimental objections to the student. His work seems unclean, unromantic, cruel, materialistic, and shocking in other respects to the untrained public. No true moralist or logician can ever assent to this popular fallacy, or think that any young man can be the worse for doing his duty. He may appear unmoved by suffering to which he is used, but would the public have him lachrymose and trembling, dreading to do anything or nothing for a patient's benefit, instead of feeling and behaving as though calm and collected?

We do not for a moment deny that the student should bear in mind that there is room for improvement in himself and his class. His zeal for his own hospital is a high sentiment, to be encouraged, but not at the expense of discourtesy to students of other hospitals. He cannot very well be expected to show so much interest in common and uninteresting as in rare and interesting cases; that would be against the fitness of things, still he must always respect the patient as well as the case. In his bearing to benevolent persons who come to a hospital with a patient he must be particularly discreet. Such persons are ever zealous for the welfare of their charges, but zealous persons are apt to be fussy, and to forget that students and house-surgeons whom they address may be busy, and that there are from one to five or six hundred other patients about, and that there may be no vacant beds. Such persons will tax the diplomacy of the student to the utmost: but in studying how to avoid offending them, he will learn one of the great accomplishments which lead to success in the medical profession.

(*British Medical Journal* 1887;ii:777.)