

## Public Health and Primary Care: Towards a Common Agenda

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### Background

According to the Acheson report on the development of the public health function in England, public health can be seen as: 'the science and art of preventing disease, prolonging life and promoting health through the organised efforts of society'.<sup>1</sup> As such it can be seen to be a function rather than narrowly a discipline. It follows that, although the existence of a group of professional workers who are designated as public health doctors, nurses and others including environmental health officers is an important part of a strategic approach to protecting the health of populations, their work is indivisible from that of many others, professional and lay, whose activities impact on public health. Of particular importance are those professionals who work as general practitioners or primary care workers in the community at the interface between lay and professional and technical action and response.

In Europe and North America three distinct phases of public health can be identified in the last 150 years.<sup>2</sup> In the nineteenth century the main causes of premature death were the infectious diseases occurring against a backdrop of urbanisation, poverty and squalor. The Victorian Public Health Movement developed in response to these problems, building on the work of medical officers of health, sanitary inspectors and their staffs frequently backed up by Public Health Legislation concerning standards for housing and the quality of air, water and food.

The focus of the first phase in this movement was on environmental change and in Europe and North America it lasted from the 1840's until towards the end of the century. As the most pressing environmental problems were brought under control, action to improve the health of populations moved on first to personal preventive medical services, such as immunization and family planning, and later to the third, therapeutic phase.

Until the discovery of insulin and the sulphonamide group of drugs in the 1930's and 40's there were in fact few medical treatments of any proven value.<sup>3</sup> The beginning of the therapeutic era coincided with the apparent demise of infectious disease and the development of organised medical treatment services in developed countries. Historically it marked a weakening of departments of public health and of the position of general practitioners and a shift of power and resources to hospital-based medical services. For a period of some thirty to forty years, until the early 1970's, a view tended to prevail that future improvements in health would come about primarily from scientific and medical treatments. Unfortunately this view became a dominant one not only in developed countries that had already reached a certain level of health development, but also in countries where infectious disease, poverty and squalor co-existed with the newer patterns of non-infectious disease which are particularly related to lifestyle.

### **The New Task and the New Public Health**

By the early 1970's the therapeutic era was increasingly being challenged. Most countries were experiencing a crisis in health care costs irrespective of the structure of their health services or the methods of financing them. This escalation in costs was in part the consequence of technological innovation in treatment methods and in part the consequence of major demographic change with very rapid growth of the elderly population. Critiques of the domination of a secondary and tertiary care model of provision began to converge with political and economic imperatives.<sup>3,4</sup>

In 1974 the then Canadian Minister of Health, Marc Lalonde, published a government report entitled 'A New Perspective on the Health of Canadians'. This report, which was a community diagnosis for Canada, focussed attention on the fact that a great deal of premature death and disability in Canada was preventable.<sup>5</sup> In effect it set an agenda for a new era of public health in Canada and it has had ramifications throughout the world. It arguably gave form to the new, fourth phase of public health.

What is emerging as the New Public Health is a synthesis of environmental and lifestyle change together with appropriate prevention and treatment interventions. Many contemporary health problems are seen as having social antecedents and underlying them are frequently issues of local and national public policy. It is argued that what are needed to address these problems are Healthy Public Policies – policies in many fields which support and protect health.<sup>6,7</sup> In the New Public Health the environment is seen as being social and psychological as well as physical and the right balance between socially orientated and technically orientated services is seen as being central.

The dominant problems to be addressed include psychological and psychosomatic disorders, cardiovascular disease, cancer, accidents and the most effective management of the degenerative diseases of old age. Quality of life is now becoming as important as age at death.

### **Health For All by the Year 2000 and a Confusion of Terms**

In 1981 the World Health Assembly adopted a global strategy of Health For All by the year 2000 (HFA 2000).<sup>8</sup> The Strategy built upon the Alma Ata declaration of 1977 which placed primary care at the centre of the health care system.<sup>9</sup> According to this strategy the task is to ensure that by the year 2000: 'all the people in all countries should have at least such a level of health that they are capable of working productively and of participating actively in the social life of the community in which they live.' The three main objectives of the strategy are to promote healthy lifestyles, to prevent preventable conditions and to enable rehabilitation of those whose health has been impaired. These objectives have been further clarified in ways which make it possible for health goals to be set and to begin to plan to promote and maintain health rather than merely to treat disease when it occurs. Within Europe the World Health Organisations Regional office has developed a set of 38 targets for Health For All which have been agreed by the member states.<sup>10</sup> These targets cover specific conditions and activities such as the reduction of deaths from heart disease and accidents and the attainment of immunisation coverage; the reduction of lifestyle risk factor levels such as tobacco consumption and abnormal drinking patters; improvements in the physical environment and the policies, services, research and educational initiatives necessary to support improvements in health. Community participation, intersectoral action and the reorientation of medical care towards health promotion, prevention and primary medical care are seen as prerequisites for the implementation of the WHO strategy.

This reorientation involves a further shift from primary medical care (a medical concept based on the equitable availability and accessibility of good quality preventive and treatment services from a team of health workers based in the community) to primary health care which is a social concept going much wider in that it is concerned with populations as well as individuals and that it seeks to involve a range of people other than trained health workers. Unfortunately there is a persisting confusion between the use of the terms general practice, primary medical care and primary health care. It is through the development and implementation of the concept of primary health care that the public health and the public health function can most appropriately be addressed.

### **Reconciling Primary Health Care and Public Health**

Vuori has argued that there are four ways in which the concept of primary health care can be interpreted:<sup>11</sup>

- (1) As a set of activities;
- (2) As a level of care;
- (3) As a strategy of organising health care;
- (4) As a philosophy.

According to Vuori, the eight activities identified as the basic elements of primary public health in the Alma Ata declaration could be taken as the most down-to-earth starting point:

- (1) Health Education;
- (2) Food supply and proper nutrition;
- (3) Safe water and basic sanitation;
- (4) Maternal and child health care;
- (5) Immunisation;
- (6) Prevention and control of endemic diseases;
- (7) Basic treatment of health problems;
- (8) Provision of essential drugs.

On the basis of this list housing and the recreational and occupational aspects of health would be excluded and a concern with other aspects of the physical environment might be considered problematic. As it is, the strong tendency among biomedically trained workers is to identify those elements which have a clear procedure associated with them and to shy away from those with wider social, organisational, or political implications.

The starting point for public health action is the recognition that most health is gained and lost in everyday life through the environments which determine exposure to hazard, or which shape lifestyle choice. It follows that public health agrees with Virchow that: 'medicine is a social science and politics is nothing else but medicine on a large scale.'<sup>12</sup>

In making the step from primary medical care to primary health care and in establishing a reconciliation between the practice of medicine with individuals and that of public health with populations, it is necessary to make the connections between the influences and determinants of health and the role of those with technical and scientific knowledge as potential enablers and advocates through a variety of activities of which liaison is one of the most important.

If WHO's other basic premises of primary health care are accepted about its being:

- (1) A level of care (point of first contact and the interface with lay care which recognises the importance and legitimacy of lay care);
- (2) A strategy based on the need for services to be accessible, relevant, integrated, based on community participation, cost-effective and characterised by intersectoral collaboration;
- (3) A philosophy characterised by:
  - Social justice and equity;
  - self responsibility;
  - International solidarity and acceptance of a broad concept of health.

The challenge is to identify the skills and functions which are needed to address the tasks in hand and to develop a model which is useful in organising services and in planning the education, training and research to support them.

### Models of Primary Care

Primary health care as envisaged by WHO is hard to find. One celebrated example was the Peckham Pioneer Health Centre established in South London in the 1930's by a pathologist, G. Scott-Williamson, and his family planning doctor wife, Dr Innes Pearse.<sup>13,14</sup> The philosophy of the centre was that of supporting the acquisition and protection of good health through a combination of individual and family assessment and the provision of a supportive environment. The centre was much more like a well endowed community centre than a conventional medical centre and included a range of social, legal and medical advisory services together with a large range of community facilities and resources. Unfortunately support for the centre was not forthcoming when the National Health Service was established in 1948 with a therapeutic ethic in the ascendancy; however at the present time the Peckham centre has begun to exert a strong posthumous influence on a new generation of practitioners.

According to the Royal College of General Practitioners, postgraduate training for general practice should cover:

- (1) Health and diseases;
- (2) Human development;
- (3) Human behaviour;
- (4) Medicine and society;
- (5) The practice.<sup>15</sup>

According to the Royal College, 'these headings which are fairly easy to remember, summarise the content of general practice. But general practice cannot be learned without learning about the conduct of the consultation\* . . . . .'

The college goes on to identify areas of work which involve liaison with educational institutions, local government, industry and other institutions of society.

\* Footnote: (definition of the consultation)

'The essential unit of medical practice is the occasion when, in the intimacy of the consulting room or sick room, a person who is ill or believes himself to be ill, seeks the advice of a doctor whom he trusts. This is a consultation and all else in the practice of medicine derives from it. The purpose of the consultation is that the doctor, having gathered the evidence shall give explanation and advice.'

In 1979, in a paper which has proved to be both influential and enduring, Stott and Davis put forward a simple but practical model of the consultation<sup>16</sup> (Figure 1).

This model has proved useful as a framework both for analysis and for organising training. It implicitly places the consultation at the centre of general practice.

Since the Royal College report on vocational training was published in 1972 there has been a sea-change in attitudes towards general practice as a career and as a field of work. At the present time, within many countries there is an excitement and energy attached to both preventive medicine and what has been becoming primary medical care which was not there 20 years ago. Some countries have passed special legislation to assist the shift in emphasis from hospital to community-based services; several have produced 'National Health For All' strategies, and perhaps most encouragingly there is a great deal of interest and activity in developing health promotion, preventive medicine and primary care at the local level. It is highly probable that the latest government proposals for the British National Health Service will give a further push in this direction.

A	B
management of presenting problems	modification of help-seeking behaviour
C	D
management of continuing problems	opportunistic health promotion

from Stott and Davis, 1979

**Figure 1** The potential in each primary care consultation

In some countries a majority of medical students now actively opt for careers outside hospitals, yet in England and Wales, for example, where many of the desirable elements for the development of primary health care exists considerable problems remain, not least in the inner-city areas and on the peripheral public housing estates. (Table I).

In part the problem seems to lie with the extent to which some or all of these elements exist and are appropriately developed. In particular there is a general lack of what might be called the epidemiological or population view of primary health care as espoused by WHO and developed particularly by Kark in Jerusalem and Tudor-Hart in South Wales.<sup>17,18</sup>

Kark has described the synthesis of a population-based public health model with health-centre based primary medical care practice with an emphasis on the development of skills for community diagnosis, health surveillance, monitoring and evaluation.

Tudor-Hart, in implicitly supporting a similar model, has particularly stressed the needs for accountability to the population served through such means as patients' committees and annual reports and meetings. He has particularly argued that there is a need to look, in a new way, on the relationship between doctors and patients as co-producers of health and that it is necessary to develop alliances between health workers and the public in defence of

**Table I** Elements of a good system of primary health care in the United Kingdom

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- (1) Existence and development of family medicine.
  - (2) Existence of a professional body to develop standards (Royal College of General Practitioners).
  - (3) Training programmes for primary Health care staff.
  - (4) Specified training requirements.
  - (5) Postgraduate coordinators (Regional advisers, course organisers and trainers).
  - (6) Postgraduate medical centres for training and continuing education.
  - (7) A move towards purpose-built premises.
  - (8) A team approach.
  - (9) Influence of psychodynamic and social science knowledge on medical practice.
  - (10) Availability of a population denominator for primary care (the list of registered patients).
  - (11) Small group meetings for medical and other staff.
  - (12) Consumer representation, patient participation groups and community health councils.
  - (13) Preventive medicine and health promotion initiatives such as the Oxford project.
  - (14) An experience of audit initiatives which goes back 20 years.
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health. However it is Tudor-Hart's view that, 'general practitioners cannot defend territory they have failed to occupy.'<sup>18</sup>

The development of appropriate information systems based on the age-sex register probably supplemented by intermittent sample surveys of the practice population to assess risk factors and answer specific questions will be a necessary step in providing the conceptual framework for a rational and comprehensive approach to primary health care. Information will also need to be linked in relating environmental profiles and the local structural influences affecting health such as employment, housing, shopping, recreation and transport provision and possibilities.

In recent years the British Royal College of General Practitioners has taken a series of positive initiatives by producing reports on prevention-orientated activities in general practice and there has been a growing interest in prevention generally.<sup>19</sup>

However four caveats can be identified to the assumption that in future preventive medicine and even the whole of public health could be subsumed under primary health care:

#### **Caveat one:**

##### *A narrow view of Health Promotion*

There is a widespread tendency to use the terms health promotion and health education interchangeably or even to run them together as one long German-sounding word. In fact a WHO working party identified 5 principles of Health Promotion which make clear that it is a comprehensive approach incorporating health education and many other activities including policy analysis, community development and organisation, health advocacy and legislation.<sup>20</sup> The translation of Health Promotion into action was detailed in the WHO Ottawa Charter of 1986, which stresses the essentially social and policy orientated nature of much of the work which must be done to improve public health.<sup>21</sup>

#### **Caveat two:**

##### *The assumption that activists are normative*

The buoyant atmosphere surrounding primary medical care in many places and the

beginnings of interest in primary health care in others, have led some to assume that in future general practitioners and allied workers will be able to take over the work of community health clinics and doctors.

One consequence of this has been that the community health services which have traditionally been responsible for ensuring population coverage are in a state of uncertainty as to their future. However there is little to indicate that as yet the motivation and skills exist throughout the workforce which would need to have them before it could be justified to close down those services which currently complement general practitioner based services. A recent survey in one English health region underlined the extent of the task in hand.

Of 120 general practices in Birmingham which took part in the survey, whereas immunisation was available in 92%, family planning in 85% and antenatal care in 78%, mother and baby clinics were available in only 49%, developmental screening in 37% and parentcraft classes in 20%, only 2% of practices offered self-help groups and 54% of general practitioners thought that they did not have the time to do preventive work.<sup>22</sup> As the 120 completed questionnaires represented a response rate of only 35%, all of these figures are likely to be overestimates.

#### **Caveat three:**

##### *The assumption that the sum of the parts can equal the whole*

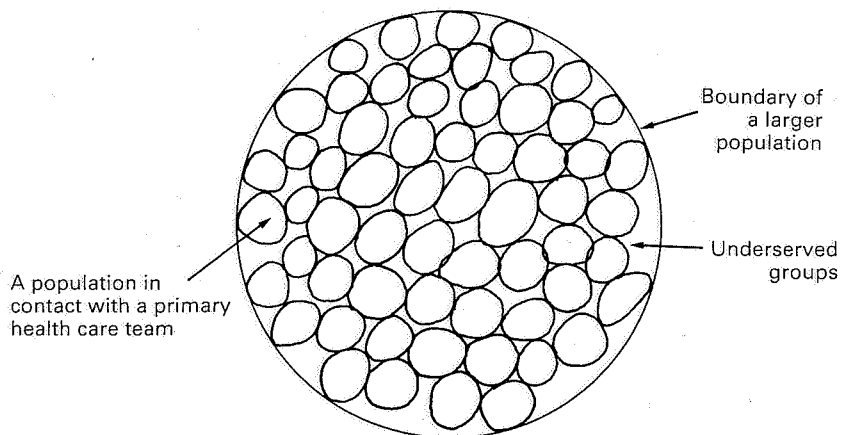
Assuming that: (1) over the next 10 to 20 years it is possible to move towards a situation where comprehensive primary medical care of good quality is available throughout the country, and that: (2) the necessary training and motivation exists to develop a public health orientation to the work of primary health care teams, it would be a mistake to assume that a separate public health capability will become redundant.

It will still be necessary to have a population overview of public health at a variety of aggregate levels (district, regional, national, etc.) both for monitoring and strategic planning. What may and should be possible is a much greater operational integration of public health work on a day-to-day basis with primary health care teams being the focus at the neighbourhood and ward level. However gaps will continue to exist, particularly with regard to underprivileged, stigmatised, or mobile groups who are not registered with a practice or only in intermittent contact (Figure 2).

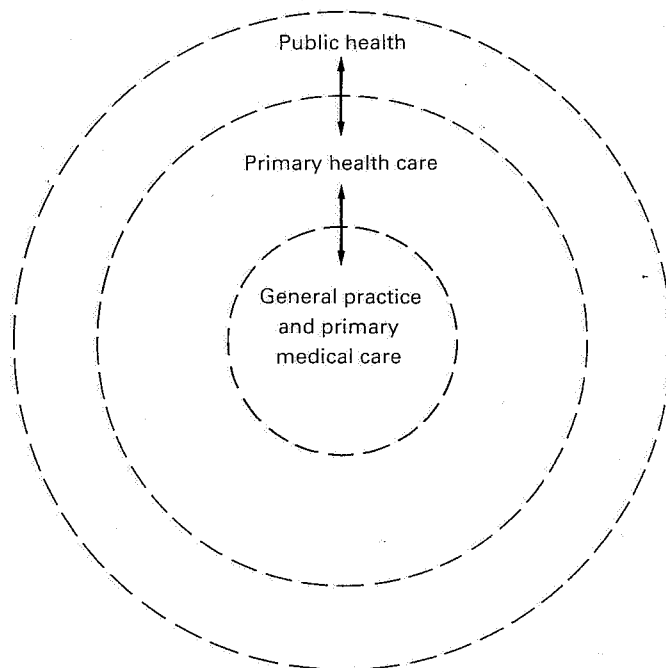
The geographical and other overlaps between practices further complicate this oversimplified model.

To fulfil the public health task it is necessary to define the work and the working relationships between the different types of practitioner and to develop appropriate training and skills so that they can work together in the most effective way. This will mean that some primary medical care workers will need to develop public health skills and that all public health workers will need to understand the needs of primary medical care workers and be able to work with and support them in their task. The meeting ground for common work is in primary health care (Figure 3).

It follows that there are extensive educational and training implications for a range of professional and para-professional staff and a need for much more joint training.



**Figure 2** The whole is greater than some of its parts



**Figure 3** The meeting ground between Primary Medical Care and Public Health is Primary Health Care

**Caveat four:***The need to reconcile conflict between individual and collective health*

At the heart of most public health issues is a conflict between individual and collective freedom, whether we are concerned with quarantine or seat belts, drinking and driving, or using CFC based aerosols. Perhaps the most poignant contemporary example is the dilemma posed by the patient who is HIV positive who might act as a reservoir of infection in the community.

This problem in the history of public health is well illustrated by a piece in 'Punch' in 1847 in which critical comments were made about the terms and conditions of service of William Henry Duncan, the first medical officer of Health for Liverpool:

'By the papers Mr Punch learns that the Town Council of Liverpool intend to appoint an Officer of Health, whose duties will consist in the direction of their sanitary arrangements, and whose services they propose to remunerate by a salary of £300 a year, with the liberty to augment that handsome income, if he can, by private practice. Mr Punch will engage to find a competent person who will willingly undertake the responsibilities of this office, on the liberal terms proposed by the Town Council of Liverpool.

'Mr Punch on behalf of the respectable medical gentleman, his nominee, will promise that he, the said respectable medical gentleman, shall devote his full attention to his official duties, and endeavour to make money by private practice only at those few leisure moments when he shall have nothing else to do. For, although a practitioner of any eminence expects, generally, to make at least a thousand a year, this gentleman shall regard his situation, bringing him £300, as of primary importance, and shall look upon this private earning as matters of secondary considerations.

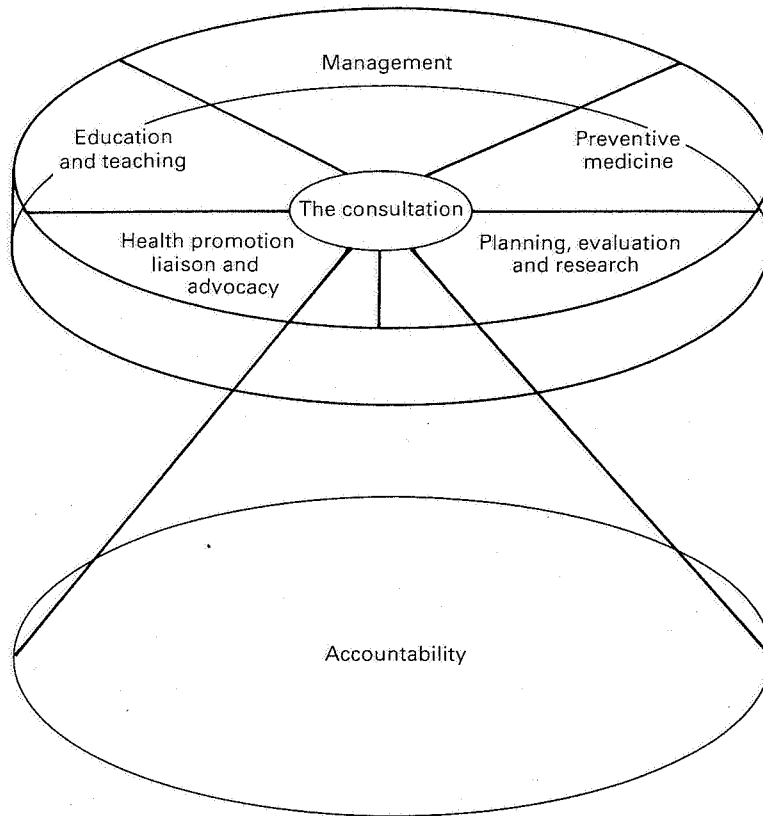
'If the Officer of Health recommended by Mr Punch shall have for a patient a rich butcher, with a slaughter house in a populous neighbourhood, an opulent fellmonger or tallow-chandler, with a yard or manufactory in the heart of town, he shall not hesitate from motives of interest to denounce their establishments as nuisances. He shall not fail to point out the insalubrity of any gas-works, similarly situated, the family of whose proprietor he may attend; and if any wealthy old lady who may be in the habit of consulting him shall infringe the Drainage Act, he shall not fail to declare the circumstances to the authorities.' (Quoted in Frazer WM, 1947 *Duncan of Liverpool*, Hamish Hamilton, London.)

The roles of advocate, mediator and enabler, whether for individuals or communities, may overlap and may conflict with one another. At the end of the day there is a need for somebody to arbitrate between individuals on behalf of the public health.

**A Model for Public Health and Primary Medical Care**

One of the few writers to actually explore the interface between primary health care and public health has been Mant, who identified 5 principal health tasks which can be undertaken by general practitioners:<sup>2,3</sup>

- (1) Monitoring the state of practice health.
- (2) The drains function; surveillance of local environmental hazards and infectious disease.
- (3) Planning tasks: nuclear war;



**Figure 4** A model for the public health work of primary medical care.

ancillary staff;  
liaison with statutory services;  
maintenance of disease registers.

- (4) Audit of the effectiveness of preventive programmes and recording risk factor levels in the community.
- (5) Evaluating intervention.

In fact this list is not a mutually exclusive classification. By taking the major tasks identified by the Royal College of General Practitioners, WHO, Vuori, Kark, Tudor-Hart and Mant together it is possible to begin to order them in a way which is logical and which has organisational and training implications. This is the beginning of a job description for the potential public health function in primary medical care. It is not exhaustive and the tasks listed are in no particular order of significance. Behind them lies an assumption of technical competence from whichever discipline is involved:

Management;  
The conduct of the consultation;  
Preventive medicine;  
Planning, evaluation and research;  
Health promotion, liaison and advocacy;  
Education and teaching;  
Ensuring accountability.

Conceptually these tasks can be envisaged as in Figure 4.

Such a model recognises the central place of the consultation in the work of general practice and primary care but identifies the other components which must be developed in order to move to primary health care. While the consultation remains at the centre there is a recognition that accountability is both directly to the individual patient and also indirectly to the public at large via general management in addition to any collective accountability developed in respect of the practise population itself.

A move towards a model such as this has implications for the education and training and style of practice of a range of health workers including general practitioners, community nurses, health visitors, health educators and community physicians. In exploring the nature of appropriate curricula which might enable a new local synthesis of practice to be created in place of that which was discarded in 1974, during the reorganisation of Local Government and the National Health Service, it is necessary to keep in sight some other workers such as social workers and environmental health officers who have tended to follow their own paths since that time.

### Conclusion

The purpose of this article has been to try and make explicit some of the current trends and assumptions surrounding the work of general practice. The 1990s are likely to see a period of radical change in the way in which clinical medicine and public health are tackled as great as any change in the past hundred years. Rather than muddle through incrementally, it might be an idea if we were to organise our thoughts and develop a coherent response to the challenges ahead. Among those challenges lie some real possibilities for improving public health and increasing professional satisfaction.<sup>17</sup>

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