The Community-Oriented Primary Care Experience in the United Kingdom

The UK National Health Service has long delivered public health programs through primary care. However, attempts to promote Sidney Kark's model of community-oriented primary care (COPC), based on general practice populations, have made only limited headway.

Recent policy developments give COPC new resonance. Currently, primary care trusts are assuming responsibility for improving the health of the populations they serve, and personal medical service pilots are tailoring primary care to local needs under local contracts.

COPC has yielded training packages and frameworks that can assist these new organizations in developing public health skills and understanding among a wide range of primary care professionals. (*Am J Public Health.* 2002;92:1721–1725)

Stephen Gillam, MA, MSc, FRCP, FFPHM, MRCGP, and Alan Schamroth, MB, BS, MRCGP

THE EXPERIENCE OF community-oriented primary care (COPC) in the United Kingdom includes the most comprehensive attempt since 1997 to embed the principles of COPC in the "new National Health Service" (NHS) emerging from the Labour government's reforms.

Despite a predominantly biomedical and humanist focus, general practice in the United Kingdom has long been infused by knowledge and skills traditionally associated with public health medicine.[1] The conceptual basis of COPC can be recognized in the writings of Will Pickles describing the use of epidemiology in his rural practice in the 1930s.[2] Likewise, the Peckham Pioneer Health Centre, established before the Second World War by G. Scott Williamson and Innes Pearce,[3] has been seen as an antecedent. The philosophy of the center involved protecting good health through a combination of individual and family assessment and provision of a supportive environment.[4]

Throughout the past 30 years, there have been eloquent pleas for closer working relationships between public health and primary care professionals. At one extreme, arguments have advocated the total usurpation of public health doctors' work by general practitioners.[5] Most have envisioned the emergence of a hybrid: the "community general practitioner." Julian Tudor Hart has been the most visible exponent of something akin to Sidney Kark's COPC in the United Kingdom. In a series of painstaking studies, he demonstrated the impact of "anticipatory" approaches to the management of cardiovascular risk factors on his practice population's health.[6] His practice, located in a Welsh mining village, took responsibility for both community and clinical functions and held itself accountable to the population served through such means as patient committees, annual reports, and meetings. He argued for new alliances between health professionals and patients as "co-producers of health."[7]

What injected new vigor into these debates in the late 1980s and early 1990s was the reaffirmation of public health following the Acheson report and the Conservative government's market-oriented reforms. The former sought to redefine and strengthen the discipline of public health medicine after several decades of decline and presaged a major expansion in the public health specialist workforce.[8] At the crux of Tory reforms was the introduction of an "internal market" separating the roles of purchasers (health authorities and fund-holding general practitioners) from the roles of health care providers. "Fundholders" could invest savings accrued through more efficient use of secondary care in practice-based services. (Fund-holding general practitioners, generally serving populations of at least 7000 patients, were allocated budgets under the Tories' internal market for purchase of most elective hospital care, staffing, and coverage of prescribing costs.) As public health doctors sought to develop strategic planning and purchasing functions within health authorities, however, fundholders often dismissed the constraining disciplines of needs assessment and service evaluation.[9]

With the evolution of the general practitioner's commissioning role, recognition of the need for new educational models grew. The King's Fund regarded COPC as one such model and initiated a program with the School of Public Health and Community Medicine of Hadassah Medical College in Jerusalem in 1991 with the following aims: (1) to pilot test the COPC approach at 4 sites, (2) to develop a training package appropriate to the circumstances of the NHS, and (3) to evaluate the COPC model as adapted in the United Kingdom.

THE KING'S FUND EXPERIMENT

Eleven primary health care teams at 4 sites—urban and rural—participated in 4-day training workshops guiding them through the conventional COPC cycle. The teams undertook a community diagnosis before selecting a specific health problem against which to develop intervention plans. Evaluation of the King's Fund program aimed to investigate the hypothesis that COPC helps primary health care teams and health authorities undertake the shared responsibilities of assessing practice populations' health care needs before devising and implementing strategies to address them. The principle of triangulation informed the evaluation, for which a range of qualitative and quantitative methods were employed. The evaluation was undertaken between June 1992 and May 1995 and focused on 4 areas: effectiveness of the workshop program, progress in the projects of COPC practices, comparison of COPC with alternative initiatives sharing similar objectives, and the generalizability of the program, including its cost-effectiveness.[10]

The success of the COPC pilot program was considered against normative criteria defined at the outset of the evaluation. While the pilot projects did not realize all of the aspirations of the original participants, significant advances were achieved. Evaluation of the pilot workshops helped in the formulation of the definitive training package, which was successfully field tested.

The workshops provided the participating teams with an illuminating learning experience and helped to develop links with other agencies. Participants were already aware of the need for time, resources, and other forms of ongoing support if they were to further their projects. The teams gained the necessary support (technical, informational, financial) from their local health authorities, although experiences at the 4 sites varied. Teams were able to make community diagnoses and identify problems on which to take action. They expended much energy on detailed problem assessments, and only a few completed comprehensive evaluations.

COPC helped to develop teamwork and interprofessional collaboration; however, the time and energy required to underpin COPC were underestimated. Some teams learned enough about basic epidemiological principles to apply these principles to other problems. Many individuals learned new skills. COPC provided new learning for health authorities, increasing managers' understanding of primary care. However, few teams came to regard the principles of COPC as central to their way of working. The utilitarian values underpinning COPC are at odds with the traditionally individualistic doctor–patient relationship. Few teams made contact with patients or their representatives at any stage in their projects.

TABLE 1—Summary of Patient-Related Outcomes

Practice 1	14 community counselors trained
	Counseling/advice provided to more than 100 patients
Practice 2	127 newly identified smokers, cessation documented in 17
	Stop-smoking clinic and individual counseling for smokers established
Practice 3	1331 patients newly screened
	Newly identified smokers (n = 348), hypertensives (n = 31), moderate/heavy drinkers (n = 166)
Practice 4	Screening coverage increased by 28.5% and 42.3%, respectively, for men and women aged 40–64 years
Practice 5	Practice-based continence service established
	47 women treated
Practice 6	51 new patients with asthma identified via postal questionnaire and telephone survey
	483 patients' blood pressure newly measured
	New services established for bereaved individuals, mothers and toddlers, elderly people, adolescents

Quantitative evidence of benefits was obtained in all 11 practices (Table 1). COPC projects yielded limited gains in terms of behavioral risk factor reduction (e.g., smoking cessation); other benefits were more difficult to measure. COPC provided assistance in terms of development of skills in collecting and analyzing health data. As a result of the small size of the practice populations, however, statistically significant changes in most outcome measures were unlikely to be detected for any but common conditions.

Many of the outcomes of COPC were intermediate, encompassing enhancement of staff skills and changes in patient behavior. Economic evaluations were therefore problematic, but a framework for considering the cost-effectiveness of COPC was developed. On average, approximately £25 700 ($38 960) was spent in support of each practice (including King's Fund and health authority expenditures). When this estimate is considered alongside information on the cost-effectiveness of a range of other interventions, the health gain that each project would have to yield to be considered cost-effective is low.[11] For example, the smoking cessation and heart disease prevention projects needed to avert only 12 and 4 years of lost life, respectively, to be cost-effective.

PROMOTING EXPANSION

Anyone versed in the principles of change management could have predicted many of the factors found to facilitate expansion of COPC programs at a local level (Table 2). Primary health care teams varied enormously in terms of how much they achieved. Much depended on the commitment of local leaders who had instinctively internalized COPC principles. These leaders, whether managers in health authorities or general practitioners, were sometimes imaginative in adapting the COPC frameworks—cutting corners if necessary—to

TABLE 2—Factors Facilitating Local Expansion of COPC

- Decisive leadership
- Multidisciplinary support group
- Active participation of staff with a public health perspective
- Visible early success at project site
- Involvement of local champions from pilot practices
- Flexibility in program application
- Strategic framework for local primary care development
- Direct managerial control over defined budgets

suit their purposes and maintain their team's commitment. Much implementation could be "bolted on" to existing workloads, but more was achieved with dedicated budgets.

The evaluation team (among others) believed that many factors were likely to inhibit expansion of the COPC program nationally. These factors have an eerily familiar ring several years later. At a time of organizational turbulence, all health authorities faced financial constraints, with the bulk of new money earmarked for the hospital sector. Several of the proposed interventions (e.g., community-based mental health promotion) were lacking in terms of evidence of their effectiveness. Some managers and health professionals were unrealistic about what could be achieved over the life of relatively short-term projects.

In summary, COPC provided an inclusive set of general principles as the basis for developing new forms of joint learning. The training package was of value to those with an interest in the professional development of many groups of health professionals. If COPC did not provide a radically new way of delivering health services in the United Kingdom, it certainly complemented other initiatives (such as fund-holding and clinical audit) that were producing increased understanding of the factors influencing the health of practice populations and how to address them. The King's Fund program spawned a number of similar projects across the country. Interest in COPC has reemerged with the continuing evolution of a primary care–led NHS.

LOOKING FORWARD

Fund-holding yielded gains for the practices involved but was criticized as inequitable, generating punitive transaction costs and failing to deliver anticipated efficiency gains from the secondary sector.[12] A new Labor government came into power in 1997 committed to rolling back the market-oriented reforms of its predecessors. However, the agenda set out in *The New NHS* white paper was potentially far more radical than the abolition of fund-holding.[12] It underlined the role of the NHS in improving health, set out a renewed commitment to equity in access and provision, and tackled the need to ensure quality through clinical governance and accountability to local communities.

The major structural change introduced to deliver these policy goals involved the formation of primary care groups, with the expectation that these groups would, in due course, mature into freestanding primary care trusts. The latter have control of unified budgets that bring together for the first time funding for primary care, prescription, hospital, and community services. Primary care groups and trusts were intended to universalize the best aspects of fundholding. They are expected to undertake 3 principal functions on behalf of their local populations: (1) improving health and addressing health inequalities, (2) developing primary and community health services, and (3) commissioning a range of community and hospital services.

Primary care groups and trusts bring together local providers of primary and community services under a board representing local general practitioners, nurses, the local community, social service agencies, and the health authority. Primary care trusts serve an average population of approximately 180 000 people. They are required to engage the populations they serve in decisionmaking procedures as they take responsibility for setting priorities.

If these organizations are to succeed in their objectives, they need to develop public health capacity and understanding across their constituent practices. Traditionally isolated small-scale general practices are being required to work in collaborative networks. A directive of primary health care teams is that they address the health needs of their population, working with other organizations to promote health and deliver appropriate care. Primary care trusts are being deluged with central directives—but little guidance—as they lead the transition from semiautonomous practice to managed care. They are struggling to make sense of their health improvement role, and they lack public health capacity.[13] COPC could provide frameworks with which to develop skills and promote the engagement of clinical staff at the front line.

Primary care groups and trusts have been described as "the essence" of COPC.[14] At best, the British primary care reforms can be seen as an uncontrolled, nationwide experiment in the application of COPC methods, but they differ crucially in being introduced from the top down rather than from the bottom up. The COPC model has been developed mainly but not exclusively for underserved populations. Descriptions of outcomes of most COPC initiatives are limited, and COPC methods are time consuming and vulnerable to domination by epidemiological data collection. Too much time is spent on assessing needs and defining population problems and too little on implementing changes in services.

Nevertheless, champions of COPC are continuing to apply their model in the current environment. Attempts have been made to streamline the cycle by simplifying the stages of "community profiling" and "problem definition."[15] Readier access to the evidence base on what systemwide interventions are most effective in addressing population health priorities (such as heart disease and teenage pregnancy) would reduce unnecessary duplication in the devising of interventions. If primary care trusts are to develop the vision required to move beyond service planning to address the social determinants of health, they will need all the help they can get.

PERSONAL MEDICAL SERVICES

A second key policy initiative has been the establishment, under so-called personal medical services (PMSs), of local contracts for the delivery of pri-

COPC in Practice: A Case Study

Alan Schamroth's 5-partner general practice of 11000 patients in north London was one of the pilot sites involved in the King's Fund program. Traditionally, there has been little incentive to address population health in UK primary care. Other than for attaining immunization and cervical cytology targets, general practitioners have typically been financially rewarded only for responsive care. Any "needs assessment" is done on the doctors' own time and at their personal expense. The training program profoundly shifted the team's thinking on primary care away from demand to unmet needs.

COPC provided both the intellectual satisfaction of identifying the health needs of the "whole" practice population and the professional reward of being better able to respond to them. The process of gaining new skills in audit and population data analysis stimulated team building, encouraged self-reflection on current practices, encouraged evidence-based practice, enhanced managerial skills, and strengthened the practice in terms of arguing for resources. COPC provided the theoretical underpinning and tools for new tasks at a time when fund-holding offered the financial wherewithal.

Under the PMS model, Alan Schamroth's COPC activity has increased, and team members view this as an exciting development. The COPC philosophy remains their guide, but they have applied the model flexibly. They seldom adopt a purist approach and have not undertaken another community profile, although in the past 8 years the area has changed both physically and socially. The slow progression through the COPC cycle is no longer perceived as disheartening, in that the team has felt less tightly bound by rigid methodological constraints. The processes of monitoring, surveillance, and evaluation have often been delayed until extra resources have become available. The team is not the huge entity it was under the fund-holding model; as a result, it has become easier to coordinate projects, and team members are more motivated.

mary care.[16] Historically, general practitioners worked under a centrally defined national contract in which they were paid piecemeal for providing additional services (e.g., contraception, antenatal care, immunizations, cervical cytology) over and above the basic care for which they received annual per-patient capitation fees. In the case of PMSs, practices negotiate a single budget to provide a comprehensive service addressing their population's particular needs. A specific aim has been to increase access to care among previously marginalized groups such as refugees and asylum seekers. This cuts down on administration and frees up general practitioners to be creative in delivering services. The ability to mix skills—to look afresh at what services are needed and how to deliver them—has given COPC a new impetus (box on this page). Currently, about 20% of general practitioners have opted to work within PMSs, and this number is growing. In the most innovative cases, practices have used PMS contracts to deliver community development activities in areas of high health need.

CONCLUSION

Several factors give reason for optimism regarding the future of COPC in the United Kingdom. If primary care trusts are to develop the vision required to move beyond service planning to addressing the social determinants of health, they will need to develop public health skills and understanding among primary care professionals. General practitioners are no longer working in isolation, and they see government policy (for example, through the new national service frameworks) now focusing on health promotion and prevention. This requires COPC strategies at a practice level.

A recent report on the United Kingdom's public health workforce highlighted shortages,[17] and this has increased pressure to expand public health training across disciplines at both undergraduate and postgraduate levels. COPC modules are already being used in new training programs, for example as part of Internet-based teaching curriculums (see http://www.ucl.ac.uk/MSc). In addition, the proposed University of the NHS (still at the planning stage but envisaged as coordinating the undergraduate training, and possibly postgraduate training as well, of all cadres of NHS staff) would offer potential opportunities for expansion of access to COPC. Last but by no means least, extra government funding for the NHS should provide appropriate financial incentives as well as support for staff and their training.[18] ■

About the Authors

Stephen Gillam is with the Primary Care Programme, King's Fund, London, England. Alan Schamroth is with the Bounds Green Health Centre, London.

Requests for reprints should be sent to Stephen Gillam, MA, MSc, FRCP, FFPHM, MRCGP, Director, Primary Care Programme, King's Fund, 11–13 Cavendish Square, London W1G 0AN, England (e-mail: s.gillam@kingsfund.org.uk).

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Contributors

S. Gillam, who was involved in developing and evaluating the King's Fund COPC package, wrote the bulk of the article. A. Schamroth contributed case study material and comments on the text of the commentary.

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