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Planning for Primary Health Care

A report of a conference held at the King's Fund Centre
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by
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King Edward's Hospital Fund for London is an independent charity founded in 1897 and incorporated by Act of Parliament. It seeks to encourage good practice and innovation in health care through research, experiment, education and direct grants.

The King's Fund Centre was established in 1963 to provide an information service and a forum for discussion of hospital problems and for the advancement of inquiry, experiment and the formation of new ideas. The Centre now has a broader interest in problems of health and related social care and its permanent accommodation in Camden Town has excellent facilities for conferences and meetings. Allied to the Centre's work is the Fund's Project Committee which sponsors work of an experimental nature.

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KING EDWARD'S HOSPITAL FUND FOR LONDON

PLANNING FOR PRIMARY HEALTH CARE

Report of a Conference held at the King's Fund Centre on 14 December 1982

Chairman: Professor B Abel-Smith, Professor of Social Administration, the London School of Economics and Political Science

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1. INTRODUCTION

In his welcome to the conference, David Hands, Assistant Director of the King's Fund Centre, said that since its foundation in the 1890s, the King's Fund had continually sought to help to broaden perspectives of those who worked in health care to examine the wider needs of communities and the population at large. The current involvement of the Fund with primary health care was an extension of a long tradition.

Recently, for example, the Fund had been involved in management education in primary care and with London's primary care services in association with the Acheson working party. A King's Fund working group, the London Project Executive Committee, chaired by Professor Brian Abel-Smith, was examining the response which the Fund could make to London's health needs, particularly primary care. Increasingly, the Fund took part in national and international debates on primary care development, particularly since the World Health Organisation Initiative and the Alma Ata Declaration of 1978. *

The conference thus fitted well into the Fund's interest in the planning, organisation and development of health care. The importance of the subject was reflected by the large numbers who wanted to attend but for whom there was no space in the conference room. He hoped that the hundred who attended would find the conference a valuable experience and an opportunity to discuss the future development of primary care within the United Kingdom.

* See Appendix 1

2. PURPOSE OF THE CONFERENCE

The conference sought to discuss, in the broadest terms, what the definition, function, role, purpose and relationship of primary health care should be in the future, said Professor Brian Abel-Smith, Professor of Social Administration at the London School of Economics, in his opening remarks as chairman of the conference.

The question of relationships might be one of the things that was focused on particularly. By the end of the day the words "patient", "client", "user" and "customer" in primary health care might be replaced by the word "member". The concept of participation was one of the ideas behind the Alma Ata Declaration.

The conference was path-breaking not only in its scope but also as it was the first time that the King's Fund had held a conference within the context of "Health for all (HFA) by the year 2000", as resolved by the World Health Assembly in 1977. Most people imagined that HFA 2000 was aimed exclusively at developing countries and had very little to do with the developed. The Alma Ata conference in the USSR had come next and since then, "Health for all" had been carried forward in the European region with the preparation of a strategy which had as yet received no publicity within the United Kingdom but which incorporated some vital points about primary health care. The strategy was now being developed into the next stage, - targets for the European region. Although it was an all-Europe exercise, that did not mean there would be a uniform approach.

One of the conference tasks would be to look at how the principles of Alma Ata could be applied in the special context of the United Kingdom. Nevertheless, the conference was being launched on a European level to present how primary health care was seen in the European region of the World Health Organisation.

3. THE CHALLENGE OF PRIMARY HEALTH CARE IN EUROPE

Dr Hannu Vuori, Regional Officer for Primary Health Care, World Health Organisation, said that "Health for all by the year 2000" was not an absolute. Goals of other slogans, such as "Liberté, egalité, fraternité" or "Workers unite", had not been achieved but they had influenced the world situation. If "Health for all" had the sort of impact on world health that the others had had in politics, then WHO would be happy. Primary health care was a key to achieving that goal.

What is Primary Health Care?

Confusion over the definition of primary health care stemmed from three fallacies: that it was invented by WHO (when it was introduced by the member states); that primary health care was only for developing countries; that primary health care was the same as primary medical care.

There were four ways of interpreting primary health care:

as a philosophy;
as an approach, a strategy towards organising health services;
as a level of care;
or as a set of activities.

Although the latter was easier to think about, the philosophy and approach were more important and the concept of primary health care must include all four interpretations.

A philosophy

Countries would claim they were working towards primary health care if they had embodied certain principles. First of all, primary health care is a means of achieving social justice and equality: closing the gap between developed and developing countries, between rich and poor within each country, between urban and rural areas, inner city and wealthy residential areas.

A second principle was self-responsibility. However during times of economic recession there was a tendency to say that people themselves were responsible for their health and society's responsibility may be transferred to the individual. The WHO approach was not to reduce

society's responsibility, but to accept that people were capable of doing much more themselves of defining their health needs, and of enjoying being more responsible for their own health.

Finally, there was the broad concept of health. As Professor Tom McKeown had pointed out, a country's health was determined less by health services than by its overall economic well-being, the level of education, housing and nutrition. If that was accepted, then there were other sectors of society which had to be taken into account when organising health services.

An organisational strategy

Strategically, health services, organised to meet population needs, had to be accessible and relevant. As well as functional integration between primary, secondary and tertiary care services, there should be community participation. Services should be cost effective. Nationally, health had to work with other ministries and locally with other services. For example, if one of the important pathological agents of ill health today in industrialised societies was unemployment, particularly of young people, then inter-sectoral collaboration must aim at least to relieve the health consequences.

Resources had to be redistributed geographically, and between primary, secondary and tertiary care. Legislative change may allow delegation of certain professional tasks. Reorientation of health personnel, with a new type of training, a redistribution of manpower and new attitudes, was needed. Improved planning reflecting changing practices led to the demand for better management.

A level of care

As a level of care, primary health care was that closest to the population and that could vary between countries. Some felt that specialists at local level constituted the best level of primary care; others saw the general practitioner as the more appropriate first contact.

A set of activities

The set of activities defined within the Alma Ata Declaration had given rise to the concept of primary care being only for developing countries. But for industrialised countries "adequate nutrition and safe water" could apply to the food requirements of the elderly or the problems of

obesity. Safe drinking water may be on tap but were European waters pollution-free for swimming or harvesting seafood? Was the whooping cough epidemic in Britain a failure of the country's "vaccination" activities? Industrialised countries had perhaps done their share towards "Prevention of local endemic diseases" but there were still many health promoting tasks to be undertaken.

Many countries still had a paternal approach to "Health education". Health professionals tend to be considered to be appropriate message carriers and patients the appropriate recipients. "Education for Health" was a better description of what was required. Perhaps it would be better to tackle education for health earlier, in schools for example.

"Treatment of common diseases" was where industrialised countries had done best, but had developed countries achieved the "Appropriate supply of drugs"? Finland had about 4,000 registered drugs, Sweden approximately 2,500 and Norway only 1,500. The Finnish approach was the more common but perhaps the Norwegian approach where there was little market duplication and drugs were under control, was more correct. In Spain, there were about 20,000 registered drugs.

Challenges

Dr Vuori suggested some challenges which countries might ask themselves:-

whether health care was related to population needs;
whether there was consumer participation, individually and collectively;
whether the fullest use was made of available resources, including the resources of lay people;
whether family health care was part of a comprehensive health system.

To achieve primary health care, organisationally, the emphasis should be shifted from illness to health; from treatment to health promotion; from cure to prevention and care, from episodic to continuous care, from a system which relied on specialists to one which relied more on general practitioners; from care by physicians to increased care by other professional groups; from specific problems care should be expanded

towards comprehensive care; from single handed to group practice; from health centres alone providing health-related access, to inter-sectoral collaboration; from clinical decision-making to consumer participation at all levels; from professional dominance to a greater, more pronounced role for lay care.

The greatest challenge was attitudes. Instead of primary health care being dictated by decisions passed down to it, primary health care should be regarded as the backbone or cornerstone of the system; secondary and tertiary care should be back-up systems. If that change were initiated, many of the other changes necessary would follow.

4. RESPONDING TO THE CHALLENGE IN THE UNITED KINGDOM

Dr David Hannay, General Practitioner and Senior Lecturer in General Practice, University of Glasgow, looked at the extent to which two principles of the Alma Ata Declaration were realised in Britain, and especially in Glasgow.

Part of the Clydeside conurbation which expanded in the nineteenth century with the industrial revolution, Glasgow now had a legacy of poor housing, a decline in heavy industry and rapidly rising unemployment. In an analysis of urban deprivation carried out on the 1971 Census data, 90 per cent of the worst enumeration indices were in Glasgow.

Included in Alma Ata was the principle that health care should be related to population needs. Glasgow, with its high proportion of local authority housing, had been subject to much urban redevelopment with traditional tenements being replaced by high rise flats. Primary health care services had been reorganised over the past ten years, firstly with the building of purpose-built health centres and secondly with the advent of area based social work departments.

A study was made of the prevalence of social and medical symptoms in the community, what people did about them and what factors were associated with symptom prevalence and behaviour. The study involved 1344 interviews of a random sample of patients registered at an eight-practice health centre with a registered patient population of 44,000.

It was found that 86 per cent of people had self-perceived physical symptoms of which one-third were referred for medical advice. About half the adults had mental symptoms, of which only one-third were referred. A quarter of the children had behavioural problems. Social symptoms showed a similar picture, although few referrals were to social workers. Of those with medical symptoms, 26 per cent did not seek professional advice although they said their symptoms were severe for pain, disability or seriousness. This 'iceberg' of 26 per cent, compared with the 11 per cent of those with medical symptoms who referred 'trivia'; i.e. symptoms which they did not think were serious and caused them no pain or disability. There were similar, though not as pronounced, results for social symptoms. The findings suggested that the primary care services were not meeting population needs, especially in mental ill-health.

Two factors raised further questions but did not necessarily answer them. There was a significant correlation between the prevalence of mental symptoms in those living in tower blocks and those who were not. And those who had a walk or a bus ride of more than 20 minutes from the health centre were likely to be significantly part of the symptom 'iceberg'.

Turning to the second Alma Ata principle, that consumers should participate individually and collectively in planning and implementing primary health care, Dr Hannay looked at the community served by an urban health centre.

A sample of people registered with one health centre showed that many were not at the address given: one third of these had moved; one third had never been heard of at the address, and one third of these addresses did not exist. This pointed to two factors: that these were the under-users of health care, changes of address only being registered if people attended the health centre; that these people were the frequent movers, urban mobility being one of the facets of modern life. The average length of stay by a family in one area was about seven years nationally; in Glasgow with its urban development, it was reckoned to be about four years. In other words, 25 per cent of the population moved each year.

Computer mapping analysis showed that as general practitioners moved into the health centre following urban development, their registered patients also moved but many moved further from the area. They still, however, remained registered with their original GP. This raised problems when continuity of care was mentioned.

One needed, Dr Hannay said, not only to know where primary health care was aiming, but also from which point it was starting.

Shirley Goodwin

Discussing the nursing response to the challenge of primary health care, Miss Shirley Goodwin, Honorary Secretary of the Health Visitors' Association, focused on three areas where the demands provoked radical change in the traditional nursing response.

First, primary health care placed the nucleus of the health system outside the institution; second, it was multidisciplinary; third, it was concerned with community participation and promoting individual and self care.

Placing the focus of the health system in the community had implications for the training and location of nurses whose basic training was in the hospital setting. The obvious solution was to teach nurses first about health and how to promote it; to build upon that the skills and knowledge needed to prevent handicap, disease and injury; and lastly to teach them how to care for the ill and dependent. But that took no account of the hospital service relying greatly upon trainee nurses to provide the greater part of direct patient care. Removing them from hospitals to the community would leave a substantial gap in the hospital workforce.

In some countries, whose nurses had full student status, nurses in training were supernumerary. Logically, therefore, there was no obstacle to moving nurses into primary care for a substantial part of their training, although changes in supervision would be needed.

Many nurses chose the profession as a means towards helping the sick. A major challenge to primary health care was to alter the attitudes of society from which potential nurses were recruited so that the aims and activities were clearly understood to be focused on health, not sickness care.

The challenge of multidisciplinary care was in nurses adapting to working co-operatively and equally with other team members. The term "attachment" implied a service peripheral to medical, not central to health care. There was no common training for the potential primary health care team to learn about teamwork while their attitudes were still flexible. Even at basic training, doctors and nurses rapidly became socialised into different professional cultures. The discrepancy in status and remuneration militated against teamwork equality. There was some resentment that part of the doctor's income came as a direct result of nursing activity, such as antenatal care, family planning, or immunisation at the surgery.

The problem of being professionals, claiming knowledge and skills supposedly inacessible to consumers, gave nurses a challenge in relinquishing responsibility for clients' health. Nurses are trained to believe it is theirs. Even health visitors had difficulty in realizing that not only were clients not 'theirs' but that responsibility for clients' health was not theirs either.

There was the suspicion that lay people were amateurs dangerously dabbling in areas belonging to medicine or nursing. Breast-feeding clubs sometimes met active obstruction from nurses, yet it was a normal physiological process, not a medical or nursing matter. Professionals often felt threatened, perhaps because the self-help groups could be better at the job. There might be a loss of status, respect - and employment - if clients no longer needed professional advice.

Primary health care nurses needed to ask themselves if their skills of observation and assessment, for example, were obvious to the client and carried out with his or her full consent and participation. Use of 'the nursing process' in health visiting might make the nature of care more explicit.

Nurses had a responsibility to work at the personal, professional and political levels to influence health and social policies to secure more resources for primary health care. This was an unfamiliar area and not easy for many nurses but was essential if "Health for all by the year 2000" was to be achieved.

Helen Rosenthal

Helen Rosenthal, of the Community Health Resource Centre, London Voluntary Services Council, said that the flowering of community health activities outside the health professions should be recognised as part of the broader definition of primary health care. The women's movement, the first round of health service cuts in the 1970s, the new militancy of hospital workers, the movements in public health, housing and welfare rights, had all contributed to the growing community health movement.

A number of shared principles underlay the initiatives that stemmed from the movement. The recognition of gross inequalities in health and provision across social classes and ethnic groups explained the initial concentration of initiatives in working-class inner city areas. It was seen that health for all depended upon the collective awareness of the causes of ill health. There was a growing understanding that access was needed to information previously monopolised by professionals. Given that information, people needed confidence to use it, either directly with a health worker or in public debate.

The most visible and identifiable of the various initiatives were the community and neighbourhood health projects, dealing with issues such as antenatal and postnatal education, sex education for teenagers and the mentally handicapped. In Manchester, a women's group successfully campaigned for a well women's clinic and stayed involved in its running. In South London a neighbourhood council and other groups became involved in planning a proposed health centre, which influenced important decisions about design, staffing and facilities and raised consciousness and motivation for the people involved. Similarly, a planning department attempted formal community group involvement in primary health care planning.

Some health professionals, notably health visitors, health education officers and some general practitioners, recognised that the techniques of groupwork and helping people define their needs - the community worker's stock-in-trade - were valuable tools, and were learning the skills too.

Community health councils had the advantage of being the statutory voice of the community, with a sizeable budget. Although hampered by the size of districts, their responsibility to respond to district matters, their limited powers and their uncertain future, they had made a major contribution to the growth of the wider community health movement.

Community involvement was not necessarily going to take a single form, which was why it appeared threatening and anarchic to some professionals. Benignly, the fear was that a worker was duplicating the health visitor's work. More extremely, the worker's credentials and qualifications were questioned. The community worker symbolised the major dilemma of the community health movement - where does community work stand in relation to the NHS?

The community worker was essentially a facilitator, claiming no special knowledge of health but knowing how to involve people in the process of thinking through which health issues were important for them. The worker knew how to find information using a wide range of sources and the expertise of health professionals. The worker knew the health service and local authority structures, and who made the decisions. In their modest way, community workers promoted health issues: prevention of ill health, education about nutrition, and maternal and child health.

In the interests of primary health care development, the NHS needed to acknowledge and make room for these activities. It would involve a shift

in the attitudes of many health workers. There had to be more input about community health in professional training. It had to be understood that no single formula was sufficient for community involvement since health needs differed between communities, and that needs changed.

Community health activity was not a substitute for health care provision by the NHS. The emphasis on what was loosely called community health care - which in reality often meant placing an impossible burden on neighbours and families - meant there was a danger in assuming that the funding of community projects would solve the problem. It would not but was needed as part of the process by which the NHS could develop a comprehensive and flexible primary health care service.

5. DEVELOPING AN AGENDA FOR ACTION

Dr Muir Gray

Opening the afternoon session, Dr Muir Gray, Community Physician, Oxfordshire Health Authority, pointed out that "communities" meant different things in different contexts. Primary health care did not fit into neat geographical categories and the health service had to be prepared to deal with this untidiness. There had to be a strategy but it was never going to be a rigid one. People had to define what they saw as their own community but there were conflicts between the local care needs and the planning needs of health authorities. A balance had to be achieved.

The primary care argument for resources had to be backed with hard data as there was hard competition for resources. Claims for general practice, health visiting or health education were not going to stand alone. To develop community work, performance indicators had to be devised as that was the way resources were allocated.

It was important to focus on objectives as it allowed a system of performance evaluation which, he believed, led to a better quality of care. Second, it might be one way to sort out professional roles. Professional practice - medicine, nursing, physiotherapy and occupational therapy - was akin to the heavy industry left over from the nineteenth century. Change was needed. Mental handicap offered some lessons. If objectives were set, from which strategies stemmed and then moved to the system of delivery - volunteers, nurses, doctors - then some of the conflict could be avoided. There would be work for all in the fields of health and ill health. Objectives, as perceived by the community and the professional, had to be the starting point from which people worked back. Where there was conflict and difference of opinion, people had to speak out.

Links with other groups - social work, housing, education - had to be high on the agenda for any debate on primary health care. Health and local authorities had to work together to cope with the untidiness of their respective boundaries. If the objectives were set and the problems worked through from where individuals experienced them, then some of the administrative problems would be sorted out.

Health professionals had to be prepared to argue the case for community-based resources. Primary health care was up against hard competition when there were cuts and closures in other parts of the NHS. High technology medicine was shown to work effectively and bids for resources were well argued and coherent. Primary health care, health visiting and general practice had to move from vague statements and activities into a policy that could be put up for resources.

Dr John Roberts

Dr John Roberts, then Regional General Administrator, West Midlands Regional Health Authority, said there was a grave problem for any bureaucracy invented in the traditional mould, in trying to identify its role in a "citizens' democracy", illustrated by the example of bringing community workers into the delivery of services. All the reflexes of the arch-bureaucrat were entirely wrong for coping with that situation. The bureaucrat, on the whole, had very poor contact with the periphery. Planning "health for all" was quite a different approach to that which had always been taken. It was important for the bureaucrat to recognise that he was planning for health, rather than health care, otherwise he completely missed the kind of business he was in.

There were six things for the regional administrator to do. He had to:-

sort out the planning system in relation to planning for health;
sort out the resource allocation;
make sure the annual review process was properly targeted for health;
look at training;
study the intelligence systems;
look closely at the role of the CHCs and the role of regions in relationship to them.

The policy on national administrative training - training the chief officers of the future - had hardly changed since its inception, despite the introduction of planning and completely different priorities. If there had been a shift in the concept within the trainees themselves, it only seemed to extend from the acute services to the brave new worlds of psychiatric services and had yet to penetrate through to primary health. Training had to be reorientated. He hoped that the WHO would take a lead in recognising that there were no training schemes adequate to make the

radical change in the concept of the bureaucrat and his role in the important process of trying to achieve "Health for all by the year 2000".

It was also important that regional administrators, teams and health authorities, encouraged by their districts, got primary health on the agenda for annual reviews. It would be a vital mechanism in monitoring the progress of the health service in trying to achieve the objectives set in 1946 by the legislators when they wrote into the first clause of the NHS Act that health was not the monopoly of the medical profession; health and the pursuit of health was the duty of the people, through the minister and through Parliament. It was not a medical service they were then inventing, it was a health service with the objective of securing improvement in the physical and mental health of the people.

Pamela Petrie

Pamela Petrie, Assistant Secretary, DHSS, referred mainly to the opportunities offered by the proposed legislation to change the status of family Practitioner Committees. She said that the legislative proposals on family practitioner services were seen as having three purposes. Changing the status of family practitioner committees was to facilitate collaboration as, since 1974, there had been an uneasy collaboration between health authorities and FPCs. It would be surprising if people who were really interested in a reorientation towards primary care in this country did not seize the opportunity that would be provided.

Second, there was the question of accountability. FPC accountability, split between the matching health authority and the Secretary of State, had not proved easy to operate. Third, in the interests of efficiency, the change was seen as a way of bringing FPCs into line with the sort of measures that were introduced for district health authorities, so that management responsibility and decision-making could go hand in hand and that people doing more important jobs could be masters in their own house.

FPCs would be able to employ their own staff, look after their own management budgets which would be funded directly by the Department. They were not going to be employers of nursing staff, nor would they be responsible for planning and financing health centres. For administration, they would be wholly accountable to the Secretary of State.

DHA and FPC chairmen would be required to meet to discuss their respective responsibilities and to work together to plan and exchange information for the future. The DHA remained the planning authority but the FPC would have to contribute vital information, which had not necessarily been provided freely in the past, to make a greater impact on planning.

Giving these powers to committees gave rise to some anxieties but the will to collaborate existed on both sides. FPCs and DHAs would be required to participate in joint consultative committees with their local authorities. They would be asked to account for their actions directly to the Secretary of State, first by producing a local profile, the purpose of which would be to inform the public, to keep the contractors aware of the situation in their area and to be a feedback to the health authority and central government on the state of local family practitioner services.

Performance indicators had been developed for FPC administration. Trials were to be carried out and it was hoped to introduce them by 1984. FPCs would be asked to participate in management performance reviews, which might be of two types. FPC chairmen and administrators might contribute to the regional or district performance review. But also, periodically, FPC chairmen would be called collectively so that for the first time outside the negotiating framework, there could be discussion between ministers and people appointed to administer family practitioner services.

Fred Reeve

Fred Reeve, then Community Services Administrator, Leeds Western Health Authority, said that the 1982 NHS restructuring was a wonderful opportunity to look at things afresh and structure management in terms relevant to primary health care. Community administrators were in potentially influential positions, more than ever before. Predominant within health districts would be an administrator and nurse working closely in a unit management team. Doctors in primary health care, whether GPs, clinical medical officers or community physicians, would now have an administrator with the principal role of looking after the interests of community health in a multidisciplinary environment.

The Alma Ata declaration provided a first class agenda item for health authorities at all levels to consider primary health care strategies. Committed primary health managers must put the Alma Ata declaration on the agenda of unit management team and DMT meetings.

A WHO project in Leeds, on management needs in primary health care, looked at the management structure in districts and practices, which emerged as two key levels of management in primary health care. At an organisational level, there were still many primary health care teams (PHCTs) which were not receiving the support they required. In the WHO study, case studies of PHCT organisation showed that the unit team - with medical, nursing and administrative representatives - had the potential to make important decisions on resource allocation.

The team at unit level was the arm of district management. If primary health care was to be a focal point of health within a national social policy, there must be a clear identification of its resource needs and their availability. Many decisions on resource allocation between primary and secondary care would be made at district level. Nationally, there would be occasional injection of special funds. However, many of the decisions on access to primary health care for local populations would continue to be made locally by GPs, local government and voluntary organisations. Most negotiations on discharge of patients into the community, or the role of primary or secondary care, would require informal decisions.

A number of issues identified in the Leeds study, had a bearing on primary health care. The community administrator must be aware of the complex standing mechanisms and their consequences for planning and day to day operational control. The independent status of GPs had to be understood, bearing in mind that the GP unlocks much of the health care system. The manager had to be aware of the complexity of organisations, agencies and institutions running primary health care and understand how it links with social services, voluntary organisations and environmental services in delivering the total package of primary health care within the Alma Ata declaration. At all times, the administrator should encourage the consideration of issues in positive primary health care teams.

Sam Edwardson

Putting family practitioner services in perspective within the total health service, Mr Sam Edwardson, Administrator, Surrey Family Practitioner Committee, said there were 200 million consultations with GPs in a year; 320 million prescriptions dispensed by pharmacists; 30 million courses of dental treatment and 6.5 million sight tests, which together cost £2,400 million in England, one fifth of the total NHS expenditure. The GP himself dealt with 90 per cent of all episodes which occurred in the practice.

In anticipation of their proposed status, FPCs had already opened their meetings to community health councils; and the legislation would again make the meetings public. The FPC approach to primary care could be sumed up as: inform, communicate, collaborate. Family practitioner services administration had inbuilt facilities to advise district colleagues about the list of practitioners, the location of services and the changes in general practice. Family practitioner services in Manchester, for example, had co-operated with the area medical officer and the research fellow in general practice at Manchester university to produce an excellent document on primary health care for hostel and sheltered dwellers.

Surrey County Council had already called a meeting of officers representing social services committees, DHAs, and district councils, to begin to plan the proper distribution of the joint finance budget and to plan the transfer of hospital patients to community care. This was due to be followed by a committee of members. It was not an attempt to set up an area authority but was one way of carrying out the necessary collaboration on planning primary health care. Collaboration rested not so much on administrative structures as on people with mutual interests working freely together in a constructive way.

The main component of FPC administration was the register, which was the basic record of the FPC population. Some of the non-sensitive information it contained could be used, for example, to trace patients in pursuance of a research programme. It had helped trace families with a child suffering from non-accidental injury and to assist GPs in setting up age/sex registers. But the essential element was computerisation of the register, the sooner the better, if FPCs were to give the maximum support to GPs for recall systems for cervical cytology, vaccination and immunisation of children, rubella vaccination and if community physicians were to be given an idea of where old people were living and where the particular problems of the community were to be found.

6. DISCUSSION

One proposal which emerged from discussion was that a national health plan, a public document open for discussion, representation, negotiation and participation, might be adopted. The government paper "Prevention: everybody's business" had not gone far enough; it had not set health targets, for example. Rather than targetting reductions in illness, a target for health might be "that no child or old person will live above five storeys", if that proved to have a causal connection with mental illness. Health targets could be politically embarrassing, for example, the repercussions of a "no smoking" policy.

The underlying approach of the NHS planning system - where districts and areas produced a local response to national guidelines - had been too sophisticated for the structure. But the new management units, working from the ground upwards, would be expected to plan for results and from that a "national plan" might grow. It was open to DHAs to produce health targets.

A disease based approach might also help. Although people were interested in health, they were also interested in how to avoid pain, disease and disabilities. Hospital acute services were part of the total approach and one way might be to centre upon diseases in the community, and work back. One also had to measure the effects of action.

Although one might wish otherwise, it was difficult to find and plan for small groups. Instead of searching first for the community, working with a larger geographical population in the realm of health might develop a sense of community.

Perhaps the project team approach, as used in hospital building, could be applied to primary health care and the planning and development of non-capital services, by assigning people already employed in the health service. However unfavourable the surroundings, health promotion could thrive if people were eager about it. Even a small proportion of the million people employed by the health service could make a significant impact on health promotion. And if lay people were the most appropriate local medium, they could be funded. Some areas employed health facilitators - doctors, nurses and other professionals - to motivate and educate primary health care teams.

Planners did not have the same views as those at the periphery. Clear targets set for GPs need not be unmanageable although planning was a problem when many of the primary care contractors were independent. A new attempt might be made towards a planning group that was fully representative of the small scale of primary care and the independence of some of the principal contributors.

Education of administrators should be weighted more towards the community services, backed by increased and improved training for primary care unit managers. And as long as the DHSS continued grading administrators according to the number of hospital beds, then the better calibre administrators would opt for the acute services. The conflict between planning and personal freedoms could not be ignored.

A more fundamental change was the turn around from seeing primary health care, health promotion or health education as the active service given to a passive recipient. The broader debate, involving social reform and spanning sectional boundaries, involved a national strategy on public policy.

Dr Vuori, who was slightly disappointed in what he saw as a "tinkering" approach, thought that perhaps a more radical change was needed. If it were agreed that some of the answers were to be sought through inter-sectoral cooperation, then one should look at how the actual situation differed from the desired one, what could be done about it, and who should be responsible for doing it.

7. SUMMARY

In summing up, Professor Brian Abel-Smith noted that the UK had further to go towards the Alma Ata than some people had first accepted. There was no disagreement that the UK still had a problem of accessibility and of inequalities. The country had so defined the general practitioner contract that one could not say that the search for the under-using patient was the GP's responsibility. He may choose to do so but the contract did not require it of him; it required him to provide service to people who contacted him.

Teamwork was not always easy, part of the problem being that people were trained quite differently. Postgraduate education had been allowed to develop in its own isolated way. Questions of the role of professionals, and their rights to do certain things, might require legislative reforms. Contracts might have to be amended. The basic GP contract had not changed fundamentally since 1911 and was miles behind current reality and expectations.

Health education (better called education for health) included giving people the opportunity to take responsibility for their own health. But the concept of lay care had not gone as far as saying whose job it was to develop it. If people were given more responsibility in curative medicine, they would then understand more about prevention.

Community participation could not be sidestepped by the existence of community health councils; Alma Ata clearly meant something at a much lower level and which was more genuinely democratic. It could be interpreted as saying: we want more people to do more things for themselves and have the confidence to do it.

Alma Ata was asking for more distribution of resources into primary health care, which involved determination within the health authority as well as among those with political control at the top. Much of it, including a national health plan, had to do with political will. But the type of revolution that was wanted was not going to come unless there was tougher leadership at the centre to see that it happened, not only at DHSS and Regional level but across all government departments. A national health policy, into which primary health care fitted, was not going to happen unless

there was a much larger effort on a multisectoral basis than had ever been seen before.

But if some of the barriers to change were understood, then a certain amount of progress could be made. Ways around it, or collaboration through it could then be worked out.

Pat Blair
King's Fund Centre
May 1983.

APPENDIX 1

KING'S FUND CENTRE

PLANNING FOR PRIMARY HEALTH CARE - A CONFERENCE HELD ON 14 DECEMBER 1982

Summary of the 'Alma Ata' Declaration

The international Conference on Primary Health Care, held in September 1978 in Alma-Ata, the capital of the Soviet Republic of Kazakstan, expressed the need for urgent action by all governments, all health and development workers, and the world community to protect and promote the health of all the people of the world. The declaration reads as follows:

1. The Conference strongly reaffirms that health, which is a state of complete physical, mental and social wellbeing, and not merely the absence of disease or infirmity, is a fundamental human right and that the attainment of the highest possible level of health is a most important worldwide social goal whose realisation requires the action of many other social and economic sectors in addition to the health sector.

2. The existing gross inequality in the health status of the people particularly between developed and developing countries as well as within countries is politically, socially and economically unacceptable and is, therefore, of common concern to all countries.

3. Economic and social development, based on a New International Economic Order, is of basic importance to the fullest attainment of health for all and to the reduction of the gap between the health status of the developing and developed countries. The promotion and protection of the health of the people is essential to sustained economic and social development and contributes to a better quality of life and to world peace.

4. The people have the right and duty to participate individually and collectively in the planning and implementation of their health care.

5. Governments have a responsibility for the health of their people which can be fulfilled only by the provision of adequate health and social measures. A main social target of governments, international organisations, and the whole world community in the coming decades should be the attainment of all peoples of the world by the year 2000 of a level of health that will permit them to lead a socially and economically productive life. Primary health care is the key to attaining this target as part of development in the spirit of social justice.

6. Primary health care is essential health care based on practical, scientifically sound and socially acceptable methods and technology, made universally accessible to individuals and families in the community through their full participation and at a cost that the community and country can afford to maintain, at every stage of their development, in the spirit of self-reliance and self-determination. It forms an integral part both of the country's health system, of which it is the central function and main focus, and of the overall social and economic development of the community. It is the first level of contact of individuals, the family, and community with the national health system bringing health care as close as possible to where people live and work, and constitutes the first element of a continuing health care process.

/continued overleaf

7. Primary health care:

   a. reflects and evolves from the economic conditions and socio-cultural and political characteristics of the country and its communities and is based on the application of the relevent results of social, biomedical, and health-services research and public-health experience.

   b. addresses the main health problems in the community, providing promotive, preventive, curative, and rehabilitative services accordingly.

   c. includes at least; education concerning prevailing health problems and the methods of preventing and controlling them; promotion of food supply and proper nutrition, an adequate supply of safe water and basic sanitation; maternal and child health care, including family planning; immunisation against the major infectious diseases; prevention and control of locally endemic diseases; appropriate treatment of common diseases and injuries; and provision of essential drugs;

   d. involves, in addition to the health sector, all related sectors and aspects of national and community development, in particular agriculture, animal husbandry, food, industry, education, housing, public works, communications and other sectors; and demands the co-ordinated efforts of all those sectors;

   e. requires and promotes maximum community and individual self-reliance and participation in the planning, organisation, operation and control of primary health care, making fullest use of local, national and other available resources; and to this end develops through appropriate education the ability of communities to participate;

   f. should be sustained by integrated, functional, and mutually supportive referral systems, leading to the progressive improvement of comprehensive health care for all, and giving priority to those most in need;

   g. relies, at local and referral levels, on health workers, including physicians, nurses, midwives, auxiliaries, and community workers as applicable, as well as traditional practitioners as needed, suitably trained socially and technically to work as a health team and to respond to the expressed health needs of the community.

8. All governments should formulate national policies, strategies, and plans of action to launch and sustain primary health care as part of a comprehensive national health system and in co-ordination with other sectors. To this end, it will be necessary to exercise political will, to mobilise the country's resources and to use available external resources rationally.

9. All countries should co-operate in a spirit of partnership and service to ensure primary health care for all people since the attainment of health by people in any one country directly concerns and benefits every other country. In this context the joint WHO/UNICEF report on primary health care constitutes a solid basis for the further development and operation of primary health care throughout the world.

10. An acceptable level of health for all the people of the world by the year 2000 can be attained through a fuller and better use of the world's resources, a considerable part of which is now spent on armaments and military conflicts. A genuine policy of independence, peace, détente, and disarmament could and should release additional resources that could well be devoted to peaceful aims and in particular to the acceleration of social and economic development of which primary health care, as an essential part, should be allotted its proper share.

APPENDIX 2

PLANNING FOR PRIMARY HEALTH CARE - CONFERENCE ON TUESDAY 14 DECEMBER 1982

List of Participants:

*	PROF B ABEL-SMITH (CHAIRMAN)	Professor of Social Administration	London School of Economics
	DR P ANDERSON	MSC Student, Community Medicine	London School of Hygiene and Tropical Medicine
	MRS B ARROL	District Planning and Information Officer	Bloomsbury Health Authority
	MR D BALL	Editor	PRIMARY HEALTH CARE
	MRS M J BERRY	Superintendent Physiotherapist (Community)	Bow Arrow Hospital, Dartford, Kent
	MRS C BISSELL	Director of Nursing Services	South West Hertfordshire HA
	MS P BLAIR	Reporter	PRIMARY HEALTH CARE (Rapporteur)
	DR D BOOMLA	Chairman, Health Policy Committee (Member, Greenwich Health Authority)	The National Association of Health Authorities
	DR E C BRAMWELL	Chairman	Surrey Family Practitioner Committee
	MISS K R BRYANT	Director of Nursing Services	Brighton Health Authority
	MS S BURKHART	Reporter	BRITISH MEDICAL JOURNAL
	MRS C CLARK	Planning Administrator	Northumberland HA
	MR R P CLEASBY	Senior Executive Officer	DHSS
	MRS A COMPTON	Supt. Community Physiotherapist Chairman of the Chartered Society of Physiotherapy Specific Interest Group for Community Physiotherapy and its future development	Southampton General Hospital
	MISS D COTTIER	Health Visitor	Tower Hamlets HA
	MR A J CRONIN	Management Consultant (on behalf of the General Medical Services Committee, BMA)	Coopers & Lybrand Associates
	PROF R H DAVIS	Professor of General Practice	Welsh National School of Medicine, Cardiff
	MR K DOBSON	General Administrator	Southend Health Authority
	MR P DOBSON	Administrator	West Sussex FPC
	DR B L DONALD	Registrar	Council for Professions Supplementary to Medicine
	DR S DOWLING	Lecturer in Community Health	Bristol University
	MISS L DYER	Physiotherapy Adviser	DHSS
	MISS S G EARL	Nursing Officer	DHSS
*	MR S EDWARDSON	Administrator	Surrey FPC
	DR S ELLIOTT	General Practitioner	East Oxford Health Centre
	MISS A EVE	Assistant District Administrator (Support Services)	Hounslow and Spelthorne HA
	DR P FREELING	Head of Sub-Department of General Practice	St George's Hospital Medical School, London

	MR S J FURNISS	Principal, CHP (Coorindation of primary health care policy)	DHSS
	MR K S GAME	Liaison Officer	Redbridge and Waltham Forest FPC
	DR J S GILMORE	General Practitioner (Member of South Western RHA)	Plymouth
*	MISS S GOODWIN	Honorary Secretary	The Health Visitors' Ass.
*	DR MUIR GRAY	Community Physician	Oxfordshire HA
	DR D J PEREIRA GRAY	Chairman, Communications Division	Royal College of General Practitioners
	MR A GREEN	Planning Officer	West Lambeth HA
	MR R GREEN	General Administrator	West Lancashire HA
	MISS H D HAMILTON	Nursing Officer	Dept. of Health and Social Services, Northern Ireland
*	DR D HANNAY	General Practitioner	Woodside Health Centre, Glasgow
	MR S A HARRIS	Assistant Administrator	North Yorkshire FPC
	PROF P M HIGGINS	Professor of General Practice	Guy's Hospital Medical School, London
	MISS T HOLLAND	Director of Nursing Services (Community)	Nottingham Health Authority
	DR J HORDER	General Practitioner Ex-President	London Royal College of General Practitioners
	MISS B M JOBLING	Director of Community Nurses Services	Royal United Hospital, Bath
	MR P L C JONES	Administrator (FPS)	Calderdale HA, Halifax
	DR W KEARNS	District Medical Officer	Paddington and North Kensington HA
	MR C KIRKMAN	PAA (Community Services)	Nottingham HA
	MR J V KNIGHTON	Honorary Secretary	Society of Family Practitioner Committees
	DR J LEACH	Assistant Administrator (Community)	North Manchester HA
	DR J LEE	General Practitioner Member of Council	Greenwich Royal College of General Practitioners
	MR D LORD	Administrator	Wolverhampton FPC
	DR J F LOWE	Regional Adviser in General Practice (Mersey Region)	The University of Liverpool
	MRS P MASON	Community Services Administrator	Brighton General Hospital
	MRS A MARK	Community Services Administrator (Acting)	Victoria Health Authority
	DR R B H MAXWELL	General Practitioner	Bristol
	Mr R J MAXWELL	Secretary	King Edward's Hospital Fund for London
	MR I McARDIE	Vice-Chairman	South Birmingham HA

	MISS L McCARTHY	P.A. PLANNING	Plymouth Health Authority
	MS N MOHYLNYCKY	Community Nurse Tutor, Nightingale School	St Thomas' Hospital, London
	DR R MORRIS	District Medical Officer	West Lambeth HA
	MR C S MOTH	Assistant District Administrator	Central Notts HA
	MR W M NAYLOR	Director	The National Association of Health Authorities in England and Wales
	DR L NEWMAN	General Practitioner	Abbey Medical Centre
	PROF Y NUYENS	Professor of Sociology	Catholic University of Leuven, Belgium
	MR E O'CONNOR	Chief Nursing Officer	West Birmingham HA
	DR T PAINE	General Practitioner	Bristol
	MR C W PARR	Administrator	Cheshire FPC
	MRS M PARRICK	Divisional Nursing Officer, Community	Harrow Health District
	MRS D PATEY	Senior Nursing Officer	DHSS
*	MRS P PETRIE	Assistant Secretary	DHSS
	MR C PETROKOFSKY	Assistant Planning Officer	Oxford DHA
	DR P PRITCHARD	General Practitioner	Dorchester-on-Thames, Oxon
	MR R G PURSER	Secretary	Society of Administrators of Family Practitioner Services
	DR Y S RAJAPAKSE	Specialist in Community Medicine	North Bedfordshire HA
*	MR F REEVE	Community Services Administrator	Leeds Western Health Authority
	MRS A J REID	Divisional Nursing Officer, Community	South Lincolnshire HA
	MRS A C RICHARDSON	District Physiotherapist	Wolverhampton HA
	MR N RICHARSON	District Information Officer	St Helens & Knowsley HA
*	DR J ROBERTS	Regional General Administrator	West Midlands RHA
	MR M S ROGERS	Deputy Director of Programmes	The College of Ripon and York St John, York
*	MS H ROSENTHAL	Community Health Resource Centre	London Voluntary Services Council
	MRS B SCAIFE	Divisional Nursing Officer, Community	Hull Health Authority
	MR J W SCAIFE	Senior Administrative Assistant Community Services	Hull Health Authority
	MR L SCREENE	Administrator	Kensington & Chelsea & Westminster FPC
	DR M G SHELDON	Senior Lecturer in General Practice	Nottingham University Medical School

	DR G SINGER	Senior Medical Officer	DHSS
	DR J D SINSON	General Practitioner Regional Adviser in General Practice, Yorkshire Region	Leeds
	DR D SLOAN	General Practitioner Member of City & Hackney DHA and City & East London LMC	Lower Clapton Health Centre
	MR R I SPENCER	District Administrator	Bromsgrove and Redditch HA
	MR P S STANSBIE	District Administrator	North Warwickshire HA
	MS B STOCKING	Research Fellow	London School of Hygiene and Tropical Medicine
	MISS M S STREHLOW	Professional Adviser	Council for the Education and Training of Health Visitors
	MISS J SWAN	Regional Nurse	North West Thames RHA
	MRS J W M TEARE	Senior Nursing Officer Community	Bromley HA
	MISS M A THWAITES	Director	Council for the Education and Training of Health Visitors
*	DR H VUORI	Regional Officer for Primary Health Care	World Health Organisation
	MISS P M WALKER	Superintendent Physiotherapist	Mount Vernon Hospital, Middx
	MS M WANN	Community Health Resource Centre	London Voluntary Services Council
	DR A E WELCH	General Practitioner - Member DMT	Calcot Medical Centre, Chalfont St Peter, Bucks
	MR P WESTLAND	Under Secretary (Social Services)	Association of Metropolitan Authorities
	MR R J WILCOX	Administrator, Family Practitioner Services	Norfolk FPC
	MR J P WILLIAMS	Vice-President	Society of Administrators of Family Practitioner Services
	MR J WOODCOCK	Unit Administrator	Northwick Park Hospital, Harrow
	MR J YATES	Planning Officer	Gloucester Health Authority
	MRS A M YORSTON	District Chiropody Officer	West Berkshire HA

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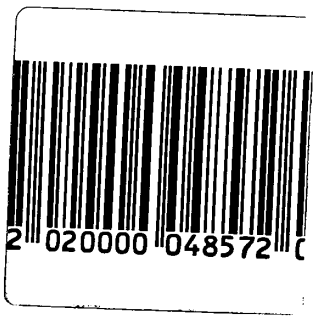
MR D HANDS - Assistant Director
MISS N DAVIES - Secretary to Mr Hands

* denotes contributor/speaker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