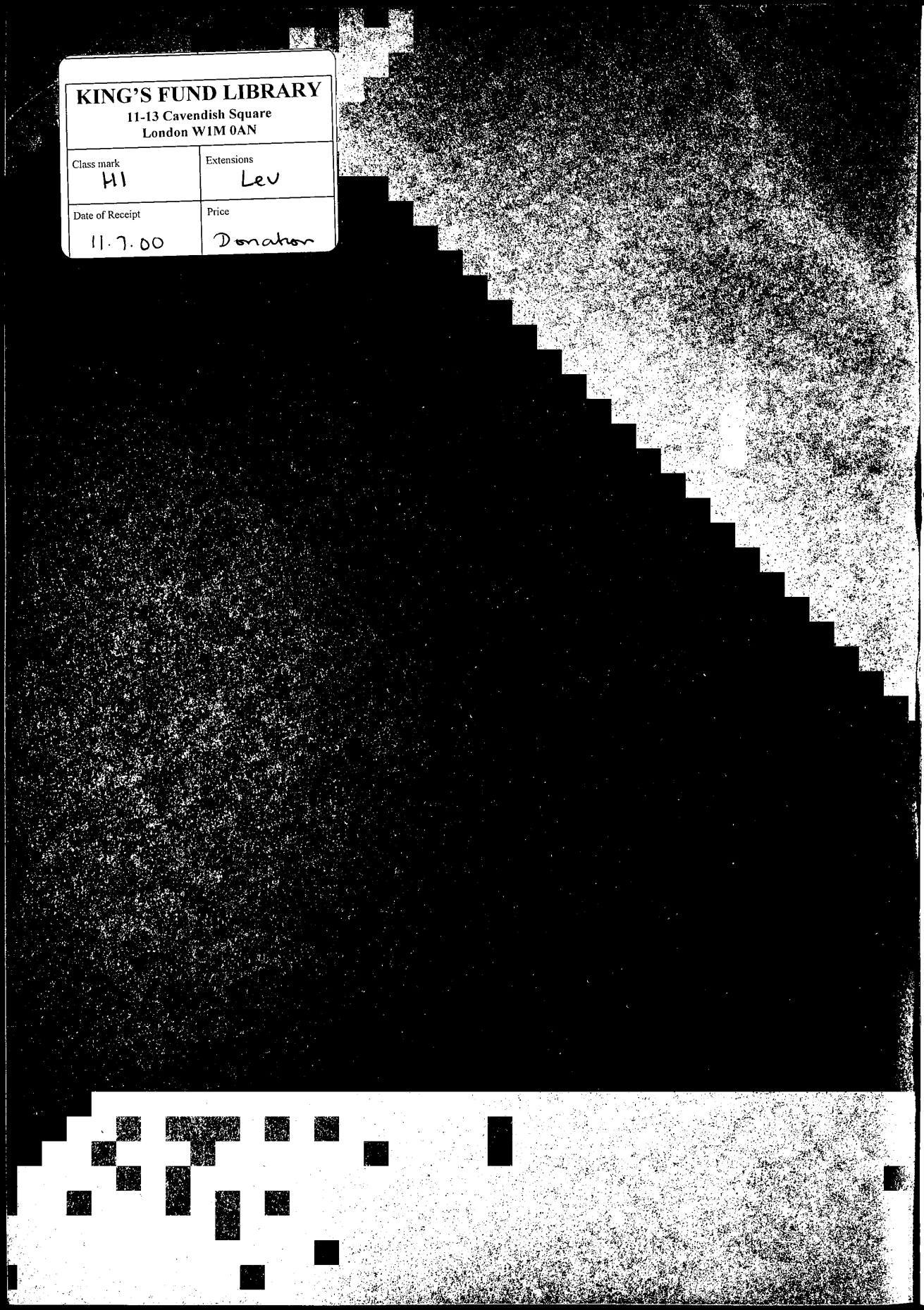
King's Fund

IMPROVING HEALTH AT LOCAL LEVEL: THE ROLE OF PRIMARY CARE

Issues arising from a King's Fund Review

By Ros Levenson
and
Lucy Johnson

The King's Fund
11-13 Cavendish Square
London W1M 0AN



This paper is based on a discussion paper prepared for a King's Fund symposium 'Primary Care and Public Health' held in November 1999.

It has now been updated to take account of views expressed at the symposium.

CONTENTS

Introduction

How can primary care develop its input into public health while also remaining focused on meeting the health care needs of individual patients and their families? How can GPs and others in the Primary Health Care Team (PHCT) best be involved in public health in ways that make best use of their individual skills and interests? These are fundamental questions that run through most current debates about the role of primary care in public health. Few people doubt that those who work in primary care settings have an immense amount of information about the individuals they see and treat, but there are mixed views on how to bring this knowledge to bear to achieve changes in the health of the population and to address inequalities in health. Opinions vary on whether all those engaged in primary care should and could be involved in broader public health issues, or whether this might best be seen as a specialty within primary care. And even where there is a shared vision of what is achievable, there is a range of views on both the support that is needed to make the broad vision into a reality and on the nature of the partnerships that may be required to make changes happen.

The debates and dilemmas are not new and have been addressed over a long period by practitioners such as Julian Tudor Hart and others. Recently, there have been several waves of change that have affected the nature of primary care organisations and their potential for extending their remit beyond the care of individuals. Before the introduction of Primary Care Groups in 1999, there had been a proliferation of new structures that had widened the role of some primary care organisations. GP Fundholding, Total Purchasing Pilot schemes and Primary Care Act Pilot schemes had all given various kinds of opportunity for widening the traditional primary care remit. Even before those opportunities, there were a number of initiatives in primary care settings that gave PHCTs opportunities to address public health/population health issues. For example, Community Oriented Primary Care (COPC) (Freeman *et al* 1997. Gillam and Miller 1997) was an early systematic attempt to engage the PHCT in public health.

However, the advent of PCGs marked a unique departure from earlier attempts to make public health part of the primary care remit, insofar as all GP practices would henceforth be part of a Primary Care Group - not just those who had a particular interest in community oriented activities or public health issues. Since PCGs have three main functions, the first of which is "to improve the health and address health inequalities of their community" (NHS Executive 1998) it has now become all the more important to take stock of the research evidence and the impressions of people working in primary care and public health in order to obtain a snapshot of progress at this stage, and to draw upon an initial agenda of emerging successes and problems, as well as identifying gaps in knowledge and understanding for the future.

Early indications are that PCGs are generally committed to improving health in their communities, but they are having to cope with enormous workloads in

their formative stage. Consequently, explicit attempts to take a broad view are, in most cases, proceeding by small steps.

The symposium - background and aims

This document is based on a background paper prepared by Ros Levenson and Lucy Johnson for the King's Fund symposium on primary care and public health, 1 November 1999. It has been updated to take into account views expressed at the symposium.

The King's Fund symposium had the following aims:

1. To consider the significance of recent and current research on the role of primary care teams in promoting public health.
2. To identify the areas where further research is needed.
3. To share and consider the experiences of public health consultants and public health specialists and of GPs, nurses and other primary care practitioners in relation to their experiences in promoting public health in primary care.
4. To explore strengths, weaknesses, problems and opportunities in developing effective capacity within primary care teams to promote public health.
5. To consider the implications for policy and practice of the above points.

Those invited to attend the symposium included:

- Doctors and public health specialists from public health departments.
- Senior public health and primary care staff from the NHS Executive and from health authorities.
- PCG chairs, chief executives and lay members.
- GPs, nurses and health visitors.
- Academic researchers.

In preparation for the symposium, background information was sought from two sources:

- A series of semi-structured telephone interviews and discussions held in the spring and summer of 1999, undertaken by Ros Levenson, Visiting Fellow, King's Fund. Material from these interviews has been drawn on extensively in this paper, as it provides an up-to-date impression of what a range of people were thinking as PCGs went live.
- A broadbrush review of the literature since 1994 on the capacity of primary care practitioners to undertake public health work, conducted by Lucy Johnson, Research Librarian, King's Fund.

As it happened, these two sources revealed many similar concerns and preoccupations. The symposium provided opportunities to look at these in more detail and to examine them in the light of emergent changes.

Emergent themes

In conducting the interviews and the literature review, it was striking that many of the themes that emerged from both sources were familiar and had been preoccupying academics and practitioners for some time. Because of the timing of our initial investigations, little had yet emerged about what the fledgling PCGs were achieving, although there was speculation about what they could actually achieve. Many of those who were active within PCGs, and within Health Authorities had firm views on the issues confronting them as PCGs developed and those issues that would confront them when PCGs eventually attained Primary Care Trust (PCT) status. Opinions were quite divided on how effective a contribution could be made by primary care to public health. At the symposium itself, there was quite an upbeat feeling about the opportunities that were around to make a real difference to health. There was also a conviction that it was not a huge step from looking at the health of a practice population to wider issues of public health across practices. However, this optimism was tempered with a sense of realism about the complexity of the issues, and the competing priorities for resource allocation.

In many cases, the disparity of views appeared to reflect personal experiences to date. Those who had been deeply involved in partnership working across agency boundaries, and those where GPs and the wider PHCT had already been involved in population health issues, were often more optimistic about what could be achieved. Others were concerned about the obstacles and competing pressures that confronted those working in primary care settings, and according to differing perspectives, could be viewed either as more pessimistic or, possibly, more realistic. Therefore, perhaps one of the big questions is not whether primary care can *ever* make an effective impact on public health (there are many examples of where it has done so), but whether it can *generally* make an effective impact and, if so, whether existing and planned structures provide the best opportunities for doing so.

Unsurprisingly, taking into account the timing of our investigations and the symposium itself, earlier debates on where the focus of public health should be (i.e. whether local authorities should play a lead role, or whether the primary care in the NHS was the natural home for public health) had subsided. It was largely taken for granted in the spring and summer of 1999 that the task in hand was to see how best to extend the role of primary care in promoting the health of communities.

Understanding the role of primary care in public health - where are we now?

The literature indicated that there is little agreement about what constitutes public health or the purpose and value of particular public health-related activities, as perceived in primary care. For example, Jordan *et al* (1998) found, in their survey of 35 practices, that 15 initially expressed confusion over the meaning of assessing health needs. Rowe (1998) found a cynical view of health profiling was common among GPs and practice nurses; others, however, felt that primary care is the best place for public health activities. For example, Colin-Thomé (1999) states:

"The primary healthcare team, with its frequent longitudinal contacts and registered population, is in a unique position to deliver both personal and population-based activities."

There is also a considerable literature on the role of nurses and, in particular, health visitors, in public health. Much of this is concerned with the optimum balance between individual and community-based work and whether it is possible to combine the two (Gould 1998; Billingham 1994).

A number of our interviewees felt that there were gaps in what primary care practitioners mean by the 'public health agenda', with a medical model still dominating. The following quotations typify the range of views expressed.

"Some PCGs are doing things, but mostly on CHD and illness prevention, rather than wider public health issues." (Director of Public Health (DPH) in a health authority).

"There are gaps in what primary care means by the public health agenda." (Director of Primary Care in an NHS Executive Regional Office).

"PCGs are very medically oriented." (Nurse on a PCG board).

"GPs are still fixated on one-to-one" (Director of Primary Care in an NHS Executive Regional Office).

"Public health is very variable at PCG level" (Consultant in Public Health Medicine).

"...still odd people doing heroic things - public health is not mainstream [in primary care]" (Director of Primary Care in an NHS Executive Regional Office).

"Should we just let GPs be doctors? A big question!" - a public health specialist.

"The GPs on the PCG are the ones who were involved in commissioning before – the rest only sit up when they think colleagues are playing with their primary care development money." - a public health specialist.

Overall, the predominant view was that there were some excellent examples of primary care involvement in the broad public health agenda, but this was not matched by the level of understanding or commitment of the majority of GPs or, as yet, by all PCGs. However, several interviewees and some of those who attended the symposium felt that PCGs could and would develop a broader feel for how they could impact on public health. This was likely to be achieved by beginning with a narrower, medical focus, starting with issues that they already saw as important for many of their individual patients, e.g. coronary heart disease and mental illness. Activities to address these problems would necessarily lead them into broader alliances and a wider public health focus to address health inequalities. A Director of Primary Care in a Regional Office thought that it would be important for PCGs to identify some "quick wins" - presumably to entice them into longer term projects. This attitude was reflected in the literature where Kilduff, McKeown and Crowther (1998) advocate starting small when undertaking unfamiliar public health projects in primary care settings.

Discussion at the symposium noted that there were real challenges to making progress with a wider view of public health in primary care. Amongst these, the dominance of medical practitioners on the PCG Board and the financial constraints were particularly noted.

It was not only the definition of public health which was seen as problematic. A nurse on a PCG board felt that there was still insufficient appreciation that primary care is not the same as general practice, and that some groups (for example, teenagers and homeless people) were less likely to attend a GP's surgery though they still had needs that could be met by primary care.

Although criticisms of the limitations of the involvement of primary care in public health are reasonable, they should not be allowed to obscure the large number of examples of local successful initiatives, some of them of long-standing. A small selection of these as mentioned includes:

- A carers support scheme that had developed within a total purchasing pilot scheme.
- An anti-poverty group with a regular session on benefits.
- Identification of over 65s in a practice to target them for benefits advice.
- Participation of GPs in drugs action teams.
- Single Regeneration Bid (SRB) funded projects, with involvement of primary care - e.g. in activities for young people and family support.

Similarly, the literature abounds with descriptions of well established local public health projects and initiatives. Pat Gordon (1995) explains how, in recent history, general practice has been developing from "a GP working alone or with a small group of colleagues, to an organisation providing community-based health services." Tony Hirst (1997) refers to fundholders who have been using waiting list information and practice profiles (among other tools) to identify need in order to commission services for their patients; and Daykin and Naidoo (1997) recount a series of projects they discovered

during their research which shows that primary care practitioners, albeit individually and perhaps alone, were including elements of public health in their work. Among the initiatives they identified was a project to train local mothers in counselling skills, another to establish a healthy eating group and one team which made use of linkworkers and specialist voluntary services especially in relation to the needs of black and ethnic minority groups.

Among interviewees, there was some feeling that, despite individual exceptions, PCGs as a whole have a low level of understanding of public health. In part, this was attributed to a relative lack of organisational development at board level. This is discussed further later in the paper.

Competing pressures

Those involved in primary care, who are also aware of the importance of public health, often experience competing pressures for their time and energy. Discussion at the symposium made repeated references to this difficulty. Interestingly, this was confirmed by both the literature and the interviews, but the emphasis was a little different in each source. The literature mainly underlines the perceived dilemma for primary care practitioners between treating individuals and becoming involved in wider aspects of population health. Graffy and Jacobson (1995) describe a conflict between the "rational, evidence-based medicine that underpins public health medicine and the individualism of the doctor-patient relationship." Similarly, Stephen Gillam *et al* (1998) state that:

"For most, a conflict remained between the utilitarian values underpinning COPC and the traditionally individualistic doctor-patient relationship."

The interviewees also referred to concerns about competing pressures, but they focused much more on pressures that resulted from political priorities. One Regional Director of public health stated:

"Public health issues are likely to get squeezed out by waiting lists - but improving health is a purpose of PCGs".

More pessimistically, a nurse stated:

"Things like the waiting list initiative make it impossible to get a foot into the public health door".

Disinvestment in certain areas was also seen as making the public health agenda harder to achieve. At the same time, new priorities, e.g. clinical governance, were making demands on clinicians' time, and there was a palpable sense of anxiety at the symposium about the need to tackle everything at once.

Some of these concerns about pressure also appeared in the literature, and Kilduff, McKeown and Crowther (1998) observe that PHCTs are constantly having to deal with demanding people, relating this not only to

patients, but also to pressure from above (from the health authority, the Department of Health and the Government). They describe the primary care climate as being one which is "typified by rapidly shifting agendas, priorities and demands, which tend to be addressed on a 'first come, first served' basis".

Taking forward public health in primary care - developing links and alliances

Collaboration with others is a cornerstone of developing a broad public health agenda and making it work in primary care. At a professional level, this has been encouraged by the Public Health and Primary Care Group which has been working at the interface between the Faculty of Public Health Medicine and the Royal College of General Practitioners. This group exists to promote understanding of the public health role in primary care, increase multi-disciplinary training opportunities and support the development of public health in primary care.

The literature review indicated that the ability of primary care practitioners to work collaboratively varies, and different commentators assess this ability differently. Stephen Peckham and Pat Turton (1998) say that while GPs are not known for their skills in collaboration or for their appreciation of the potential contribution of their patients, efforts have been made to encourage this and GPs themselves have been trying to cultivate networks with other agencies. That GPs have been working on the collaboration issue for some time is highlighted by Peter Mumford (1997). He says that over the last 20 years, they have learnt how to manage partnerships with varying degrees of success.

Meads *et al* (1999) point out that the development and delivery of a public health strategy depends on a range of relationships which may be new and different or previously neglected or difficult - relationships which could be further complicated by having four different types of PCG. Smith, Regen and Shapiro (1999) believe that for the PCG board to work effectively, strengthened relationships between itself and the stakeholder groups at a strategic level will be necessary so that PCG functions, such as health improvement and commissioning, can be fully implemented.

Discussion at the symposium struck an optimistic note insofar as it was felt that there were new and strengthened opportunities for partnerships between PCGs and other organisations, both within and outside the NHS. These relationships would be likely to flourish all the more if the Board itself "modelled" partnership in the way it worked, and if it was supported by the health authority.

The symposium discussions went on to support the idea of the development of new and different partnership models through the public health research agenda. It was suggested that this should include work on the collaboration between primary care practitioners and others (including the lay community) within a social model, rather than a medical one.

What kind of links?

Several commentators, including David Colin-Thomé, (1999) raise the issue of who should be included in the PCGs' collaborative networks. The inclusion of departments other than social services, including housing, leisure, youth services, environmental health services, education and transport, is necessary.

Links and alliances were widely discussed by those who were interviewed and at the symposium. Some had a broad vision of where such links were needed, including neighbourhoods and schools, with an emphasis on developing effective models of public involvement. Others suggested that a true partnership with social services was essential, implying that existing partnerships with social services (in spite of their place on PCG boards) were not always as satisfactory as they should be.

Several factors were identified as being conducive to the fruitful development of links with others:

- Availability of resources, linked to the requirement for partnership working, e.g. through SRB funding.
- Co-terminosity e.g. with district councils.
- An appreciation that GPs and the PHCT do not have to do everything and lead everything themselves; others can do a lot, as long as they have support from primary care.
- A constructive relationship with the local authority (not just social services).
- A local history of partnerships.
- A designated Strategic Health Alliance worker (although this was mentioned in one place only).

The key to success, according to one DPH, is:

"Opportunism, backed up by a strategic perspective".

Health Improvement Programmes

Health Improvement Programmes (HImPs) should clearly be important in forging and operationalising partnerships between PCGs and others. However, opinion varied on how effectively they were doing this in their first year of operation. One PCG Chief Executive saw the HiMP as a muddled process in which his PCG had little involvement. A DPH pointed out that HImPs need to be based on the planning and priorities guidelines, and not just medically focused. A PCG Chair described a formal link to the local HiMP. The HiMP reference group in his area had wide membership and his PCG had used the HiMP to develop a 23-point action plan. This variety of levels of involvement and approaches confirms the early impressions of Arora *et al* (1999); it will be further evaluated through the forthcoming NHS Executive and King's Fund project, which is part of the

national evaluation of Primary Care Groups and Trusts. This project includes both a tracker survey, examining data gathered on HImPs in 77 sites, as well as more detailed studies of six sites[1].

Some links had grown opportunistically out of local contacts. For example, one PCG had a health needs profile drafted by a secondee from the local City Council.

Supporting public health in primary care

Organisational support is essential for the effective implementation of new roles and responsibilities in primary care. This theme emerges in the literature (Ruta *et al* 1997) and in the interviews and was endorsed in the symposium. Support includes reliable back up from the health authority, without which projects can suffer and enthusiastic individuals can end up taking on the burden of the entire initiative, only for it to fade and die once they have left the organisation. This support is geographically variable and the quality differs widely (Rowe 1998).

However, as Robson (1995) puts it, even forward thinking administrative authorities were "floundering" in establishing adequate structures and policies for dealing with coherent planning in primary care. Meads *et al* (1999) ask whether health authorities can objectively fulfil the dual role of PCG developers *and* monitors of the NHS. Taylor, Peckham and Turton (1998) also raised the issue of health authorities' reliance on the medical model when approaching population based care, which may not be absolutely appropriate in primary care led public health.

These issues were also of concern to those who were interviewed by the King's Fund. The value of different kinds of support was noted, including support for organisational development and a more specific support by way of public health expertise. The level and nature of both kinds of support was variable.

Public health support

First, public health support varied in content, quality and quantity. A PCG Chief Executive said that his PCG had been offered one day a month from a public health consultant. Others felt that PCGs actually got what they needed. In some PCGs, a public health consultant had been co-opted to the board and in other places there was a very high level of public health support. In one health authority area, PCGs each had a consultant and a health promotion specialist; most Public Health Departments are evidently not large enough to offer this kind of support, however.

[1] For more information on this project, please contact Gill Malbon or Stephen Abbott at the King's Fund.

Even where public health support to PCGs was satisfactory, the fact remained that there was little consensus on how much support was enough, and how much would be needed as PCGs developed. Indeed, a public health consultant in an NHS Executive Regional Office observed that, looking forward to PCTs, it was interesting that there will need to be a named finance director on PCT boards, but it is not clear that there will be a need for a named public health director on those same boards. This consultant also raised the question of whether there was, in fact, enough public health expertise to go round to meet the needs of primary care organisations. This meant that it was essential to maximise the input of people in the PHCT who were currently engaged in public health activities, e.g. practice nurses, health visitors and district nurses. The question of capacity was discussed in some detail at the symposium, as it was felt that there was a need to look at the capacity of people to improve the public health, wherever those people were working and however they were organised.

In some areas, networks had developed to bring together primary care practitioners with anyone who defined themselves as working on public health. These networks appeared to be useful.

A Postgraduate Dean noted that whatever the level of public health support, GPs - and not just those on the PCG board - needed to learn how to make use of it. He suggested that most PCGs will buy in specific expertise, for example, on health needs assessment; the big question for primary care was how that expertise would be applied?

Broad support for PCG development

Broader support for PCG development was also seen as important. A Postgraduate Dean felt that the level of support available from health authorities to primary care should be one of the concerns that prospective GPs should consider, in addition to the qualities of the particular practice. Thus, support for GPs, as well as the quality of the primary care/public health interface, is likely to be an issue that affects recruitment and retention of GPs..

Opinion was divided on whether primary care organisations had an adequate vision about public health, and just needed support and expertise to realise the vision; or whether the vision had to come from health authorities, for example, by giving a lead on tackling health inequalities. Those who supported the former option sometimes had worries about whether the available budget was adequate to support PCGs in their development. A number of people at the symposium lamented that there was still an imbalance in the relative levels of investment in primary and secondary care. Others wryly noted that organisational turbulence and the changing future role of health authorities meant that many staff were preoccupied with hanging on to their jobs, or were in the midst of changing jobs. Different views were expressed at the symposium about whether health authorities were essentially moribund, or whether they were on the verge of a renaissance in a new, strategic role that would enable them to offer leadership.

In terms of other support, e.g. from the NHS Executive and its Regional Offices, there was a wide range of views, with little agreement on what would be ideal and whether what was being delivered was good enough. No clear view emerged about the role of the centre - whether it was "too woolly" or "too involved".

Many of the disparate views on organisational development reflected the fact that PCGs are in their infancy. A public health consultant stated that:

"There is a huge organisational development agenda - organisations are just settling down."

The lack of time to address change was lamented by several people.

"People need time out to reflect - but they don't have the time."

There was little consensus on what effect moving to PCTs would have on the public health agenda. Some felt that it would strengthen it, others saw it as a distraction, focusing attention, once more, on structures. One person was undecided whether it would help or hinder, suggesting that:

"...if PCTs are doing good work in one or two areas it may divert them as PCTs do have to run the world, but if a PCG is doing little, it may move them on."

Education and training issues

There was widespread agreement that education and training were important in developing the capacity of primary care practitioners and PCGs to increase their effective involvement in public health. Both the interviews and the literature (Graffy and Jacobson 1995) confirmed the need for public health training for GPs, and also for training for public health specialists in primary care: a study conducted in Northern Ireland showed that accredited training for GPs had more emphasis on disease management and service management than on health promotion (Bradley and McKnight 1997).

Doyle and Thomas (1996) support the need for changes in training as well. They imply that it is not just the curriculum that needs altering, training methods may also need to be analysed. Primary care is an isolated discipline and "team work may not be well enough developed to allow for a 'democratic' strategy". Kilduff, McKeown and Crowther (1998) also highlight the need to introduce change carefully; they state that changes to primary care education should be incremental, dynamic and on-going, reducing a reliance on the 'one-off' solution which tends to be divorced from mainstream primary care activity.

The training required does not necessarily all have to be found outside the practice. Billingham (1997) provides two examples of health visitors

transferring their own skills to others in their PHCT. One example focused on encouraging breast feeding; the other focused on work with older people.

Interviews added weight to the view that training those in primary care on public health was more complicated than just equipping them with specific skills. Rather, encouraging GPs, in particular, to change their mindset was one of the more important goals. A public health specialist suggested that there was a need to train the whole PHCT on public health, and not to focus exclusively on GPs. Several people agreed that developing the skills of people to work together was an important part of the educational process and that there was a need for team building in PCGs; in most instances, however, group away-days had been focused on specific topics, rather than board development.

Although there was clearly a long way to go, isolated education and training initiatives had been popular and successful where they were offered. These included learning sets, opportunities for experiential learning, placements for those in public health and primary care, and multi-disciplinary workshops for wider audiences.

Discussion at the symposium underlined the importance of making a significant shift from primary care seeing itself (and being seen) as concerned with "sickness" and reorienting itself towards a greater emphasis on "health". The problems of potential demarcation disputes between NHS and other workers was recognised, and the need for changed attitudes and flexibility was seen as important within and beyond the NHS and primary care.

Next steps

There are many issues and questions that require continuing debate and new approaches. Some of the questions that were debated in the symposium, and are likely to generate continuing discussion include:

- How can those in primary care develop a better understanding of public health, and how can those working in public health develop a better understanding of primary care?
- Ideally, should all members of the PHCT be involved in public health in some way? If so, how could that be facilitated? And if not, how could primary care be organised in order to allow *de facto* specialisation in public health for some of those working within PHCTs?
- How can effective partnerships between professionals in primary care and in public health and other sectors be most easily established and maintained? What are some of the barriers to this and how can they best be surmounted?
- How effective are PCGs at present in addressing the broad public health agenda? What would enable those PCGs who are less involved with public health to become more involved?

- Do the new NHS structures give adequate opportunities to promote public health by utilising the expertise and experience of primary care practitioners as individuals and of PCGs as (ultimately) free-standing bodies?
- What kind of role could - and should - the PHCT play in addressing the non-health care determinants of personal health?
- What should be prioritised in devising and implementing public health programmes in primary care?
- Does primary care have a role in facilitating community development?
- How can local people, their community organisations and their elected representatives engage in improving health and reducing inequalities?
- Are there ethical issues in relation to primary care and public health? Where might there be conflicts between "primary care" and "public health" values?
- What is the current evidence on the effectiveness of public health activities in primary care?
- What are the priorities for future research into the role of primary care in public health?
- What are the key messages on primary care and public health that need to be heard by the Department of Health, other government departments and politicians?

It is hoped that this paper will help to encourage debate and inter-sectoral co-operation to address these questions.

References

Arora S, Thompson S and Davies. A. *Developing Health Improvement Programmes - lessons from the first year.* King's Fund. 1999.

Billingham, Kate (1997) The new public health nurse's perspective in primary care. *Primary Care*, 7 (6), pp. 8-9.

Bradley, Terry and McKnight, Agnes (1997) The educational needs of GPs for health promotion in primary care. *International Journal of Health Education*, 35 (4), pp. 126-128.

Colin-Thomé, David (1999) Primary care perspectives. In Griffiths, Siân and Hunter, David (eds) *Perspectives in public health*, Radcliffe Medical Press, Oxford, pp. 179-189.

Daykin, Norma and Naidoo, Jennie (1997) Poverty and health promotion in primary health care: professionals' perspectives. *Health and Social Care in the Community*, 5 (5), pp. 309-317.

Doyle, Yvonne and Thomas, Paul (1996) Promoting health through primary care: challenges in taking a strategic approach. *Health Education Journal*, 55 (3), pp. 3-10.

Freeman R et al. (1997) Community Development and involvement in primary care.. King's Fund.

Gillam S and Miller R (1997) Community Oriented Primary Care - a public health
experiment in primary care. King's Fund.

Gillam, Stephen, Joffe, Michael, Miller, Rachel, Gray, Alastair, Epstein, Leon, Plamping, Diane (1998) Community-oriented primary care – old wine in new bottles. *Journal of Interprofessional Care*, 12 (1), pp. 53-61.

Gordon, Pat (1995) Core values. *Health Service Journal*. 23 March 1995, pp. 24-25.

Gould, Elizabeth (1998) All for one, and one for all. *Nursing Times*, 94 (1), pp. 32-33.

Graffy, Jonathan Jacobson, Bobbie (1995) General practitioners and public health doctors: sharing common goals? *British Journal of General Practice*, 45, pp. 640-642.

Hirst, Tony (1997) Local health needs assessment for general practice patient populations. *Practice Nurse*, 14 (9), pp. 566-568.

Jordan, Joanne, Wright, John, Wilkinson, John, Williams, Rhys (1998) Assessing local health needs in primary care: understanding and experience in three English districts. *Quality in Health Care*, 7 (2), pp. 83-89.

Kilduff, A. McKeown, K. and Crowther, A. (1998) Health needs assessment in primary care: the evolution of a practical public health approach. *Public Health*, 112 (3), pp. 175-181.

Meads, Geoff Killoran, Amanda Ashcroft, John and Cornish, Yvonne (1999) *Mixing oil and water: how can primary care organisations improve health as well as deliver effective health care?* Health Education Authority, London.

Mumford, Peter (1997) Choices for GPs: lessons from a development programme. *British Journal of Health Care Management*, 3 (8), pp. 429-431.

NHS Executive (1998*) An organisational development resource for Primary Care Groups*, NHS Executive, October 1998; 6.

Peckham, Stephen Taylor, Pat and Turton, Pat (1998) An unhealthy focus on illness. *Health Matters*, 33, pp. 8-10.

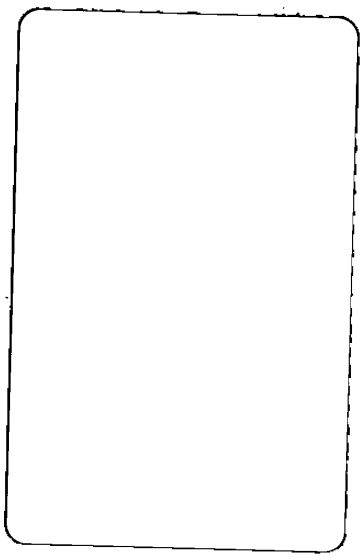
Robson, J. (1995) GPs, patients, and the distance between them. *BMJ*, 310, p. 73.

Rowe, Ann (1998) Profiling in primary care – making it possible. *British Journal of Health Care* Management, 4 (3), pp. 140-143.

Ruta, D.A. Duffy, M.C. Farquarson, A. Young, A.M. Gilmour, F.B. and McElduff, S.P. (1997) Determining priorities for change in primary care: the value of practice-based needs assessment. *British Journal of General Practice*, 47, pp. 353-357.

Smith, Judith, Regen, Emma, Shapiro, Jonathan (1999) Lending a hand. *Health Service Journal*, 27 May 99, pp. 24-26.

Taylor, Pat Peckham, Stephen and Turton, Pat (1998) *A public health model of primary care – from concept to reality.* Public Health Alliance, Birmingham.



From the Public Health Programme at the King's Fund, 11-13 Cavendish Square, London W1M 0AN; Tel: 0171 307 2672.