

From reactive to proactive:  
how to move from managing sick individuals  
to creating healthy communities

Luke Allen

Eleanor Barry

Claire Gilbert

Rory Honney

Eleanor Turner-Moss

BJGP Debate & Analysis

1,286 words, 12 references

## Shifting focus from sickness to health

The NHS is one of the most valued institutions in the UK<sup>1</sup> but there are concerns around its sustainability. Originally created to keep communities healthy and treat disease, the contemporary system is heavily biased towards managing illness in secondary care. The Wanless report<sup>2</sup> and the Five Year Forward View<sup>3</sup> have argued for a reorientation towards greater investment in community-oriented prevention to maximise long term health gains.

Community-level prevention involves addressing the social determinants of health which include housing, education, employment, and the food environment.<sup>4</sup> These non-medical 'causes of the causes' account for up to 90% of health outcomes<sup>5</sup> and GPs see them at work in their patients' everyday lives.<sup>6</sup> Despite the fact that individual lifestyle choices are heavily constrained by deeper socioeconomic conditions, the dominant political health narrative emphasises individual-level 'healthy choices' above societal change.

Less than 5% of the health budget is spent on population-oriented prevention and health promotion<sup>7</sup> and the 2012 Health and Social Care Act left overstretched public health teams with the responsibility to address social determinants.<sup>8</sup> At the community level, factors like fast food outlets, cheap alcohol, dangerous traffic, air pollution, and the lack of affordable fruit and vegetables drive up the prevalence of chronic disease and multimorbidity. Left unchecked, these factors increase consultations, costs, and complexity for local GPs. General practice currently holds responsibility and financial risk for the health of listed populations, but doesn't have the means to address the 'upstream' non-biomedical factors that drive health outcomes.

## An expanded role for general practice

Whilst Britain's demography, lifestyles, and burden of disease has evolved over recent decades, the basic formula of general practice remains unchanged. GPs reactively consult the subset of their listed population that has the means and motivation to seek care; managing problems after they have manifested in their patients' lives.

We envisage a near future where practices collaborate to share data and work alongside public health teams, patients, and local organisations to proactively engage with communities to make them more health-promoting places to grow, learn, work, and age. GPs would identify modifiable

determinants and support the development, implementation and evaluation of interventions to address them. GPs have a unique patient- and community-centred perspective; a crucial voice in balancing individual and population best interests within a challenged system. As with safeguarding, each GP hub might have a named practitioner who leads population health work. Unlike other non-clinical roles (research, management, teaching etc), population-level prevention should directly reduce demand, albeit with a built-in time lag.

We are the first to admit there is currently no slack in the system, and no appetite for more service redesign or additional responsibilities. However, we are also keenly aware that business-as-usual is unsustainable. GPs are well positioned to identify social factors that cause illness in our patients, but underuse functions to relay this information to public health teams, and currently have no time, staff, resources, or training to do it themselves. We are encouraged by elements of the Sustainability and Transformation Plan (STP) structures in development which, if properly funded, could support some of the aspirations we have for prevention-orientated primary care.

### How do we get there?

To work effectively in population health roles, GPs need basic public health knowledge and skills, as well as training in advocacy, persuasion, community organising, policy, and local politics. This content should be delivered at medical school, GP vocational training sessions (jointly with public health registrars), and as continuing professional development.

System incentives to encourage engagement with population working include time, money, resources, support staff, and recognition. At an organisational level there need to be shared information systems, databases, work-plans, objectives, and governance structures between public health and primary care. Shared responsibility for health outcomes, risk, and finances would also engender deeper integration around keeping people well. Standardised working relationships between GP practices (or networks of practices) and public health link workers would help to nurture local cross-organisational communication, as would introducing a named GP lead for population health.

As the government pushes working at scale in hubs and clinical networks with responsibility for the care and services of 30,000-50,000 patients, opportunities are emerging for GPs to use their

experience to work with public health teams, clinical commissioning groups and local authorities to develop community prevention strategies.

The introduction of the Quality and Outcomes Framework and enhanced services contracts have made screening, immunisations, and primary prevention a routine part of general practice. Whilst primary care is very successful at preventing disease in individuals, there has been less emphasis on addressing common drivers of illness at the local population level. The review of the Quality and Outcomes Framework allows an opportunity for greater community focus.

To support prevention-oriented working NHS England, Clinical Commissioning Groups need to adopt longer-term funding horizons and work plans and move to commissioning outcomes rather than activity. The benefits of reducing childhood obesity take longer than 3-5 years to manifest.

There is room to experiment with paying GPs to engage with existing platforms for joint working: Health and Wellbeing Boards, Joint Strategic Needs Assessments, and Better Care Fund activity. There is also scope for greater GP representation in Joint Strategic Needs Assessments, strategy development, and policy evaluation. The introduction of local workshops where GPs and public health teams can scope out possible interventions for local problems would further support integrated working around community-level prevention.

Engagement with external agencies is also required for the development of health creating societies.<sup>9</sup> This may involve collaborating with local businesses, councillors, local authorities, community groups, and patients to work on issues that influence health.

Leaving the consultation room is a radical departure from traditional general practice but community engagement and population working are fundamental elements of national and international blueprints for primary care.<sup>3,10,11</sup> More guidance for localities and GP clusters would help to support the transition from rhetoric to reality.

## Barriers to this vision

Whilst effective community-level prevention could conceivably reduce demand and costs, the initial investments and time-lag represent high barriers to entry, especially in the current climate. Any

gains will accrue to patients, GP surgeries, acute trusts, Clinical Commissioning Groups (CCGs), and the wider local economy, however costs of addressing social determinants are mainly borne by councils and local businesses. This disconnect impedes action. Close collaboration between GPs and local public health teams is central to the population health approach but these relationships have fractured over recent years.<sup>12</sup>

CCGs are increasingly signalling a desire to invest more in prevention, however they continue to focus on individual-level interventions (such as NHS Diabetes Prevention Programme and weight management programmes) which largely ignore the social determinants of health. Within CCGs, national policy directives and secondary care spending tend to dominate the spending agenda and there is relatively little flexibility in budgets to fund initiatives in local population working.

### Mission improbable

Preventing illness and keeping people well is good for patients, good for health workers, and good for national finances. Even though schooling, workplaces, cycle lanes, trees, and the price of chips have nothing to do with medicine, these social determinants have a much larger bearing on local health outcomes than diabetes management or antihypertensives. GPs are well placed to advocate for improving health outcomes of local populations by using their data and insight to identify social drivers of disease. With training, incentives, and support from public health teams, a reformed primary care sector stands to deliver real improvements by looking beyond biomedicine to influence the structures of society. As Virchow said 'politics is nothing but medicine on a large scale'.

Change on this scale may sound improbable, requiring huge investment, training, yet more system reform, and the concerted actions of politicians, commissioners, and practitioners. Nevertheless, we represent a new generation of population-minded doctors who are committed to making this form of general practice work, for the good of our patients, the NHS, and our profession.

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