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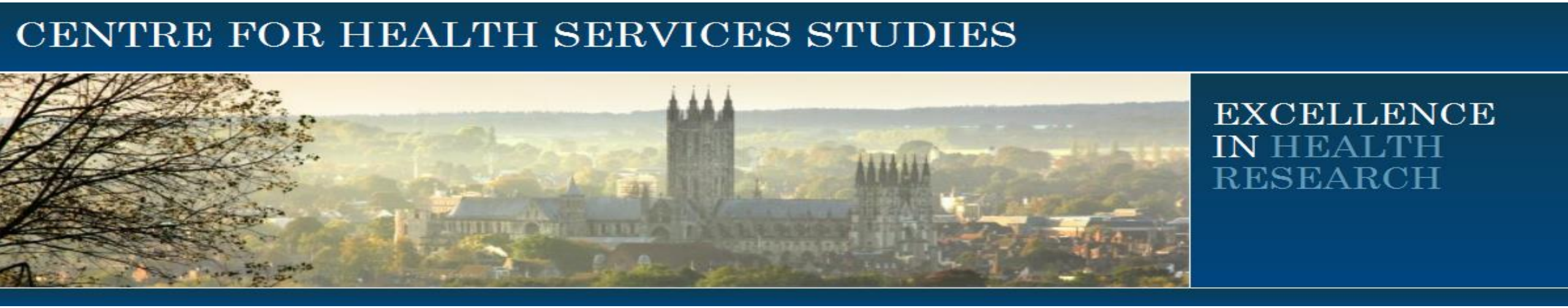
Delivering disease prevention and health promotion in primary health care

Professor Stephen Peckham



Evidence review and Synthesis

- Aim: to identify the current extent of knowledge about the health improvement activities in general practice and the wider primary health care team.
- The objectives were:
  - To map the range and type of health improvement activity undertaken by general practice
  - To scope the literature on health improvement in general practice or undertaken by healthcare staff based in general practice and identify gaps in the evidence base.
  - To synthesise the literature and identify effective approaches to the delivery and organisation of health improvement interventions
  - To identify the priority areas for research

Methods

- Combined primary care and public health terms
- Restricted to UK general practice – but key international papers were discussed where relevant
- Review date 2014
- Staged selection process involving reviews of titles and abstracts:
- This resulted in the identification of 1,140 papers for data extraction with:
  - 658 of these papers selected for inclusion in the review, of which
  - 347 were included in the evidence synthesis
- We also undertook 45 individual and two group interviews with primary healthcare staff

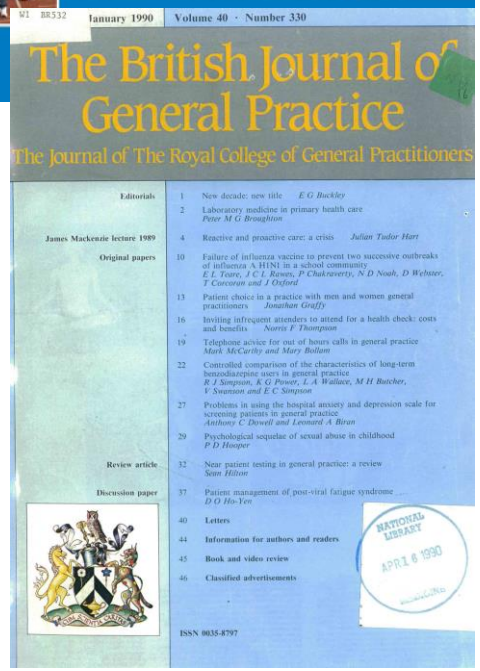
Methods: “Real world” and literature definitions

- 20 local public health reports
  - 2 from each regional health
  - Authority area
  - One “rural”, one “urban”

- Searched for “GP”, “general practice”, “primary care”,

skimmed the reports.

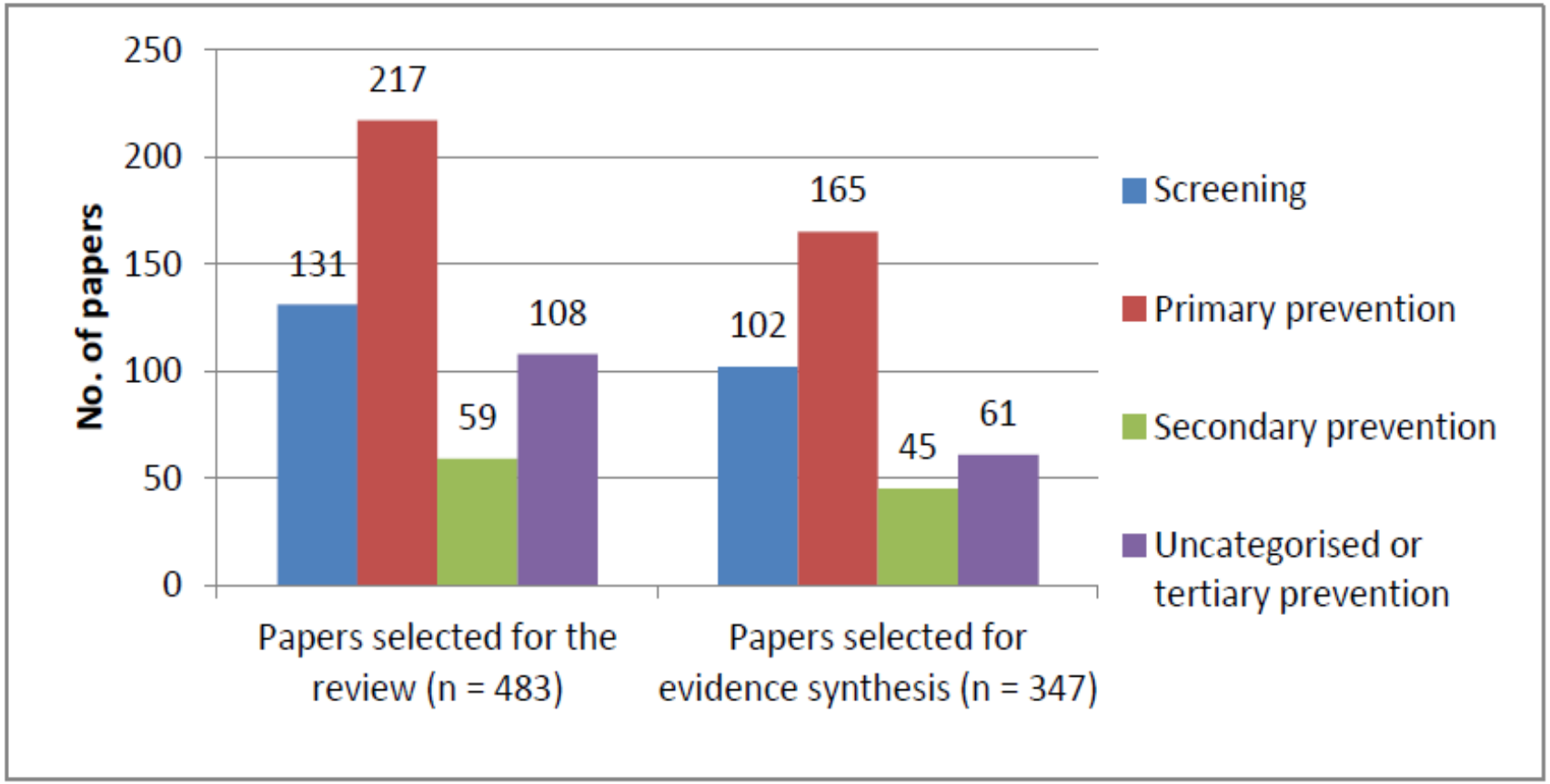
- Made note of diseases discussed in reference to GPs, and well as particular activities mentioned.



- Hand searched 3 journals
  - British Journal of General Practice
  - Health Promotion International
  - Journal of Public Health

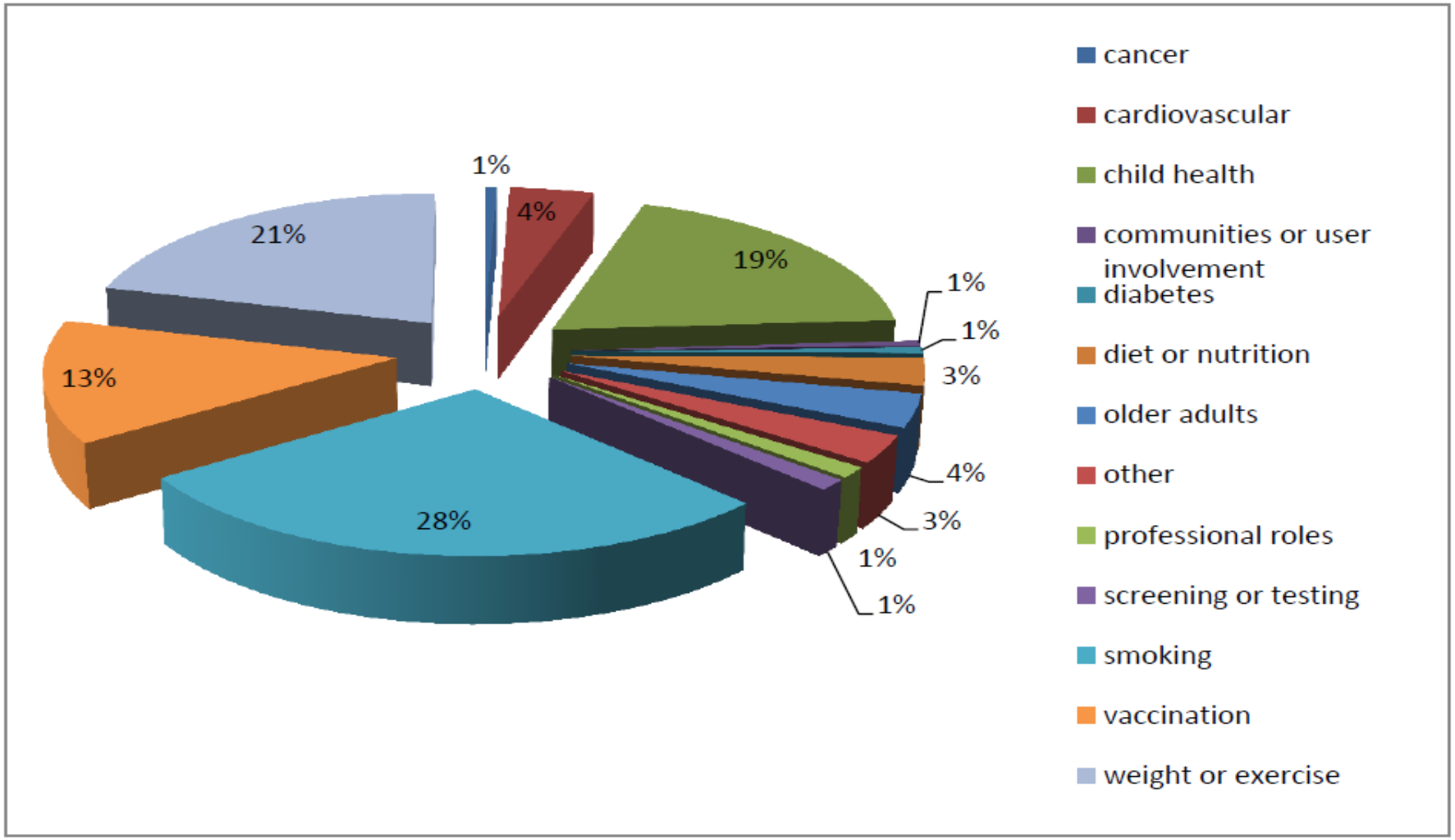
- 1990-2010 (based on 1990 GP contract)
- Checked keywords of the relevant articles.

Distribution of topics in selected papers for review and for synthesis

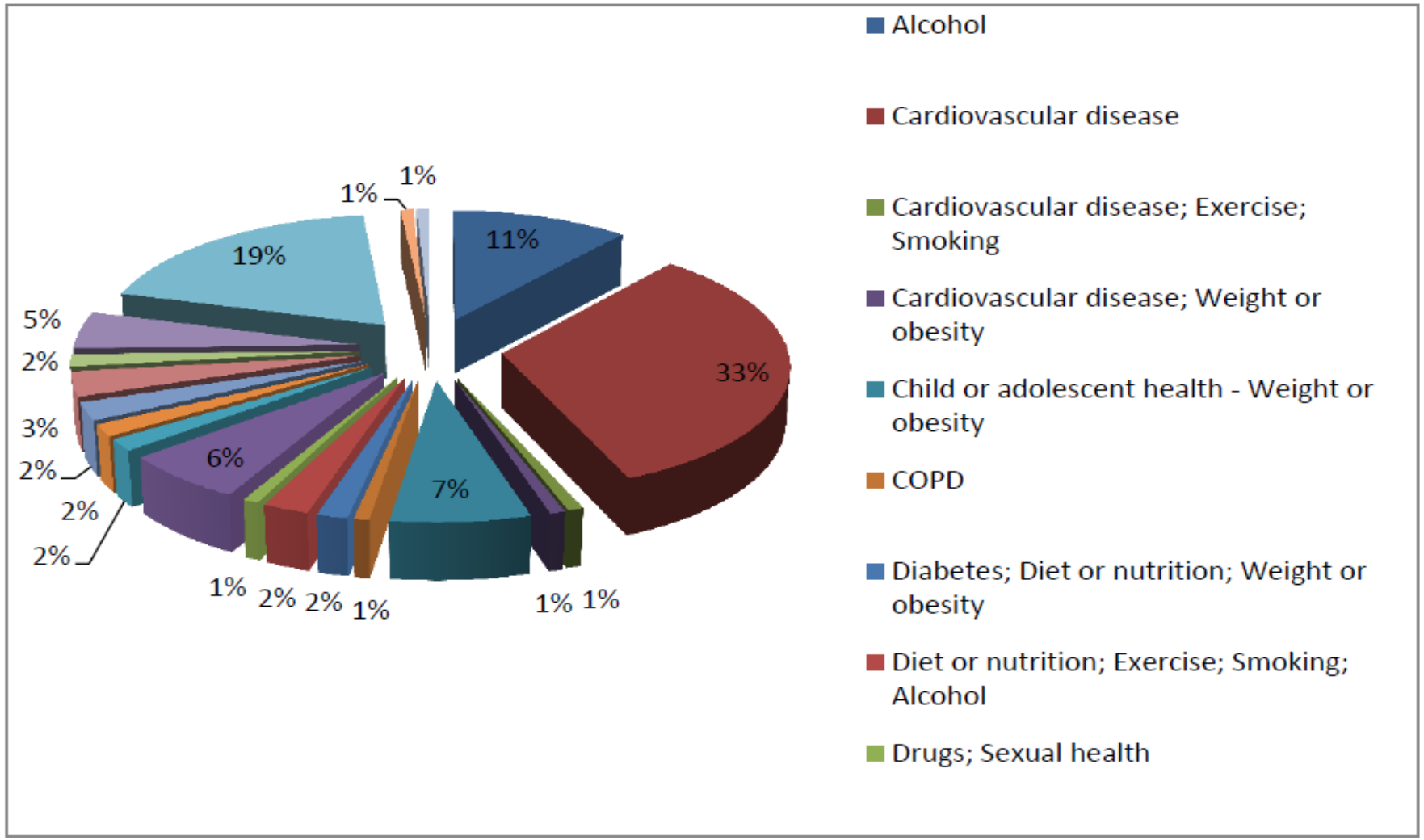


Some overlap between papers that discussed more than one category: ie primary and secondary prevention

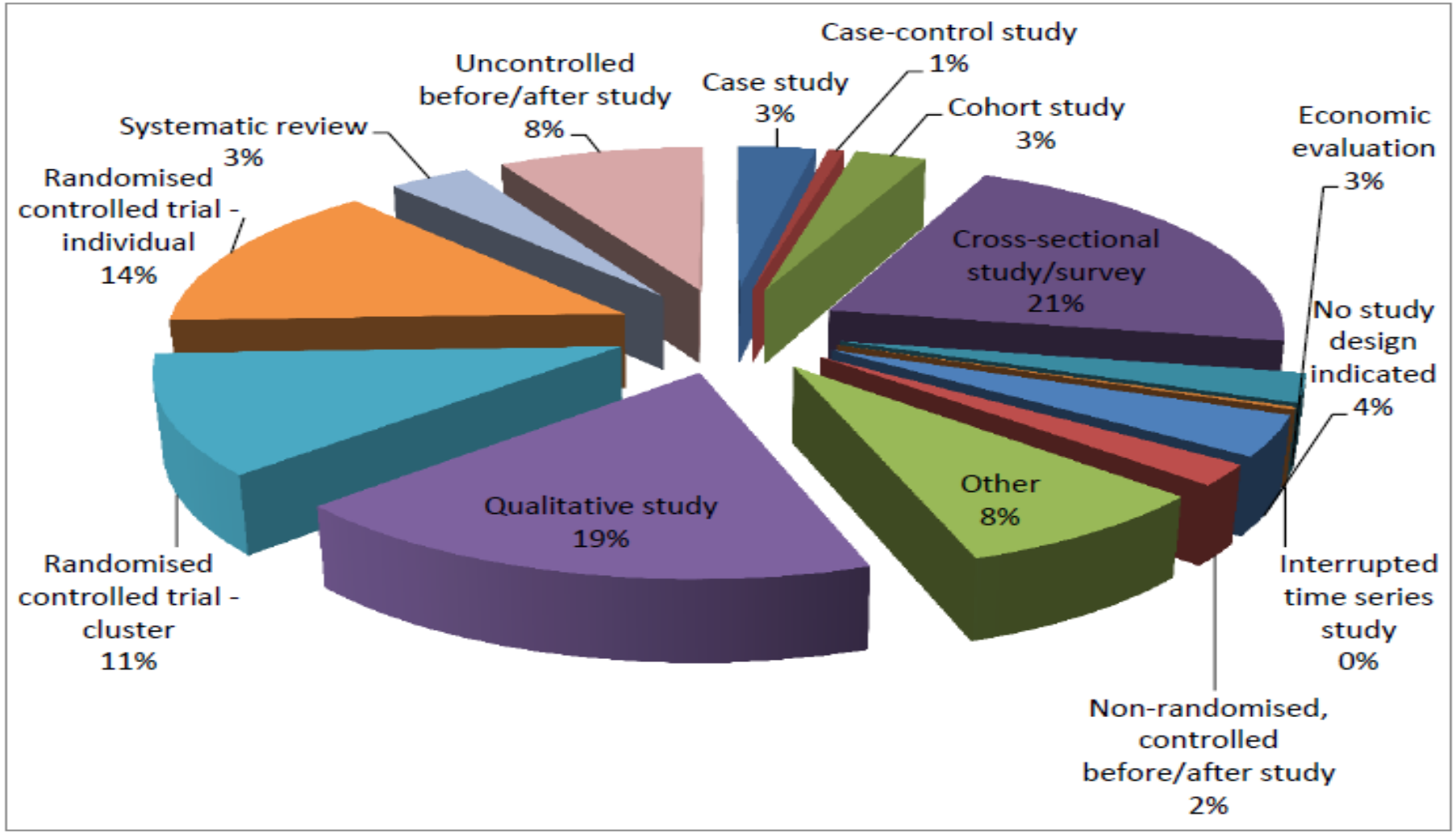
Distribution of topics of papers classified as primary prevention



Overview of secondary prevention paper topics



Distribution of study designs



Incentivising public health in primary care by financial payment

- Europe wide survey of GPs: lack of reimbursement is a key reason for not engaging in health promotion activities

  (Brotons C, Bjorkelund C, Bulc M, Ciurana R, Godycki-Cwirko M, Jurgova E et al. Prevention and health promotion in clinical practice: the views of general practitioners in Europe. *Prev Med* 2005; 40(5): 595-601)

- In the UK two approaches introduced:
  - Physician payments for activity
    - Task orientated payments (1987)
    - Good evidence of behaviour change
  - Organisational payments for health promotion activities (2004 - QOF)
- P4P:
  - Little evidence that health outcomes are improved by P4P
  - Can help improve recording for disease registers
  - Weak correlation between P4P and reduction in emergency hospital admissions for selected clinical conditions

Main findings

- Currently there is insufficient evidence to strongly support many of the health improvement interventions undertaken in general practice and primary care more widely.
- There are some interventions that provide population health improvements – brief interventions for stopping smoking being a good example.
- There is also some evidence to support specific interventions being undertaken with some patient groups and in some locations.
- Further research is needed to strengthen these areas to provide more supportive and clear evidence.
- There is an urgent need to undertake better quality and more relevant research studies that examine the way interventions are delivered and organised to support continuing developments in health promotion and prevention being prioritised in policy and practice.

Gaps in the Evidence Base

- There is an absence of research and a lack of evidence for effectiveness (obesity/exercise promotion) from existing research.
- much literature has a medico centric focus and does not examine broader supportive roles or non-medical interventions.
- few studies examine professional roles
- There is a lack of research examining the costs/benefits in terms of health outcomes of primary and secondary preventive interventions
- There is insufficient evidence that compares different ways of organising and delivering health improvement in general practice and primary care.
- More research is required that examines contextual issues relating to the patient and to local environment and socio-demographic factors.

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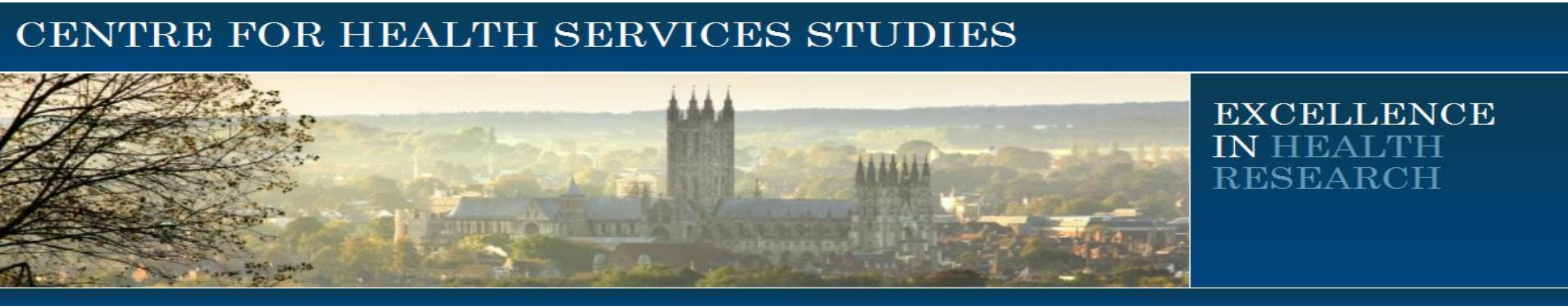
Implementing public health in primary health care in the UK



Changing organisational models for PHC in UK

- 7,527 practices in England:
  - Average 7,645 patients per practice
- Contract model: mix of capitation, fee for service, performance payments and targeted funding
  - General Medical Services (69.4%)
    mainly traditional partnership model
  - Alternative Personal Medical Services (2.1%) + 0.9% limited company
    for private contracts (eg Virgin health Care)
  - Personal Medical Services (27.4%) + 0.1%limited company
    enhanced medical services contract to extend practice services (from mid 1990s)
- 68% of practices belong to a practice federation
- New models of care integrated care and primary care “at scale”
- All practices belong to Clinical Commissioning Groups (health care purchasers)

Primary medical care and public health in the UK

- Health improvement and the prevention of ill health increasingly seen as a key element of primary care:
  - Alma Ata declaration 1978 and The World Health Report 2008 - Primary Health Care (Now More Than Ever)
- Policy makers placing more emphasis on health improvement as an approach to addressing chronic diseases
  - 1987 – payments introduced for health promotion activities
  - 2004 – Some public health activities including in national primary care pay for performance scheme (QOF)
  - Public Health White Paper 2010 “Healthy Lives, Healthy People”
- Professional bodies increasingly supporting health improvement as a core element of primary care physician practice
- Primary care not significantly seen as key in Marmot review
- Prevention and primary care role now central to developing new care models in UK

Current policies and issues in England

- National policy tends to focus on key clinical issues and interventions supported by incentives have tended to focus on individuals (eg QOF) resulting in a skewing of activity and consideration needs to be given to supporting alternative incentive structures
- Policy tends to focus on the narrow clinical roles
- Time and resource pressures constrain GPs' ability to address health improvement with their patients
- Expansion of practice team driven by QOF payments – practice nurses and healthcare assistants becoming more involved in health promotion and health monitoring
- Future shortage of nurses and GPs
- Shift of public health from NHS to local government has distanced public health professions from general practice

Current government/political party responses

- Generally limited:
  - Focus on staff numbers rather than roles
  - Focus on clinical service delivery
  - Limited commitments to increasing primary care budget
- Focus on integrated care and calls for more prevention activity but no formulated specific proposals
- Some reference to early detection, more prevention in primary care
- Less emphasis on paying for performance – potential withdrawal of the Quality and Outcomes Framework scheme
- Emphasis on social prescribing - but often seen as a demand management approach

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- Team members:

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- HS&DR - The contribution of general practice to health improvement: synthesis review and a scoping study

  http://www.nets.nihr.ac.uk/projects/hsdr/09100152
- The views and opinions expressed therein are those of the authors and do not necessarily reflect those of the HS&DR programme, NIHR, NHS or the Department of Health.

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