Original Scientific Paper

Perspectives on the delivery of population health services in primary care

Tom Love DPH BA is a lecturer, Deborah McLeod PhD DPH the research manager, and Helen Moriarty MGP MRNZCGP FAChAM a senior lecturer in the Department of General Practice at the Wellington School of Medicine and Health Science. They presented a version of this paper at the Health Services Research and Policy Conference held in Wellington in December 2001

ABSTRACT

While improved integration between the public health and primary care sectors has been a consistent aim of health policy makers for many years, there remain important barriers to achieving this goal. One significant barrier has been lack of understanding on either side of the public health/primary care divide of the practical imperatives to which practitioners must respond: primary care practitioners may not perceive the public health value of their resources and activities, while public health practitioners may not understand the challenges of collecting or reporting data or implementing programmes in a primary care setting. We explore these issues using examples drawn from ethnicity recording and immunisation initiatives, and show that the difference in perspectives can have concrete consequences.

Key words

Primary care, public health, immunisation, ethnicity

(NZFP 2002; 29:318–321)

Background

Population oriented primary health care is a common theme in the current debate about the direction of New Zealand's health system overall, and primary care in particular.[1,2] Although the integration of public health and primary care services is not a new theme in health policy, it has been expressed more vigorously in recent times.[3,4] However stronger expressions of interest in aligning primary care and public health services are not often matched by discussions about practical advances in this area. In this article we argue that one of the barriers which exists between the two fields is the disciplinary focus of practitioners on either side of the public health/primary care divide, and that this difference in perspectives has practical consequences for the effectiveness of both public health and primary care policies.

The health reforms of the 1990s did not have an explicit focus upon integration between public health and primary care. The founding document of those reforms was primarily concerned with structural and financing issues in the health sector rather than service integration, and makes no mention of the public health primary care interface.[5] However the more flexible funding mechanisms heralded by those reforms did, in the event, allow for primary care and public health to be considered in a more integrated fashion. For example, the government's Policy Guidelines for Regional Health Authorities (RHAs) in 1994/5 instructed RHAs to improve coordination between population health and personal health services,[6] while the Central Regional Health Authority's Purchasing Directions document for the same year refers to reforming primary care to give greater emphasis to illness prevention.[7] More recently the National Health Committee's report on primary care explicitly articulates a role for primary care in comparing the health of different population groups, keep-

ing track of individuals for regular preventive care and working with communities to target priority health problems.[4]

The current government's Primary Health Care Strategy places a strong emphasis upon the public health role of primary care services, directing new primary health organisations to play an active role in population health initiatives, to share information with public health services, to draw upon public health expertise and to use a population perspective when planning and delivering services.[3]

Some primary care organisations and individual practitioners have taken great strides in adopting public health ideas to inform and improve their services. For example, smoking cessation programmes and advice are frequently provided by general practitioners,[8] while health providers increasingly combine public and personal health services within a single organisation.[9] However there remain important areas in which the disciplines of primary care and public health do not work effectively together, for example in implementing national screening programmes and collecting information for population management. Even immunisation, a fundamental area of public health delivery in primary care, does not generally achieve very high population coverage in New Zealand.[10]

The public health and primary care world views

Public health, as the name suggests, focuses on the population perspective. The delivery of population health is based on data compiled from sources such as epidemiological studies that use population based measures, for example odds ratios and relative risks. In contrast, the personal health care practitioner is concerned about the individual patient who presents to them. There can be difficulty applying results of randomised controlled trials and population based studies to an individual case. This is illustrated in a comment from a general practitioner:[11]

'*...it is the relationship between you and your patient, and you come to a decision because you are treating an individual, ...[not] population based, group based, which is very different from individual based.*'

If population health initiatives are to be delivered successfully in primary care, then they need to be supported by well grounded research and information. Such research in turn requires an infrastructure so that population level data can be collected, for example to identify health care utilisation by different population groups across geographic areas. In the past decade primary care has developed an infrastructure which could be used to collect this sort of information. However, population focussed and individual focussed practitioners have different views about the use of information. These different approaches can influence the use of data and the way in which it is collected and recorded at the source.

Effective data collection in primary care must be linked to the way in which the data will be used

The collection of ethnicity information in general practice demonstrates the practical consequence of different public health and primary care views about information. Effective data collection in primary care must be linked to the way in which the data will be used, and ideally should reflect an outcome relevant to the practitioner. For example, while knowing a patient's ethnicity may have an impact upon care of that individual, collection of the entire practice ethnicity data is not important in delivery of care at a personal level. In providing care to an individual patient, ethnicity data does not need to be either collected or recorded consistently – a comment in the patient's notes is sufficient. On the other hand, if ethnicity data is to be used in planning population health care, the data must be collected consistently and must be able to be extracted from the practice management systems.

The following comments illustrate the different viewpoints surrounding ethnicity data collection.[12] The first from a Maori health researcher illustrates population health reasons for collecting ethnicity data:

'*The Crown has a constitutional obligation to meet Treaty obligations for Maori. This requires the monitoring of social indices making a Maori/non-Maori distinction to ensure that Treaty obligations are being met.*' – Maori Health Researcher.

The second quote from a policymaker reveals an expectation and assumption that general practice will accept the responsibility to collect the data:

'*It's up to the GPs. Now there is so much that governments can do but it actually requires some sort of collective responsibility to make a difference. And I hope GPs will be part of that, and perceive it as part of their social responsibilities.*' – Policymaker.

The final two quotes, one from a general practitioner and one from a practice manager, demonstrate that while general practice is in a position to collect ethnicity data, the data is not necessarily seen as useful at the service delivery level. Additional commitments of time and resource are needed to provide the data for use in population health planning.

'*There are no benefits [from collecting ethnicity data], I honestly don't think we should.*' – Practice Manager. '*Yes, general practice is in a good position to collect this data. It's our responsibility and we'd do it well.*' – GP.

While data collected in primary care can be used in population health, for this to be successful the primary care sector must understand the way in which the data could be used to analyse populations. Equally, health

policymakers must understand the issues for primary care in collecting the data. When public health and primary care practitioners do not understand the perspectives of each others' disciplines they are unlikely to be able to convince each other of the importance of their separate agendas.

The case of childhood immunisation

Childhood immunisation is an important population health initiative implemented in a primary care setting. There is a good public health rationale to change and update childhood immunisation schedules as new knowledge and vaccines become available. As a consequence there have been 19 changes to the childhood immunisation schedule since its introduction 40 years ago. The changes have all been for good reasons: new formulations of vaccination (for example oral vs injectable, yeast-based vs human plasma based, combination preparations), and changes in optimal timing, both in response to the increasing availability of vaccine combinations and to changing patterns of disease epidemics.[13]

However, the rate of change of schedule revisions has accelerated over the decades, and the schedules have also become increasingly complex, covering more and more disease entities. Each change carries with it the risk of a missed cohort of eligible patients who may not obtain the correct number or nature of immunisations for the current regime. For example, tetanus vaccine had been administered at 15 years of age, but in 1996 was brought forward to 11 years. A 4-year cohort of young people who were not age 15 but over 11 years of age at the change in the schedule are now at risk of incomplete immunisation coverage. It falls upon health service providers and parents to remember collectively that these children need a catch-up immunisation.

Primary care faces significant challenges in implementing such frequent change. Catch-up regimes create particular implementation problems. Until recently there have been no financial incentives to close the gap between optimal and actual immunisation cover for individuals. In fact there have been financial disincentives to the individual patients, the practices and practitioners that in the longer term represent costs to public health.[14]

Frequent schedule revisions cause confusion, not only for parents and providers but also for health officials. A poster issued by the Ministry of Health in November 2000 about the intended changes for February 2001 was withdrawn at the end of January. It contained an error in the printed immunisation schedule table, and some people had found the message on the posters to be confusing or misleading.[15] To compound these problems, performance indicators based upon percentages of the practice population that are immunised don't always support the desired response from health providers. The denominators for the practice population, those eligible and those families 'willing' to immunise children form shifting ground which can change as much as the absolute number of immunised. Unfortunately the hard to reach for immunisation are also at the greatest risk for vaccine-preventable diseases.

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The disconnection between the valid public health rationale for updating the childhood immunisation schedule and the challenge of implementing such updates within primary care is an important demonstration of the concrete consequence of different world views in public health and primary care. Lack of understanding about the primary care issues involved in the implementation of this public health service contribute to an immunisation system which, in the end, is less effective than it could be.

Key Points

- Expressions of interest in aligning primary care and public health services are not often matched by discussions about practical advances in this area.
- There remain important areas in which the disciplines of primary care and public health do not work effectively together.
- When public health and primary care practitioners do not understand the perspectives of each others' disciplines they are unlikely to be able to convince each other of the importance of their separate agendas.
- The clash of world views between primary care and public health represents an important challenge to better integration between the two fields.
- Unfortunately the hard to reach for immunisation are also at the greatest risk for vaccine-preventable diseases.

Promising signs

There is certainly not cause for despondency about the integration of public health and primary care in New Zealand. There are many effective initiatives which work across the two fields. Indeed, there are examples of immunisation programmes which have achieved very good results. The National Health Committee has reviewed a number of programmes aimed at the immunisation of hard to reach populations. One of the most effective programmes provides a particularly good example of a public health programme provided within a primary health care framework.

Porirua is an area of high health need. However it has a particularly high immunisation rate by New Zea-

land standards. This has been achieved by employing immunisation coordinators with strong links to local primary health care providers. The local knowledge of the coordinators and the strong support which they receive from local general practices are important factors in the success of this service.[16] The roles of the coordinators include:

- Working with practice nurses and other child health carers directly in providing immunisation to children, and following up individual families where appropriate.
- Coordinating audits of immunisation coverage across the whole of the geographic area.
- Helping other providers of immunisation with quality improvement activities, such as monitoring the cold chain.
- Maintaining communication between public health and personal health providers with interests in immunisation.
- Organising and contributing to immunisation training programmes.

This service represents a public health programme which is strongly founded in local primary care services. It makes effective use of existing primary care infrastructure such as practice registers and recall systems, but it does not duplicate them for public health purposes. This may seem to be a simple and obvious approach to the problem, but it is all too often lost in the enthusiasm to set up new public health programmes. If these approaches can work for immunisation they also have the potential to work for other population health services, such as cervical and mammography screening.

The clash of world views between primary care and public health represents an important challenge to better integration between the two fields

Conclusions

In a somewhat different context CP Snow famously argued that a clash of two cultures could cause at best ineffective and at worst dangerously misguided policies.[17] Aspects of his concern apply to the fields of public health and primary care: the clash of world views between primary care and public health represents an important challenge to better integration between the two fields. As a consequence each party is sometimes poorly informed about the imperatives and objectives of the other. Effective utilisation of New Zealand's primary care infrastructure will result in public health gains, but first a better working understanding on both sides of the primary care/public health divide is required.

If the promise of the Primary Health Care Strategy is to be fulfilled, both public health and primary care practitioners will need to take care to understand their sometimes opposing points of view, and to ensure that they can reach effective compromises to achieve their ultimately shared goal of improved health for New Zealanders.

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