TALKING ABOUT 'PUBLIC HEALTH'

An exploration of the public health roles of primary care practitioners in England

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ABSTRACT

The British Government, since 1997, have placed a strong emphasis on public health and the reduction of health inequalities. Alongside this, they have progressed a major reform of the NHS which aims to 'shift the balance of power' to the frontline. Primary care is an increasingly important aspect of the Government's new agenda, which aims to improve health for everyone, and for the worst off in particular.

This thesis identifies general practice, and the core practitioners that work within it, as key potential contributors to a public health agenda. But 'public health' is a conceptually contested terrain, and as a concept, can be understood and interpreted in a myriad of ways. The impact of this lack of shared understanding is explored both for policy making and implementation, and for the development of public health practice in primary care.

This research brings together public health and primary care literatures in order to illuminate the historical and organisational contexts within which current developments are taking place. It critically analyses the public health discourse of New Labour policy documents in order to explore the ways in which 'public health' is understood and talked about within recent government policy, and the government's expectations of primary care practitioners, in terms of their public health roles. Finally, the research draws on case study material from one (pre-2002) health authority area in England to examine practitioners' understandings of public health, and their perceptions of their public health roles. Using Wenger's (1998a) social theory of learning as a framework, it looks at the organisational and wider contexts in which practitioners work, and explores how varied and unclear understandings of public health, both in policy and practice, might be affecting practitioners' engagement with public health.

The study highlights the dangers of vagueness surrounding the term public health, and finds a tendency both in policy and practice to regard it as a set of activities, rather than as an approach to work. Its malleability means that it can be interpreted both in a politically acceptable way, and in a way that fits within existing practice. Thus, as a concept, it loses its radical edge and is no longer something that challenges or guides policy and practice. The research finds that the ways in which practitioners interpret public health can contribute to their non-engagement in the public health agenda. This is not helped by conflicts within policy which threaten the development of stronger public health roles within general practices. The thesis concludes by recommending the development of shared understandings of public health, particularly as a value-driven *approach* to work, rather than as a set of activities.

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CHAPTER ONE

INTRODUCTION

This chapter introduces the research by describing the focus of the investigation, its setting, and its context. It describes the rationale for, and the purpose of the study, and outlines its key aims. It also introduces the reader to the structure of the thesis through a brief description of the content of each chapter.

1.1 BACKGROUND

The Labour government in the UK, since 1997, have placed a strong emphasis on public health and the reduction of health inequalities. They have vowed to improve the health of everyone, and of the worst-off in particular. Alongside this, they have progressed a major reform of the NHS which aims to 'shift the balance of power' to the frontline, and to raise the profile of primary care. Whilst New Labour's overall strategy is a national one, political devolution to the four UK territories, and the proposed devolution to the English regions, offers new potential for variation and innovation in policy formation. England, Northern Ireland, Scotland and Wales, while sharing some common themes, have already taken different routes towards the organisation of public health. This thesis, however, chooses to focus on the detail of England's policies.

In England, then, 'primary care' is expected to become increasingly involved in the government's mission to improve the nation's health, and narrow the health gap. The potential for primary care to improve health and reduce inequalities is being developed in three key ways.

- First, policies are being used to re-shape the nature and function of primary care, and the practitioners who work within it. A focus is being placed on improving access, delivering services more efficiently and effectively, and tackling key issues - such as cancer, coronary heart

disease (CHD) and stroke, mental illness, and accidents - through prevention and public health measures.

- Second, organisational rearrangements are facilitating the move to work in new ways, with an emphasis on partnership, local leadership, innovation and flexibility. This organisational overhaul has seen the creation of Primary Care Groups and Trusts (PCG/Ts), and more recently, Strategic Health Authorities (StHAs); and the introduction of other new organisational structures and programmes, including Public Health Observatories, Public Health Networks, Health Action Zones, Healthy Living Centres, PMS (personal medical services) Pilots, and a new contract for General Medical Services.
- Third, public health is gradually becoming more integrated into the training and education of primary care practitioners. There is a proliferation of new multi-disciplinary modules in public health, and much energy is being put into the identification, audit and development of public health skills. However, whilst recent efforts have attempted to clarify standards and skills at public health specialist and practitioner levels, the roles and skills of the larger group of 'grass roots' workers has received less attention (Cowley 2002).

1.2 Focus of the Study

The term primary care, as used above, denotes a level of care, as apart from secondary or tertiary care, for instance. But the term can be interpreted more broadly as a set of activities or processes (discussed further in Chapter 2). Even as a functional sector within the health services, though, primary care is difficult to pin down. It can be seen to encompass a broad range of health and community workers, as well as community groups, patients, their carers, friends and families. Primary care practitioners, then, can include a wide range of disciplines, both within and outside of the NHS.

At the core of the primary care sector in England, though, are general practices (discussed in detail in Chapter 3). Since they are the principal setting for the delivery of primary care in the UK, general practices form the main

focus of this research. This thesis identifies General Practice, and the core practitioners that work within it, as key potential contributors to a public health agenda. Collectively, they have access to a vast majority of the population at various important points in people's lives. 'Liberating the Talents' (DH 2002a:3) explains that general practices

> provide the full spectrum of care from primary prevention through to specialist disease management and palliative care. Primary care services are delivered in the real everyday world where life is lived, where health is shaped and where the majority of care takes place.

They cross the boundaries of sickness and health, home and hospital, birth and death. They are local, accessible, and continue to be trusted by the majority of people.

Together, practitioners in general practice develop an important understanding of their local population and its health needs. This information needs to be utilised in order to make services more sensitive and relevant to local needs. The opportunities to pass health information and advice on to individuals, families and communities, make them important providers of health promotion and education. Since they have become increasingly responsible for the provision of childhood and travel vaccinations, screening services, and the management of chronic disease, practitioners within general practice also have important roles in primary, secondary and tertiary prevention.

Practitioners in general practice also have an opportunity to become more involved in their local community, in working towards identifying and reducing those risks and exposures which influence the health of the local population, and in helping to tackle health inequalities through community development and policy change. They are important advocates not only for individual patients, but also for local communities. They are also in a good position to build partnerships with other agencies locally in order to develop programmes to improve health.

There are two more reasons why general practice is an important focus of this study. Firstly, the historical development of general practice - particularly since

the 1980s, as practices have enlarged, taken on new roles, and adopted different forms (such as the new PMS practices) - has meant that general practices are far from homogeneous organisations. Both their organisational structures and their work practices differ greatly. This diversity, and its impact on the range of practitioners working within those practices, makes for a fascinating context. Secondly, general practice is an increasingly significant organisational unit in primary care. It has been an important focus for government policy since the 1980s, as attempts have been made to regulate, standardise, and target practices through the imposition of new roles, national guidelines, new bodies like the Commission for Healthcare Audit and Inspection (formerly the Commission for Health Improvement), and the National Institute for Clinical Excellence. The importance of analysing general practice as sites of multi-professional team work, with both clinical *and* public health responsibilities, at both individual and population levels, is essentially overlooked.

That practitioners in general practice (as a part of the broader primary care) should have a stronger role within the public health function, then, is clear. However, the huge scope of both the public health and primary care agendas, and the lack of clear definitions, makes the strengthening and integration of them complex and problematic. Despite the heightened interest and clearer policy emphasis, there remains much variation in the type and quality of public health activity engaged in at primary care practice level. Practitioners in general practice remain a largely untapped resource within the public health function. It has been recognised that much activity at this level does not sit within the formal, established professional roles of practitioners, or indeed within the normal rules of the organisation (Taylor et al. 1998, Billingham and Perkins 1997). The Health Development Agency's 'Public Health Skills Audit' (Burke et al. 2001) acknowledged that although expected to develop new public health roles, some nurses recognised a wide range of development needs, seemed marginalised within public health, and reported limited access to opportunities to fill these gaps. There remains little understanding of why public health activity is confined to 'pockets' of good practice and innovation.

The developments within primary care and public health are taking place against a complex historical backdrop which has led to a 'mosaic' of organisational structures, a myriad of accepted (formal and informal) processes, and a confused blurring of practitioners' roles. In order to strengthen the public health function within primary care, there must be a greater comprehension and appreciation of why some practitioners engage in the broader public health agenda, and why some do not. We know of a number of impediments to carrying out public health within primary care practices: practitioners in general practices, on the whole, are struggling with too few staff and too many patients. As the frontline of a 'national sickness service', they have a tough job managing the primary/secondary care interface, treating minor illness and managing chronic illness. Their clinical domain has enlarged as medical, pharmaceutical and technological advances have meant that more and more treatments can be taken on in primary care. When the immediate pressure to cure and to treat is on, then, to what extent can they get involved in public health work?

A number of authors have further suggested that the general practice setting is not conducive to public health work (Meads *et al.* 1999, Cornell 1999, Kilduff *et al.* 1998, Ayres *et al.* 1996). Connelly and Raines (2001), in their report on the role of public health in PCGs, suggest that, within general practice, the medical model is likely to predominate, lack of time is a continuous pressure, and the public health skill base in primary care continues to be under-developed. Moreover, the lack of clarity over the definition of public health and primary care, the breadth of the public health agenda, the tendency for it to be divorced from decision making, and difficulties in achieving equity and promoting meaningful public participation, are some of the perennial problems in developing public health approaches which affect all providers in the NHS (Connelly and Raines 2001).

Yet where public health approaches in primary care work, they can have a profound impact on the health and well-being of local populations. There are numerous examples of good practice, reflecting many important lessons

learned, and demonstrating what can be achieved when people and organisations work together (see HDA 2003, DH 2003a for examples).

Whilst many important changes promise new opportunities and power for primary care practitioners[1] to overcome some of the barriers outlined above, and become more involved in the public health function, these largely focus on structure, rather than the influence of interacting individuals within organisations (MacKian 2002:216). Public health roles in primary care are confused. The ways in which they relate to existing roles, and to the roles of other actors within the public health system, are unclear. It is apparent that the government's agenda is being forged through a conceptual minefield in which many terms are altogether too poorly specified, under-theorised and inter-linked in practice to serve as categorical markers for what is or is not 'public health work'. This means that there is a lack of understanding as to how these ongoing developments will take shape in practice.

1.3 Aims Of The Study

In light of the current expectation that primary care practitioners become more involved in improving the health of the public, this research aims to explore what form those expectations take in English policy, and what shape they take within general practice - the 'bedrock' of primary care. It brings together the public health and primary care literatures, in order to examine the contexts within which current developments are taking place, and draws on empirical research to explore the ways in which practitioners understand public health and public health roles.

The research focuses on the notion of public health as a conceptually contested terrain, and as a concept which can be understood and interpreted in a myriad of ways. The impact of this lack of shared understanding is explored both for policy making and implementation, and for the development of public health practice. The research analyses the ways in which public

[1] Whilst it often makes sense to talk about primary care practitioners in general, it is those practitioners within general practice which are the particular concern of this thesis.

health is talked about and understood in policy, and compares that with practitioners' own understandings of public health and of their public health roles. It looks at the organisational and wider contexts in which practitioners work, and explores how varied and unclear understandings of public health, both in policy and in practice, might be affecting practitioners' engagement with 'public health'.

Since the study is concerned with the *general practice* context (as opposed to wider primary care), just a few of the many disciplines that might be involved in primary care have been selected for inclusion as participants. These are: General Practitioners (GPs), Health Visitors (HVs), Practice Nurses (PNs), District Nurses (DNs) and Practice Managers (PMs). These have been chosen because they are widely considered to be the 'core' general practice team (Taket 2001, Audit Commission 2002), and because they are predominantly based in the general practice. Many other disciplines could have been included - perhaps most obviously, school nurses and midwives. However, whilst their very important roles within public health are acknowledged, they are not included for several reasons: other practitioners *tend* to be less 'attached' to general practices (although practices vary), and thus their role *tends* to be less influenced by the culture and characters of the practice; also, the study is bound by time and resource considerations and, as such, needs to restrict its scope for practical reasons as well as for its final validity and reliability.

1.4 The Structure of the Thesis

This research carries out three main functions. First, it brings together public health and primary care literatures, in order to illuminate the historical and organisational contexts within which current developments are taking place. Second, it critically analyses the public health discourse of New Labour policy documents in order to explore the ways in which public health as a concept is understood and talked about within recent government policy. Within this, the study explores the government's expectations of primary care practitioners, in terms of their public health roles. And finally, the research draws on case

study material to examine practitioners' understandings of public health, and their perceptions of their public health roles.

The first main function of the study is presented in Chapters two and three. Chapter two introduces and discusses the meanings of both 'public health' and 'primary care'. They are identified as ambiguous concepts with a range of interpretations. This discussion explores my own perspective of public health, as researcher, and situates it within a continuum of understanding. The rationale for bringing public health and primary care together, introduced above, is discussed further in Chapter two, by drawing on international developments to highlight the potential opportunities. The chapter describes the influence of political, organisational and local factors on the development of public health roles. It suggests that a focus on both structure *and* agency is important, and introduces the theoretical approach that guides the research as a whole. This approach is influenced by role theorists, and by Wenger's (1998a) social theory of learning.

Chapter three continues the examination of the study background, and explores general practice, and the core practitioners within it, more specifically. It presents a historical analysis of the key developments in general practice, and of the changing characteristics and roles of the five professional disciplines in this study. This discussion also briefly touches on the broader issues of gender, class and ethnicity, and their relationship to status and power. Whilst the scope of this thesis does not permit detailed analysis of these issues, they are acknowledged as potential influences both on inter-professional relationships within general practice, and on understandings of and approaches to public health. Finding that roles and professional identities have changed, the chapter explores the implications of various changes for their public health roles. A number of factors have acted to distract practitioners from the public health values that have previously helped to shape their roles. In particular, the emphasis on 'modernisation' and other professional and political priorities are presenting a number of challenges for practitioners in general practice.

These two study background chapters, along with Chapter one, set the scene for the data collection and analysis by considering a wide range of key literature. The research process is explained in Chapter four, which presents the research questions, and their position within the overall aim of the research, and describes my approach to answering them. It describes the theoretical approaches and the methods used, reflecting both on my position as a researcher, and on some of the limitations arising from the pragmatic realities of 'real world' research.

Chapters five and six carry out the second main function of this research, which is to analyse recent policy documents relevant to public health and primary care. Chapter five concentrates on the government's expectations of primary care practitioners, in terms of their public health roles, and describes the content and context of the policies. It also looks at the ways in which public health as a concept is constructed within policy documents. Chapter six continues the focus on policy, and presents a critical analysis of public health discourse in order to examine the government's understandings and perspectives of public health.

The analysis in Chapters five and six draws on key points from a wide range of policy theorists (described in Chapter four). However, given the study's concern with the ways in which public health is talked about, it is guided particularly by the 'critical discourse analysis' approach outlined by Fairclough and Wodak (1997). This approach is influenced by an interest in the interplay between language, ideology, understanding and power.

Chapter five finds that whilst the government are asking practitioners to become more involved in public health, they remain vague about what the term *means*. Public health can be seen to be constructed of seven key themes which are themselves problematic, ill-defined, and used in multiple ways. Chapter six, which looks at the meanings and understandings of public health within policy documents in more detail, finds that beneath a public health rhetoric, which alludes to a societal approach to public health, lies a 'safe' and unchallenging approach which draws on biomedical and epidemiological

explanations of health and ill health. Moreover, this underlying approach is presented within a 'morality' discourse which is dominated by notions of efficiency, cost effectiveness and personal responsibility. In examining the ways in which the term 'public health' is used within policy documents, the chapter finds a great deal of vagueness about what it means. Indeed, this 'flexibility' of the term is found to be useful, since it can be interpreted in more 'politically acceptable' ways.

The meanings of public health in policy, as well as being fascinating in themselves, provide us with a useful interpretation against which to analyse meanings of public health in practice. This brings us to the third main function of this research, which is presented in Chapters seven and eight. These chapters present the findings of the qualitative research which was carried out in one (pre-2002) health authority area in England. This empirical inquiry was guided by a case study approach which allowed me to study the complexities of the key issues in depth. Fifty-five practitioners from fifteen general practices participated in the research. During the data-collection phase (from September 2001 to December 2002), I interviewed the practitioners either singly or in small groups, and made observation notes on visits to the practices. A short questionnaire was used, mainly as an interview tool, but also to collect additional information. Analysis of the data was informed by the 'framework' approach described by Ritchie and Spencer (1994).

Using the interview and observation data, Chapter seven looks at the ways in which the practitioners describe their roles in general, and their public health roles in particular. It finds that the ways in which practitioners think about and define public health has a clear influence on their engagement with it. In general, public health did not appear to be a big feature of practitioners' roles. As in policy, public health tended to be interpreted in relation to the practitioners' current practice. Thus, public health roles were typically described as activities within preventive medicine and health education. This again demonstrates the 'malleability' of the term. Chapter seven also examines the practitioners' discussions about public health in light of the seven key themes which were so prominent in the public health policy discourse.

Many of the themes received little attention by practitioners, and some concepts, such as 'collaboration' and 'patient and community involvement' were interpreted in very narrow ways. This suggests a mismatch between policy interpretations of public health as a series of processes (albeit rather vague ones), and practitioners' interpretations of it as a set of tasks and activities (mainly within preventive medicine and health education).

Chapter eight continues the analysis of practitioners' understandings of public health by examining the ways in which they define and describe it. Practitioners were generally very confused about what the term means. The analysis suggests that limited understandings of the term might be serving to restrict a practitioner's potential involvement in 'wider' public health practice. In particular, the tendency to regard public health as a set of activities, rather than as an approach to work, can set public health in competition with general practice, and allow practitioners to 'dismiss' or pass over public health responsibilities, perhaps due to 'lack of time', or not enough resources. This is perhaps amplified within a political environment which prioritises a particular notion of 'productivity' based on quick, measurable results, which are amenable to performance management. This chapter is particularly mindful of the multitude of factors which play a part in influencing the practitioners' roles and understandings of public health. It finds that the practice 'culture' is an especially important consideration, and notes that a supportive and facilitative practice culture, which can accommodate wider public health perspectives, and which is open to change, may enable practitioners to see beyond the 'lack of time' factor which currently seems to inhibit the incorporation of a public health approach into everyday practice.

The final chapter – Chapter nine – brings the main findings of the study together, and discusses and compares the understandings of public health and public health roles identified in the policy analysis and in interviews with practitioners. Using Wenger's (1998a) social theory of learning, and drawing on discussions in previous chapters, Chapter nine explores the importance of understandings in the making and shaping of practitioners' public health roles. It looks at differences and similarities in interpretations of public health, and

discusses the implications of these various perspectives for the public health activities of primary care practitioners. Finally, it reflects critically on some of the limitations of the study, making suggestions for future research.

The findings from this study hold several important implications for public health policy implementation in primary care. The research highlights the 'vagueness' surrounding the term public health, which allows it to be interpreted in a way that is both politically acceptable, and in keeping with current practice. From the policy point of view, the research identifies three main factors that threaten the development of stronger public health roles within general practices: the drive for efficiency and value for money which is central to New Labour's modernisation agenda; the emphasis on the notion of personal responsibility within public health policy, which tends to focus on the lifestyle and behaviours of individuals; and the separation of the 'public health' and 'health inequalities' agendas, which leads to a narrow, relatively non-challenging interpretation of public health within primary care.

From the practice point of view, the research finds that public health is generally seen as a set of activities, rather than as an approach to work. This perspective is unhelpful because: it allows people to pass the responsibility for public health to others; it permits people to excuse themselves from public health work due to 'lack of time'; and the 'art' of public health has a tendency to get lost behind the primacy of 'science'. These factors contribute to the non-engagement of primary care practitioners in the public health agenda.

CHAPTER 2

STUDY BACKGROUND 1:
PUBLIC HEALTH AND PRIMARY CARE POLICY AND CONTEXTS

2.1 INTRODUCTION

This chapter begins to describe what we know so far about public health and primary care. It explores the two concepts, discussing their various meanings in theory and in practice. Within this discussion, it is important to bring my own interpretation of public health into the open, and locate it within a range of different perspectives. The chapter describes the complexity of factors which might influence the development of public health in primary care. This discussion of context also serves as useful background to the government's current health agenda, describing as it does the recent political and organisational changes.

In exploring the ways in which primary care practitioners engage with public health, it is important, within this study, to appreciate both the practitioners' understandings and perspectives of public health, and the complexity of the political, social, economic, organisational and local contexts within which they work. This chapter puts forward a case for this argument, and describes the theoretical framework which guides the research as a whole.

2.2 DEFINING 'PUBLIC HEALTH' AND 'PRIMARY CARE'

Whilst the political commitment to public health and primary care across the UK is clearly present, the lack of clarity surrounding the use of the two terms is unhelpful. According to Griffiths and Hunter (1999:1), public health has the potential to be everything, but risks being nothing - "merely a diffuse and confusing collection of ideas that are not seen to produce any concrete product".

The term 'public health' is a complex one, used in a multitude of ways, and often without clear definition. As a concept, it consists of a wide range of social, political and economic interpretations, with many lay and professional practices, values and ideas embedded within it (Richman 2003). The confusion around the vocabulary of public health is significant

> because the concepts we use to make sense of the world direct both our perception and our actions. We pay attention to what we expect to see, we hear what we can place in our understanding, and we act according to our world views (Wenger 1998a:8).

The sometimes subtly varied 'meanings' attributed to public health, then, will influence the entire policy process – from the identification of policy 'problems', to the making of policy, to the ways in which that policy is implemented.

2.2.1 Meanings of 'Public Health'

Nijhuis and Van Der Maesen (1994) split the term into its two constituent concepts – public and health - and look at the ontological interpretations of each on continua from 'individual' to 'collective' for the former, and 'medical' to 'social' for the latter (see figure 2.1).

Figure 2.1 The Public Health Continuum: Ontological Interpretations of Public Health (adapted from Nijhuis and Van Der Maesen 1994)

It is clear from this continuum that the term 'public health' is open to multiple interpretations. Discourses on health are products of the particular contexts in which they are produced. They are therefore closely attached to other interests and agendas – professional, economic, political, cultural, ideological. The most pervasive discourse on health, at least in the industrialised world, is 'biomedicine'. The biomedical discourse is characterised by scientific medicine. Inherent within this are concerns with the specific aetiology and nosology of diseases, and with particular clinical diagnostic and treatment protocols. This tends to be within the context of the individual practitioner-patient relationship (Robertson 1998). Baum (1998) describes this as leading to the 'clockwork model of medicine', whereby if a part of the body is not working properly, it is fixed.

This biomedical discourse has influenced not only the structure and function of the NHS, but also the ways in which Public Health as a profession has developed in recent years. The focus of the profession has, over time,

become more medical, concentrating first on immunisation/vaccination and personal preventive approaches, and later widening to include the responsibility for promoting the health of specific groups within the community (Peckham and Wirrmann 2003). The founding, in 1972, of the Faculty of Community Medicine (later to become the Faculty of Public Health Medicine, and more recently, in 2002, the Faculty of Public Health), ensured the professionalisation of Public Health and secured its domain as a medical specialism. Until very recently, membership of the Faculty was limited to registered medical practitioners who had either attained an appropriate academic standard by passing an examination or, at the discretion of the Council, were deemed to have made distinguished contributions to community medicine (Warren 2000). Public Health professionals, then, until 2001, have largely consisted of medical directors of public health and their teams of public health consultants and specialists based within health authorities (Peckham and Wirrmann 2003).

There have, however, been various challenges to this biomedical discourse. The most significant, at least for this thesis, is the discourse of 'new public health'. New Public Health adopts a different view of the causality of ill health, and recognises that health outcomes are affected by factors outside of the healthcare sector. By emphasising social determinants of health, such as poverty, unemployment, poor housing and other social and economic inequities, new public health "takes an explicit theoretical position with respect to what makes some people healthy and others not" (Robertson 1998:160).

It focuses, then, on systematic and systemic social and economic inequities (in terms of access to a range of social and economic resources such as money and power and esteem) as major factors which affect the health of individuals and certain social groups. Within this discourse, new public health has called for such broad health strategies as 'strengthening communities', 'healthy public policy', and intersectoral action to achieve health. It has employed concepts such as 'community development' and 'empowerment' as key strategies for improving health (Robertson 1998). This approach has been strengthened

and promoted by the World Health Organisation (WHO), for example, in its *Health for All* strategy (1977).

In addition to these more 'official' discourses, the sociological literature reveals a large number of ways in which health is perceived by 'ordinary people' (e.g. Blaxter 1990). These 'lay' concepts of health are not necessarily opposed to medical concepts, since the two will have 'learnt' some aspects from each other, but they are often complex, subtle and sophisticated. They tend to differ over the life course, and between the sexes. Men for instance, often see health in terms of physical strength and fitness, whereas women tend to refer to ideas of energy, ability to cope, and social relationships. Definitions are related to social contexts as well as individual experiences – health might be seen by one person as absence of illness, and by another as psycho-social wellbeing.

There is frequently a moral element to discourses on health. This is particularly clear in the arguments of those who emphasise biomedical and epidemiological explanations of health, and who, as a consequence, hold a commitment to and faith in an ultimately biological (and hence often behavioural) explanation of health. The 'population health' perspective (Robertson 1998), for instance, makes the argument that access to health care is not the only – and, perhaps, not even the most important – determinant of health. This perspective draws on the 'health field' concept which was introduced in the Canadian 'Lalonde Report' (1974) as a theoretical justification for reorienting health policy. This report, radical for its time, suggested that improvements in health must be sought through improving the environment, moderating risky lifestyles, and increasing our understanding of human biology. However, this perspective tends to give equal weight to all putative 'causes' of ill health, with the result that economic inequities are neutralised and reduced to a single causal factor which might be thought of as 'prosperity' (Robertson 1998). With this neutralisation of social determinants, the tendency has been to focus on the lifestyle component of causal factors. The lifestyle approach to explaining and improving health has been criticised

widely, most notably for its tendency to blame victims for their ill health (see below).[2]

'Public' is an equally contested concept. It is used widely, but often carelessly. Barnes, et al. (2003), in their analysis of public participation discourse, state that the idea of 'constituting the public' is important since notions of 'the public', 'the community' or 'citizens' can be viewed "as social constructions, formed out of a range of discourses and ideologies that are historically embedded in institutional practice" (p.380). They find in their analysis that within policy initiated attempts to engage with the public there has been evidence both of ambiguity and confusion about the concept. Common sense notions of 'the public' are problematic given the power of public officials to constitute the public in particular ways, and given the variety of processes which serve to exclude people from public participation.

When conjoined with 'health', public implies a collection of people – perhaps a locality, a neighbourhood or a population. It can also conjure notions of 'community'. This brings further conceptual complexities, given that 'community' can be seen in terms of 'communities of interest', which might not necessarily share geographical characteristics. However, the dialectic between individualism and collectivism remains, and is fundamental in the understanding and development of public health concepts and strategies (Baum 1998). As two competing ideologies, they have a powerful effect on people's interpretations as to why ill-health occurs. Baum (1998) states that one of the direct consequences of individualism for public health is a tendency to blame victims for their ill health; "... the social, structural and epidemiological perspectives on health are, at best, a confusing background to explaining why individuals have particular health problems" (p.79).

Whilst individualism has been an important philosophy behind health education and health promotion movements (which can be seen as forming part of the broader public health movement), it hasn't achieved the position of hegemonic ideology. Indeed, the focus of attention within recent public health policy and

[2] See Hunter (2003) for a more comprehensive critique of the 'health field' concept.

literature is on social models of health and on 'collective' or population approaches (that is, somewhere within the upper right quadrant in diagram 2.1). This has certainly been affected by the political efforts, especially since the late 1990s, devoted to understanding and reducing health inequalities, which are increasingly understood within a collective approach. However, modern individualism (and the associated idea of a Protestant work ethic) remains a pervasive ideology, and health is often viewed in today's society in moral terms – as self control, self-discipline, self-denial and willpower. Blaxter (1997), for instance, looked at how people think about inequalities in health. Using data from the Health and Lifestyle Surveys, she found a clear 'moral' theme in her research (with health being, to a considerable extent, dependent on behaviour), and suggested this as a reason why very few people explained health inequalities in terms of social structural factors. Popay et al (2003a) explored these issues further and found a similar moral overtone in their in-depth interviews with people living in disadvantaged areas. However, their research highlights the ways in which different methodologies provide different and not necessarily complementary understandings of lay perspectives on the causes of inequalities in health. They found that during in-depth interviews, participants were also able to provide vivid accounts of the way in which inequalities in material circumstances have an adverse impact upon health.

2.2.2 Defining 'Public Health'

Building on the widely used definition of public health as "the science and art of preventing disease, prolonging life, and promoting health through the organised efforts of society" (Acheson 1988), four key purposes of public health have been outlined:

- To improve the health and wellbeing of the population
- To prevent disease and minimise its consequences
- To prolong valued life
- To reduce inequalities in health

(Healthwork UK 2001).

Many attempts have also been made within the policy field to clarify the key practices within public health, and the focus of its work (see for instance, WHO, 1986, DH 2001b, Scottish Executive 2000, 2001, Mason and Clarke 2001). The work of the Tripartite Group[3], and more recently Skills for Health, who are undertaking the production of standards for public health practice, has also been useful (Healthwork UK 2001, Skills for Health 2003). Their standards cover ten main areas of public health practice which elaborate on the previously mentioned four key purposes. The ten areas are:

1. Surveillance and assessment of the population's health and well-being.
2. Promoting and protecting the population's health and well-being.
3. Developing quality and risk management within an evaluative culture.
4. Collaborative working for health and well-being.
5. Developing health programmes and services and reducing inequalities.
6. Policy and strategy development and implementation.
7. Working with and for communities.
8. Strategic leadership for health and well-being.
9. Research and development.
10. Ethically managing self, people and resources.

Public health, then, is both a 'goal' (as in, 'the aim is to achieve better public health'), and a means to achieving that goal ('doing' public health in order to reduce health inequalities). It is a 'thing' – an entity – and a collection of practices.

The itemisation of standards and skills, however, only goes so far in helping us to clarify what public health means or entails. Understandings of public health are informed by people's values, experiences and ideologies, and by their sets of assumptions about the social world (Baum 1998:63).

> Recognition of these values is important and their role in public health policy should be openly debated. Indeed, their central importance to public health suggests that practitioners would benefit from clarifying their own values, determining how they affect their world view and by being aware of

[3] The Multi-disciplinary Public Health Forum, the Faculty of Public Health and the Royal Institute of Public Health have worked together under the name of the Tripartite Steering Group since 1998.

the values and motives driving other players (Baum 1998:64).

Public health, and these standards, can be viewed through different lenses or perspectives. Three main overarching perspectives can be loosely arranged along a continuum from macro to micro levels of organisation and analysis (Walsh *et al.* 1995, Baum 1998). Each perspective starts from different assumptions about the origins of disease, and each produces its own justification for a particular program of intervention in the name of health. These are outlined in figure 2.2.

Figure 2.2 Three main perspectives for approaching and assigning causality in public health

(Adapted from Walsh, et al. (1995:147), and Baum (1998:79))

The biomedical psychosocial perspective focuses on biological theories of disease causation and the effects of biomedical interventions on health. It also raises questions about individual and social behaviour, personality structures, coping repertoires and resources, and sense of control and self-efficacy in the experience and reporting of signs and symptoms (Walsh et al. 1995). This perspective focuses on the individual. It suggests health improvement programmes that emphasise individual properties and deficiencies – for instance, genetic predispositions, signs, symptoms and physical syndromes amenable to medical intervention. The focus on behaviour intimates action plans which are aimed ultimately at individual transformation and change through a range of social-psychological models and theories. Such programmes might include educational programmes, workshops in, for example, stress management, mutual aid, and support groups.

The epidemiological perspective begins with disease patterns in populations or groups and looks for differential risk factors, including biological predispositions, as well as behavioural and environmental exposures. It is often referred to as 'population medicine' (Moon and Gould 2000). It therefore has strong links with the biomedical perspective. Moon and Gould (2000:3) state that an important principle of epidemiology is that human disease has causal and preventive factors that can be identified via systematic investigation of who gets ill. It therefore seeks to describe, quantify and postulate causal mechanisms for health phenomena in the population, focusing on variations in levels of mortality and morbidity between population groups. Walsh et al. (1995) point out that "because it seeks pathways from relative risk to specific disease endpoints" (p.148), the epidemiological perspective tends to focus on personal behaviours, aiming at explanations that endorse the importance of individual decisions in minimising personal risk. It is true to say, however, that there are a number of approaches contained within this perspective, some of which (for instance, social and critical epidemiology) place more emphasis on social and structural determinants (Moon and Gould 2000).

The social-structural perspective brings large-scale cultural, social, economic, and political processes to the foreground and "seeks to understand the

pathways through which they produce differential risks" (Walsh et al. 1995:149). It explores the effects of fundamental mechanisms of social control and distribution of resources and power on the social construction of knowledge about health, and on responses to risk factors, signs and symptoms. Adopting this perspective "means raising questions about how social structure may affect personal choice" (*ibid.*). It brings the social environment into focus and makes it as palpable and pathogenic as the physical world. This perspective brings the reduction of health inequalities more clearly into focus. It shifts the focus not only from health improvement to tackling health inequalities, but beyond that to confronting inequalities in general. It leads to a greater emphasis on, and commitment to, tackling social injustices, through measures which tackle social deprivation, poor housing, food poverty, and so on.

These perspectives are not mutually exclusive, and not one of them gives a 'complete picture'. Rather, each one will bring to the fore certain issues, whilst relegating other issues to a blurry background. This in turn will lead to particular responses, based on the assumptions made. A person's understanding of public health, then, will be shaped by which of these perspectives they see the world - or more specifically, health and illness - through.

Walsh et al. (1995) point out that the social-structural perspective is more difficult to realise for a number of reasons:

- social structures are abstract and elusive, whilst physical and psychological explanations for behaviour are much easier to evidence;
- Western societies have a bias towards explaining social events in terms of personal characteristics, rather than in terms of situational factors. This highlights a tendency towards reductionism "at the expense of integrative, intuitive, and convergent styles of knowing" (p.150);
- recognition of the importance of social-structural factors in creation of health and illness can lead to a sense of powerlessness. Locating explanations at individual or institutional failures, on the other hand, leads

to much more manageable action plans, if less effective. A deeper social analysis can sometimes lead to explanations that are so complex as to feel like either a call to revolution or an admission of defeat.

Despite this, the New Public Health movement seeks to reinvigorate the social-structural perspective. It calls for an approach driven by core principles of equity, collaborative working and participation with communities. These are principles which have filtered through to recent policy, in rhetoric at least. 'Partnership' and 'participation', particularly, are buzz words to be found in most health policy documents.

Understanding 'public health' within this thesis

There are difficulties with imposing any definition of public health, and it should rather be seen within a 'continuum' of interpretation. However, the three perspectives outlined above provide a useful framework to guide my analysis of public health discourse both in policy documents and in interviews with practitioners. Given the focus of the 'new public health' movement on social environmental concerns, and on issues of social justice, equity, and reducing health inequalities, my own approach to public health is driven predominantly by a social-structural perspective which looks beyond the individual, and the biomedical psychosocial explanations. The view taken in this thesis is that public health must capture the importance of a community or population focus, and must take account of, and therefore seek to influence, the effects on health of wider social structures. This is partly because a key goal of public health, in my view, must be to reduce health inequalities – a task which can only successfully be tackled within a population perspective.

Bringing this social-structural perspective to the fore, though, is not to ignore altogether the other two perspectives. A significant and undeniable part of 'public health' is taken up by those tasks which could be categorised as 'public health medicine'. These include vaccinations, the investigation and control of infectious diseases, and the science of epidemiology. These should be seen, though, as elements which form a necessary, but not exclusive, part of 'public

health'. Furthermore, individual care and treatment, or, say, a policy of educating patients about the risks of smoking, whilst not falling within 'public health' according to my interpretation of the term, can certainly be carried out with a wider societal (public health) approach. This might then lead to other action being taken, such as working on policies and strategies, or planning and delivering community development programmes. This further action *would* then be defined as contributing towards wider public health.

2.2.3 Defining 'Primary Care'

Primary care, like public health, has suffered various transmutations in meaning, often resulting in a dilution of impact, or a simplistic concentration on general practice. It can be viewed variously as a set of activities, a process, or a level of care (Summerton 1999). Its notion as a functional sector, alongside secondary and tertiary sectors, has significantly influenced the pattern of health care systems in many countries (Starfield 1998). Peckham and Exworthy (2003) add a fourth 'level' of health care to these – that of self care or care by family and friends.

In its most simple terms, 'primary care' is a substitute for 'Primary Medical Care' – indicating those sections of the health service which act as the 'first port of call' for patients. In this sense, the term 'primary care' is generally used to refer to 'general practice' (described in detail in Chapter 3). It also comprises community health services including community nursing, professions allied to medicine, community paediatrics, community mental health services, and so on, and increasingly, pharmacies and new primary care access points such as NHS Walk-In Centres. The activities of a primary *medical* care team are essentially reactive, using medical technical expertise and tools to eradicate, or at least lessen, an illness or discomfort which is presented to them.

But the notion of Primary Care as Primary *Health* Care is much more radical, and its consequences much more significant. It emphasises

> the promotion of health through a partnership between health and other professionals and the community, as well as a system of treatment and curative care based on meeting the health needs of the majority of the population to be served (Macdonald 1992: 9).

This definition clearly points to the common ground between public health and primary care. Disappointingly, this new approach (despite receiving global attention since the International Conference of Alma Ata in 1978) has, until recently, made little impact on the structure or delivery of health care in the UK. However, the exhortation of the Alma Ata declaration, to place primary care at the centre of health care systems, has been a feature of the UK Government's strategy throughout the late 1980s and 1990s, although the forces driving the policies have varied.

Meads (1996) explains that the recent call for a 'primary care-led NHS' contains four dimensions: it is locally-led; relationship-led; citizen-led and consumer-led. It is not only about where priorities for health care are agreed, but also about who takes part in this process. It contains, then, a drive towards more effective partnership working and collaboration not only with other agencies (in all sectors), but also with the local community.

Primary care is seen in this thesis in a broad way which encompasses primary medical care, primary health care and general practice. It includes many practitioners and activities both within and outside of general practice. However, as described in Chapter one, general practice forms the bed-rock of primary care in the UK. This, and the core practitioners within it, are the focus of this study.

2.3 Bringing Public Health and Primary Care Together

Chapter one described the rationale for bringing the public health and primary care agendas together. Primary care practitioners are an important, and as yet untapped, resource within public health. But the development of public health roles within primary care in general, and general practice in particular, is not easy. Some of the barriers were outlined in Chapter one.

Developments in other countries, though, as well as innovative practice and research in this country, suggest various ways in which some of the barriers can be overcome, and opportunities exploited. Community-Oriented Primary Care is an approach which has been more widely rehearsed on the international scene than in the UK (Gillam and Miller 1997). It is a cyclic approach which consists of defining and characterising the target community, identifying and prioritising the problems of most concern to the community itself and/or to the professionals involved, modifying the primary care service provision to that community in order to improve its health and, finally, establishing systematic monitoring, evaluation and reassessment of the effectiveness of the programme (Iliffe *et al.* 2002:647).

The World Health Organisation, in its Health For All strategy, has also attempted to clarify wider public health approaches to primary care. The strategy places great importance on intersectoral working, the diminution of professional hierarchies, the pursuit of equity and the participation of the community (WHO 1977).

Drawing on these international approaches, and on their own research project in the UK, Taylor *et al* (1998) describe a public health model of primary care relevant to this country. This model focuses on key elements to a public health approach:

- Equity (the focus on under-served groups, improving health for all);
- Collaboration (the need to work intersectorally);
- Participation (the need to involve the public in improving their health); and
- Strengthening community action.

Primary care could work towards equity by ensuring that people play an active part in the planning and delivery of services, actively encouraging participation and community involvement. This approach draws on advocacy but goes beyond the care of the individuals in a practice population. It requires mechanisms to facilitate the involvement of service users and needs a

structure of accountability. Whilst PCTs are going some way towards facilitating these structures and mechanisms, practices are generally a long way off, with patient participation being a minority activity, and often one that is based on information giving rather than real involvement in decision making (Brown 2000, Paine *et al.* 1999).

Based on their public health model of primary care, the same authors describe a continuum of activity demonstrating the different levels through which progress towards such a model might be made (Turton *et al.* 2000). In what they describe as a 'weak' level, the reactive medical practice is focused on the sick individual, and the public health activity is largely evidence-based medicine and tertiary prevention. At 'intermediate' level, the practice engages in population (practice list)-focused care, carrying out some proactive medicine, but which is still individual based. Public health activity at this level would include the collection and use of population data from the GP system, mainly quantitative in nature, the use of practice profiles, and a concern with communicable and chronic diseases. At 'strong' level, the practice engages in multiprofessional (intrasectoral) team work, working proactively with a focus on prevention. They describe this as community-oriented primary care. Public health activity at this level would include health promotion, local health needs assessment, the setting up of rehabilitation processes linked with local community resources, and the use of epidemiological data from public health departments for the whole area, not just for the practice. Their final level demonstrates a synthesis of shared planning and implementation between individuals, health professionals and the community. The practice engages in multiprofessional (intersectoral) team work, taking a proactive approach which includes the concern for addressing the needs of disadvantaged groups, and setting up and using mechanisms for community involvement. Public health activity at this level would include participative and collaborative needs assessment and health promotion, active partnerships with community health groups, and drawing on wider public health skills as well as community resources (Turton *et al.* 2000:212).

In light of these developments and innovations, and despite the previously described problems, the government has made it clear that primary care practitioners are key players within a developing public health workforce. There seems to be a conceptual gap, though, between recognising that primary care practitioners (notably nurses) have an important part to play in public health, what that part might look like, and the relationship of that activity to other primary care/nursing practice. Reconciling that role with existing contextual factors adds further complexity. The wide variation in the understanding and conceptualisation of 'public health practitioners' exemplifies the extent to which the discussion is often dislocated from the context of existing practice in primary care.

Essential to the ongoing debate around the development of public health practice in primary care, then, is an understanding of the context into which new roles must develop. The next section of this chapter briefly explores this context from a number of different vantage points: the political context; the organisational context; and the context provided by people and places – that is, the 'community'. The discussion highlights the complexity of the factors that influence public health practice in primary care.

2.4 THE CONTEXT

2.4.1 The political context

Health policy is made and implemented within an environment shaped by a huge number of factors, including ideology, politics, social demographics, economics, and professional agendas. Public health policies particularly are fascinating in the way they reflect a change in attitudes and the development of knowledge over the decades (Baggott 2000). Public health activities are not carried out in a social vacuum, and various powerful interests will contribute to the shaping of both the definition of public health problems, and the policies and programmes in response to them (Levenson 1998). This is reflected in the change in attitudes over the decades towards health and how to improve it.

During the nineteenth century, emphasis was placed on ill health prevention, through public policy interventions such as slum clearance, paving of city streets, and provision of effective sewage and water systems. Today, such measures and their benefits are generally taken for granted. The 'prevention is better than cure' approach led to the extension of health services towards a notion of improving health through health education. The Central Council for Health Education was established in 1927 "to provide information to persuade the public to change to healthier habits" (Jacobson *et al.* 1991: 3), and later, the Health Education Council was set up in 1968 to create "a climate of opinion generally favourable to health education, develop blanket programmes of education and (target) selected priority subjects" (Health Education Council (HEC) 1968, quoted in Jones 1997: 4). Throughout the decades that followed, many other agencies followed suit, enhanced by mass publicity campaigns focusing on 'looking after yourself'.

So, throughout the latter part of the twentieth century - despite the acceptance that many major public health problems were associated with malnutrition, poor housing conditions and hazardous work sites (see Jacobson *et al.* 1991, Whitehead 1992) - public health evidently moved further away from its advocacy of social reform, focusing in more politically acceptable directions. In the 1990s, the government made its first explicit attempt to provide a strategic approach to improving the overall health of the population when it published 'The Health of the Nation' (DH 1992). Its impact has been criticised widely; despite the new consciousness that had emerged regarding the health-risks caused by the environment, the 'lifestyle' focus remained central to the strategy (thus maintaining its political acceptability, but losing any radical edge) (Hunter 1998). However, the Health of the Nation strategy (and its equivalents elsewhere in the UK) in many ways set the scene for the ensuing public health agenda (Hunter 1999).

New Labour's own strategy (DH 1999), which was bolstered by the independent inquiry into inequalities in health (DH 1998a), proposed a "contract for health", based on a "three-way partnership between people, local communities and the Government" (DH 1999: paragraph 1.39). Whilst

individuals were expected to take "the responsibility to improve their health, and the health of their families", the Government were to provide "national co-ordination and leadership" by creating the "climate for our health to be improved" (DH 1999: paragraph 1.40). A major programme has begun in England to "[narrow] the health inequalities that scar our nation, and [to improve] health for all" (DH 2001c: i). The government's strategy, which aims to cut across all departments, includes action at the national, local and individual levels.

Intertwined with this development of the public health function are wider ideological and political shifts concerning the structuring and organisation of health care, the function and power of medicine in modern society, and the role of the medical profession within it. Ideological differences and political wrangles over power and status have been a feature of the NHS since its inception in 1948. There were furious battles between politicians and the medical profession over its final shape and form (Ranade 1997). Whilst both Beveridge and Bevan had acknowledged the superiority of prevention over cure, the medical profession wielded considerable power as 'experts' of health knowledge. The resulting system clearly reflected medical priorities and values and ensured that "curative, hospital-based medicine dominated at the expense of prevention, health promotion and community services" (Ranade 1997:9).

The current agenda to move toward a primary care-led NHS forms part of the attempt to restore this balance, shifting the focus from hospitals to the community, and, supposedly, from cure to prevention[4]. A number of important factors have contributed to this agenda. Firstly, the economic stringencies placed upon the public sector by the Conservatives under Thatcher meant that strategies were sought to improve efficiency and curb expenditure. Primary care was seen as a means of coping with potentially costly patients either before they became acute enough to call for more expensive hospital intervention, or as a way of providing treatment more cheaply than in an

[4] The relatively minor degree to which this shift from cure to prevention has directed primary care policy will emerge throughout this thesis.

institutional setting (Klein 2001). In addition, bringing discipline to the seemingly uncontrolled spending and prescribing powers of General Practitioners represented another (unpopular) target in controlling public spending. Linked to this is the argument that professionals no longer hold the same position of authority in society, to the extent that they are experiencing 'deprofessionalisation'. Whilst a number of high profile scandals have done little to help the cause of the professions, a challenge to their status can also be attributed to the rise of managerialism or 'new public management' which takes away some of the autonomy that at one time characterised the activity of the professions (Exworthy and Halford 1999, Norman and Cowley 1999).

Secondly, the 'public' served by the NHS has altered, both in its nature, and in the way it is perceived by the government. As population demographics have shifted, so have population needs. Environmental, economic and social changes have altered the type and nature of threats, or 'risks' to our health (Beck 1992). Alongside this, efforts to redefine the public as 'consumers' - with the emphasis on patient choice, quality, standards and responsiveness – influenced a number of key policies affecting the role and position of primary care services; the function of primary care staff were more clearly defined, expanded (bringing in wider health promotion roles) and actively managed and scrutinised. More recently, patients have come to be regarded more as active 'partners' than passive 'consumers', and 'lay expertise' is becoming more acknowledged and more important (DH 2001d, Coulter 2003).

Thirdly, an important influence on health policies throughout the 1990s is the persistence, and indeed widening, of the gap between the health of those at the top and bottom ends of the social scale. During the last two decades, we have developed an improved and wider understanding of the causes of ill-health and health inequalities; and with this, our acceptance of such inequalities has correspondingly decreased. The Black Report represented an important shift in this respect. Labour's unfettered support for it in opposition (next to the Conservatives' futile attempts to bury it), pre-destined their quick response to its issues once elected. Their own enquiry - the Acheson Report (DH 1998b) - made 39 recommendations which sought to address the wider

socio-economic determinants of health, inequalities in health across the lifecycle, and inequalities in health related to gender and ethnicity. These recommendations presented a significant challenge to everyone involved in improving the health of the public. Whilst the document emphasised the importance of prevention over cure, though, the role of primary care in this remained ambiguous - only a few recommendations related specifically to this sector. Although Acheson's message has permeated policy rhetoric, with important (potential) consequences for primary care, there remains an up-hill struggle to raise the profile of wider social determinants of health, and to translate that knowledge into action.

A final issue is the role of interest groups in pressing for changes in public health approaches and policy. Public health interest groups have a long history (although it remains largely undocumented). Broad-based social-issue groups, local campaign groups, and specific issue groups such as those campaigning against tobacco, have all spoken out for public health. Importantly, though, many interest groups, including Trade Unions, community action groups, local authorities, the voluntary sector, ethnic-based interest groups, and sympathetic health workers, began, in the 1980s, to form a patchwork coalition which brought together ideals from the political left with a new agenda. This 'new' public health movement shifted health responsibility from the individual to the social, and was more global in reach than previous approaches. The Public Health Alliance was launched in 1987 and later joined with the Association for Public Health to form the UK Public Health Association (UKPHA). It is now a unifying and powerful voice for the public's health and well being in the UK, "focusing on the need to eliminate inequalities in health, promote sustainable development and combat anti-health forces" (UKPHA 2004).

All of these factors impact, to a greater or lesser extent, on primary care, which is to take a greater role in leading a 'new' health service "that does not just treat people when they are ill but works with others to improve health and reduce health inequalities" (DH 1997: paragraph 1.1). To this end, a number of important organisational changes have occurred within primary care and public health at national, regional and local level.

2.4.2 *The organisational context*

Structural change within the NHS has been ongoing almost since its inception. The 1997 election, though, brought about a new raft of changes which have important consequences for primary care and public health in England. Perhaps the most important of these structural changes was the development of Primary Care Groups/Trusts (PCG/Ts) (and equivalent organisations in the Devolved Administrations). Whilst the new PCG/Ts build on the history of preceding fundholding arrangements, they represent more than just another structural progression; they are an acknowledgement that the potential for good public health lies in primary care - an acknowledgement which "flies in the face of the history of primary care in the UK" (Meads and Ashcroft 2000: 4).

English PCG/Ts were established to improve the health of, and address health inequalities in, their communities; to develop primary care and community services across their patch; and to advise on, or commission directly, a range of hospital services for patients within their area which appropriately meets patients' needs (DH 1997). According to government policy, their role in improving the health of the community involves:

- taking the lead with the public and their partners on public health issues;
- developing Health Improvement and Modernisation Programmes (HIMPs[5]) based on health needs and integrating service planning and health promotion;
- engaging fully in Local Strategic Partnerships (LSPs)[6] and other community based health and care initiatives.
  (DH 2002b:8)

[5] HIMPs evolved out of the earlier 'Health Improvement Programmes' (HImPs) (see Hunter 2003:132 for further discussion of HImPs and their progression to HIMPs).
[6] The Local Government Act 2000 placed a new duty on all Local Authorities to produce community strategies, which are to be prepared and implemented through Local Strategic Partnerships. An LSP is a single body that brings agencies and organisations from all sectors together at a local level, so that different initiatives and services support each other and work together. The idea is that they operate at a level which enables strategic decisions to be taken, and is close enough to individual neighbourhoods to allow actions to be determined at community level (DETR 2001).

As new organisations, charged with exigent responsibilities, PCG/Ts have had to mature extremely quickly. By April 2001, many of them had already dealt with inception, development, mergers, termination, re-development, fusion with social care, and increasing responsibility. The government has made clear the importance of PCTs in its plan to 'shift the balance of power' in the NHS in favour of frontline staff and the community (DH 2001e); by 2004 they controlled 75% of the total NHS budget. Moreover, health authorities (in England) have been abolished to make way for fewer, more remote, Strategic Health Authorities (StHAs), with overall responsibility for 'performance management', building capacity, and supporting performance improvement. These changes aim to give 'frontline professionals' (particularly GPs), and the community, the power to reform local services, thus placing even more emphasis on the primary care practitioner (Milburn 2001).

The shift in the balance of power has incorporated a reorganisation of public health expertise. Each PCT is to have a strong public health team, "engaged with local communities, local authorities and non-Governmental agencies and focused on improving health, preventing serious illness and reducing health inequalities in the populations they serve" (DH 2002b:15). Each of these teams has a Director of Public Health (DPH) who, importantly, could be a medical or a non-medical public health specialist. Since the fragmentation of expertise (from fewer previously long-established public health and health promotion teams within health authorities) is a recognised concern, the government set out plans for (virtual) public health networks of skills, knowledge and experience in every area, "designed according to local needs and circumstances" (*ibid:* 15). This is to enable the provision of public health expertise which cannot be provided in every PCT, but which can be made available through the network. More public health teams are also situated within each StHA, headed by senior public health doctors/medical directors, and in each of the nine regional offices of government, headed by regional DsPH.

The redesign of structures at local level has brought some significant challenges, however. Early research on the success with which new PCG/Ts were managing to grapple with the public health agenda was disappointing. New public health teams have been slow to establish, directors of public health slow to appoint, and public health networks difficult to realise. The new relationships between PCTs and other bodies are also difficult to ascertain. Moreover, whilst there is new potential for non-medical specialists to play an important role in PCTs, the majority of appointments to the new DPH posts have so far been doctors (Peckham and Wirrmann 2003). These difficulties are reflected in the HIMPs (and earlier HImPs), which in many cases were found to be lacking in a vision for health improvement, inadequately focused on reducing inequalities, and poorly prioritised within PCG/Ts (HDA 2000, Hunter *et al.* 2000). Organisational change and policy 'overload' have taken their toll on primary care, and Hunter (2003) reflects that HImPs/HIMPs have fallen off the agenda, or at best, been subsumed into local delivery plans introduced in 2003.

Another key area of reform relevant to public health is the introduction of many new programmes designed to develop innovative models of service delivery. Health Action Zones (HAZs) – one of a collection of similar initiatives, including Education Action Zones, Employment Zones, New Deal for Communities, New Start, Surestart, Healthy Living Centres (HLCs), and a continuation of the Conservatives' Single Regeneration Budget (Powell and Moon 2001) – were announced as a way of exploring "new, flexible, local ways of delivering health and healthcare" (DH 1998: para 10.3). Their focus is on improving interagency collaboration, and they have been set up in areas of deprivation and poor health to tackle health inequalities and modernise services through local innovation.

Organisational issues within general practice, such as the size of the organisation or team, its history, type, culture, flexibility, and its management and development of staff, finance, quality and change, will also affect, to some degree, the public health activity of primary care practitioners. In the field of primary care, the organisational environment can be extremely confusing, and

is subject to frequent change. Primary care practitioners may fall within one of a number of organisations or teams, being employed by the PCT; an NHS Trust; the GP practice; or, as in the case of GPs, they may be self-employed. In addition, a practitioner may have a role in a team convened to focus on a specific issue such as child protection, infectious diseases, or coronary heart disease prevention. These teams are often formed to draw together the views and expertise of several different disciplines, each of which will come carrying its own 'organisational baggage'. In recent years, more innovative structures have allowed greater integration of nursing teams - the bringing together of community nurses perhaps previously managed and contracted along different structural paths - or a tinkering with the standard General Medical Services model of primary care provision. General practice issues, and new organisational flexibilities brought about in the NHS (Primary Care) Act (1997), are explored in greater detail in Chapter three.

The confused amalgamation of organisational structures in primary care means that practitioners are often working within quite different organisational contexts. There is a growing body of work addressing the changing organisational arrangements required to facilitate interagency working around a 'social model' of public health, largely focusing on the mechanics of, and structural arrangements for, partnership (see O'Keefe and Hogg 1999).

As well as an organisation's structure being important, there are aspects of process - the *way* in which the work is carried out - that will influence practitioners' work. There are several crucial factors in a strong public health approach. These include the extent to which the organisation, team or individual collaborates and communicates with others; the extent to which the community is involved; issues of leadership and learning; how national and regional policy is incorporated and implemented; and how motivated and innovative the team or organisation is.

The strength of many of these processes will be related to organisational structure. Communication, for instance, might be facilitated when the organisation or team is of optimum size, is not hampered by historical issues,

predicts and reacts well to change, and is not dominated by any one particular professional or professional group. Research has shown that collaboration with different organisations will be facilitated by organisational coterminosity - when different organisations or teams are responsible for the same 'patch' (Exworthy and Peckham 1998). In addition, Thomas and Corney (1993) demonstrate that differences in contractual status between members of a primary care team will influence significantly any attempts to improve collaboration, and Elston and Holloway (2001) assert that professional identities and the traditional power structure generates some conflict between GPs, nurses and practice managers, which affect collaboration.

Community participation could be facilitated by a number of factors. Macdonald (1992) points out that it needs some structures for it to be meaningful - such as a forum for people to be able to get together to voice common concerns and aims. The organisational culture and structure needs to be conducive - not dominated by one profession or idea, or strictly hierarchical and inflexible. Brown has shown that "the individualist and bio-medical focus within the practice list inhibits broader concepts of community participation" (Brown 1994: 341). McIver (1999) has also noted that tension could be created because of the 'top-down' type of management within the NHS and the 'bottom-up' approach of public participation.

The current emphasis on 'team working' in health care and other public services, makes leadership and the inter-play between individuals and groups all the more important. Teamwork implies that solutions to problems can be worked out as a group rather than by individuals, and that it is possible to arrive at a shared philosophy and to act as an organic entity (Barber and Kratz 1980). Whilst teamwork should facilitate the contribution of individual professionals, it does create pressures for the modification of roles and adaptation of skills. Leathard (1994) summarises some of the potential pit-falls of inter-professional team work thus: time-consuming consultation; administrative and communication costs; differing leadership styles, language and values between professional groups; separate training backgrounds; inequalities in status and pay; conflicting professional and organisational

boundaries and loyalties; practitioners being isolated with little management support; lack of clarity about roles; negative mutual perceptions and latent prejudices. It challenges the boundaries between members of the team, and between the team and others.

Barber and Kratz (1980) argue that two preconditions exist to ensure the functioning of a team: firstly, the purpose of the team needs to be clarified and the roles of its members made explicit. This does not mean rigid definitions, but rather the confronting of issues. Secondly, there needs to be an environmental and organisational framework within which to function. The team must maintain, though, its ability to cope with change, to deal with crisis, and to interact with the wider environment. Thus, both 'macrostructural' issues (the organisational structure, the professional occupational hierarchy, management structure, and so on) and 'microstructural' issues (personal knowledge, skills, temperament, experience and style of communication, and inter-personal relations) are important.

MacKian (2002) uses the concept of social capital to look at the capacity within organisations to engage in partnerships, and to understand the role it may play in improving public health. She states that "It is reasonable to expect that each agency's internal stock of social capital will have an important role to play in the formation of social capital in the wider partnership and community" (MacKian 2002:211). She examines the complex interplay between organisational culture and social capital, concluding that we "need to develop a better understanding of the internal makeup and culture of the agencies expected to work in health partnerships" (p.215).

2.4.3 The Local Community Context: People and places

The influence of the public on the activities of health professionals has already been mentioned in the sense of the wider conception of 'the public', and their re-modelling over time as consumers, citizens, or partners. There is, however, considerable variation in demographics and characteristics of local communities, and different areas have changed to varying degrees, depending

on the wider context. For instance, in England, mining towns have struggled with loss of industry, new towns have emerged in the ever-widening London commuter-belt, and port towns such as Dover have often had to house disproportionate numbers of asylum seekers and refugees. Phillimore (1993) notes that "the characteristics of places may be as important as the characteristics of people for an understanding of particular patterns of health" (p.176, quoted in Popay *et al.* 1998: 632).

The profile and characteristics of communities, and the way in which self-identity and 'lay experience' is 'constructed' within that community will have an important effect on the work of health professionals. 'Place' is "more than a set of static environmental deficits or provisions" (Popay *et al.* 1998: 639). Non-material factors associated with 'place' will shape people's action as individuals seek to mould social norms and obligations in specific ways. Thus, not only will needs differ between and within communities, but also the ways in which those needs are presented will vary.

The relationships between practitioners and their patients are important. Coulter (2003) explains that patients can play a part in healthcare in three main ways: in diagnosing their problem and caring for themselves (self-care); in shared decision-making, by choosing the most appropriate form of treatment for acute conditions in partnership with health professionals; and in self-management, by actively managing chronic diseases. The notion of people being 'fully engaged' with their own health and healthcare is an important focus of the government's current approach (Wanless 2002, 2004). A variety of factors will influence the degree to which people engage with these roles, including their perceptions about the effectiveness of medical treatment, perceptions of one's own state of health, and feelings of confidence or self-efficacy. These perceptions, as Coulter points out, are influenced by age, gender, educational level, cultural norms, social networks and co-morbidity. Some of these factors will have a complex interrelationship with the place in which people live.

The development of, and access to the internet, and the proliferation of health information in this and other media, has also altered the position of 'lay knowledge' in health professional encounters. Patients are often more familiar with researching their own health, and might approach their health practitioner with clear ideas of what they do or do not want from them. Coulter notes that the patient of the future "will be better informed, less deferential, and less willing to tolerate poor quality care" (2003:44). The changing expectations of the public will have an important influence on the shaping of practitioners' roles.

2.5 A Theoretical Focus on Roles

Clearly, any examination of primary care practitioners' perceptions of, and contributions to, public health requires an appreciation of the contexts, in all their complexity, in which they work. A theoretical focus on roles and relationships might offer some insight here. It is clear from the discussion above that 'roles' are situated within an organisationally, socially, and politically complex context. In addition to this context are the multitudes of factors associated with the practitioner him/herself – including personality, background, experience, training, and of particular importance to this research, his/her understanding of public health. Role theories can help to link theories about organisations to theories about individuals.

'Role Theory' has been described by Handy (1993) as relating to interactional perceptions and assumptions between members of a role set – that is, those people with whom the focal person interacts. It is based on a premise that a theoretical focus on roles and relationships might aid the exploration of an individual's perceptions of, and contributions to, certain situations, whilst keeping in view the social context and the broad structures shaping our lives. Strawbridge (1993) explains that 'role' can provide a 'conceptual bridge' between personality and social structure.

The multidisciplinary ownership of role theory, though, renders the term 'role' open to various definitions (Shead 1991). Most simply, a role can be thought

of as "a set of expectations and behaviours associated with a given position in a social system" (Pugh 1966, quoted in Beishon 1974:51). This notion gives primacy to the interpersonal relationships involved in role 'performance'. Thus, in the health care context, a practitioner occupies a certain position, and their role performance in that position is determined by social norms, demands and rules (not least those attributed by their status as a 'professional'); by the role performances of other practitioners in their respective positions; by patients, carers and others who observe and react to the performance, and by the individual's particular capabilities, training and personality.

Role theory has been used as a conceptual framework in a number of health care studies - for instance to explore role ambiguity and conflict in nursing (Riggin 1982, Shead 1991); the perceived roles of health care assistants (Workman 1996); the perspective of practice nurses (Thomas and Corney 1993); the role of the public health nurse in child protection (Hanafin 1998); and the nursing / medical boundary in a hospital ward (Allen 2001). However, much of this research has tended to focus on the inter-professional conflicts between doctor and nurse at the more clinical, hospital based end of the health spectrum. Moreover, there is a tendency within such research to focus on structural issues above agency.

Different philosophical approaches to social enquiry have led to a number of different 'models' of role theory. A structuralist-functionalist framework, for example, defines role in terms of reciprocity, which emphasises rights and duties. It would propose that there is little scope for choice in how a role is performed, though a distinction is made between instrumental or task-oriented roles and expressive roles more concerned with emotions or feelings. Both of these are believed to serve societal functions (Parsons 1951). Other theories point to the ambiguous nature of social interaction, and to the possibility of disagreement and conflict about how roles should be performed. Symbolic interactionists, for example, emphasise the 'making' as well as the 'taking' of roles; that role expectations can be negotiated and that there is creativity and choice in how people perform their roles and relate to others (Rose 1972).

There are limitations in both these sets of models in that they assume either too much conformity to expectations or too much choice. Giddens would likely assert that within many models, 'role' is too 'given', with little scope for individual preference, and no recognition of different meanings that people attach to their behaviour. He criticises the contractual models, therefore, for depersonalising 'role' (Giddens 1984: 83-86). Interactionist models, though, are often criticised for ignoring constraints of social structure, and for often failing to provide explanations that move beyond the minutiae of small-scale encounters (Walmsley *et al.* 1993). The relationship between social structure and human action is the motivation for Giddens's 'structuration' theory. This theory is based on the idea that structure is both input to and output of human actions – that there is a social structure in the form of traditions, institutions, moral codes, and established ways of doing things, but that these are produced and reproduced through social interaction (Giddens 1984).

The inherent functionalism of a role theories framework risks limiting the capacity to explore potentially important dimensions of public health / primary care. Perhaps a more sophisticated way of exploring and explaining 'role sets' and role performance is provided by Wenger's (1998a) notion of 'communities of practice'. Although he does not seek to address directly the theoretical issue of the structure-action controversy, Wenger works within assumptions similar to Giddens's. He believes that since theories of role making and role taking are essentially about *negotiation*, they must look to identity and situated experience as well as social structure and wider theories of power and social practice. Wenger (1998a) explores this idea of negotiation of meaning in his social theory of learning.

Wenger's work focuses on social learning systems, and his interests lie in understanding the connection between knowledge, community, learning and identity. His central idea, that human knowing is fundamentally a social act, has profound implications for the way we think of and attempt to support learning. Whilst social scientists have used versions of the concept of community of practice for a variety of analytical purposes, the origin and primary use of the concept has been in learning theory. One of the strengths

of Wenger's theory, though, is that it provides a broad conceptual framework which has relevance for the practitioner as well as the theoretician. Indeed, whilst the concept of community of practice has been adopted most readily by people in business, it has also found a number of practical applications in organisational design, government, education, professional associations, and development projects.

One theoretical application in particular has influenced its use in this research. Popay et al (2003b) use Wenger's framework in their analysis of public health work in local health systems. They see the framework as a useful way of examining practice as a combination of both the cultural, historical and structural features of context, and the personal, biographical features of individuals as they engage with structures. It helps to rebalance the focus on issues of *agency* within structure.

An element of Popay et al's work involved developing an understanding of the values and ideas – including the impact of national policy imperatives - that shape public health practice and policymaking in local systems. Their 'mapping' of reflexive communities at work illustrates

> how the process of implementing the new public health agenda is being shaped less by the policy intentions of central government and more by the experiences of local people in local places, as they in turn negotiate the new spaces open to them and form their own reflexive communities of understanding (Popay et al. 2003b:28).

Their work highlights how people can and do exercise considerable agency within the boundaries of structures, as they "weave a complex web of knowledge and experience together to create their own personal 'map' of context" (p.30). Interpretations of this context then structure their knowledge and practice.

Popay et al drew on three key concepts from Wenger's framework – identity, engagement and practice – and the relationship between them. The framework identifies learning as an integral part of our everyday lives – it involves an encompassing process of being active participants in the practices

of social communities, and constructing identities in relation to these communities. "Participating in ... a work team, for instance, is both a kind of action and a form of belonging. Such participation shapes not only what we do, but also who we are and how we interpret what we do" (Wenger 1998a:4).

Wenger's social theory of learning is located at the intersection of several key intellectual traditions (see figure 2.3).

Figure 2.3 Social theory of learning: intersection of intellectual traditions (Wenger 1998a:14).

The horizontal and vertical axes set the main backdrop for Wenger's theory, where learning as participation is caught in the middle of two key tensions: the tension between theories that give primacy to social structure and those that give primacy to action; and the tension between theories that address the production and reproduction of specific ways of engaging with the world, and those that are concerned with the social formation of the person, the cultural interpretation of the body, and the creation and use of markers of membership such as rites of passage and social categories. The horizontal axis is key, as learning as participation

> takes place through our engagement in actions and interactions, but it embeds this engagement in culture and history. Through these local actions and interactions, learning reproduces and transforms the social structure in which it takes place (Wenger 1998a:13).

But learning also acts more dynamically, as both the vehicle for the evolution of practices, and, through the same process, the vehicle for the development and transformation of identities.

Wenger uses the concept 'communities of practice' as a point of entry into the broader conceptual framework for a social theory of learning, as well as a constitutive element of it. It integrates the key components of *meaning* (learning as experience); *practice* (learning as doing); *community* (learning as belonging); and *identity* (learning as becoming).

An important aspect of Wenger's social theory of learning for this research is its focus on understanding as a process of negotiation. Wenger describes understanding as "always straddling the known and the unknown in a subtle dance of the self. It is a delicate balance. Whoever we are, understanding in practice is the art of choosing what to know and what to ignore in order to proceed with our lives" (Wenger 1998a:41). Individuals, then, will 'translate' (or negotiate) the vague thing that is 'public health' according to their world view, experience, interpretation of context, and so on.

2.6 SUMMARY

This chapter has explored public health and primary care both as theoretically ambiguous concepts, and as contested terrains. It discussed a range of public health discourses and perspectives, and presented a theoretical framework which will guide the later analysis of public health discourse in policy documents and in interviews with practitioners. Importantly, it brought my own interpretation of public health in to the open, and has made clear my allegiance to a social-structural perspective, which brings issues of large-scale cultural, social, economic, and political processes to the fore.

Given the ambiguity of the two concepts, and the diversity of ways in which they can be interpreted, it was important to have this more theoretical discussion, before moving on to explore the bringing together of public health and primary care in practice. Section 2.3 of this chapter discussed the rationale for developing primary care's involvement in public health. That primary care practitioners can make valuable contributions to the public health function, is a key principle behind the government's drive to shift the balance of power from the centre to the local. Whilst there are important barriers to overcome if primary care is to become fully engaged in public health, there are also some opportunities, highlighted by developments in other countries, and by research and innovations in this country.

In order to develop public health activity in primary care, though, we must be cognisant of the context into which new roles must develop. Section 2.4 discussed the political, organisational, and community contexts, and highlighted a number of factors which influence the development of public health in primary care.

It is clear from the first four sections of this chapter that an examination of the ways in which primary care practitioners engage with public health must take into account their understanding and perspective of public health, as well as an appreciation of the contexts, in all their complexity, in which they work. The final section of this chapter, then, described the theoretical approach which guides the research as a whole. It introduced role theories, explaining that the concept of 'role' can help us to make the conceptual links between the individual practitioner and the social structure. However, through discussing the limitations in various different 'models' of role theory, it made the case for Wenger's (1998a) notion of 'communities of practice', as a more appropriate theoretical framework for this research. Wenger's theory brings together several key intellectual traditions, and serves as a useful guide to combining an examination of the cultural, historical and structural features of context, with the personal, biographical features of individuals.

This chapter, then, has introduced the theoretical frameworks which guide this research, and begun to explore the study background. Chapter three moves from the more general and theoretical discussions of primary care and public health, to discuss general practice, the core practitioners within it, and their relationship to public health in more detail.

CHAPTER 3

STUDY BACKGROUND 2:
GENERAL PRACTICE AND PUBLIC HEALTH

3.1 INTRODUCTION

The previous chapter explored definitions and meanings of public health and primary care, and introduced frameworks for understanding public health and public health perspectives. It made the case for primary care having an important role in public health, and for that role to be strengthened. It explored some of the barriers to and opportunities for a stronger role, and examined the political, organisational and community contexts within which that role must develop. This chapter moves from the general context of primary care to discuss general practice, and the core practitioners within it, more specifically. It outlines the key developments in general practice in England, and discusses the public health role of general practice from a historical vantage point. The chapter goes on to discuss the changing characteristics and roles of the key practitioners in this study, exploring the historical development of the professional disciplines, and the implications of changes for their public health roles. This chapter helps to set the scene for the data collection and analysis by considering a wide range of key literature.

3.2 WHAT IS GENERAL PRACTICE?

General practice is the principal setting for the delivery of primary health care in the UK. Since primary care is promoted nationally and internationally as the key means of enhancing health status, recent primary care policy has placed general practices "at the political core of the NHS" (Moon and North 2000:1).

The term 'general practice' can mean several things. Peckham and Exworthy (2003) interpret it in three ways: as premises, as a managerial unit and as a

site of service delivery. Thus, it can be used to refer not only to the building – the physical premises of the health centre or 'surgery' – but also the collection of practitioners who work within it (*ibid*: 102), as well as the set of tasks those practitioners perform. Whilst many policy documents would have readers believe that general practice *is* primary care, it is rather an organisational unit within it – one part (albeit very significant) of an increasingly complex web of primary care services (Audit Commission 2002). Although there is an increasingly wide range of practitioners working within, or attached to general practices, the GP is generally the most dominant of these practitioners. As such, the term 'general practice' can have a fourth meaning, as it is often used to mean the profession to which GPs belong. This is misleading, and serves to restrict the complex organisational entity that is general practice to a single, dominant professional group.

NHS general practice is distinctive in both the way it is organised, and the context in which it operates. Several key features lead to this distinctiveness (Moon and North 2000):

1. *Its generality, and its role as gatekeeper to specialists, controlling access to secondary care.*

   This gatekeeper role used to apply solely to GPs, but as roles have changed, a greater variety of professions are now able to refer directly to a wider array of specialists. In addition, new sophisticated triage platforms, such as NHS Direct, Walk-In Centres, and enhanced pharmacies, reflect an emphasis on choice at first contact.

2. *Its status as the initial point of contact with the NHS for individuals who decide to seek biomedical health care.*

   Practices operate on a list system, and some 99 per cent of the population is registered with a GP. It represents eight out of ten patient contacts with the NHS (but only one fifth of NHS spending) (Audit Commission 2002:4). The geographical distribution of practices makes them readily accessible to most patients (Peckham and Exworthy 2003). Other ways of accessing primary care are now in place, including NHS Direct and Primary Care Walk-In Centres. The important position of the general practice as first point of contact, though, is unlikely to be diminished.

3. *The nature of the relationship between the practice and the patient.*
   The continuity of care provided to a patient and his/her family allows close contact with, and knowledge of, the health needs and problems of that individual patient. "Over time, this relationship can have valuable implications for continuity of care and for the appreciation of the social, economic and geographical contexts that constrain patients' health and their responses to treatment" (Moon and North 2000:3). Whilst this relationship used to be between the patient and the family doctor, now, as GPs work increasingly in partnerships and as part of multi-disciplinary teams, it is increasingly taken on by the practice, rather than the individual GP.
4. *The partnership as the main unit of organisation, and that partnership's independent contractual status.*
   This has given GPs and practices a great deal of autonomy in the services that they provide and the way they provide them.

However, within general practice lurks a huge amount of variation. Historic patterns of funding and staff, and a situation where for a long time investment in practices depended upon the GPs' willingness to dip into their own pockets, has left an uneven distribution of resources across the country: "The highest resourced areas have twice as much funding per head – for example, £63 in Oxfordshire compared with £33 in Gateshead – and more than double the number of GPs as the lowest resourced areas" (Audit Commission 2002:5). Moreover, these under provided areas tend to be in deprived regions with greater health needs – a situation described by Hart as the Inverse Care Law (Hart 1971).

The relatively 'unplanned' development of general practice, largely due to the autonomy of GPs afforded by their independent contractual status, has left wide variation in the size of practices, in the type (and quality) of services provided, and in the numbers and types of staff working within them. The result is that each practice has a unique organisational culture, shaped by its history, its population, its geographical situation, and the training, experiences, interests and personalities of its staff.

3.3 THE HISTORICAL DEVELOPMENT OF GENERAL PRACTICE

The historical development of general practice is discussed in some length by Moon and North (2000:13), "from its humble origins as a quasi-trade, to the beginnings of its key role in today's health service". Throughout this time, from the early 19th century to the present day, 'the practice' has developed from the often squalid room in which the GP based his work into a complex and sophisticated organisational entity. This development has taken place both within a policy shift towards a primary care-led NHS, and an ideological shift towards 'new public health'. This is reflected in the changes that have occurred within general practice, as premises, managerial unit, site of service delivery and profession.

3.3.1 General Practice as premises

General practices are local and (physically at least) reasonably accessible, with an average practice population (in 2002) of 5,800 patients (Audit Commission 2002:14). Only about sixteen per cent of primary care premises are owned by the NHS, with the majority being owned by GPs (63%), and the (growing) remainder being owned and financed by the private sector (Audit Commission 2002, Wanless 2002). There is, therefore, much variation in physical size and structure.

The growth in size and complexity of practices has been rapid – in 2001, one-third of GPs worked in partnerships of six or more compared with one in five in 1988 (Audit Commission 2002), and practices have often struggled to cope with the concomitant growth in infrastructure. Recently, though, practices have benefited from a number of schemes which have supported their physical fabric. As the responsibilities for improving facilities were increasingly taken up by the government, practices became increasingly purpose built, larger and better equipped. New Labour made plans to continue this modernisation of premises with an anticipated £1 billion of investment in primary care facilities (DH 2000:45, Audit Commission 2002, Peckham and Exworthy 2003). As a result, practices are becoming more suited to multi-purpose activities, more

accessible and more inviting. This not only improves the quality of service provision, but also opens up the potential for more diverse and multi-disciplinary teams, and for more innovative use of what should be a convenient and accessible community building.

3.3.2 General Practice as managerial unit

As a managerial unit, general practice has become much more complex. The practice, and primary health care team, grew as the (initially unpopular) notion of doctors working in group practices got off the ground (Moon and North 2000). The Family Doctor Charter (BMA 1965) included elements within it which allowed the direct reimbursement of practice staff, the reimbursement of the costs of practice rents which enabled larger premises to be sought, and a range of other changes, including various payments for services such as contraceptive care and advice, and cervical smears.

In addition to the direct employment of more staff (predominantly administrative support staff and practice nurses) by the GPs, the 'attachment' of local authority nurses (district nurses, health visitors and midwives) to practices was introduced from the 1950s onwards by "some forward-looking MOHs [Ministers of Health]" (Moon and North 2000:24). Whilst this was not universally welcomed, more and more GPs, urged on by the profession's leaders as well as the government, participated in the attachment schemes. The 1974 reorganisation of the health service, which transferred nursing staff from local authorities to community nursing departments, further encouraged the development of attached teams, and nurses were subsequently deployed in practices, rather than in geographical areas within the local authority.

So, the growth in size of general practices has been accompanied by a dramatic expansion in the employment of practice nurses and other practice staff, as well as the attachment of an increasingly diverse range of other health and social workers. In addition to this, through the GP fundholding scheme, and later, similar schemes, the practice has been expected to play a greater role in the commissioning, as well as the provision of, services for their practice

population. The management function with general practice, then, is of increasing importance.

The introduction of new management in the 1980s and 90s introduced both "a significant counterweight to medical power within the NHS, and the basis for a growing private sector-influenced culture of performance measurement and competition" (Moon and North 2000:29). The idea that general practice might be managed, and that GP autonomy might be curbed, subtly altered the roles of the practitioners within general practice. Increasingly, the job of managing the practice has been taken up by practice managers, who have played an important part in the shaping of the organisation (see section 3.5.6).

3.3.3 General Practice as a site of service delivery

As a site of service delivery, the practice has seen some profound changes in the last half century. A wealth of policy documents throughout the 70s and 80s (including DHSS 1976, 1986a, 1987) focused on broadening the scope of primary care and general practice, which affected the roles of all practitioners within the practice.

Assisted by the growing diversity in employed and attached staff, practices were increasingly able, and expected, to offer a wider range of services in response to the health and social needs of their population. A key change, especially from the late 1980s onwards, was the role of general practice staff in the promotion of health and the prevention of disease. Williams *et al* (1993:44) suggest that the White Paper *Promoting Better Health* (DHSS 1987) "signified a major turning point regarding not only the issue of prevention, but also the place and function of primary health care within the NHS" (quoted in Moon and North 2000:35).

The paper, though, was still a far cry from the public health approach developed by the WHO (1978). It defined primary health care in narrow, professional terms. Consequently, a major part of the political response to the challenge of improving primary care was to alter the contracts of those

providing such services in order to reward or enhance performance (Marks 1988). Much emphasis, therefore, was placed on screening, immunisations and clinics (e.g. well person, diabetes, heart disease, anti-smoking, and so on) within general practice. Targets, linked to pay and incentives, were set to encourage co-operation. These changes were reflected in a new GP Contract (DH 1989a), which made substantial changes to the terms of employment of GPs. It also included an obligation to provide health promotion services to the non-elderly population. Most of these tasks were delegated to the nursing staff.

Another key policy change at this time was brought about by the NHS and Community Care Act (1990), which essentially gave effect to the White Paper *Working for Patients* (DH 1989b). Whilst this paper does refer, in some detail, to the organisation of general practice, most critics are agreed that the essential focus is quite firmly upon hospitals and hospital doctors (Higgins and Ruddle 1991). There is also only fleeting reference to public health and community based services. However, the paper, and the Act following it, carried profound implications for the organisation of the NHS, as well as continuing to embed an ethos of managerialism, choice, and value for money. The emphasis for GPs was on satisfying their patients. In true Thatcherist style, they were to open themselves up to competition, 'winning' patients over with a broad range of high quality services, whilst keeping the Family Practitioner Committees (and later, Family Health Services Authorities) happy by keeping costs to a minimum.

A further key impact of this policy was the shift of tasks and services from hospitals and institutions into the community and the general practice. Increased day surgery, patients coming out of hospital 'quicker and sicker', and more care being provided in a community setting for people with long-term disabilities, all have implications for the workload and organisation of general practice and community nursing (Martin 1987). These developments helped to shift the emphasis within primary care further towards a clinical, individualist approach, as the increasing amount of time dealing with the immediate needs

of individual patients served to push wider (community-oriented) public health roles down the practice's list of priorities.

Throughout the 1990s, a new policy shift towards a primary care-led NHS has taken place alongside an ideological shift towards 'new public health' (see Chapter 2). During this time, a number of significant changes occurred which shifted the balance towards (and within) primary care away from hospital services, and which started to push health improvement and the prevention of illness onto the agenda. *The Health of the Nation* (DH 1992), and a number of subsequent documents which set out the nursing professions' contribution to health improvement and the importance of focusing primary health care services on the practice population (NHSME 1993a, 1993b), appeared to be taking on board aspects of the new public health agenda which recognised the need for a collaborative, holistic approach.

3.3.4 New pressures for general practice

The expectations of a 'modern' general practice were summarised in 1996 as:

1. making ill people better where possible,
2. reassuring well people who think they are ill,
3. helping people with chronic illness cope in their own homes; and giving appropriate support to patients needing palliative care in their homes,
4. encouraging well people to remain well,
5. acting as cost effective gatekeepers to secondary care and other services,
6. providing continuity within, and performing a co-ordinating role over, health services available to patients, and
7. influencing the development of specialist services.
   (NHSME 1996:18-19)

These expectations have been built on and developed further, from 1997 onwards, as part of the broader 'modernisation' of the NHS, where the focus has essentially been on improving the speed and quality of care that patients receive (DH 2001f). Practitioners in general practice are increasingly expected to do more, better, faster. Their roles are expected to expand in several directions. First, the task of improving the population's health and reducing health inequalities is placed increasingly within their remit. The move towards

strengthening the connection between primary care and public health is endorsed by the Royal College of General Practitioners:

> Primary care has the registered patient base, the information systems (based on the lifelong health record), the experience of commissioning and an understanding of the local communities. These are sound reasons for general practice being at the heart of the public health agenda, working in close collaboration with public health physicians (House of Commons Select Committee on Health 2001).

Shanks *et al* (1995) highlight the advantages of an approach that explicitly combines epidemiological analysis with the personal knowledge of primary care practitioners. Whilst the epidemiological approach is valued for its ability to look beyond patients who already demand health care to those who don't demand it but need it, the main advantage of the primary care perspective is the personal knowledge that primary health care teams derive from extended day to day contact with their patients.

In line with this aim, then, practitioners are expected to play a part in the planning and management of the PCT, to work directly with a growing number of outside agencies and organisations, and to become active partners in the wide range of community based projects designed to improve health and reduce inequalities. Within their practice or primary health care teams, practitioners are expected to break down professional barriers and work collaboratively, mixing and sharing their skills in order to improve both effectiveness and efficiency. Practitioners are also increasingly encouraged to take on specialist areas of expertise, including new roles in minor surgery (DH and RCGP 2002, DH 2003b). This is in line with the more general shift in care from secondary care to primary care.

In addition to these quite onerous expectations, there are a number of other pressures facing general practice, including those which ensure the work is both 'better' and 'faster' than before (in accordance with patient expectations). The Audit Commission (2002:42) outlines these pressures:

- Clinical Governance reviews
- NHS Plan targets
- Patient expectations:
  – choice of treatment

  - opening hours
  - length of consultation
  - quality of care
- More complex patient needs
  - ageing population
  - more co-morbidity
  - social problems
- More complex treatments and national clinical standards
- Professional development
  - GP appraisal
  - revalidation
  - training and development
- Prescribing incentive schemes
- Hospital visits and delays for elective surgery.

A further challenge is posed by the continually moving and overlapping role boundaries between existing and new members of staff. This occurs within the practice, as some practitioners take on more skills and responsibilities (such as nurse prescribing, or practitioners with special interests), and new practitioners are taken on board (for instance, nurse practitioners and complementary therapists). There is a significant shift recently, in the transference of traditional GP roles (such as diagnosis, referrals, and treatment of minor illness) to practice nurses and nurse practitioners. Such changes are also influenced by the introduction of new organisations outside of the practice, such as NHS Direct, or NHS primary care walk-in centres.

3.4 Taking on the Public Health Agenda in General Practice

Whilst the expectation is clear that primary care practitioners have an important role, or potential role, to play in public health, there remains little agreement about what form that should take. It is "a fraught issue, with experts divided over how much of a public health responsibility primary care should, or can, take on" (House of Commons Select Committee on Health 2001:para 67).

3.4.1 Barriers

There are a number of factors which have impeded the development of a public health approach within general practice. Some of these factors are structural. Glendinning, for instance, points out that the individual GP contract,

and its associated system of remuneration, served to reinforce the 'small businessman' mentality of GPs who often remained unwilling to be involved in the development of comprehensive, integrated, community-based services (Glendinning 1999). Moreover, rigid funding mechanisms, "which remain largely restricted to reimbursing GPs for the costs of the accommodation needed to provide general medical services under their individual contracts" (Glendinning 1999:121), are inappropriate for the kind of multi-purpose, multi-disciplinary developments being promoted by Government.

Meanwhile, Government policy has afforded much greater weight to the more straightforward tasks of general practice which can be described in terms of 'evidence-based' activities which can be easily and quickly costed, targeted, monitored and evaluated. Despite everything we know about structural influences on health and inequalities, public health roles of professionals in general practice have been primarily identified as that of delivering education and advice to individuals (predominantly around lifestyle issues such as smoking, diet and exercise).

This very narrow conceptualisation of primary health care has done little to instil a public health approach at this level. Structural peculiarities have further inhibited its potential. By raising the proportion of general practice income gained from capitation fees, for instance, general practice finance targeted the GP's pocket, and the contributions of other members of the primary health care team were largely ignored. Moreover, such a system provided disincentives to include 'high cost' patients, such as the very young, the very old, people with multiple needs or long-term disabilities, on the practice list.

The introduction of a wider public health agenda also challenges the traditional roles and skills within general practice, which are essentially focused on individual care. This understandably causes feelings of apprehension (Hennessy 1995). This pressure is amplified given the realities of general practice, in which the time spent with patients must always be balanced with the increasing bureaucratic and administrative demands from above, and with the increasing demands from those patients themselves. Keeping up with these demands, meeting the immediate clinical needs of patients, and at the

same time working to reduce health inequalities and improve public health, is a huge challenge to all those working within general practice. According to the RCGP, this

> calls for general practice to move from action 'down stream', where the effects of a problem are seen, to 'upstream' where the causes are, whether those causes are strictly within the disease model or within the wider social, economic or environmental models (House of Commons Select Committee on Health 2001).

Whilst the country's first national health strategy (DH 1992) did much to promote the wider public health agenda in primary care, "the clash of different organisational cultures and agendas, tension between different public health perspectives and between rival professional groups, and the conflict between the public health agenda and the need to 'balance the books'" (Baggott 2000:65) all served to inhibit its implementation at local level. (For a more detailed critique of the strategy, see Baggott 2000).

3.4.2 Opportunities

In the late 1990s, the government began attempting to address some of these structural and cultural impediments to implementing a public health approach. The 1997 NHS (Primary Care) Act, and associated discussion papers (e.g. DH 1996a, 1996b), challenged some of the structural and financial rigidity that had previously stymied change. The Act introduced new flexibility to primary care provision in order to encourage creative approaches to service delivery. Its PMS (Personal Medical Services) Pilot schemes allow individual practices, groups of practices including PCTs, and/or community trusts to negotiate unique arrangements for service provision, including salaried general practitioners, extended roles for nurses, and reconfiguration of practice/community boundaries for organising care (The PMS National Evaluation Team 2002) (See Box 3.1). Whilst Baggott (2000) notes that the public health implications of these arrangements vary, they have allowed flexibility in services which is more geared towards meeting the needs of deprived communities and groups, such as homeless people. First wave pilots targeting vulnerable populations have experienced high levels of success in

improving access to appropriate healthcare (The PMS National Evaluation Team 2002:20).

Box 3.1 Key objectives for the PMS pilot:

- A clear focus on public health
- New approaches to address the needs of deprived areas / vulnerable groups / tackle inequalities in health
- Aims to tackle recruitment issues in under-doctored areas
- Closer working with social care
- Whole PCO approaches
- Improved access
- Utilisation of GPs with a special interest
- Innovative use of primary health care team roles
- Provision of a range of extended services through PMS+

(DH 2001a)

These flexibilities in general practice complement the growing number of local programmes and collaboratives such as HAZs and HLCs (described in Chapter 2).

A new GP contract (in place from April 2004), which "heralds new investment for NHS general practice" (BMA 2003a), represents a further attempt to iron out previous structural and financial impediments to change by:

(i) providing new mechanisms to allow practices greater flexibility to determine the range of services they wish to provide;
(ii) rewarding practices for delivering clinical and organisational quality, and for improving the patient experience;
(iii) facilitating the modernisation of practice infrastructure, helping GPs achieve a better work/life balance, supporting the development of practice management, and recognising the different needs of GPs in different localities;
(iv) replacing the current flawed pay mechanisms with guaranteed levels of investment through a Gross Investment Guarantee which allocates resources on a more equitable basis and allows practice flexibility as to how these are deployed from the global sum;
(v) supporting the delivery of a wider range of higher quality services for patients and empowering patients to make best use of primary care services;

(vi) simplifying the regulatory regime around how the contractual mechanisms will work

(BMA 2003b).

Whilst practitioners within general practice have always been involved in social dimensions of health at an individual level, the new challenge is to be effectively involved in these social dimensions at a population level. "This will require a range of skills which few primary health professionals currently have" (Fisher *et al.* 1999:749). It will also require a substantial shift in the culture and mindset of general practice.

3.5 Practitioners Within General Practice

Practitioners within general practice, then, are now facing a much greater push by the government to become active partners in local and national strategies to improve health and reduce health inequalities. They also have many more opportunities to be involved in collaborative projects at local level. However, the ways in which this will be achieved, and the barriers (both structural and cultural) that need to be addressed, receive scant attention. The need for general practices to develop as organisations in order to realise their potential in contributing to the public health function, and the function of the PCTs is clear (Burtonwood *et al.* 2001).

In practice, and day to day parlance, the 'primary health care team' (PHCT) is usually limited to the 'core' NHS practitioners working within or attached to the general practice: GPs, Practice Nurses, Health Visitors, District Nurses. However, in theory, and certainly for the WHO (1978), the 'team' would be a much wider one, comprising a range of other services brought in to facilitate the health care of people in the community (see, for instance, Audit Commission 2002:13). Given that most ill-health is not treated by the medical system at all, but rather by the patient him/herself, or by family members, they too should be included in the PHCT. However, whilst the impressive growth in numbers and types of practitioners involved in general practice has altered the shape of PHCTs, they largely remain dominated by the GP, "by right of inherited tradition" (Hart 1988:x). This has been reinforced by official guidance

which has tended to pay lip-service to multidisciplinarity (Moon and North 2000:7).

The way in which each PHCT functions varies enormously, as does the extent to which the practitioners work as a 'team'. We know that team work in primary care is essential to meet the goals of the new public health agenda (Ovretveit 1990). Moreover, the teams must be more inclusive than ever, learning to appreciate and incorporate the values and skills of a range of professions, from clinical practice to complementary therapies and community development. For any team to work effectively, each member needs to have a clear understanding of his/her own function, appreciate and understand the contributions of other professions, and recognise common interests (Gilmore *et al.* 1974). Gambril (1986) suggests that, in retrospect, "it is surprising that primary health care teams have worked as well as they have in most cases, since little thought was apparently given to the difficulties which might arise when a group of professionals were brought together by the stroke of an administrative pen" (p.106). Much of the development of the various professional groups involved has proceeded with little thought being given as to how their roles and responsibilities should relate to those of other disciplines concerned, or even to other members of their own profession:

> ...The basic lack of knowledge of the other professions' training, roles and responsibilities, the effects of different employment status, remuneration, professional management structure and accountability, were rarely discussed, let alone the more subtle but probably more important issues of confidentiality, status, leadership and, above all, the need for effective communication within the team (Gambril 1986:106).

In the development of inter-professional relationships, the nature of power dynamics and inequalities in status are also an important consideration. There is an abundance of literature on the power dynamics involved in relationships within and between nursing and medicine, and between professionals and the users of health services. Intricately related to issues of power and status are the underlying issues of gender, class and ethnicity.

In most western countries, and certainly within the UK, the relationship between medicine and nursing reflects traditional power imbalances related to

professional hierarchy. At the top of this hierarchy are doctors, whose omnipotence amongst health care professionals reflects their income, prestige, and authority. The power of physicians appears to arise from knowledge and social class (Zelek and Phillips 2003), as well as their gender and ethnicity. Grimshaw (1986) observes that the history of the medical profession is one "which can be read partly as the attempt to establish white male hegemony over medicine, and what are seen as medical priorities can sometimes be seen as serving to legitimate status and hierarchies within the profession" (p.222). Within medicine, though, there are hierarchical relationships between specialisms, and historically, GPs are low in this hierarchy compared with hospital consultants. Their independent status (see section 3.5.1), however, has afforded them considerable autonomy and power within general practice.

There is a complex relationship between gender and status. Modern, professional medicine has traditionally been a masculine profession (Symonds 1997), and this has been associated with their particularly high status in society[7]. The rising proportions of women in medicine are raising questions as to whether the status of medicine as a profession will be affected[8]. However, whilst the numbers of women entering the medical profession are increasing (in 2003, 61 per cent of all acceptances to medical school were women (BMA 2004)), women tend to be concentrated in particular (lower status) areas of medicine, such as general practice and public health (Pringle 1998). Within general practice, the woman GP is frequently a second-class citizen among the doctors within the practice. A high proportion work part-time, in salaried or casual positions rather than in partnerships, and earning less for the hours that they work (Pringle 1998:158).

The relevance of gender to nursing, as an activity and as a profession, has also been discussed extensively in the sociological literature. Nurses traditionally play a subordinate role in health care teams, and their role is still primarily associated with the feminised role of caring. This gendered and

[7] Comparisons are often made with doctors in the former Soviet bloc whose limited training and prestige is associated with the fact that the majority of them were women (Pringle 1998:4).
[8] In August 2004, Professor Carol Black, president of the Royal College of Physicians, told the Independent that the increasing numbers of women doctors could make the profession less powerful and less influential in the future (see Laurance 2004).

hierarchical view of nursing persists, despite the efforts of nurses who have fought hard over the last 40 years, both to relinquish the 'Nightingale' tradition of the 'handmaiden to the doctor', and to emphasise their separate contribution to health care and achieve a degree of autonomy and independence. In general practices, then, it is most often the male GPs who preside over the female nurses[9], giving the GPs a double advantage in terms of power and status.

Class divisions within medicine, and between medicine and nursing, tend to receive less attention in the sociological literature. Research by the BMA (2004) revealed that just 1.8% of new students at medical schools in the UK come from the most disadvantaged backgrounds, whereas nearly two thirds come from the highest social classes. Possible reasons for this could be discrimination (in recent years applicants from the highest social classes were twice as likely to be accepted as those from working class backgrounds), or the financial concerns for students. The introduction of top-up fees is likely to increase the middle-class dominance within medicine. A focus group study by Greenhalgh et al (2004), which investigated school pupils' perceptions about medical school, found that there were striking differences by socioeconomic status. Pupils from lower socioeconomic groups held stereotyped and superficial perceptions of doctors, saw medical school as culturally alien and geared towards 'posh' students, and greatly underestimated their own chances of gaining a place and staying the course.

The nursing profession, on the other hand, primarily attracted working class or immigrant women whose background fostered unquestioning obedience to authority (Ehrenreich and English 1972, Peplau 1999). However, Pringle (1998) notes that there has been a significant shift in class relations within nursing, as modern nursing was "removed from its historical antecedents in domestic service and established as a respectable occupation for middle- and upper-class women (Abel-Smith 1960)" (Pringle 1998:188). Nursing became a career for educated women, which has been confirmed over time by the growing emphasis on educational qualifications and the movement of nurse

[9] Note that amongst my interviewees, only 4 were men. All of these were GPs.

training into the universities. Pringle concludes that given their similarities in social background, the subordination of nurses to doctors could not be a simple matter of class domination. It remains an important issue, though, in nurse-patient relationships, and in the nurses' understandings of, and approaches to, public health.

The issue of ethnicity within medicine, nursing and general practice has also received little attention in the academic literature. Yet, like gender, it is intricately related to status and power. Whilst overall, ethnic minority students are over-represented in medical schools compared with the UK population as a whole (BMA 2004), ethnic minority doctors are disadvantaged throughout their careers in several ways: they face discrimination and harassment; they are over-represented in lower grades of the profession; there are more complaints made against ethnic minority doctors; and there are more suspensions (Coker 2001). The presence of a glass ceiling in hospital medicine might influence the choice of ethnic minority doctors to become general practitioners (Dadabhoy 2001).

However, in general practice there is a striking lack of GP trainers and undergraduate tutors from minority groups. One reason for the under-representation is that more minority GPs are single-handed. This is a result of discrimination in the past, when doctors filled single-handed posts in deprived and isolated areas spurned by others (De Wildt *et al.* 2003). Whilst the Royal College of General Practitioners has moved towards addressing institutional racism within general practice (Joshi and Pringle 1999), the issues are likely to remain for some time. In nursing, too, an element of racism in British nursing recruitment policies has meant that minority ethnic groups have continued to be over-represented in lower grade posts, doing unpopular shifts and in unpopular specialities (Symonds 1997). These issues remain largely unexplored in general practice.

Gender, class and ethnicity, and their related issues of power and status, are likely to affect not only the relationships between professionals (Leathard 1994, Leiba 1994), but also the relationships between those professionals and

their patients. In addition, it is possible that such dynamics influence the ways in which practitioners (and professional groups) think about and approach public health and health inequalities. Power relations, however, alter over time. The increasing numbers of female doctors, the transfer of work from GPs to nurses, and the increasing employment of salaried GPs are just some of the issues that are likely to effect power dynamics in general practice in the future.

With this background in mind, the remainder of this chapter examines the historical development of the core disciplines within general practice that are the focus of this study. It discusses the key issues they face, and explores their expected public health roles.

3.5.1 General Practitioners (GPs)

GPs and their Professional History

GPs have a unique relationship within the public sector in that they are (mostly) independent contractors to the NHS, and so, in effect, owners of small businesses. This independent status is something for which GPs have fought hard, and the battle has shaped their profession considerably. GPs have had to carve out their role both within the developing NHS, which had for a long time been dominated by the hospital consultants, and within society as a whole. Their status as professionals is linked both to their role in society and their clinical expertise. This clinical expertise can be seen as the possession of a discreet body of specialist or specialised knowledge which is not typically available to those outside the profession (Harrison *et al.* 2001).

The 'profession' of general practice was a late developer compared to its cousins in hospital medicine, and it remained stifled, until recent years, within a professional model associated, in an early 20th century vein, with Gentry and science (Hart 1988:44). Hart (1988) describes this as the Osler model of Medical Professionalism, after Sir William Osler, the most influential example

of, and advocate for, this professional model. The consequences of such a model were profound:

> Medical training was not geared towards the improvement of health or continuing care of disease in the whole population, but to the creation of a force of men with episodic or crisis-oriented skills for salvage of serious disease, increasingly concentrated in specialist hands in hospitals (Hart 1988:60).

Moreover, the social assumptions of the Osler model, in which "the social content of doctoring was ignored, minimized, or sentimentalized into charity for the sick poor" (Hart 1988:53), was to be the basis for the stubborn opposition put up by GPs, first in 1912 and then in 1948, to Lloyd George's Insurance Act and the NHS Act, respectively. (In a plebiscite taken by the BMA in January 1948, 84 per cent of GPs voted against the introduction of a NHS (Morrell 1998)). The bitter divide that existed between general practitioners and the government hampered the progress of the profession for many decades.

Several reports in the 1950s (Collings 1950, Hadfield 1953, Taylor 1954) presented conflicting evidence on the quality of care delivered by GPs in those early years of the NHS. Of these, Collings' survey was particularly damning, concluding that "The overall state of general practice in England is bad and still deteriorating. Some working conditions are bad enough to require condemnation in the public interest. Inner city practice is at the best unsatisfactory and at the worst a source of public danger" (1950:563, quoted in Morrell 1998:3). The report was extremely important in mobilising opinion in favour of constructive change (Loudon and Drury 1998). It was clear that the specific function of general practice within the NHS required definition (Morrell 1998).

Throughout the 1950s and 60s, a number of important developments took place in the history of the GP. The establishment of the College of General Practitioners in 1952 (which received its Royal charter in 1967), gave the professionalisation of general practice a boost. In terms of their professional model, Balint, a Freudian psychoanalyst "of unusually practical bent" (Hart 1988:88), posed a challenge to Osler. Balint's ideology, first outlined in 1957, focused on care of the soul and defined a wide area of need that was currently ignored or rejected by specialists and was not included within the medically-

oriented Osler model (Balint 1964). He recognised that a large proportion of patients who fell into the hands of specialist physicians had no evidence of organic disease. He saw, in GPs, the opportunity to approach these patients in a new way, in which the causes of anxiety and unhappiness would be sought with a view to treatment by "remedial education aiming at insight, rather than tablets aiming at suppression of symptoms" (Hart 1988:88). Importantly, this approach highlighted a role for GPs which, rather than being inferior to that of hospital specialists, might, for a large group of patients, be more effective and less dangerous. Balint's ideas, then, helped form the foundations for an ideology of general practice independent of hospital specialism; Hart claims that "for the next 25 years Balintry was the principal innovating force in British general practice" (1988:88).

Another important feature of Balint's ideas was that he showed how inappropriate the undergraduate training of GPs was to common problems confronting them. Medical education had been on the agenda for some time, with the recommendation that GPs undertake three years of postgraduate vocational training being incorporated into the Medical Act of 1950. It was, however, to be two decades later before compulsory vocational training was introduced (Morrell 1998). The first professor of general practice was appointed in Edinburgh in 1963, and the Royal College of General Practitioners (RCGP) produced two reports which set the scene for the newly emerging vocational training programme (RCGP 1969, 1971). In their book *The Future General Practitioner* (1972), the College set down the content of general practice for educational purposes, dividing this into five areas as outlined in the 1969 report. These five areas were:

- Clinical practice: health and disease
- Clinical practice: human development
- Clinical practice: human behaviour
- Medicine and society
- The practice

(RCGP, 1972:xii).

The role of GPs

The Future General Practitioner placed great emphasis on this training programme and expected that it would lead the new GPs to behave in a way that was consistent with the College's idea of the role (see Box 3.2). Their job definition reflects some of the changes in thinking and practice of the general practice profession which have been brought about by a range of theoretical, medical, technological and social advances. Loudon and Drury (1998), for example, discuss in detail the profound effect on the clinical content of general practice attributable to the changes in the pattern of diseases since the 1940s:

> Where the work of the general practitioner in the first half of the twentieth century was dominated by infectious diseases, the work of the general practitioner at the end of the century consists more and more of dealing with the long-term care of chronic disease, health promotion, and screening for asymptomatic disease (p.98).

As the general practice profession has sought to meet these changing needs, and at the same time to identify their particular niche within society and the NHS, the underlying philosophy of practice has broadened to one of 'holism' – incorporating biological, psychological and social elements. The increasingly open and broad nature of the general practitioner's role - which Willis (1995) describes as 'medicine without boundaries' – became their strength. Heath comments that "All aspects of human existence are legitimate concerns of the general practitioner provided that they are presented as a problem by the patient" (Heath 1995, quoted in Harrison *et al.* 2001:5).

BOX 3.2 A concise definition of the GP's job (RCGP, 1972:1):

"The GP is a doctor who provides personal, primary and continuing medical care to individuals and families. He may attend his patients in their homes, in his consulting-room or sometimes in hospital. He accepts the responsibility for making an initial decision on every problem his patient may present to him, consulting with specialists when he thinks it appropriate to do so. He will usually work in a group with other GPs, from premises that are built or modified for the purpose, with the help of paramedical colleagues, adequate secretarial staff and all the equipment which is necessary. Even if he is in single-handed practice, he will work in a team and delegate when necessary. His diagnoses will be composed in physical, psychological and social terms. He will intervene educationally, preventively and therapeutically to promote his patient's health"

Whilst the General Medical Services Committee (1996) and the General Practitioners Committee (2002) have contributed to the further definition and specification of 'core services' and key attributes for 'good medical practice', the job definition has changed little since it was written.

GPs and the public health agenda

Such a broad and comprehensive role, though, presents an unmanageable challenge. On top of that, GPs are now also charged with increasing equity and enhancing public health, which demands a concern for not only the problems of those patients who present to them, but also those in their community who do not. This challenge, as well as the 'encroachment' of other health professionals on the GP's traditional work remit, has prompted the profession to ask fundamental questions about the GP's purpose and role definition (see for instance Olesen *et al.* 2000, Heath *et al.* 2000). One answer is that GPs are pushed into specialisms, with the aim of becoming community consultants. Professor Sibbald suggests a new identity for GPs of the future as "community based medical consultants specialising in the management of patients with complex co-morbidities" (quoted in Kmietowicz 2003:1352). This move would pull GPs further towards an individualistic, clinical role, and further away from a community-oriented public health role. In addition, public health does not seem to be considered as a potential specialism for some GPs – in the Department of Health and RCGP's document (2002) on implementing a scheme for GPs with special interests, the term 'public health' does not receive a single mention.

Some of the political measures used by the government to shape the role of the GP and encourage them to perform specific activities (such as health promotion or minor surgery) were discussed above. The government is clearly expecting a shift in attitude, behaviours and actions of primary care staff, and, through PCTs, it is expecting them "to take the lead in developing and redesigning systems in primary and secondary care as well as tackling public health issues locally" (DH 2002b:8).

The House of Commons health select committee on public health commented that GPs are "in a central position for the dissemination of health advice and they would seem to be a main plank of the public health function" (2001:paragraph 69). However, they also conclude that

> GPs' wider public health role often takes a back seat to the other functions they must carry out ... GPs are also, in general, not used to or trained in taking a public health perspective. They work with the concept of individualised care, and to make the shift to a population overview would require a great deal of support (paragraph 70).

For many GPs – those not actively involved in early commissioning and fundholding arrangements, the introduction of PCG/Ts brought them their first experiences of working towards a population approach, and of planning services in collaboration with a wide range of providers and disciplines. PCTs, whilst having a multi-disciplinary, multi-agency focus, strongly rely on professional support for success. However, the national tracker survey of PCTs found that only 61% of PCT board chairs felt that a majority of their local GPs positively supported the organisation (Wilkin *et al.* 2002:3).

A number of barriers to incorporating a public health approach into a GP's existing patterns of work have been identified. These include the tendency of GPs to focus on disease management, the time constraints bound by short patient consultations, financial constraints, poor information management and technology, and lack of skills in areas such as community health needs assessment. Recognising a skills shortage in this area, the CMO recommends "more opportunities for GPs to gain training and experience in public health practice", and local programmes which will "foster public health approaches in primary care staff and encourage those with existing skills to make full use of them" (DH 2001b:34). Innes (2001), however, points to a more fundamental conflict between New Labour values and the traditional professional values of GPs (see Box 3.3).

A similar conflict, according to Pratt (1995), exists between 'practitioner values' and 'practice values'. Practitioner values, he explains, "reflect the central importance of the individual patient and the need for the practitioner to give the highest priority to that individual" (p.4). These values are strongly held by primary care practitioners - particularly GPs who have traditionally had a highly

individualistic approach to their practice. More recently, though, practice values have been pushed to the fore and, since the 1960s, have impacted on all practices. Practice values are "those appropriate to improving the health of a population. They reflect the central importance of maximising health gain for a population within the available resources" (Pratt 1995:4). They are broadly synonymous with those of 'new public health'. Whilst Pratt explains that practitioner and practice values in some ways support each other, they are often in conflict, with any 'truce' often being tentative and fragile.

Despite the exhortation of Hart, and others, that "effective general practice demands work with patients' communities as well as with individual patients" (Hart 1988), the development of a public health approach in the profession of general practice has largely been sidelined. In practice, it is the orthodox medical approach which has tended to dominate general practice, and as a result, disease processes have received more attention than health promotion, the care and treatment of individuals has taken priority over the prevention of illness at the community level, and clinical intervention has largely overwhelmed broader social and environmental action (Baggott 2000).

BOX 3.3 Comparison of values

New Labour values	*Professional values*
Openness	Confidentiality
Equality	Respect for an elite
Quality (as defined by Government)	Quality (as defined by profession)
Management	Professional judgement
Political leadership	Professional leadership
Democratic accountability	Self-regulation
Teamworking	Maintenance of professional roles
Maximising service levels	Retention of control over service delivery
Partnership	Professional autonomy
Customer empowerment	Professional expertise
Modernisation	Conservatism
General health improvement	Commitment to individual patients/clients

(reproduced from Innes 2001:44)

The professional and policy literature presents no clarity around public health roles and expectations. A recent report for the GMC (Mihill 2000), which discusses many of the issues currently facing GPs, pays scant attention to the public health agenda, or to the public health roles of GPs. It suggests that working within PCTs and partnerships provides an opportunity for GPs to change the focus of their role away from seeing every patient, and towards concentrating on the more complex cases. The implications are that an even

more individualistic, biomedically-oriented role could develop. Several commentators interviewed for the report voice the opinion that GPs are not the best people to take on a public health or health promotion role. They point out the differences between personal medical services and public health, and the lack of skill base or outlook of most GPs to think about public health problems.

Literature and policy that does engage with the public health role of GPs is overwhelmingly focused on the education, promotion and advice aspects of the role, and is concerned with evidence-based approaches and cost effectiveness. There are two major difficulties in clarifying a public health role for GPs. The first of these is the multiple, often contradictory or unrealistic nature of a modern GP's role which expects that they work

> not only as medical scientist, but also as an educator, priest, beautician, government representative, researcher, marriage guidance counsellor, psychotherapist, pharmacist, friend, relative, financial adviser, as well as anthropologist - intimately familiar with the local community, its needs, traditions, dialects, and ethnic composition (Helman 2002:620).

GPs are often supposed to be 'ideally placed' to manage an almost endless list of problems in primary care. However, little regard is paid to the views of GPs concerning the competing demands on their time. Given such a wide scope to their role, Griffiths (2002) suggests that a single GP can contribute only a little to public health. Bringing GPs together under the rubric of the PCT, she suggests, has much more potential. The second difficulty is caused by the employment status of the majority of GPs, who work as independent contractors to the NHS (and hence are business people). This maintains an emphasis on money maximisation within each practice which is unlikely to sit comfortably with a wider public health brief.

These tensions faced by GPs, and the lack of understanding of their implications for public health roles, have resulted in the development of what Harrison (2001) describes as a mismatch between what is believed about GPs (the rhetoric) and what GPs actually do (the reality): In *rhetoric*, the GP provides a full range of services, working to a biopsychosocial model, and is available at all hours; In *reality,* the GP provides limited services, working to a bio(psycho) model, and is limited in availability (p.6).

3.5.2 Community Nurses

What do community nurses do?

The nursing workforce in the community make up a large and important part of the NHS workforce. As such, "the nature of nursing work and the profession of nursing itself are firmly intertwined with health and social policy developments" (Masterson 2002:332). Nursing in primary care has a long and proud tradition, providing care to individuals, families and communities in their homes, workplaces and schools, and in surgeries (DH 2002a). Early on, a single nurse would often hold a generic nursing role, administering to the needs of all patients/clients outside of hospital, and performing a range of clinical, caring and administrative tasks. Since then, though, nursing roles in PHC have become increasingly specialised, so that generic community nursing roles are now present only in very rural areas (Drennan and Williams 2001). A further element of the community nurse's role, particularly for those conducting home or family visiting, was that of public health and health promotion. Evolving at a time when child mortality was high, community nurses were charged with educating mothers in basic health and hygiene.

The nature of community nurses' work, and the services they provide, are shaped by many contextual factors including NHS policy directives, professional initiatives, the proliferation of scientific knowledge and technical expertise, and changes in health and population profiles. Nurses have been forced, over the past few decades, to reassess their role and examine their practice "in a climate of shifting priorities and competing demands" (Albarran and Whittle 1999:2). Whilst policy may not be the most important contextual factor, it is probably the most influential (Unsworth 2001). Recent policy changes which have emphasised the move towards a primary care-led NHS and the strengthening of the public health function have played a large part in the present development of community nursing. In addition to policy, though, local context, as well as organisational structure and culture, also play an important part in shaping nurses' roles. Finally, the way in which nurses construct their role identity (Melia 1987), and a host of individual factors such as experience and knowledge of the organisation (Manion 1993, Clarke *et al.*

1998), confidence and skills (Mason *et al.* 1991), and interpersonal relationships with the PHC team, all determine the ways in which nurses practice.

Recent Developments in Community Nursing

In 1986, a major review of community nursing known as the Cumberlege Review (DHSS 1986b) highlighted that nurses in the community are ideally placed to respond quickly to the needs of individuals and families. It emphasised the importance of the nurse's role in the promotion of health and the prevention of illness as well as support of elderly or handicapped people in the community, together with those who care for them. The recommendations included proposals for improving the organisation of community nursing services, making better use of nursing skills and improving training. The report was met with mixed reactions, though. GPs were particularly against the report's proposals to plan, organise and deliver nursing on a neighbourhood basis. Ottewill and Wall (1990) suggest that this antipathy can best be explained by reference to the nature of the relationship between GPs and community nurses, which, since the inception of both professions in the 19th century, continued to reinforce the assistant or handmaiden status of the nurse. The subservience of the nurse to the doctor reflected gender relationships within society at large, as well as nascent professional relationships within hospitals. This supremacy of the GP vis-à-vis community nurses was overtly challenged by Cumberlege and her colleagues, and GPs reacted with predictable fervour. Whilst the report was well researched, with justified recommendations, the GPs ensured that the proposals were not fully implemented.

Despite this, the review was influential at the 'grass roots' level, with many district health authorities responding positively to the concept of neighbourhood nursing (Ottewill and Wall 1990:433). It also prompted the expansion and development of skills in the community nursing specialities. Many policy and structural changes, including the NHS and Community Care Act, and those associated with developing a Primary Care-led NHS, have

accentuated these changes, giving nurses within Primary Care even greater prominence within the 'new' NHS (DH 1993a, 1993b, 1997, 1999, 1999, 2001e).

An important part of the development of community nursing has been the introduction of a clinical career structure, in which nurses can develop into specialist and advanced practitioners, with the help of post-registration education and practice (UKCC 1990, 1994a). Many nurses, following registration, will work at the 'professional' level of nursing, in which newly qualified nurses consolidate their training, and develop confidence and competence. However, the UKCC recognised that in order to meet the specialist health care needs of patients in the community, further educational preparation would be required. This further education, leading to a specialist community health care nursing qualification, is intended to prepare nurses to develop knowledge and skills in the following broad areas:

- Clinical nursing practice,
- Care and programme management,
- Clinical practice leadership, and
- Practice development

  (Albarran and Whittle 1999:8).

The course is designed to equip nurses to exercise higher levels of discretion in decisions regarding patient care provision. It was also decided, though, that specific programmes should prepare practitioners to meet the specialist needs of patients or client groups (UKCC 1994a). Eight specialist areas for community health care nursing practice have been identified:

- General practice nursing
- District nursing
- Public health nursing - health visiting
- School nursing
- Occupational health care nursing
- Community learning disability nursing
- Community children's nursing
- Community mental health nursing

The UKCC's idea of a seemingly clear hierarchical career structure, and a unified discipline with distinct specialist areas, is much more confused in practice[10]. This confusion is exacerbated by the numerous nursing titles in common currency, and by the UKCC's reluctance to acknowledge all but a few (Dodd 2000). Specialist and advanced practice are both difficult to understand and describe – it is difficult to see if they are about levels of education and academic ability, or about practice. Thompson (1996:260, cited in Dodd 2000) attempts to clarify the main terms (See Box 3.4).

The unified discipline was created to integrate existing strengths in order to better meet the broad range of health care needs within community settings. However, in practice, the different branches of community nursing have tended to remain separated, mistrusting each other and maintaining inter-professional rivalries (Billingham and Boyd 1996). Nursing staff working within PHC have been accused of being fiercely protective of their own work areas and roles. Whilst Unsworth (2001:16) argues that community nurses are essentially working towards the same goal - "they exist to assess health needs, and plan and deliver care to address those health needs" - Hyde (1995:23) contends that in practice, "a common focus which binds all eight named specialist ... nurses is hard to find". Despite the professional territorialism of the different groups, the essentially generalist nature of many of their roles means that role parameters and practice agendas are, to a large extent, flexible and negotiated. This can, according to Carr, "lead to issues of

BOX 3.4 Nursing Terms

Specialist Nurse: Usually a senior nurse with specialist experience and training in a particular field of nursing, who cares for a group of patients within that field (e.g. diabetes).
Nurse Practitioner: More of a generalist who has a broad spectrum of patients to care for and a high level of responsibility, which includes controlling her own caseload, running minor illness clinics and prescribing treatment.
Community Specialist Practitioner: Has undergone statutory standards of education to degree level and is the only recordable qualification of the three with the specialism being practice nursing, district nursing, health visiting, etc, not just asthma or diabetes.

[10] Note that the UKCC ceased to exist in April 2002, when its functions were taken over by the new Nursing and Midwifery Council (NMC).

uncertainty in relation to 'What is my business?'" (2001:336). These unclear boundaries and associated professional rivalries can mar the working relationships of practice nurses, district nurses, and health visitors (Mackenzie and Ross 1997).

Ongoing negotiations and consultations regarding changes to the national nursing register aim to better reflect the generic nature of nursing and simplify the existing 15-part register. The NMC (Nursing and Midwifery Council), which took over the functions of the UKCC when that ceased to exist in April 2002, has recommended a three-part register. In this, two parts are for nurses and midwives, and the third part is for 'public health', with the registrants being known as 'public health practitioners'. This has huge implications for both nursing and for the way in which 'public health' is seen in the profession. One consequence of the new three-part register might be a split, both between and within disciplines, between those who 'do' public health and those who 'don't'. There are also important implications in terms of the educational preparation for registration as a 'public health practitioner'. Registration will depend on the standards of public health practice which are being worked on by Skills for Health UK (2003). The new register is also, importantly, part of the movement towards making the traditional titles of specialist nursing obsolete. This move will be interesting since, although distinctions between different nursing disciplines are to a certain extent being eroded, there are still key features of each - largely based on location of work (e.g. the practice, a patient's home, the community) - some of which derive from historical roots and permeate professional identities. These important changes will help to shape the degree to which, and how, public health is formally embedded within nursing.

Current expectations of Community Nurses

The recent nursing strategy - *Making a Difference* - confirms the important role that community nurses will be expected to play in the New NHS:

> Nurses, midwives and health visitors are vital to delivering this bold programme of change. They are already playing key roles in establishing primary care groups and trusts, developing health improvement programmes and service agreements and building

> integrated pathways for patients. As the new NHS develops we want nurses, midwives and health visitors to play a central part in implementing national service frameworks, and securing quality improvement through clinical governance (DH 1999:10).

In order to live up to these expectations, as well as cope with the increasing burdens placed on primary care, community nurses are having to re-assess and expand their scope of practice. There is a growing evidence base for extending the roles of nurses and health visitors, particularly in the areas of prescribing, management, and public health (Walsh *et al.* 2003, Elliott *et al.* 2001, Guest *et al.* 2001, Reid and ENRiP Team 2001, Elkan *et al.* 2000, Kinnersley *et al.* 2000, Shum *et al.* 2000, Luker *et al.* 1997). The nurse practitioner role has long been advocated as a means of improving care for the population (Stilwell 1981, Burke-Masters 1986, cited in Carr *et al.* 2001), although it is yet to be widely integrated into primary care. The role is akin to that of a GP, and there is no limitation to the nurse practitioner's practice (RCN 1997). The changing role of the nurse has made role boundaries more difficult to identify. It also means that there is a great deal of variation in practice within the discipline and specialist groups.

Public Health Roles

The idea that community nurses should play a prominent role in developing public health approaches is not new, but began to be discussed more vigorously in the 1990s. Since that time, the term public health nursing has been used, rather confusingly, in a number of ways: Firstly, it is used to describe the general contribution of all nurses to public health; secondly, it is used in relation to some diverse nursing specialities (such as infection control nursing, and community-focused health visiting); and finally, the idea of public health nursing as a named profession has generated much discussion (for instance, Billingham 1991), and has been put into practice in specific areas (see Khan and Landes 1993). The use of the term in the UK, then, is vague, and there is little discussion of how it relates to public health nursing in other countries, where the term has been used for much longer (Khan and Landes 1993, Craig 2000).

Looking at the general contribution of all nurses to public health, the Royal College of Nursing argued that public health approaches can be incorporated into nursing practice at an individual level as well as at population, group, community and policy levels (RCN, 1994). It identified six key activities for public health work in nursing which can be incorporated into practice:

1. Assess the health needs of local populations through the compilation of health profiles.
2. Support people to participate in the life of their community to influence factors that affect their health.
3. Increase health resources in communities by establishing local networks.
4. Build healthy alliances and a supportive infrastructure to provide information, resources and practical help for community initiatives.
5. Engage with the local statutory and voluntary groups to work towards health-related policies and actions.
6. Increase uptake of health services by ensuring they are accessible, offered appropriately and effectively targeted.

The SNMAC (Standing Nursing and Midwifery Advisory Committee) report (1995) recognised the long traditions of public health work carried out by some nurses, such as health visitors, school nurses, occupational nurses and those working in communicable diseases. In addition, it suggested that many others were also ideally placed to increase their contribution to public health. The report urged nurses in every sphere of practice to become "thoughtful in promoting public health strategies and interventions, working together with the people and communities they serve" (quoted in Morgan 2000:158-9). The CPHVA[11] (1997) also contributed to the debate and outlined concepts which underlie public health work. These ideas have been confirmed and reiterated in recent government policy documents (such as DH 1999, 1999, 2001b, 2001g), and a programme to develop the public health aspects of nursing, midwifery and health visiting is underway. In a new framework for nursing in

[11] The CPHVA (Community Practitioners and Health Visitors Association) is both a professional association and trade union, and was founded as the Health Visitors Association in 1898.

primary care, the department of health describe 'public health / health protection and promotion programmes that improve health and reduce inequalities' as one of the three 'core functions' to be provided by nurses, midwives and health visitors (DH 2002a:8).

The extent to which public health activities are carried out in practice, however, is limited – often being restricted to rare examples of innovative and relatively unsupported activities. Despite apparent enthusiasm for involvement in public health work, many barriers remain which prevent such work in practice (Cheater and McMurray 2002, ENB 2000, Hoskins 2000, Plews *et al.* 2000, Fox 1999, De Witt and Carnell 1999, Rowe *et al.* 1998, Billingham and Perkins 1997, Lomax and Wright 1997, Dalziel 1992). Craig (2000:1) suggests that there is a clash between the exhortation by UK nursing bodies to develop community nurses' public health functions, and the primary care reforms during the 1990s, which continued to draw nurses into more individualised, medical models of practice. It is apparent that new or expanded public health functions can not be absorbed within the demands of existing roles.

Ewens' (1998) study of community health care nurses' role perceptions highlights that an individualised, person-centred, holistic approach to care continues to dominate practice. She concludes that the public health role within community nursing remains underdeveloped and is equated with primary prevention with the well population.

3.5.3 Public Health Nursing – Health Visiting

Health visiting is the branch of community nursing most often associated with public health. Recent policy identifies it as being pivotal to the government agenda for improving the health of individuals, families and communities. But, as the table below shows (table 3.1), public health is not a new concept in health visiting (Appleby and Sayer 2001).

Cowley (1996) describes the origins and subsequent development of health visiting as part of the developing public health movement. Changes in its focus and nature, she explains, mirror those in the rest of public health. Whilst

the very first health visitors emerged during the latter part of what Cowley describes as the first phase of public health, which concentrated on physical conditions and environmental change, the profession did not begin to develop formerly until the end of the nineteenth century, by which time the focus of the public health movement had shifted to individual, personal, preventive and medical services. Their introduction was strongly linked with the work of sanitary inspectors, although during these early stages, the roles of the two occupations were strictly separated by both class and gender (Cowley 1996). Early health visiting, therefore, focused on "moral education and teaching the labouring classes the skills of housekeeping and family values" (Caraher and McNab 1997:380).

Whilst health visiting is undoubtedly rooted within the public health movement, Caraher and McNab (1997) suggest that its early history is often described romantically and idealistically. Although early health visitors carried out much public health work, Symonds (1991:256) notes that this was conducted within the "private sphere of the home and motherhood". Caraher and McNab (1997) describe the first health visitors as regulators on behalf of the state. Whatever their motivation for entering this new occupation, early health visitors were essentially in charge of creating responsible mothers among the labouring classes, monitoring the welfare of this social group on behalf of the state in order to maximise their contribution to the future workforce and ensure their potential participation in the imperial army. Early health visitors, then, represented a compromise between family liberties and state supervision.

Some more radical early health visitors recognised the effect of poverty and poor housing on child mortality rates and fought to change social policy with some success (Appleby and Sayer 2001). Dingwall (1977), though, notes a decline in their radicalism throughout the initial phase of their development. As a result of political, social and professional developments, health visitors could be seen to be drifting away from their early public health role, towards a more medical, task-oriented one.

The Jameson Committee, in 1956, made clear the medically-oriented intentions for health visiting, in its recommendation that health visitor courses should be:

> ... practical in their approach to all aspects of the work ... build[ing] on the foundation of nurse and maternity training, adding new knowledge and relating previous knowledge to the facts of domiciliary practice, especially in association with general practitioners and hospitals. Practical knowledge of home management is necessary ... Much emphasis should be laid on the family welfare aspects of all visiting and on 'mental hygiene' (Ministry of Health *et al.* 1956:X, quoted in Robinson 1982:25)

In 1962, as recommended by the Jameson Committee, the Council for the Education and Training of Health Visitors (CETHV) was established as the regulating authority[12]. Their curriculum for a 'new breed of health visitor' established the health visitor as a nurse with post-registration qualification who provides a continuing service to families and individuals in the community. The term 'health visitor' started to be used less in official documents, with the generic terms 'community nurse' or 'primary care nurse' taking precedence or incorporating health visiting (Cowley *et al.* 2000:14). This indicates an increasing blurring of roles between the different practitioners within the community nursing workforce.

The new CETHV did much to reassess the role of the health visitor. Their 'principles' of health visiting (CETHV 1977) were underpinned by the 'value of health', and were to provide a guiding basis for their work. The principles captured "the proactive stance and breadth of the health visiting endeavour" (Cowley *et al.* 2000:36), and are still considered to be relevant and important to contemporary health visiting practice. They have also formed the basis of later inquiries, for instance, into the difficulties of evaluating health visiting (Campbell *et al.* 1995), and on the development process and thinking around developing standards and competencies for health visiting (UKCC 2001).

Whilst the profession was calling for a shift towards a family and community focus, other changes in policy and structure, and the persistent narrow,

[12] Responsibility for regulation subsequently passed to the UKCC in 1983.

medical focus of the NHS, made the implementation of such an approach problematic. Cowley *et al* (2000:36) write that "It has been increasingly difficult to maintain a preventive, public health stance in a health service focused on clinical effectiveness, increasing resource efficiency and measurable individual interventions" (see also, Cowley 1997).

New Labour's political support of a family-centred public health role for health visitors (DH 1999) is beginning to open up new opportunities for the discipline. However, whilst health visitors are increasingly being given political, educational and managerial support for their public health roles, some tensions remain. Where health visitors remain within general practices, and are still charged with carrying out complex child development checks, they are unlikely to be able to widen their role substantially. Moreover, Caraher and McNab (1997) argue that recent approaches, such as that outlined in the SNMAC report on the Public Health Role of Nurses, Midwives and Health Visitors (1995), still seem to put health visiting and its contribution to public health within a medicalised model of purchasing and providing health services and providing professional care.

There remains much diversity within the profession, with role boundaries proving to be mobile. Whilst some health visitors clearly work on a population basis, this is not the case for others (Caraher and McNab 1997), and studies suggest that some health visitors are not utilising all dimensions of their role (Knott and Latter 1999, Jinks *et al.* 2003). Related to this is a lack of understanding by others of their broader role. In Knott and Latter's (1999) study, for instance, which looks at health visitors' work with single, unsupported mothers, the participants perceived health visiting as being concerned almost exclusively with babies.

The CPHVA has maintained its long held view that everything a health visitor does is public health (CPHVA, 1997). However, a key issue, which has been discussed since the early 1990s, is whether the work of health visitors should be redirected to contribute to an overall public health approach to health care, or whether health visitors should become new public health nurse specialists

(Billingham 1991, Craig 2000). Whilst health visiting is more traditionally seen as a branch of public health, public health activities are generally developed outwith public health departments, and often are not recognised as public health, or not supported (Craig 2000:7). Also, the current direction of primary care structures is drawing health visitors further into primary care, resulting increasingly in the need to work with a medical individualistic approach and less with a population focus (Craig 2000). If public health is seen as a branch of health visiting, on the other hand, attention could be focused on those practitioners who can and do work with a collective approach, focusing on population or community health needs rather than individual ones (Craig 2000). The dilemma is whether the profession should be the key player in the public health function, with all health visitors becoming specialists in public health practice, or whether their role is one of contributing to public health within and alongside their current practice. In the case of the former, there are significant implications for current health visitor practice and for the future of health visiting training.

Discussion of the public health role is confused, as people use the same term to describe very different approaches. The standing nurse and midwifery advisory committee, for instance, claimed that health visiting is all about public health because of its role in health promotion with individuals and communities (SNMAC, 1995). This is misleading, though, as public health in health visiting can be interpreted as activity relating to public health medicine priorities (for instance, contact tracing for tuberculosis, or health service needs assessment), or it is used to describe health visitors carrying out community development activity.

The key issues in the historical development of health visitors, and the ways in which they impact on their public health role, are summarised in the table below.

Table 3.1 The Historical Development of Health Visitors (HVs)

Period	**Characteristics and Role definition**	**Implications for public health role**
1890s - 1946	Universal home visitor, usually female, middle class. Initially worked for voluntary organisations, later for local metropolitan boroughs. Offers 'friendly' advice to mothers on home and family health, predominantly around issues of hygiene and disease prevention, in order to reduce infant mortality and improve child health. From 1907 (Notification of Births Act), responsible for child surveillance and carrying out a home visit to each new born baby. From 1925 a midwifery qualification was a pre-requisite (Cowley et al. 2000).	Concerned with public health, but within the private sphere of the home and motherhood. Dirt theory of disease dominated, as did behavioural, advice-giving approaches. Child surveillance duties cut links with sanitary inspectors and focused activity more on individuals, rather than the environments in which they were forced to live (Cowley et al. 2000:12). Policy influence/change left to radical few (Appleby and Sayer 2001).
1946 - 1962	Duties (under Local Authority) in the care of expectant and nursing mothers and of young children extended. Concerned with health of the household, preservation of health and precautions against the spread of infection. Increasingly important part to play in health education and social advice (Robinson 1982, Cowley et al. 2000).	Child surveillance duties dominated role; links with medical model strengthened. Expected to work closely with GP but 'not encroach on the province of the nurse ... or of the sanitary inspector' (Robinson 1982, quoted in Cowley *et al.* 2000:12). Cutting the links with sanitary inspectors focused HV activity "even more closely on individuals, rather than the environments in which they were forced to live" (Cowley *et al.* 2000:12).
1962 - 1974	'New breed' of HV: nurse with post-registration qualification. Work includes: 1. Prevention of mental, physical and emotional ill health and its consequences; 2. Early detection of ill health and the surveillance of high risk groups; 3. Recognition and identification of need and mobilisation of appropriate resources where necessary; 4. Health teaching; 5. Provision of care; to include support during times of stress and advice and guidance in cases of illness and in the care and management of children. (Cowley *et al.* 2000:15)	Public health role continued to be predominantly focused on the private sphere of family life, essentially individualised and geared towards behaviours. Insistence on nurse training ensured that new HVs all served a period of time in general hospitals. This served to 'subvert' the formerly radical profession, training them within a medical model marked by individualism and unquestioning obedience (Dingwall 1977). By this time, health visiting had "clearly fallen under medical control" (Cowley 1996:314). The priority was infant welfare, and a holistic public health approach, geared towards social and environmental change, was increasingly diluted.
1974 - 1997	HVs increasingly became attached to general practices. CETHV reassessed role and identified 4 principles of HV practice (which still apply today) (CETHV, 1977): 1. The search for health needs 2. The stimulation of the awareness	Focus shifted from individual to family and community, and widened scope to include community action and policy change. But, transfer of HVs from the LA to the NHS, which was hospital-oriented and cure-focused, inhibited the establishment of a wider public health approach and arguably

	of health needs 3. The influence on policies affecting health 4. The facilitation of health-enhancing activities. Role shifted to that of empowering people to take responsibility for health. Child development continued to be a mainstay of role.	eroded links with LA colleagues such as social workers and environmental health officers. Introduction of general management (1980s) meant HV's role became increasingly dominated by complex child development procedures. Attachment to general practices generally focused their attention towards patients on the list, rather than neighbourhoods. Working within a medically-dominated practice culture likely diminished their autonomy and capacity to become involved in wider public health action. While the role, in theory, widened to encompass broader public health approaches, in practice, it became more narrowly focused on individual prevention / promotion (increasingly on a medical model) and child development.
1998+	'Modernised' role: family-centred public health role, working with individuals, families and communities to improve health and tackle health inequalities. HVs need to work in new ways, across traditional boundaries with other professionals and voluntary workers (DH 1999). Expected to take on leadership roles, initiate and develop programmes, and work towards improving the health of neighbourhoods or groups such as homeless people. Expected to use community development skills to help local communities to identify and address their own health needs (DH 2001h). Expected to be involved as PCT board members.	Health inequalities firmly on the agenda and HVs recognised as key public health practitioners. Focus of attention widened from just young children. Principles of community development taken on board, and community based, population approach of public health expected to be integrated with individual and family work.

3.5.4 District Nursing

District nurses are the largest group of community nurses in the United Kingdom. The overall responsibility for assessing and planning how patients' and families' needs are met remains an essential element of their role (Kennedy 2002). The evolutionary development of the district nurse's role has taken on a new pace in recent years (see table 3.2 below), although some district nurses "seek to continue with their traditional role while all around them the world is changing" (Unsworth 2000:113).

Despite the talk of role development, and a recent focus on making more efficient use of district nursing services (Audit Commission 1999, RCN 2002), role definitions for district nurses remain vague. They are often encompassed within the broad roles of 'community nurses' or 'primary care practitioners'. Indeed, Hesketh (2002) reports that district nurses believe that as far as policy makers and managers are concerned, they have become merged into a homogenous group labelled 'community nurses' and their specialist skills and expertise are neither acknowledged nor recognised. They believe, in short, that they have become invisible. The need for clarity regarding the role of district nursing was recognised several decades ago, and continues to be reiterated in recent work (Richardson 1974, Worth 1996, Bliss 1998, Audit Commission 1999).

Discussion of the public health roles of district nurses is even more limited, and restricted to very few theoretical and hypothetical debates (Hoskins 2000, Band 2003). Other studies have identified a lack of affiliation, amongst most district nurses, with a population or public health perspective (Cowley *et al.* 1996, McDonald et al. 1997). The literature suggests that district nurses tend to identify with health education rather than health promotion or public health in their role (Cantrell 1998, Ewens 1998).

Several commentators, however, have noted the particular skills of district nurses, as well as characteristics of their practice, which make them suited to a broader public health role. District nurses often hold a considerable amount of information about house-bound and older patients which could form a valuable part of a team's examination of health needs. In rural areas, district nurses frequently fulfil, in some permutation, the functions of district nursing, health visiting, school nursing, and community midwifery (Lauder *et al.* 2001). They are "often the first to recognise changes in health needs and, because of their acceptability within the community, often have access to private accounts of health which may not correspond to accounts that are given in public" (Band 2003:202). They would be well placed to look at health needs assessments of patients within their areas of contact and expertise (i.e. older people, and disabled and chronically ill people). Or they could work with a community

development approach with sections of the community such as older people. They have access to a large population, both well and ill, in a variety of settings. Unsworth (2000) suggests that they could work on areas of special interests and develop health promotion activities around these – for example, activities which raise awareness of common leg problems and aim to advise at-risk individuals on how these can be avoided. Cernick and Wearne (1994) note too, that they are often excellent networkers.

It seems that these skills, and the potential for district nurses to carry out a wider role, have long gone unrecognised, both in policy, and by colleagues within and outside the NHS. District nurses have been persistently viewed as providers of clinical care (Bliss and While 2002). The RCN reported that the role of primary health care nurses was often restricted because of a lack of understanding of their role (RCN 1980); and a RCGP report acknowledged that GPs may have seen the expanding role of the nurse in the context of providing assistance with technical tasks, as opposed to greater involvement in health promotion and counselling (RCGP 1986, Bliss and While 2002). More recently, the audit commission stated that the roles of district nurses are very much determined by those referring patients to them, and the referrers' understanding of district nursing. They find in their research that the majority of referrals are task-oriented, reflecting the referrers' limited knowledge of the services that district nurses can provide (Audit Commission 1999). This supports earlier findings, for example by Worth (1996) and Bliss (1998).

The key issues in the historical development of district nurses, and the ways in which they impact on their public health roles, are summarised in the table below.

Table 3.2 The Historical Development of District Nurses (DNs)

Period	**Characteristics and Role definition**	**Implications for public health role**
1830s to 1946	Provided family care outside of hospital, essentially nursing the sick poor in their own homes, or providing comfort and care to the dying. This included obligation to teach the patient and family appropriate basic nursing skills necessary to the maintenance of care (Sweet and Ferguson 2000). District nursing included a wide range of duties, delivered at variable standards, by nurses with minimal or no training under a diverse range of management and supervision. They were formally established as Queen's Nurses in 1887. In many cases, the DN worked with multiple roles, encompassing those of HVs and midwives, and advising on matters of health and hygiene.	Role revolved around responding to immediate physical needs of patient requiring treatment, but also fulfilled a social need for health care provision for the poor. Instructive/educative role grew from a medical perspective and was directly related to the DN's approach to the care of the sick (Sweet and Ferguson 2000). DN commonly became confidante and counsellor, with the potential to influence and educate individuals on a wide range of issues.
1946-1974	Stereotypical DN seen as having maternal or semidomestic and dominantly female role as a generalist, concerned more with 'caring' than with 'curing'. Attached to general practices from the 1960s. DNs were encouraged to have discreet clinical sessions within the surgeries (e.g. for ear syringing, urinalysis, dressings) (Gupta 2000, DH 1968). These services, though, were often not seen as priority and PNs increasingly took on such tasks. As women were increasingly encouraged to have their babies in hospital, the DN's workload was reduced. 'Traditional' district nursing role centres on provision of care to patients at home (rather than previously more encompassing role of provider of care outside hospital). According to what the patient wanted, DNs "carried out any number of tasks from making breakfast for patients, to polishing their shoes, meeting their basic hygiene and complex terminal care needs, to offering specialist advice" (Griffiths 1998:235)	Many DNs came under hospital nurse management or under community-based control of HV directors of nursing – they were thus barred from direct participation in their own management. This is likely to have constrained the DN's role within the medical agenda, or within the practical and political priorities of hospitals and nursing managers. Closer attachment to PHC teams led to reduction in team working on locality basis. Patients often geographically dispersed, so idea of DN being a well-known figure in local community is largely an image from the past (Audit Commission 1999). Role developments tend to be more specific to the particular needs of a practice, rather than the needs of a locality or defined population. This is likely to reduce the public health aspect of their role.
1974-1997	Complexity of role increasing as result of increasing dependency of community patients and more intermediate and secondary care taking place in the primary care setting (Audit Commission 1999). Much of role focused on helping to care for chronically ill patients, in partnership with the patient and his/her family. Significant proportion of patients (about 7% of all contacts in 1999) seen in residential	Role focused on technical skills geared towards the care of ill patients. Any health promotion likely to be secondary or tertiary. Working in a 'family' context includes responsibility for health and welfare of carers, as well as helping/educating the carer(s) to look after the patient. Work in residential homes provides

Period	**Characteristics and Role definition**	**Implications for public health role**
	homes (Audit Commission 1999). Increasing emphasis on technical (as opposed to personal) nursing care (Audit Commission 1999). (Many traditional nursing practices transferred to social carers following implementation of NHS and Community Care Act in 1993). More emphasis placed on holistic and comprehensive assessments (Ross and Mackenzie 1996:59). Many trusts increased the role of DNs in health education and health promotion. They were seen to have an important role in advising patients, often at an informal level, in areas of accident prevention and general health information (DHSS 1976, McDonald *et al.* 1997). Mandatory training for district nursing was not introduced until 1981. Community nursing was included as a module in all pre-registration courses in 1988 (Bliss and While 2002). DN education moved to degree level in 1994, and included a greater emphasis on evidence-based practice.	potential for group health promotion activities and for assessment of needs on a small 'community' basis. Removal of 'personal' care might lessen the 'holistic' nature of role, and weaken the close relationship with the patient and family. On the other hand, it might free up time to develop other (possibly public health oriented) roles. Emphasis on holistic care management might enable more strategic approach to meeting needs in a community, as well as moving on from working within a strictly medical model. Developments in training were important in raising the status of community and district nursing. DNs now in a stronger position to work autonomously. This may lessen their status as 'assistants' to GPs (Bliss and While 2002).
1998+	"District nurses are registered nurses with an additional qualification that enables them to assess (and reassess) patients' and carers' needs in their homes, to plan appropriate services for patients, to implement and evaluate programmes of planned nursing care, to manage a nursing team and to supervise the performance of all staff attached to the team. Crucially, district nurses work at the boundary of health and social care delivery and make a major contribution to the multidisciplinary assessment of patients, the formulation of care packages and liaison with social services and others in service delivery" (Audit Commission 1999:8) Expected to take opportunities to help people with chronic illnesses to manage and control their condition (e.g. as part of the 'Expert Patient' initiative) (DH 1999). Expected to be involved in planning of services as a PCT board member. Employed by PCTs but most remain practice-attached. Some new roles developing, e.g. to offer specialist services to the elderly or those with learning disabilities, or to offer nurse-led services to vulnerable groups. Some of these new roles cross professional and	Shorter periods of hospital stay, rising number of elderly people and the trend toward caring for chronically ill people at home, has meant that DNs spend more time caring for people at home. The role has maintained a very individualised approach. RCN offers DNs a framework for future practice but does not directly refer to a PH role (RCN 2002, Band 2003). NSF for older people highlights multisectoral approach to promoting health, independence and wellbeing in old age – this is likely to be a key role for DNs and could strengthen their public health perspective (Band 2003). PCTs bring potential for developments over larger locality area. Growth in number of specialist posts which focus on medical technical roles – could detract from public health roles of all DNs. Many DNs see themselves as managers rather than givers of care

Period	**Characteristics and Role definition**	**Implications for public health role**
	organisational boundaries. Nurse prescribing introduced. Increasing involvement in intermediate care (e.g. in step-down units) as patients come out of hospital earlier. Increasingly concerned with the health and welfare of carers.	– loss of 'hands on' nature of work (Hesketh 2002). This could allow them to develop a broader public health approach.

3.5.5 Practice Nursing

Practice nurses occupy a unique position amongst community nurses, being largely employed and managed directly by GPs. Working outside of the NHS nursing structure in this way leaves them somewhat isolated in surgeries, and not often in contact with peers. In addition to this, they are often working part-time. This situation has both advantages and disadvantages. Many practice nurses welcome the opportunity to work outside of the constraints of a hierarchical nurse management structure, in the belief that they will achieve a greater level of autonomy. On the negative side, however, there is potential for lack of professional supervision and development, as well as the network of support that usually comes from belonging to a larger organisation. The direct employer/employee relationship may mean that practice nurses must negotiate their own contract, conditions of service and study time to meet professional development needs. This situation can leave practice nurses isolated and at risk, and has directly impacted upon both their employment and financial status (Gupta 2000).

Practice nursing is a relatively recent phenomenon, with numbers only becoming significant in the early 1980s (Carey and Jones 2000). The growth in their numbers and roles arose from changes within Government policy and the increasing pressures on primary care (see table 3.3). The tasks that they perform are keenly related to the needs of the GP, and, particularly after changes made to the GP contract in 1990, practice nurses were essentially employed first to minimise the workload of the GP, and second, to maximise profit (Carey and Jones 2000).

During this time of growth, practice nursing developed in an ad hoc way, and, unlike other groups, it did not have a recognised post-basic qualification. This, and the concerns held by district nurses and health visitors that their roles were being usurped by the newly inflated practice nurse population, fuelled arguments between these groups about who should do what (Carey and Jones 2000, Jeffree 1998). Practice nurses have had to fight harder than other disciplines to be recognised as valuable and equal members of the primary health care team, often in the face of articles and editorials in the nursing press denigrating them as 'untrained' and 'professionally naïve' (Carey and Jones 2000:294).

The role of practice nursing remains poorly defined, and there is limited data on their activities and skills (Audit Commission 2002). When Ross *et al* (1994) looked at the tasks of 620 practice nurses in one health region, they found that the activities they engaged in were very wide ranging – from primary prevention, to administrative tasks, such as stocktaking and cleaning. Often the first point of contact with the public, they gave telephone advice on clinical matters, dealt with emergencies and gave first aid. Ross *et al* found that whilst the practice nurses were overqualified for tasks such as cleaning and chaperoning GPs, most were not well prepared for the broad range of tasks that they were undertaking (Ross and Mackenzie 1996).

The lack of clarity surrounding their role has led to it being defined as task oriented in its approach – a perception which maintains medical dominance over the role (Quinney *et al.* 1997, Carey 2000). Practice nurses have "too often focused upon their contribution to the achievement of medical outcomes rather than the holistic nature of care" (Carey 2000:313). Even following the establishment of practice nursing as a distinct branch of specialist practice, the role remained indistinct. It was differentiated from that of the district nurse only in the clinical environment for care provision – being in the general practice surgery, rather than in the patient's home (UKCC 1994b, Carey 2000).

In the current political and social climate, in which people are encouraged to take responsibility for their own health, the role of the practice nurse as a health educator and role model has gained prominence. They clearly have an important role in promoting a healthier lifestyle in individuals. However, the

extent to which practice nurses adopt a public health approach to their work is unclear. Although it is increasingly recognised that working with individuals can only have a limited effect on the broader factors influencing health, and community development strategies are encouraged, very little has been done to describe the practice nurse's role in such strategies. Moreover, there are a number of barriers to adopting such an approach which are yet to be addressed. These barriers include the predominantly clinical focus of tasks, an increasing work load (especially as attention shifts from secondary to primary care), the influence of GPs over the roles and activities of practice nurses, and their physical location within the surgery.

Working as a practice nurse, then, inevitably leads to taking an individual perspective. However, Hope (2000) contends that this can feed into a broader collective process for health improvement, for instance, through involvement in PCTs. Morgan (2000:161) echoes current political rhetoric by saying that practice nurses "need to be willing to stimulate local action to improve the environment and increase resources for health". Such a role, however, seems a long way from current nursing practice, and attracts little discussion either in policy or amongst the profession. Indeed, it has been suggested that more of the day-to-day work of general practice could be devolved to practice nurses and that their roles could be expanded, for example in developing triage, and even diagnosing, referring and prescribing (BMA 2002, Audit Commission 2002). Such a move might threaten the development of a broader public health role, since it seems likely to increase the individual and clinical aspects of their role, and tie them even more closely to the practice surgery.

The table below provides more information on the historical development of practice nurses, and the implications of these developments for their public health role.

Table 3.3 The Historical Development of Practice Nurses (PNs)

Period	**Characteristics and Role definition**	**Implications for public health role**
1913 – 1965	First PN employed in 1913 (Jeffree 1998). Generally very isolated professionally. Working alongside the GP in the community, the role of the PN could be very broad, and span complete age range of practice population. They were often involved in administration of medicines and provision of treatment room services. Lack of definition of role, and lack of any specific training for practice nursing led to large variation in type and standards of tasks performed.	Working alongside GPs tended to make them 'handmaidens' to the doctor, with little autonomy. Mainly worked to an individualistic, medical model.
1966 – 1989	1966 Family Doctors Charter enabled GPs to employ nurses as part of their ancillary staff. As employees of GPs, they continued to be relatively isolated, with little sense of a collective voice. PNs developed as a professional group during the 70s and 80s. The 1st formal education initiative was a training programme organised in 1971 for PNs and treatment room nurses. Prior to this, education was either informal (e.g. through peer support and PN groups), or not specifically for PNs. It was not until 1988 that the RCGP set up a working party to help PNs to identify their training needs (Gupta 2000). Began to develop role from treatment room nurse and concentrate knowledge and practice in areas such as women's health, asthma and diabetes. Most PNs maintained their generalist role, though, providing care for a wide range of people, ages and conditions (Gupta 2000). They were generally responsible for a variety of tasks, usually including immunisation, women's health, dressings, routine injections, removal of sutures, collection of blood and other samples, recording electrocardiograms and ear syringing. They often provided a minor illness service (Reedy 1980, Ross *et al.* 1994, Gupta 2000).	Unconstrained by a nursing management structure, they were often able to adopt an extended role and were able to exploit new opportunities opening up in general practice (Gupta 2000). Lack of a clear role definition, and lack of comprehensive training specific to practice nursing, meant that PNs often became 'experts' in particular tasks or diseases (e.g. cervical cytology or asthma). This may have increased their focus on individuals, and moreover, on sick or at risk individuals. Their position as employees of GPs may in some cases restrict role development and maintain their status as 'handmaidens', working to doctors' orders. This is unlikely to foster a public health approach.
1990 – 1997	A census by the DH revealed that PNs were predominantly female and white (Atkin et al. 1993). Most PNs recruited directly from hospital (Gupta 2000). ENB validated its first educational programme (20 day course) for PNs (Gupta 2000). Practice Nursing was recognised by UKCC (in 1994) as one of 8 community specialist practitioner programmes, with PN degree level qualification (Gupta 2000).	Status as community specialist practitioner offered the first real opportunity for PNs to achieve equal recognition to other community nurses. The 1990 GP contract was designed to increase focus on a preventive, proactive approach, with a formal endorsement of health promotion.

Period	**Characteristics and Role definition**	**Implications for public health role**
	1990 GP contract promoted employment of many more PNs, and encouraged them to look for a more autonomous role in the practice team. Many new required tasks were delegated to the PN. Their role included: new patient medical, health checks for those adults not seen within 3 years, annual over-75 health assessments, health promotion clinics, and working towards set targets for cervical screening and child immunisation. Roles and experience developed in chronic disease management, health education, screening and lifestyle change. Their role increasingly moved away from a treatment room perspective to that of health promoter (Saunders 2001). Most PNs have confined their roles to the delivery of care within the general practice. Some, however, have developed services that involve home visits and assessment.	However, PNs had limited independence to develop their own ideas and approaches, because of the prescriptive nature of the new structure for health promotion funding, and the power relations within general practice (Russell 1997). The medical approach adopted in government targets (DH 1992) served to limit the true potential of the nurse in the promotion of health, emphasising individualistic health education rather than wider population-based approaches to care provision.
1998+	Roles more expansive than before – types of service provided can range from tasks such as ear syringing and venepuncture, through nurse-led chronic disease management programmes where the nurse takes responsibility for the management of certain conditions within agreed protocols. They are required to work effectively on interpersonal level with clients and staff, have a broad range of clinical knowledge and skills and understand the context in which general practice operates (Saunders 2001). Some PNs have developed specialist skills in e.g. asthma, minor surgery and family planning. Degree of specialisation will depend on size of practice, support of GP partners, health needs of practice population, etc. They are expected to collaborate in the development of practice profiles, analysing data from it in order to target particular health issues within the practice and inform the PCT strategic plan (Saunders 2001). Their involvement in audits (made possible by improved IT) is also important. Increasingly expected to be involved in PCTs and other community initiatives.	Most health education activity occurs in area of chronic disease management (Creed and McCusker 2000). Increasing focus on ill or at risk individuals likely to mean that most health education/promotion is secondary or tertiary. Specialisation by many PNs in specific disease areas reduces their generic role (e.g. as health promoters to the whole practice population), but may facilitate co-ordinated approaches to improving specific aspects of the practice population's health (e.g. in developing a comprehensive asthma strategy). This 'specialist' may also be a very useful source of information for PCTs and other strategic bodies. Opportunities to get involved in PCTs and community initiatives likely to be restricted for many PNs by their GP employers (since there would be time and cost implications).

3.5.6 Practice Managers

The job of managing the practice, once the domain of the GP partners, has increasingly been taken up by practice managers – described in 1995 as "one of the fastest growing health care occupations in the UK" (Huntington 1995:1). As practices grew in size and complexity following the 1966 GP contract, the first practice managers were appointed to deal with the increased organisation and administration (Hasler 1992). The introduction of practice managers was to allow GPs and nurses to devote maximal time to clinical work.

Early practice managers were often women, appointed from the ranks of practice staff. Their job was to 'ensure the smooth running of the practice' (Huntington 1995). Their roles very much depended on the size of the practice, the views of the GPs as to what 'management' involved, and the willingness of GPs to delegate specific functions. Huntingdon (1995:2) points out that

> As independent contractors and employers, GPs in their own practice, like Alice in Wonderland, can take the word 'management' and make it mean whatever they choose it to mean ... they are in a position to determine who does what.

Some practice managers' roles, therefore, were confined to administrative tasks, and they were often embedded with other roles such as secretary or senior receptionist. Amongst these early practice managers, there was a large variety in educational attainment, expertise and former work experience. They tended to be embedded within the 'culture' of the practice, and loyally administered to an individual doctor's needs, with very little say in either the operational or the strategic management of the practice (Huntington 1995). During the 1970s and 80s, though, the role of the practice manager evolved as practices developed. Managers took on more responsibility for finance, personnel, administration, maintenance of premises, ordering supplies, and became more involved in practice decision making (Westland *et al.* 1996).

1990 was an important year for practice management in two respects. Firstly, the new GP contract, and the introduction of fundholding, made good

management paramount[13]. This prompted recruitment from outside general practice, and men entered the occupation in larger numbers. Huntingdon (1995) notes that GPs often favoured the appointment of personnel who had retired from the forces, or who had retired early from financial institutions. These employees brought new 'rigour', skills and expertise in management, albeit to an unfamiliar field. The 1990 GP contract, GP fundholding, and the introduction of total purchasing, "all serve to give practice managers greater power to determine the size and composition of primary care teams" (Sibbald 1996:33). Secondly, the newly formed Family Health Services Authorities (FHSAs) began to curtail the GPs' freedom, and began to develop a stake in practice management and its development. These bodies sought to influence the recruitment, utilisation and development of practice managers.

Further developments in general practice and the increasing political attention on primary care, have all served to increase the importance of the practice manager's role. Since their introduction in the early 1970s, practice managers have moved from administration to operational management, and from operational to strategic management. Since the 1990 GP contract especially, they have played a greater part in the shaping of the organisation. As their potential to influence the practice's strategic planning increases, so does their potential public health role. They might influence the way in which the practice engages with and involves their patients, or the practice's response to local issues such as homelessness or drug abuse, and national issues such as teenage pregnancy or coronary heart disease. The increasingly important place of practice managers within general practice also potentially allows the GP to concentrate his/her attention on the health of the practice population.

Practice managers, however, hold a tricky position. These predominantly non-medically trained managers have no formal authority to exercise when dealing with medical staff. Indeed, s/he may even by employed directly by the GPs, whom s/he may see as being in a hierarchical position above him/her. Their roles, then, are determined to some extent by the practice culture, and the

[13] Indeed, some practices became fundholders in order to enable them to increase their management capacity.

attitudes of the GPs. A further tension is that their primary role is to manage the practice as a 'business'. Thus, practice managers, often non-health professionals, might tend to steer the practice toward money and business-oriented goals which rarely concur with the public health needs of the practice population.

3.6 SUMMARY

Section 3.2 described general practice as the principal setting for the delivery of primary health care in the UK. But the term 'general practice' can be interpreted in a number of ways, including: as premises, as a managerial unit, as a site of service delivery, and as a profession. Section 3.3 took a historical approach and described the main features of, and changes within, NHS general practice. Recent changes have brought new pressures to bear on general practice, which is expected to 'modernise', like other public services. Importantly, the task of improving the population's health and reducing health inequalities is being placed increasingly within the remit of practitioners in general practice. However, section 3.4 pointed out that there remains little agreement about what form the public health role of primary care practitioners should take. This section described a number of new opportunities, as well as persisting barriers, to developing a public health approach within general practice.

The remainder of this chapter looked at practitioners within general practice, and featured a historical and critical discussion of each of the five disciplines chosen as the focus of this study. The literature indicated that whilst GPs are expected to incorporate a public health approach into their practice, there are many barriers which hinder this. Section 3.5 identified two major difficulties in clarifying a public health role for GPs: first, the multiple, often contradictory or unrealistic nature of a modern GP's role is so wide that it might be difficult to see how a single GP might contribute significantly to public health; and second, as owners of small businesses, many GPs maintain one eye on money maximisation for their individual practice. This is unlikely to sit comfortably with a wider public health brief.

This section then went on to describe community nurses and their recent development, which set the context for more in-depth discussions of each nursing discipline in turn. The chapter described how the nursing profession has made attempts to clarify the public health role of community nurses, but outlined a number of barriers. These include professional territorialism between the different disciplines, which are a result of deep-seated professional identities; their location within general practices, where power dynamics between more influential GPs and more subservient nurses, might limit or shape the nurses' roles; the move towards skill mixing[14], which is creating new hierarchies of generalists and specialists; and the primary care reforms which have continued to draw nurses into more individualised, medical models of practice.

This section highlighted the public health roots of health visitors, and described their modernised role, which is supposed to encompass more family-centred public health work. The public health future is looking brighter for this discipline than for others, but there is a great deal to achieve before the government's modernised role becomes a reality. Various developments since 1946 have progressively narrowed health visitors' roles, and focused them on individuals, rather than the environments in which they live. This has allowed a great deal of variation to develop within health visiting, with many health visitors not utilising all dimensions of their role. Whether the discipline is to split, with some HVs becoming public health practitioners, leaving others to focus on the more individual tasks, or whether it is to move as one towards a new role as public health nurses, the implications, for health visiting, and for other disciplines who work with them, are great.

For district and practice nurses, the story is mixed. A number of changes over the last half-century, have served to draw these nurses away from public health roles. Whilst the RCN, in its framework for future practice in district nursing, does not directly refer to a public health role, the NSF for older people

[14] Skill mixing, in essence, means the breaking up of the tasks, responsibilities and requirements of a particular role and the possible re-assignment of those tasks to others (Symonds 1997:239-240).

highlights their potential input in promoting health, independence and wellbeing in old age. For practice nurses, the specialisation of many practitioners in specific disease areas is significant, with their focus on chronic disease management perhaps superseding a more general and broader public health role. Their location within the practice, and their status, often as direct employees of the GPs, is another important feature which might influence the extent to which their roles can encompass public health.

The final part of section 3.5 looked at practice managers, and the growing importance of their role. Whilst their position as managers of the business has grown, in general, to be more autonomous and distinct from that of the GP owners, their roles are still very much determined by the GPs they work for. The discussion in this chapter highlighted the tricky position of practice managers, who are often not medically trained, and who have no formal authority over the medical staff they work with. They are likely to be driven by money and business-oriented goals, which might be at odds with the public health needs of the practice population.

This chapter has described in detail the potential for each discipline to become more involved in public health, as well as some of the barriers that would need to be overcome. The chapter showed that roles and professional identities have shifted and changed over the years, and that during the latter half of the twentieth century, a number of factors have acted to distract practitioners from the public health values which have, in earlier times, helped shape their roles.

CHAPTER 4

METHODS OF ENQUIRY

4.1 INTRODUCTION

This chapter explains the strategy by which the research was conducted. Patton (1990) describes a strategy as a framework for action – it provides basic direction and guidance, but also includes fundamental assumptions and epistemological ideals. The chapter begins, therefore, by identifying and discussing the research paradigm, and providing explanations for the choices made regarding research approach and methods. It then describes the research process, providing details of the way in which the study was carried out, the participants, the data collection techniques, the procedures used for analysing the data, and ethical issues confronted in the course of the research. An attempt is made to describe and explain the role of the researcher in this research, and understand how the relationship between the researcher and other participants helped shape the processes and outcomes of the investigation. Finally, the trustworthiness of the research data is scrutinised in a discussion of the validity and rigour of the research process, and limitations arising from the pragmatic realities of 'real world' investigation are considered.

4.2 A PHILOSOPHICAL RATIONALE – THE RESEARCH PARADIGM

The methodological paradigms debate in the social sciences literature is well rehearsed and encompasses a myriad of responses to questions of ontology, epistemology and methodology. Whilst different paradigms have been extensively reviewed and compared (e.g. Lincoln and Guba 1985), there is a tendency to simplify the debate into a dualism between two extremes. Patton (1990:37), for instance, argues that the debate has centred on the relative value of two fundamentally different and competing inquiry paradigms: logical-positivism, which uses quantitative and experimental methods to test hypothetico-deductive generalisations; versus phenomenological inquiry, using

qualitative and naturalistic approaches to inductively and holistically understand human experience in context specific settings.

Because of the complexities of this paradigm debate, methods decisions can be highly controversial. In the past, methods decisions tended to stem from disciplinary prescriptions, concerns about scientific status and old methodological habits. However, Patton (1990) argues that methods choices should not be constrained by "routine ways of thinking and paradigmatic blinders" (p.38). Rather, they should be based on situational responsiveness and attention to methodological appropriateness. Methodological appropriateness is about making sensible methods decisions given the purpose of the inquiry, the questions being investigated, and the resources available (*ibid.*). Eichler (1991) too, argues that by moving on from the deductive versus inductive dualism, all researchers can now legitimately use a variety of methods in the research process.

The introductory chapters of this thesis have discussed the complexity of the study's focus, with the ambiguity of the key concepts, and the rapidly changing political, organisational and social environment in which public health and primary care are delivered. A great deal of thought is needed at the planning stage to ensure that the methodology is sensitive to this complexity and ambiguity.

The central aim of the research is to explore the public health roles (both real and perceived) of key primary care practitioners in English general practices, in the context of new health and social care structures, and wider political and ideological contexts. Within this, there is a focus on understandings of public health and public health roles, and the ways in which these understandings can influence the implementation of public health policies in general practice. The study seeks to analyse these understandings, first from a government policy perspective, and next, from the perspective of primary care practitioners themselves. In order to achieve this, the following research questions are posed:

1. What is expected of primary care practitioners, in terms of their public health roles?

a) How is 'public health' represented and discussed in New Labour policy documents?

b) How are the public health roles of primary care practitioners described in policy documents?

2. How do primary care practitioners see public health and their public health roles?

a) How do they talk about and understand 'public health'?

b) How do they describe their public health roles in practice?

c) To what extent do understandings of 'public health' and 'public health roles' differ amongst primary care practitioners, within and between disciplines?

3. How do these understandings of 'public health' compare with those found in policy documents, and what are the associated implications for public health policy implementation in primary care?

These questions necessitate the analysis of both agency (the intentionality and causal power of the actors involved) and structure (the social conditions which may constrain or enable actors, or which, in any case, influence them), at a number of different levels, in order to explore the emergent nature of meanings, practices, and intentions in local primary care settings. They require the linking of a micro-social exploration, to the macro-social dynamics of social life. An analysis of public health/primary care policy must be predicated on the idea that problems and policies need contextuality (Sibeon 1988). Consequently and inevitably, this study is essentially multi-framed, drawing on a number of integrative theoretical frameworks (Bryant and Jary 1991), which employ concepts and ideas drawn from a number of different paradigms. It is important that these frameworks are neither restrictive nor reductive. An inductive, qualitative approach will mean that ongoing analysis of data will allow opportunities to change the focus according to the interplay between theory, concepts and data, and thus be sensitive to the constantly changing field of study.

Drawing on Sibeon's (1988) anti-reductionist sociology as a basis for policy analysis, this research achieves large-scale pluralistic and methodological reach which draws in several theoretical schools. Included in this integrative approach, then, are a number of different branches of interpretive sociology which aim to explain social action by understanding the ideas, values, interpretations, meanings and the social world of individuals, as well as approaches which prioritise the social organisation of society and the effects of the distribution of resources and power on people's behaviour and attitudes. Wenger's (1998a) social theory of learning (described in Chapter 2) brings together the key intellectual traditions which inform this research, and serves to guide the integrative approach.

The research questions, which are centred on understandings of public health and public health roles, but which also require an exploration of the complex social and organisational relationships that form the context within which primary care practitioners work, suggest a dual approach to this research, in which:

a) Public health/primary care policy is analysed in order to explore the way in which 'public health' is discussed in policy, and to assess the formal expectations of primary care practitioners in terms of their public health roles; and
b) individual practitioners are studied in order to explore their own understanding of public health and their public health roles, in their immediate context of the general practice team, and within the wider socio-political context.

The theoretical frameworks and methods for each of these two sections are set out below.

4.3 The Policy Analysis

4.3.1 Theoretical framework

Health policy means different things to different people. Walt (1994) suggests that for most people, health policy is concerned with *content* – for instance, the best method of financing health services, or how to go about improving health

care delivery. For her, though, health policy is about *process* and *power*. She is concerned with who influences whom in the making of policy, and how. The study of health policy, therefore, encompasses a broad range of approaches, which have informed a rich corpus of literature. Marshall (2000), who uses feminist and discourse approaches to explore gender equity policy, summarises some of the key issues drawn from this literature. They are:

1. A 'policy window', which provides an opportunity for policy formulation and implementation, can open because of a change in the political stream (a change of government, party politics, or a shift in national mood); or because a new 'problem', amenable to policy interventions, captures the attention of policy makers (Kingdon 1984). The consideration of policy ideas, and their path through the policy making process, depends on 'value acceptability', or the degree to which a given idea fits with national culture or ideology (Marshall 2000).
2. Loose networks of policy professionals and advocates operate within policy communities. These networks mobilise around specific interests and have close interactions with policy makers (Sabatier 1991). The 'logics' or 'models' for public policy are framed within these policy communities (Anderson 1989, Marshall 2000).
3. Interest groups affect policy sometimes by being key insiders, and sometimes by activism from outside (Marshall 2000).
4. Values are continuously shifting. At different times, therefore, health policy may value equity, quality, efficiency, or choice (Marshall 2000).
5. A number of different mechanisms can be used to translate policy goals into concrete policy actions. These include: mandates, inducements (e.g. grants), capacity-builders, and system-changers (McDonnell and Elmore 1991, Marshall 2000). The choice of tools and policy implementation strategies will be significant (Marshall 2000).

Much research and theory has sought to elucidate the complex processes of implementation – that is, the translation of policy into action. Implementation is an important part of policy making. There is a broad conceptual division, within policy implementation theory, between that which takes a 'top-down' approach, and that which looks from the 'bottom-up'. A top-down approach to policy

making regards the validity of the goals of policy makers, and their capacity to make them explicit, as vital. It places an emphasis, therefore, on the making and shaping of the policy at the governmental level. The normative view embedded within the top-down approach, that goal setting inputs should come from the top, has been challenged by a number of 'bottom-uppers'. Hjern et al (1978), for instance, state that programme success is far more dependent upon the skills of specific individuals in 'local implementation structures' than upon the efforts of central government officials. 'Bottom-uppers' claim that policy is much better negotiated at the bottom by those who are expected to carry it out and by those who are affected by it. They criticise the top-down models for their tendency to ignore the perspectives and input of other actors, such as street-level bureaucrats or local implementing officials, and to underestimate the ability of these actors to employ strategies to get around central policy, and/or to divert it to their own purposes (Sabatier 1997). Both 'top-down' and 'bottom-up' approaches are pertinent to this enquiry, since it seeks to explore the influence of 'understandings' of public health both in public health policy making at central government level, and in the negotiation of public health roles at local level.

A number of policy analysts, from both 'top-down' and 'bottom-up' approaches, have specified preconditions for effective or 'perfect' policy implementation (Hogwood and Gunn 1984, Sabatier and Mazmanian 1979, 1980). Several of these preconditions stand out as being particularly relevant to this study of public health policy. These can be divided, as Powell and Exworthy (2001) suggest, into three 'streams': policy streams, process streams, and resource streams.

Policy streams are concerned with policy ends or aims and objectives. It is important, for 'perfect' implementation, that policy objectives are clearly understood, agreed, and consistent (Hogwood and Gunn 1984, Sabatier and Mazmanian 1979, 1980). The vague and contested nature of public health as a concept, and as a policy end, is likely to effect the clarity of the policy stream.

The process stream is concerned with the means of achieving policy ends. The technical and political feasibility of policy objectives are as important as their desirability. The objectives must be based upon an adequate theory of

cause and effect which, ideally, shows a direct relationship between the two, with few, if any, intervening links. The implementation process needs to be clear, and co-ordinated, with fully specified tasks, and high levels of political support. The success of this process also depends upon the commitment and skill of individuals within the local implementation structures. This is difficult within public health policy, where the strategy must necessarily be a long one, where our knowledge of the mechanisms to improve it are limited, and where success depends on the action (and commitment) of a large number of actors in a wide variety of sectors.

Finally, the resource streams focus on the resources to achieve policy ends. Hogwood and Gunn (1984) highlight the importance of adequate time and sufficient resources being made available to the programme. For public health policy, this is difficult, since resources for it must compete with other priorities, such as the 'must do' targets of balancing the books and reducing waiting lists (Powell and Exworthy 2001).

These key points provide useful guidance for my analysis. However, given the focus of the present study on the ways in which public health is talked about in policy documents, this study must also learn from policy analysts who, in a 'post-positivist' vein, have shifted their attention to discourse and an investigation of the power of language, persuasion and argument (e.g. Majone 1989, Fischer and Forester 1993). This approach recognises the influence of knowledge and values in the characterisation of the policy process and outcomes (John 1998).

'Discourse' is used by Lupton (1992:145) to refer to "the manner in which individuals and institutions communicate through written texts and spoken interaction". Discourse analysis is used to examine textual and oral communication and their relationship to society and social structures (Horsfall and Cleary 2000:1292). Since the focus of discourse analysis is on "the use of language to create, sustain or challenge constructed social realities in particular situations" (Horsfall and Cleary 2000:1292), it provides a useful approach to explore the social construction of 'public health' within policy documents. A 'discursive approach' to social policy analysis:

> can help to uncover how the use of language is connected to broader social processes and practices, such as the reproduction of social relations or the construction of knowledge (Hastings 1998:192).

The growing literature which analyses policy discourse shows how language is "marshalled to construct selective versions of the nature of the problem, or how narrative devices are employed as part of a persuasive strategy to convince readers of the appropriateness of a policy 'response'" (Hastings 2000:133). Dominant or hegemonic discourses define the parameters of a designated 'problem', and consequently, the ways in which that 'problem' will be dealt with. This makes discourse an important part of this policy analysis.

There are many different approaches taken to analysing discourse, which draw on a number of philosophical traditions (van Dijk 1997a, b). Sociolinguistics and pragmatics, for instance, guided analysts towards a focus on the discursive nature of language use, speech acts and verbal interaction. They emphasised the necessity to study actual language use in their socially and culturally variable contexts. Cognitive psychologists, inspired by questions of learning and knowledge acquisition, explored the mental processes of text comprehension (van Dijk 1997c).

Post-structuralism contends that language is not simply a transparent communicative medium for talking about a pre-existing reality. "Rather, language is involved in producing or constructing reality, specifically our perception or knowledge of the world and the meanings we make about it" (Hastings 2000:131). The meanings of particular words are contingent on the particular discourses associated with them. Similarly, the discourses play a part in inculcating and sustaining or changing ideologies (Fairclough 2003). These ideologies are important in contributing to "establishing, maintaining and changing social relations of power, domination and exploitation" (*ibid.* p.9). By critically examining language, we can begin to reveal layers beneath taken-for-granted surface meanings and explore the relationship between language and ideology (Lupton 1992).

It is these ideas about the interplay between language, ideology, understanding and power which have influenced the 'critical discourse analysis' approach outlined by Fairclough and Wodak (1997), which provides a

theoretical framework for this study's methodological approach. Critical discourse analysis is a multidisciplinary enterprise which seeks to go one step beyond observation, systematic description and explanation of text, seeing it also as a political and moral task. It sees itself "not as dispassionate and objective social science, but as engaged and committed" (p.258). This is not to deny the rigour and validity of such an approach, however: "standards of careful, rigorous and systematic analysis apply with equal force to critical discourse analysis as to other approaches" (p.259). Interpretation of texts is about judging and evaluating them, as well as understanding and explaining them. Fairclough and others have used critical discourse analysis to great effect in analysing political discourse, getting behind the rhetoric in order to uncover hidden meanings (e.g. Fairclough 2000).

4.3.2 Methods

Policy discourse analysis refers to a number of methodological approaches. Whilst there is no strict step-by-step method, it always involves the repeated reading of text/s, using coding to identify categories and to enable patterns and trends within the policy to be identified.

For the purposes of this study, a search was conducted of policy documents – green papers, white papers, reports, strategic reports, action plans, etc – which are relevant to public health. In order to capture more recent policy changes, only documents published since 1997 were considered for inclusion. This produced a shortlist (see Appendix A). The documents in this list were then scanned and assessed according to their relevance to primary care, and their relevance to policy implementation (i.e. whether they contained policy action points, targets, guidelines, and so on). Table 4.1 shows the list of documents included in the final analysis.

Table 4.1 Policy documents included in analysis

Year	Title (and abbreviation)
1997	The New NHS: Modern; Dependable (NEW NHS)
1999	Public health practice resource pack (HV DEV)
1999	Saving Lives: Our Healthier Nation (SL OHN)

Year	Title (and abbreviation)
1999	Making a Difference (MAD)
1999	NSF: Mental Health (MH NSF)
2000	NHS Plan: A plan for investment; a plan for reform (NHS PLAN)
2000	NSF: CHD – modern standards and service models (CHD NSF)
2001	NSF – Older People (OP NSF)
2001	New Commitment to Neighbourhood Renewal: National Strategy Action Plan (NCNR)
2001	National Strategy for sexual health and HIV (SEX STRAT)
2001	The Report of the CMO's project to strengthen the PH function (CMO R)
2002	STBOP: The next steps (STBOP)
2002	Liberating the talents (LTT)
2002	NSF: Diabetes – delivery strategy (DIAB NSF)
2003	Tackling Health Inequalities: A Programme for Action (TACKLING HIs)
2003	The New GMS contract (GP CONTRACT)

Several strategies were then employed. First, the documents were scanned in order to capture the main points. They were then entered into the qualitative analysis software programme 'NVivo'[15]. (Fortunately, all the documents are available in electronic form so could be translated relatively easily into a text format which is readable by the software). NVivo was then used to facilitate key word/phrase searches using a custom dictionary (table 4.2). The dictionary was influenced both by the literature, and by the themes identified in the initial reading of the documents. It was tested with four documents first (chosen for their particular relevance to public health). An examination of the key words in context for these four documents highlighted further terms for inclusion.

The dictionary was then applied to all 16 documents. Searches were conducted using NVivo, and each 'find' was explored and analysed in context in order to assess the relevance of the passage according to the 'notes on usage' contained within the dictionary. This was important because of the ambiguity and potential overlap of some of my key words, which I found to be unavoidable. For instance, one of my keywords - 'involvement' - was sometimes used in documents to describe the involvement of professionals or

[15] NVivo is discussed in more detail below (section 4.3.3) under the sub-heading 'indexing'.

organisations in something. In my analysis, though, the word 'involvement' is reserved for the involvement or participation of patients, communities or the public. In such cases, where 'involvement' in the document was used to describe the collaboration of different professionals / organisations, the passage was re-coded 'collaboration'.

For relevant finds, the coding was expanded to cover the entire relevant passage in order to facilitate further analysis of the key word in context. This meant that one passage may include one or more mentions of the particular keyword. For this reason, and because policy documents contain so much repetition, through their use of headings, summaries, bullet points, tables, diagrams, and so on, any passage counts generated from these searches should be treated with caution, and as nothing more than a general indicator. That said, the passage counts (following manual re-coding according to the relevance of finds), provide an interesting overview of, and crude comparison between the documents.

Sections of the documents, and some of the passages found through the keyword search, were also subjected to a close qualitative analysis guided by the methodology of 'critical discourse analysis' (Fairclough and Wodak 1997). This focus on language and style provided cues to certain ways of 'reading' the texts in their social and political context. Sixteen policy documents obviously present a large amount of data for analysis. This meant that choices had to be made about which features to examine in detail. My focus was on exploring the understandings and perspectives of public health which appeared to guide New Labour's health policies. In exploring public health perspectives, I chose to focus in greater detail on what I consider to be their two main health White Papers, in terms of their influence in shaping subsequent policy documents; these were New NHS: Modern and Dependable (1997) and Saving Lives: Our Healthier Nation (1999). Given the size of these documents, my focus was on key sections within them, particularly opening chapters which set the scene for the document, and which describe the rationale for the policy changes proposed.

Table 4.2 Custom Dictionary for Policy Analysis

KEYWORD	NOTES ON USAGE
Public health	Discussion of public health - not when simply used in a title (e.g. DPH, etc)
Inequalities or variations	Inequalities, variations or inequities in health, health care service provision/access, outcomes, health determining factors (e.g. housing)
Poverty or social exclusion	An acknowledgement of its impact on health and the need to tackle it
Health improvement or improving health	Improve, improving, improvement – of health or determinants of health
Community development	For the improvement of health and/or reduction of health inequalities
Empower*	Empower, empowering, empowerment - of community/patient
Collaborat*	Collaborate, collaborating, collaboration - in order to improve health / tackle determinants of ill-health
Participat* or involve*	Participate, participating, participation, or Involve, involving, involvement – with/of community/patient/ public
Protection	Protection from health risks
Prevent*	Prevent, preventive, preventing, prevention – of ill-health, or determinants of ill-health
Promot*	Promote, promoting, promotion – of health, or determinants of health

*the use of 'wild-cards' allowed various uses of the concept to be included in a single search.

4.4 THE CASE STUDIES: PRIMARY CARE PRACTITIONERS

4.4.1 Theoretical Framework

The second section of this study is suited to a case study approach. Yin (2003:13-14) describes a case study as an empirical inquiry that:

- investigates a contemporary phenomenon within its real-life context; when
- the boundaries between phenomenon and context are not clearly evident; and in which
- multiple sources of evidence are used.

The case study approach permits the researcher to study selected issues in depth, and in sufficient detail to unravel the complexities of a given situation

(Denscombe 1998). "Approaching fieldwork without being constrained by predetermined categories of analysis contributes to the depth, openness, and detail of qualitative inquiry" (Patton 1990:13). This approach is useful in this study too, because unlike ethnographies, which usually require long periods of time in the field, and participant observation, which "assumes a hefty investment of field efforts", "... case studies are a form of enquiry that does *not* depend solely on ethnographic or participant-observer data" (Yin 2003:11, original emphasis). This suits the need for an eclectic and multi-method approach to data collection necessitated by the research setting, which is dynamic and constantly changing, and by the ambiguity of the key concepts, which require 'empathic neutrality' – "not proving something, not advocating, not advancing personal agenda, but understanding" (Patton 1990:41).

Qualitative study of people *in situ* is a 'process of discovery' – a process of learning what is happening (Lofland 1971). Whilst such research is characteristically inductive and unconstrained by predetermined theories, it is important to approach the fieldwork with some orienting ideas and tools (Silverman 2000).

Primary care focus: The roles of practitioners

The first task, then, is to 'frame' the study's focus, and identify the key concerns within the very broad arena of 'primary care'. As explained in Chapter one, this study is concerned with key practitioners (in a selection of core disciplines) within their immediate general practice environment. However, the 'roles' of the practitioners, and their understandings of public health, are shaped by a complex interaction between many factors, both within and outside the general practice setting. The exploration of these factors is shaped and guided by Wenger's (1998) social theory of learning and the notion of 'communities of practice' (described in Chapter 2). This helps us to focus on role making and role taking as a complex process of interaction in which identity and understanding are vital.

Public health focus

Public health can be thought of in many different ways (see Chapter 2), and it is the aim of this research to explore other people's understandings of the term. In order to do this, it is important, methodologically, not to impose *my* understandings on research participants. However, my own perspectives of public health should not be denied to the reader. It is realistic and inevitable that my understanding of public health, which is shaped by my education, experience, background and values, will in turn influence my approach to this research. It is important, then, that my perspectives of public health are made explicit at the outset, so that they can be established within a broad framework of understanding which guides the research process. This was done in Chapter two, where a framework of understanding, which draws upon the 'public health continuum' (Nijhuis and Van Der Maesen 1994), and '3 perspectives of public health' (Walsh *et al.* 1995), were described. The framework provides guidance in my exploration of public health understandings and perspectives.

4.4.2 Methods and the research setting

The unit of analysis in this research is the individual practitioner. This is important in maintaining the project's focus on the individual, and to draw out differences and similarities between different members of different disciplines involved in general practice. However, an important part of the data collection is the gathering of 'ethnographic' information regarding the context within which they work – the immediate context of the general practice, and the less immediate contexts relating to the PCT and geographic area they are situated within. A number of methods are therefore employed – interviews, observation, questionnaires, and document analysis - in order to explore the practitioners' public health roles within context. It was decided that where possible at least one of each of the chosen disciplines should be interviewed in each practice.

The site area

One (pre-2002) Health Authority area[16] was chosen as the locality for this research. The area was chosen for a number of reasons. Being a large county in mid-England, it contains within it a mixture of urban, semi-urban and rural towns and villages. It is an area which is growing rapidly, due to the opening up of several major transportation routes linking it to both London and industrial cities in the North. Its population is diverse, according to ethnic mix, age, and socio-economic indicators of social class, and broadly compatible with averages for England and Wales.

According to the national census (2001), the age structure of the county is roughly similar to England and Wales, with 21.2% of the population aged between 0 and 15, and 14.2% aged 65 and over (compared with 20.2% and 16% respectively, for England and Wales). The proportions of single (27.3%), married/re-married (53.8%), separated/divorced (11.4%) and widowed (7.5%) people are also roughly the same as England and Wales as a whole. 93.7% of the county's population were born in the UK, whilst 4.2% were born outside the EU. This compares to 90.6% and 6.9% for England as a whole. However, these figures might not reflect the growing numbers of asylum seekers and refugees, particularly in certain towns within Centre PCT and North 4 PCG.

Only 0.7% of the county's residents (aged 16-74) describe themselves as long term unemployed, whilst 66.7% are employed, 2.8% unemployed, 5.7% students, and 11.9% retired. Whilst the percentage of people with qualifications at degree level or higher (36.6%) are good, compared with the national average, 63.4% have no qualifications, which is double that in England and Wales. The Health Authority suggests in its public health report (2001) that low income is a relatively important issue for all but the south of the county.

The level of health inequalities in the county is high. According to the Public Health Report (2001), death rates are over 50% higher in the most deprived parts of the county, compared with the least deprived, and hospital admissions

[16] In 2002, as a result of 'Shifting the Balance of Power' (DH 2001e), Health Authorities were dissolved, leaving smaller PCTs and larger Strategic Health Authorities.

for respiratory disease are over twice as high. Coronary heart disease accounts for 19% of deaths in the county, but there is a great deal of disparity between the least and most deprived wards. Cancer accounts for 25% of all deaths in the county, and bears the same relationship with deprivation as CHD.

Organisationally, at the onset of the research, the area contained within it one early PCT (in the South of the area), one PCG in the process of qualifying for PCT status (in the centre of the county), and 4 other PCGs (in the North) which, at the time, were consulting on what form they should take. (The options proposed were based on a direct progression to 4 PCTs, a merger to form 2 PCTs, or a large-scale merger to form just one PCT. In the event, the latter option was chosen) (See figure 4.1). The boundaries of the health organisations are not coterminous with the County, District and Borough Councils.

Using the Index of Multiple Deprivation Score, the health authority's public health report ranks the area roughly covered by North 1 PCG as having the highest deprivation score, on average, in the county. The most deprived ward, however, is contained within Centre PCG's boundaries, and the least deprived within those of North 4 PCG[17]. The patterns are supported by the general practice level proxy measure of need (see Baker and Hann 2001), which uses the Jarman Index, and the low income scheme index data, which scores the cost of prescriptions which are exempt on the grounds of low income as a percentage of the cost for all prescriptions (see Lloyd *et al.* 1995). These both place the PCTs in the following order, according to levels of 'deprivation' or 'need', from high to low deprivation: Centre PCT, North PCT, South PCT[18]. However, there is a great deal of variation between wards within the same PCT area. South PCT, for instance, and some parts of North PCT (particularly

[17] These statistics are based on Local Authority and ward data, but the HA public health report states the patterns as being similar for PCG/Ts.

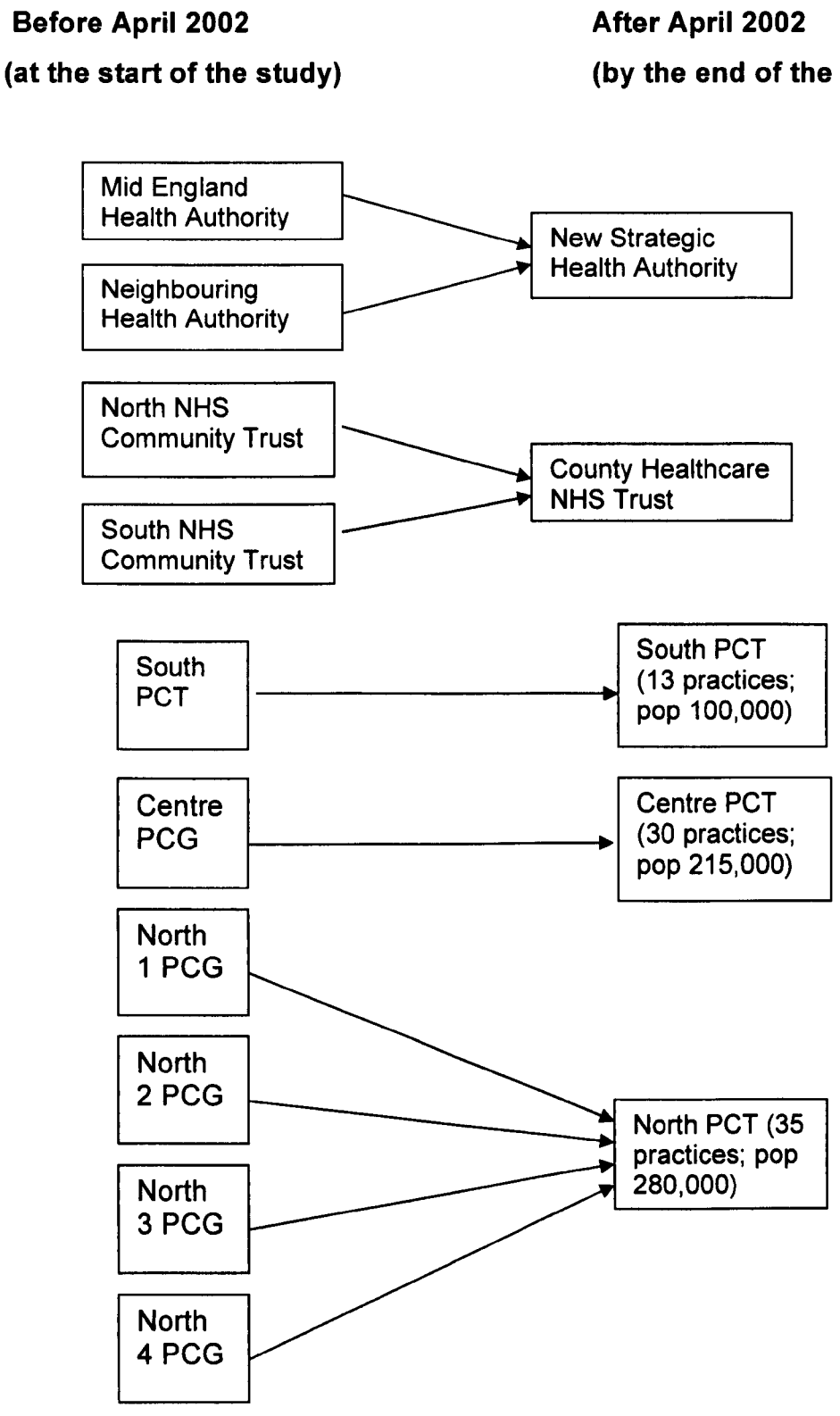
[18] This information was acquired from the National Database for Primary Care Groups and Trusts which is a product of the National Primary Care Research and Development Centre at the University of Manchester. They request that the following acknowledgements are made: to Dr Deborah Baker, database director, for devising it; Justin Hayes at University of Manchester, for constructing it; SEE IT consultancy for designing and building the map interface; and Andrew Wagner, Mark Hann and David Reeves (NPCRDC) for their work in cleaning and validating the data sets. Andrew Wagner is the database manager (a.wagner@man.ac.uk).

PCG 3), are affected by inequalities in access to services such as shops, GPs and primary schools. This reflects their rurality.

Within the area as a whole there are 78 general practices[19] (some with several surgeries), which demonstrate a diverse range in size, history, staff and structural arrangement. Unfortunately, (un-anonymised) practice level statistics were unobtainable.

[19] There were 77 when the research began in October 2000.

Figure 4.1 The main health organisations within the research area, before and after re-organisation in 2002



The context

In order to build a picture of the health and organisational issues within the area, contact was made with each PCG/T and semi-structured interviews were held with a key member of the board/executive committee responsible for public health / health improvement. In addition, documents were requested which gave more information on the PCG/T priorities, the health needs of the area, and the practices within the organisation. The interviews and document requests were guided by the literature review and by ongoing discussions with the project steering group[20]. Links were made where possible with nurse board members, and these links sometimes led to permission to attend nurse meetings. This information gathering process was continued throughout 2001 and 2002, which was important because of all the organisational changes taking place during that time. In some cases, documents such as the HIMP were downloaded from the PCG/T internet site; however, most sites were not fully up and running until the end of the research and, even then, they tended not to hold up to date information.

The organisational changes made the information gathering process very difficult, since contacts made in the early stages of the research often later 'disappeared' to somewhere else in the organisation or elsewhere. It was clear, during this process, that the organisations were in a state of disarray. Frequent requests for fairly basic information (such as a copy of the HIMP) and contact details were often met with confusion and a request that I call back in a few months. The 4 PCGs in the North were facing particular uncertainty since they were confronting the most comprehensive of the transitions, with 4 discrete organisations being merged to form one. It was clear, throughout this time, that organisational change was on the top of everybody's priorities, which meant that requests to talk about public health were not always welcomed.

Links were also made, and interviews carried out, with individuals in the North and South Community NHS Trusts and the Health Authority's Public Health Department (all three of these organisations ceased to exist after April 2002).

[20] The project steering group was made up of a wide range of professionals (18 in total) from academia, policy and practice, across England. The group met 3 or 4 times a year for the duration of the project.

In addition to interviews with members of these 'middle-tier' organisations, a number of informal interviews were conducted with individuals who specialise in public health / primary care at a regional or national level. These interviews were extremely helpful in building a picture of the policy issues and in gathering information about other pertinent research and developments. They were semi-structured and lasted an average of one hour (with the shortest being 30 minutes). Detailed hand-written notes were taken and written up immediately after the interview. See appendix B for a summary of the information gathered from this phase.

The pilot practice

Many of these interviews were important in helping to structure the further data collection and in designing the interview and observation guides. The first interview guide was 'tested' with a pilot practice in September 2001[21]. In this pilot practice, a supportive practice manager allowed me to spend a day in the practice, meeting and chatting with the staff and interviewing himself, a district nurse and a practice nurse[22]. The interviews were semi-structured and the (very basic) interview guide was based around 5 key areas: general and public health roles; understanding of public health; examples of public health activity engaged in; opportunities to engage in public health; influences on public health activity.

The pilot study was useful in several ways. It allowed me the opportunity to gain confidence in my interviewing skills, and encouraged me to think of techniques which might be used to facilitate the process of information gathering. Although a tape recorder was brought along, two of the three interviewees preferred me not to use it. This was surprising, but allowed me to prepare myself in the future for the possibility of having to hand-write interview notes. All notes were written up (and the taped interview was fully transcribed) immediately on returning to the office, and they were analysed using the approach detailed later in this chapter.

[21] The pilot practice was recruited by word of mouth and contact was facilitated by the Senior Manager of Primary Care in the North Community NHS Trust.
[22] These are included in the total number of interviews carried out.

The interview guide was amended slightly in light of the pilot study (see Appendix C for final interview guide). The main effect of these amendments was to add simple prompts which might be useful in getting the participants to think about and to verbalise their understanding of an ambiguous and complex subject. The schedule was kept as simple as possible, though, since the interview needed to maintain the freedom to weave around the key areas in an unstructured way. The interviews usually started with general questions in order break the ice, then gradually moved on to more specific questions, while, as inconspicuously as possible, asking questions intended to check the veracity of statements made by the participant. As a result of the pilot study, I also decided to use a short questionnaire (see Appendix D) as an interview aid. This was sent out to most participants[23] prior to the interview (n=22), and acted as a further 'check' on responses made in interview, freed up some interview time by collecting 'routine' information such as year of qualification and training courses attended, and acted as a further prompt, if needed, in the interview.

Interviewing as a technique

Another important function of the pilot study was the opportunity it afforded to explore some of the methodological issues described in the literature. This allowed me to become better informed and more sensitised to the problematics of asking questions for research. The purpose of interviewing is to find out what is in and on someone else's mind; it allows us to enter into the other person's perspective, and assumes that the perspective of others is meaningful, knowable, and able to be made explicit (Patton 1990). This process of asking questions and getting answers is a much harder task than it may at first seem (Fontana and Frey 1998). The methodology literature is replete with discussions on the assumptions and moral problems present in interviewing, with the controlling role of the interviewer, and with the

[23] The questionnaire was introduced after a number of interviews had already been conducted. Also, where impromptu interviews were held (after meetings, etc), the questionnaires were either given to the participant at the start of the interview or posted later. Some participants either forgot or were reluctant to complete the questionnaire, but since it was seen mainly as an interview tool, these were not pushed for the sake of a higher response rate.

interviewer-respondent relation (see for example Marcus and Fischer 1986, Crapanzano 1980, Lofland 1971). Discussions on the importance of a researcher's gender (e.g. Gluck and Patai 1991, Eichler 1991) and race (e.g. Mirza 1992) have "further problematised concerns about membership and understanding in interviewing" (Fontana and Frey 1998:51).

Whilst unstructured or semi-structured interviews allow a greater depth to be achieved, given their qualitative nature, they require a high level of skill and technique on the part of the interviewer (Patton 1990). The interviewer's skill, experience, training, changes resulting from fatigue, shifts in knowledge, and so on, may all affect the quality of the data. However, this is more than offset by "the flexibility, insight and ability to build on tacit knowledge that is the peculiar province of the human instrument" (Guba and Lincoln 1981:113). Of great importance to the process of interviewing, and making the most of the experience and the opportunity to collect 'good quality' data, is the ability to reflect on one's own position as researcher. Throughout the course of the research I regularly documented my reflections in a research diary. These reflections helped me to make sense of my own role in the research, as well as hone my interviewing technique.

Fontana and Frey (1998) discuss some of the basic elements of unstructured interviewing. The following section considers these elements in the context of my own experiences, and discusses implications for validity and reliability of the research.

Accessing the setting, gaining trust and establishing rapport

As an 'outsider', both to the area being studied and to all health professions, the process of negotiating access was long and time-consuming. It involved many day trips to the area just to 'meet and greet', to get my face and name established, and to feel my way through the complex organisational networks in the area. This process, whilst resource-consuming and often frustrating (enduring many cancelled appointments and long waits), was immensely important in establishing myself and my credibility as a researcher.

The 'settings' that I needed to access proved to be many and diverse, often with different 'tactics' required for each. The first important consideration was ethical approval. Given that my participants are NHS employees, permission was sought, and granted, from the medical ethics board at the health authority. As the health authority ceased to exist after April 2002, permission was also sought from each PCT (only one of which had a formal procedure in place). Permission was also granted by the University Ethics Board, and the research was guided throughout by the ethical principles developed by the British Sociological Association. Subsequent to ethical approval, the 'middle-tier' organisations proved relatively straightforward to access, although the organisational disarray meant inevitable practical difficulties such as constantly changing contact details and un-filled posts. General practices, on the other hand, were much more problematic.

General practices are predominantly independent businesses which are generally keen to demonstrate a high degree of autonomy from the PCG/T. It was rare, therefore, that my hard-won contacts in the 'middle-tier' organisations actually helped me to access a general practice. I was surprised and a little frustrated that approval and indeed positive support from a PCT often did nothing to smooth my way into a practice. Practices were approached individually by letter via the senior partner and the practice manager. Letters were sent, in a series of 'batches', according to a purposive sampling frame which was chosen (in light of the literature review) to represent a range of characteristics, including size, geographical location, rurality, and organisational form. Purposive sampling is useful in constructing a meaningful sample in this instance, because it allows for far greater (theoretically informed) flexibility (Silverman 2000). Thus, as new factors emerge, the sample can be increased in order to say more about them, or unexpected generalisations in the course of data analysis may lead to the seeking out of new 'deviant' cases. As Alasuutari explains, "a narrow case-analysis is broadened ... through the search for contrary and parallel cases, into an example of broader entity" (Alasuutari 1995:156, quoted in Silverman 2000:108).

The letters, sent to both practice manager and senior partner, briefly described the research, and requested the participation of their practice. An information leaflet, and a separate sheet explaining what participation in the research would involve, were also enclosed (see Appendix E). The well-documented pressures faced by general practitioners and associated primary care staff (in terms of short-staffing, lack of time, additional pressures such as new roles, expanding patient lists and increasing paper work) – not least at this time of massive organisational upheaval, were predicted to be problematic in the recruitment of participants.

A number of measures were taken to try to counter this. It was made clear that the time spent within practices, and the methods employed there, were flexible: several visits could be made over a long period of time, so as to fit in with practitioners as much as possible; interviews could be held either individually, or in groups (perhaps fitting into existing group meetings, such as nurse meetings); where interviews are held, they would be approximately 30 to 45 minutes long (although in reality, many practitioners gave more time). It was decided not to offer telephone interviews at this stage, because this would incur a lost opportunity to visit the practice and make important observations. It was proposed in the information leaflet that I make a visit to the practice in order to interview the practice manager, a GP, a practice nurse, a district nurse and a health visitor. It was also requested that I might sit in on practice / primary health care team meetings (in order to make observations and meet other practitioners), and be given access to general documents such as practice information leaflets, practice development plans and patient population / practice profiles, where possible. The leaflet emphasised that all information would be treated confidentially, and that individuals and organisations would be anonymised. Practitioners were asked to sign consent forms prior to interview to ensure that they understood the purpose of the research, and the ways in which the data would be used (see appendix F). The leaflet also highlighted the potential benefits to practices and practitioners: that any concerns they had regarding the developing public health function could be fed back up to the developing PCTs; that the researcher could attend

practice/primary health care team meetings to give information sessions on developing public health policy and roles; that individual practitioners, through the research, would be made more aware of important ongoing changes to the public health function and to primary care policy; and that all participants would be kept informed through research updates and a final short report.

Two weeks after sending the letter, a telephone call was made to the practice managers in order to ascertain whether or not permission would be granted. This process of seeking permission was a very long and frustrating one. The first practical difficulty was often getting through to the practice manager, whose calls are generally fielded by the receptionist. I was repeatedly told that the practice manager was too busy and that I should call back another time. The letters often had little impact, and written information was often requested again, which delayed the process of recruiting practices considerably[24].

Fifty-eight practices were approached during the period August 2001 to February 2002. These practices were 'chased' by phone up until July 2002. By July, 39 of the 58 practices had refused access. 15 of these had sited work pressures or 'lack of time' as their reason for non-involvement. Typical responses from practice managers include: "There is just no time. We have one GP away on long term sick and another about to retire"; "We've got two nurses off sick, we've got absolutely loads to do for the PCT and there's just no time"; "We are one GP down, off on long-term sick, so we are really struggling with the work load".

A further 7 practice managers sited 'lack of interest' as their reason for non-involvement. Typical responses included: "No one is interested – there's too much else to do"; "I passed everything on to the GP, so unless he gets in touch you should assume he isn't interested". One particularly clear response (which at the time knocked my confidence considerably), came from a GP via e-mail (within just 2 days of sending the letter):

> "...This is a spectacularly bad time to be asking GPs to give up their

[24] These issues at least confirmed that a questionnaire survey of practices would likely have been met with very little enthusiasm and to have resulted in a very poor response rate.

> time (and their staff time) on any issue, but particularly one which rates at the bottom of my personal list of priorities. ... Are you sure this is a feasible project?".

Other reasons for declining access were more ambiguous and included: "We don't do things like that. Dr A is quite funny about things like that"; "The GP just said no". One practice manager would not even grant permission to attend a (usually open) protected learning time event (in order to give me a chance to meet practitioners and ask them if they were interested in taking part), held jointly with another practice who were happy for me to attend. The reason given was 'confidentiality', although it was stressed that ethics approval had been granted and that confidentiality would be respected.

Eight out of those initial 58 practices were continually chased up by phone until July 2002, with no response at all.

Several entries in my research diary during this initial phase of recruitment noted the impression that letters sent to the practice often went unseen by most of the practitioners there. Whilst the letters clearly stated that the research was interested in the nursing disciplines as well as GPs, it appeared that the nurses often did not see or hear about my letter, or were not consulted on the response. For instance, when one practice manager explained that the GP wasn't interested, I asked if any of the nurses were interested in talking to me. He responded "Well, you could try asking if you like".

Communication between practitioners at some practices seemed to be particularly poor. When speaking to another practice manager, for example, who declined access due to work load resulting from one GP's long term absence, I made several attempts to gain access to other practitioners in the practice. When I asked if I might be able to attend a primary health care team meeting in order to meet practitioners and explain the research to them, the practice manager responded:

> "We don't have primary care team meetings. I think we used to have them but they've sort of fallen by the wayside. The GPs don't meet with the nurses any more. If they need to speak to them, they contact them".

I pushed further and asked "would it be possible to have the number for the health visitors and district nurses so I could ask them if they would be able to meet me?", to which he responded

> "I don't know the number for the health visitors. I know they're at the Little Road clinic. Let me just see if I can find the number [long pause]. No, I can't find the number, but if you contact Little Road you'll get through. The district nurse is based in this practice. I don't know what her direct line is, but if you come through to reception and ask for the district nurse's room they should put you through".

My request to attend team meetings was frequently met with the news that they did not happen:

> "The problem is, team meetings are a bit hit and miss now. We used to have them, but now people are just too busy. We have protected learning time sessions, so people see each other then, but if a GP needs to talk to a health visitor, then they just call them up".

Similarly, another practice manager explained that they no longer have team meetings because "they've been superseded by the protected learning time".

The high rate of refusal to participate in the research threatened to make a mockery of my carefully made plans and somewhat idealistic sampling frame. However, as I had sent requests out to practices in 'batches', I was able to choose the practices on which to concentrate my future efforts according to the types of practice which had previously agreed or declined. Whilst the difficulties of recruiting participants led the sample to be ultimately more opportunistic than purposive, I managed, in the end, to obtain a sample which broadly met the original criteria for selection (see Appendix G for characteristics of final sample). This is not to say, of course, that the sample may not be biased in other ways. Public health is a topic that some practitioners are much more willing to engage with than others, through personal interest, and so on. It might be the case, therefore, that my sample of practitioners are more likely than most to think about and be involved in public health activities. However, since this research does not aim to produce any broad generalisations to a wider population, this potential bias is not

necessarily a problem in terms of reliability or validity of results, so long as it is acknowledged and discussed.

Another problem arose from the experiences of recruiting participants. It seemed clear that the practice managers and GPs were largely acting as powerful gatekeepers to the health visitors, district nurses and practice nurses, simply by not informing them of the research. I decided to approach these practitioners directly, where possible, in order to boost the number of participants. For DNs and HVs, who are employed by the Trust, this was relatively straightforward, and a number of contacts were made through the nurse board members and through attendance at nurse meetings. Both HVs and DNs were generally very willing to participate, with the main hindrance to their participation being the practical one of lack of time to fit me in. Practice nurses, being usually employed by the General Practice, were more difficult to access. I was wary of the important gatekeeping role played by the GP and wanted to avoid going behind his/her back. Several PNs who I met at meetings were willing to give me their time for an interview. This was, however, often without their employing GPs' knowledge / consent. In such cases, I respected the practice nurses' own decision on whether or not to participate. For other practices, I continued to approach practice managers and GPs, which was sometimes helpfully facilitated by a health visitor or district nurse's recommendation.

Whilst this long and often frustrating process hindered the course of my data collection phase, it taught me a great deal both about the dynamics within general practice and primary care, and about the pressures faced. The power held by GPs and practice managers clearly affected my chances of accessing other, supposedly 'independent' practitioners. Fontana and Frey (1998) say that since the goal of qualitative interviewing is *understanding,* it becomes paramount that the researcher establishes rapport. Learning about the 'culture' of general practice was an important part of the process of gaining rapport, which I found quite different for the different disciplines involved.

Deciding how to present oneself

> The decision of how to present oneself is very important, because after one's presentational self is 'cast' it leaves a profound impression on the respondents and has great influence on the success (or failure) of the study (Fontana and Frey 1998:58-9).

My position as 'outsider' afforded me both opportunities and problems. Had I a background in medicine or nursing, the process of negotiating access to the culturally (in terms of independence and autonomy) and practically (in terms of patient confidentiality) closed space of general practice would likely have been made easier. Indeed, that professional status might also have opened up alternative or additional methods of data collection, such as participant observation. However, in a study which encompasses a range of disciplines, and which explores, to some extent, the dynamics between those, my lack of association with any one of them was helpful. I could present myself both as a concerned and interested academic, keen to act as a conduit for information flowing from 'frontline' practitioner to policy maker (and vice versa), and as a humble 'learner' (Wax 1960), eager to understand the 'realities' of life in general practice. Naivety (real or not) was a tactic which seemed to 'soften' interviewees (particularly GPs) and open them up to dialogue about their thoughts and feelings.

At a time of disillusionment amongst the professions - with the Government, with constant change, and with the apparent failures and increasing demands of the NHS - I was fortunate to be able to disassociate myself from this and present myself as independent, and consequently 'on your side'. This was important in eliciting the interviewees' views about and understanding of public health, since I was clearly not there to check up on responses or activities, but rather to listen in a non-judgemental fashion. The literature holds many debates regarding the rights and wrongs of the researcher's opinions entering into interviews. According to traditional techniques, the interviewer is expected to avoid getting involved in a 'real' conversation in which she answers questions asked by the respondent or provides personal opinions on the matters discussed. Others believe that by engaging in a 'real' conversation with 'give and take' and empathic understanding (see Daniels 1983), the

interview becomes "more honest, morally sound, and reliable, because it treats the respondent as an equal, allows him or her to express personal feelings, and therefore presents a more 'realistic' picture than can be uncovered using traditional interview methods" (Fontana and Frey 1998:67-8).

Whilst eliciting the interviewees' own understandings of public health was an important part of this research, my independence from the NHS allowed me to engage, to a certain extent, in 'real' conversation, in which I was genuinely open about the ambiguous and complex nature of public health. I felt that this was an important part of establishing rapport, and many interviewees expressed their gratitude for the opportunity to talk about this confusing topic without feeling under pressure to give the 'right answer'.

My 'presentational self' was frequently misrepresented in practice, though, with some interviewees assuming I was someone else, despite my best efforts to convince them otherwise. It was often assumed, for example, that I was either from, or associated with, the PCT, with 'Public Health' (which was often given an organisational entity which it does not possess in reality), or with the Department of Health. Where this was the case, interviewees tended to treat me either as 'expert', asking me for the 'right' answers to questions, or as 'adversary', where gripes were aired in a sometimes personal manner. One practice nurse, for instance, was frustrated by the lack of communication from 'public health officials', which she described as 'you lot'.

Understanding the language and culture of the respondents

The medical meta-language of the NHS is a code that can be hard for non-members to understand. My familiarisation with the policy context, and prior experiences in the non-NHS health context[25], were important aids to my understanding of the current 'jargon' and acronyms. This was an important part of gaining credibility from the participants and ensuring the smooth flow, and efficient use, of interview time.

[25] This experience includes previous work in community development (in the non-governmental sector) and an ongoing Masters in Public Health.

Observation

"Becoming a skilled observer is essential even if you concentrate primarily on interviewing because every face-to-face interview also involves and requires observation" (Patton 1990:32). This observation entailed the reading of non-verbal messages, being sensitive to how the interview setting can affect what is said, and being carefully attuned to the nuances of the interviewer-interviewee interaction and relationship. In addition, observations of the ways in which practitioners appeared to relate to each other and to the organisation during the site visits were recorded as field notes.

Documents

Whilst a list of documents that would be requested from PCTs and practices was made early on in the research, based on what should be mandatorily available, it was soon discovered that in many cases these documents were not produced, and/or were withheld. Thus, documentary information gathered from PCTs was patchy, and from practices was minimal. Particularly surprising in the case of general practices was the lack of practice profiles, which are supposed to be produced by every practice, but which were rarely available. This experience, whilst frustrating for me, tells an interesting story in itself which describes the current organisational turmoil, and the focus on organisational change to the detriment of other priorities. As well as requesting documents from the organisations and interviewees, I regularly checked relevant web-sites for news items, minutes of meetings and documents to download. The paucity of documentary information meant that they played a less significant part in the research than expected. Whilst I read the documents in order to inform my understanding of local issues and ways of working, I did not subject them to in-depth analysis. This experience underlined the importance of visiting and talking to practitioners in their practices. (Summaries of the information gathered from each practice are outlined in appendix H).

4.4.3 Literature Searching

The literature described in this thesis provides important contextual information which guided the research as a whole, and allows the results to be situated within existing knowledge. This section outlines the process of searching for relevant literature.

'Core texts' were identified by searching library catalogues as well as through citation indexes and bibliographies. E-mail alerts from key publishers highlighted new texts.

Journal articles were identified through systematic searching of several on-line databases (see Appendix I). In addition, e-mail alerts which summarised the contents of several key journals were set up. These enabled the quick scanning of every new edition for any relevant articles. Two journals – the British Journal of General Practice and the Community Practitioner Journal – were searched by hand (all editions since 1997 up until the final re-write of the literature review).

Policy documents and 'grey literature' were identified through the web sites of government departments, other government bodies, and relevant non-governmental organisations. Databases such as BOPCAS (British Official Publications Current Awareness Service) were also used. An e-mail alert service run by 'Info for local' (http://www.info4local.gov.uk) was a very useful way of receiving up to date notice, on a daily basis, of policy, press releases and research across a wide range of government departments and 'quangos'[26] within specific categories. Nursing organisations and bodies, as well as regional and local NHS and related organisations were searched, mainly through web site links. A final, and very valuable, source of information came through my participation in various e-mail discussion groups (see appendix I). These groups often provided very up-to-date notice, discussion and commentary on relevant issues and policy. They also acted as a pool of

[26] 'quango' stands for Quasi-Autonomous Non-Governmental Organisation. It includes organisations like the Health Development Agency.

expert knowledge and advice of which questions could be asked – this was a particularly good way of picking up grey literature and information on ongoing research.

A set of keywords for literature searching was developed (see appendix J). These keywords were combined using Boolean logic (Hart 2001) in order to progressively narrow the search and improve the relevance of the returns. The precise Boolean expressions used differed between databases. New keywords identified in highly relevant hits were also searched.

Results of each search were recorded in a literature search log (see Appendix K). Hits were scanned according to selection criteria based on authority (reputability of publisher, and so on), significance (works regarded as having significantly developed the topic), currency (works since 1997 were prioritised, except for seminal works, for which no age limit was set), and relevance to topic and aims of the research (Hart 2001:26). Once read and assessed in greater detail for relevance, literature was entered into the bibliographic referencing computer software 'EndNote', with keywords, abstract, notes, and details of where the source is located. This bibliography was itself searchable using the program's sophisticated search facility.

The literature search was broad and thorough during the first year of the research, casting the net wide and far before discriminating and 'mining' for detail (Hart 2001). A more focused systematic search was repeated several times throughout the lifetime of the project.

4.4.4 Data Analysis

The analysis of data in this study was informed by the analytical approach described by Ritchie and Spencer (1994). The general principles of this 'framework' approach have proved to be versatile across a wide range of studies, and help guide the researcher through the various stages of the analytic process. Ritchie and Spencer point out the importance of the visibility of the methods used in qualitative data analysis: "policy-makers and practitioners need to know how the findings of the research have been

obtained" (p.175). However, the detailed process of analysis is notoriously difficult to describe, for, "although systematic and disciplined, it relies on the creative and conceptual ability of the analyst to determine meaning, salience and connections" (p.177).

Qualitative data analysis, according to these authors, is essentially about detection, and incorporates the tasks of defining, categorising, theorising, explaining, exploring and mapping (p.176). The 'thematic' approach to data analysis involves the identification of key themes and patterns. This approach is suitable in this study because it allows the analyst to proceed in a concept generating *and* concept-driven way (Grbich 1999). It is informed and guided by relevant conceptual frameworks, but is also sensitive to the discovery of new concepts and relationships in raw data. It achieves this through flexibility and openness, and an acceptance that phenomena are complex and their meanings are not easily fathomed (Strauss and Corbin 1998). This is particularly important in this research, which explores more 'subjective' phenomena such as 'understandings' and 'attitudes'.

Other key features of the 'framework' approach underline its appropriateness to my overall research paradigm: It is 'grounded', being heavily based in, and driven by, the original accounts and observations of the people it is about. It is dynamic, and open to change, addition, and amendment throughout the analytic process. It is systematic, and allows methodical treatment of all similar units of analysis. It is comprehensive, allowing a full, and not partial or selective, review of the material collected. It enables easy access to, and retrieval of, the original textual material. It enables comparisons between, and associations within, cases to be made. And finally, the analytic process, and the interpretations derived from it, can be viewed and judged by people other than the primary analyst (Ritchie and Spencer 1994:176).

Familiarisation

The approach involves five key stages. The first is familiarisation. This began with transcribing the interviews, and keeping and re-reading notes of

observations. Notes taken during or immediately after the interview were further ways of recording early interpretations of, or thoughts on, the data. Each interview transcript was also re-read, sometimes whilst listening to the tape-recording, and a contact summary form, which was based on the main interview questions, was completed for each. Miles and Huberman (1994) suggest that these forms are useful for guiding the next contact, and for serving both as a reminder of the contact at a later stage, and as the basis for data analysis. During this familiarisation stage, I listened to and read through the material, building notes of key ideas and recurrent themes. I was "not only gaining an overview of the richness, depth, and diversity of the data, but also beginning the process of abstraction and conceptualisation" (Ritchie and Spencer 1994:179).

Identifying a thematic framework

The second stage is identifying a thematic framework. This is a progression of the preceding stage, during which recurrent themes and issues which emerged as important to the respondents were identified. It also draws both on the literature, and the research questions. The key focus of this research is 'understandings' of public health and public health roles. This necessitates an examination of what practitioners describe as their 'public health activities'. However, it also seeks to situate this within an exploration of other factors that might influence a practitioner's public health role. In the analysis, then, three key areas were explored:

- understandings of public health,
- given examples of public health activities, and
- factors which influence public health roles.

The first of these areas is informed by the two frameworks described in Chapter two. The first framework looks at ontological interpretations and splits the term 'public health' into its two constituent concepts. It identifies continua of understandings for each concept, from individual to collective on the one hand, and from medical to social on the other. The second framework looks at perspectives of public health and identifies three main perspectives – biomedical psychosocial, epidemiological and social structural. Each starts

from different assumptions about the origins of disease, and produces its own justification for a particular program of intervention in the name of health.

The analysis of public health activities is guided by the ten main areas of public health practice identified by Skills for Health (see Chapter two), and by the categories of public health activities used in the questionnaire (Appendix D), which was based on Holman's (1992) typology, and which was used in Northern Ireland to assess the contribution of nurses, midwives and health visitors to the public health agenda (Poulton *et al.* 2000).

The final area – influencing factors – is informed by my examination of the literature, and identification of the key 'contexts' within which factors might be grouped: the socio-political context, the organisational context, and the local 'community' context. In addition, there are potential factors associated with the individual practitioner, such as experience, skills and attitudes.

Indexing

Whilst these frameworks and a priori issues helped to guide the process of analysis, the process of indexing also responded to emergent issues raised by the interviewees themselves, and analytical themes arising from the recurrence or patterning of particular views or experiences (Ritchie and Spencer 1994). 'Indexing' refers to the process of systematically applying the thematic framework or index to the textual data. During this process, categories in the initial version of the framework are refined, and new themes are developed. This is a process which "involves both logical and intuitive thinking. It involves making judgements about meaning, about the relevance and importance of issues, and about implicit connections between ideas" (p.180).

In order to facilitate the process of indexing, the transcripts were entered into the qualitative software analysis program NVivo. This program enables the researcher to quickly and easily store, retrieve, organise and search data, and keep good records of hunches, ideas, searches and analyses. With NVivo, "it is easy to be playful with the data, to try out ideas ..., and to be flexible in how the theoretical model is constructed and portrayed" (Gibbs 2002:xxii). Gibbs rates NVivo highly for its ability to handle fine-grained analyses, and to

facilitate an exploratory approach. The feeling of being distant from the data is a common criticism of computer-aided qualitative data analysis. However, NVivo makes it easy to jump back to the data to examine the context of coded or retrieved text, ensuring that the researcher remains close to the data, keeping a sense of the interview as a whole.

Charting

Charting involves stepping back from the individual transcripts in order to build up a picture of the data as a whole, and to consider the range of attitudes and experience for each theme. In this research, I used charting to examine similarities and differences both between and within disciplines, and between and within different practices. To these charts could also be added observational details which help to build a picture of the organisational contexts.

Charts were drawn from the original thematic frameworks around each of the three areas: understandings of public health; public health activities; and influencing factors. During this 'charting' stage, passages of text, grouped according to their index reference, were studied. A distilled summary of the respondent's views or experiences was entered on the chart, with reference to the original text so that the source could be traced and examined.

Mapping and interpretation

Whilst emergent categories, associations and patterns had already begun to arise during the indexing and charting phases, it was at the mapping and interpretation phase that the "serious and systematic process of detection" began (Ritchie and Spencer 1994:186). This stage required the review of charts and research notes in order to compare and contrast the perceptions, accounts or experiences of interviewees. This process is "not simply a question of aggregating patterns, but of weighing up the salience and dynamics of issues, and searching for a structure rather than a multiplicity of evidence" (ibid:186). Whilst this process was 'paper-based', NVivo was a helpful tool in frequently going back to the data.

4.5 SUMMARY

This chapter has described and explained the process of the research as a whole. It presented the research questions, and their position within the overall aim of the research, and described my approach to answering them. Two main parts of the research were identified: the analysis of policy, and the study of individual practitioners within their immediate and wider contexts. The chapter explained the ways in which the theoretical frameworks described in Chapter 2 – the public health continuum (Nijhuis and Van Der Maesen 1994), the perspectives of public health framework (Walsh et al. 1995), and Wenger's (1998a) social theory of learning – are used to guide the research.

Section 4.3 described the policy analysis. It outlined key points from a range of policy theories, which provide useful guidance for my analysis, and went on to emphasise the importance of discourse in this study. It introduced critical discourse analysis (Fairclough and Wodak 1997), which guides my methodological approach. The methods of analysis were explained, including the identification of policy documents for inclusion; the construction of a custom dictionary, which was then applied to the policy documents using the search facility in NVivo; the qualitative analysis of those keywords in context; and the more in-depth focus on language and discourse, mainly within two key white papers – *Saving Lives: Our Healthier Nation*, and *New NHS: Modern and Dependable*.

Section 4.4 discussed the second part of the research – the case studies of individual practitioners. This section described the rationale for my theoretical approach, and detailed the methods employed, the site area, and the selection and characteristics of the research participants. Through this discussion, I explored my own position as researcher. The section described some of the challenges presented by case study research, and the problems faced during the course of data collection, and discussed the implications of these for the validity and reliability of the research data. It also included a description of the methods and strategies employed to search and identify the relevant literature. Finally, the chapter explained how the 'framework' approach described by

Ritchie and Spencer (1994) guided the methods of data analysis in a way that allowed new theories and concepts to emerge from the data, whilst being guided by an overall theoretical framework.

This chapter, along with the background chapters, has prepared the ground for the remainder of this thesis, which is concerned with presenting and discussing the data analysis.

CHAPTER 5

'PUBLIC HEALTH' IN POLICY

5.1 INTRODUCTION

This chapter presents the first part of an analysis of recent English policy documents pertinent to public health and primary care. Together with Chapter 6, it seeks to answer two key questions:

a) How are the public health roles of primary care practitioners described in New Labour policy documents? (What is expected of them?)
b) How is 'public health' represented and discussed in these policy documents?

The chapter begins by describing the content and context of the policies. This progresses from the policy background in Chapter two, and looks specifically at the sixteen documents chosen for analysis. It then begins to explore the policy expectations of practitioners in general practice, specifically with regards to their public health roles. In order to understand the expectations of practitioners in more detail, the chapter goes on to critically analyse the ways in which 'public health' is conceptually constructed in policy. A number of 'themes' are identified which are key to public health policy discourse.

5.2 CURRENT ENGLISH HEALTH POLICY: AN OVERVIEW[27]

The political and ideological changes (described in Chapter 2) which led up to New Labour's electoral success in 1997, paved the way for a greater focus on public health and primary care. Labour in opposition had shown such commitment to the Black Report's recommendations that they were obliged to act swiftly once in office. The White Paper *The New NHS: Modern;*

[27] It is important to note that given political devolution to the four UK territories, this analysis shall concern itself only with *English* policy.

Dependable (DH 1997) announced their commitment to changing both the structure and culture of the health service so that it "does not just treat people when they are ill but works with others to improve health and reduce inequalities" (para 21). The paper introduced 'the third way' of running the NHS – "a system based on partnership and driven by performance" (para 63). It announced a plethora of new programmes and initiatives designed to meet its goals of reform and modernisation. The NHS (Primary Care) Act which accompanied the paper enabled new structural freedoms, such as PMS pilots, to develop, and paved the way for a new GMS contract. As well as extra resources and a reduction in red tape, the paper promised a greater focus on primary care, in the name of decentralisation of decision making, which was to be realised through comprehensive structural change (particularly the creation of PCG/Ts). An array of new incentives and sanctions were announced in order to improve quality and efficiency, and the introduction of HImPs, HAZs, and other collaborative programmes, aimed to place a greater emphasis on health improvement and the reduction of health inequalities.

New Labour's ensuing public health strategy, outlined in *Saving Lives: Our Healthier Nation* (DH 1999), which was bolstered by the independent inquiry into inequalities in health (DH 1998a), proposed a "contract for health", based on a "three-way partnership between people, local communities and the Government" (p175). It aimed to improve the health of everyone, and of the worst off in particular. This paper placed 'the public health function', and the strengthening of it, in the limelight. Whilst being of relevance to all in health care, it highlighted primary care as a domain in which public health should be improved. Furthermore, it named health visitors as public health practitioners and highlighted the contribution of all nurses to public health. Several other programmes and documents were prompted by this recognition. The paper heralded new structures, further financial investment, and new standards and targets.

One of the programmes emanating from *Saving Lives* was the Health Visitor and School Nurse Development Programme. From this, came the *Health Visitor Practice Development Resource Pack* in 1999. This document focuses on strengthening the public health role of health visitors, helping them to

develop what it calls a 'family-centred public health role'. It identifies the tackling of health inequalities as part of the role of health visitors, and as a 'core competency'. The document as a whole portrays a strong focus on community development and empowerment, and on addressing the wider determinants of health. Whilst its primary focus is health visitors, the pack recognises that the collaboration and support of others - particularly in the primary health care team - is vital.

Making a Difference, published in the same year, was also directed at nurses, midwives and health visitors – especially health visitors and school nurses with relation to the public health strategy. It explains the government's strategic intentions for nurses, midwives and health visitors, and its commitment to strengthen and maximise their contribution to the public health agenda. It describes an expansion and development of roles, which is balanced by a commitment from the government to improve the education and working conditions for nurses. Within this commitment, it announces more nurses, strengthened education and training, a new career framework, and better pay for nurses.

In 2000, just three years after the release of *New NHS*, came an important strategy document – *The NHS Plan: A plan for investment. A plan for reform.* This paper reiterated the aim to improve health and health care for patients and communities, and to use new investment in the most efficient and effective way. It promised a great deal of new investment in NHS facilities and staff, but made it clear that this is a 'something for something' deal. In return for investment, the government wants reform; changes in structure, but also in culture. Whilst being of great importance to all those in the health services, this document directly refers to primary care practitioners as key agents of this reform. Although the government were at pains to point out that the *NHS Plan* was not intended to supersede the previous white papers, this was somewhat inevitable given the impact of the plan on the ground.

The long awaited publication of *The Report of the Chief Medical Officer's Project to Strengthen the Public Health Function* was finally announced, four years after the project began, in 2001. The scope of this report was to consider public health in its widest sense, to enable everyone to see more clearly the

contribution they can make and the support that will be available to them. It therefore targeted a very wide audience, both within and outwith the NHS. It made some important steps in clarifying the constitution of the 'public health workforce', dividing them into three broad groups: professionals, practitioners, and the wider workforce. Within primary care, it specifically recommended that health visitors and school nurses develop stronger public health roles as public health practitioners.

Also in this year, the *National Sexual Health and HIV Strategy* was published. This strategy aimed to improve health, sexual health and well being through an improvement in services, information and support for all who need them, and by reducing inequalities in sexual health. It announced extra funding to support new initiatives, better information, and the development of professional education and training. GPs, nurses and primary care teams were amongst the target audience for the document, and it made clear its aim to strengthen the role of primary care in sexual health. The strategy fits with a broad notion of public health: It is strong on addressing the determinants of health, on prevention, and on taking a population approach.

The *New Commitment to Neighbourhood Renewal: National Strategy Action Plan*, published in 2001, is the only document chosen for inclusion within this policy analysis which emanates from a non-health government department. This is because of its important consequences for health improvement and the reduction of health inequalities. In all the poorest neighbourhoods, it proposes common goals of lower worklessness and crime, and better health, skills, housing and physical environment. It aims also, to narrow the gap on these measures between the most deprived neighbourhoods and the rest of the country. This strategy, it would seem, is so cross-cutting as to require the commitment and support of primary care practitioners, alongside those in other sectors. Given this assumption, the document is interesting for its lack of mention of primary care practitioners.

Shifting the Balance of Power: The Next Steps was published in 2002, at the end of a discussion period prompted by this document's precursor (Shifting the Balance of Power in the NHS: Securing Delivery, 2001). The first document follows on from the *NHS Plan* and sets out the organisational changes the

government is making in order to support the Plan. *The Next Steps* sets out the way forward on implementing the policy of shifting power and resources to 'frontline' staff and local communities, in order to deliver the NHS plan and reform the way in which health care is delivered. It reiterates the need for a change in structure and culture, and proposes a devolution of resources. It heralds the creation of "a renewed and powerful role [in public health] at the most local level" (p.15). Whilst this document spans the whole of the NHS, it focuses on PCTs and 'frontline staff'. It is not clear, however, who exactly is at this 'frontline'.

Also in 2002, *Liberating the Talents* was published with the subtitle 'Helping Primary Care Trusts and nurses to deliver the NHS Plan'. This document proposes a new framework for planning and delivering nursing services in primary care. Within this framework, it describes three core functions of nursing – one of which is public health. The document illustrates how these core functions can be carried out in practice. It highlights the importance of primary care, and of nurses within primary care, and promotes new roles, innovation and changes in practice.

Another long-awaited document – *Tackling Health Inequalities: A programme for action* – was published in 2003 following a long consultation process and the publication of an important cross cutting review (see DH 2001i, 2002c, HM Treasury 2002). This programme for action cuts across all policy levels, and a range of government departments, and sets out plans to tackle health inequalities over the next three years. It establishes the foundations required to achieve the national target for 2010 to reduce the gap in infant mortality across social groups, and raise life expectancy in the most disadvantaged areas faster than elsewhere. It emphasises the roles of Local Authorities and PCTs in achieving these goals.

Also in 2003, and following a long period of awkward political and professional negotiations, the *New General Medical Services Contract* was launched. The new contract aims to encourage significant additional resources into primary care, to improve services to patients, and to revitalise general practice. It contains within it some important legal, administrative and financial reforms which have a great potential impact for the ways in which services are

delivered in general practice. It gives GPs more control over their workload and career development, allows them to opt out of providing out-of-hours and other 'additional' services, and introduces a system of financial incentives aimed at rewarding those GPs who provide high quality care.

Since 1999, there have also been a number of *National Service Frameworks* (NSFs) produced. By 2003, they had been published in the following areas – paediatric intensive care (1999); mental health (1999); coronary heart disease (2000); older people (2001); and diabetes (2002) (only the latter four are included in this analysis). New NSFs are continuing to emerge (in long term conditions, renal services, and children). The NSFs are aimed at improving services through setting national standards to drive up quality and tackle existing variations in care. They are, then, essentially *service* focused, with a priority on high quality treatment and care. However, they also focus strongly on prevention strategies, and have the concern with inequalities as an underlying theme. They each announce further national and regional support, for instance through modernisation funds, complementary programmes, and implementation groups. Primary health care teams are a key audience for these documents, and are presented with a plethora of targets and standards to meet.

A more recent arrival - the second Wanless Report (2004) - was published by the Treasury after my analysis had been conducted. However, its omission from this analysis is not considered to be significant, since it reiterates much of what has already been said in previous documents. It places an emphasis on prevention of ill health, since this will, in the longer term, reduce the cost of the NHS, and recommends that we move towards a 'fully engaged' scenario, in which there are high levels of public engagement in health and health care.

The policy documents, individually and collectively, seek to impact upon the roles of those working in the NHS, and the ways in which they work. They were chosen for their significance to public health practice in primary care. Whilst the overview has taken a chronological approach, however, it is important to recognise that different policies will impact upon different 'levels' within the health system. Some policies, then, will target (and possibly influence) the

work of individual practitioners more directly than others. Whilst major white papers such as the *New NHS* and the *NHS Plan* are macro (systemic) level policies, seeking to influence the structure and culture of the overall health system, other papers, like *Liberating the Talents*, or the *Health Visitors Development Pack*, are more concerned with the delivery of services by individual practitioners. Many policies, in fact, cut across many levels. *Saving Lives,* for instance, encompasses policy decisions at systemic, programmatic and organisational level policies (Frenk 1994). With this in mind, then, the next section looks at the policy documents in more detail in order to identify what is expected of primary care practitioners in terms of their public health roles.

5.3 Targets of Public Health Policy: Primary Care Practitioners

In finding specific information relating to primary care practitioners as 'targets' of the policy documents, and in order to explore the expectations made of these practitioners, a number of word/phrase searches were carried out (in NVivo) using the following keywords:

front line, front-line, frontline
primary care team(s)
nurse(s), nursing
GP(s), general practitioner(s)
public health role(s).

5.3.1 General role expectations

Analysis of the documents shows an expectation that roles within primary health care teams are to change. They are a clear part of the government's new drive to prevent ill-health and to tackle the underlying causes of health inequalities. There is an emphasis on all practitioners becoming more involved in planning / designing, as well as delivering, services according to local need. This is expected to make services more locally responsive, and more efficient. Primary care practitioners are seen as important conduits of information about health, both 'upstream' and 'downstream', between the decision makers at local and national levels, and the individuals in their community. They are,

therefore, expected to have a good understanding of the wide range of health and health-related needs within their community.

In order to do this, practitioners are expected to 'innovate' and to become more involved with other organisations. PCTs are the main vehicle through which practitioners are expected to help plan services, although Local Strategic Partnerships are also mentioned as something with which 'frontline staff' should become involved (LTT 271)[28]. They are expected to work collaboratively both with other service providers, and with their patients and local communities.

As well as new roles in planning services, the documents highlight new or enhanced roles around specific issues. This is particularly clear in the NSFs. The CHD NSF, for instance, spells out an element of the primary care practitioner's role in the prevention of coronary heart disease:

> "General practitioners and primary care teams should identify all people at significant risk of cardiovascular disease but who have not developed symptoms and offer them appropriate advice and treatment to reduce their risks" (CHD NSF 20).

Similarly, roles in diabetes management, mental health, sexual health, and preventing falls and osteoporosis in older people, are highlighted. Although some of the NSFs (particularly for mental health and older people) contain some broad standards concerned with prevention and promotion of well being, those targets and recommendations directed specifically at primary care practitioners tend to be medical and individualistic in nature (drug prescribing or screening, for instance).

5.3.2 Specific role expectations

Nurses and health visitors

The Nursing strategy *Making a Difference* and *Saving Lives: Our Healthier Nation* set out the intention to develop the public health contribution of nurses, midwives and health visitors as a major part of the NHS workforce. *Making a*

[28] In this and all subsequent references, the letters refer to the abbreviated title of the policy document (see Chapter 4, table 4.1), and the numbers correspond to the paragraph number (in text only format).

Difference gives the clearest idea of the expected contribution of this group to public health. It describes nurses and HVs as:

> "... public health workers, focusing on whole communities as well as individuals, fulfilling the public health functions of community profiling, health needs assessment, communicable disease control and community development. Health visitors and community nurses, working close to where people live in local communities, are acting as advocates for vulnerable groups and people who are socially excluded, making sure they have access to mainstream health services. We want to encourage, sustain and extend these developments" (MAD 483).

The expected part they play in reducing health inequalities is further articulated in the extract below:

> "Through their work with people who are vulnerable, those who are socially excluded and those at greatest risk of ill health, nurses, midwives and health visitors can help tackle health inequalities, targeting those in greatest need ..." (MAD 485).

Numerous practice examples describe situations in which nurses and HVs have worked 'innovatively' in order to meet local need, for instance: a district nurse running a session for a local carers group on preventing falls; various practitioners working with a women's refuge to deal with domestic violence issues; health visitors working with local community activists and a range of agencies to develop a programme of community initiatives.

The extension of nurses' and HVs' roles is also discussed throughout the documents, both in terms of taking on more advanced and specialised roles, in areas such as diabetes or sexual health, as well as taking on work currently done by GPs. Within the documents, old demarcations between nurses (usually associated with the *location* in which they work: either in the practice, in the home, or out in the community) are somewhat blurred. Instead, new distinctions emerge according to the level of skills possessed – creating two broad categories: generalists and specialists. The expectation is that practitioners will 'skill mix', and some will develop advanced and specialised roles. This necessarily requires a new breed of practitioner to take on those 'lesser' tasks. *Liberating the Talents* states that:

> "There will be more generalists working in teams across all settings bringing the flexibility needed to provide care to individuals, families and communities. Support workers / health care assistants and registered

> nurses will become a more important part of the primary care workforce" (LTT 89).

This has wide implications for the entire primary care team – including the GPs, who are passing many of their traditional roles over to nurses. The implications for public health roles are somewhat unclear – especially the degree to which public health roles are 'generalist' or 'specialist'. *Liberating the Talents*, though, identifies 'public health' as one of the three core functions of *all* nurses in primary care, "whatever the title, employer or setting". It describes this function as:

> "Public health / health protection and promotion programmes that improve health and reduce inequalities" (LTT 77).

In addition to all nurses and HVs having a general public health role, it is expected that some will develop specialist roles, "Leading and delivering priority public health programmes" (LTT 94). This inevitably will have a profound effect on the education and training of nurses and HVs. This was picked up in the *CMO's Report*, which announced that

> "The public health content of specialist community nursing programmes will be reviewed in the course of the strategic programme for public health and nursing and the health visiting and school nursing initiative" (CMO R 266).

That nurses and HVs have a role to play in public health, then, is clear. However, further discussion of what that public health role is to look like in practice is generally avoided – except, that is, in the case of health visitors and school nurses.

'Public health roles' are mentioned in 47 passages throughout the documents. Thirty-one of those are in the *HV development pack* and predictably discuss the public health roles of health visitors and school nurses. The pack focuses on developing what it calls a 'family-centred' public health role for health visitors. According to the document,

> "The family-centred public health role means a change of emphasis to increase community based and targeted public health activities that have long been advocated by the [health visiting] profession" (HV DEV 148).

Whilst the historical links between health visiting practice and public health are

acknowledged, the family-centred public health role of health visitors is described as something new, which health visitors are encouraged to develop.

The document goes on to describe the role in some detail and suggests ten 'competencies' for health visitors: interagency working; working with groups; population health needs assessment; family health needs assessment; multidisciplinary team working; addressing health inequalities; health protection programmes; community involvement and development; priority parent education; and population based health promotion. A further element of the role involves leadership, and health visitors are expected to lead 'their teams' and 'colleagues' in public health work (although the document is vague about who these colleagues and teams consist of) (HV DEV 55, 479).

It seems, then, that whilst there is an expectation that all nurses contribute to public health and the reduction of health inequalities, it is only in certain disciplines (health visiting, school nursing, occupational health nursing and communicable disease control nursing) that a 'public health role' is explicitly discussed. The focus on health visitors as public health practitioners is logical, given their historical roots and the guiding principles of their profession, which resonate strongly with public health principles (see Chapter 3). However, it draws attention away from the professed expectation that public health is to be embedded within the roles of *all* nurses.

GPs

GPs are often mentioned in the documents as individuals with whom other people should be working. They are seen as 'key' people who need to be 'on board' with new changes, programmes or initiatives (see HV DEV 381, 669, 683, 1212). However, their role in general is little discussed, and their public health role is never explicitly mentioned.

GPs are expected to work with others, particularly nurses, to plan and provide services which meet the needs of the local population. However, whilst 'holistic care' is incentivised in the new GMS contract, and opportunistic health promotion will be funded through essential and additional services, services

which "address specific local health needs or requirements" are considered as 'enhanced' services - "services not provided through essential or additional services" - hence, they are services from which GPs can opt-out if they wish. The 'proper' role of the GP, according to the contract, is "the care of patients who are or believe themselves to be ill" (GP CONTRACT 142). Taken at face value, this role description is devoid of any public health elements, but rather is focused on individualistic, biological/psychological medical treatment.

Whilst the new GMS contract says that "the role and status of a GP as a generalist will be developed and valued" (389), there is a great deal of discussion around GPs developing specialist roles, or special interests, for instance in ophthalmology, orthopaedics, dermatology and ear nose and throat surgery (NHS PLAN 837).

Within the documents, there is very little discussion of GPs' roles in public health. The CMO's report, however, recommends that "there should be more opportunities for general practitioners to gain training and experience in public health practice" (CMO R 297). This, and the rather basic description of a GP's 'proper role' within the new GMS contract, implies that public health might become a speciality for a few GPs, rather than be considered as an integral part of the role of every general practitioner. At the same time, though, their support of other practitioners in public health work is frequently implied (for instance in the health visitors' development pack). They are also expected to play leading roles in PCTs, which, in turn, have major roles to play in public health. Thus, it would seem that GPs require a good understanding of public health, and an appreciation of their (important) part within the public health agenda.

The expected public health roles of practitioners in general practice, then, remain vague. They are clearly seen, in policy, to be an important part of the public health agenda. However, there are many un-addressed conflicts between this and other policy expectations - particularly those associated with efficiency and effectiveness (discussed in more depth in Chapter 9). Since public health roles are never made explicit (except, perhaps, for health visitors), the policy discourse can be interpreted in many different ways

according to the meanings and assumptions associated with 'public health'. This is explored further in the following section, which looks at a number of concepts that fall within 'public health' in policy discourse.

5.4 'Public health' Characteristics

Four of the sixteen documents chosen for analysis stand out as being documents with a strong public health focus. The first is often referred to as the public health white paper – *Saving Lives: Our Healthier Nation*. However, rather than offering a distinctive definition of 'public health', the document describes some of its characteristics:

> "Public health is multi-disciplinary and multi-agency ..." (SL OHN 1152)

> "Public health is not just about the wider aspects of population health. For those with chronic and longstanding conditions, improving the outcome of care can mean reducing disabling complications and enhancing quality of life." (SL OHN 1244)

Despite the document's avoidance of a definition, a number of key 'themes' emerge which betray its particular notion of what public health is:

- **Collaboration/partnership:** public health is portrayed as 'everybody's business' – it requires collaborative action by a wide variety of contributors, including Government, local authority, the NHS, voluntary organisations, business, and so on;
- **Community involvement/participation:** the public themselves - that is individuals, families and communities, are key contributors;
- **Population as well as individual perspective:** the scope of public health is broad, and includes action to improve population health, community health, family health and the health of individuals;
- **Focus on inequalities:** public health is concerned with reducing inequalities, and sees the targeting of the 'worst off' as a way to do this.

The second key public health document is the *Health Visitors' Practice Development Pack*. This document has a very specific target audience, aiming as it does to strengthen the public health role of health visitors. It offers

several partial descriptions, rather than a comprehensive definition, of public health:

> "Public health is a way of looking at health that takes the population as the starting point ..." (HV DEV 72).
>
> "Public health is made up of a wide range of activities including health promotion, protection and prevention as well as healthy public policy and individual and community empowerment" (HV DEV 73).

The document also describes what it means by a 'public health approach':

> "A public health approach means looking at health needs across a community or population group and having a responsibility for improving the health of a local community or practice population" (HV DEV 139)
>
> "A public health approach means looking at health needs across a population, targeting inequalities, working in partnership with others and tackling the causes of ill health" (HV DEV 389).

Once again, collaborative action, the reduction of health inequalities, and a population perspective are raised. In addition, several other key themes are noted:

- **Addressing determinants of health:** health promotion, protection and prevention are recognised as important ways of tackling the underlying causes of ill health;
- **Healthy public policy:** the health of the public should be improved through policies and strategies;
- **Community empowerment:** individual and community empowerment is an important strategy within public health.

The third key public health document is *The Report of the CMO's Project to Strengthen the Public Health Function*. This document has had significant impact on the organisation and delivery of 'the public health function' in England. It is also the first of the documents to offer a definition of public health (although the definition itself is not new - see Acheson 1988):

> Public health is "the science and art of preventing disease, prolonging life, and promoting health through the organised efforts of society" (CMO R 43).

This definition is used, the document reports, because it reflects

> "the essential elements of modern public health - a population perspective, an emphasis on collective responsibility for health and on prevention, the key role of the state linked to a concern for the underlying socio-economic determinants of health as well as disease, a multi-disciplinary basis which incorporates quantitative as well as qualitative methods and an emphasis on partnership with the populations served" (CMO R 44).

Interestingly, whilst this definition raises a concern for the underlying socio-economic determinants of health, it does not specifically refer to inequalities as a target for public health action (although the report does make some reference to inequalities/variations elsewhere).

The final, and most recent key document, on the other hand, is devoted to the issue of inequalities – *Tackling Health Inequalities: A Programme for Action*. It is interesting that this document mentions the term 'public health' rarely (sixteen times in total). It offers no definition or discussion of public health, and does not explicitly make a link between its programme for action to tackle health inequalities and what has previously been called 'the public health function'. Despite this, however, it is clearly driven by the same commitment – to improve health and reduce inequalities, and to work together to tackle the wide ranging and underlying causes of ill-health through prevention, promotion and protection. Its avoidance of the term 'public health' may reflect an appreciation of the confusion which often surrounds the term.

There are, then, a number of recurring themes which illustrate the government's understanding of what constitutes 'public health', as expressed in these policy documents. These are:

- Multi-disciplinary collaboration
- Community Involvement
- Focus on inequalities / equity
- Community development / empowerment approach
- Population as well as individual perspective

- Addressing determinants of health through protection, promotion and prevention
- Improving health through policies and strategies

These themes provide a useful starting point for further analysis of the ways in which public health is discussed in policy documents. The application of a custom dictionary (see Chapter 4, table 4.2) to the sixteen documents produced a table of passage counts (table 5.1 below). It is important to remember two points when interpreting this table. First, that since the coding was expanded to incorporate entire relevant passages, rather than just the keyword itself, the counts are not of the number of times that word appears, but rather the number of passages in which it appears. The word may appear more than once within that passage. Secondly, since each document was of different length, and the counts are 'simple' counts, rather than percentages of the total word count, comparisons between documents on the basis of these counts are limited in value. In addition, note that two themes – population perspective, and improving health through policies – were not used to generate counts, but rather highlighted text for further qualitative analysis.

With these caveats in mind, the table highlights the frequency with which these key concepts are mentioned in policy. Some, like collaboration/partnership, prevention and inequalities are particularly common. It is striking that the concept collaboration/partnership featured much more frequently in the New Commitment to Neighbourhood Renewal than in other (department of health) documents. Prevention is a strong theme in most of the documents, and outnumbers promotion in frequency counts. The absence of 'prevention' from the New NHS might reflect the systemic (macro) focus of this policy document.

The coding of passages, as well as giving a useful overview of the documents, facilitated further qualitative analysis of the key themes and the ways in which they are constructed within the policy documents. It is to this that we turn in the next section.

*Table 5.1 Passage counts based on key 'theme' searches of policy documents**

Theme / Document	Collaboration	Involvement	Inequalities	Empowerment	Addressing determinants			
					Prevention	Promotion	Protection	Poverty
CMOs report	21	7	14	10	7	12	7	4
New NHS	49	8	12	1	0	4	0	0
NHS Plan	50	4	32	5	31	9	2	6
SL OHN	54	8	3	2	49	42	6	24
STBOP	42	19	11	6	6	1	5	0
Tackling HIs	44	22	178	6	39	20	0	26
MAD	27	2	14	2	8	13	5	4
LTT	9	7	7	1	12	3	2	1
HV DEV	35	28	18	26	29	52	15	8
GP Contract	28	3	0	2	2	4	1	0
NCNR	170	39	9	22	16	6	0	19
SEX STRAT	26	11	12	1	57	22	1	4
OP NSF	38	14	6	0	71	53	1	3
MH NSF	47	18	10	1	24	32	3	11
Diabetes NSF	17	10	11	11	15	4	0	1
CHD NSF	12	9	23	3	44	15	0	1
TOTALS	*669*	*209*	*360*	*95*	*410*	*290*	*48*	*111*

*The counts are of the number of passages in which the theme was discussed, rather than the number of times the keyword itself was mentioned. Each 'theme' may refer to a number of words, e.g. 'collaboration' would also include partnership and joint working (see the dictionary in table 4.2, Chapter 4, for clarification).

5.5 'PUBLIC HEALTH': A COLLECTION OF PROBLEMATIC CONCEPTS

5.5.1 Collaboration

The idea of multi-disciplinary collaboration between professionals and organisations is clearly a strong one in all the documents. Collaboration is, indeed, a practice highly esteemed by the present government which exhorts all agencies to engage in 'joint working', and which has put in place a number of measures to facilitate the process. It is perhaps, then, less a feature of the government's view of what public health is, but rather a feature of their more general 'modernisation' process, and their commitment to the 'third way' which emphasises intersectoral partnerships and networks[29].

The terms collaboration, partnership, multi-agency and joint working are used inter-changeably. This can be seen in the following paragraph, from the HV development pack, which attempts to describe what 'partnership working' means:

> "Partnership working is the sharing of information, skills and resources to work together towards agreed objectives ... This is a challenging agenda for all involved as collaborative working is not always straightforward. The differing organisations in any multi-agency work are likely to have a range of potentially competing priorities which need to be taken into account and it takes time for different professional and lay people to get to know and trust each other sufficiently for effective joint working. However, the impact of work undertaken in partnership with others is likely to be far greater than that which can be achieved alone" (HV DEV 521, my emphasis).

This extract is an example of where 'over-wording' is used (that is, the use of a proliferation of different words in the same area of meaning). Fairclough (2000) suggests that over-wording may be indicative of intense ideological preoccupation, "suggesting that a particular area of meaning is especially significant or problematic" (p.163).

This passage also hints at why people might want to go to the effort of working

[29] Indeed, a statutory duty to work in partnership was introduced in the Health Act 1999.

collaboratively (although not particularly convincingly) – to produce results which are 'likely to be' far greater than those which can be achieved alone.

Collaborative working is frequently cited as generally a 'good thing to do'. However, this is often with little explanation of why, or indeed how. Given that the practical difficulties of partnership working are well understood, it would seem wise to spell out exactly why those working in or for 'public health' should be committing themselves to overcoming such barriers. Within public health, the need for joint working could be related to the wide-ranging nature of determinants of health - from genetic abnormality to air pollution, or from a poor diet to the stress of commuting to work (Turner 2003) - and hence, the wide-ranging, and necessarily collaborative efforts required to tackle them. This is recognised to a limited degree in the NHS plan, but otherwise is understated:

> "The NHS cannot tackle health inequalities alone. The wider determinants of ill health and inequality call for a new partnership between health and local services" (NHS PLAN 913).

5.5.2 Involvement

Patient and public involvement or participation is another common theme in much of the present labour government's policies. Like 'collaborative working', it is commonly espoused as 'a good thing to do'. However, the terms are never actually defined within these documents. Indeed, they are used in a number of different ways.

'Involvement' is sometimes used to mean the involvement of patients/public in organisations or initiatives (for instance, as members of a decision making body, or board):

> "Empowering and enabling patients and the public to participate in decision-making and make their views heard about their own health, individually and collectively, is central to this NSF, for example through the diabetes network" (DIAB NSF 361)

Several documents talk about the importance of patients and/or the public being able to influence change, perhaps in the types of services on offer, or the ways in which they are delivered, for instance:

> "All services should review their location and opening hours to match their local population's needs, and will have to be able to show that users and potential users of services are involved in developing access policies" (SEX STRAT 330).

The idea of what I shall call *altruistic* involvement – that is, the involvement of individuals / communities in programmes, and in decision making, for the good of their community or 'the public' - is a common one. 'The community' are expected to be involved, for instance, in health needs assessment, in planning services which address the issues that affect their health, in helping to deliver those services, in monitoring and evaluating them, and even in devising strategies to involve the community further.

Reasons for involving patients/public are rarely given in the documents; but where they are, there appears to be a general consensus that involvement leads to services which are more effective and 'relevant' to local people, and that such a process strengthens the confidence that the public have in the services and the providers:

> "Communities need to be consulted and listened to, and the most effective interventions are often those where communities are actively involved in their design and delivery, and where possible in the driving seat" (NCNR 191).
>
> "Through these partnerships PCTs will develop innovative and effective ways to involve people and give them confidence that local services have their interests at heart" (STBOP 229).

Apart from this, it seems to be accepted that patients and the public simply have a right to be involved – although what form this involvement should take is less clear.

As well as *altruistic* involvement, the documents speak of a more *self-serving* involvement – that is involvement in one's own care and health improvement. Individuals (and their carers/families) are expected to be involved in the

planning of their care, and in "deciding, agreeing and owning" how their illness will be managed (DIAB NSF 164).

Related to this is an individual's 'participation in' (or rather, acceptance of) a service that is offered, such as a programme of secondary prevention and cardiac rehabilitation (CHD NSF 28), or a drug treatment programme (Tackling HIs 21). Additionally, several documents suggest that the very process of participation is 'good for you':

> "When people are involved in making the decisions which affect their lives their self-esteem and self-confidence rise, in turn improving their health and well-being" (SL OHN 1130).
>
> "Learning to mobilise support at work and to participate in problem solving and decision making can improve mental health" (MH NSF 203).

This idea that participation is good for you is also extended from the individual to the community. Participation is seen in some of the documents as a means of community development or empowerment:

> "Community development work can be particularly effective in building the health capacity of local communities. It involves working alongside local people to enable them to find ways of addressing the issues that they see as affecting their health by generating local partnerships and action" (HV DEV 141).

Overall, patient and public involvement, within the policy documents, maintains a service-oriented focus, rather than a focus on public health.

5.5.3 Inequalities

Whilst the CMO's report on the public health function somewhat underplayed 'inequalities' as an issue (with it not featuring at all in the section entitled 'what is public health?'), the Tackling Inequalities Programme For Action similarly underplayed 'public health', mentioning it a mere sixteen times (mostly referring to public health networks, directors or observatories). This implies that public health and tackling health inequalities may be being presented as two separate, albeit related, agendas. Discussion of inequalities within the other

documents frequently refers to 'unacceptable variations' in service access, quality or provision.

Despite this, though, there is certainly a new commitment to tackling such unacceptable variations, and this is a welcome change in policy documents compared with those written before 1997. This commitment is demonstrated in many ways – not least in the announcement of national health inequalities targets and the publication of a Cross Cutting Review of health inequalities (HM Treasury 2002). Many of the strategies proposed for combating health inequalities run through all the documents – targeting the 'biggest killers' (CHD and stroke, cancer, mental illness, and accidents); reducing variations in access to services and in quality of care; improving information so that more is known about the inequalities that exist. There is also a recognition that action and resources must be targeted towards those most in need.

5.5.4 Empowerment

The usefulness of community development approaches within the public health agenda is clearly recognised in most of the documents, but especially within the HV development pack.

> "Community development work is an effective way of tackling issues that restrict people's health choices and regenerating and empowering communities to influence local health policy and service development.
>
> Working alongside local people on issues that they know to be important in their lives can help reduce inequalities in health" (HV DEV 349-350).

The HV development pack then goes on to give examples of public health work using community development methods, which include community based health support groups, peer education projects, working with excluded and 'hard-to-reach' groups such as the homeless, refugees and young unemployed men, and addressing the wider determinants through economic regeneration and employment - for instance, creating jobs through lay employment health projects (see HV DEV 352-358).

In other documents, community development is seen as a way of addressing health determinants, delivering health improvement, engaging and building the health capacity of local people, narrowing the health gap, and increasing social support in deprived communities.

Community development and community empowerment are sometimes used interchangeably (e.g. in HV DEV). They often reflect a community or population perspective within the document. However, empowerment is also talked about, particularly within the Diabetes NSF, as 'patient' empowerment, which can have a much narrower meaning – perhaps involving simply the provision, to patients, of access to their own health records (315). In the new GP contract, for instance, there are two passages which discuss 'empowering' patients so that they make 'best use of primary care services' and use those services 'effectively' (GP CONTRACT 9 and 51). What this could mean in practice is unclear – it could simply mean the provision of patient leaflets listing phone numbers of services. Similarly, SL OHN claims that NHS Direct will be a way of 'empowering' people in relation to health as it provides them with rapid access to health advice and information. This is a wholly different concept of empowerment to that espoused in the health visitors' development pack or Tackling Health Inequalities: Programme for Action.

Given the diverse interpretations of 'empowerment', then, it should be a concern that in the majority of passages, no definition or interpretation is offered at all. In terms of implementation, 'empowerment' might simply involve the provision of information to a patient, or the changing of appointment systems in order to encourage (or empower?) people to use the services effectively.

5.5.5 Population Perspective

A population perspective is a common theme through all the documents in this analysis, and is indicated by numerous discussions of population statistics – particularly those which highlight inequalities. The CMO's report and the HV development pack identify a population perspective as a key element of a public health approach, as this passage shows:

> "Public health is a way of looking at health that takes the population as the starting point. By taking an overview of the population we can see what the key health issues are for that population be it the practice population, neighbourhood, PCT or region. We can also see what needs to be done to improve their health and tackle inequalities. With a population perspective it is possible to identify and address the wider determinants of health such as poverty, unemployment, social exclusion, transport, education and the environment" (HV DEV 71).

Many of the documents clearly encourage a population approach to improving health and tackling health inequalities:

> "The NHS will develop, implement and monitor strategies to reduce the risk of developing Type 2 diabetes in the population as a whole and to reduce the inequalities in the risk of developing Type 2 diabetes" (DIAB NSF 204).
>
> "The NHS and partner agencies should develop, implement and monitor policies that reduce the prevalence of coronary risk factors in the population, and reduce inequalities in risks of developing heart disease" (CHD NSF 189).
>
> Community health needs assessments should be carried out in order to: "learn more about the resources, needs and priorities of the local population" (HV DEV 158).

Whilst the adoption of a population perspective is described as an important aspect of working with a public health approach, there is an acknowledgment, in several of the documents, of the need to balance that population perspective with individual care. For instance:

> "The balance needed between individual clinical and population health perspectives needs to be acknowledged by both primary care and public health teams" (CMO R 296).
>
> "The new role described in this pack aims to strengthen the community based, population approach of public health and integrate this with individual and family work" (HV DEV 51).

The health visitors' development pack attempts to clarify the nature of this balance:

> "An assumption is sometimes made that public health work means working with groups rather than individuals, but as the above continuum illustrates one-to-one work is an essential part of an overall public health

> approach. However, this individual work does need to be set in a wider population context. The wider population view can help you and your team decide how to use your skills and resources more effectively ..." (HV DEV 129).

Public health, then, is about being able to take a population *as well as* an individual perspective. This is important since it opens up the potential of those practitioners who work solely, or predominantly, with individual patients being able to develop their public health roles.

5.5.6 Addressing Determinants

The prevention of ill health and the promotion and, to a lesser extent, protection of health are clearly important concepts within all the documents in this analysis (illustrated by the number of passages discussing them). Particularly within the documents focused on specific illnesses - such as CHD, Diabetes, mental ill-health, and sexually transmitted infections (STIs) - prevention and promotion are mentioned repeatedly as important strategies for reaching public health goals. Indeed, the HV development pack acknowledges health promotion, protection and prevention as three 'activities' which help 'make up' public health (para 52).

In some documents, a 'health' or 'lifestyle' focus dominates. For instance, promoting physical activity and healthy eating are heralded as ways of tackling CHD and diabetes, and promoting the use of condoms is a key strategy in preventing unintended pregnancy and STIs.

However, the need for a multi-agency approach to health promotion and illness prevention is recognised in Making a Difference (75), which sees the Health Action Zone as an ideal mechanism for this to happen. The MH NSF identifies both the need for collaboration and the importance of a community or population perspective in mental health promotion:

> "initiatives designed to promote social inclusion – for example, Sure Start, Welfare to Work, New Deal for Communities and the work of the Social Exclusion Unit – will all strengthen the promotion of mental health ..." (MH NSF 134).

> Mental health promotion needs to include "a combination of methods to strengthen ... communities in tackling local factors which undermine mental health" (MH NSF 179).

Links are made, then, to tackling the wider determinants of health such as poverty and social exclusion. A search for these two keywords found repeated mentions in some of the documents, although neither word was mentioned at all in the New GP contract, STBOP, and New NHS, and only once in the Diabetes NSF, CHD NSF and LTT. This is perhaps surprising given the current recognition that poverty and social exclusion have a profound effect on health and are at the core of health inequalities. Reassuringly, this is picked up both in Saving Lives and in Tackling Health Inequalities:

> "We believe in working across Government to attack the breeding ground of poor health – poverty and social exclusion ..." (SL OHN 117).

> "The Government's aim is to reduce health inequalities by tackling the wider determinants of health inequalities, such as poverty, poor educational outcomes, worklessness, poor housing, homelessness, and the problems of disadvantaged neighbourhoods" (Tackling HIs 69).

The lack of discussion of poverty and social exclusion in the majority of the documents, though, might reveal a persistent underlying belief that these issues are not predominantly within the 'health' domain. This is particularly so in the majority of the more 'micro' policies (with the exception of the HV development pack), which show a lack of connection between poverty/social exclusion and primary care practitioners' roles.

5.5.7 Improving health through policies and strategies

Involvement in policy and strategic decision making for the good of the public's health is discussed, albeit weakly, in the policy documents in this analysis. 'Healthy public policy' is supposed to be one of the wide range of activities making up public health (HV DEV 72), and is described as being able to promote sexual health at local and national levels and address inequalities (SEX STRAT 140).

Individuals and organisations at various different levels are encouraged to become involved in policy. A core element of the regional public health function, for instance, is to:

> "contribute to national policy formation and to developing regional implementation plans shared between agencies for national policies on all aspects of public health" (CMO R 153).

At a more local level,

> "Local players are encouraged to undertake and make public a prospective health impact assessment of major policy decisions that are likely to have a direct or indirect effect on cardiac health. Retrospective assessments or evaluations of policy will help to monitor how a policy is affecting or has affected health following its implementation and to modify or inform future direction" (CHD NSF 222).

Health visitors are encouraged to "get involved and influence planners, managers and policy people in the PCT" (HV DEV 687), and to "influence policy and priorities" (HV DEV 165). The HV Development Pack states that

> "There is a great deal that can be done to contain the risks of accidental injury. Health visitors can help households identify risk, minimise environmental hazards and to influence public policy" (HV DEV 715).

Beyond these somewhat vague exhortations, though, there is little in the way of guidance or mechanisms that specify which, how and to what extent, people should be involved.

The ways in which these main themes are discussed in the policy documents are summarised in table 5.2.

Table 5.2 Summary of the ways in which public health themes are discussed

THEME	SUMMARY OF THEME'S USE IN POLICY
Collaboration	This is a strong theme across all public policy, although there is little to describe the need for collaborative working within/for public health specifically. It is often promoted as a 'good thing to do' rather than an essential part of public health work.
Involvement	This is a commonly mentioned concept, although used in a number of different ways, including: *'Altruistic' involvement* - Involvement of patients/public in organisations (e.g. as patient rep) (to make the organisations/services more relevant to local need and improve public confidence in them); - Involvement in programmes, initiatives, decision making (for the good of their community/'the public'). *'Self-serving' involvement* - Involvement in one's own care and health improvement through taking part in decision making and planning and managing one's care; - Participation in a service, such as secondary prevention or rehabilitation. *'Empowering' involvement* - The use of 'involvement' as a means of empowering individuals, groups and communities. Its use is primarily associated with a service-oriented focus, rather than a focus on public health.
Inequalities	There is much acknowledgement that inequalities or variations in health or health services exist, and that this is unacceptable. However, the emphasis on inequalities in services tends to be stronger, and the reduction of inequalities more generally is not always presented as an integral part of the public health agenda – they appear to be portrayed as two separate, albeit related, agendas.
Empowerment	Community development/empowerment approaches are recognised as important within public health, as a way of addressing health determinants, narrowing the health gap, etc. However, the word 'empowerment' is also sometimes used in a much more narrow, individualistic sense – e.g. 'empowering' patients to use services effectively, or to look after their own health.
Population perspective	Public health is clearly seen to require a population perspective, but the need for this to be balanced with the individual approach is also conveyed. Thus, one-to-one work is seen an essential part of an overall public health approach so long as it is set within a wider population context.
Addressing determinants	Prevention, promotion and protection are seen to form part of public health work. In some documents, a health or lifestyle focus dominates. In others, the need for multi-disciplinary approaches to tackling wider health determinants are recognised. Poverty and social exclusion are not discussed in many of the documents, though. This might reflect a belief that they are not important issues for the NHS.
Improving health through policies and strategies	This theme is discussed briefly in several of the documents and is encouraged at national, regional and local level. However, there is little further guidance on what is expected.

5.6 SUMMARY

This chapter began with the premise outlined in Chapter 4, that public health discourse is an important part of the policy making process. The way in which 'public health' is conceptually constructed, and the way in which it is 'talked about' in policy, shapes both the way that public health is framed as a policy 'problem', and the associated policy 'response'.

The chapter described the first stage of the analysis of 16 key policy documents. Section 5.2, which gave an overview of current English health policy, outlined the great many changes which have been made across the NHS and other public services, at all levels. These changes have had the aim of improved efficiency and effectiveness at their heart. They include organisational rearrangements; an emphasis on partnership working and patient and public involvement; a shift in the balance of power towards local primary care organisations; as well as the introduction of new national standards, and bodies to oversee the delivery of these. The overall challenge is to improve the health of all, and to reduce health inequalities.

In the third section (5.3), all documents were analysed in order to explicate the general and specific public health role expectations made of primary care practitioners. It found that practitioners, as part of the NHS 'front line', are required to be working towards the aim of improving health, and reducing health inequalities. Their particular location in the community gives them privileged opportunities to work with a range of others, including the communities themselves, to identify health and health-related needs, and to seek to meet those needs through planning and delivering new and innovative services. Also, as a part of the NHS, they are expected to work towards delivering services of better quality with greater efficiency. This presents significant challenges for primary care practitioners.

The fourth section (5.4) looked further into the nature of these 'public health' expectations. It described a thematic analysis of the documents in order to identify the key characteristics within 'public health', as constructed in policy. It identified a number of keywords which were consolidated into seven key

themes. A qualitative analysis of the use of these keywords in context, presented in section 5.5, found that 'public health', itself a conceptually contested term, is constructed of a number of equally problematic concepts. Many of these concepts are not defined, and are used in multiple ways which can encompass a broad scope of understanding and practice.

Whilst the government is exhorting practitioners to develop stronger roles in public health, they are not clear about what that means in practice. The government's understandings and perspectives of public health are explored further in Chapter 6, through a more in-depth analysis of public health policy discourse.

CHAPTER 6

EXPLORING PUBLIC HEALTH PERSPECTIVES IN POLICY

6.1 INTRODUCTION

This chapter moves on from Chapter 5, in order to consider public health policy discourse in more depth, using Fairclough and Wodak's (1997) critical discourse analysis approach as a theoretical framework. It turns to some of the intricacies of New Labour's discourse, and examines two white papers in more detail. *The New NHS* and *Saving Lives: Our Healthier Nation* were chosen because of their importance in constructing New Labour's approach to health, public health and healthcare. They are the documents from which many of the subsequent programmes, initiatives and policy documents emanate.

In critically examining this discourse, the chapter analyses the public health policy rhetoric, suggesting that it presents important challenges for the government's wider modernisation agenda. The chapter begins to scrutinise some of the sub-text hidden behind the rhetoric, which allows us to explore the government's meanings and perspective of public health. The analysis examines how language is used to construct selective versions of the nature of 'public health' as a policy problem, and how narrative devices are employed to construct a persuasive account of the appropriateness of the government's policy 'response'.

6.2 A SOCIAL STRUCTURAL PERSPECTIVE?

Both the *New NHS* and *Saving Lives* clearly recognise the impact of social, economic and environmental factors on people's health. These factors are also implicated in the persistence of health inequalities. To this end, both documents describe the government's mission to improve the health of everyone and the health of the worst off in particular. As part of this mission,

the *New NHS* describes a vision of a 'modern and dependable health service' "... that does not just treat people when they are ill but works with others to improve health and reduce health inequalities" (para 21).

Within the *Saving Lives* document (and particularly in Chapter 4), a number of measures are announced which focus on the distribution of wealth, and of education and employment opportunities. The document announces, for example, a range of tax and benefit reforms, such as the Working Families Tax Credit (which was later replaced by the child tax credit and the working tax credit). It introduces the first ever national minimum wage in this country. It announces other benefits such as the winter fuel payments for pensioners, as well as schemes such as the Welfare to Work programmes which aim to help equip people with the education and skills they need to get jobs and keep them.

These are measures which indicate an important shift within government towards a social-structural perspective which aims to alter some of the social processes that affect health. In reality, many of these initiatives have received criticism in their implementation. The tax credits, for instance, have encountered problems with administration and take-up, and their direct impact on poverty has been limited (Wilson 2004, Bateman 2003, Brewer *et al.* 2001). In addition, the minimum wage was considered by many to be far too low (although it has seen a gradual rise since its introduction).

There is a more fundamental challenge, however. Both *Saving Lives* and *New NHS* are clearly presented within New Labour's ideology of the 'third way' – an ideology which prioritises 'modernisation':

> "We are engaged in a wide-ranging programme of modernisation: modernising education, modernising welfare, modernising social services and, in The new NHS White Paper, modernising the National Health Service. A modern approach to improving health and closing the health gap is a key part of this programme" (SL OHN 134).

'Modernisation', like 'Third Way', is an ambiguous concept, a 'creation in language' (Fairclough 2000). But, these two concepts can be associated with a number of key themes – particularly enterprise and the 'new global

economy', free trade and competition – which can be seen to shape New Labour's ideology[30].

In *Saving Lives*, it is stated that:

> "A modern and successful country needs more people in better health" (SL OHN 134).

This statement contains an important assumption. The assumption is that all the readers conform to the same notion of what a 'modern and successful' country looks like - that is, one that is economically as successful as possible. Within the framework of 'modernisation', this is not open to question. However, one question that remains, is to what extent can 'public health' be achieved within such a system? – that is, within an economic (business-oriented) system which rests upon inequalities both at national and global levels.

Labonte (2003) summarises some of the risks for health that arise through the global drive towards 'free trade' and economic liberalisation. There are, he suggests, largely negative impacts on poverty and inequality, the environment, and the capacities of national governments to protect the welfare of their citizens and be guided by goals of health and human development. On this last point, Pollock and Price (2000, 2003) have explored the public health implications of the World Trade Organisation system and trade agreements – particularly GATS (general agreement on trade in services). They argue that the trade-off between policy autonomy and economic growth raises urgent public health questions, and that the principles that lie at the heart of social welfare systems in Europe are being challenged.

There is, then, an awkward paradox caused by the apparent misfit between the implications of a social-structural approach and the government's overall framework, characterised by the 'third way' and modernisation. It could be argued that New Labour are trying to square the circle of inequalities and ill-health within a socio-economic system which favours market capitalism and

[30] For more on this, see Fairclough's (2000) analysis of New Labour discourse through an examination of political speeches and texts, in which he explores the political discourse of the 'third way' in detail.

competition. This challenge is thorny and is concealed by government, rather than tackled head-on. It leads us to look more critically at public health policy discourse in order to examine what lies behind the rhetoric. There are four key ways in which a critical analysis of the policy documents reveals the government's underlying perspective of public health. These are explored in the remainder of this chapter.

6.3 Localising and Individualising the Structural / Material Factors

Within a societal focus, a distinction can be made between macro-structural issues, including economic and employment issues, and area-focused factors, such as pollution, traffic, access to facilities, housing and crime (Popay et al 2003). There is a tendency within the documents, however, to stick to 'safer', domestic social determinants rather than challenging the underlying, but arguably much more pernicious, systemic processes (such as, economic, trade and defence policies).

Consider, for instance, the following extracts:

> "To do all that, we need to tackle the complex causes of ill-health - causes in individuals' own lives, and in wider community issues" (SL OHN 311)

> "They [Health Authorities] will act in partnership with Local Authorities and others to identify how local action on social, environmental and economic issues will make most impact on the health of local people ..." (NEW NHS 211).

> "Community health staff, such as midwives, can also draw attention to the wider health needs of the community, where the real solution may lie in action on education, housing, transport or reducing air pollution" (NEW NHS 277).

The 'problems' are localised, and re-framed as 'community factors', or the problems of run-down communities. As we can see in the extract below, this also shifts the onus of responsibility from the government to the communities themselves:

> "Communities can tackle poor health, which springs too from a range of wider, community factors - including poverty, low wages, unemployment, poor education, sub-standard housing, crime and disorder and a polluted environment" (SL OHN 70).

But New Labour arguably go one step further. By linking social determinants predominantly to health behaviour, rather than directly to health outcomes, they are *individualising* these structural/material factors, making the crucial issues of material deprivation a matter of 'personal responsibility'. As the government states in *Saving Lives:*

> "we believe that people can be instrumental in shaping their own futures, rather than being victims of them" (150).

This can be seen in the way in which smoking is highlighted within *Saving Lives:*

> "We want people to stop smoking. But we also want that policy to have a greater impact among the less fortunate, where the harm caused by smoking is greater. To do that we have to address the complex interactions of social, economic and personal factors. Tackling smoking achieves both our objectives - improved health for all, and especially better health for the worse off" (155).

Whilst this discussion on smoking began with the government's recognition that "there are powerful factors beyond the control of the individual which can harm health" (154), and their admission that they have "a clear responsibility to address these fundamental problems" (154), the government has succeeded in reducing its role, in this instance, to "making clear the nature and scale of risk" (156) and ensuring that information is provided so that these individuals can make informed decisions.

6.4 Employing Moral and Contractual Discourses

The second issue is the tendency for the government to employ compelling moral and contractual discourses within their documents. The notion of 'responsibilities' is key to both *New NHS* and *Saving Lives*, and indeed, within New Labour discourse as a whole (Levitas 1998). The words 'Responsibility/-ies' or 'duty/-ies' occur a total of 121 times within the two documents, indicating that they are a preoccupation within it. Much of this discussion around

responsibility is aimed at local bodies (NHS Trusts, PCTs, Local Authorities, and so on), particularly in *New NHS,* and, in *Saving Lives*, at patients or the public.

But it is difficult for New Labour to simply drop the sense of reciprocity which is embodied in the dyad 'rights and responsibilities' (Levitas 1998). So it employs instead the concept of 'opportunities'. In *Saving Lives*, what might be thought of as the 'rights' of individuals (to work, education, better health, and equal opportunities) are transposed into 'opportunities': 'Sports and leisure opportunities' (326); 'training opportunities' (433); 'new opportunities to learn and acquire skills' (443); 'opportunities for work' (534); 'evening up opportunity' (519); 'the opportunity to move off benefit into work' (550); 'opportunities for better health and prevention of disease' (1017); 'opportunities for development' (1055); and 'opportunities for health promoting interventions' (1179).

So the responsibility of government is transformed into one of providing opportunities:

> "And the Government has the responsibility of giving everyone throughout our country the opportunity for better education, better housing, and better prospects of securing work" (SL OHN 176).

In this way, the government can legitimately remind individuals of *their* responsibility to *take up* those opportunities. These macro-structural issues are therefore bound within a notion of personal and moral duties.

Saving Lives is particularly characterised by moral and contractual discourses. It makes an implicit 'deal' with individuals which essentially boils down to 'we'll do our bit, but you must do yours'. This is an individualist discourse. The 'deal' which is proposed is primarily one which individuals enter into; it prioritises self-responsibility. This moral discourse also slides into authoritarian discourse, whereby the government is trying to govern the behaviour of its citizens/subjects:

> "Individuals are central to our new vision for better health. People need to take responsibility for their own health ..." (167).

The following extracts from *Saving Lives* show how this sense of duty is framed in terms of personal, economic and social justifications for improving health:

> "Good health is fundamental to all our lives. We all treasure our own health, and the health of our families and friends. Good health is the bedrock on which we build strong families, strong communities and a strong country" (124).

> "But the better everyone's health is, the greater the ability of the NHS to use its resources to best effect. If people are healthier, their demands on the health service will be less than they would have been - leaving resources and facilities available for those who need them more" (129).

> "Better health is central to economic performance. A healthier workforce improves productivity and performance. ... Ill-health is expensive in both economic and human terms. Cutting the cost of sickness at work will help to decrease burdens on business" (132).

Justified in this way, the texts make authoritarian statements which include complex moral judgements. For instance, the preface to *Saving Lives* states that, whilst "It's not the Government's job to tell people what to do",

> "Everybody should try to look after themselves better, by not smoking, taking more exercise, eating and drinking sensibly" (9).

The following section, which forms the opening of the Prime Minister's Foreword (a key 'scene-setter' for the document as a whole), is particularly interesting, and worthy of further discussion:

> "In our country today, too many people suffer from poor health.
> Too many people are ill for much of their lives. Too many people die too young from illnesses which are preventable.
> But at the same time, many people realise the value of better health. Many already take exercise, eat properly, and don't smoke.
> I believe that by working together, we can tackle poor health, and achieve the aim of better health for everyone, and especially for the least fortunate. To do that, we have to combat the key killers in our country – cancer, heart disease and stroke, accidents and mental illness" (paras 13-16).

The first 3 sentences here make bold and gloomy statements in which the rather ambiguous 'people' are set up as the agents of complex processes – in effect, as agents in their own destruction: 'too many people suffer'; 'too many people are ill'; 'too many people die'. The following sentence puts these statements into perspective by intimating *who* those 'too many' people are. It sets up an implicit distinction between those who value their health and look after themselves properly, and those who don't realise the value of better health. Here, the document is telling a 'blame-the-victim' story (Stone 2002:144), which locates control in the very people who suffer the problem. Indeed, the issue of lifestyle choices, and the tendency towards victim-blaming associated with that, are prominent in the document. See, for instance, the 'Ten Tips for Health' included at the beginning of the document (reproduced in appendix L).

The next paragraph is then vague – it mentions 'working together', but gives no idea of who this involves (leaving the onus on the individual hanging in the air); it claims that 'we can tackle poor health', with no clarification of *who* constitutes 'we', and *how* it might be tackled (leaving the issue of 'good' and 'bad' lifestyle choices in the reader's mind). The idea of social inequalities is mooted for the first time in the last part of sentence 6: 'and especially for the least fortunate'. This makes a connection between those who don't realise the value of better health, and 'the least fortunate', but makes no connection to the complex processes involved in making the 'right' lifestyle choices, and how these choices are effected by wider social, economic and environmental factors.

The complexity of these processes is perhaps further denied by the inclusion of the final sentence, which suggests a greatly simplified solution to the 'problem' set out: "to combat the key killers in our country – cancer, heart disease and stroke, accidents and mental illness". The document lists the 'key killers' as a statement of fact, as an assumption. This is an assumption which is driven by a biomedical perspective. It achieves a simplification of the issues involved by focusing our attention on 'enemies' (note the use of the words 'key killers' – a martial metaphor which attributes human qualities to the

diseases[31]). These enemies are both politically acceptable (within New Labour's ideology), and acceptable within the biomedical model which still dominates (those with the most power within) the health service. Note how much less acceptable this list would have been had it read 'to combat the key killers in our country – poverty, environmental pollution, social exclusion and inequalities in opportunities for good education and employment'.

The linking of people's personal responsibilities for health to a duty to 'our country' and to business, is repeated many times within the documents. In this way, government and business, or rather the decisions they make, are disregarded as potentially negative agents in the causation of ill-health. This leaves underlying social processes unchallenged.

The strong moral and contractual discourses in the documents - which place a clear onus on individuals and their personal, economic and social duties to make the 'right' choices and improve their own health - undercut the discourse of social-structural change. They provide a much easier way out for the government, and for those within the health service who are conditioned to practise within a biomedical perspective. Moreover, this approach can be justified within a discourse of stakeholding and communitarianism, where individual responsibility can be enforced through the twin pressure of the global economy and the community as policeman (Levitas 1998).

6.5 Creating a Narrative Which Prioritises Efficiency

The third strategy is closely linked to the second, and also depends on a convincing narrative – this time an economic one. The economic discourse is pervasive in both documents, but particularly in *New NHS*. The tone of this document is dominated by service issues associated with speed and reliability, responsiveness and dependability (para 24). This is perhaps not surprising given the justifications offered for the white paper. The opening chapter of the document builds up a 'story of decline' (Stone 2002:138-145) in which the NHS

[31] See Arrigo (1999), for instance, for a discussion of the implications of the use of martial metaphors for medical justice.

has become slow, unresponsive, unreliable and of variable quality - due largely to the pressures caused by a rise of public expectations, the cost of new medical technology and changing demographics. The consequent 'story of control' is built upon the idea that these pressures are exaggerated, and that they occurred partly because of the previous government's under-spending.

Within this story of decline and control, the government's "new emphasis on improving public health and tackling health inequalities" (para 46) is seen as a way of meeting some of the daunting challenges that lie ahead for the NHS (i.e. controlling costs in the longer term). The improvement of 'public health' is therefore presented here as an 'efficiency' strategy, rather than as an issue of social justice. This focus on costs has led to the Treasury's increasing interest in public health issues. The latest Wanless report (2004), for instance, makes a strong case for strengthening public health as a means of making the NHS more affordable in the future. This transformation of the motive for 'public health' from one of basic rights to one of cost-cutting, has potential consequences for the ways in which it is both understood and practised. It is easy to see, for instance, how the moralistic overtones described above can achieve significance over issues of social responsibility.

The notions of 'efficiency', 'excellence', and 'quality' are clear within the government's approach. There appears to be an expectation that improved public health (and reduced health inequalities) will result from making the health service more efficient and of better quality. This is resonant of a biomedical perspective which places an emphasis on biomedical interventions on health through the healthcare services.

6.6 Being Vague

When trying to hold together, or at least fudge over, a number of paradoxes, there is an advantage in vagueness. The more unspecific the language is, the more open is the discourse to various interpretations by differently positioned readerships.

This ambiguity can be seen often in these and other white papers. Consider, for instance, the following paragraph from *Saving Lives*:

> "This White Paper is a significant step towards better health. It sets out a new, modern approach to public health – an approach which refuses to accept that there is no role for anything other than individual improvement, or that only Government can do something. An approach which no Government in Britain has adopted before" (18, in Prime Minister's Foreword).

This description of the government's approach to public health is baffling. The clause which includes 'refuses to accept that there is no role for anything other than ...' is a confusing double-negative. The next section is equally vague: 'only the Government can do something' – the answers to *about what?*, and *how?*, are evaded. The only thing we know for sure, from this paragraph, is that this new approach will be different to those adopted by previous British governments.

This 'strategy' for concealing important tensions within public health is best explored by looking at the sixteen documents as a whole. In them, the term 'public health' is used frequently, but in several different ways, and with a great deal of imprecision. The definition of public health used in the CMO's report is vague and encompassing. What is meant by the suggestion that public health is 'the science and art ...' is unclear – except, perhaps, that it might draw on scientific and artistic 'principles' or approaches[32].

The definition frames 'public health' as a policy goal – a goal which is achieved when diseases are prevented, when health is promoted, and when lives are prolonged. These goals are articulated through a plethora of more quantifiable targets - for instance, 'to reduce the death rate from cancer in people under 75 years by at least a fifth by 2010' (SL OHN:628).

However, public health is also about policy *means* – promotion and prevention are methods by which the goals of 'public health' can be achieved. The

[32] This itself is interesting, because it hides within it (without acknowledging) important debates around what is science, and what is art (see Chalmers 1982).

documents often refer to 'the public health function'. Whilst this is not defined, the word 'function' indicates that public health is concerned not only with the activities involved, but also, to some extent, the structures and processes involved in carrying them out. There is a tendency within the discourse, for the means to overshadow the goals.

In all, the term 'public health' is mentioned 684 times in the 16 documents. In the majority of these cases (511 of 684), the term is used as an adjective by collocating it with a total of 95 different words or phrases. Many of these words or phrases are used only once; others are used many times. This again reveals the huge scope of the term 'public health' and the confusing way in which it is used almost without limits.

These collocations support the conceptualisation of public health as a goal and a means. Further, a number of sub-categories can be identified:

As a goal:

- 'Action' goals: e.g. ph action; ph activities; ph initiatives; ph practice; ph services.
- 'Problem-solving' goals: e.g. ph problems; ph needs; ph goals; ph objectives; ph gains.

As a means:

- 'Structural' means: e.g. ph infrastructure; ph workforce; ph networks.
- 'Processual' means: e.g. ph capacity; ph expertise; ph knowledge; ph intelligence.
- 'Epistemological' means: e.g. ph approach; ph mindset; ph concepts; ph principles.

In addition, there are several adjectival uses of the term which do not fit into any of these categories, but which reinforce the vagueness of the term – for instance: 'ph picture', 'ph roots', and 'ph considerations'.

'Public health' (as a process) is also frequently represented grammatically as an entity, through nominalisation – the transformation of a clause into a nominal or noun-like entity. One consequence of this is that the agents of the

processes - people who initiate or act upon other people or objects, are often absent from the texts. It is also significant that 'public health' (as an inanimate noun) is being presented as the agent of verbs, in place of human agents. This contributes to the elision of human agency in, and responsibility for, processes in accounts of 'public health'. Taken further, one might suggest that the text mystifies and obfuscates agency and responsibility in public health.

In the following extracts, for example, public health is listed as an agent alongside PCTs, GPs, primary care, and others. This is confusing since it implies a false distinction between the agents of 'public health', and PCTs or 'primary care' - after all, PCTs are supposed to be part of the new delivery mechanism for public health:

> "Primary care and public health need to work together to develop the potential for primary care to improve health, reduce inequalities and improve services" (CMO R 294).

> "Get support in the right places from the beginning e.g. the PCT, key GPs, public health, paediatricians" (HV DEV 683).

The confusing nature of public health as a collection of people was illustrated in the CMO's report. The enormity in scope of the 'public health function', and the organisational diversity of public health practice (at least when viewed from a social-structural perspective), makes the notion of 'a public health workforce' extremely complex. The flexibility in the use of the term, then, can be very useful. However, vague references to 'public health' as an entity, as in the extracts above, lead the reader to draw a line around 'public health' – a line which includes public health professionals (largely medical specialists in public health), but which excludes all those practitioners and others who are a vital part of a broad approach to public health. This serves to maintain the exclusivity of 'public health' as a specialism.

The water is muddied still further with the occasional use of the term 'public health' simply as a short-hand for 'the health of the public' – as in "Protecting the Public Health" (STBOP 566).

The term is used, then, rather confusingly, to refer to a variety of policy goals, mechanisms, and processes; to a function; an intangible 'phenomenon' (such as an approach, or a mindset); and the state of the public's health. Despite this ambiguity, the government's desire to develop 'capacity and capability' (SL OHN 1282), 'core competencies' (CMO R 226), 'leaders and champions' (SL OHN 1176), 'rigour and drive' (SL OHN 1302), and 'high standards' (SL OHN 82) in public health are discussed throughout the documents. 'Public health' apparently requires an evidence base, knowledge, information and surveillance to 'underpin it' and it is to be:

> "Subject to the same concerted development and performance management as every other area of Government policy, so that we can secure real and rapid progress" (SL OHN 1302).

'Public health', then, encompasses a huge conceptual domain which is both poorly specified and under-theorised. Moreover, as shown in the discussion in Chapter 5 on the key themes within public health, it also encompasses a number of other problematic concepts. Despite this, it is often reified within the documents to something which can be performance managed, and something for which competencies and standards can be set (or at least implied). Its use as an adjective on a large number of occasions can give us the sense that it is much more 'solid' (and defined) than it actually is. This is very convenient – we need to *believe* in public health, and that it can be improved, strengthened, and 'performance managed', without questioning too deeply *how* this will happen (given that 'public health' can appear to be anything and everything), or *who* is going to make it happen.

6.7 SUMMARY

This chapter, by moving on from the analysis in Chapter 5, described a more detailed discursive analysis, mainly of two key white papers, in order to examine the government's perspective of 'public health'. It showed that whilst the policy rhetoric speaks of the importance of a social-structural approach to public health which tackles the 'wider' domains of influence on health, and which places inequalities in the foreground, this is in conflict with New Labour's

ideological commitment to the 'third way' and 'modernisation'. This presents many challenges to the social-structural interpretation of 'public health'.

A critical analysis of the policy discourse, however, revealed a policy approach to public health which is dominated by a more 'safe' combination of biomedical and epidemiological perspectives, beneath the thin veneer of its social-structural rhetoric. There is a strong onus on individuals and their (moral) duty to make responsible decisions regarding their health and lifestyle. There is a focus on risk groups and the (local) physical, economic, social and cultural exposures they might face. And there is an apparent reliance on the health service, through its improved efficiency, quality and access, to improve public health and reduce health inequalities.

This discourse is part of the policy process – it forms the policy problems and affects the policy solutions. It therefore has important implications for the ways in which the roles of primary care practitioners are shaped. The analysis suggests that managerial discourses of efficiency and cost effectiveness are speaking louder than that of a social-structural approach to public health. Within this, the biomedical and epidemiological approaches to public health seem to have more resonance. It is these perspectives, then, which are likely to shape the roles of primary care practitioners within 'public health'.

It is to the primary care practitioners that we now turn. The following two chapters explore the participant practitioners' perspectives of public health, and their understandings of their public health roles.

CHAPTER 7

PRIMARY CARE PRACTITIONERS AND THEIR PUBLIC HEALTH ROLES

7.1 INTRODUCTION

As described in Chapter 4, fifteen practices were visited throughout the data collection phase, and forty-one interviews were carried out with practitioners. Most of these were individual interviews, although four were joint interviews involving two or three practitioners, and one was a group discussion with ten health visitors. Four were fairly brief chats, but nonetheless yielded some useful information and so are included in the data set. Twenty-two of these practitioners also completed a questionnaire, which was used mainly as an interview tool, to stimulate discussion. A total of 55 practitioners participated in the study. These were spread across the three PCT areas, and across the five disciplines chosen for this study (although fewer GPs and PMs were recruited than I had initially hoped). There was also a good mix of full and part time workers, and of experience in terms of years spent practising (see appendix G for characteristics of sample).

Observation notes made during and after visits to practices provide interesting and important additional detail on the context in which the practitioners work. They help the researcher, and the reader, to place the practitioner back in her[33] work environment – an environment which can have a considerable influence on her working life. A brief summary of comments about each participant practice is included in appendix M.

These interviews, observations and questionnaires provide the basis for both this chapter and the next. This chapter commences by examining the ways in which primary care practitioners see their roles in general, and their public

[33] Since only 4 of the project participants were male (all GPs), 'she' and 'her' will be used when talking about practitioners in general in order to avoid clumsy alternatives.

health roles in particular. It then begins to explore the ways in which public health is understood by practitioners, in light of the previous two chapters which explored interpretations of public health in government policy. It does this by taking the seven key public health 'themes', identified in the policy discourse (Chapter 5), and discussing their prominence (or obscurity) within the practitioner interviews.

7.2 General Roles

7.2.1 Practice Nurses (PNs)

The 12 practice nurses interviewed possess a diversity of experience, and job titles, ranging from treatment room nurse to nurse practitioner[34]. Their roles are equally broad, and the interviewees described many of the activities associated with practice nursing which are described in the literature – activities such as cervical screening, travel health and family planning, as well as "basic treatment room tasks" such as dressings, ear syringing, and taking blood pressures. The role generally encompasses health education and promotion with 'well' individuals, as well as more 'routine' medical tasks.

In a couple of the larger practices, the tasks are split between lesser and higher qualified practitioners. For instance, in practice 16, the treatment room nurse does "more hands on things like ear syringing, wound dressings, perhaps taking bloods, giving injections", whereas the practice nurse "is much more health education, health promotion and doing surgeries" (PN16)[35]. Several practices employ a health care assistant to take on these more routine tasks, leaving the practice nurses to do the more 'specialist' work.

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[34] These different titles are considered, for the purposes of this thesis, as 'variations' of practice nursing since they all adopt the traditional practice nurse's position within the surgery, and all perform elements of the traditional practice nursing role. Some of the practitioners themselves, though, would avoid the title 'practice nurse' in favour of a more specific, or a 'higher-rank' title.

[35] In this and all subsequent quotations, the interviewee is identified using an abbreviation of her discipline (e.g. PN), and a number which identifies which practice she works in. Whilst this is rather impersonal, it enables those practitioners who work in the same practice to be readily identified, and makes a quick and easy link between the interviewee and the practice (allowing cross-referencing with Appendix M).

The tendency to specialise in chronic illness or areas such as family planning is the first of two key role changes which were apparent in the interview data. Diabetes and asthma management are specialist areas which particularly seem to have fallen within the practice nurse's remit. Whilst the practice nurse remains, to some extent, a "Jack of all trades" (PN38), the move towards more chronic disease management appears to be taking some practice nurses away from their more 'traditional' health promotion role. PN15 saw this shift away from seeing "totally well people" as a positive one:

> "Originally [my role] was set up to do health checks really, and get them – it was an exercise the practice had to go through to earn money basically, wasn't it. So it started like that, but it's moved into more useful, prevention is useful, but I'm not so sure it's so useful on a one-to-one basis, so we're moving more into secondary prevention where our skills are needed" (PN15).

This was not always the case, though. PN16 indicated that her health promotion work is being accentuated by recent government policy:

> "Very much on coronary heart disease – very much led by the National Service Framework, which we're trying to achieve. And so that's really dominating my work at the moment. But that encompasses a lot of the other health promotion work that I was doing, because it encompasses stopping people smoking, exercise, healthy eating, really the whole concept of healthy living, and keeping yourself well" (PN16).

The second key change involves their role in triage work and the treating of minor illness. PN16 stated that the 24 hour access policy has driven a change within her practice towards open access triage nursing. This involves making on the spot decisions as to whether the patient's problem must be referred to the GP, or whether she or one of the other nurses can deal with it. For the nurse practitioner (PN17), the role is extended even more into domains previously held by GPs – such as diagnosing, referring and prescribing.

In the case of all the practice nurses I met, the role remains clearly within the practice. As already identified in the literature (see Chapter 3), the roles and experience of PNs tend to be focused on chronic disease management, health education and lifestyle change. The wide role seems to be easily

'compartmentalised', generally in terms of the skill involved in carrying out particular tasks. This can afford practitioners the opportunity, especially within larger practices, to move up a hierarchy from treatment room nurse, to triage, specialist areas, and nurse practitioners. For the participants in this study, group work, and work 'in the community' does not appear to be a feature of the role, except in the case of specialist clinics for diabetes, for instance, which occur within the practice.

7.2.2 District Nurses (DNs)

The 11 district nurses interviewed range from newly qualified practitioners to experienced team leaders and practice teachers. They described their role primarily as caring for the house-bound. Within this broad role there is little evidence of specialising in particular issues – although several nurses admitted a 'special interest' in palliative care, and one in wound care.

Several practitioners noted the holistic aspect of the role which involves checking housing, safety and financial issues, as well as the more clinical assessment of their blood, urine, and so on, designed to prevent deterioration of a patient's condition. In addition to the commonly mentioned tasks – palliative care, wound care, diabetic care – the role includes some one-to-one prevention and health education. One practitioner, for instance, described carrying out health promotion with a newly diagnosed diabetic, which would involve talking to the patient about his diet, and "checking the feet" (DN21b). Their 'holistic' role might also encompass an interest in the health and well being of carers and members of the patient's family.

One nurse described the importance of the "social side" of her role:

> "There's a lot more to it than just going to do – because sometimes you're the only contact with the outside world if you like, you know, and people just want a chat, they just want to talk about everything. It's much more personal, because you're a guest in their house ..." (DN11).

There appears, then, to be a somewhat 'unofficial' element of the district nursing role, which is not easy to describe. As DN21b replied when I asked her about her role:

> "Erm, *officially*, it's caring for people at home who can't make it to the surgery. I mean, that's quite brief. It's more than that" (DN21b).

The 'official' role was described by one nurse as "curative". Indeed, it predominantly appeared to involve "crisis" care, and is almost exclusively situated within the patient's home. This supports the literature which highlights the clinical and task-oriented aspects of the DN's role. There was an indication, though, that some DNs are willing to get involved in community projects. One nurse (DN75a) described a scheme that she is involved in, which promotes independence by helping people aged over 50 with their daily living activities. Another (DN68b) described her involvement in a healthy communities collaborative pilot which aims to prevent falls amongst older people. It is interesting to note, though, that these were both more experienced district nurses. The newly qualified practitioners showed no inclination to (or expectation that they should) be involved in such work.

7.2.3 Health Visitors (HVs)

The 11 health visitors talked about very broad roles, which tended not to be described in terms of specific activities. There appears to be a great deal of variation in the role, as one HV explained:

> "... there's no clarity about the health visitor's role. I mean, the health visitor's role is what you can make – what you make it as and what you feel you can offer" (HV75).

There is a clear focus on children under 5. One health visitor (HV16) described this as an erosion of their former more encompassing role. However, most of the practitioners interviewed also described a family or a community focus.

They often described their role as "supportive" or "empowering", working with "the well", "in a sort of health education type preventative model" (HV5). One health visitor summed it up as:

> "following the three principles of health visiting, which is searching for health needs, identifying health needs, and targeting resources appropriately" (HV15).

Child development and child protection were described as key aspects of the role, and "routine weights and measures, and minor illness" and immunisations (HV11) featured more strongly for some than for others. HV75 described how, by looking at the way her team offered these 'routine' services to the under 4s, they were able to 'condense' that work and "go off and do other things" such as men's health groups, health checks for the over 75s and others, and specific work around HRT and the menopause. For others (e.g. HV19 and HV16), the amount of 'routine' work limited their opportunity to be involved in other things.

The provision of secondary prevention and support to patients who had suffered from heart disease was described by several practitioners as a relatively new aspect to their role. For HV11, this tied into initiatives which aimed at improving the lifestyle of these patients through cheaper access to sports centres, and so on. This reflected the initiative within North PCT for nominated health visitors to become cardiac rehabilitation nurses within practices. This was a response to a particularly high rate of coronary heart disease within the area.

The interviews reflect the diversity within the discipline which is highlighted in the literature. Where some have 'managed' their case load, perhaps on a corporate basis (HV72), so as to be able to take on broader roles, others seem wholly consumed by the 'routine' development checks required for the under-5s.

7.2.4 General Practitioners (GPs)

The 5 GPs in this study talked ambiguously about their role, tending to focus on 'wider' activities such as being involved in hospital accreditation, management of the practice, and being a GP appraiser (GP15), working with the PCT on mental health (GP64), and doing urino-gynaecology work at the hospital (GP68). The two GPs who talked more generally about their role appeared to have differing opinions about how it has changed. GP17 stated that "we're personally involved in doing a slightly narrower range of things than when I started". GP68, on the other hand, felt that:

> "we've got a lot more stuff to do. I mean, just look at the heart disease prevention for instance. You've got to check everybody's cholesterol, and they're fairly tight guidelines. You've got to do lots of additional blood tests, monitor those blood tests. Once upon a time we used to see ill people. Now we see well people who are worried" ... "Most of us are trained to pick up appendicitis, and to sort out bad sore throats, and help people to die quietly, but I think we've inevitably taken on more and more of a role" (GP68).

Their role has clearly been affected by the increased roles of other practitioners in the practice, for instance, with practice nurses taking on more of the chronic disease management, where the doctors are left "just vaguely supervising on the side of prescriptions" (GP68). On the other hand, though, the changing expectations of both the government and the public, which was identified in the literature, appear to have made their mark.

7.2.5 Practice Managers

The 5 practice managers in this study described their role broadly, in terms of co-ordinating the non-clinical aspects of the practice:

> "Making sure everything is working, our rotas are in place, dealing with the finance, dealing with personnel problems, health and safety, computers" (PM17).

For PM68, the responsibility for finance appeared to be the most important; he is involved in "keeping a tally of exactly what's coming in and going out, and

identifying, or trying to find savings, cheaper options". This highlights the 'small business' aspect of general practices. PM64 expressed her role as "primarily keeping the doctors happy, with everything that's non clinical. And to keep the doctors happy is to keep everybody else happy". This reflects the formal hierarchy found within most practices.

7.3 Public Health Roles

Thirty practitioners expressed an opinion on whether or not they have a public health role. Of those, twenty said that they do (5 PNs, 4 DNs, 7 HVs and 4 GPs), and three said that they do not have a public health role (1 PN, 1 DN and 1 HV). Seven said yes and no (2 PNs, 4 DNs, and 1 GP).

The practitioners' consideration about whether or not they have a public health role is based on a variety of interpretations of what public health is. For instance, DN11 felt that she has a public health role because she gives vaccinations and looks at her patients holistically. DN15 felt that she has a public health role "because we can influence people whether they have their flu jabs or their immunisations". PN11 felt that by putting up posters ("that nobody reads"), and by encouraging people to stop smoking, she is promoting health and therefore carrying out a public health role. GP15 felt his public health role is to "support the messages broadcast by the public health people".

Amongst the health visitors, HV58 felt that the "vast proportion" of her work is public health, and that this is made no less important by the fact that it is nearly all with individuals "on a one-to-one basis". HV19 saw ante-natal parent craft as an important part of her public health role because it is helping to give the child a healthy start, and HV17 felt that her "preventative and supporting and educating role" falls within public health. The one HV who felt that she didn't have a public health role felt that public health is "very very fuzzy". She admitted, though, that she uses "an awful lot of [her] nursing skills, observational skills, to be able to direct people with regards to their own health".

These examples begin to show the broad and varied ways in which public health is understood by practitioners. They also indicate that the way in which the practitioner understands public health plays a part in determining the extent to which she believes she has a role to play in it. This is expressed succinctly by DN21 in the following extract:

> EW: "Right. So, would you say you have a public health role do you think?"
> DN: "I suppose. It depends on how we would define public health" (DN21).

Many practitioners simply had never considered whether or not they have a role to play in public health, and found it very difficult to do so when I posed the question. Indeed, many who attempted to define public health, struggled (see Chapter 8). This is an indication of the obscurity and insignificance of the term within general practice as a whole.

Despite this, when asked to discuss public health activities that they were involved in, the practitioners responded with a large range of examples. These have been grouped in the table below according to the categories which were used in the questionnaire, with an additional two categories that emerged from the data. Immunisations and individual health advice can be seen to be the most commonly mentioned public health activities, although group health advice was also mentioned relatively frequently, especially amongst health visitors. Health visitors, perhaps unsurprisingly, gave more examples within the community development category than the other practitioners, although an example of the analysis of health needs in the community was only described by one practitioner (a practice nurse). Activities within the healthy policies category were the least mentioned, with no-one raising the issue of lobbying for improvements in, for example, housing or the environment. However, such action at a more individual level was apparent, with five practitioners describing examples where they have written letters, or made phone calls, on behalf of a patient.

In addition to the examples of activities provided by practitioners in the interviews, the questionnaires asked participants to tick the categories above

to indicate whether or not they carried them out. On comparing questionnaires and interview transcripts, it seems that practitioners were more likely to tick the categories on the questionnaire rather than raise them in an interview. (For instance, in the questionnaires, 5 out of 22 practitioners said that they lobby for improvements in housing, etc.). This is not surprising, since it is easier to tick something already mentioned than to recall and describe it voluntarily. Immunisations and the provision of individual health advice, though, remain the most frequently ticked activities. The majority of the examples, then, fall within the preventive medicine and the health education categories[36].

Table 7.1 Practitioners' examples of 'public health activities'

	PNs N=11	DNs N=9	HVs N=11	GPs N=5	*TOTAL N=36*
PREVENTIVE MEDICINE					
Immunisations	3	2	5	2	*12*
Individual health checks	2	5	2	0	*9*
Individual screening	0	1	1	0	*2*
Individual rehabilitation	3	1	4	0	*8*
HEALTH EDUCATION					
Individual health advice	3	2	3	4	*12*
Other advice or info (e.g. housing)	0	1	1	1	*3*
Group health advice	3	1	5	1	*10*
HEALTHY POLICIES					
Influence policies for health	0	0	2	2	*4*
Lobby for improvements	0	0	0	0	*0*
COMMUNITY DEVELOPMENT					
Collect info on community health	1	1	2	0	*4*
Analyse info on health needs	1	0	0	0	*1*
Work with community groups on projects	0	2	4	1	*7*
Work with other agencies on projects	1	3	2	0	*6*
Target particular groups and work with them	1	1	4	0	*6*
OTHER					
Health protection (infectious disease)	1	1	0	2	*4*
Patient advocacy	2	0	2	1	*5*

[36] The results of the questionnaires in this study closely reflect those of a study by Jinks *et al* (2003) which presented health visitors with the same list of categories in a questionnaire, and which found much higher numbers of examples within the preventive medicine and health education categories than in the public health policy, community empowerment or health protection categories.

The numbers of practitioners interviewed in each practice were too few to comprehensively analyse for differences between practices. However, there was no evidence in the data to suggest that public health roles might be seen differently by practitioners in larger or smaller, or rural or urban practices.

Whilst it is interesting to see which activities the practitioners choose to talk about as examples of public health activity, this only tells part of the story about their understanding of public health. As White (1999:8) explains, "It is not necessarily the activities which distinguish different perspectives on public health work ..., but the approach taken to those activities". In order to further explore the *approach* taken to public health by the practitioners in this study, it is necessary to explore the ways in which practitioners talk about public health.

The remainder of this chapter presents an analysis of the interviews according to the seven key 'themes' which dominate the public health policy discourse. It examines the extent to which, and how, the themes are discussed by practitioners within an interview which clearly expressed itself to be about 'public health'. This gives us an indication of how the practitioners interpret those concepts which form an integral part of public health in policy discourse.

7.4 Constructing 'Public Health'

7.4.1 Multi-disciplinary collaboration

The practice of working with others, both within primary care teams and elsewhere, was mentioned in most of the interviews with practitioners. However, it was only described as an element of public health working (without prompts from the interviewer) once, when a health visitor in the group discussion, during a lively 'brainstorm' about what public health means, suggested:

> "I think collaborative working as well, not just with your own agency, but with other agencies" (HV).

Collaborative working seemed to mean different things to different people. For many, working with others meant simply consulting with, or referring to, other practitioners for the benefit of a client or patient. In this sense, it was indistinguishable from the ways in which the practitioners talked about 'teamwork'. Some described "liaising", "networking", or "inter-agency working".

Several practitioners said that working with other agencies and organisations is not a strong feature of their work, although working with others within the primary care team was common, as this practice nurse/nurse practitioner described:

> EW: "Does it come into your role at all to work with other agencies or organisations?"
> PN: "Not really. I mean, not from the public health point of view, I don't think. I mean, we work, erm, very much interact with everybody else *here*, you know, like the physios, and the midwives and all this sort of thing. And I'm, because I was a midwife too, sometimes I see ante-natals and what have you, if they can't get to the clinic, or they have a problem, or whatever. So we wouldn't have somebody say from the housing department come and be with us in here. It doesn't quite work that way" (PN17).

It is interesting how this practitioner chose her words carefully, changing the words "work with" to "interact with". These imply quite different things. Indeed, the penultimate sentence in the extract above suggests that, for this practitioner, working with others entails them physically being in the practice with her. Other practitioners talked about "drawing on" other organisations, and "talking" to them about patients and so on. Sometimes this would involve simply a one-way exchange of information. The focus, then, is largely on *communication,* rather than team work or collaboration. Moreover, this communication is usually centred around individual patients, or prompted by a particular (medical) problem.

Other practitioners described working collaboratively, or "in partnership", within various projects, such as Sure Start, a healthy communities collaborative geared at preventing falls amongst older people, and cardiac rehabilitation, where health visitors have worked with the council sports centre for the benefit of cardiac patients.

One health visitor, who is actively involved in community projects and various multi-disciplinary groups, described the benefits of collaborating with others. She explained that when different agencies get together around a certain issue - in this case domestic violence, new sources of funds can often be found, for instance, by tying together money targeted at crime and health improvement programmes:

> "So it's only by working collaboratively like that you can actually look and see that a) the resources probably are there, and b) that they can be targeted properly" (HV15a).

She described a further benefit of collaboration in that a project often has more chance of success within a community if it isn't seen as being owned by 'health' or 'police' or 'education'. So, whilst individually these agencies can be "a turn off" for certain people, collectively, they can take a new approach.

GP64 noted the importance of collaboration for public health when he said that "health should be taken out of just medical health. We need to be working with the local council and things" (GP64). However, he went on to describe lack of time as a key hurdle to his own participation in such work:

> "... It's just not the best use of our time to be sitting in meetings for several hours not being productive" (GP64).

This quote suggests that his own perception of 'productivity' is as much of a hurdle as the lack of time. There does, though, appear to be a number of potential concessions which might help overcome the barriers: "They need to be held over lunch time, with lunch provided, at a place that is accessible by car, with good parking, and so on" (GP64).

In eight of the interviews, practitioners expressed annoyance at not being involved with the planning of programmes or policies. This indicated a lack of collaboration (beyond mere one-way communication). DN28, for instance, felt that whilst she was told that things were happening within the practice, there was no discussion about why or how they were happening. This precluded her

from playing an active part in the changes being made. This lack of involvement was described both at the practice level, for instance, in terms of not having any input into how a new policy (such as a NSF) should be tackled, and at higher, more strategic levels. Lack of involvement in planning often meant that the practitioners were either unhappy with a project, or felt no sense of ownership of it. PN36 described, as an example, the smoking cessation strategy which was "set up completely separately" to the practitioners, and which, to her, "seems very badly organised". In the group discussion, the health visitors described their frustration that the HIMP had landed on their desk with no discussion or consultation with them at all. One health visitor felt that they had been actively excluded from having an input.

This lack of connection or collaboration with others is even more evident between primary care practitioners and the public health department[37]. HV58 commented:

> "The public health at the health authority, we've *never* had anything to do with them at all. They've never fed us any information, they've never asked us to do – I mean, they might as well not exist, as far as we're concerned" (HV58).

Several of the GPs talked about receiving faxes from the public health department, and described how they would contact them in order to report a notifiable disease, but this was the extent of their communications. HV75 added "you get documents that come down, but that's about it. It's very much a distant thing". Amongst the practitioners I interviewed, then, there appeared to be limited collaboration *for* public health, and virtually *no* collaboration *with* Public Health.

[37] Since, at the time of interviewing, the PCTs were still in the process of setting up their public health teams, the practitioners talked about the former public health departments within health authorities. (Indeed, most practitioners showed no awareness that the organisations were changing in this respect).

7.4.2 Community Involvement

The issue of community, patient or public involvement was very rarely raised in the interviews. Just one practitioner – GP17, seemed to have a specific interest in patient involvement:

> "My main central role has been in the area of patient involvement. And in involving the public in decision making. And I think that several of the things that have happened over the last few years in the health service may have been influenced in their thinking by things I've said to the right people at the right time. I have no evidence for it, but it's remarkably uncanny how they mirror the things I've said!" (GP17).

In this case, the GP is keen to have the voices of the public represented in decision making processes. She is a strong figure in the community and is well known for her involvement in many different groups, activities and projects locally.

Another GP also described his involvement in a 'patient panel', and why he felt it was important. He described, though, a different notion of 'involvement':

> "Well, things like going on to the patient panel, it's nice to be able to explain to people how things work, because a lot of people don't understand how things work, or don't want to know how things work" (GP15).

For him, the patient panel was about having the opportunity to explain difficult decisions to patients so that they understand the complicated decisions that have to be made in the name of rationing. When I asked whether this process ever had any impact on decisions made at either practice or PCT level, GP15 remained silent. I asked, then, if it was just about imparting information, to which he replied:

> "These people appreciate that information. It's important; that's why they're going. Cavaliers are not going there are they?" (GP15).

An entirely different aspect of involvement was described by two health visitors who were explaining the part they played in a 'mini' Sure Start initiative:

> "... well, we did the canvassing. Carol and I did the canvassing and had the open sessions, and talked to families, and sat outside nurseries on freezing days and found out what people wanted, and talked to the professionals and then they pulled it all together into a report" (HV15a).

What then happened to this report is unclear, but the process described is one of going to some effort to canvass opinion, rather than simply impart information. The use of the word 'canvass' also implies a certain amount of activity within the community in order to get local people interested and involved in the shaping of the project.

7.4.3 Focus on inequalities / equity

The discussion of inequalities within interviews was minimal. Just one practitioner – DN75b – described it as an element of public health. She explained:

> "I suppose from a health visiting and district nursing point of view, [public health is] the health inequalities in an area, how to meet the people's needs, promoting well health, keeping people well, especially in health visiting, obviously it's looking at the well population and maintaining their health and preventing illness. And with our patients also, because it's not just nursing we go in to do, we go in to promote their health" (DN75b).

This district nurse had recently (within the previous year) completed her degree in community health care nursing. She explained that public health was "quite a large feature" of her degree course, with about three of the six modules, in her opinion, being specifically about public health.

Whilst some practitioners recognised the link between wider inequalities and poor health, and believed they were issues that they "would get involved in to some degree" (HV11), their role was often restricted to dealing, in a rather minor way, with the consequences of them. HV11, for instance, described public health in terms of health education, and her own role in terms of giving lifestyle advice, and providing secondary prevention (cardiac rehabilitation).

GP15 raised the issue of whether or not he, as a GP, is the best person to tackle health inequalities. The pressure to work more efficiently and cost effectively seems to be shaping his role and limiting the extent to which he feels he can contribute:

> EW: "And in terms of health inequalities in your local population. I mean, you have an individual focus, and that's quite clear, but in terms of your practice population, do you get much of a feel of what are the health inequalities? And do you get much of a chance to do anything about that?"
> GP: "I think it'll depend on which GP you ask. I mean, there are lots of issues that patients come in with, but I'm not sure I'm the best person to do anything about those things. I'm certainly not the most cost effective person to do so. Because there's so much pressure on the clinical work. We're always being pushed to work in more efficient ways" (GP15).

This GP also works within a very busy, under-staffed practice, which is struggling to cope with the more immediate needs of its practice population.

To several practitioners, health inequalities were more clearly about inequalities in access to services than anything else. This led one practice nurse to produce an interesting twist on 'disadvantage':

> EW: "I wonder, if we're thinking about public health in terms of reducing health inequalities, and maybe targeting socially excluded groups, do you think there is a role there for practitioners in general practice?"
> PN: "Erm. Well, we work in an area where there are a lot of patients like that. We have a lot of what people might consider to be 'undesirables'. I mean, in actual fact, it was a problem, because, because of our location we had so many patients like that, we were getting so many of the allocated patients, the asylum seekers, the substance abusers, people with major health problems, single parents, that, you know, you could almost say that people that didn't fit into those categories were disadvantaged. And of course, they're not the high users of the service".
> EW: "Right. So they were disadvantaged because"
> PN: "they were finding it harder to access the services. Yes, that's right" (PN64).

There seems to be some confusion, then, about the nature and importance of health inequalities, their connection to the state of the public's health, and the various strategies which might be employed to deal with them. There is also a

more fundamental question of whether practitioners in general practice are in a position to do anything about such complex and deep-rooted issues.

7.4.4 Empowerment

The notion of 'empowerment' was raised by 10 of the practitioners interviewed. It was often difficult to tell, though, how they understood the term. In several instances, it referred to a supportive role:

> "Our role is facilitating and empowering the families to live healthy and happy lives" ... "being there for people when they are ready to make the change" (to a "more active and healthy life") (HV11).

It often encompassed the provision of something by practitioners to enable people to do things for themselves:

> "empowering people, I suppose. It's an awful word, but we're trying to give people back the ability to make their own choices, really, with the right sort of information" (HV5).
>
> "... to empower patients to improve their own health" (GP46).

Sometimes, the difference between 'empowerment' and health education was unclear. In these cases it became associated with changing the patient's lifestyle:

> "Empowerment, trying to educate them to take charge of their own health" ... "empowering the patient to perhaps change their smoking habits, or change their eating habits, change their alcohol habits, change their exercise habits" (PN16).

One health visitor extended the concept further and suggested that her role includes trying "to empower people to change the environment they're in" (HV15a). She suggested that she could do this by helping them to get moved, putting them in touch with people who might be able to change their circumstances, making sure they get their benefits. This view maintains, then, an individual client perspective, rather than one of community empowerment.

The same practitioner, though, during a group discussion, pointed out a much more complex side to 'empowerment':

> "There is an empowering role in there, but you've got to change the system to be empowered. You can't be empowered to do anything if the system doesn't allow you to do it. It's about systems change as well" (HV15a).

This understanding of 'empowerment' opens up a new set of challenges, and could potentially lead a health visitor to carry out a very different role which includes political lobbying as well as individual support. In this case, the practitioner is more active than many, in working with policy groups at a local level, and in being a voice for change. She and her colleague recognise that they take a more proactive and 'social' approach than many other health visitors, despite acknowledging that their work is often restricted by the number of under-5's on their case load, and the lack of staff and time to deal with them.

The questionnaire that some of the practitioners filled in prior to their interview prompted some discussion about 'community development type' work. Several practitioners (within the three nursing disciplines) noted that whilst they would like to take on more of this type of work, they don't get an opportunity to, given their current work load. Practice and district nurses were more likely to see it as being a feature of the health visitors' role than their own.

7.4.5 Population as well as individual perspective

Few practitioners spoke about the importance of a population perspective within public health. When discussing their roles, they spoke primarily of working with individuals and/or families. This was particularly the case for practice nurses, who, being employed by the GPs in the practice, had their target population, and working locality, more clearly determined than other community nurses. The practice nurse, therefore, stays predominantly within the practice walls. This creates physical barriers to widening the role to include community based public health work. One practice nurse clearly didn't see such work as part of her 'expected' role within the practice:

> "And who's going to pay you to do that? Because we're paid to work in practice, so, you know, as much as we'd like to be involved, I'm not sure that that's where we can go, is it? They [the GPs] say we're not insured to work outside the practice" (PN68b).

GP15 saw a population perspective as the defining feature of public health – a feature which differentiated it from general practice:

> "I think the way I see public health is very much different from general practice. Public health pursues a different agenda than maybe GPs do. Whereas the GPs are individuals looking after other individuals' needs, public health is a body I guess, that looks after the great, or the health at the national or regional context" (GP15).

Later in the interview, he described how these two perspectives are often in conflict. This GP was denying, or at least diminishing, his potential contribution to public health by attributing it a 'mass population' focus, rather than a local population, or community one. In a similar way, GP68 drew a narrow line around the contribution of the primary health care team to public health:

> "Well, I think everybody in the primary health care team has a public health role, yes. I mean, we're there not as a mass population thing, but certainly as an information to individuals thing, yeah" (GP68).

Other practitioners are more involved in working in the community. This is demonstrated by the number of public health activities described by practitioners which involve setting up and running groups, working on community projects, and identifying and meeting needs within the (local) population. A great many of these took the form of group 'clinics' and/or education sessions (such as parenting groups). Such 'group work' was seen by some practitioners to be an important aspect of public health. DN21b, for instance, felt that she doesn't really have a public health role because, although she carries out health promotion, this is on a one-to-one level:

> "We do diabetes health promotion, and prevention. But not in group form, not what I would call 'public health', it's one-to-one really. It's a big difference, isn't it, really, from health visitors" (DN21b).

A health visitor in practice 58, however, presented a different opinion when she suggested that public health is *more* effective when carried out with individuals who come forward with a problem:

> EW: "So, who do you see as the target of public health activity? Is it groups of people, or ..."
> HV: [shakes head]
> EW: "No?"
> HV: "No. In fact, I think it's perhaps more effective if you're *responding* to something that somebody comes to you with, they've identified the need themselves" (HV58).

The focus on individuals was explained in a number of ways. HV75, for instance, highlighted the importance of one-to-one visits, where important issues can be identified, as well as the more population based approach. She explained that:

> "It's all very well having this umbrella thing, saying yes we're doing this, this, CHD or whatever, but you still need to get to grips with it at an individual level" (HV75).

Other practitioners described a sort of 'ripple' effect, where although "the community are the target", "we're doing it all the time with one-to-one contacts" (HV11). As this district nurse explained:

> "I think you can do it [public health] with individuals, and then hopefully if you could influence them they would then cascade that down to other people" (DN15).

For other practitioners, it is surprising how little a community or population focus featured within their concept of public health. This reflects a lack of priority given to it in their day-to-day work, which remains overwhelmingly individualistic. Indeed, for DN75b, who, from her recent training, had a good understanding of public health as working with communities and dealing with health inequalities, incorporating a public health role into her day-to-day practice which is clinically and individually focused was difficult.

Whilst most practitioners could describe anecdotally the key issues within their area, in terms of high coronary heart disease, or high levels of teenage

pregnancy, very few of the practices I visited had practice or community profiles. This district nurse explained:

> EW: "What sort of - do you feel that you have a bigger picture of community health needs and inequalities as district nurses, or as a practice?"
> DN: "No. I don't think that's happened yet. I think as an individual practitioner you would need to take that on board. You would need to do a health needs assessment. I certainly, whilst I've been in this practice, I haven't, as a group of district nurses, we've never done a health needs assessment" (DN68a).

Some of the health visitors I spoke to expressed the desire to fill the gaps in their knowledge of the local area's needs:

> EW: "With needs in the community, do you feel that you have quite a good understanding of what the community's priorities are?"
> HV: "Yes, but I do think doing a health needs assessment would make it clearer, and would be a good thing to do, and I would like to do that" (HV19).

Lack of time was sometimes a factor in not conducting these profiles. HV11 described how their practice profile has been put "on the back burner as other things have come in". In addition, the paucity, and poor quality, of information was another reason for not producing community profiles. Many practitioners bemoaned the poor access to statistical information. HV72 explained that:

> "I mean, even setting up our practice profiles, there's a certain amount of data that I would want for that practice profile, like how many mothers under 18 or 19 do we have on the patch. The only way I can find that is by hand counting through my files!" (HV72).

A further hindrance, though, was lack of skills. The health visitors I met in the North PCT area explained this skills gap and asked me if I could help them find a framework which would help them carry out a needs assessment.

7.4.6 Addressing determinants of health

Public health was clearly associated with health promotion and illness prevention by practitioners in all disciplines. In these cases, health promotion

was almost always described in terms of giving information. Practitioners largely saw themselves as having an awareness of lots of different issues, and a responsibility to give information and advice; they were there to "influence", "persuade", "advise", "encourage", or "educate" people to "do the right thing". This education largely focused on lifestyle issues, or reducing behavioural risks, as shown in the following extract:

> "I think, well, every patient you go to you try to advise them, if they ask, or if you can see something that they're doing is not really very good for them, then you say to them, 'well, you shouldn't really be doing that'. I suppose everything we do is related to public health" (DN15).

Advice is predominantly given opportunistically, and is usually directed at the patient in the consulting room or at home. Whilst it seems to concentrate on a number of topical issues - particularly smoking, but also inoculations for flu and MMR (around which there have been recent controversies), the range of advice seems to be potentially limitless. For instance, one health visitor recounted a conversation she had with a mother about the family's forthcoming holiday to Greece:

> "I said whatever you do, don't eat swordfish. And she looked at me, and I said, don't! Don't eat swordfish, don't eat marlin and don't eat shark. And she said why?, and I said because it's high in mercury, I read it in the paper! Now that's public health!" (HV15a).

Health visitors and district nurses, when visiting people in their homes, felt the responsibility to comment on a range of behaviours which they regard as unhealthy. HV75 regards this as 'public health' work:

> "When you're in a home, I mean, you come across somebody that's smoking 60 fags a day or whatever, and there's a new baby in there, well that to me is a public health issue as well" (HV75).

> "If we meet somebody else and we feel they should have a smear or something, then we get them in and persuade them to have a smear. So that's public health as well isn't it!" (HV75).

Further key aspects of public health, as described by practitioners, involve preventive work – particularly through vaccinations and the identification of (biological and behavioural) risk factors through screening and health checks.

The national impetus on smoking has clearly influenced the practitioners, and most interviewees mentioned smoking cessation somewhere in their interview.

Infectious diseases were also associated with public health by many practitioners across all disciplines (although less so by health visitors). As well as preventing these diseases through vaccination programmes, practitioners identified the need to be aware of the signs and symptoms of specific diseases, and to be responsible for alerting the relevant authorities of an outbreak:

> "When I saw you were going to ask about public health roles I really had to think about what public health is. It's about information – informing the relevant authorities about outbreaks of infectious diseases" (PN11).
>
> "Obviously public health is immunisations isn't it. And outbreaks of salmonella, and all that sort of thing?" (GP68).

Whilst lifestyle issues tended to dominate the discussions on health determinants, some practitioners acknowledged that there are other factors that can influence health. Several district nurses felt they were taking 'wider' issues on board in their holistic assessments, where they took in not only the medical aspects of a person's health, but also issues such as whether the person is coping in their environment, whether he or she can deal with financial issues, or has a good diet.

Other practitioners described the part they can play in affecting these wider issues. This usually took the form of advocating for individual patients, writing letters to the housing department, or helping them to get their benefits. For instance:

> "At an individual level, I can probably do more by signing someone's DLA form than by prescribing antibiotics. Getting people back into work is a really important public health issue" (GP64).
>
> "If I went into an individual and I'd maybe gone for a simple flu vaccine say, if I went and that individual was living somewhere that was wholly inappropriate, then I would discuss that with them and refer them to an agency that could help with housing say, if we thought they had benefits needs, we have a benefit counsellor that we can refer to. So we would,

we would on a smaller level, you know, look at other things that impact on their health" (DN68b).

Several practitioners talked about the link between poverty and ill health. HV5 remarked upon the frustration that such issues are still not being tackled effectively:

> "... obviously it's to do with poverty, it's to do with housing, it's to do with, and I think local authorities understand that, that you know, poor housing, poor self esteem, poor prospects make for poor health. But I don't think we've quite all got together yet, I still think health are down here, prescribing statins for CHD, you've got a few people talking about diet, it hasn't sort of married together. And I mean the Black report came out many years ago, and that showed there and then about inequalities in health being to do with lower social classes living in poverty and all the rest of it, and we still haven't really come to terms with that" (HV5).

Another health visitor recounted an episode during her training in order to make a similar point – that tackling poverty is often not taken seriously by health professionals as a strategy to improve health:

> "I mean, I can remember we did this exercise where we had to look at, it was sorting out healthy diets for a family on an income of 30 odd pounds or whatever. So we as a group settled down and said we're not doing this. We just refused to do it. Because this is, we find this, it's unfair, when you're actually categorising this family, and I still have a problem with this, that you're saying that because you're poor, you can only have - rather than actually looking at the causes of their poverty, and trying to change the situation so that they can afford to buy decent food, not have to go and [wait in supermarkets for discounted items]" (HV15a).

However, this health visitor had imaginative ways of thinking about potential solutions to some of the issues she sees in her local community, including setting up a community garden, and a LETS system whereby people could trade with each other in skills (such as gardening, decorating, or baby sitting), rather than in cash. She noted how her role was determined by the community and their needs. She works in a relatively deprived area, and commented how different her role would be if the area was more affluent.

Discussions about the effects of poverty on health sometimes led to a feeling of despair, as this practice nurse described:

> "When a lot of the problems are down to poverty, you feel how can you help, sometimes, don't you? Because it doesn't matter how much you preach and give people advice, if they can't afford it; so it really does need to be tackled from that point, doesn't it, getting people out of poverty, and they maybe have the resources then to listen and to act on what we're telling them" (PN68c).

PN36 was one of several practitioners who regarded these wider factors as outside of their control in general practice.

Sometimes, though, as in the case of this GP, there appeared to be a very limited understanding of the complex relationship between deprivation and health:

> "I think we're aware of where the social deprivation is. But I mean, and obviously where there's relative social deprivation there's a lot of health issues that relate to that I suppose. The thing I find extraordinary is how many ways that the people who seem deprived manage to continue to damage themselves by smoking and drinking and - [laughs]. But it's, you know, there is relative deprivation" (GP68).

7.4.7 Improving health through policies and strategies

The almost complete absence of a political or strategic approach to public health is perhaps not surprising given the lack of priority given to community or population perspectives, and the lack of understanding, or feeling of hopelessness, with regards to tackling the effect of 'wider' issues such as poverty on health. Very few practitioners mentioned an involvement in policy or strategic decision making for public health improvement.

One GP, in response to the list of public health activities in the questionnaire I gave him, felt that he does "try to influence policies like that, say with regard to smoking, or exercise" (GP64). Another felt she influences policy making, for instance, through participating in setting up the HIMP locally (GP17). Other practitioners played a more involved part in local policies by sitting on PCT

boards, like HV5, who commented: "I do influence the policies now, but only because of the broader role that I undertake, really" (HV5).

There was no apparent involvement in national policy, however. Two practitioners felt that it was important that they made their voices heard in an effort to influence policy change, but both admitted that it's something they don't do. In interviews, no-one described an example of lobbying for improvements (although five respondents to the questionnaire did tick this box). Indeed, one health visitor pointed it out as something that she feels she ought to do:

> "I don't lobby, I don't politically lobby enough, you know, we don't write as a group and moan about things perhaps" (HV5).

PN68a, though, felt that rather than this being her responsibility as a health professional, lobbying for improvements is something that we should *all* do, as members of society:

> "We don't actually lobby do we? But then, anyone can lobby can't they? You know, as a society, we need to, you don't have to be a health professional to know that there's a problem. But how many people actually lobby enough to change? I mean, we're all good at sitting and muttering about things, but actually to get up and do something" (PN68b).

7.5 SUMMARY

This chapter set out to explore the ways in which practitioners describe their public health roles. It suggested that the ways in which practitioners think about public health has a clear influence on their practice. Section 7.2 showed that public health is not a big feature of practitioners' roles in general. Indeed, it highlighted several role changes which are drawing the practitioner away from public health. These include the increased focus on chronic disease management, the growing emphasis on efficiency and speed of access, and the increasing tendency to specialise in clinical areas. The only discipline for which public health is perhaps gaining prominence is health visiting. The role

of many health visitors, though, remains dominated by 'routine' work with under-5's.

Section 7.3 explained how, in attempting to describe public health roles, the practitioners drew on narrow and varied interpretations of what public health means. 'Public health' was therefore being interpreted flexibly in order to justify actions (or non-actions) as public health. Public health roles were typically described by practitioners as activities associated with preventive medicine and (largely individualistic) health education. Whilst health visitors were more likely than other practitioners to describe community development type work as public health, there was little focus, overall, on collecting and analysing information on community health needs, or on influencing policies for health.

Moving on from this, section 7.4 began to explore the ways in which practitioners conceptualise public health. It analysed the extent to which, and how, the practitioners talked about the seven 'themes' of public health, which were found (in Chapter 5) to be dominant in public health policy discourse. This section found that many of the key themes receive very little attention by the practitioners, despite the interviews clearly being 'about' public health. Some of the concepts were interpreted in particularly narrow ways. There was little evidence of collaboration for public health, and very little sign of connections with the PCT, or with Public Health professionals. Patient and community involvement was understood in diverse ways, for instance, as the explaining of decisions to patient representatives, or as canvassing the community about a new project. In a similar way, 'empowerment' was seen to encompass anything from giving information, to community development. But this broad notion of empowerment was not often associated with 'public health'. The majority of the practitioners were clearly focused on the individual patient, and lacked a population perspective. Given this, it is perhaps unsurprising that there was a noticeable lack of discussion and understanding of inequalities, and their connection with the public health agenda. Whilst some practitioners understood the links between 'wider' issues such as deprivation or social exclusion and health, their responses were predominantly

focused on changing people's behaviours. Other responses were often seen as being outside of their control in general practice. Consequently, there was an almost complete absence of a political or strategic approach to public health.

This chapter has highlighted the importance of a practitioner's understanding of public health for the way in which she interprets her public health role. The next chapter – Chapter 8 - goes on to explore practitioners' understandings in more detail in order to see how the concept is defined and approached.

CHAPTER 8

TALKING ABOUT PUBLIC HEALTH

8.1 INTRODUCTION

It was shown in the previous chapter (Chapter 7), that practitioners often had either particularly narrow medical/individualistic views of their public health roles, or were generally very vague about what public health encompassed and how they might contribute to it. An analysis of the interviews which focused on the seven key public health themes identified in the policy discourse, showed very little discussion, and often quite specific interpretations, of those concepts which appeared to be so important in the government's conceptualisation of public health.

This chapter takes up the issue of the practitioners' understandings of public health and explores it further. It does this firstly, by examining the ways in which practitioners attempt to describe and define the term, and secondly by exploring the practitioners' perspectives of public health. In so doing, it identifies two new issues which are prominent within the practitioners' public health discourse. These are the idea that public health is somehow contrary to, or 'versus' primary care, and the idea that extra time has to be found for public health work. In discussing this latter idea, that there is not enough time for public health, the chapter explores some of the contexts within which the practitioners work, and discusses the influence of the practice 'culture', the community, and other, wider factors, on their public health roles.

8.2 DEFINING PUBLIC HEALTH

When asked what they understand by the term 'public health', practitioners gave a wide variety of responses. In almost a third of the interviews/discussions (12 out of 41), practitioners were clearly confused about

what it meant. A number of interviewees suggested that different people see it differently. One DN described age as a factor in this:

> "I think we each see it differently, perhaps. I think perhaps it depends on how old you are as to how you see it" (DN15).

Several practitioners clearly doubted their own interpretation of public health, and often asked me if I thought they had understood it correctly. Whilst most practitioners found public health very difficult to define or explain, several practitioners felt that they were 'doing it' anyway. It came across as something that they didn't really think about:

> "It's like a lot of things isn't it, that we do, we sort of know what to do, but when you come to a definition or whatever, it's sometimes a bit harder isn't it?" (DN11).

It also appeared to be 'present', but under different labels. This often demonstrated a degree of malleability of the term. For instance, in the second extract below, the assumption that people "are just doing it" appears to conceal a rather narrow definition of public health – or, at best, an inability to define it:

> EW: "Do you think that public health is quite prioritised within that?"
> PN: "Not as public health per se. It is coming out, but under different titles" (PN 16).

> "I think sometimes maybe people are just doing it, but don't put a label on it. As I say, I think nurses go in to see patients and they sort of do a holistic assessment, and if something influences what they're doing – so they maybe doing it, but not sort of thinking ah yeah, that's what I'm thinking here, or what I'm doing" (DN75a).

The vagueness surrounding 'public health' can be seen in the definitions offered by practitioners. Out of the nine practice nurses who attempted to define public health, the majority described it either as "the health of the public" (PN11, PN16, PN36, PN68) or "the health of the community" (PN16, PN75). The other practice nurses expressed variations on the idea of public health as "making sure everybody is as healthy as possible" (PN28). However, these vague definitions can conceal very different understandings. Compare, for instance, the following two extracts:

> "To me, public health is health of the public. It's more like knowing the signs and symptoms of meningitis. I also think of infectious diseases and the Public Health Laboratory Service" (PN11).

> "Well, logically, it's the general health of the public at large. But it has all sorts of issues like our water supply, or health and safety issues in factories and working environments" (PN36).

For PN75, public health is clearly about access to services and facilities, despite the very broad definition:

> "I suppose to me, public health is just the overall health of local communities, you know, from accessing medical centres, and whatever, right down to whether there's enough buses to get people to the health centres, or whether there's enough facilities for child play areas" (PN75).

The district nurses' definitions of public health were diverse. They also provided vague (although arguably 'common sense') definitions, such as:

> "Well obviously it's the health that affects us all, doesn't it, I would say" (DN11);

> "I mean, public health is *our* health, isn't it. It's everybody's health. I mean, *that's* public health" (DN68a);

> "public health is individuals' health isn't it" (DN68b).

However, the idea of health education and tertiary prevention was more prominent within the district nurses' discussions. One practitioner expressed this (if rather hesitantly) in terms of 'influencing people':

> "Erm. I think it's influencing people to, well, not to look after themselves, but to er. I don't know really!" (DN15).

Two of the district nurses offered more clearly formed broad definitions. DN21, for instance, suggested that "it's the mental, physical and emotional wellbeing of individuals in the community". DN75b - the only practitioner to volunteer that health inequalities are an aspect of public health - suggested different understandings of public health depending on one's professional "point of

view". Whilst she expressed a fairly broad notion of what public health means to her, she was also finding her place within that as a district nurse – that is, to promote the health of her patients.

Two district nurses identified cleanliness (or lack of it) with public health. DN11, for instance, whilst deciding that public health is "the health that affects us all" (quoted above), explained the first thoughts about public health that came to her mind:

> "When I first, when I first thought about it, I thought something dirty" (DN11).

This idea of public health involving cleanliness influences DN28's perception of her public health role:

> "For me, public health work also forms part of my everyday work, such as sterilisation of equipment, and making sure everything is clean" (DN28).

Education, prevention and promotion were also key themes in the health visitor interviews. The idea of public health as 'supporting' and 'empowering' people to "reach the best possible potential" came up several times. This incorporates mental, emotional and physical aspects of health.

Amongst the GPs, one saw public health rather generally as "community health" (GP5). Another (GP17) recognised that whilst public health is, on one level, "the total health of that community", it also exists at two other levels:

> "At another level it's that formalised approach to looking at the health of communities which is done by public health doctors, which involves the academic consideration of evidence, and deciding on policies, and influencing government and health services and social services, in order to deliver policies that affect the health of that community. And between those two, of course, there are individuals, public health doctors, who is the person we ring up because the school rings up in a panic because a person in class 2A has got meningitis" (GP17).

This GP, then, is identifying different activities, and different actors associated with them, within the public health function. She makes an implicit distinction,

within her interview, between 'affecting' public health (which primary care practitioners do through their day to day work), and 'doing' public health (which public health doctors do). Another GP makes a similar distinction between 'Public Health' ("with a big P and a big H"), which is the formal Public Health service, and "the general public's awareness of its health issues" (GP68).

The two practice managers who offered definitions of public health concurred with the all encompassing and vague notion that it is "the health of the public at large" (PM64); "Everything is public health isn't it?" (PM17).

Many practitioners, then, had great difficulty in trying to define public health. They were often confused about its meaning, and responded in very vague terms. However, the idea that public health is about the health status of the community or the public at large came across strongly. Such broad definitions of public health as 'the health of the public' provided a great deal of flexibility in the ways in which practitioners went on to discuss the part they play in it. It is a malleable term which sometimes concealed a great deal of confusion, and sometimes a variety of narrow, restrictive understandings. The next section employs the framework described in Chapter 2 (Walsh *et al.* 1995) to further explore the practitioners' perspectives of public health. This, and the subsequent two sections, analyse the degree to which, and how, the practitioners engage with the public health agenda.

8.3 Practitioners' Perspectives of Public Health

Within the interviews with practitioners, a biomedical psychosocial perspective appears to be dominant. Indeed, within this perspective, the reduction of behavioural risks appears to be the strongest driving force behind their role. In much of the discussion around education or influencing people, there is the sense that the responsibility for good health is being placed firmly with the patients. The goal is individual transformation and change. The practitioners' role in this is often to provide the information that the patient requires to make the 'right' decisions. The practitioners talked about the importance of passing on health messages, through patient information leaflets, notice boards,

patient libraries, opportunistic advice, and promotion campaigns. Activities such as immunisations, holiday vaccinations, cervical screening, and health checks were the most frequently mentioned. Discussion of community development and empowerment, on the other hand, featured much less frequently.

Whilst many practitioners recognised issues other than the obvious medical need – such as poor housing or deprivation - they generally continued to approach their work with a biomedical psychosocial perspective. This leads them to make individualist responses, perhaps in terms of advocating for individual patients, or giving individual advice.

One health visitor, in a group discussion, acknowledged the difficulty of promoting health to people who do not prioritise their own health:

> "I think you've also got to get people to see that it's important. And often the people that you need to target have – I wouldn't say that health often comes at the top of their list. It might often be other things like their house, or income, rather than perhaps their health sometimes. So it's getting them to see that it's important. Sometimes when you go in spouting off about, you know, smoking, living a healthy lifestyle, you know, sometimes people that you are trying to target don't perhaps always relate to it in a way that you'd like them to. It's not a priority perhaps" (HV).

This health visitor appears to see public health through a lens which highlights the relative risks and biomedical-psychosocial responses, and which ignores, or at least relegates to the background, the effects of exposures (physical, economic and social and cultural), and wider social processes. Rather than taking an approach which starts where the client is – perhaps helping that person or family to deal with what *they* see as more pressing problems, such as their housing or income – this health visitor sees her role as insisting that health (indeed, *her* version of 'health') *should* be at the top of their list of priorities.

Within the interviews, the word 'epidemic' was often associated with public health, indicating an understanding of the epidemiological perspective.

However, where such an approach was taken, the practitioners often disassociated themselves from the response, seeing public health instead as someone else's role. This was a job for 'Public Health' – the "big P big H" people (GP68). Within the epidemiological perspective, a focus on diseases (and associated responses such as hygiene and infection control) was most common, particularly amongst the practice and district nurses.

Where wider socio-economic issues were recognised by some practitioners as important health determinants, they were generally seen in terms of particular characteristics of the local community. With a few exceptions, these characteristics were rarely talked about as features that could or should be changed. They were seen as annoyances, as issues which caused 'problems' and contributed to high workloads within general practice. But they appeared to be seen as (taken-for-granted) 'features' of the local community. The consequences of such features, then, were largely characterised as 'unpleasant', but not particularly 'unjust'.

Since they appear fixed within the biomedical psychosocial perspective, their responses are either individualist, or are somewhat defeatist. There was a feeling that the responsibility for 'wider' issues is beyond the control of those working in general practice. This practice nurse, who believes she does have a public health role, describes its limitations:

> "It [public health] is a much broader thing, including the conditions that people live and work under. And we are fairly limited in what we can do. We can give people health advice, how they can eat more healthily, or not smoke, or exercise, but an awful lot of people's health is influenced by factors outside our control" (PN36).

Some practitioners shifted the responsibility for such issues onto others, like the local authorities:

> "I see the council being, or should be involved in providing housing for people of disadvantaged groups, so that we can reduce the number of people that are on the streets ..." (PN38).

For those few practitioners who demonstrated a societal or community development approach, this was seen as being added on to their 'normal' role.

HV15a, for instance, describes it as "much more like a social worker's type job, *as well as* health visiting". This type of work, because it was considered 'extra', had to compete with her 'core' work as a health visitor.

8.4 Public Health Versus General Practice

A key theme within the interviews, was the practitioners' tendency to view public health as something different from, or opposed to, general practice. It was frequently described as a collection of people – a department, who have very little to do with those in general practice. The lack of connection between Public Health departments and primary care practitioners was pointed out in Chapter 7, in the section on collaboration. This separation of 'public health' as an entity enabled the practitioners to disassociate themselves from it. Public health 'roles', then, could largely be attributed to other people. GP15, who described public health as a body which looks after health at a national or regional level, explained that:

> "If I see public health, that's what I see – public health versus general practice. General practitioners have got different responsibilities" (GP15).

PN16 explained how she felt that people

> "... see it as the public health department, that deals with perhaps communicable diseases, and the things that you'd expect public health to deal with" (PN16).

Similarly, a district nurse explained:

> "I always think of it as like policy makers and the department looking at health trends in general, and immunisation, and erm management of erm disease, and policy makers, as a public health department. That's how I would think of that" (DN68a).

The remoteness of this body of people further excluded primary care practitioners from its domain:

> "I think Public Health has been a thing up there that people find very difficult to get access to" (HV5).

The following extract from a group interview illustrates some of the assumptions that were made about 'public health people' which served to further remove them from the practitioners' own world:

> EW: "OK. Well, I still get the feeling that you see public health a little bit as a group of people, a department. Would that be fair?"
> PNs: "Mmmm. Yeah" (PN68 a, b and c).
> PN: "Suited people! In an office" (PN68a).
> EW: "Health professionals?"
> PN: "Not necessarily, no. Sort of, I'm looking at them as Government appointed people, high powered, highly paid. That's how I see them" (PN68a).

Several practitioners, when discussing public health, talked about 'them' and 'they', highlighting the feeling that public health is other people's responsibility. For instance:

> "If there's any epidemic, I think public health people think as if there's epidemics, and they look after, they sort it out, don't they? I think that's people's main perspective of public health" (DN15).

> "It's just to keep people healthy, really, I think. That's their main role" (PN68a).

Many interviewees saw the potential for primary care practitioners to become involved in public health work. However, this work was frequently described as an extra to their main role. As PM15 described:

> "Coming into general practice, I've found that public health and health promotion are just luxuries – doing the day to day work is more than enough to cope with" (PM15).

According to this PM, getting involved in public health projects takes the nurses away from their main role: "... the nurses are paid to do their job – anything that takes the nurse away from that needs a budget to pay for them to take time out" (PM15). The practice nurse at the same practice agreed that nurses would never be able to be involved in public health projects "unless people have protected time for it and it's part of their role" (PN15).

Public health work, then, was frequently regarded as in competition with the practitioners' main roles:

> "I mean, we can't just neglect all the wounds that need dressings to go out and do public health" (DN21b).

This demonstrates an understanding of public health as a set of activities which can be added on to a core role, *provided* there is sufficient time (and inclination). Time is a crucial factor here, and came up in most interviews as a hindrance to carrying out public health work. However, this analysis of the interviews indicates that there is a poor understanding of public health as a *process*, or as an approach to working. It is often seen in terms of tasks and activities, and is seen alongside, or sometimes in competition with, general practice, rather than as something which can be integrated into it.

8.5 Influencing Factors - Making Time for Public Health

In regarding public health as sets of activities or tasks that are 'extra' to their core roles, the practitioners identified a number of factors which create barriers to carrying out public health in practice, and which influence their role in general. Many of these factors have been discussed in the literature (see Chapters 2 and 3), and encompass a wide range of complex issues associated with the wider social, economic and political context, the organisational context, and the local community.

Amongst the most consistently cited barriers to public health work were practical issues such as lack of time and resources, particularly given the apparent lack of staff (especially GPs) in the area. This was especially the case in practice 15, where practitioners were struggling to keep up with their caseload. Practitioners frequently commented that they lacked the time and money to 'do public health'. During the course of the interviews, though, many other influencing factors became apparent, which suggests that the relationship between time and public health work is much less straightforward.

8.5.1 Organisational 'culture'

The time spent visiting and observing practices, sometimes for several hours whilst waiting for interviewees to become available, provided useful contextual information as well as giving me a 'taste' of what the practice was like as an organisation. I was struck by how different each one felt in terms of general impressions and 'friendliness'. Locality often played a part in determining what the practice was like, as did the size. Each practice had developed a particular 'identity' or 'culture'. MacKian (2002:209) uses the word culture to refer to the "ordinary"; "the ways, the forms, in which groups handle the raw material of their social and cultural existence". In an article which examines the complex interplay between organisational culture and social capital, she comments that "It is reasonable to expect that each agency's internal stock of social capital will have an important role to play" in building the partnerships necessary for health improvement (p.211). She believes that a better understanding of social capital can serve to crystallise our attempts to understand the roles of the actors involved in sustaining health. The cultural dynamics within the practice, then, are an important consideration for the ways in which practitioners negotiate their role.

Many of the organisational issues raised by practitioners are well documented in the literature. For instance, HV72 suggested that the attachment of HVs and DNs to specific general practices could be detrimental to those practitioners' wider roles in the community. On the other hand, though, as PN16 pointed out, the location of community nurses in a different building to the rest of the primary health care team can be harmful to teamwork. Several practitioners in this study referred to the practical difficulties of communicating with their team, and often resorted to writing messages in books, sending e-mails, or booking appointments. Sometimes physical location could make communication difficult, where, for instance, a large rural practice is split across three surgeries which are several miles apart.

Some practices had developed a particular 'culture' which could be seen to either facilitate, or inhibit, public health approaches amongst their staff.

Practice 17, for instance, is a physically small village practice. It has an informal, friendly, and family-oriented atmosphere. The small waiting rooms, which are close to the practitioners' consulting rooms, have inviting children's play areas. There are large display boards with a variety of community notices. For the practitioners, there is plenty of general meeting space where they often stop to chat to each other. There is a large and relaxed common room (which doubles as a community space for groups), where practitioners meet every Friday and have lunch together (provided by the practice). The health visitor commented that "there's a lot of partnership among the team. I mean certainly, I mean this practice here is the best practice I've worked at. From the point of view of communicating with each other". She also pointed out that the support and enthusiasm of colleagues can be an important factor in helping a public health initiative get off the ground. The senior GP partner is well known locally for being involved in projects in the community.

The 'culture' of a practice seems to be historical, very much influenced by the attitudes and personality of the GPs, and perpetuated by the practitioners working within it. The health visitor attached to the single-handed practice 5, which had encountered particularly serious difficulties with the GP, described how this 'culture' can not only affect the professionals within the practice, but also the 'type' of person who uses it:

> HV: "It has made such a difference, you know - and almost as much as the people that are actually professionals in there, the actual practice population that you have, because there's a certain climate or culture within the practice that attracts a certain clientele, really"
> EW: "In what ways do the clientele -"
> HV: "Well, it was a very instant access GP kind of instant cure type surgery, but there wasn't sort of a lot of long term planning or care of people, so it was the people that sort of wanted something there and then that day, and weren't ever interested -"
> EW: "- so a medicine?"
> HV: "Yeah, a medicine, or a certificate or something - but weren't too keen to plan how things were for the next year or whatever" (HV5).

Practice 11, a large urban practice, which seems known locally for its high levels of involvement in new and innovative developments, was described by the PN as "a fast-forward moving practice"; "they do lots of training and are always taking on new things". However, she explained how the practice "is

very money oriented", and how this could stifle public health developments, which would only be taken on enthusiastically if they generated income. She commented that "there's lots of enthusiasm, but I've yet to see anything followed through in this practice, unless they get some money out of it". "They are often just thinking about the money rather than the patients". She added:

> "I don't really get an opportunity to run with things [new projects]. It's difficult here – there are 6 GPs and the only interest they have in common is money" (PN11).

The practice looks new, smart, and 'flashy'. Yet it has a very formal feel that fits with its efficient business-like culture. The waiting rooms are sparse and rather clinical, with short rows of plastic seating in various different places, well detached from the practitioners' area. There is an emphasis on organisation, rather than patient comfort. Notices pinned to the wall encourage patients not to waste staff time. PN11 describes money as "a big problem in communication". The practice obviously prioritises efficiency, and whilst there are regular practice meetings, they are only attended by certain (senior) staff. HV11 commented that she communicates very much with her peers (other health visitors), but "as a practice, it's at a different level. The GPs need to know about the important things, but there has to be a difference". Thus, there is formal communication on a 'need to know' basis, rather than a culture of teamwork and informal discussion.

Management and employment issues were often discussed by the practitioners in their interviews. Whilst many DNs and HVs felt that their managers did not have much influence over their role, several commented that their managers had little understanding of their work (being from a different discipline), or of working in the community (being from the hospital). HV72 explained the impact of this on her public health role:

> "We're managed by an ex-district nurse, so health visiting has really struggled because of that. So it has been a real struggle trying to keep the role afloat. And I think because of that, because if you don't have somebody with a real interest in a discipline at managerial level, that discipline doesn't move forward does it? So I think that has probably been the biggest hold-back to developing a public health role, to allowing health visitors to determine their own direction, their own work"

(HV72).

HV72 felt that public health leadership suffered as a consequence of having a district nurse manager:

> "If we are going to be participating more in public health, we need somebody from our own background, who has an understanding of our skills, and who can actually then direct those skills to meet the needs of public health" (HV75).

The management of practice nurses by their GP employers seemed to make a difference not only to that practice nurse's role, but also to the way in which they fitted into the team. The GPs have a great deal of influence over the way in which the practice is organised and the way in which it functions. They play a large part in shaping the practice 'culture'. Practitioners across all disciplines described the influence that GPs can have on their role, often in a 'taken for granted' way. Sometimes, the attitudes of the GP could determine which specific functions a practitioner will or won't do. For instance, in practice 15, the health visitors were stopped from giving baby immunisations because "the GP's decision was that the G grade was far too high a grade of people to be giving injections to babies" (HV15a). In practice 16, meanwhile, the GPs believe it is inappropriate for practice nurses to give baby injections, so *they* are not allowed to do so.

HV58 pointed out other ways in which the GPs can influence health visitor roles:

> "... some practices are very territorial – sort of *my* building, *my* patients, you know, nobody else will darken our doors, or *my* health visitor. If you're in a practice like that then it's very difficult. Yes, they can stop you doing, certainly things *within* the practice, and can show disapproval if you're doing things like the first timers group – 'well, what are you doing that for? You should be here, helping us with our flu jabs'" (HV58).

HV72 added that:

> "If you're based with, or working with a surgery, the GPs see your time as time for their patients, and if you're off doing something else, public health type work, or anything, then they're quite jealous of that time

being taken away from their patients, to do something else" (HV72).

Some HVs and DNs, being employed by the Trust, were able to varying degrees, to maintain some independence from the GPs and the practice – although this way of working seems to be a threat to the notion of teamwork:

> "We keep ourselves quite separate actually. We're employed by the PCT, and GPs aren't. Even the fact that the Trust rents this room from them. We work out our own case loads, we leave them written messages, we can leave the message on their computer. Erm, no, I don't think they do influence us really. We run our own ship, really" (DN21b).

For PNs, though, this is much more complicated:

> "... we're all GP employed, so the whole push of the job is GP determined, and they're looking very much more at dealing with illness than preventing it in the first place. Or dealing with ill health rather than maintaining good health" (PN15).

The general practice traditionally operates on a strict hierarchical system, with the (mostly male) GPs firmly at the top. The (predominantly female) practice nurses employed by those GPs are just as firmly at the bottom. In practice 15, the cultural and power dynamics between GPs and practice nurses has led to a very poor working relationship between them. There is very little evidence of teamwork. Indeed, according to the PM, "The GPs just tolerate the [practice] nurses ... They are polite and nice to each other, but they don't work together as a team". For this reason, they don't attend practice meetings, despite being invited. PM15 added that "there's no real reason for the animosity – it's just that everyone is overworked, and so defensive and vulnerable. They don't think anyone works harder than they do". Despite this, the DN says that they work well as a team – "better than some places I've been in, when it's a case of them and us still". The practice as a whole, though, is clearly struggling with too few staff, too many patients, and too little space. They are, as the PM explained, simply "fire fighting". But their lack of teamwork, and the animosity between GPs and the nurses, is preventing them from thinking about their work in new ways.

Whilst the practitioners in some practices communicated with each other more easily than in others, there is very little (or at least a very narrow) sense of teamwork within the interviews. Practitioners often described instances where they had asked a favour of someone, or had talked to a colleague about a particular patient. These instances were offered as examples of teamwork. In several practices, not only was there a clear lack of teamwork, there also seemed to be very little communication between the practitioners. HV19, who feels that teamwork in her practice "could be a lot better", explained that they have "no meetings with the GPs whatsoever. There's no primary health care team meetings. They have their own meetings". She added

> "If I want to speak to a GP, I have to seek them out and catch them at the right time. Some of the GPs if they haven't got time can actually be quite dismissive, so if they're in one of those sorts of moods, I actually make an appointment to see them" (HV19).

Team meetings were often sporadic or non-existent, and often not well attended (especially by GPs). Whilst opportunities to meet each other informally, over coffee or lunch seemed important, only three practices managed this on a regular basis.

The relationship between practitioners was characterised by the referral of patients. Sometimes, inappropriate referrals were cited by interviewees as an indication that other practitioners did not fully understand their role. Inaccurate role expectations were a further cause of annoyance, and of poor working relationships amongst the 'team'.

The data in this study indicates that organisational factors can influence the public health roles of practitioners in important ways. Many of these factors are already discussed in the literature. However, this research highlights the importance of considering the internal character of the practice, and not just the structural façade. Often, whilst lack of time is cited as a reason for not developing new projects, or working in new ways, it may be that the 'culture' of the practice stifles any opportunities that might otherwise be made. GP64 believes that a key factor in good team work is shared values. If the practice does not have shared values, and does not discuss them, challenge them, and

work together to achieve them, then public health is much less likely to flourish.

8.5.2 The Community

Many of the practitioners also claimed that their role in general is determined by the needs of the community. This was generally meant in a rather simplistic sense, given the relationship between practitioner and patient; thus, the practitioner's role is to deal with whatever (medical) problem the patient presents her with. Other (non-medical) problems are dealt with at the practitioner's discretion, and usually by referring the patient to someone else.

Characteristics of the community influence this relationship – for instance, in practice 15, which is close to several deprived estates, the PM states that "it is the patients, and where they are coming from that is the problem here. We're just over-run with problems". Particular issues such as high numbers of single people, or fragmented families, people who are new to the area, who have migrated there because of its proximity to several major cities, were also raised as issues which help to define the type of work practitioners are engaged in. GP68 explained the effect of this on his role:

> "Well, places like [this] are a bit prone to it, because there's a big influx of new people, without family, without that family superstructure, so you find that you have a sort of pastoral role, or patriarchal role, where there isn't granny around because Granny's in Devon, or South East London, or wherever, and there's nobody to ask except the doctor, about all sorts of things really" (GP68).

For the two health visitors I spoke to in this practice, the characteristics of the community were an important influence on their role. They were both very pro-active HVs; they were involved in community development initiatives, and were advocates for the community as well as for individuals and families. They both admitted that their role would look very different if they worked in a less deprived area, where they felt they would be less involved in community development, and in applying for funding to help improve the wellbeing of their clients. Since they both admitted to preferring the 'type' of health visiting that they were engaged in, though, it is likely that their (social as opposed to

medical) *approach* to practice within a more affluent area would remain the same.

Whilst many practitioners stated that 'the community' influenced their roles, their knowledge of local issues was often quite limited. It was noted in Chapter 7 (section 7.4.5) that most of the practices I visited did not have a practice or community profile. I found it surprising, when conducting the interviews, that those practitioners in rural practices, when talking about their local area, did not raise issues of social exclusion or access to services (issues which might have been particularly relevant in such areas).

By grouping the practitioners into the three PCTs (and North PCT into its 4 local health groups/former PCGs), we can explore the differences in responses between practitioners working in different geographical areas. Any inferences must be treated with caution, since the numbers of participants in each area are small. However, it is interesting to note that the 5 practitioners in North 1 PCG all expressed particularly medical interpretations of public health, focusing on medical preventive and lifestyle education activities. The area is one of the more deprived in the county, and has very poor CHD mortality statistics. It is possible, therefore, that the PCG/T's focus on CHD prevention has influenced the practitioners' understanding of public health (and focused them on lifestyle issues, for example). The 12 practitioners in the more affluent South PCT, by comparison, appeared to have a less medical approach, although understandings varied a great deal within that.

The relationship between 'the community' and the practitioners' public health roles, then, are complex. The presence of particular issues, such as high rates of CHD or mental illness, are likely to prompt specific activities focused on these. The characteristics of the community, such as educational background, access to the internet, and so on, are likely to affect the relationship between the practitioner and the patients. High numbers of so-called 'needy' patients – refugees, homeless, drug users, and so on – might also prompt specific (public health) action to be taken to meet the needs of these groups. However, they might also 'overwhelm' the practice, leaving them capable of doing little other

than responding to the healthcare needs of the individuals who walk through the practice door.

8.5.3 Role expectations – The 'wider' context

The 'formal' expectations of others – the government, the professional bodies, and the public - also influence a practitioner's role. These expectations have changed over time. HV16 commented that health visitors were now less involved than they used to be in their community, for instance, in the schools, play groups, mothers clubs, and so on, and, as a result, were not as well known by the local population. HV11 also felt that much more of her work now takes place within the surgery, and that she carries out fewer home visits. She associated a shift in perspective within her profession with the move, in 1974, of health visiting from Local Authority employment to the NHS. She commented that since then, "it seems very difficult for the profession to move on".

Several practice nurses also described changing professional expectations within their discipline. PN16, who had spent 18 years as a practice nurse, explained:

> "Certainly initially, my role was very much task oriented, and I was like the doctors' handmaiden. And the doctor would say 'I want this doing', and I would do it unquestioningly. So now, nurses, certainly practice nurses, aren't doctors' handmaidens any more. They actually think for themselves. And if they don't agree with something, they would actually say. Or if they felt that they weren't competent, or that they weren't trained to do something, then they would say" (PN16).

Whilst this practitioner described a much stronger identity for practice nurses, influenced partly by the fear of litigation, the roles of practice nurses continue to be influenced very much by the GPs they work for.

'Background' issues such as technological and medical advancements were described as influencing roles. PN36 explained that more medical input is now expected for each patient or condition. Tied in with this is the pressure to meet an ever expanding array of targets, for blood pressure, or cholesterol levels,

for instance. These changes and targets emphasise a medical scientific focus to the practitioners' work. Alongside this, cuts in other services, such as social work and school nursing, and the tendency for patients to be released from hospital 'quicker and sicker', have also affected nurses' roles. In particular, the role boundaries between social work and health visiting are increasingly blurred.

The proliferation of initiatives like Sure Start were seen by some practitioners as providing new opportunities. However, they were sometimes seen as a threat to professional roles. Both HV11 and HV5 felt annoyed that Sure Start had "appeared" and is carrying out work which "is virtually health visiting" (HV5). They felt that their wider role was being "under run" (HV5) or undermined by the initiative, and saw it as taking over aspects of their role which they "were never really funded properly to do" (HV5).

There were mixed views amongst the practitioners about the expectations of patients. Many blamed their increasing workload on the fact that patients expect and demand more and higher standards. Their greater access to health information was also seen to play a part in this. Patients sometimes knew more on a particular topic than the practitioners – this altered the balance of power in the relationship (HV15b). The contradictory and inflammatory nature of some of the health information in the media, though, was seen to trigger an extra burden for practitioners as they would have to allay patients' fears around controversial issues such as contraceptive pills, HRT and the MMR vaccine.

The balance of power within the practitioner-patient relationship was commented on several times. PN11, who had practised for 27 years, explained that people's respect for nurses had dwindled. Similarly, GP17 described how general practitioners' former power had been "diluted", giving them "less real power in terms of being able to influence the habits of a whole community". Likewise, GP68 explained that the "pedestal" on which GPs have formerly stood "is most definitely rocky". He felt that this has led to cynicism on

the part of the patient which can harm the relationship between practitioner and patient.

The increased accessibility of health information was also seen to have helped create a culture in which the 'worried well' come to a professional "to be patted on the head" (PN36) and told everything is fine. These patients, with their demands for instant access and treatment, were seen as major contributors to the excessive workload in general practice. Triage systems are increasingly being used to 'weed out' such patients.

For some practitioners, their perceived expectations of patients were at odds with public health. HV58 explained that whilst appointments could be used for 'public health', it is difficult to fit this into what parents *expect* from the appointment. She felt that she had to meet the parents' expectations, whilst also "trying to highlight the issues which perhaps they had not expected to be highlighted". This is an indication that HVs believe themselves to be seen by the public primarily as *medical* practitioners.

Their perceived identity amongst the general public is interesting. Some health visitors believed that they are seen primarily as nurses, whose role it is to perform the 'routine' functions such as vaccinations, and hearing and developmental checks. Others were horrified that some parents expected them to be able to sort out baby sitters. HV15a made the following comment on role perception:

> "A colleague of ours got asked by a mother how much phosphorous there was in a banana. Now, if a parent asked me that, I would be seriously worried about my role! Literally. Because that is just so, it's probably important to that person, but it's not my role to be looking at that sort of – I don't know, I couldn't work like that" (HV15a).

Similarly, several district nurses explained that many of their patients expected them to make them breakfast, light the fire, and so on. These seemed to be aspects of an informal role which district nurses sometimes carried out, but at their discretion. They were reluctant for such tasks to be seen as a part of their formal role.

The adequacy of the practitioners' training in terms of preparing them for the job was discussed in most interviews. Several practitioners pointed out that there is much variation in training, with some areas more "go ahead" than others (HV11). Six practitioners (2 HVs, 3 DNs and 1 PN) said that their training did not prepare them for their role in the community. HV15b added

> "And I only trained four years ago, and no, it doesn't make you prepared at all. I wasn't ready for what I met" (HV15b).

HV75 felt that there is a lack of a public health focus in training, and one of the health visitors in the group discussion felt that it remained too medical. Indeed, a community practice teacher and nurse manager described the problem of taking new nurses on board and virtually 'stripping' them of their medically-oriented training in order to put the skills back together in a new way – a way that better suits working in the community.

Whilst practice nurses especially had undertaken additional training courses which might have helped them to develop a public health approach, several practitioners noted that there are few opportunities to take up additional training in public health – HV75 explained that the few courses that exist are generally too expensive.

Within the interviews, it was interesting to explore the impact that PCTs were having on the practitioners' roles. The interviews were carried out during a time of flux, when two of the three PCTs were still in the process of forming (although the 6 PCGs had existed since 1999). South PCT was the most established, having formed in 2000. It was clear in the interviews, perhaps predictably, that the PCTs had not yet made much impact on the practitioners. They were seen as being pre-occupied with organisational change, and with trying to respond to government directives (for instance, in smoking). Many practitioners showed very little understanding of the form and function of the PCTs, and several saw it as yet another organisational change which was going on in the background. It was rarely associated with 'the public health function', but was rather seen as a body which is involved in "clerical" duties

(DN15), and developing guidelines in response to government policy. In this sense, they were seen as more geared towards national directive than local need:

> "To my knowledge, I thought that they [PCTs] were more following the government directives and the national service frameworks. I mean, that's what they're doing really. I don't know that it's actually being done on looking at the population and deciding locally what the needs are" (DN68a).

Those practitioners within North PCT, which had maintained a sub-structure of four local health groups, felt that a more local focus had been achieved, and that the local health groups (which were the former PCGs) were getting to know the local area and its needs.

Several practitioners were somewhat cynical about the level of impact that could be achieved. Some practitioners, particularly those who had gone through many organisational changes before, considered that they will continue their practice in the same way, driven more by the needs of their patients than by the PCT. One practice manager saw the PCT's ability to influence general practice as weak, given that "a GP practice is an individual unit that they don't control" (PM64). GP15 rather cynically saw PCTs as a part of a plot by politicians to devolve responsibility for the NHS, which he saw as a sinking ship, down to a local level. Thus, the role of the PCTs is to "rearrange the deck-chairs on the Titanic whilst we all know that the thing is going to go down" (GP15).

Very few practitioners saw the potential for PCTs to make positive changes for public health. Indeed, HV16 and HV72 were both worried that their new employers, being "very much GP oriented" (HV72) and "very medically oriented" (HV16), might actually stifle their public health work. Several, though, described what they saw as good initiatives which had emanated from the PCT, and talked about how initiatives of their own had got some support from them. Others were disappointed that they weren't more involved in decision making, or were frustrated by the time and energy it takes to get their voices heard.

When asked about government policy, and the degree to which it affects their work, there were mixed responses from the practitioners. Many practitioners were unaware of recent policy documents in any detail. National Service Frameworks were commonly mentioned. Some practitioners felt that the impact of these had yet to reach them, but that "presumably, somewhere along the line, it's going to maybe affect our work" (DN11). DN11, however, was one of several practitioners who felt that they are "dealing with a lot of the problems already" (DN11). DN15 felt that sometimes policies were "a bit silly really", and did not have much of an impact on her role, although she admitted that "you've got to be seen to be doing it". PM15 was rather negative about the potential for NSFs to influence her practice since they "are waving over the GPs' heads". She added: "what's the point of this huge detail about the health of the elderly, when there's already stuff they can't grapple with? They are firefighting, that's all". NSFs, in her practice, get "filed". Other practitioners, like HV16, have "no idea" about the content of recent policy documents, because they "get on with what [their] population needs".

HV5, who is a nurse representative within the PCT, was more positive about government policy, commenting that NSFs "are beginning to tie a lot of things together". She liked "the way they have sort of preventative targets in, and educational targets in, as well as purely reducing this or reducing that". However, she felt that "the government is very prescriptive - it tries to encourage innovation, but you have to be in such tight controls, really". In contrast to the majority of practitioners who felt the government has little influence on their roles, PN16 commented that her role, and the way it has changed, has "all been government led. As the government brings down new guidelines, your role adapts to encompass that". However, she pointed out that frequent changes in policy direction were unhelpful: "We're just sort of going in one direction, and then some new policy comes down, and then we all change, and we go in another direction". DN28 also felt that public health is led by government, and in fact saw her public health role as "meeting the targets that get sent down from the government". Thus, in contrast to a 'bottom-up' approach to public health in primary care, geared towards meeting

the needs of the local community, this district nurse sees public health as very much 'top-down'. However, she added that "the government targets are not always realistic, that they are a bit idealistic. Nurses' and patients' priorities are not being reflected because of a lack of time and money".

Where practitioners, or practices, were making a concentrated effort to implement new policies, it was the basic targets – and especially those targets which are tied to money – that were extracted from the documents, apparently leaving much of the policy 'message' behind. For instance, in practice 16, the CHD NSF is distilled into the auditing of figures for "how many patients have got their cholesterol below a certain level, how many patients are on aspirin, how many patients were seen in our coronary heart disease clinic" (PN16). HV58, who had no idea about the kind of response her practice was making to the NSFs and to HIMPs, said that "they [GPs] just look at the targets". GP17 commented that whilst NSFs are helping them, on the one hand, to concentrate effort on the practice population as a whole (for example, in cardiovascular disease prevention), they are, on the other hand, "narrowing us down, because they tell us exactly what we've got to do, and we tend to only do what we've *got* to do!". Indeed, PM64 added that

> "If they're not our targets, then we can't do anything about them, really. Because with the best will in the world, we can't throw the funding at it to sort it out. Because we can't affect it anyway. So the only targets we've concentrated on are the ones we can make a difference to".

The general messages of the policy documents, then, do not seem to be filtering through to the practitioners. They tend to be read narrowly, in terms of 'must-do' targets. Moreover, they are closely linked to money; a target that will bring in extra funds is a priority, whilst changes that might cost money are disregarded, or at least treated cautiously.

For some health visitors, who heard the broader messages about the need for a change in practice and in culture, there were difficulties in translating policy into action. A HV in a group discussion talked about how a lack of time is preventing health visitors from stepping off "this hamster wheel" and changing the way they work:

> "... because our managers sit there and tell us that we've got to change, and you know, we've got to look at the HIMP, and erm, saving lives, you know, smoking kills, all these documents that we – now, what are you gonna do about it? And then, we'll sit there and say, well, you know, what do you want us to do about it?! Well, we have very good ideas about how we can perhaps tackle some of these issues, but there doesn't seem to be any sort of framework, or guidance, or you've got to do these things, but you've still got to do everything else that you've got as well. And we seem to be on this continuous cycle where we know if we stop doing this, this and this, that we'll free up more time. But nobody will give us the permission, or, you know, we can't just drop things to allow extra time to do these wonderful things that they're talking about. So we're in this constant sort of 'no win' situation. Which is frustrating for us" (HV).

This practitioner has begun to identify a number of barriers to moving towards a public health approach which are more complex than simply 'lack of time'. Whilst she and her colleagues have good ideas about what they would like to do, she feels prevented from implementing them because of the conflict that exists between these new roles and her perceived 'formal' role expectations. She feels that she needs 'permission' and support in order to be able to change her role identity.

8.6 Summary

This chapter has looked at the ways in which practitioners define and describe public health. It showed how limited understandings of public health might be serving to restrict a practitioner's potential involvement in a public health approach. Practitioners are generally confused about public health, and there is a tendency to define it very broadly. However, vague definitions can conceal both a great deal of confusion, as well as narrow, restrictive understandings of the term. The tendency to regard public health as a set of activities, rather than as an approach, can set public health in competition with general practice. Where public health is interpreted in a broad way – in a way which steps outside of the biomedical psychosocial perspective - public health roles are often seen as *extra* to the practitioners' core roles. These extra roles are easily dismissed, due to lack of time, for example; or the responsibility for them can be shifted to other people. Public health comes across as something which practitioners are rarely able to make time for.

The practitioners describe a number of factors which influence their role in general, and their public health role in particular. Many of these are already noted in the literature. Section 8.5 drew attention to some of these influencing factors. It discussed how 'formal' role identities can sometimes be resistant to change. Policy is doing little to affect this - the broad messages of government policy are getting lost, with those in general practice simply extracting the 'achievable' (medical) targets from them. However, the section noted some of the differences between the practices, and the cultural dynamics within them. It noted that a supportive and facilitative practice 'culture', which can accommodate public health perspectives, and which is open to change, may enable practitioners to see beyond the 'lack of time' factor, and encourage the incorporation of a public health approach into everyday practice.

CHAPTER 9

DISCUSSION AND CONCLUSIONS

9.1 INTRODUCTION

This chapter explores the findings of the research, using Wenger's (1998a) social theory of learning as a theoretical framework. It discusses and compares the understandings of public health and public health roles which were identified in both the policy analysis and the practitioners' interviews, and explores the implications of these for the development of public health roles in general practice. It identifies several key factors which threaten to inhibit the development of public health approaches in primary care. The chapter concludes the thesis by highlighting the key findings of the research, some of its limitations, and some suggestions for further research.

9.2 UNDERSTANDING PUBLIC HEALTH

This thesis contends that public health discourse is an important part of the policy making process. A clear and shared understanding of public health, which translates into clear policy aims, is a key determinant of successful policy implementation (Hogwood and Gunn 1984, Sabatier and Mazmanian 1979, 1980). It was discussed in Chapter 4, how the policy objectives must be based upon an adequate theory of cause and effect – that is, that the means of achieving improved population health must be consistent with our understanding of health and those factors which influence it. Clarity of purpose, process and resources, therefore, are very important. Moreover, discourse analysts have shown how language can be used to construct selected versions of a policy 'problem', and persuade the readers of the appropriateness of a particular policy response (Hastings 2000).

Understanding is also important in practice. Chapter 2 discussed how the negotiation of meaning is an active process of identity construction and

practice. Understandings of public health are shaped by the particular discourses within which a person or group of persons are participating, and will, in turn, shape both their identity and practice.

This research identified that 'public health' is interpreted and understood by policy makers and practitioners in vague and flexible ways. The analysis of policy documents presented in Chapter 5 looked at the government's expectations of primary care practitioners in terms of their public health roles. It found a confusing vacillation between, on the one hand, 'public health' as a part of all primary care practitioners' roles, and on the other, 'public health' as a specialist role which should be developed by some nurses (notably health visitors) and some GPs. Whilst practitioners are generally exhorted to become more involved in 'public health', their expected public health roles are far from clear.

Indeed, there is also a lack of clarity within policy around what 'public health' is, or entails. This is reflected in the interviews with primary care practitioners, for whom public health is also a vague and malleable concept. Chapters 7 and 8 highlighted the diverse, confused, and often very narrow ways in which public health is interpreted. Generally, 'public health' was seen to occupy an insecure and obscure position within the general practice domain.

9.2.1 'Public health' in policy

Chapter 5 described how public health is seen as both policy goals, and policy means. There is a tendency, though, in policy, for means to overshadow ends – or even to become ends in themselves (Hunter 2003). Public health goals encompass a huge number of cross-cutting targets and objectives, many of which are associated with the *process* of public health action, rather than its aim. The means, though, are shrouded within a number of problematic concepts, such as collaboration, involvement and empowerment. A glance at the literature on, say, partnerships, or public/community involvement, is sufficient to remind us of the conceptual range within each term. Arnstein's (1971) 'ladder' of participation, for instance, detailed seven 'levels' of

participation, from non-participative 'manipulation' and 'therapy', where the aim is to cure or educate the participants, to 'citizen control', where the 'have-nots' handle the entire job of planning, policy making and managing a programme. Whilst this latter notion of participation is closer to that advocated in local initiatives such as Healthy Living Centres, it is only rarely realised in practice. Moreover, it is the former, non-participative notions of participation that are mostly intimated in policy. Often, the use of these terms in health policy tends to be vague, and frequently within a focus on services (rather than public health) and individuals (rather than communities).

The analysis of policy showed that whilst the policy rhetoric suggests a 'wide' (social-structural) interpretation of the term, it is in fact discussed predominantly within a more narrow, biomedical psychosocial perspective, which emphasises the responsibilities of the individual to look after and improve their own health. Thus, whilst the broad and ambitious rhetorical statements in policy suggest important social and political changes in one direction, the intricacies of the public health discourse in policy suggest, at best, little change in the government's perspective to health and the causality of ill health, and at worst, a shift *away* from such social-structural ideals. The analysis pointed to three key factors which threaten to further prevent primary care practitioners from developing stronger public health roles. These are considered in the remainder of this section.

a) The drive for efficiency

The drive for efficiency and accountability has been partly responsible for a number of important role changes within general practice - particularly those associated with 'skill mixing' amongst nursing staff. Problems with recruiting and retaining GPs across the country (but specifically in areas of deprivation), has also triggered a re-thinking of the GP's role. This is leading, in part, to the reconfiguration of GPs as medical specialists or consultants, with various categories of nurses picking up on the more 'general' tasks. One policy in particular, which requires that "By 2004, patients will be able to see a primary care professional within 24 hours, and a GP within 48 hours" (DH 2000:102),

has potentially major implications for the ways in which patients are dealt with in general practice. New demarcations between practitioners, based on levels of skills, are emerging as a result of a greater focus on the allocation of tasks to suitable practitioners for greater speed and efficiency. This encourages a 'task-oriented' response, where people are seen in terms of their problems, and problems are seen in terms of the medicalised responses they prompt. Charles-Jones et al (2003:72) suggest that

> an unintended consequence of the increasingly active management of primary care is not just the effacement of the social. Rather, it is to encourage the actors to construct even more intense hierarchies of distinction, not just of themselves as professionals, but of patients and work.

They point out that this move seems to depart radically from earlier claims that general practice is a distinctive field of social or biographical medicine. One consequence is the categorisation of the identities of different practitioners into a hierarchy of value. In this technocratic model of roles, particularly within nursing, the sole object of the practitioner-patient encounter is the completion of a task. In the words of Charles-Jones et al: "medical work is distributed between doctors, nurses and unqualified staff in ways which make explicit the reduction of general practice work to sets of biomedical problems or tasks" (2003:71).

Within this new organisation, then, attention is moving away from the traditional claims of practitioners to attend to the broader psychosocial and environmental correlates of ill health. "Instead, it categorises patients on the basis of their biomedical problems and on the sets of tasks needed to accomplish their disposal" (*ibid.*: 72). This task-driven approach was apparent in interviews with practitioners, many of whom defined public health in terms of specific tasks, and bemoaned the lack of time to add any 'extra' tasks onto their already busy workload. As GP15 said: "... there's so much pressure on clinical work. We're always being pushed to work in more efficient ways".

There are also dangers inherent in subsuming public health into an economic discourse. The recent interest of the Treasury in public health and health

inequalities is significant in highlighting the government's economic rationale for improving health. Wanless (2002, 2004), for instance, used scenario modelling to assess the resources required to deliver high quality services to improve health. He persuasively argues that lifestyle changes such as stopping smoking, increased physical activity and better diet could have a major impact on the level of health resources required in the future. This is a good and well-rehearsed argument[38]. However, there is a danger that this economic rationale reinforces the notion of individual responsibilities over collective responsibilities.

b) The notion of personal responsibility

Scambler (2002) suggests that under the aegis of the philosophy of the Third Way, "personal responsibility is being extended to 'expose' as morally culpable the failure to be, or to become, economically self-sufficient or non-deprived" (p.108). Policy aims to 'empower' the individual to engage with risks constructively, so that recourse to the limited resources of the NHS is not necessary. Swanson (2000), discussing this notion of personal responsibility within both Blair's and Clinton's (US) approaches to welfare reform, notes that their rhetoric and policies "have much in common with Reagan's (and Thatcher's) in terms of locating the solution to economic and social problems in the reform of individuals' character and not in government or community efforts to alter structural conditions or relations" (p.36).

Within their moral and economic arguments for greater levels of community and individual responsibility for health, the injustices and deep-rootedness of health inequalities receive much less attention. Indeed, in the Wanless Report (2004), personal responsibility comes even more sharply into focus, with the major 'upstream' causes of health inequalities left largely unaddressed.

This morality discourse was identified within the policy documents. Chapter 5 described how even the term 'empowerment' can be seen to be associated

[38] There is nothing new in this, but perhaps when the government hears it from the former NatWest bank chairman, as opposed to a public health specialist, they find it more credible.

with the shift in responsibility for health and well-being onto the patients/individuals themselves. The term empowerment is often related, within the policy documents, to an individual lifestyle/behaviour approach, whereby individuals might be 'empowered' to change their potentially 'unhealthy' habits. Within such an approach, wider determinants of health such as poverty or poor housing – often factors which exacerbate the adoption of unhealthy lifestyles – are effectively ignored.

A morality discourse was also present in some of the interviews with practitioners. Whilst many practitioners appeared to recognise that lifestyle choices are complex, and are dependent upon interactions within social and cultural contexts, several practitioners confessed to being bemused by the fact that their patients should fail to heed their advice and continue to make 'unhealthy' lifestyle choices. This perhaps highlights the inadequacy of the 'individual' interpretation of 'empowerment' described above – despite being 'empowered' by information/education, the patients' behaviours did not change.

c) The separation of 'public health' and 'health inequalities' agendas

The false separation of the 'public health' and the 'health inequalities' agendas, pointed out in Chapter 5, is interesting. The increased inequalities in health status between socio-economic groups, ethnic groups, geographical areas, and so on, have been an important ideological influence on recent public health policy. The Acheson Report, like its predecessor the Black Report, reiterated the importance of addressing material factors and specified the urgency of policies to reduce income inequalities and improve the living standards of households at the bottom end of the social scale. Whilst for some, equity is a key pillar of public health, it tends to be side-lined in much health policy. The publication of health inequalities targets was a positive indication of a shift in culture and values. The inclusion within the PCT's remit of a health inequalities brief, was hopeful. However, there is little sign that the health services are embracing such a goal as their *raison d'être*. Indeed, the most important discussions about the health inequalities agenda recently have

occurred outside of 'health', and alongside, as opposed to within, the public health agenda. The important cross-cutting review of health inequalities, for instance, like the Wanless reports, have emanated from the Treasury, rather than from the Department of Health. At a local level, too, the Sure Start programme, developed outside of the health sector, is beginning to deliver some positive outcomes both for partnership working and community involvement, and for the wellbeing of families (although it is still too early to assess longer term affects on health) (National Evaluation of Sure Start Team 2004).

While it is essential that the public health agenda has multi-disciplinary ownership and commitment from all departments across government, this elision of the more 'radical' health inequalities remit from 'public health', reinforces the more 'traditional' (medical) roles of the Public Health profession. Further, it allows the NHS to continue to interpret its own role in public health within a relatively non-challenging biomedical psychosocial perspective.

This was clearly the case for the majority of practitioners interviewed for this study. In the interviews, the reduction of health inequalities was linked explicitly with the public health agenda only once, by a newly qualified district nurse. Whilst some of the practitioners showed an awareness of the existence of inequalities, they were not able to conceptualise their role in relation to it - except, perhaps, in dealing with some of its consequences. For some practitioners, the emphasis on inequalities in service access and quality, which permeates policy, had clearly filtered through. But for practitioners confined to the practice setting, who are witness to the disproportionate amount of practitioner time taken by the more disadvantaged and 'needy' patients, the idea of 'equity' can be a confusing one. A population approach, and a perspective which is sensitive to issues of social justice, and mindful of the impact of social-environmental factors on health and well being, is essential if health inequalities are to be understood and challenged. This was often found to be lacking in the practitioners' discussions.

Given the flexibility of the term, and the tensions between 'wider' interpretations of public health and the government's modernisation agenda and the Third Way, it is perhaps unsurprising that 'public health' does not form a strong or clear message in policy. It has a confused and indistinct nature within policy discourse. The policy expectations of primary care practitioners, in terms of their public health roles, are also unclear. The following section explores these expectations, and compares them with the ways in which practitioners talk about public health and their own public health roles.

9.3 The Public Health Roles of Primary Care Practitioners

There is a general, though rather vague, expectation that practitioners will become more involved in improving people's health and reducing health inequalities, mainly through helping to plan and deliver more locally appropriate services. Their roles within PCTs are a key aspect of this new focus on health improvement. Moreover, they are encouraged to participate in new structures established to improve local health – such as HAZs, HLCs, and Sure Start. Some general practices are being given new flexibilities within PMS contracts, as part of the encouragement to work in new ways.

Ironically, many of the practitioners in this research were at best wholly unaware of PCTs, and at worst suspicious of them, with a few community nurses worrying that their practice might become constrained within a more medical approach. PCTs were rarely associated with public health, and instead were seen to be bureaucratic or 'clerical'. They were seen by several primary care practitioners as central government 'puppets' in policy implementation; they exist to meet central targets in smoking cessation, for example, or to implement the national service frameworks. The practitioners' potential role in feeding their local knowledge and information back up to the PCT, in order to influence local services, seemed, as yet, both unrecognised and unrealised.

The policies talk about devolution, of both 'power' and responsibilities, to the 'frontline'. Yet they are unclear about who this 'frontline' is. In many cases, the

'frontline' appears to stop at the PCT. Perhaps the expectation is that primary care practitioners *are* the PCTs – the boards of these organisations are, after all, formed by their representatives. (The previous paragraph pointed out how wrong this assumption is, however.) Perhaps it is also because general practice makes such a tricky frontline to conceive. General practices cannot be treated as uniform organisations, and their sovereignty affords them significant power and an air of potential stubbornness where policy directives are concerned. This autonomy is being challenged, for instance by the new GMS contract, which more specifically defines the 'core services' of general practice, and by PCTs, which are granted a number of tools to 'encourage' uniformity. However, organisational autonomy has also enabled very different 'cultures' to develop, from one practice to the next. These cultures might prove to be more resilient. A 'frontline' which cannot (easily) be told what to do (beyond broad contractual agreements) is rather less attractive for government.

In addition to this, the government's professed aim to decentralise decision making, and grant local organisations and practitioners greater autonomy to be able to develop their services around the specific needs of their local communities, is in conflict with their modernist-style appeal toward improved efficiency and standardised delivery. The modernisation agenda, whilst proclaiming de-centralist principles, is shaped very directly from the top (Dixon 2001). Whilst NHS organisations have been given some discretion over the determination of local priorities, they have faced a major extension to the regime of central target setting, inspection and (potentially) the imposition of sanctions.

There was evidence in the interviews with practitioners that their practice was directed more by trying to reach central targets, than by the needs of their communities. There was disappointingly little discussion of innovative solutions to local problems – stepping out of the medical/individualistic model of service delivery seemed difficult. Their knowledge of local HIMPs was minimal, and several practitioners perceived these to be wholly centrally determined. In their discussion of policy, several practitioners indicated that where a policy document (such as a NSF) is picked up for implementation, it is

the quantitative, short-term, 'achievable' targets that are focused on in practice.

The conflicting messages in policy leave primary care practitioners, to a certain extent, in the dark with regards to their expected public health roles. Whilst they are being told (albeit in a metaphorical whisper) that they are an important part of the public health function, their part within this 'function' is unclear. It is also set within other policy expectations which can constrain their opportunities to engage with public health. The only attempt to clarify the public health workforce (in the CMO's report) is vague and unhelpful. It is inconclusive for public health practitioners, except that it recommends that health visitors and school nurses develop public health roles as public health practitioners. Attempts are being made, for instance, through the nursing and midwifery council's new register, to drive forward the idea of public health practitioners as a reality. Yet lack of clear political support, deep-rooted professional identities, and practicalities of training stand in the way.

9.3.1 'Public health' in practice

The analysis pointed to the complex relationship between 'understandings' of public health, and public health roles/activities. For instance, in some cases, a narrow understanding of public health, as individualistic health promotion and disease prevention, was associated with a narrow range of public health activities being described (activities within preventive medicine and individualistic health education). Similarly, some practitioners, who understood public health more broadly - for instance to include community development approaches to reducing inequalities – described a correspondingly broad range of public health activities, and saw themselves as having important public health roles. Other practitioners, though, whilst describing a broad understanding of public health, found it difficult to identify their own place within it. The feeling that 'public health' is so encompassing as to be out of the practitioner's control leads to her redefining it in order to fit more comfortably with her current practice. Some practitioners, by 'translating' public health in a particular way, failed to see how their own practice influences the public health

agenda, and therefore lacked an understanding of how (or indeed why) they might develop a stronger public health role.

These findings echo those of Popay et al (2003b:6) who, in research conducted during the same time, but in different localities, identify three ways in which the construction of understandings shape processes of engagement and alignment. They summarise these as:

1. *Peripheralisation by choice* – where people choose to position themselves at the periphery of public health often because of the demands of their 'core' work;
2. *Marginalisation by misconceptualisation* – where people fail to see the connections between their own work and the public health agenda;
3. *Alignment and ownership* – the territory of the champions of public health who see the connectedness across organisational agendas, seek to reconceptualise public health work and evangelise about possibilities.

The analysis of public health roles within general practice, then, presents a complex picture. Wenger's (1998a) social theory of learning, and his 'communities of practice' concept (described in Chapter 2), can help us to decipher the ways in which practitioners 'understand' and engage with public health. Learning, according to Wenger, is about participation in the practices of social communities. The four main components of his social theory of learning were outlined in Chapter 2. They are: meaning, practice, community and identity.

Meaning

We can think of *understanding* as being closely related to Wenger's concept of 'meaning': it characterises the process by which we experience the world and our engagement in it as meaningful. Understandings, like meanings, are negotiated. They are dynamic and historical; they imply the engagement of a

multiplicity of factors and perspectives; and they can be partial, tentative, ephemeral, and specific to a situation. Interpreting and acting, doing and thinking, understanding and responding, are all part of the ongoing process of negotiating meaning.

Wenger describes the negotiation of meaning as involving the interaction of two constituent processes: *participation* and *reification.* Participation "refers to a process of taking part and also to the relations with others that reflect this process. It suggests both action and connection" (1998a:55). Participation is fundamental to the negotiation of meaning. "It is a complex process that combines doing, talking, thinking, feeling, and belonging" (p.56). Within the interviews with practitioners, there is very little evidence of the practitioners *participating* in public health. Whilst some of their work might contribute towards public health, they tend not to see it in public health terms. They find talking about public health difficult, and seem unused to thinking about it. There is little sense of 'belonging' to a community of public health practice.

Wenger uses the concept of reification very generally "to refer to the process of giving form to our experience by producing objects that congeal this experience into 'thingness'" (1998a:58). Through this process, he explains, we create points of focus around which the negotiation of meaning becomes organised. Reification, in this sense, encompasses a wide range of processes that include "making, designing, representing, naming, encoding, and describing, as well as perceiving, interpreting, using, reusing, decoding and recasting" (p.59). Reification thus shapes our experience. In Chapter 6 it was noted that public health is reified in policy discourse – it is made to appear more solid and defined than it actually is, through nominalisation (the use of the term as a noun to describe an entity which goes undefined), and by frequent reference to the 'machinery' of public health (workforce, organisations, actions, leadership, and so on). This highlights the 'double edge of reification' which is pointed out by Wenger, who notes that "the power of reification – its succinctness, its portability, its potential physical persistence, its focusing effect – is also its danger. The politician's slogan can become a

substitute for a deep understanding of and commitment to what it stands for" (p.61). He continues:

> The notion of assigning the status of object to something that really is not an object conveys a sense of mistaken solidity, of projected concreteness. It conveys a sense of useful illusion (p.62).

The flexibility of the term 'public health', and the ways in which it can be used and interpreted, is therefore politically useful. It can, in short, be made more palatable, by 'reducing' it to fit better with the government's ideological approach. The reification of public health in policy is an important tactic in encouraging us to believe in public health without questioning too much *how* it is going to happen, or *who* is involved. This is important given the apparent difficulties in defining the public health workforce, and in explaining the roles played by various actors within it.

Whilst public health is reified in policy discourse, there is little evidence of this in the practitioners' discourse. Most practitioners were clearly unused to talking about, or thinking about, public health. Their understandings of it, on the whole, were unsophisticated, and often drew on 'common sense' to produce vague and unhelpful definitions such as: 'it's the health of the public'. As each interview progressed, though, the practitioners' own understandings of public health often emerged. These were seen to be diverse, and often rather narrow, although they were predominantly focused on various aspects of health education and medical prevention. This is perhaps an indication of the very shallow, very tentative ways in which they understand public health. They find it difficult to give form to their understanding since they have little experience of it to project. This is shown in their lack of vocabulary with which to talk about public health. Wenger explains that words, as projections of human meaning, are a form of reification. Where public health is reified by practitioners, it is done so in a way which distances themselves from it. It is seen sometimes as a separate department or group of people, and sometimes as 'the health of the people', which is described as a concrete, immutable thing, rather than as a host of complex processes, of which they are a part.

Participation and reification, according to Wenger, come as a pair. They form a unity in their duality. It is through their various combinations that they give rise to a variety of experiences of meaning. He warns that their complementarity yields a profound principle for endeavours that rely on some degree of continuity of meaning – such as communication or collaboration (or, indeed, public health). If too much reliance is placed on participation, at the expense of reification, "then there may not be enough material to anchor the specificities of coordination and to uncover diverging assumptions" (Wenger 1998a:65).

> If reification prevails – if everything is reified, but with little opportunity for shared experience and interactive negotiation – then there may not be enough overlap in participation to recover a coordinated, relevant or generative meaning (p.65).

What is clear, from listening to both policy and practitioners, is that public health lacks continuity of meaning. In practice, it is nebulous: it lacks a vocabulary, or any sense of focus. In policy, despite the fact that it is, to a certain extent, described in writing and through documentation, there is little sense of action and interaction. Human agency in, and responsibility for, public health is reduced and obfuscated.

Community and Practice

Moving on to the next two components of Wenger's social theory of learning, let us now consider the term *community of practice* as a unit. In his association of community and practice, Wenger (1998a:84) describes three dimensions of the relation by which practice is the source of coherence of a community:

1) mutual engagement: through mutual engagement, participation and reification can be seamlessly interwoven.
2) a joint enterprise: this can create relations of mutual accountability without ever being reified, discussed or stated as an enterprise.

3) a shared repertoire: shared histories of engagement can become resources for negotiating meaning without the constant need to 'compare notes'.

Membership in a community of practice is a matter of mutual engagement; it is what defines the community. Various things, like talking on the phone, exchanging e-mail, and so on, can all be part of what makes mutual engagement possible. But being included in what matters is a requirement for being engaged in a community's practice. In their interviews, many of the practitioners expressed frustration at not being included: in their practice's response to particular issues, or particular policies; in the PCT, for instance, in the creation of the HIMP; and in the shaping of initiatives such as Sure Start, or smoking cessation services. Many practitioners showed a tendency to 'go it alone', conferring with colleagues about a particular patient as and when necessary. Of course, a community of public health practice need not, and indeed, is unlikely to, centre around the general practice. But the interviews showed little evidence of mutual engagement with practitioners or agencies outside of the practice either. Of particular importance is the lack of involvement in, or connection to, either the formal public health services, or the PCT, who have a considerable public health remit. There are a few exceptions to this, including the two health visitors who described working with Sure Start, those practitioners who described being part of a team to tackle domestic violence, for instance, and those who talked about collaborating with others in order to meet particular clients' needs.

The result of the collective processes that reflect the full complexity of mutual engagement, is the negotiation of a joint enterprise. A joint enterprise is "defined by participants in the very process of pursuing it. It is their negotiated response to their situation and thus belongs to them in a profound sense, in spite of all the forces and influences that are beyond their control" (Wenger 1998a:77). Here, the important point is not that everybody believes the same thing, or agrees with everything, but that their joint enterprise is commonly negotiated. The existence of this joint enterprise is what allows participants to negotiate the appropriateness of what they do. Over time, the joint pursuit of

an enterprise creates a shared repertoire of resources for negotiating meaning. These include routines, words, tools, ways of doing things, stories, actions, or concepts "that the community has produced or adopted in the course of its existence, and which have become part of its practice" (p.83).

Public health features little in the joint enterprise or the shared repertoire of the practitioners in this study. It does not exist as an orienting goal or ideal which might help to shape their practice. Rather, as explained in the previous section, their actions are increasingly accountable to an enterprise which prioritises efficiency, the effective completion of (mainly medical) tasks, and the speedy delivery of results (preferably in terms of quantifiable targets). The repertoire includes an abundance of routines, tools and protocols to assist practitioners in this enterprise. The creation of a joint enterprise for public health might help the practitioners to develop a clear public health intention. Without this, they are likely to remain committed to their current mindsets.

Identity

Identity, the final component in Wenger's social theory of learning, is intricately related to practice. It is produced as a lived experience of participation in specific communities. "An identity, then, is a layering of events of participation and reification by which our experience and its social interpretation inform each other" (Wenger 1998a:151).

Practitioners in primary care have strong professional identities which will colour their negotiation of the self in practice. Chapter 3 described the often deeply embedded historical and political elements which have shaped professional identities within medicine and nursing. Whilst the medical profession is dominant within the health service, the recent professionalisation agenda of nursing has raised uncomfortable issues. Walby and Greenwell (1994) argue that power is at the centre of the professionalisation debate. The detail of the debate is about the diverse ways this power is negotiated. "Hence the interprofessional relations between doctors and nurses are frequently understood as ones of a struggle over position and power" (p.59).

Professionalism has a tendency to be simplified by an association with various 'traits' or characteristics (Carr-Sauders and Wilson 1962, Greenwood 1957). The basis of professionalism resides on the fact that members of the profession hold a distinct body of knowledge - their training is controlled by the profession, and they are hence expected to be able to act with almost unquestioned professional autonomy. The 'creation of experts' by professional bodies is exclusionary - it tends toward a 'we know best' attitude which is contradictory to an ethos of collaboration and participation.

Rawson (1994) sees professionalism mostly as "strategies for closure of professional boundaries" (p.47). In traditional ideologies of professionalism, he notes, segregation and hierarchy are essential mechanisms of control over work. Thus, professionalism can be seen as a barrier to the development of inter-professional teamwork and collaboration between occupations, as each profession holds on to its own specialist point of view, so as to foster disputes and semi-autonomous sections rather than co-operation (Strauss 1962, Leiba 1994). Professionalism, then, might indicate that clear demarcations can be made between role boundaries, creating clear divisions of labour between, say, doctors, nurses, and less skilled carers.

Whilst role boundaries are less than clear in practice, the shift in roles which is accompanying the drive for efficiency and skill sharing (described above), is tending to reinforce the identity of the GP as the person at the top of the hierarchy (Charles-Jones et al. 2003). This begins to move the GP towards an identity that is the consultant in primary care, within a hierarchy that resembles that found in hospitals. "The GP is thus elevated to become a biomedical specialist and at the same time the nursing role is being extended and segregated" (p.79). As well as unintentionally contributing to the reduction of the patient's identity to a pathological label, this move is unlikely to facilitate teamwork. The interviews with practitioners highlighted the already considerable power of the GPs to direct and influence the work of other practitioners in the practice[39]. If their power is to increase, their support of

[39] Indeed their role as gatekeeper became evident during my attempts to access practitioners

public health work within the practice becomes more vital. However, if their focus continues to become more overtly biomedical, the profile of public health work is likely to become even lower than at present.

The shift in roles between GPs and nurses is more evident, within the data, than changing role boundaries within nursing. The blurring, within policy, of the old demarcations between nursing disciplines, is less evident in practice. Most of the practitioners continue to hold to 'traditional' aspects of their professional identities - particularly those associated with the location in which they work. This can colour one practitioner's views about what a practitioner in another discipline does. Many practitioners felt that their role was not really understood by their colleagues, and cited instances of inappropriate referrals as examples.

This is an important context for the development of public health roles in primary care. Overall, the interviews show that public health forms very little part in the practitioners' identities. None of the practitioners described themselves as public health practitioners, and a few did not consider themselves to have a public health role at all.

The flexibility with which 'public health' could be interpreted by practitioners allowed them to define it *within* their current scope of practice. Thus, public health is to a certain extent shaped by the practitioner's professional identity and her conception of her 'formal' role. Some district nurses, for instance, brought in aspects of 'holistic' care and cleanliness, seeing an interest in their patients' physical and social environment as part of their public health role. This role remained, though, within the context of the individual patient-practitioner encounter, and maintained a focus on clinical health, and on reducing risks posed by individual behaviours.

Some health visitors looked more broadly at the notion of supporting and 'empowering' people to reach their full potential in terms of mental, physical and emotional health. Their interpretation of 'health' was wider, since many of their clients are 'well'; hence, they saw health 'potential' rather than simply

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to participate in this study. GPs have the capacity to exclude practitioners from a multitude of

health status. This indicates a greater focus on more general prevention and promotion, and on 'empowerment'. For the interviewees in this study, though, this remit once again remained largely within the client-practitioner encounter, although the clients were more likely to be seen as family units than as individuals.

The practice nurses in this study interpreted public health within the confines of their work within the practice, seeing their public health role as helping patients to better manage their chronic disease by encouraging them to change their habits, or opportunistically offering health education advice to other clients. The diversity in interpretations of public health and public health roles reflected the diversity in practice within this disciplinary group. Whilst some saw the passing on of health messages, through information boards and leaflets, as their public health role, others were more focused on seeking and meeting health needs through audits and screening, for chlamydia, for instance.

The GPs in this study seemed to identify public health as a professional domain which was different to their own, and which was associated with the more 'formal' Public Health services. This indicates that they draw clearer demarcations around and between professional remits, and are more familiar with Public Health as a body of experts with whom they deal at certain times – to report the finding of an infectious disease, for instance, or a case of food poisoning. This might indicate the stronger identity of GPs as belonging to a 'mature' profession which is distinct from others. Their view of Public Health, then, was largely that of a 'specialism' within medicine.

Whilst GPs identified a 'less formal' public health (with a small p and small h), they lacked any sophisticated understanding of it. Like the other practitioners, they interpreted this within their own interactions with individual patients. Any conception of the complex processes by which social structural factors impact upon health and health behaviours, then, were limited, and the responsibility was again placed upon the individuals.

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opportunities, simply by failing to pass on information.

Generally, public health was predominantly understood by the practitioners in this study within the biomedical psychosocial perspective which tends to direct their practice. The preoccupation with behavioural risk factors reflects government policy, but also fits with the practitioners' individualised approach. Likewise, the medical aspects of public health, such as vaccinations and screening, featured a great deal more than more 'social' aspects such as community development, or campaigning for, or taking part in, social, environmental and political change for health. A narrow, medical interpretation of public health allows the practitioner to explain and justify her role in medical prevention or health education, without ever thinking beyond that to other, wider determinants of health and health inequalities. Thus, public health, which should, by nature, be constantly *challenging,* can be interpreted in such a way that its challenging aspects are cauterised.

9.4 Public Health as 'Something To Be Done'?

This analysis found that 'public health' is interpreted sometimes as a set of activities and tasks, and sometimes as an approach to practice. Similarly, one of the GPs interviewed pointed out that public health can be seen both as something to be 'done', as well as something to be 'affected'. However, it is the former interpretation – public health as activities and tasks 'to be done' - which tends to dominate both policy and practice. There are several key implications of this.

Firstly, it leads practitioners to interpret public health *in relation to* their existing roles. That is, people decide whether or not they have a public health role based on what they do or don't do. For instance, a health visitor might feel she has a public health role because she gives vaccinations; a district nurse might feel she does not have a public health role because she doesn't do group work. Thus, rather than being seen as something which motivates, or challenges, their practice, it is regarded as a 'category' into which they can fit some of their activities. This is also the case in policy, where 'public health' is defined in a specific way in order to fit *within* the government's existing ideology – in this case, modernisation and the Third Way – rather than to challenge or question it.

A second, and related point, is that if public health is seen as a set of activities or tasks, which may or may not fit neatly within existing roles or practice, it is too easy to knock off the agenda, or to pass the responsibility for it to someone else. This happens in policy documents, where 'public health' is described as though it were an entity, in order to reduce human agency in it. It was seen in Chapter 7 also, how some practitioners interpret public health in such a way as to diminish their own responsibility for it. Seeing it as the control of infectious diseases in the population, for instance, or health protection and safety, tends to make it the responsibility of Public Health Doctors[40]. Where practice nurses, district nurses and GPs see it as work in the community, responsibility for it is often passed to health visitors. This is what Popay et al (2003b) call 'marginalisation by misconceptualisation'.

Public health also too easily becomes something that is in competition with existing roles. Where practitioners' time is limited, public health becomes seen as something which would have to be 'done' in place of something else. For most practitioners, there is simply no competition. As a district nurse said, "we can't just neglect all the wounds that need dressings to go out and do public health" (DN21b). Public health work, then, is sometimes seen as 'extra' to the practitioners' core roles. Even where practitioners considered themselves to have a public health role, their public health activity was often subject to having the time (and money) to do it. This perception, that there is no time for public health, is indicative of the way in which it is understood. Seeing public health as a range of tasks or activities allows the practitioners to define it as peripheral activity – work *on top of* their core role.

A third point, also related to the previous two, is that the interpretation of public health as a set of activities or tasks entails the reduction of the complex and varied to the simple and standard. Chambers noted within the world of development, that "many professionals seem driven compulsively to simplify what is complex and to standardise what is diverse" (1997:42). This seems

[40] This has happened in policy too, where the interpretation of public health as a medical specialism safely identifies it as the responsibility of a (nebulous) group of others – 'Public Health'.

particularly common within general practice, and indeed, within the NHS in general. Yet it is particularly destructive to the notion of developing public health roles.

There is a key tension here. In order to work towards a shared public health enterprise or mindset, we need to achieve greater conceptual clarity for the term 'public health'. But public health is inherently a contested terrain. There is much to risk by 'hemming it in'. In order to illustrate this point, let us explore the consequences, for the broad vision of public health, of the drive towards competency based education.

Within educational circles associated with primary care and public health, the notion of 'competence' abounds. Yet it is a concept that receives little critical analysis. Ashworth and Morrison (1991) define competence as "a wide concept which embodies the ability to transfer skills and knowledge to new situations within the occupational area" (p.257, cited in Beach 2002:83). However, they then question whether it is a capacity, bits of behaviour or a particular outcome. This leads us to ask firstly how knowledge and competence are linked; and secondly, whether the latter always demonstrates the former.

Public health encompasses a wide variety of activities and issues. Its sphere of practice is large, and it is difficult to pin-down. The construction of a list of 'requirements' in the form of competencies, then, may amount to a *reification* of public health, restricting its scope, and leading professionals down a "potentially problematic route as ... [they] somehow try to get all the required characteristics 'right'" (Beach 2002:80).

"Competency based education ... rests upon the premise that occupationally derived tasks can be isolated and converted into identifiable outcomes capable of assessment" (Webb 1992:227). However, the practice of public health, as recognised by Acheson (1988) in his widely used definition, is an 'art' as well as a science. Assessing the knowledge base behind the practical 'art' of public health is arguably problematic, if not impossible. This leads to a

concern that the notion of 'competence' in public health is associated with the *reduction* of it as a broad concept to its more scientific aspect. Competencies can be linked to the professionalisation agenda: "the systematic knowledge base of the professions is thought to have four essential properties. It is specialised, firmly bounded, scientific and standardised" (Schön 1987, cited in Beach 2002:80). Where science is emphasised over art, and bureaucracy over adhocracy, an anti-innovatory culture may develop in which individual innovation and novelty are only tolerated within limits. "It is in the specifying of occupational competencies that a skills based outcome *training* rather than a process oriented professional *education* has been gradually established" (Webb 1992:227, original emphasis). Perhaps public health needs to work more from broad principles than prescribed rules.

A final consideration of competencies stems from the belief that they "involve a surreptitious subordination of the individual to the alleged needs of the organisation" (Performance and Innovation Unit 2001:79). Webb (1992), going even further, suggests that new 'competency' driven initiatives in professional education are "a mask for the superintendence of expert labour by the state", and "a vehicle for endorsing the increasingly market oriented context within which employers now operate" (p.224). Whilst this view might be dismissed as mere cynicism, it does point to the possible *commodification* of public health, where the focus on competencies forms part of the increased control by the centre, 'enforcing' new training practices, with the aim of greater consistency and reliable transportability of the qualified worker.

This discussion highlights the tension between the 'art' and 'science' of public health. The Faculty of Public Health, speaking from a predominantly 'scientific' public health perspective, argues that defined professional competencies are required to ensure public safety and accountability. This is a legitimate argument within an area that is still medically driven, but is much more difficult to argue within the more 'artistic' elements of and approaches to public health.

'Art' can be defined as "skill in doing anything as the result of knowledge and practice" (Oxford English Dictionary 1989). This linking of skill, knowledge and

practice reminds us of the importance of *experience* in the process of learning and doing. The Merriam-Webster dictionary (2004) considers art to be "the conscious use of skill and creative imagination". *Intentionality,* therefore, and the use of imagination, are other important aspects in the application of skills. As we can see from these definitions, artistry "is not reducible to the exercise of describable routines" (Schön 1992:51). As a result of this rather elusive nature of 'art', Marks-Maran and Rose (1997) note that ignorance and prejudice link it to "untested practise and strongly held beliefs which are fundamentally inferior to scientific, validated knowledge and 'facts'" (p.4). Certainly in policy, which calls for the measurement and performance management of public health, the art of public health tends to get lost. In practice too, the call is for competencies and standards, rather than knowledge and capability. There is a need, then, for greater conceptual clarity regarding the 'art' of public health.

9.5 Developing Communities of Public Health Practice

The understanding of 'public health' as a set of activities and tasks is preventing practitioners from engaging more fully with it. There needs to be a shift in perception, then, from public health as 'task-driven', to public health as 'value-driven'. Values, beliefs and behaviour are at the crux of a public health approach. Yet people appear to be trapped by norms of behaviour, by routines, and by lack of resources. Moreover, they are often working within organisational cultures which keep them in the same (conceptual) places, and reward them for being there. Changes in policy are providing new potential for practitioners to work in new ways. Whilst the government's encouragement to be creative and innovative is laudable, it does not fit neatly within their more powerful drive to standardise and manage services. Moreover, MacKian comments that "policy changes may give people the *opportunity* or *power* to act, but without the right culture these opportunities will not automatically be seized" (2002:216, original emphasis).

Chambers, writing about development professionals, said that "If whole systems are to shift and transform, it will be because of the sum and interaction of innumerable personal actions and changes in what sort of people

we are" (Chambers 1997:232). Within the government's recent drive to strengthen the public health function, a great deal of the focus has been on structure. This has effectively ignored the influence of interacting actors within organisations (MacKian 2002:216). Wenger's social theory of learning has helped us to situate 'meaning' within a complex web of identity, community and practice. It shines new light on the interaction between individuals, and between those individuals and their contexts.

This thesis has underlined the importance of understandings of public health for the making and shaping of public health roles. Communities of practice develop around things that matter to people. As a result, their practices reflect the members' own understanding of what is important. Whilst outside constraints can influence this understanding, it is the members themselves who develop practices in response to these external influences.

Understandings of public health therefore play an important part in agency and intentionality. They influence the ways in which practitioners negotiate their role. Shelton and Darling, in their article on managerial leadership, suggest that clear intention serves as a magnifying glass, providing "a new lens through which [practitioners] can make new perceptual choices – choices that otherwise would have been missed, thus creating lost opportunities" (2001:266). In primary health care, all practitioners should be clear about their public health intention to help them make the choices they face in every day practice, without missing opportunities. At the organisational level, this 'intentionality' also acts as a reminder that all collaborators should be involved in visioning and planning processes: "If employees are not involved, they are likely to be perceptually incapable of seeing and, hence, of creating new possibilities. Instead, they remain committed to their current mindsets, unable to make the perceptual choices required for successful execution" (*ibid.*: 266).

Vagueness about what 'public health' means, and the lack of shared vocabulary with which to talk about it, means that public health policies are confusing and primary care practitioners are confused.

> An adequate vocabulary is important because the concepts we use to make sense of the world direct both our perception and our actions. We pay attention to what we expect to see, we hear what we can place in our understanding, and we act according to our world views (Wenger 1998a:8).

This research has highlighted the lack of a 'common ground' on which to build the public health function. Wenger et al (2002) describe this 'common ground' as the domain of a community of practice. "Whatever creates that common ground, the domain of a community is its *raison d'être*. It is what brings people together and guides their learning" (p.31). Practitioners in general practice are being pushed and pulled in several directions, but notably are being directed by the modernisation agenda which demands higher quality services, delivered more quickly and efficiently. Within this, the public health message needs to be stronger, louder and clearer.

Communities of practice are important in making the shift from public health as competency based, to public health as knowledge based.

> They can retain knowledge in 'living' ways, unlike a database or a manual. Even when they routinize certain tasks and processes, they can do so in a manner that responds to local circumstances and thus is useful to practitioners (Wenger 1998b:5).

Developing communities of public health practice, then, might help practitioners to make the shift, in their conceptualisation of their public health roles, from being task driven to being *value* driven. For this to happen, it is important that they develop a shared understanding of public health.

9.6 Summary and Final Reflections

This research, rather than simply finding out what practitioners are *doing* in terms of public health, took a step back and explored what practitioners *think* about public health: how they understand it, and how they engage with it as a concept. Whilst this analysis was conducted alongside an analysis of policy interpretations of public health, it is *not* an assessment of whether or not, or how well, the public health policy is being implemented. However, the research investigates an important part of the policy making process –

particularly the part played by discourse and understandings in both the 'making' of policy and the practice of individuals - and its results hold several important implications for policy implementation.

The research highlighted the dangers of the 'vagueness' surrounding the term 'public health'. Its malleability means that it can be interpreted both in a politically acceptable way, and in a way that fits within current practice. Thus, it loses its radical edge, and is no longer something that challenges or guides policy and practice. The public health rhetoric in New Labour policy, which indicates a societal focus to health and health improvement, is being undermined by the policy detail, which emphasises 'safer' biomedical and epidemiological approaches. Specifically, three important factors were found to threaten the development of stronger public health roles within general practices: the drive for efficiency and value for money which is central to New Labour's modernisation agenda; the emphasis on the notion of personal responsibility within public health policy, which tends to focus on the lifestyle and behaviours of individuals; and the separation of the 'public health' and 'health inequalities' agendas, which leads to a narrow, relatively non-challenging interpretation of public health within primary care. In the face of these dominant policy discourses, the 'societal' public health message is getting lost.

Public health was also found to be seen as a set of activities, particularly by practitioners in general practice. This follows the emphasis in policy of public health *means* over public health *goals*. The research highlighted some of the consequences of this perception. First, it allows people to pass responsibility for it to others; second, it permits people to excuse themselves from public health work due to 'lack of time'; and third, the 'art' of public health has a tendency to get lost behind the primacy of 'science'. These factors contribute to the non-engagement of primary care practitioners in the public health agenda.

The research identified the potential importance of organisational culture in being able to foster a public health approach in practice. The ways in which

the practice staff work together, communicate, share ideas, and support each other are potentially extremely important in the development of public health roles. However, the research managed to touch only briefly on such issues, given the difficulty of gaining access to the field as a non-health professional. There are many difficulties with researching intangible aspects of organisational culture, such as 'friendliness' or 'social capital'. However, a greater amount of time spent observing interactions and activities within practices might enlighten some of these issues further. In addition, widening the scope of enquiry to primary care practitioners outside of the five core disciplines might provide an interesting and different perspective on the organisational culture of general practices.

This research makes few claims to generalisability. It was carried out at a specific (and particularly difficult) time, during which PCTs were being established, the structure of the public health function was being reformed, and the primary care practitioners were being confronted with a wave of new policies and initiatives. Moreover, it focused on a selection of practices in one area within England. Whilst measures were taken to ensure that the sample of practices and practitioners were diverse in their characteristics, the limitations presented by the small size of the sample, remain. In particular, the number of practitioners, limited by the difficulties of getting practices to participate in the research (see Chapter 4), meant that few comparisons could be made between practitioners in different practices, and therefore between different practice and area characteristics (such as deprivation, rurality, size, and so on). This is unfortunate, and could perhaps be followed up in further research on a larger scale.

An investigation with wider scope might also allow for exploration of important and fascinating issues that could only ever form part of the background to this research. The power dynamics within general practices, for instance, and their influence on the relationships between practitioners, and on practitioners' approaches to public health, are largely unexplored within the sociological literature. Since there are often stark distinctions in gender, class and ethnicity

both within and between professional disciplines, such issues would be an important focus for further research.

This thesis, though, presents important findings regarding the ways in which public health is understood in policy and practice, and the relationship between these understandings and the public health roles of primary care practitioners. The development of shared understandings of public health, particularly as an *approach* to work, rather than as a set of activities, is vital. It is difficult, when viewing public health as an approach to work, to give concrete examples of ways to improve practice without sounding idealistic. But the concept of communities of practice might help us to think about the education and practice of practitioners in new ways. It is important that practitioners are driven by *values*, rather than tasks, and that they develop a sense of public health 'intentionality'; they need to be energised and politicised for public health (with a small 'p' and a small 'h'). This will entail thinking about 'productivity' and 'efficiency' in new ways, so as to diminish the constant push towards the performance of manageable tasks, and emphasise the pull towards jointly *affecting* the public's health through the proactive seeking and meeting of health and health-related needs. It will impact upon the training and education of practitioners, so that public health knowledge and capabilities are developed alongside skills and competencies. And it will require the creation and fostering of communities of public health practice, in which those dimensions that are necessary for the 'art' of public health to flourish – notably, mutual engagement, a joint enterprise, and a shared repertoire – are developed.

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LIST OF APPENDICES

APPENDIX A

Policy Documents considered for analysis, indicating those chosen for inclusion (3rd column)

Year	Title (and abbreviation)	Inc ?	Reason
1997	*Restoring the vision: Making health the incentive* (National Association of Commissioning GPs)		Not Govt policy
1997	*NHS (Primary Care) Act*		Acts not included
1997	*The New NHS: Modern; Dependable* (NEW NHS)	✓	White paper
1998	*Acheson Report of Independent inquiry into the causes of inequalities in health*		Independent inquiry
1998	*CMO's Project to strengthen PH Function in England - Emerging findings*		Interim report
1998	*Shared Contributions, Shared Benefits:* The report of the Working Group on Public Health and Primary Care		Independent report
1998	*Supporting Families* (Green Paper)		Green paper
1999	*Health Act*		Acts not included
1999	*Public health practice resource pack, DoH* (HV DEV)	✓	Includes guidelines for action
1999	*Saving Lives: Our Healthier Nation* (SL OHN)	✓	White paper
1999	*Making a Difference* (MAD)	✓	White paper
1999	*NSF: Mental Health* (MH NSF)	✓	Guidelines for action
1999	*Clinical governance: quality in the new NHS* (DoH)		Marginal relevance
1999	*Reducing Health Inequalities: An action report (DoH)*		Summary of action taken
2000	*Local Government Act*		Acts not included
2000	*NHS Plan: A plan for investment; a plan for reform* (NHS PLAN)	✓	Strategic plan
2000	*NSF: CHD – modern standards and service models* (CHD NSF)	✓	Includes guidelines for action
2000	*New Deal for Communities: Guidance from the Department of Health*		Guidance
2001	*NSF – Older People* (OP NSF)	✓	Guidelines for action
2001	*New Commitment to Neighbourhood Renewal: National Strategy Action Plan* (NCNR)	✓	Action plan
2001	*National Strategy for sexual health and HIV* (SEX STRAT)	✓	National strategy with PH relevance
2001	*Preventing Social Exclusion (SEU)*		Guidance and update
2001	*Primary care, general practice and the NHS Plan*		Additional notes to NHS plan
2001	*The Report of the CMO's project to strengthen the PH function (DoH)* (CMO R)	✓	Key report with recommendations for action
2001	*National Health Inequalities Targets announced*		

APPENDIX A

Year	Title (and abbreviation)	Inc ?	Reason
2001	*Shifting the Balance of Power within the NHS: Securing Delivery*		Discussion document
2001	*House of Commons Select Cttee on Health - 2nd Report on PH*		Report
2001	*Govt Response to House of Commons Select Cttee on Health's 2nd Report on PH*		Response to report
2001	*PH Skills Audit: Research Report* (HDA)		Research report
2001	*From Vision to Reality*		Update summary
2001	*Tackling Health Inequalities: consultation on a plan for delivery*		Consultation
2001	*Establishing the new Health Professions Council* (DoH)		Marginal relevance
2001	*Local Strategic Partnerships: Government Guidance (DETR)*		Guidance
2001	*Power to promote or improve economic, social or environmental well-being: Guidance to local authorities* (DETR)		Guidance
2002	*STBOP: The next steps* (DoH) (STBOP)	✓	Action plan
2002	*Delivering the NHS Plan*		Update summary
2002	*Liberating the talents* (LTT)	✓	Action plan/guidance relevant to PC nurses
2002	*Tackling Health Inequalities: results of the consultation exercise (DoH)*		Consultation exercise
2002	*NSF: Diabetes – delivery strategy* (DIAB NSF)	✓	Guidelines for action
2002	*National Service Frameworks: a practical aid to implementation in primary care.*		Guidance
2002	*Securing our Future Health: Taking a long term view*		Review from HM Treasury
2002	*Guidance on tackling health inequalities through Local Public Service Agreements*		Guidance
2002	*Health and Neighbourhood Renewal: Guidance from the Department of Health and the Neighbourhood Renewal Unit*		Guidance
2002	*Tackling Health Inequalities: 2002 Cross cutting review*		Review
2003	*Keeping the NHS Local: A new direction of travel (DoH)*		Marginal relevance
2003	*Reducing Health Inequalities. Local Government and the NHS working together (LGC, HSJ, HDA)*		Not government document
2003	*Local government scrutiny of health: Using the new power to tackle health inequalities (Lucy Hamer, HDA)*		Not government document
2003	*Overview and scrutiny of health: guidance (DoH)*		Guidance
2003	*Tackling Health Inequalities: A Programme for Action* (TACKLING HIs)	✓	Guidelines for action
2003	*The New GMS contract* (GP CONTRACT)	✓	Key policy
2003	*UK National Action Plan on Social Inclusion 2003-2005*		Update report

APPENDIX B

Summary of information gathered from 'middle-tier' organisations and national/regional 'experts'

Organisation	Information gathered
South PCT	Interviews: Health Promotion Specialist Primary Care Development manager Meetings attended: PCT Protected Learning Time session. Nurses and Therapists forum (x 4). Documents collected: Primary Care Investment Plan (PCIP) (2001-03), Practice Population Profiles (2001) HIMP (2000/01) HIMP action plan (2002) Minutes of board meetings News releases (from internet)
Centre PCT	Interviews: Health Promotion Specialist Nurse board member Meetings attended: Nurses and therapists meeting PCG board public health sub-group meeting Documents collected: PCIP (2000-02) Minutes of board meetings (from internet) News Releases (from internet)
North PCT	Interviews: Health Improvement Officer (from PCG 1) Health Promotion Officer (from PCG 4) Nurse board member Meetings attended: Health Care Professional Development forum Nurses and Therapists forum Documents collected: PCG 1 { HIMP (2001/02); PCIP (2001); Clinical Governance Development Plan (2001/02); Selected News Releases PCG 2 { PCIP (1999-2002); HIMP (2000-01) PCG 3 { PCIP update (2000); HIMP (2000); 'East County Alliance' sub group notes (x3); Clinical Governance Action Plan (2001-02) PCG 4 { PCIP (2002-03); Minutes of board meetings (from internet)
South Community NHS Trust	Interviews: Locality nursing manager
North Community NHS Trust	Interviews: Senior manager primary care
Health Authority	Interviews: Public Health nurse specialist Director Public Health Documents collected: HIMP (2000) (HA) HIMP (2002-05) (StHA) 'Health in the County– overview'

	Public Health Report 2000 Public Health Report 2001 – Health Inequalities
'experts'	Interviews: Nursing Officer - Inequalities and Public Health Strategy Branch, Department of Health, London Director of Public Health (non-medical specialist), Bristol Researcher, Public Health Resource Unit, Oxford Senior Lecturer in Public Health, Oxford

APPENDIX C

INTERVIEWS WITH PROFESSIONALS IN PRIMARY CARE

Interviewer's guide

1. Your situation/job: (i.e. GP attached? history? Experience?)

2. Your role:
   ... could you describe what you do?
   ... has your role changed much? How? Why?
   ... do you feel lit is understood by others? ...

3. Do you have a public health role?
   ... clear role?
   ... part of formal training?
   ... fits easily with other activity?

4. Can you give (write down?) some (4-5) examples of public health activity you are, or have been, involved in?
   ... explore ...
   ... describe an example - how did it come about?
   - who else is involved?
   - who leads it?
   - is it part of formal role?

5. Do you feel you have much opportunity to get involved in 'public health' work?
   ... can you describe your community?
   ... what are the public health issues of your local community?
   ... explore any local initiatives in response to these issues

6. How do you understand the term 'public health'?
   ... Any 'key words'? (think individual vs community; medical vs social)
   ... Who carries it out?
   ... Who is the target?
   ... where has that understanding come from? Whose ideas have shaped it?

7. Do you carry out health promotion as part of your job?
   ... what sorts?... how?... with whom?
   ... is this different to PH role?

8. What has been your practice's response to the HIMP or the NSFs?
   ... and your individual response?
   ... how aware are you of these and other policies?
   ... do they influence your work?

9. What / who would you say your public health role is influenced by? (+ve or -ve)
   ... personal values?
   ... expectations of others?
   ... policy?
   ... training?
   ... internal / external pressures?

Respondent No.: PC__ ___

PRIMARY CARE PRACTITIONERS AND THEIR PUBLIC HEALTH ACTIVITIES

I would be extremely grateful if you would take a few minutes to complete the questions below. The information you provide will form useful additional information to our interview.

1. What is your job title?

District Nurse	☐	GP	☐
Health Visitor	☐	Midwife	☐
Practice Nurse	☐	Other (please specify below)	☐
Treatment room nurse	☐	_____	

2. Who is your employer?

NHS Trust ☐ Name of Trust: _____

PCT ☐ Name of PCT: _____

General Practitioner ☐

Other (please specify) ☐ _____

3. Is this job full-time (30 or more hours per week), or part-time (less than 30 hours per week)?

☐ Full-time

☐ Part-time

4. How many years have you been in this current post?

_____

5. In what year did you complete your training?

_____

6. **Please list below any professional qualifications you hold (e.g. RGN Diploma, RGN Degree, RHV):**

_____

_____

7. **Please list below any other Post-Registration qualifications that you hold, including academic degrees and diplomas:**

_____

_____

_____

_____

Please turn to next page to fill in the table ...

8. Please indicate which of the activities below you carry out as part of your professional work. If you do not carry out an activity, but know that someone else in your practice does, please put that person's job title in the relevant column below.

ACTIVITIES	Yes, I do this	Someone else in the practice does this (please state the job title of this person)
PREVENTATIVE MEDICINE:		
Provide immunisations		
Carry out health checks on individuals		
Conduct individual screening (e.g. cervical cytology screening)		
Rehabilitation with individuals with established disease to minimise complications (e.g. foot care for people with diabetes)		
HEALTH EDUCATION:		
Give individual health education / promotion advice		
Provide advice/ information about other issues, such as benefits, housing, etc.		
Provide health education advice to a group (e.g. to a women's group, or in a school)		
HEALTHY PUBLIC POLICY:		
Influence policies affecting health		
Lobby for improvements in e.g. housing, play areas		
COMMUNITY DEVELOPMENT:		
Collect information on the community's health issues		
Analyse information on the community's health needs		
Work with community groups on project(s)		
Work with other agencies / organisations on project(s) or programme(s)		
Target particular client groups and work with them on health issues		

Many thanks for taking the time to answer these questions.

Erica Wirrmann, Researcher
Oxford Brookes University, Department of Sociology and Social Policy,
Headington, Oxford OX3 0BP (Tel: 01865 484 942)

APPENDIX E

[DATE]

[NAME]
[ADDRESS]

Dear Dr [NAME]

RE: Public Health and Primary Care Research

I am writing to ask whether you would be willing for some members of your practice team to participate in a research project which is exploring how, and to what extent, primary care team members are involved in public health projects in their local area. I am a DPhil research student at Oxford Brookes University, and am carrying out this research as part of a larger project which is funded by the lottery to look at public involvement and the development of public health in primary care.

An enclosed leaflet describes the research in more detail, and an information sheet for participants highlights what participating might mean for you as a practice. Part of the aim of the project is to find out how the public health roles of primary care practitioners might be better supported in the future, so I hope to be able to feed into, and be of help to, the practice's own development of its public health function, in light of new PCT changes.

I would be most grateful if you would agree to your practice being involved in this project - I shall endeavour to disrupt the practice as little as possible. I understand that it would be helpful to discuss this in more detail when you and your colleagues have had time to consider this proposal, so I suggest that I telephone your practice in a couple of weeks' time. If you would like to contact me in the meantime, I would be very happy to hear from you.

Many thanks for your time, and I look forward to speaking to you soon.

Yours sincerely,

Erica Wirrmann
Researcher.

Research Methods

This research will use a case study approach, with a range of qualitative methods. It will rely mainly upon semi-structured interviews with primary care practitioners in a number of different disciplines (GPs, Health Visitors, Practice Nurses, District Nurses, Practice Managers) from around 15 practices in Northamptonshire. Other methods, which could include group discussions, observation of meetings, and collection and analysis of practice documentation, will fit around the individual needs, wishes, and time constraints of the participant practices.

In addition to this, though in less detail, I will be getting a feel for what is going on at NHS and Primary Care Trust level through interviews, observation of meetings and collection and analysis of documentation.

The first phase of the field work will be carried out in Northamptonshire, the main case study site, up until the Spring of 2003. Discussion groups and workshops will be carried out in 2 other case study sites from the beginning of 2003. These will draw on the findings of the qualitative work in the first phase, and will be used to corroborate the results of the initial research.

OXFORD BROOKES UNIVERSITY

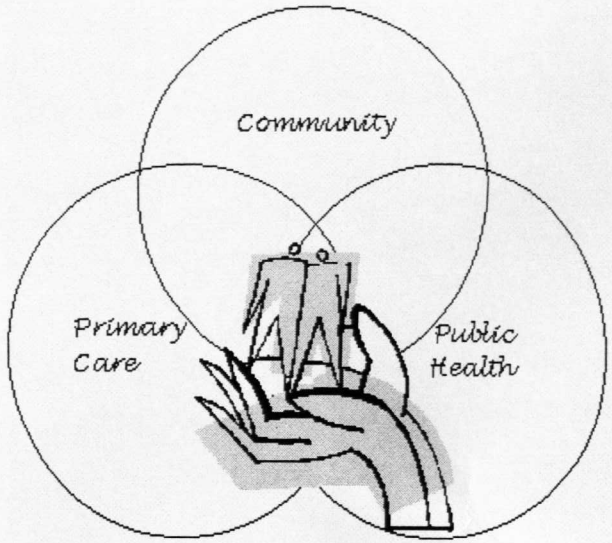
It is an exciting time for this research, with many changes happening both in Primary Care and Public Health. It is being carried out from September 2000 to September 2003, and will form the basis of my PhD at Oxford Brookes University.

It is also designed, however, to be useful to those practices participating in the research, and flexible so as to meet their needs as much as possible . Feedback, and opportunities to contribute to the design, will occur at every stage.

The research has been approved by the Ethics Committees at both Oxford Brookes University and Northamptonshire Health Authority.

If you would like to see a copy of the full research proposal, or would like any more information, please do not hesitate to contact me.

Primary Care Professionals and their Public Health Roles



Erica Wirrmann
Oxford Brookes University

An exploration of the public health activities of primary care professionals

There is currently a great deal of emphasis on developing the public health function, with much of this emphasis being directed towards Primary Care. The Chief Medical Officer's report on strengthening the public health function states that public health approaches in Primary Care staff should be fostered, and those with existing skills should be encouraged to make full use of them.

This is a time of great change for Primary Care, with many increased roles and responsibilities, especially in light of the Government's paper 'Shifting the Balance of Power' (2001).

It is also an important time in the development of a stronger, more cohesive vision of Public Health - one in which everyone has a part to play, where individuals and organisations work collaboratively together, and in participation with their communities, in order to improve health, and reduce health inequalities.

Much of the onus for a strengthened public health function falls on workers at the local level. It is essential that Primary Care practitioners are supported in this, and their development needs recognised.

Primary Care practitioners are a vital part of a stronger public health function, yet often feel marginalised within Public Health (Health Development Agency, Public Health Skills Audit Report 2001).

The Aims of this Research

The main aim of the research will be to examine the public health roles of primary care professionals. It will focus on gaining some understanding of both formal and informal public health activities of a range of practitioners working in primary care.

Key Questions ...

- What are the public health roles of key primary care professionals?
- What is the understanding that primary care professionals have of their own, and each other's, public health roles?
- What is expected of them, in terms of their public health role?
- What does an individual's public health role look like in practice?
- How congruent with reality are expectations of the public health role of primary care professionals?

This research will inform the development of the public health functions within primary care at a local level, suggesting ways in which the public health roles of key primary care professionals might be better supported in the future.

This research project is funded by the Economic and Social Research Council and the UK Public Health Association.

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Dept of Sociology and Social Policy
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PRIMARY CARE PROFESSIONALS AND THEIR PUBLIC HEALTH ROLES

A RESEARCH PROJECT

Some questions answered ...

What might your practice get out of participating in this project?

At a key time in primary care, this project aims to support the development of the public health function at a local level.

It will enable participants, individually, or in groups, to discuss their public health activities, to explore ways in which their public health roles could be enhanced or better supported, and to examine their public health roles in the context of wider changes in both primary care and public health locally (with the development of the Primary Care Trusts, and local Public Health Networks) and nationally (with National Service Frameworks and Health Inequalities Targets). Practitioners interviewed so far have indicated that they have found this a valuable experience.

Feedback will be offered to the participant practice, in written form, throughout the research process. If the practice wishes, a group meeting could be held towards the end to discuss the project's findings. Any articles or reports emanating from the project will be made available to participants.

The project will enable the views of participant practitioners to feed into, and influence, the development of the public health function locally within PCTs and Strategic Health Authorities. The current Director of Public Health at Northamptonshire Health Authority is particularly keen to see this happen.

What will the project need from you as a practice?

This project is mainly using one-to-one interviews for information gathering. I am looking to interview at least one individual, if possible, from a range of disciplines. The interviews will be approximately 30 to 45 minutes long.

Any other information, such as practice leaflets, or practice profiles, where available, would also be useful, as would an opportunity to sit in on practice meetings, or observe practitioners in practice.

My promises to you:

- I will adhere to strict ethical guidelines (guaranteeing complete anonymity).
- I will keep participants informed.
- I will respect the pressure of work that primary care practitioners are already under, and will aim *not* to add to their burden, outside the time required for interviews.

APPENDIX F

THE PUBLIC HEALTH ACTIVITIES OF PRIMARY CARE PRACTITIONERS

CONSENT FORM

Researcher's Details:

Erica Wirrmann
Research Student
Oxford Brookes University
Timber Annex, Headington Hill Hall
Headington Hill
Oxford
OX3 0BP

01865 484 942
ejwirrmann@brookes.ac.uk

		Please Initial Box
1.	I confirm that I have read and understand the information sheet for the above study and have had the opportunity to ask questions.	☐
2.	I understand that my participation is voluntary and that I am free to withdraw at any time, without giving reason.	☐
3.	I agree to take part in the above study.	☐
4.	I agree to the interview / discussion group being audio recorded	☐

_____	_____	_____
Name of Participant	Date	Signature
_____	_____	_____
Name of Researcher	Date	Signature

APPENDIX G

Participant practitioners – Characteristics of final sample

Total number of practitioners met: 55.

Total number of interviews (including group discussions): 41
(NB: 4 of these were brief chats with individual practitioners lasting only about 15 minutes but they are included since they yielded surprisingly rich data.)

Average length of interview (excluding brief chats): 53 minutes
(shortest = 20; longest = 160).

Breakdown by area:

North PCT: 18 (+10 in group discussion)
PCG 1: 5
PCG 2: 4
PCG 3: 4
PCG 4: 5
Centre PCT: 11
South PCT: 16

Breakdown by discipline:

Practice Nurses: 13
District Nurses: 11
Health Visitors: 11 (+ 10 in group discussion)
GPs: 5
Practice Managers: 5

Breakdown by full or part time workers:

Full time: 33
Part time: 8
Unknown: 14

Breakdown by years spent practicing:

0-5 years: 13
6-10 years: 8
11-15 years: 10
16-20 years: 8
21-25 years: 2
Unknown: 14

APPENDIX H

Practice information map

ID	PCT	Size*	Rurality	Information
5	North	Small	Urban	Patient information booklet; Observation notes; Interviews: HV and GP (brief chat).
11	North	Large	Urban	Patient information booklet; Observation notes; Interviews: HV, PN and DN.
15	South	Small	Semi-urban	Patient information booklet; Observation notes; Interviews: 2 HVs (joint), PN, DN, GP and PM.
16	South	Medium	Semi-urban	Attendance at PHCT meeting; Interviews: HV and PN.
17	South	Medium	Rural	Observation notes; Interviews: HV, PN, DN, GP and PM.
19	South	Small	Rural	Interview: HV.
21	South	Large	Rural	Interviews: 2 DNs (separate interviews).
28	North	Medium	Rural	Patient information booklet; staff employment handbook; Observation notes; Interviews: PN, DN (brief chat) and PM.
36	North	Medium	Semi-urban	Patient information booklet; Interviews: PNa, PNb (brief chat), DN and HV (brief chat).
38	North	Small	Rural	Observation notes; Interview: PN.
58	Centre	Small	Urban	Interview: HV
64	Centre	Medium	Urban	Attendance at PHCT meeting; Observation notes; Patient information booklet; practice business development plan; Interviews: PN, GP and PM.
68	Centre	Large	Urban	Attendance at PHCT meeting; Observation notes; Interviews: GP, PM, 3 PNs (joint), 2 DNs (joint).
72	North	Large	Semi-urban	Observation notes; Interview: HV
75	North	Large	Semi-urban	Observation notes; Interviews: HV, PN and 2 DNs (joint).
N/A	North	N/A	N/A	Group discussion held with 10 HVs from a number of different practices within North PCT.

*Practice size: Small = 1-3 GP partners; Medium = 4-6 GPs; Large = 7 or more GPs.

APPENDIX I

Sources and tools for literature searching

The list below summarises these main literature sources. Other, more serendipitous sources are not included.

Databases:

ASSIA: Applied Social Sciences Index and Abstracts
http://www.brookes.ac.uk/services/library/
Caredata (electronic Library for Social Care)
http://195.195.162.66/elsc/caredata/caredatasearch.htm
Medline http://www.ncbi.nlm.nih.gov:80/entrez/query.fcgi
ProQuest Medical Library http://global.umi.com/pqdweb?RQT=306&TS=1054652695
RCN Journals database http://arc.ucl.ac.uk:8590/: British Nursing Index, CINAHL, SIGLE (System for Information on Grey Literature in Europe)
Web Of Science (social sciences citation index) http://wos.mimas.ac.uk/

Journals:

British Journal of General Practice (by hand)
Community Practitioner Journal (by hand)
Public Health Reports (e-alerts)
Critical Public Health (e-alerts)
Public Health Nursing (e-alerts)
Health and Social Care in the Community (e-alerts)
Journal of Epidemiology and Community Health (e-alerts)
Journal of Interprofessional Care (e-alerts)
Sociology of Health and Illness (e-alerts)
British Medical Journal (e-alerts)
Health Policy and Planning (e-alerts)

Policy searching

BOPCAS: British Official Publications Current Awareness Service
http://www.bopcas.com/members/
Info for local http://www.info4local.gov.uk
Department of Health http://www.doh.gov.uk/index.htm
Social Exclusion Unit (ODPM) http://www.socialexclusionunit.gov.uk/
Teenage Pregnancy Unit http://www.teenagepregnancyunit.gov.uk/
British Medical Association http://www.bma.org.uk/ap.nsf/Content/__Home_Public
Royal College of General Practitioners http://www.rcgp.org.uk/
Practice Nurse Association http://www.practicenurse.org.uk/
The Queen's Nursing Institute http://www.qni.org.uk/public/loggedin/
Nursing and Midwifery Council (formally UKCC)
http://www.nmc-uk.org/cms/content/home/
General Medical Council http://www.gmc-uk.org/
Institute of General Practice http://info.exeter.ac.uk/sshs/igphome.htm
NHS Alliance http://www.nhsalliance.org/
National Association of Primary Care http://www.primarycare.co.uk/flash/index.htm
National Primary Care Research and Development Centre
http://www.npcrdc.man.ac.uk/
National Primary and Care Trust Development Programme
http://www.natpact.nhs.uk/

APPENDIX I

E-mail Discussion Groups

Politics of Health Group
Public Health
Public Health Intelligence
Health Equity Network
Health Promotion
HInet (Healthy Living Network)

APPENDIX J

Keywords for literature searching

	Key words	*Limits*
People	Primary Care Practitioner Community Nurse Practice Nurse Nurse Practitioner District Nurse Health Visitor General Practitioner / GP Practice Manager Public Health Nurse	1997+ English Language
Organisations	Primary Care Primary Health Care General Practice Local Government	1997+ English Language UK
Issues	Public health Population health Community health Health improvement Health inequality Health promotion Partnership Collaboration Team work Community involvement	1997+ English Language UK

APPENDIX K

Example of Literature Search Log

Source	Search terms	Limits	Hits (relevant hits)	Date	Notes
CINAHL	Public health AND district nurs*	97-03 English	22 (5)	01/06/03	Search also 'community health nurs*'

Liam Donaldson

Chief Medical Officer

Ten Tips For Better Health

1 Don't smoke. If you can, stop. If you can't, cut down.

2 Follow a balanced diet with plenty of fruit and vegetables.

3 Keep physically active.

4 Manage stress by, for example, talking things through and making time to relax.

5 If you drink alcohol, do so in moderation.

6 Cover up in the sun, and protect children from sunburn.

7 Practise safer sex.

8 Take up cancer screening opportunities.

9 Be safe on the roads: follow the Highway Code.

10 Learn the First Aid ABC - airways, breathing, circulation.

APPENDIX M

Participant Practice Information

(Small = 1-3 GP partners; Medium = 4-6 GPs; Large = 7 or more GPs)

Practice identity number and comments	
5	**Small, urban practice, North PCT (PCG 1).** Single-handed PMS practice. Small, generally sparse waiting room with front desk forming the barrier between it and the corridor, off which several consulting rooms were based. Waiting room contained a magazine rack (general women's and activities magazines) and a notice board which displayed private consultation price lists (e.g. for travel vaccinations, etc) and details of contraception available. General feeling in surgery was a little hostile - receptionist unhelpful to me and abrupt to patients on phone. Seemingly poor communication and unfriendly atmosphere amongst the staff at the practice. It is a small practice, so passing in corridors is likely, but communication did not appear to be very friendly. GP spoke in very raised voice, and authoritative tones to PM. PM and PN shrugged and rolled their eyes when they heard his voice in the background. The practice was facing difficulties at the time of the research, to which the HV only alluded. It subsequently became known publicly that the GP had lost his licence to practice in 2002. Difficult working relationships with this GP had meant that the practice team was undeveloped, it had acquired a bad reputation locally, and staff were unhappy.
11	**Large, urban practice, North PCT (PCG 1).** PMS practice which seems known locally for its high levels of involvement in new and innovative developments. The PN describes it as a "fast-forward moving practice"; they "do lots of training and are always taking on new things". Large, purpose-built, new (5 years) building, with GP rooms, and other clinic rooms all radiating from the central front desk. These include space for complementary therapists including aromatherapy, hypnotherapy, osteopathy, etc (all of which can be used by patients not registered). Also has an in-house pharmacy. Rooms upstairs (with plenty of computer terminals) for admin and general use, and for meetings. Separate rooms for HVs and DNs, each with computers. Room for receptionists and secretaries has head-set phone answerers so that the receptionist on front desk does not have to answer phones. Receptionists take it in turns to do these shifts. The practice has a very formal feel. Waiting rooms are quite sparse and clinical with short rows of plastic seating in various different places, with an emphasis on organisation rather than on patient comfort. There are notice boards in various places, which are fairly sparse and well organised, and display general information about the practice - what is available, what to expect, how not to waste staff time, etc. There are also special boards on info for carers, for mothers, etc. The PN mentioned that although it is a good and "very forward thinking" practice, it is "very money oriented". She comments that "There's lots of enthusiasm, but I've yet to see anything followed through in this practice, unless they get some money out of it". The practice employs health care assistants as well as PNs. It is a training practice which used to be fundholding. They have team meetings once a month, although not all practitioners attend (DN says she never attends).
15	**Small, semi-urban practice, South PCT.** PMS practice, ex-fundholding, which has a closed list, and is extremely under-staffed and lacking in space. Practice occupies space in a large building, shared with community services, within hospital site. There is a large reception area, with two different main front desks - one for the practice and one for community services. The practice front desk also has a smaller desk for new patient registration. Clinical space is very cut off from patient space, and is rather a maze. The treatment room and nurses are very separated, geographically, from GPs, and the receptionists and admin workers occupy several different spaces within the surgery. There is clearly not enough space - lacking in rooms for clinics etc. HV, MW and DN have consulting rooms close to PNs. The PM points out that there is poor communication amongst the team, but a particularly bad relationship between PNs and GPs. According to the PM, "The GPs

Practice identity number and comments	
	just tolerate the nurses". They "don't have a good relationship. They are polite and nice to each other, but they don't work together as a team". For this reason, they don't attend practice meetings, despite being invited. She comments that "There's no real reason for the animosity - it's just that every one is overworked, and so defensive and vulnerable. They don't think anyone works harder than they do". Despite this, the DN says that they work well as a team – "better than some places I've been in ... when it's a case of them and us still". The practice also employs a triage nurse.
16	**Medium, semi-urban practice, South PCT.** The practice is about half way between two major towns, being about 20 minutes from each. The community nurses are not based in this practice, but are in a health centre on the other side of the road. This causes problems with communication and general interaction amongst the team. They come together for team meetings in the health centre, although GPs often don't go. The HV is upset about lack of communication between medical centre and health centre and says that she does not feel part of a primary care team. PN says: "we tend to have books now that we leave messages in - it's not so personal. Sometimes you don't even know the staff, if there's staff changes. Another member of staff comes along and you just don't get to know them in the same way". The practice employs treatment room nurses as well as practice nurses who provide a 'minor casualty' service.
17	**Medium, rural practice, South PCT.** Physically small, village practice, GMS, ex-fundholders, training practice. Very small waiting room area downstairs, with notice boards, quite close to practitioners' general office/workspace. Another waiting room upstairs, close to practitioners' consulting rooms. Set out more like a children's play area - seats around edge with games, etc in middle. Informal and relaxed. Large display board with info on child safety/accident prevention, and other more general community notices. Practice has informal, friendly atmosphere, with quite a 'family' feel. There is lots of general 'milling about' space where practitioners chat to each other. Small kitchen upstairs, with large common room - very relaxed; also used for holding groups (e.g. ante-natal). General office space downstairs - informal, and place to chat. PM indicated that on Fridays they tend to have lunch together, with sandwiches provided by the practice. The HV comments that "there's a lot of partnership among the team. I mean certainly, I mean this practice here is the best practice I've worked at. From the point of view of communicating with each other." Senior GP partner is well known locally for being involved in lots of things in the community. They do not have a practice profile.
19	**Small, rural practice, South PCT.** Community nurses are not attached to this practice but are in a nearby health centre. No visit was made to the practice. Interview was carried out with HV in a different setting. She feels that teamwork at the practice/health centre "could be a lot better". She says that they have "no meetings with the GPs whatsoever. There's no primary health care team meetings. They have their own meetings". She adds: "if I want to speak to a GP, I have to seek them out and catch them at the right time. Some of the GPs if they haven't got time can actually be quite dismissive. So if they're in one of those sorts of moods I actually make an appointment to see them".
21	**Large, rural practice, South PCT.** Brief visit made to the practice. Two interviews carried out with 2 DNs. 3 surgeries, fairly dispersed across rural area (about 7 miles between each). 1 is within a different county, although it is still in the same PCT. This sometimes causes problems with ordering equipment, etc. The geographical distance also makes communication difficult. DN21a says that not much effort has been put into teamwork. They have had "only one practice meeting in the last year here", although she adds that the monthly meetings are just starting up again now (around the 'Protected Learning Time'). DN21b also feels that communication could be improved within the team, although she says she can leave the GPs written messages, or messages on their computer. Although the HV has a base in the same room as the DNs, there is no

Practice identity number and comments	
	sense of teamwork: "The health visitor is in the same room as us, but her work is so different it doesn't even seem to cross over, not at all, no. And she would say the same. I mean, I think her work load is so heavy with the younger age group, the babies and things, that it just seems a world away from ours, really. That's no fault from either of us, really". The DNs have a great deal of autonomy and 'run their own ship' (DN21b).
28	**Medium, rural practice, North PCT (PCG 2).** Physically small PMS practice, split into two surgeries within a mile or so of each other. Main surgery undergoing extensive building work, so quite disrupted. Consists of a main corridor with consulting rooms off it either side. It is a hectic surgery, very small, with lots of people on top of each other and squeezing past each other in the corridor. It has a friendly, relaxed, and informal feel, with much 'banter' between the staff. The staff seem hurried and are obviously struggling with an overwhelming work load, but there is a good atmosphere between them. PM appears to be quite a strong 'paternal'/organising figure. The practice offers a large range of clinics, including CHD prevention, well woman, well man, and health promotion. PM describes it as a "progressive" practice – he says that they like to get in on new initiatives early in order to "get a head start". Practice has monthly PHCT meetings. The DN and PN both say that communication and team work is good, although the DN feels that "more discussion would be good. Whilst I know that things are happening, for instance the move to PMS, I have not been involved as much as I would like in the discussions of why they are doing things. I feel that there are not enough meetings, that they are not a priority".
36	**Medium, semi-urban- practice, North PCT (PCG 3).** Purpose-built, modern airy building. Large nursing team, with triage nurse and treatment room sisters. Communication is good according to the DN, though the PN feels that it is "a real problem". She explains that it is very difficult ever to catch the GP in to perform simple tasks such as signing prescriptions. She says the doctors are "fine", but it is "actually just managing to get hold of them" that is the problem. The practice have only just started having a team meeting (around the PLT), but the PN says they are sporadic (only two in the last few months) and only last an hour.
38	**Small, rural practice, North PCT (PCG 3).** New and smart purpose built practice (4 years old). Entrance onto large waiting room, with big main reception desk to side, and smaller nurse reception desk opposite. Small dispensary in waiting area. Corridor runs off the waiting room which leads into the clinical area - consulting rooms, etc. Another door, off the 'clinical corridor', and close to reception leads into the administrative hub, with files, desks, and 'glass box' office at end for PM. Patients are called by a visual display board, showing their name and the room they are called to, which bleeps when a new name goes up. There is little informal interaction, therefore, between the staff and those waiting in the waiting room. Friendly atmosphere, although on an impersonal level. PN picks up on this in interview and says that whilst the building is "brilliant", it's a shame that the staff are so disconnected from the patients. She says that "now the treatment area is all as a suite, sort of thing, and the patients are in a different area, and the reception is a different area, and all the consulting rooms are in one specific area, you don't have that physical contact with patients, just to say hi, or smile at them. Which I miss. ... you're missing out on that personal contact with a group of people because [in the previous system], while you were calling somebody, you'd see somebody else there, and you could see how they were, and you could say good morning." A couple of small notice boards in the waiting room area display various notices of local clubs and services and the details of the practice's contraception services. PN says that there is good rapport between the practice staff and the community staff, and that the practice team work hard at maintaining good communication.
58	**Small, urban practice, Centre PCT.** Only a very brief visit made to the surgery. One interview was carried out with a health visitor in her office. Interview carried out with HV, who feels that the team works well together.

APPENDIX M

Practice identity number and comments	
64	**Medium, urban practice, Centre PCT.** PMS, ex-fundholding practice in town centre. Has been around for over 100 years, but has grown substantially. Has in-practice pharmacy and a lot of extra space for meetings, events, coffee, etc. Has an integrated nursing team. The practice team seem to get on very well. I attended a PHCT meeting which was focused on organisational learning and improvement issues. The team meet frequently for 'chats', over coffee and lunch, etc. The GP feels that the team works well together. He explains "It's all about values ... This practice really does have shared values. It's a family practice and we all work well together because we are all working towards the same thing". The practice is situated on the boundary of 2 of the 3 most deprived wards of the town and within walking distance from all 3 most deprived wards. Due to them keeping their list open until recently, the practice has a greater number of asylum seekers, refugees, substance users and travellers registered than other (non-specialist) practices in the town. The practice have a particular interest in mental health. After research they developed the role of PC mental health nurse, which they have now mainstreamed, and which they disseminate to other practices. The senior GP (who retired in 2002) had many outside interests, particularly in the PCT.
68	**Large, urban practice, Centre PCT.** A large, new and spacious practice. Reception area quite sparse, and very segregated from the rest of the practice. There is not much in the way of information boards, leaflets, etc. Practice well equipped with meeting space, and physical layout facilitates meeting in corridors or over coffee. Large relaxed staff room and coffee room downstairs. Friendly practice – there is an ease of communication between staff. I attended a PHCT meeting, in which all practitioners discussed practice issues. One DN said that they meet with the GPs every morning for a chat over coffee. DN68a feels that they work 'fairly well' as a team, although she suggests that they could "work better with the health visitors than we do". The practice presents quite a 'business like' atmosphere, with a receptionist uniform, very smart building/facilities, and patients shielded from the rest of the practice by a large front desk, a door, and sets of stairs and corridors. The practice is not PMS but is considering it for the next round. They have in-house counsellors, and a benefits advice worker for 1 day a week.
72	**Large, semi-urban practice, North PCT (PCG 4)** One brief visit made for HV interview. Not an overly friendly atmosphere within the practice, despite its location in the centre of a community estate. It has a bizarre reception system where the patients are given a plastic number by the receptionist. They then sit down in rows facing the reception desk, and flashing lights and a buzzer above them say what number is being called. This system doesn't seem to work very well and causes some confusion for patients. It also feels rather anonymous and 'unhelpful'. The doctors' consulting rooms are all behind the reception desk in a separate part of the building, so quite separated off from the patient waiting area. There is also a nurse treatment area at the other side of the waiting room. There is a big notice board on what services the nurses offer. Another notice board displays information on giving up smoking with a couple of community organisation and group session leaflets. The HVs work to a corporate case load which has helped them to be more flexible in their roles. They keep an up to date practice profile.
75	**Large, semi-urban practice, North PCT (PCG 4).** Fairly new building in the centre of town. Lots of rooms for practitioners, including physiotherapists, etc. General notice boards contain information on lots of self-help groups. Formal feel, with a feeling of remoteness from the patients/public. The HVs have a shared office. The PN describes the practice as "very proactive as far as us doing lots of things", and "very good as far as education and whatever, study days and things". She also feels that they work well as a team, and is able to propose her own changes and developments to the practice.