



Primary Care in the Twenty-first Century

Realising the promise of rapid service access and well-coordinated person centred health and social care at every stage of life

Summary

- The NHS remains one of the world's better health care systems. But the proportion of the UK's GDP allocated to health and social care is only about three quarters of that now spent by leading European nations. To meet changing needs health and social care providers in England must improve their capacity to offer convenient access to preventive and 'common need' diagnostic and treatment services to people of all ages, and also to provide well-coordinated social and health care to individuals at high risk of suffering avoidable episodes of serious illness and needlessly losing their independence.
- If personal and public health is to be raised to the highest possible level improving primary health and health related social care – which together represent little more than a fifth of combined NHS and local authority social service outlays – is vital. Health care will in future move more towards professionally facilitated prevention and primary care supported self-care in the community, backed by the relatively infrequent use of highly specialised services supplied in hospitals.
- The unique attributes of British general medical practice will allow it to serve as a central plank for continuing service development. The formation of local Health Federations and related primary care focused organisations could in future lend itself to holding single budgets for health and related social care along the lines proposed by advocates of the Primary Care Home approach to service improvement. This would offer significant gains for service users. Wherever cost effective, services ought to be 'made' by local care providers. Where necessary they should be purchased from other sources.
- There is a large body of evidence indicating that Community Pharmacy can play an extended part in delivering accessible health care, alongside roles like reducing prescription errors and facilitating better medicines use. Increasing the number of clinical pharmacists working in GP practices is a valuable step. But it cannot substitute for a clear vision for the future of community pharmacies as 'first contact' health care providers.
- If community pharmacists successfully extend their clinical care roles this would free general practice and linked community capacity to work towards reducing inappropriate hospital admissions and unduly long inpatient stays. Without well planned, pro-active, interventions pharmacy skills will be under-used and the established community pharmacy network lost. Yet if each community pharmacy in England were able to take on just 10 per cent of the average general practice's existing workload over the next five years, this will release approaching 5,000 GPs and similar volumes of practice staff for additional service provision.
- Responsibility for achieving more effective primary care working arrangements lies mainly with GPs, nurses, social workers and pharmacists themselves, because only they are in a position to adequately understand the tasks with which they are engaged and the detailed needs of the people they serve. However, individual professionals alone cannot transform the NHS. Excellent national leadership and appropriate funding and governance systems are also vital for nation-wide success.
- Nine out of 10 people in England currently live within a 20 minute walk of a community pharmacy. Some planners may wish to see savings made via concentrating dispensing in warehouse-like facilities and increasing the use of medicines home delivery services. Yet at a system-wide level a potentially more desirable way forward could be to extend pharmacist prescribing and improve shared health record systems. This would combine convenient local medicines supply with more accessible forms of 'pharmacist first' care in areas ranging from managing blood pressure to providing better chronic obstructive pulmonary disease (COPD) and type 2 diabetes prevention and care.
- The health and social care system in England has been affected by imbalances that are linked to the fact that social care is means tested while NHS care is free. This has created perverse incentives that may in the past have undermined services such as community nursing. Inadequate high level leadership also impairs service quality. But if health gain focused co-operative professional enterprise can be combined with well-informed decision making and robust national and local resource allocation strategies that effectively support the delivery of well-coordinated primary care, further improvements in individual and population health will be achieved.

Introduction

Sophisticated hospital care can be life-saving, or play an important part in preventing and alleviating disabilities and restoring normal daily activities. Even after hopes of cure have faded, hospital treatments extend survival and relieve acute distress. When people refer to Britain's National Health Service as being one of the world's best health care systems it is frequently because of its capacity to offer access to hospital care – the provision of which is conventionally estimated to account for around two thirds of all UK health service spending – without individuals having to worry about its immediate affordability for them and their families.

The continuing ability of the NHS in England and the other UK countries to provide 'cutting edge' acute and elective hospital care to people in exceptional medical need will remain essential if it is to go on being trusted. However, for public health to be raised to the highest standards possible, and for people living with long-term conditions and established disabilities to be able to maximise their wellbeing, excellence in the delivery of 'high technology medicine' in institutional settings alone is not enough. It must be accompanied by the robust provision of primary health care (including – as primary care is defined here – community nursing and pharmacy, and also community mental health care) together with social services that offer high quality support for daily living and, when it is needed, access to residential care.

Total NHS spending on 'family practitioner services' (including all community medicines costs, and public spending on general dental and ophthalmic services) today accounts for only a fifth of total health service outlays. Yet the work of GPs, community pharmacists and other primary care professionals is central to the cost effective provision of health care as a whole. In well-functioning systems, primary care provided by not only GPs but also health professionals like nurses and pharmacists provides 'first contact' support across populations that is when it is required to be person-centred, continuous (that is, is based on relationships that endure over time) comprehensive and well-coordinated – see Box 1.

Primary care services should also be convenient and pleasant to use as measured by the standards of the communities in which they are provided, and able to respond quickly and reliably at the interface between self-care and professionally delivered interventions. There is robust evidence that a good relationship with a freely chosen primary care doctor, preferably sustained over years, is associated with better health outcomes than would otherwise be possible (Starfield et al, 2005). NHS general practice has been described as '*the soul of a community orientated health-preserving system*' (Berwick, 2008).

Effective primary care complements and reinforces the impacts of 'impersonal' public health programmes aimed at creating protective environments and stimulating beneficial behavioural changes across entire populations. It also enables specialised disease-centred interventions to take place in timely and optimally productive ways. Without good primary care, hospitals are inevitably burdened by avoidable or unduly late admissions and by inappropriately delayed discharges.

As Figure 1 outlines, the activities of GPs, community pharmacists and allied service providers range from primary prevention (disease avoidance via measures ranging from immunisation to smoking cessation) and responding to trauma and acute symptoms through to providing diagnoses and referrals to specialists. Primary care practitioners also provide secondary prevention (early stage disease treatment) and support for people with long term conditions, and can be central to late stage illness and end-of-life care.

The needs of children and young adults are normally very different from those of people in their eighties and above. Even within age groups individuals' requirements vary widely. Yet primary care as a whole should be inclusive and offer a set of familiar 'front doors' to health and allied care to all members of the community.

Figure 2 is indicative of the changing nature of health and social care and the potential for community pharmacy to – in constructive partnership with General Practice – play an increased part in meeting modern service needs. Demand for enhanced primary care will continue to expand as new health technologies present fresh opportunities for prevention and treatment outside hospitals and GP's surgeries, and increased levels of education and access to information change public and professional understandings of health and illness and generate new service expectations. Twenty first century health care will almost certainly move further in the direction of professionally facilitated preventive self-care in the community, backed by the relatively infrequent use of highly specialised services in hospitals.

General Medical Practitioners have always been central to NHS primary care. For many people their General Practice (and, within it, their GP) is, especially after they have had children or have entered the later stages of their lives, their natural 'Primary Care Home' (Colin-Thomé, 2011). At best, primary care provides places in which individuals are known, and to which they choose to go when seeking to cope with health related challenges because they trust that they will receive good guidance and support. There is evidence that competent general medical practitioners manage risks and identify self-limiting conditions that do not need further investigation with a relatively high degree of reliability, as compared to colleagues with more narrowly focused medical expertise.

Box 1. Good Primary Care

The development of consistent, person focused and technically robust primary care services aimed at both the delivery of excellent individual support and public health improvement has for many decades been recognised as central to the pursuit of 'health for all'. In 1978, for example, the Alma Ata declaration called on all governments to invest in improving primary care as the cornerstone of effective health services development. More recently the current Director-General of the WHO noted that international evidence overwhelmingly demonstrates that health systems oriented towards primary health care produce better outcomes, at lower costs and with higher user satisfaction, than more hospital centric systems.

The available literature (see, for instance, Chambers and Colin-Thomé, 2008) identifies the hall-marks of good primary care as including:

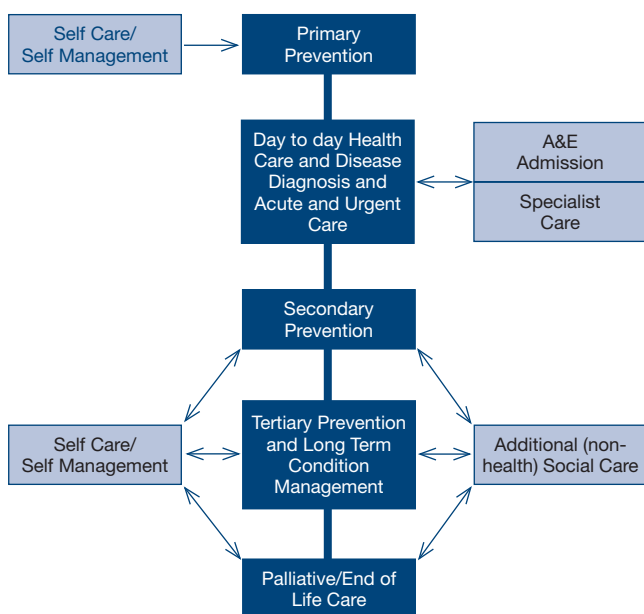
- comprehensive first point of contact care that is conveniently accessible for all members of a community, and which covers all common health needs;
- continuous person and family focussed care, consistent with individual requirements for privacy and choice;
- the effective and systematic management of chronic/long term diseases;

- referral to and the coordination of outpatient and inpatient specialist care as and when appropriate; and
- care for the health of entire populations as well as that of each person within them.

In countries like the UK today high quality primary provision also involves medical and pharmaceutical care in residential homes, and the capacity to offer tailored support to ethnic minorities. However, although the centrality of good primary and associated community care and preventive services is widely acknowledged, there are often pressures that can serve to draw funds away from such areas into higher cost secondary and tertiary care centres.

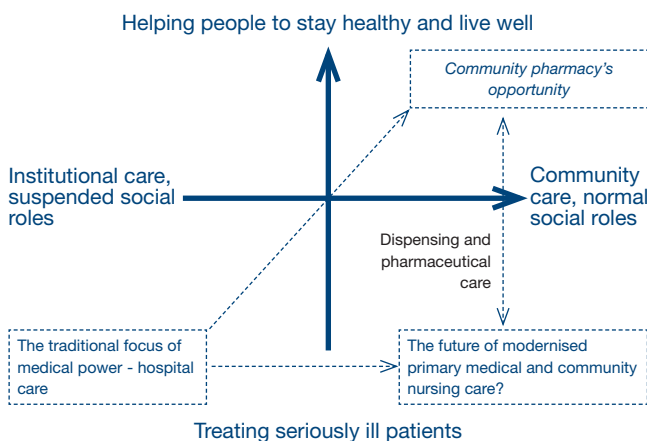
Further, even though research indicates that most NHS primary medical care is of good standard there are nevertheless reasons to believe that further progress could be made in areas ranging from prescribing and helping patients take medicines to best effect through to improving early stage disease diagnosis and the better coordination of home support. Better joint working between health professionals who are either co-located or working in good communication across different sites can contribute to such goals, providing all those involved are adequately motivated to improve overall health and social care outcomes.

Figure 1: Primary Health and Social Care



Source: the authors

Figure 2: The Direction of Health Care Development



Source: the authors

Note: Population ageing and allied factors will increasingly focus the work of primary care doctors and nurses on supporting people with serious and complex health problems who are living as normally as possible, whether or not they are in receipt of residential care.

Community pharmacy has an opportunity to support this transition and to extend its role to include self care support, risk factor management and first contact health care provision for common conditions.

As well as providing diagnoses and care directly, a central role for general medical practice as a specialism is to efficiently manage risk and route individuals requiring interventions that cannot be made in the practice setting to other appropriate providers (Forrest et al 2006; Foot et al, 2010). However, General Practice is not always as highly valued as its proponents believe it ought to be.¹ Sociologically, this may in part be because GPs can be seen as bridging the gap between 'scientific medicine' and less technical, more personal, forms of care and support.

But even if it is true that GPs by virtue of their roles have stronger insight into the psycho-social needs of health service users than many hospital based professionals and also that the quality of most of their care is good (Goodwin et al, 2011), there is long-standing evidence of difficulties and discontinuities in NHS primary and linked Local Authority social care provision in relation to both physical and mental health. There is much to commend NHS general medical practice. Yet overall

1 Famously, in 1958 Lord Moran, then the President of the Royal College of Physicians, observed that there was a career ladder in medicine, and that it was one 'off which they [General Practitioners] fell'. Despite the progress of the last half century such negative attitudes can still be found today, not least amongst the memberships of some hospital Trust Boards. Similar divides exist in professions like pharmacy.

standards of community care often fall short of the ideal, in part because of coordination problems. There are now opportunities to correct such failings.

Questions about primary care fitness for purpose are not new. They date back to the 1950s and before – see, for example, the 1920 'Dawson Report' and Collings, 1950. Box 2 highlights some of the findings of these analyses. Reforms such as those introduced via the 1966 'Doctors' Charter' (which restricted the size of individual GP 'lists' and encouraged increased practice staffing and larger GP partnerships – at that time a majority of British GPs still worked alone or in two handed partnerships) and later measures like the establishment of the NHS internal market sought to strengthen the NHS through enhancing primary care and its capacity to play a central role in delivering services or guiding their improvement. So too did the more recent creation (in England) of Clinical Commissioning Groups (CCGs) and NHS England.

Yet the extent to which such measures have been successful in achieving their declared ends is – to date, at least – at best questionable. As with the polyclinics advocated during the last Labour administration (Darzi, 2008), suggested forms of progress have often sought to generate efficiencies via the formation of bigger primary care organisations and through service 'integration' in the sense of co-locating GPs with not only wider

Box 2. From Dawson to Collings

Following the end of the first world war the then Liberal politician Christopher Addison (a doctor who subsequently became Leader of the House of Lords during the 1945-51 Attlee administration) sought to transform the then Local Government Board into a new Ministry of Health. He became the first Minister of Health in 1919.

Because of 'austerity' linked concerns about health spending Addison lost this position within two years, but not before he had commissioned a radical report by the Royal physician and war hero Sir Bertrand Dawson (who became Lord Dawson) on the future provision of medical and allied services. An interim document, which became known as the Dawson report, was published in 1920 (Dawson, 1920). This strongly advocated the formation of an integrated primary and secondary health centre based system. Although no further action was instituted at the time, this pioneering analysis subsequently underpinned arguments in favour of the formation of a systematically structured national health service.

However, when in part due to the continuing efforts of individuals such as Addison the NHS was eventually established in 1948 it pragmatically combined arrangements that had independently evolved in the preceding half century. General medical practice and community pharmacy were (along with local authority

based service assets such as district nursing and public health expertise) important elements within the original NHS. But they were not joined together in a well-coordinated manner, and their quality was at best 'patchy'.

The latter fact was highlighted in 1950 by a survey published in the *Lancet* by an Australian doctor and qualitative ethnographic researcher called Joseph Collings (Collings, 1950). He had been commissioned by the Nuffield Trust to assess the state of general medical practice in the NHS.

In fact his work was never fully published. Yet what did become available revealed many reasons for concern about the then isolated and poorly supported situation of GPs. Collings judged general medical practice to be an anachronism which needed rapid and comprehensive change. This view was initially rejected (Wilkie, 2014). However, starting with the formation of the then College of General Practice in 1952 and the BMA published 1954 Hadfield report *Good General Practice*, it in time opened the way to fundamental reform via an adaptive incremental process which in contexts like the interfaces between community pharmacy, general practice and community nursing has continued through to the present.

multi-disciplinary health and social care teams but also specialist physicians. The pursuit of performance gains via the more assertive managerial planning and direction of professional work has typically been implicit in this sort of approach.

There have also been multiple efforts to further develop community pharmacy and nursing services in England, Scotland and the other UK nations. (See, for instance, Clukas, 1986; DHSS, 1986; DoH, 2000; Scottish Executive, 2002; Smith et al, 2013, 2014.) But the degree to which such initiatives have in reality enabled NHS primary and LA social care providers to work together in less fragmented, more efficient, ways and adapt pro-actively to the changing requirements of the people they serve is again questionable. Inadequately coordinated approaches represent a significant barrier to improving outcomes in areas such as providing high quality, affordable, services for older people with complex care and support needs (Humphries, 2015).

At worst, some NHS improvement attempts could be accused of being based on 'magic thinking', rather than carefully evaluated evidence and well-designed implementation strategies. Some of the professionals interviewed during the preparation of this report said that declining primary and community care resources relative to NHS total spending, coupled with rising patient demands, unwanted organisational disruptions, increasing bureaucracy and a shortage of young doctors willing to enter general practice, mean that today *'it has never been more difficult to be a GP.'* However, another very experienced doctor said *'I cannot remember a year when there was not low morale – its normal'*.

There is also evidence of pharmacist and community nursing discontent, albeit NHS services have to date been much better protected from 'austerity' than social care and other Local Authority services like – for instance – ongoing adult education for people with learning disabilities. Claims of there being a crisis in primary care, or in the NHS more widely, should therefore be viewed with some caution (Dayan et al, 2014). They are in part linked to conflicts about whether or not UK (public) health care funding should be strictly cash limited that date back at least to the start of the 1950s, and might even be linked to a national debate that began in the aftermath of World War 1.

Such disputes should arguably be regarded as normal in democratically led, politically controlled, environments. On some occasions funding and performance problems may be over-stated, and on others they have been misstated. The NHS has often been characterised by what appear to be scandal led changes or 'shock' reorganisations, rather than well directed incremental evolution.

However, even if the underlying health service situation is more robust than is sometimes suggested, there are from a patient perspective substantive primary care linked problems ranging from the time it can now take to get a GP appointment (especially with a doctor who has a personal relationship with the individual seeking attention) through to fears that the GP based approaches may, especially in contexts where there are strong demands for the avoidance of 'unnecessary' diagnostic testing costs, undesirably slow access to timely specialist advice. Poor quality primary care can also discourage health service users from pro-actively seeking to protect their health, and so add to long term costs and/or health loss.

Negative approaches to health care demand management may make people feel that they should not 'bother' health professionals with what are probably minor problems, but could in a minority of instances be early manifestations of serious disease. The consequences of such phenomena have included not only relatively low rates of early stage disease diagnosis in fields such as cancer care, but a more widespread neglect of 'trivial' health issues that can in some cases herald disability or life threatening events associated with, for example, underlying vascular disease.

There is some evidence of such failings in the working of other strongly GP centred health care systems, like that of Denmark (OECD, 2015). As noted above, there have in Britain also been problems relating to the co-ordinated provision of primary medical care with other forms of community health and social service support. Such phenomena link in part to the fact that Local Authority social and allied care provision was not made *'free at the point of demand'* in the way that access to NHS care was guaranteed after the end of World War II.

With the decline of infectious disease and the consequent rise of non-contagious disorders of later life the need for services that facilitate satisfactory independent living despite their users having to cope with multiple morbidities has risen. Compared with most if not all other health care systems the NHS has met this challenge well, within the boundaries of the resources made available by successive governments (WHO, 2015). But even so it is arguably the case that clinically and socially desirable progress could have been achieved faster.

The existence of the NHS could in some instances have hidden ongoing failings in service areas that lack the social standing of specialised medicine. The creation of a universal health service in 1940s Britain was intended to sweep away the heritage of the Victorian Poor Law. It has largely achieved this goal in fields like the supply of most medicines and basic access to doctors. Yet the record of the British system in supporting people with health and related problems associated with economic disadvantage and daily living difficulties does not

compare as well as might sometimes be hoped with that of EU countries like The Netherlands, France, Germany and Sweden. Such realities help to account for the relatively modest ranking of the UK on scales such as the European Health Consumer Index (EHCI, 2014), and may partially explain the persistence of reducible health inequalities despite the 'welfare State'.

Relationships and cultures that deliver better health

There is research showing that many people facing serious health challenges wish their GPs to be the primary co-ordinators of their treatment and support, and that most GPs wish to play this role well (Parsons et al, 2010). Yet in reality the ability of the existing NHS and social services system to deliver complex, multi-faceted care in the community and to handle transfers between different hospital and other service providers in timely, convenient and 'user friendly' ways is often limited.

GPs frequently report that they cannot always invest the time and other resources needed to coordinate the support required by vulnerable individuals. But many also seem unable or unwilling to pass this role on to colleagues such as community matrons or district nurses in a timely manner. Similar points apply in contexts like the management of vascular disease risks, and the extended part that professionals such as community pharmacists could play in this and allied fields.

Such observations ought not to obscure the realities of service under-funding, as and when they exist. Nevertheless, there is a case for saying that General Practitioners and Community Pharmacists could, together with the other professional groups providing primary health and social care, in future do more to help improve the quality of services by overcoming sectional concerns and strengthening commitments to 'integrating' care by working together more effectively. Regardless of structural issues or even financial incentives, appropriate ethical imperatives are essential for the delivery of adequately coordinated primary care in today's environment.

Some critics argue that GPs tend to over-emphasise the importance of services under their immediate control, and fail to support adequately the development of the primary care system as a whole. At the same time Community Pharmacists (CPs) can appear – at least to some observers – to be unduly concerned with processes of drug supply which may not be optimally cost effective from a public interest perspective, or always ideal from a consumer convenience viewpoint.

It may also be suggested that hospital oriented professionals and managers are on occasions inadequately informed about the role of primary care, and can fail to act in the best overall interests of the communities they serve because of an (albeit understandable) desire to defend 'their' institutions as free-standing entities in competition with other parts of the health service. Such phenomena might, for example, underpin opposition to forms of primary care led budget holding that their advocates believe would allow more flexible and better managed approaches to the delivery of NHS patient support across community and institutional boundaries.

Assuring the stability and sustainability of NHS hospital services is important. But it would be self-defeating if this were to be pursued in ways which undermine the capacity of the health service to offer the best possible care with the global financial, technical and human resources available, and make it needlessly difficult for desirable change to be achieved. Determining the 'right' number of hospital beds and the marginal costs and benefits of reducing inpatient care capacity or other forms of service at any one point in time is a complex and often uncertain task. But long term progress will probably require relative increases in the provision of the full range of community based facilities, alongside continuing adaptations in the configuration of specialist services.

'Pharmacy first'?

Against the above background, this report considers the development of primary care in the context of the NHS as a whole, and the changing health and social care related needs and abilities of the country's population. In the light of NHS England's *Five Year Forward View* (the FYFV – NHS England, 2014) and recent initiatives such as the National Association for Primary Care's support for the Primary Care Home concept (NAPC, 2015) and the joint NAPC/Royal Pharmaceutical Society consultation '*Improving patient care through better general practice and community pharmacy integration*' (NAPC and the RPS, 2015), it considers aspects of the relationships between GPs, community pharmacists, community nurses and other primary care providers. It also explores how further improvements in their collective performance might best be pursued.

Given factors such as emerging IT based opportunities for enhancing processes like providing information, diagnosing mental and physical illnesses and prescribing and dispensing medicines, this analysis in addition addresses questions relating to how independently located community pharmacy services can contribute further to the promotion of self-care and provision of better co-ordinated and more affordable primary care. Given financial pressures and the ongoing introduction

of ‘constructively disruptive’ health technologies (EXPH, 2015) and new consumer demands, continuing health sector change is inevitable. A fundamental challenge for professionals like GPs and community pharmacists relates to the extent to which they will be able to play a positive role in actively shaping new models of service governance and delivery.

One of the main findings of this report is that the existing community pharmacy network is a resource that could and arguably should be developed in ways that will allow it to go on supplying medicines in cost effective ways, while also offering ‘first contact’ access to clinical care in the community in a progressively more efficient manner. Failures to establish and implement a strong vision for Community Pharmacy alongside that for General Practice could threaten the NHS as a whole, and the interests of the public it serves.

Future progress will almost certainly challenge the traditional demarcation lines between medical, nursing and pharmacy practice and weaken the borders between prevention and treatment, as well as those between professional support and self-care. Other developments in the organisation, management and delivery of professional services will also be needed, including (probably if not certainly) increases in the scale and complexity of primary or integrated primary and secondary medical care organisations and their capacity to streamline service delivery.

However, as the work of economists such as Joseph Schumpeter (1942) and Ernst Schumacher (1973) has in the past highlighted, the relationship between organisational size and variables such as innovation and personal service quality and satisfaction is not straightforward. Inadequately considered changes can have perverse results. There are costs to, as well as efficiencies of, increased scale that should be balanced against the overall benefits provided for communities, individual service users and ‘hands on’ providers. At worst, creating larger organisations can serve sectional managerial ends, as distinct from public interests in better access to personally focused professional support.

From Medical Dominance to Managed Care?

The formation of the NHS in 1948 was partially inspired by the Soviet Union’s pioneering attempts after 1918 to establish, in very much harder circumstances than those facing Britain at any point in the twentieth century, a universal health care system. Yet the establishment of the NHS was not a ‘*nationalisation of the means of health care production*’ like that of the railways and other key utilities undertaken by the Atlee government during Britain’s late 1940s post-war recovery. Its most prominent immediate architect, William Beveridge, was a Liberal, and the concept of universal health care was strongly supported by Conservatives such as Winston Churchill and Henry Willinck, England’s wartime Health Minister. Aneurin Bevan, who as a subsequent Labour Minister rejected the Bismarkian social insurance model and favoured a tax funded National Health Service, described the creation of the health service as an example of the practical application of Christian values rather than as an achievement of secular socialism.

Voluntary, private and previously Local Authority run institutions were taken into public ownership in 1948 and combined to form a unified NHS hospital service. However, the Teaching Hospitals retained a special self-governing status, and the National Health Service as originally formed was a tripartite structure. It included practitioners such as GPs, community pharmacists, dentists and opticians who were independently contracted to the Minister of Health and who owned their premises, as well as the Local Authority controlled and funded district nursing, health visiting and public health services.

These community based resources were no less a part of the overall NHS system than the nationally owned hospitals, although the structure of the new service perpetuated the ‘gate keeping’ divide between primary and secondary care that had existed in British medicine from the last decades of the nineteenth century. In the Community Pharmacy sector the new health service adopted a mixed corporately and individually owned retail model that had also emerged in the late Victorian era.

In its initial decades the NHS was not strongly managed by individuals other than health professionals, amongst whom the medical profession was indisputably dominant. Further, its financial resources were in the main allocated on an incremental basis, rather than via either a competitive or a robustly supported ‘non-market’ process. Most of the reforms introduced in the last 60-70 years can be seen as attempts to better plan, manage and co-ordinate care provision offered by either the NHS alone, or by the NHS and Local Authorities in combination. The time line offered in Figure 3 highlights some of the major steps involved in the development

Figure 3. The Evolution of the NHS in England – an Outline Timeline

1942-46	Sir William Beveridge's report <i>Social Insurance and Allied Services</i> proposed the creation of the modern welfare State and the establishment of the NHS in 1942, although the concept of a National Health Service dates back to 1910. A White Paper was published by the wartime coalition government in 1944 and the NHS Act was passed in 1946, a year after Aneurin Bevan became Minister for Health.	1999	The short lived but relatively popular Primary Care Groups (PCGs) were set up
1948	The NHS is established with the opening of Park Hospital in Manchester	2000-02	The NHS Plan is published, with proposed hospital service improvements to be financed via the Private Finance Initiative. NHS funding growth is accelerated, and Primary Care Trusts replace PCGs with the intention of further developing the utility of the NHS purchaser provider divide. Secretary of State Alan Milburn announced plans to introduce Foundation Trusts in 2002, and potentially 'awkward' CHCs were abolished in 2003
1949	The Nurses Act sought to establish a new basis for nursing, and concerns about the affordability of the NHS were expressed.	2006-2009	<i>Our Health, Our Care, Our Say: a new direction for community services</i> seeks to promote the development of better coordinated primary health and social care. The RCGP first proposes the formation of GP Federations and Lord Darzi subsequently leads a review calling for greater service integration and increased clinician involvement in health care quality management
1950-56	JS Collings found that <i>'the overall state of general practice is bad and still deteriorating'</i> . A one shilling prescription charge was first levied in 1952, and initial attempts are made to promote the formation of group practices. In 1956 the Guillebaud Inquiry found that the NHS was affordable and that there was no evidence that its establishment had led to extravagant health care spending.	2010-12	The new coalition government publishes <i>Equity and Excellence – Liberating the NHS</i> which leads on to the 2012 Health and Social Care Act. This involves the abolition of PCTs and the formation of Clinical Commissioning Groups (CCGs) as well as a range of other innovations, including the establishment of NHS England and Public Health England
1962	Enoch Powell launches a plan involving the establishment of district general hospitals serving local populations of about 125,000 people	2013	Sir Robert Francis presents the final report of the Mid-Staffordshire NHS Foundation Trust Public Inquiry
1966	The 'Doctor's Charter' introduces new incentives for the development of better staffed GP practices	2014	The Five Year Forward View (FYFV) sets out NHS England's strategic approach to questions such as reducing health inequalities, improving care quality and meeting projected health and social care funding shortfalls. It highlights the potential role of new care providers such as multispecialty community providers (MCPs) and primary and acute care systems (PACs) perhaps run along lines parallel to those developed by US accountable care providers.
1974	The first major NHS reorganisation seeks to put in place a unitary structure involving 90 Health Authorities in England and 14 Regional Health Authorities. However, the Executive Councils that previously administered family practitioners services are replaced by Family Practitioner Committees that continued to function in relative isolation. Community Health Councils were created. They enjoyed a significant degree of critical autonomy. Functions such as district nursing and public health are removed from local government, but social service provision remains under LA control and is in health context subject to charges	2015	The National association for Primary Care publishes its 'Primary Care Home' proposals, and the NAPC and the Royal Pharmaceutical Society conduct a joint consultation on closer working between community pharmacies and general practices. NHS England announces support for the employment of more pharmacists in practices, but it becomes clear that the cap on private social care costs proposed by the Dilnot Commission in 2011 will not be implemented in the foreseeable future and that an increasing crisis in local authority funded social care provision is putting increasingly severe pressures on NHS Trust finances. The November 2015 Comprehensive Spending Review led to the announcement of increased freedoms for English local authorities to fund social care via raised Council taxes. An NHS budget increase of £4 billion was also announced, in line with NHS England requests.
1976	<i>Sharing Resources for Health in England</i> signals a new approach to NHS resource allocation		
1983	The Griffiths Report marked the introduction of general management in the NHS, although its impact on primary care development is relatively limited		
1986	<i>Neighbourhood Nursing: a Focus for Care</i> and the Nuffield report <i>Pharmacy</i> raise important questions about the future of community nursing and community pharmacy. However, progress towards more effectively coordinated service provision remains limited.		
1989-91	Following an intervention by Margaret Thatcher, the White Papers <i>Working for Patients</i> and <i>Caring for People</i> lead to the 1990 NHS and Community Care Act. The NHS internal market with GP Fundholding and more autonomous hospital Trusts at its centre was established in 1991.		
1997	Tony Blair's new labour government moves rapidly to end GP Fundholding and the White Paper <i>The New NHS: Modern, Dependable</i> promises a non-market approach based on collaboration rather than competition. It also opens the way to the establishment of NICE and what is today the CQC		

of primary care within the wider evolution of the health service in England.

The British Medical Association originally opposed the creation of the NHS, along with sections of the national press. Some doctors' representatives feared an undermining of medical authority and income. Yet following the establishment of the new health service doctors found themselves able to retain substantive control over their work, and hence to play a central role in directing the use of its publicly provided funds. At the same time the ability of specialist elites within medicine to, especially in London, accrue additional private income remained intact.

Even in the 1960s Health Ministers such as Enoch Powell could set policy at a strategic level in relation to matters such as the configuration of hospital care, yet had little impact on the conduct of day-to-day professional work. Hospital doctors were contracted to regional authorities rather than the institutions in which they worked. GPs were individually contracted to the Minister of Health, albeit their day-to-day accountabilities for service quality were in the main to their professional bodies and to a lesser extent to the Executive Councils that at that time administered their payments, along with those to community pharmacies, dentists and opticians.

This period has – particularly in relation to hospital care – been described as one of 'medical dominance', and as a 'golden age' for medicine (Burnham, 1982; McKinlay and Marceau, 2002). NHS patients no longer had direct 'power of purse' over those providing them with care, while non-clinician led health service management had yet to emerge in its modern form. Doctors decided, patients complied and tax payers paid. Notwithstanding funding system variations, much the same state of affairs existed in other countries at that time, including the US (Freidson, 1970a, 1970b).

However, this situation began to change in the UK with the first major NHS reorganisation in 1974 and the subsequent introduction during Margaret Thatcher's premiership of (following the 1983 'Griffiths Report') general management and the NHS 'internal market'. It was also at the start of the 1980s that the then Health Minister Dr Gerard Vaughan began questioning the prescription medicines supply rather than patient care focused role of NHS community pharmacists that emerged from the end of the 1940s.

Hospital pharmacy began to take a more pro-active clinical – or at least drug safety oriented – role in the wake of the Thalidomide tragedy at the start of the 1960s. But NHS Community Pharmacy had become increasingly centred on high volume prescription medicines supply. At the 1981 British Pharmaceutical Conference Vaughan commented '*one knew there was a future for hospital pharmacists, one knew there was a future for industrial*

pharmacists, but one was not sure that one knew the future for the general practice [community] pharmacist' (Anderson, 2007). This intervention led to a process of role reassessment which has continued through to the present day.

GP Fund-holding

GP Fund-holding was first established in 1991. The National Health Service and Community Care Act 1990 also created more independent Hospital Trusts, governed by chief executives and Boards and to which medical consultants were for the first time directly contracted. NHS Trusts over time became more like private 'for profit' institutions. As the NHS record on service integration and the care quality problems revealed by the Francis Inquiry (2013) indicate, this approach has had mixed outcomes (Lester, 2015). While many aspects of service provision have been improved by the non-medical NHS managerialism that has evolved since the 1980s, failures have on occasions harmed care quality. The 1990 Act may also have exacerbated aspects of the NHS and social care funding divide, so perhaps creating new incentives to cut back in areas like NHS community nursing.

Both GP Fund-holding and NHS Trusts were central to forming a more market-like system of NHS resource distribution and service delivery. However, thanks in part to the demands of competition law and the questionably logical continuation of the NHS 'purchaser-provider divide' after GP Fund-holding was abandoned, the costly, complex and highly bureaucratised manner in which NHS 'internal market' contracting subsequently developed was not in line with its early advocates' intentions. Money was supposed to 'follow patients', whose care was intended to be increasingly tailored to their personal needs. But in reality, critics argue, care patterns became determined by rigid contracts and a purchasing/commissioning process that tended to be centered on cost control and basic standard setting rather than creative quality improvement (Box 3).

Up until the end of the 1980s GPs could refer patients more or less freely to the hospital care providers of their choice. Yet the adequacy of the mechanisms that had evolved for compensating hospitals for changing levels of service use was limited, and there were also fears that general practitioners had inadequate incentive to keep people out of hospital when their care could be better provided at the practice level or in other less costly settings. Fund-holding was intended to address both these problems, in part by encouraging GPs and their practice colleagues to adopt a pro-active 'make or

Box 3. Quality Management

The history of 'quality management' dates back over a century, to work like that of the American Frederick Taylor and the conversion of craft work to mechanised factory production. This was followed by the contributions of pioneers like Walter Shewhart of the Bell Telephone Company on process quality control, and subsequently that of post World War II 'quality gurus' such as William Edwards Deming, Joseph Duran, Kaoru Ishikawa, Shigeo Shingo and Tom Peters.

Such commentators introduced concepts ranging from the need to 'drive out fear' in 'learning organisations' (based on the belief that most people want to do a good job, and that performance monitoring and feedback should therefore be supportive rather than punitive) through to 'just in time delivery', 'total quality management', 'continuous performance improvement', 'business process re-engineering' and 'transformational leadership'.

Well known examples of attempts to apply such thinking in health care range from the work of Florence Nightingale during and after the Crimean War to, in the twentieth century, the contributions of Dr Avedis Donabedian and more recently those of Dr Don Berwick. The creation of bodies such as NICE and

what is now the CQC stemmed from attempts to apply 'quality management' concepts to the running of the NHS.

For the purposes of this analysis two points are worth special emphasis. First, although quality management techniques can release savings through, for instance, reducing waste associated with redundant activities and concentrating effort on meeting external and internal 'customers' highest priority requirements, there is robust evidence that if cost saving becomes a primary goal this often results in aspects of product and service quality being undermined.

Second, actions which devalue the status and undermine the motivation of workers are in any field likely to have similar detrimental consequences. In health and social care systems good management is essential. But over-management is dangerous. If managers come to see themselves and their inevitably sectional objectives as more important than people using health and social services or more legitimate than the professional goals of and judgements of the clinicians and other individuals delivering care, their efforts will almost certainly have counter-productive consequences.

buy' approach to supplying services for their practice populations.²

A variety of alternative solutions to resolving these problems might have been selected at the start of the 1990s. For example, a non-market approach could (in some ways like the Scottish NHS system today) have involved improving systems for monitoring and evaluating professionally determined GP referral patterns and adjusting centrally directed hospital resource allocations to reflect local preferences and national service improvement priorities.

However, one positive effect of the seven year GP Fund-holding 'experiment' that took place in England between 1991 and 1998 was that the practices that successfully took part in it (along with the 'multi-funds' and 'total purchasing pilots' that emerged) demonstrated – at least within the primary care arena, if not so clearly in the hospital sector – the potential of devolved GP led 'purchasing' to deliver desirable service improvements in relatively brief periods of time.

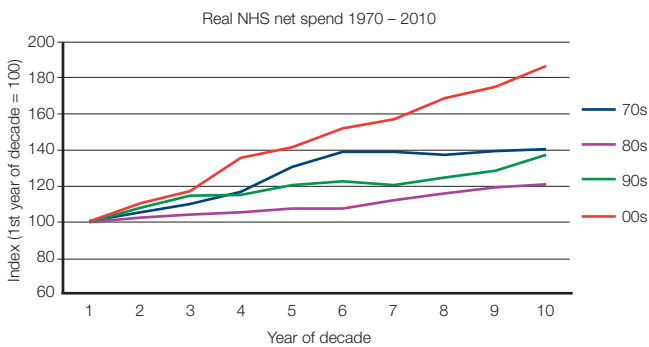
² Both during the GP Fund-holding era and subsequently in the case of CCG commissioning GPs have on occasions been accused of improperly 'paying themselves' to provide additional services to their populations, sometimes by or on behalf of interests seeking to secure increased earnings for their own companies or Trusts. But provided all interests are properly declared and decisions are at due points audited to ensure probity and cost effectiveness, this is what 'ACO type' local budget holding is intended to achieve. Where it is cheaper and better primary care providers should 'make' services themselves. In other circumstances they should buy them from others as efficiently as possible.

Fund-holding by a practice or practices was found at the time to incentivise the imaginative use of money that was not tied to particular disease or care groups for the benefit of the individuals and entire populations. (See, for instance, le Grand et al, 1998; Brereton and Vasoodaven, 2010).

Yet despite its positive dimensions, GP Fund-holding was unpopular with the then Labour opposition and with the BMA, as well as with sections of the GP community itself. It is sometimes claimed that Fund-holding divided General Practice, albeit in reality it can more accurately be said that it revealed important differences in leadership and care delivery capacities that already existed. In addition, some hospital staff members and NHS managers involved in the nascent process of institutionalised (contract bound) commissioning saw GP Fund-holding as a threat. It was consequently abandoned soon after the start of the first Blair administration, which was elected to power in 1997.

Opponents of what was sometimes termed 'NHS marketisation' welcomed this step. Yet it was followed by a series of other attempts to harness market-like mechanisms within the health service. These eventually led to the establishment of Primary Care Trusts (PCTs), and initiatives intended to develop 'world class commissioning' skills and to promote the formation of Foundation Trusts. This seemingly relentless process of change was, it has often been claimed, responsible for

Figure 4: NHS Funding Growth



Source: Steer, 2015

Note: real NHS funding in England grew by 5 per cent in the period between 2010 and 2015, which is a similar rate to that recorded for the NHS as a whole in the first half of the 1980s and above that in the second half of the 1970s. Recently announced expenditure increases in England mean that NHS funding will ultimately grow by 15-20% in real terms in the decade 2010-2020.

undermining GP and wider health sector morale during the first decade of the current century.

'Serial change' was commonly experienced as disruptive and lacking adequate justification. But alongside these structural changes, NHS funding was dramatically increased in the first decade of the twenty first century (Figure 4). Public satisfaction with the NHS rose in line with better resourcing, that gradually took NHS funding as measured by the proportion of GDP devoted to health close to the OECD mean. This allowed improved service quality, as indicated by measures like reduced waiting times for hospital care. Developments were also introduced in areas such as community pharmacy. These took the shape of services like 'minor' ailment treatment schemes, pharmacist led repeat dispensing arrangements and Medicines Use Reviews (MURs).

However, there is no evidence that such innovations have – although useful – to date fundamentally transformed primary care performance. It can be argued that after the formation of PCTs the extent to which local GPs and other primary health care professionals were able to play effective local roles in finding and implementing radically better ways of meeting changing health needs was in fact diminished.³ Some PCTs were regarded as successful. But others were seen as lacking the insight and capabilities needed to promote better service provision through commissioning.

³ It is also of note that during the first Blair administration decisions were made both to replace the by then well-established Community Health Councils (that had originally been created via 1974 NHS reorganisation) and to stop regular contact between NHS Trust and Authority chairpersons and the then Secretary of State. Although presented in ways that suggested a concern for NHS democratisation and consumer empowerment, such actions might also be considered consistent with a desire to impede more forceful 'bottom-up' policy challenges.

The coalition government elected in 2010 was not initially expected to introduce further major structural changes in the NHS. Hence the far reaching reform plans published later that year in the English White Paper *Equity and Excellence: Liberating the NHS* were for many a shock. The new arrangements eventually set out in the 2012 Health and Social Care Act (that came into full effect in England in April 2013) were intended by the then Conservative Secretary of State for Health, Andrew Lansley, to provide definitive solutions to the problems faced by the NHS. Yet regardless of their theoretical strengths and weaknesses their implementation ran into a variety of difficulties.

It would be beyond the scope of this brief outline to attempt to describe in detail the development of the NHS in the last two to three years. However, the remainder of this section offers observations relating to the ongoing evolution of the primary care system in England, with special relevance to general medical and pharmaceutical care and providing community nursing and social services.

Health service spending

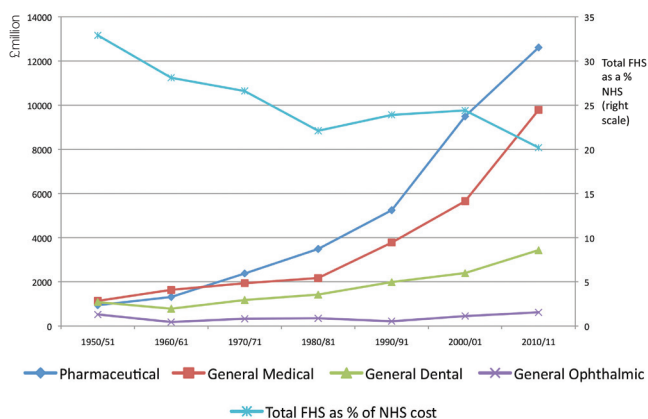
Total UK NHS funding rose from 3.5 per cent of GDP in 1949 to about 8.5 per cent of GDP in 2013/14. There was as already described particularly rapid growth in the period between the end of the 1990s and 2009. Since then NHS outlays have slightly fallen as a percentage of total national resources, although in 2016 they should recover again following recently (November 2015) announced increases in health service funding in England. At the same time overall local authority social care spending – which broadly accounts for an additional 1 per cent of GDP – has reduced since 2008-09.

Health and Social Care Information Centre estimates (HSCIC, 2015c) indicate that outlays on adult social care for the population aged over 65 will have dropped in real terms by about 15 per cent between then and 2015/16. This trend has increased pressures on the NHS. In future the ability of Local Authorities to increase local community charge payments to help fund enhanced social care should help stop this decline. However, this alone unlikely to restore such provisions to past levels, let alone to match Scandinavian public investments in care for groups such as mentally and physically frail older people.⁴

Within the health sector total, FHS/primary care spending fell from around a third of all NHS costs in the 1950s to about a fifth today. This has in part been because of increased private payments for ophthalmic and dental services, and also because of relative falls in community

⁴ Current negotiations between central and local government may also be touching on issues such as the extent of LA land holdings, and the degree to which such capital assets should be used to fund current outlays in areas such as residential and other social care provision.

Figure 5: Cost of Family Health Services (FHS) at 2010/11 prices, UK, 1950/51 - 2010/11



Source: Hawe and Cockcroft, 2013

pharmaceutical costs associated with the genericisation of many commonly dispensed medicines (Figure 5).

General Medical Service (GMS) costs currently represent about 8 per cent of all NHS spending, or about 0.7 per cent of GDP. The proportion of NHS funds devoted to the GMS has declined as compared with five to ten years ago (it stood at around 10 per cent of NHS costs in 2004/5), albeit the General Practice workforce is larger than at any previous time. Bodies such as the RCGP and the NAPC have recently called for spending on general medical care to be increased to 11 per cent of NHS costs. Spending on General Pharmaceutical Services net of drug costs currently represents a little under 2.5 per cent of all NHS outlays.

Public debate about the extent to which health service spending should be increased each year in real terms to meet rising costs can be confused by failures to take into account variables like the impacts of increased wages, as opposed to those stemming from changes in demand for care and expenses incurred as a result of the introduction of new medical technologies. However, it is worth highlighting the fact that health service and allied spending in the UK remains below the OECD average when expressed as a percentage of GDP. It now stands at close to half the proportion of GDP spent on health in the US and around three quarters of that recorded in Germany, France and The Netherlands.

While 'higher' professional salaries such as those for GPs and hospital consultants in the UK compare reasonably well with reported Western European earnings, the total numbers of doctors and pharmacists employed by the NHS are relatively low as compared with the levels reported in countries like Spain, France and Germany. At the same time, spending on social care in countries like Sweden and the Netherlands is over 3 per cent of GDP, in addition to their health care outlays. This further increases the overall difference between health and social care spending in England and other parts of the UK as compared with that in other more highly developed nations.

The NHS remains in global terms one of the world's best resourced and run health care systems. Yet the fact that it pioneered service delivery that is still in the main free at the point of demand and funded by general taxation rather than social insurance appears to have promoted policies that have over the long run been more tightly focused on cost control than those judged appropriate in other more affluent countries. The UK system today is more centralised and politicised than alternative social insurance based health care models in other parts of Europe. This could have offset the advantages associated with the fact that tax funding is cheaper to raise than financing gathered via competing insurance schemes.

This situation may or may not have disadvantaged the British population to date. But from the perspective of ensuring the future quality of primary health and social care it is important for such trends to be well understood. Otherwise electoral and governmental choices might be distorted by exaggerated perceptions of the cost of the NHS or the supposed generosity of the health related welfare benefits available in the UK as opposed to other parts of the EU.

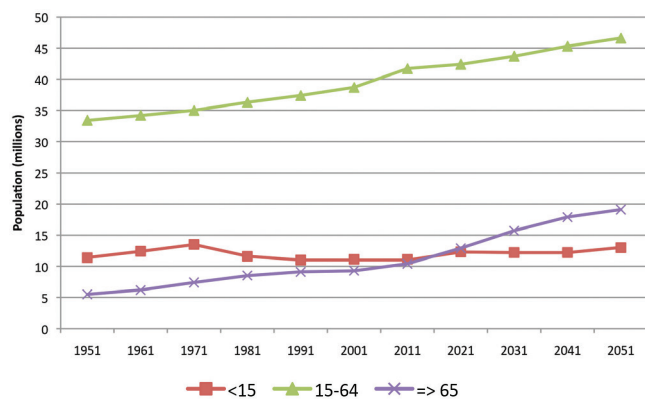
The impacts of population ageing

In 1948 there were 5 million British people aged 65 and over, out of a total UK population of about 50 million. Of that 5 million, only about 200,000 individuals were aged 85 or over. Average life expectancy at birth was 68 years, and for people aged 65 it was a little under 14 years. Today, by contrast, there are over 11 million aged over 65 out of a total population of some 64 million (Figure 6). About 1.5 million people in the UK are now aged 85 years and over, and this number will more than double in the next twenty years. Average life expectancy at birth for males and females combined is just over 80 years. At age 65 it is now 21 years.

Such advances in survival are in part attributable to the success of the NHS, and in particular to reductions in infectious and cardiovascular disease mortality in child, 'working age' and early later adult life. However, it is often (incorrectly) claimed by political and professional commentators alike that population ageing has been the main driver of increased health care costs and that it will in future threaten the financial viability of health services as currently constituted in this country and elsewhere in the world.

It is true that population ageing is changing the balance of hospital and primary health and social care workloads – health care systems need to adjust to accommodate this and associated trends (WHO, 2015). It is also true that at any given point in time older adults are, outside the field of maternity services, likely to require more health care than younger ones. Yet it is not the case that,

Figure 6: UK resident population and projections by age group, 1951-2051



Projected national data

Note: in 1951 there were 200,000 British citizens aged 85 and over, compared to about 1.5 million today. By 2051 this total will have risen to over 4 million. However, in part because of immigration patterns the UK will by the 2030s have become one of the least aged countries in the EU, and in social and economic terms is likely to be significantly less affected by population ageing than countries such as China

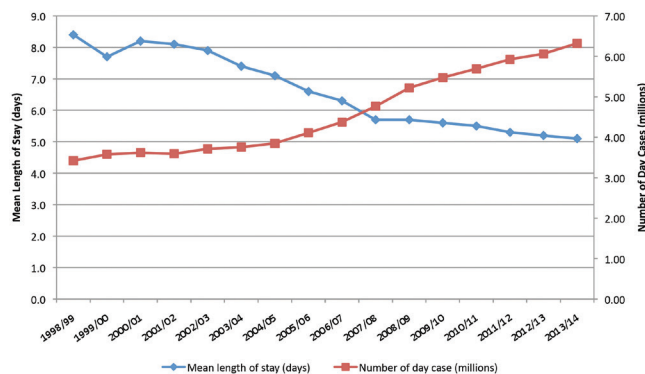
to date at least, population ageing has by itself been a major driver of increased total spending.

The best available evidence indicates only about 0.2 per cent of the 3-4 per cent average annual increase in NHS costs seen in past decades was due to this cause *per se*. In future decades the yearly extra spending on health care needed because of the impacts of population ageing may rise to about 1 per cent of total NHS outlays. Yet this will not be an unmanageable problem, especially if better primary care led case management strategies prove able to mitigate the cost impacts associated with rising absolute (as distinct from age specific) rates of long term ill-health and multi-morbidity.

The future challenges associated with ageing in this country are substantially less than those now facing nations like, for instance, China or Iran, which are entering into a much more rapid period of change in their population structures than that being experienced in Western Europe. The benefits of increased longevity and healthy life expectancy achieved in the last century or so significantly outweigh any costs that can reasonably be attributed to extended survival. This is in large part because as death is postponed, so too are the costs of end of life care and to varying degrees those associated with having to live with disability.

If healthy life expectancy can be extended in line with overall life expectancy gains, the net economic costs of such progress could prove negative. However, this is not to deny that population ageing will over time require greater investment in preventive services and effectively coordinated health and social care provision in the community. It is once again important from the perspective of assuring the fitness for purpose of primary

Figure 7: Average length of hospital stays, England, 1998-2014, and day surgery numbers



Source: HSCIC, 2015b

health and social care that such phenomena are widely understood, and that appropriate service developments are identified, funded and implemented.

Falling hospital bed numbers

The number of hospital beds available for the treatment of inpatients has dropped dramatically since the start of the 1950s. At that time there were roughly 11 beds per 1000 population across the UK as a whole. Today the equivalent figure is about 3 per 1000, and within that total there are approaching twice the number of beds per capita available in Scotland as there are in England (Hawe and Cockcroft, 2013). Even since the late 1970s average acute bed availability per 1000 total population has fallen by over 40 per cent in England. The decline in mental illness and learning difficulty inpatient beds available has been about twice that figure, and is projected to fall further in the coming decade.

Such changes have been offset by reduced lengths of stay and greater use of day surgery (Figure 7), along with improved community (including nursing home and residential) care. Care home beds are a critically important resource, albeit their total number has also fallen since the 1990s (Laing, 2015).⁵ In general the population is better housed and more able to cope with the challenges of recovery or living with mental or physical disabilities at home than was so when the NHS came into being.

Even so, it is salient to note that the NHS in England has only about a third of the acute hospital beds than is the case in, for example, modern Germany, and that in some areas shortages of social service and community nursing resources are significantly delaying hospital discharges. Recent data indicate that such effects lead to the loss of in excess of a million hospital 'bed days' a year in England alone. Failures to further develop primary care as defined in this report would in future exacerbate problems of this type.

⁵ There are currently around 400,000 public and private residential and nursing home beds in the UK

Larger GP practices

At the start of the 1950s there were some 22,000 GPs working in the UK NHS, outnumbering the then 15,000 hospital doctors by a third or more. Many practiced alone, and home visiting was common place.

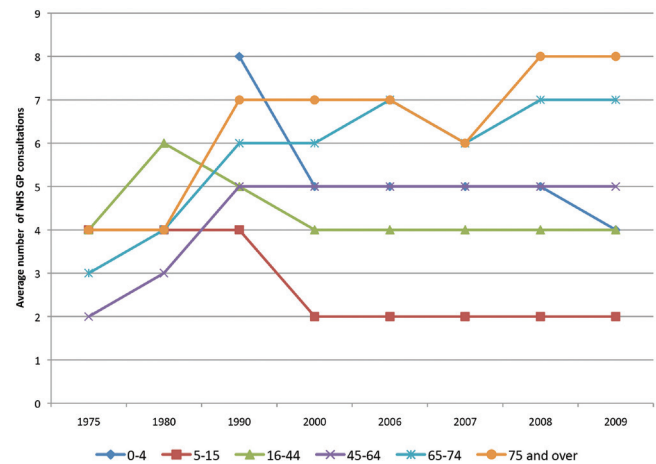
Today there are about 40,000 GPs in the UK as a whole, over three quarters of whom work in England. This is less than half the equivalent number of hospital doctors presently employed. Less than 10 per cent of GPs now work on a single practitioner basis, and home visiting by patients' own GPs is relatively uncommon. The modal practice size has risen to between five and nine medical members. In England practices rather than individual GPs are now contracted to the NHS via NHS England, and they have in total some 90,000 non-medical full time equivalent (FTE) staff members.

Seventy per cent of the individuals employed as non-medical practice staff undertake administrative and clerical work. The number of nurses working in general practices remains relatively modest – there are about 15,000 FTE practice nurses in England, which translates to a little under 25,000 individuals. In recent years the ratio of practice nurses to GPs has remained stable. About a third of all general practice consultations are undertaken by practice nurses (Hawe, 2009). They are now responsible for over 100 million patient contacts a year out of the General Practice total of approaching 350 million consultations a year (Figures 8a and 8b). For comparison about 1.6 million people a day use community pharmacies, although the annual number of health related consultations undertaken in pharmacies has been estimated to be closer to 450 million (NHS England, 2013).

From a demographic perspective, the proportion of female GPs has risen during the lifetime of the NHS. So too has the proportion of the GP workforce over 50. Over half of all family doctors are now in this age bracket. Presently available data suggest that many older GPs are (partly in response to changing pension fund regulations, and new limits on the size of pension funds that enjoy tax benefits) contemplating retirement. This, coupled with uncertainties as to the proportion of younger women doctors who will choose to return to practice after completing their families, has caused some commentators to express fears that GP numbers will soon fall dramatically. It has been claimed that around 5 per cent of surgeries might have to close by 2020.

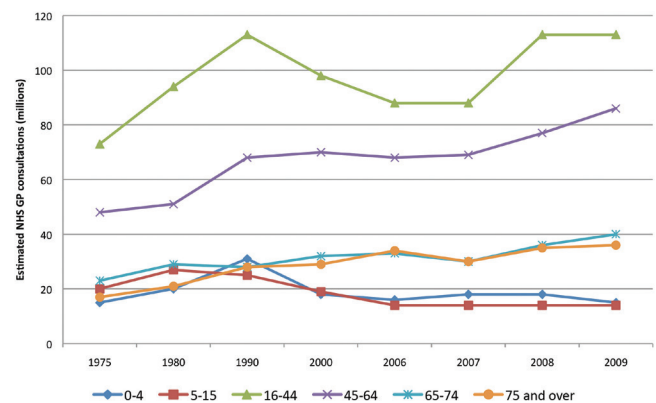
But against this the present government has promised to increase the GP workforce in England by 5,000 practitioners within five years (see next section). The likelihood of a significant collapse in NHS GP care provision in England is limited. However, as is discussed below, there will almost certainly be an increasing need to employ more practice staff such as nurses, clinical pharmacists and individuals with non-clinical backgrounds who have been trained as

Figure 8a. GP consultations per capita by age group, UK, 1975-2009



Source: OHE

Figure 8b. Total numbers of GP consultations by age group, UK, 1975-2009



Source: OHE

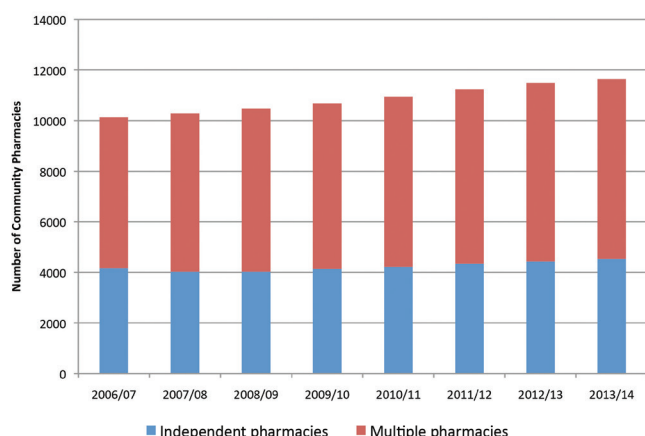
physician assistants in the General Practice setting. The development of community pharmacies in ways that will relieve GP workloads and meet NHS user expectations for access to convenient, safe and otherwise valued services could also prove a viable way forward, if adequate action is taken to secure this end.

Community pharmacy roles

There are presently approaching 12,000 community pharmacies in England, compared with 8,000 GP practices. The latter number has fallen in recent years, while the total for pharmacies has risen. There are around 30,000 community pharmacists employed in England, which represents a similar number to that for GPs. English CPs are supported by over 100,000 other staff, ranging from registered pharmacy technicians to counter assistants with varying levels of training.

Since the 1950s there has not been an increase in the number of registered pharmacists working per community pharmacy comparable to that seen in

Figure 9: Number of community pharmacies owned by independent and multiple contractors* on a PCT pharmaceutical list, England 2006-2013



Source: HSCIC, 2014b

* A multiple pharmacy is defined as one consisting of 6 or more pharmacies. Contractors with 5 pharmacies or less are regarded as independent.

relation to the number of doctors working per general practice. Relatively few pharmacies have more than one registered pharmacist on duty at any one time. But the ownership of community pharmacies in England has become more corporate. Outside London, over 60 per cent of all community pharmacies are now grouped in chains of five or more (Figure 9). At the same time the annual number of prescription items dispensed by community pharmacies in England alone is now over a billion. This compares with about 200 million in 1950 and 500 million at the beginning of this century.

A number of factors have accounted for this rise. They range from an extended use of medicines to control vascular disease risks through to the increased number of older people living in the community. About 60 per cent of all community issued prescriptions are now dispensed for people aged 60 and over, which in England means that the average individual of that age receives well over 50 NHS prescription items a year. The equivalent figure for the population aged under 60 years is approaching 9 items per person per year.

It might be argued that the increased workload associated with the recent growth in dispensed item numbers (which over the last decade has been linked to a 30 per cent decline in average net ingredient cost per prescription) will fully occupy most community pharmacists. Yet the introduction of new dispensing technologies coupled with strategies ranging from the more effective use of pharmacy technicians to – in appropriate circumstances – increased prescription durations⁶ could in future liberate pharmacist time. This reality, coupled with the fact that

⁶ There is evidence that it is not always in patient or public interests to confine supply quantities to 28 days or less as opposed to, say, three month periods.

at present pharmacy is the only health profession with a surplus of UK educated graduates, provides evidence that there is a genuine opportunity for extending the clinical role of NHS community pharmacists, provided service users find this an attractive option and that pharmacist and other stakeholders have the necessary motivation to extend their clinical care inputs.

Community nursing

The umbrella term community nursing covers services provided by personnel ranging from district nurses to community matrons and health visitors. NHS community services also employ care assistants, as well as professionals like physiotherapists. In total, even including nurses employed by Mental Health Trusts to deliver community services, only about a fifth of the overall NHS nursing workforce is located outside the hospital sector. The available data indicate that since the beginning of this century there has been a 50 per cent decline in the number of individuals employed as district nurses in England, leaving them at a 'critically endangered' level (HSCIC, 2014).

Increases in the number of other staff have to a degree mitigated this trend. Even so, the Royal College of Nursing (2012) has expressed alarm about a dilution and loss of skills in the community nursing workforce in a period in which there is increasing need for high quality community care. There is evidence that in some areas the work of community nursing teams has become dominated by inflexible, narrowly task oriented, approaches centred on relatively unskilled activities (Gill and Taylor, 2011). Despite recent attempts to develop more integrated care and initiatives such as the establishment of the Better Care Fund,⁷ there are doubts about the quality of social services and community nursing service collaboration in many localities.

There are likewise concerns about the 'dissociation' of GP and broadly defined community nursing care. In less pro-active practices and localities there are problems relating to the timely delivery of good quality community services to people living with conditions that put them at high risk of emergency hospital admissions, or becoming prematurely dependent on residential care.

The historical origins and social status of nursing and allied care provision in this country are quite distinct from those of medicine and pharmacy. It can be argued that since the 1974 NHS re-organisation which transferred the provision of functions such as district nursing and health visiting away from Local Authority control, this area has lacked the supportive leadership and

⁷ This as from April 2015 has made approaching £4 billion of what is in large part funding transferred from the NHS available for Local Authorities and CCGs to jointly spend on social and allied community services.

institutional sponsorship needed to protect public and patient interests in its ongoing development.

Individuals interviewed during the development of this analysis highlighted funding and financial reward issues, and the negative impacts that creating separate community matron posts may have had in terms of depriving district nursing teams of appropriate professional leadership. A core reason why it has been difficult to retain professional staff in community nursing services is that many have not been offered an environment in which they feel it is attractive to work and possible to deliver high quality professional care. At the same time access to Local Authority social care has decreased. Some commentators believe that the LA commissioning approaches used have on occasions 'auctioned down' the quality of social and community nursing services to unacceptably poor levels.

The problems facing NHS community service providers have now in part been acknowledged by agencies such as NHS England. It recently commissioned the Queen's Nursing Institute to develop a resource to help ensure that localities have sufficient numbers of community nurses in place. There is a commitment to training an additional 10,000 'frontline' community nursing staff by 2020, and the Primary Care Workforce Commission (2015) concluded that all localities should as a matter of priority seek to have an adequate 24 hour community nursing service in place.

Such developments are encouraging. But they should not conceal the systemic failure of the NHS in recent decades to develop community nursing and allied services that are better suited to meeting the needs of a 'post-transitional' population. The approach adopted in England may be seen as comparing poorly with examples such as that set by, for instance, the Buurtzorg community care programme in the Netherlands (RCN, 2015).

This last initiative offers an illustration of 'self-managed' organisation. Although its viability in the more unequal and class divided British cultural environment has not been demonstrated, the Buurtzorg model (along with related Swedish strategies) provides a setting in which person-centred care can be delivered in ways which enable nursing and other non-medical staff a high level of self-realisation and professional reward. It is therefore an important experiment for practitioners interested in realising the promise of concepts such as the NAPC's 'Primary Care Home' to explore. It is possible that the thinking it embodies could be applied in ways which will in future allow better collaborative working between GPs, pharmacists, community nurses and other primary health care colleagues in order to generate increased service user satisfaction and enhanced care outcomes.

Current Opportunities

The extent to which NHS primary care can currently be said to be well managed in England is debateable. The decades between the end of the 1940s and the present day saw what might be termed a 'slow-motion managerial revolution' in the organisation of hospital care, not only in the UK but also in much of Europe and in the United States. Yet in the case of primary care, 'post Griffiths' general management has not in the main been developed, and where it has been instituted its achievements have been of questionable desirability.

The recent establishment of Clinical Commissioning Groups, coupled with the formation of the local General Practice Federations that have been advocated by the Royal College of General Practitioners for approaching a decade (Lakhani et al, 2007), offers improvements. But despite recent steps like extending the part played by CCGs in the development of primary care, this hope is accompanied by continuing uncertainties. Although the post GP Fund-holding 'commissioning experiment' in the NHS may have been well intentioned, many of the professional and other leaders interviewed during the preparation of this report said that it has not been able to adequately facilitate the establishment and coordinated local delivery of services needed by communities in the late stages of demographic, epidemiological and social transition. In areas like Community Pharmacy positive change has also – although cumulative – been relatively slow, while the provision of skilled district nursing care has until recently at least been in decline.

As previously recorded, in the 1960s the American sociologist Eliot Freidson articulated concerns relating to the dominance of the medical profession in the health sphere, and what he judged to be a self-interested emphasis on 'clinical freedom' as opposed to the appropriate provision of public and patient interest focused care. Yet towards the end of his career Freidson had become worried about the unwanted impacts of health sector managerialism and regulatory systems that he increasingly saw as heralding destructive bureaucratisation. He feared that such trends were leading to controls that threaten patient interests by promoting undue rigidity and undermining the quality of discretionary decision making in day-to-day treatment and care. Eliot Freidson in effect argued that professional values are needed as a counter balance to protect service quality against inadequately informed managerialism and/or political interventionism (Freidson, 2001).

The NHS today differs considerably from the health care system that existed in late twentieth century America. However, if in future NHS primary care is to be able to help meet public expectations for both the efficient and effective use of hospital resources as well as the provision of high standard community services, there

will be a continuing requirement to complement skilled managerial direction with 'modern' professionalism and enhanced responsiveness to the preferences of service users at all stages of their lives.

During the prelude to the May 2015 general election NHS England's *Five Year Forward View* highlighted a number of ways in which primary care and allied service improvements might help generate the gains needed for the health service to stay within budget and perform well in the period to 2020. The advances suggested ranged from the creation of urgent care networks to help manage demand for emergency treatments through to the (re)establishment of 'viable' local hospitals and the formation of Multispecialty Community Providers (MCPs) and/or integrated Primary and Acute Care Systems (PACS).

These and other what are now termed 'Vanguard' initiatives link back to earlier experimental schemes trialled in England, including the sixteen Integrated Care Pilots (ICPs) established in the wake of the 2008 *NHS Next Stage Review*. MCPs can to a degree be compared to the polyclinic concept previously advocated by commentators such as Lord Darzi. They could also be developed in ways that reflect the recent formation of Accountable Care Organisations in the United States. ACOs are groups of service providers that typically include primary care practitioners, nursing homes and hospitals, and that take responsibility for meeting all the relevant needs of a given population for a specified period of time and within a defined budget (Shortell et al, 2014).

There are a variety of ways in which NHS primary care could develop over the coming decade (Rosen, 2015). Of these it currently appears that defined budget initiatives designed to meet registered population needs over specific time periods are the most promising. There can be no guarantee that forming ACO type systems will enable the NHS to overcome the challenges now facing it in England and other parts of the UK. However, the National Association for Primary Care (2015) has argued that 'Primary Care Home' based models that reflect the ACO approach deserve close attention.

Such organisations might in future be formed by building on the emergence of GP Federations, and be designed to serve populations of 30-50,000 or perhaps more people.⁸ They could offer benefits similar to those attributed to the 'multi-funds' that in the UK formed in the later stages of GP Fund-holding. Establishing MCPs in a manner consistent with the NAPC's recommendations does not require structural mergers which dissolve the unique identities of smaller participant organisations.

8 Given the variability of local community care requirements and differing service development opportunities between localities, attempting to impose unduly rigid service development specifications would risk being counter-productive.

Apart from the motivational advantages this might bring, it could also permit the ongoing flexibility needed for new configurations to form with a minimum of disruptive impact on service provisions, as and when this would be desirable.

The formation of Primary and Acute Care Systems (PACS) also relates to the ACO model, the establishment of which in America was stimulated by the passage of President Obama's 2010 Affordable Healthcare Act. However, PACS are arguably more likely to involve formal mergers of hospital and primary care services. Some of those interviewed during the preparation of this report suggested that this would be a robust and sustainable way forward, given the organisational strength and durability of large hospitals. Others argued against this option, in part because of fears that 'hospital take-overs' could damage primary care and distort overall patterns of service use.⁹ They expressed the view that public interests will best be served by maintaining a clear focus on the distinct principles for excellence in primary care delivery established by researchers such as Starfield, and building logically on the discrete strengths of this country's established primary care system.

The NHS structure and 'single payer' funding system has some advantages as compared with the alternative arrangements typically in place in other developed countries (Davis et al, 2014). There is no reason to doubt that it could, given sufficient will, be further strengthened without counter-productive reorganisations. The importance of the National Association for Primary Care's recent '7 point plan' and its work on developing the Primary Care Home concept of a practice population based approach to effectively coordinating personalised health and social care is in part linked to the fact that it reflects a commitment to patient care centred values, coupled with the use of appropriately designed performance and outcome metrics. Some important elements of the NAPC's proposals are highlighted in Box 4.

Forming larger organisations is sometimes seen as a means of integrating complex activities. But there is no evidence that simply bringing different health and social services together under a single management 'umbrella' would (as with the co-location of GPs and specialist doctors in shared premises) in itself create the relationships, values, commitment and expertise needed to sustain long term solutions to the multi-faceted problems of optimising health and social care coordination.

9 In circumstances where hospitals are not competing for market share against rival providers such risks may be significantly reduced. Even so, the view taken here is that a primary rather than secondary care led approach is likely to enjoy significant advantages from a public interest perspective.

Box 4. Improving Primary Care

The National Association of Primary Care's 7 Point Plan (which was first published in 2014) can be regarded as an attempt to apply evidence based principles of quality management to the delivery of person and patient centred population-wide health and social care. Its key priorities relate to:

- defining the value of care around outcomes that matter most to patients/service users;
- supporting new models of primary care provision that should help to ensure that service users' personal requirements are met effectively and efficiently;
- aligning incentives and contractual models that support improvements in local population health outcomes;
- developing a workforce that is responsive to the needs of the populations being served, rather than focused on meeting those of the professional groups within it;
- supporting 'real time' innovation across collaborative networks, in part through the IT based use of well-

designed activity and performance metrics in ways that are seen as important by all those taking part;

- purposeful, not just positional, leadership representing the breadth of primary care; and
- working to influence policies in ways that effectively support the realisation of the ambitions summarised above.

The thinking underpinning the NAPC's Primary Care Home concept and that of the 50 Vanguard care model implementation projects now (as of December 2015) being supported by NHS England can similarly be seen as seeking to apply the principles of service quality management to the task of continuously improving health and social care. Encouraging progress has been reported. However, as with the multiple pilot projects that across the world have repeatedly demonstrated the capacity of clinical pharmacy in both integrated and independently sited community settings to deliver good quality health care, core challenges relate to universalising good practices in ways that defend the local integrity of professional work and stimulate autonomous improvement practices.

The history of community nursing after 1974 calls into serious doubt the wisdom of transferring the control of community service funding to bodies that have a dominant interest in institutional care provision. The fact that countries like Sweden have maintained a clear separation between health and social care in order to protect funding levels and maintain discrete service objectives can also be taken to be indicative of the need for caution with regard to adopting care integration strategies based on the imposition of organisational and budgetary unity, as distinct from preserving 'natural' plurality while incentivising functional collaboration.

The next main section of this report further discusses how barriers relating to the provision of better organised, individually responsive yet efficient at scale, health and social care might best be overcome. But before that two areas central to the immediate future of the NHS primary care are further considered. The first relates to how the parts played by non-medical staff working in General Practice should be extended. The second further addresses how independently located community pharmacies and the people employed in them will best be able to contribute to twenty first century primary care, alongside other service providers.

The fact that there are now new opportunities for clinical pharmacists to work in General Practice settings is a welcome development. But this should not undermine awareness of the continuing need for community pharmacies to supply medicines and allied products in convenient and cost-effective ways, or of opportunities

for them – as and when service users elect to access pharmacies for health care delivery – to extend their contributions to facilitating self-care and providing direct access to pharmaceutical and allied treatments in ways consistent with the cost-effective attainment of good quality care standards.

General Practice teams

When individuals are facing serious health problems many wish to be guided by GPs who they not only know to be qualified professionals but are familiar with as people who are a part of the social network/human capital that they and their local communities 'own', and are hence highly trusted. Arguably, the fundamental test for General Practice in the period to 2050 is to retain its heritage of being a local resource for patient populations while also being a major influence on clinical commissioning. Ideally, it needs to be 'small' in personal relationship terms, yet 'large' in the sense of being able to act as an important system-level NHS care commissioner and provider.

The recently announced 'New Deal for General Practice' – see Box 5 – recognises the centrality of GP care in the NHS, and promises to increase GP numbers in England by 5,000 by 2020. It also offers to increase the rest of the General Practice workforce by a similar number, including a commitment to making 1,000 Physician Associates available in general practices by the end of the current decade.

Box 5. 'New Deals' for General Practice and Community Pharmacy?

In 2014 NHS England's pre-election *FYFV* called for better funding and support for general medical practice, in order to further improve the NHS's overall performance through enhanced primary and secondary disease prevention and better population-wide access to well-coordinated primary/community medical, nursing and pharmaceutical care. In June 2015 the Secretary of State for Health offered his vision of a 'new deal' for GPs to help achieve such goals in England.

Drawing in part on the work of the 'Roland Commission' – see main text – the plan outlined by Jeremy Hunt included earmarking £10 million for general practices in need of special support and the recruitment of 5,000 new GPs and another 5,000 practice support staff (including practice nurses, district nurses, physicians' associates and practice based primary care pharmacists) by the end of the current Parliament. It also built on a commitment to provide £550 million for the modernisation of GP surgeries and improving community based care announced in March 2015, and heralded contractual changes that should offer greater working freedoms for practices in return from the introduction of extended '7 day' NHS care arrangements.

Subsequently, it was also announced that everyone in England will have a GP who is recognised as being personally accountable for coordinating their physical and mental health care needs. The Secretary of State in addition noted the importance of general practice in the wider public health context, and the fact that about 20 percent of the average GP practice's workload is associated with supporting people affected by

problems such as social isolation, housing difficulties, personal relationship issues and the consequences of unemployment. He emphasised the need for robust linkages between general practice and social, community and mental health care.

This package of initiatives has been generally welcomed, although warnings have been sounded with regard to issues such as the extent to which the financial incentivisation of specific professional practice improvements could have perverse consequences in other important areas of work that do not receive special funding. From the perspective of this report it may also be suggested that more attention might usefully be paid to the establishment of a parallel, effectively integrated, 'new deal' for community pharmacists working outside the general medical practice setting.

Recent calls by the Treasury to increase the use of online pharmacy and home delivery services (Cmnd 9164, 2015) appear to be supportive of drug distribution cost saving strategies that might in time lead to significant reductions in the numbers of independent and/or chain pharmacies across the UK. However – as initiatives such as the development of Healthy Living Pharmacies may be taken to indicate – it could well prove counter-productive to ignore the actual and potential contributions of pharmacies to clinical care delivery and wider public health improvement, especially if in future the 'public health'/population level preventive use of medicines outside the conventional sphere of disease treatment in doctors' surgeries becomes – as is discussed in Box 7 below – more widely accepted.

These plans in part stem from the work of an independent Primary Care Workforce Commission which formally published its report in the summer of 2015 (PCWC, 2015). *The Future of Primary Care* noted that although the number of hospital consultants increased by 48 per cent in the decade 2003-13, the number of GPs increased by only 14 per cent. Such data may be taken to be evidence of a skewed and inadequately managed pattern of workforce investment during the decade or so of rapid NHS funding growth that ended shortly after the time that the 2008 global financial crisis commenced.

During the first 10-15 years of this century primary health and social care provision did not keep pace with the rapid expansion of complex specialist hospital activity, and the parallel decline in hospital bed numbers available in England. This led to an accumulation of risks. Failures to adequately anticipate and forestall this situation can – notwithstanding measures such as the introduction of a revised national contract in 2004 that rightly or wrongly removed GP responsibility for providing night and weekend care – be taken as an illustration of not only professional leadership limitations, but also significant

weaknesses in NHS governance and direction at its higher levels.

In line with the information reported earlier in this review, the Commission also observed that there was a 38 per cent drop in the number of community nurses in the ten years 2001-2011. Only in pharmacy are there enough new professionals being trained in the UK to meet or exceed anticipated future demands for health sector staff. In the institutional setting in particular, nursing care in Britain has in recent decades been substantially dependent on professionals who have qualified in poorer countries. Recently announced changes in the funding of nursing education may not help change this situation.

There have also been consistent shortfalls in the numbers of doctors trained in this country. This may in part have been related to attempts to maintain the status and relative earnings of medical staff trained in the UK, along with fears that British graduates will if there are not adequately attractive opportunities available domestically swiftly seek employment elsewhere in the English speaking world. But whatever the reason, many of the NHS's current financial and service delivery

problems can be linked to an inadequate supply of suitably skilled staff.

The Primary Care Workforce Commission recommended that GPs should retain their central responsibility for primary medical care quality and the delivery of person centred support. It also argued that the balance of General Practice activities should over time move more towards incorporating population based 'public health' approaches in relation to the management of health related risks. Greater numbers of non-medical practice staff could help to make the adoption of 'community oriented primary care' strategies (see Geiger, 1993) and practices possible.

For example, *The Future of Primary Care* claimed that if medical assistants were to undertake 50 per cent of the administrative work currently done by GPs, this would release the equivalent of 1400 doctors for clinical work in England. Physician associates (graduates with relatively brief training in key health care areas) could also take on more primary care tasks, as too – depending on their availability – could nurse practitioners and pharmacists working in practice settings. Shortly before the publication of the Commission's report, NHS England announced pilot funding for 'practice pharmacy' posts.

So far funds sufficient for the support of about 400 such appointments have been announced. Employing pharmacists in GP surgeries can be taken as recognition of their value, and might help provide a partial solution to limitations in the number of doctors seeking careers as GPs. Yet the long term economic sustainability of such a way forward is as yet uncertain. There will be significant costs to be met in successfully establishing a more team based model of primary medical care delivery. But its advantages should include allowing longer GP consultation times for patients with relatively extensive needs. Other Commission recommendations related to:

- encouraging greater use of emails and (security permitting) web based communications in both intra-professional and practitioner/patient interactions;
- creating single points of access for community health and social care needs assessments;
- improving career structures for nurses and others working in primary health care;
- funding 24 hour 7 day community nursing services to facilitate timely hospital discharges;
- ensuring that there is equitable geographical access to good quality General Practice; and
- developing local Federations that involve both GPs and community pharmacists.

The extent to which such aspirations can be translated into actual service improvements will in large part depend

on the financial and allied incentives influencing the behaviours of individuals and organisations. Constructive change in General Practice and other primary care services will be possible if it is pursued in a realistic manner and development investment is sustained over sufficient periods of time.

However, if the performance of NHS primary care in delivering not only continuing personal support for individuals living with complex needs but also interventions for people who require quick and easy service access is to be optimised, improving practice based care co-ordination is not the only goal. Despite some outstanding examples of comprehensive provision, it is highly unlikely that larger General Practices will be able to meet both the growing need for continuing medical care for more seriously ill individuals and parallel demands for the rapid and convenient delivery of preventive and day-to-day self-care support and 'maintenance' services for children and adults. Additional ways of offering safe, timely and convenient treatment, support and advice are also likely to be required.

Clinical pharmacy in the community

Before the establishment of the NHS, community pharmacists in Britain played an important part in providing health care as well as in dispensing the comparatively limited (often pharmacy made) range of effective medicines then available. But the creation of the health service coincided with the first pharmaceutical revolution. This generated a wave of drug innovations that started with the introduction of new, industrially manufactured and packaged, antibiotics like the penicillins and the tetracyclines, coupled with products like isoniazid for the treatment of tuberculosis. Such developments were followed later in the 1950s by the marketing of products such as the early anti-depressants, diuretics for the control of blood pressure, polio vaccines and the first oral contraceptives.

Combined with NHS funded access to medically prescribed items (prescription only medication was also a relatively novel concept at that time), pharmaceutical progress greatly increased the Community Pharmacy dispensing workload. Pharmacists became less engaged with treating health problems directly, and more narrowly focused on medicine supply (Taylor and Carter, 2002; Anderson, 2007).

Today, General Practices are larger and more difficult to access than in the past and are, as already outlined, having to deal with patient and population needs that differ markedly from the infection related requirements that were more prevalent when the NHS was first established. At the same time new technologies and better use of skilled pharmacy technicians are promising ways of freeing pharmacists from at least some aspects of the medicines supply and dispensing task, and of

improving communication and record sharing between all NHS service providers and users.

In England, changes ranging from the introduction of more GSL and P (free sale and pharmacy only) medicines to the funding of 'minor' ailment treatment initiatives, smoking cessation services and other local schemes – alongside the national funding of Medicine Use Reviews (MURs) and, more recently, the New Medicines Service (NMS) – can be seen as preparing community pharmacy for the delivery of an extended primary health care role. The same may be said of initiatives such as repeat dispensing schemes, the establishment of 'Healthy Living Pharmacies', and the different but related approaches to developing community pharmacy being introduced not only in UK countries like Scotland but in national settings like those of Australia, Canada and the US (Box 6).

In recent decades there has been an increased understanding of issues such as how community pharmacy's traditional 'volume supply' based business model and in the UK the matching structure of NHS pharmacy contracts has tended to curb the profession's ability to move from dispensing towards clinical care, and provide services that require time to be spent on establishing flexible dialogues with service users in

order to provide effective solutions to health problems. Yet there is also growing evidence on the capacity of pharmacy based services to deliver better outcomes in areas such as the support of people with conditions like COPD, asthma, chronic pain or diabetes.

Nationally and internationally, research findings from pilot schemes indicate that Community Pharmacists could play more important roles in areas ranging from the detection of mental health problems to the management of long term physical conditions and the reduction of vascular disease risks like raised blood pressure in middle and later life (Box 7). However, despite a plethora of examples of successful small scale initiatives, pharmacists have across the world faced problems in establishing 'scaled up' health care roles. Finding ways to augment and over time replace 'item of service' based dispensing income streams with a sustainable health care revenue base lies at the heart of this challenge.

The view taken here is that independently located pharmacies and pharmacists could and should in future play a more central part in providing easier first and when appropriate subsequent access to clinical care, provided that in future all primary care interventions are – with due service user permission – entered into a common health

Box 6. National and Global Pharmacy Developments

Throughout Western Europe and North America many examples are available of community pharmacy based initiatives that promise better health outcomes. Well researched illustrations of the latter exist in areas ranging from the prevention and treatment of type 2 diabetes and its precursor states through to disorders such as, for instance, osteoporosis (Taylor et al, 2015). In countries like Canada there has also been general progress towards pharmacist prescribing in not only emergency situations but in the management of long term conditions. The best known instance of this relates to the provisions for independent pharmacist treatment instituted in Alberta, although related advances have also been achieved in other Provinces.

In the UK relevant pharmacy development examples include the introduction of NHS funded Medicines Use Reviews in England in 2005, the establishment of the Scottish Chronic Medication Service in 2010 and the formation of the English New Medicines Service in 2013. The latter seeks to support medicines taking in the especially vulnerable period after treatments for long term use have first been prescribed. In addition, local initiatives such as the Community Pharmacy Future (CPF) project – a collaboration between Boots UK, The Co-operative Pharmacy, Lloyds Pharmacy and Rowlands Pharmacy – have highlighted the potential value of extended pharmaceutical care.

The results of the CPF indicated that some £400 million a year could accrue to the NHS in England from work

in just one field, that of the early detection of Chronic Obstructive Pulmonary Disease and the appropriate care and support of individuals and families affected by COPD. Other examples of innovative pharmaceutical care provision range from the encouragement of 'pharmacy first' approaches to seeking care for common conditions in Yorkshire through to greater pharmacist involvement in clinical research and the treatment of skin conditions in Cornwall (Turner, 2015; Bearman, 2015).

As general medical practices grow larger and more complex, the NHS and pharmacists working in it will (along with other health professionals) have increasing opportunities for systematically extending the clinical and allied preventive support offered to the public in easily accessible premises, provided these can be satisfactorily linked via robust IT systems to GP practices and other primary care facilities. This approach, which may to a degree be taken to mirror the primary and secondary health centre model envisaged by Lord Dawson almost a century ago, might well in time generate major economies in ways genuinely consistent with better service quality and outcomes. However, immediate pressures for cost savings in the narrower field of drug distribution may impair the 'reach' of the current community pharmacy network before its new utilities can emerge, unless relatively rapid steps are taken towards realising community pharmacy's extended promise.

record. The establishment of the latter in the NHS will open the way to independently sited pharmacy services being able to improve access to a variety of diagnostic and therapeutic services without the integrity of medical and wider health records being undermined.

This is not to deny the value of GPs being able to build up continuing relationships with patients in ways which will help them to identify atypical states and serious illnesses as and when they occur. But it is to accept that many interventions – like, for instance, vaccinations or prescribing medicines for ‘first contact’ and preventive purposes and for treating common (as distinct from minor) chronic illnesses – could often be conveniently delivered in pharmacies as well as, when service users prefer it, in general practices.

Not all health policy analysts accept the case for extending the clinical role of community pharmacists. They argue instead that it would be better for them to focus on minimising drug supply costs and optimising the prescribing and use of medicines. For instance, Mossialos et al (2013) warned that (internationally) attempts to change the role of CPs could cause disruptive pressures elsewhere in primary health care economies. They suggested that there is to date inadequate evidence that community pharmacists have the competencies needed to deliver clinical care to the standards achieved by nurses and doctors in hospital clinics or by GPs and their practice team members.

The HOMER trial of home based medication review (Holland et al, 2005) is a source of evidence sometimes quoted in support of such views. It found that home visits to patients by pharmacists undertaken after they had been discharged from hospital care in East Anglia in order to help improve medicines taking had the paradoxical effect of increasing hospital re-admission rates, without enhancing survival rates or quality of life related outcomes. This research also generated data indicating that the didactic approach taken by the pharmacists involved in this project undermined patients’ confidence in their medicines taking abilities, and hence was likely to have impaired rather than improved their drug usage (Bienkowska-Gibbs et al, 2015).

However, it is important not to over-state the significance of such studies. With regard to the HOMER trial, for instance, the research conducted did not involve community or primary care pharmacists with established relationships with local GPs and the patients being treated (Smith, 2015). Individuals working in primary care situations with which they are not adequately familiar and for which they have not been fully trained cannot be expected to generate the same outcomes as those who have established robust contextual relationships and are better aware of both the problems to be avoided and the opportunities to be taken.

With regard to the conclusions reached by Mossialos and his colleagues, they may not apply in the context of

Box 7. Reducing the Age Specific Incidence of Vascular Disease and Dementias through new models of Pharmaceutical Care

In December 2015 the President of the Academy of Medical Sciences, Professor Sir Robert Lechler, called for more attention to be paid to the opportunities for new and established medicines to be used as instruments for prevention and public health improvement, as opposed to their traditional applications as curative or symptom relieving agents (Brimelow, 2015). To date the most widely publicised example of such a strategy relates to the proposed use of statins in combination with low dose anti-hypertensives for the primary prevention/delay of events such as strokes and heart attacks (Wald, 2015).

Such thinking has to date proved controversial, not only because of apparent concerns about drug safety and the relative desirability of promoting healthy life styles rather than medicines use, but also because of its potential impacts on GP practice workloads. It may be argued that if doctors spend too much time on preventive activities of any type, access to medical care in the event of frank disease could be undesirably reduced. Some commentators might also – even if immediate safety issues were resolved beyond reasonable doubt – be opposed to permitting alternative health care providers to facilitate public access to medicines such as combination products

for the primary prevention of vascular disease. This is because of the wider impacts this may have on the medical control of access to, and the public’s use of, medicinal drugs as a whole.

Beyond vascular disease prevention, there are already other areas in which non-conventionally supplied pharmaceutical interventions are having or could have important ‘public health’ impacts. They range from smoking cessation support and the control of dental caries to the prevention of HIV transmission and – potentially at least – the occurrence of osteoporotic spinal disorders and some cancers. As bio-pharmaceutical innovation continues and humanity’s knowledge of fundamental disease causes and developmental pathways expands, many additional opportunities for such preventive interventions will emerge.

In the coming ten to twenty years this is, for example, likely to be so in relation to Alzheimer’s Disease and other forms of dementia. Figure 2 (page 3) of this report suggests that in future community pharmacists might be able cost effectively to play an extended role in helping healthy people to choose pharmaceutically based preventive care, as well as in areas like enhancing access to genetic and other risk testing and promoting health protective lifestyles.

nations like England where primary care faces significant shortfalls in medical staff availability. Throughout the UK significant effort has already been put into preparing for substantive extensions in the role of pharmacists. Qualitative interviews undertaken to inform this analysis suggested a degree of medical as well as public support for the concept of providing clinical pharmaceutical care in not only hospital clinics and GP practices, but also in the independent community pharmacy setting.

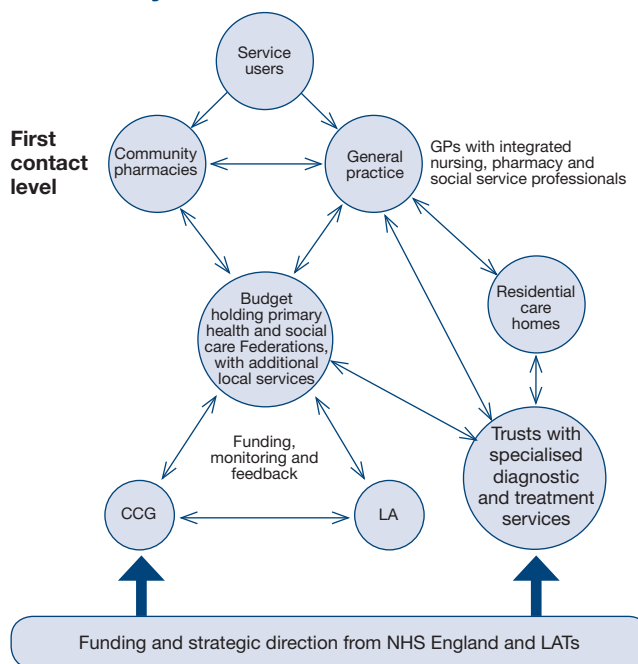
This is not to deny the need for appropriate competency assessments and Community Pharmacy staffing and governance standards, or that on occasions pharmacists themselves may be reluctant to adapt their ways of working to meet new patterns of need and service affordability. But if innovations such as the introduction of graduate ‘physician assistants’ are to be introduced in General Practice it would seem perverse to reject the further extension of appropriately structured health care delivery roles in regulated pharmacy settings. Likewise if the further development of nurse practitioner roles in community settings is to be welcomed, the same might be taken to apply to pharmaceutical care extensions in not only general practice but also in independently sited pharmacies.

Innovation cannot normally be achieved without taking managed risks. Waiting for definitive evidence of safety and effectiveness to emerge before adopting new service concepts can be a recipe for stasis. The transformative idea of the NHS itself would almost certainly have been still born, had not the national leaders of the day been determined to proceed on the basis of logic and good will at a time when the country was recovering from a period of extreme danger and great financial loss. Today, by contrast, British society is more secure and in some respects more risk averse than it has ever been before. However, if primary care in general and Community Pharmacy in particular are to move forward in ways that offer significant improvements for service users, decisive policy choices are ultimately going to have to be made.

Achieving Faster Access to Better Care

Figure 10 outlines a possible future model for NHS primary/community health and social care. A single ‘one size will fit all’ approach cannot be applied in every urban and rural area of a country as diverse as England is today. There is no one ‘magic bullet’ solution capable of guaranteeing answers to all the care cost and quality challenges facing the NHS. But it is realistic to seek a broad framework within which ‘pro-active General Practice and Community Pharmacy’ could more effectively work with care providers such as community nurses, social service professionals and specialist physicians to deliver better support to people living with conditions that, without good care, are

Figure 10: A future model for NHS primary/community health and social care



likely to result in a poor quality of daily life punctuated by recurrent inpatient admissions.

The unique success of general practice throughout the UK is based on continuity of personal care delivery coupled with the capacity to understand and meet the needs of registered practice populations. Yet although GPs play a vital part in primary care, a constructive vision for the future should not over-emphasise their centrality, or deny the importance of forming good relationships between all actors in the NHS (Colin-Thomé, 2011). Well-coordinated and clinically empowered Community Pharmacy services could, for example, contribute more to the appropriate management of long term conditions in partnership with, or as an integral part of, bodies such as GP Federations and/or organisations such as MCPs.

To be cost effective, this will almost certainly require them to become an alternative direct source of some types of care currently offered in General Practice, rather than merely a provider of services aimed at augmenting work that continues to be done by GPs and their immediate colleagues. There is good reason to believe that as IT based links and diagnostic and other support instruments become increasingly available in pharmacy settings and in places like residential and nursing homes, pharmacists will – subject to regulatory restraints – be able to offer a progressively widening range of direct access illness and preventive services.

With regard to supplementary and independent pharmacist prescribing, a degree of progress has been made in the UK over the course of the last decade. But despite the importance of medicines and medicines use expertise to the identity of pharmacy as a profession, it is arguable that more significant advances have

to date been made in the field of nurse prescribing. Internationally, it could also be said that pharmacy prescribing in England is not as far as advanced as it is settings such as, for instance, Alberta in Canada.

The extent of such differences should not be exaggerated (see, for instance, Makowsky and Guirguis, 2014). But it may be concluded that for future 'pharmacy first'¹⁰ policies to be effective it will be essential for community pharmacists to be able to combine extended prescribing competencies with their dispensing management and supervisory capabilities. Relaxations in regulations that presently prevent independent local NHS pharmacies from sharing the use of robotic dispensing machines is one example of the type of reform that might foster future service improvements.

Important progress towards transforming primary care provision is already taking place in 'Vanguard' sites and in a number of other localities (Shortt, 2015). The efforts of agencies like the RCGP, the NAPC and the Royal Pharmaceutical Society are also of value. It is encouraging, for instance, that the National Association for Primary Care's initial Primary Care Home proposals have received support from NHS England. Other relevant initiatives range from the establishment of pooled local health and social care funding systems through to recent plans for a new voluntary General Practice contract. This could, in return for extended commitments to seven day service provision, offer a less bureaucratic operating environment for GPs and help foster schemes such as those involving pharmacists more closely in the monitoring and delivery of patient care.

In the field of community nursing, innovations like – for instance – the establishment of 'virtual wards'¹¹ and common systems of IT based health and social care record keeping also promise enhanced performance. Whatever the failures and distractions of the past, the need to invest in primary health and social care improvements is now recognised at the national level as well as in an increasing number of localities, albeit the amounts of time and financial and human resource needed to establish more appropriate cultures and greater levels of trust and inter-professional collaboration should not be under-estimated.

Examples of excellent practice already exist throughout the country. Yet sustainable progress may prove difficult to achieve in areas which have been less likely to attract 'champions' for new ways of working. From a broad sociological perspective resistance to change is often greatest in settings where people lack shared confidence in their ability to adopt innovative ways of working, and

might have more reason than most to doubt the integrity of those advocating changes like hospital bed number reductions.

Effective change strategies are therefore likely to permit significant degrees of variation. From a social theory perspective voluntarily led and accepted community progress is likely to be plural rather than regimented. Undue centralisation can create 'dependency' cultures that sap entrepreneurialism and inhibit change through over-rigid remunerative and regulatory structures. Nevertheless, many members of the public expect and value service consistency between localities, and there are dangers that in the absence of adequate interventions that provide national direction and the sustained incentivisation of agreed primary health and social care improvements, NHS development will continue to be patchy and variable to an extent which confuses and dismays a significant proportion of its users. Without consolidating action, even performance in exceptional areas may in time slip back when charismatic leaders leave or special funding arrangements (and with them the 'Hawthorne effects' likely to be associated with pilot projects) come to an end.

Such observations point to the potential value of revised nation-wide payment systems that reward and normalise cross boundary data sharing and 'joined up' service delivery, as opposed to 'silo' working and sectional-interest focused 'business as usual' attitudes (Porter and Lee, 2013). Such measures could prove valuable in facilitating more effective work sharing between General Practice and Community Pharmacy, as well as in higher profile contexts such as improving health and social care coordination in order to facilitate earlier hospital discharges. Without measures that effectively create increased capacity in General Practice for the support of people with relatively complex requirements it will be difficult to achieve significant changes in hospital utilisation.

However, financial incentives are not the only drivers of cultural and functional adaptations. In the NHS individuals and groups and local government also need to resolve a range of ethical and value based dichotomies that have in the past stood in the way of better care coordination and productive joint working. Issues that should be more openly discussed and better understood include:

- **Access 'versus' continuity?** The available research points to tensions between meeting calls for rapid diagnosis and care when individuals are in acute distress or seeking to manage common problems that may be discomforting but are perceived as normal daily matters, as against requirements for 'high trust' personal care that are likely to demand continuing relationship based responses. The latter are most needed when people are facing potentially life threatening or life changing difficulties. Coping with the latter can be seen as 'special' in that it calls for identity shifting psychological

¹⁰ That is, policies aimed at encouraging more people to initially present for diagnosis and treatment in 'healthy living pharmacies' or similar settings.

¹¹ Which allow people living in the community to temporarily receive 'hospital at home' support

and behavioural accommodations. All health systems struggle with providing services to meet these two different types of need in an empathetic, adequately coordinated and affordable manner.

There is a case for saying that health service users should be seen by their GPs even when they are expressing 'common care' needs, in order to build therapeutic relationships and mutual understanding. However, there is also an obvious risk of 'swamping' General Practice with tasks such as treating transient infections, providing immunisations and managing conditions like 'normal' hypertension, stable diabetes, asthma or COPD.

Larger general practices may manage this tension by differentiating between service provision by a patient's 'own doctor' and care offered by other staff. However, from both a service user and a public health perspective, building arrangements via which providers such as community pharmacy based staff can safely and cost effectively offer convenient 'pharmacy first' access to preventive, diagnostic and common illness treatment services is a potentially desirable way forward. This will be particularly so if it can be achieved in ways that enhance the integrity of the health records available to GPs and their long term relationships with the people they serve.

- **Large integrated systems 'versus' small diverse organisations?** As previously noted, this is an important topic in the contexts of both general practice and community pharmacy. Larger service providers are by definition likely to be better able to realise benefits associated with the delivery of care at increased scale, even if in practice this goal is not normally achieved via mergers and 'take-overs'. Yet there is also evidence that small organisations can provide environments which are less bureaucratic and in which it is easier to offer support that is experienced as person centred. It can be argued that the UK appears to be relatively strongly focused on forming large organisations with markedly hierarchical power and reward distributions as compared with other European countries, albeit there is also evidence that the performance of NHS doctors in communicating effectively with individual patients is robust in international terms.

Despite the traditional role of independent practitioners in the primary medical and pharmaceutical care systems,¹² the NHS may have been less oriented towards the pursuit of benefits likely to be associated with small professionally led organisations working in circumstances which encourage effective

collaboration than, say, its French or Belgian counterparts.¹³ To the extent that this conjecture is true, multiple sociological and economic factors are likely to underlie it. But for the purposes of this analysis the key point to emphasise is that approaches such as the formation of local Health Care Federations and the NAPC's 'complete clinical community' concept (Chana, 2015) seek to bridge the 'large versus small' organisation divide. Their goal is to combine the benefits of personal relationship based transactions with systemically embedded competencies.

The practicalities of achieving local and/or national remuneration and governance arrangements that can translate this promise into a day-to-day reality have not yet been fully addressed. However, recent research on topics like increasing productivity via establishing self-managed organisations (Laloux, 2014) suggests that meaningful progress in this direction is possible, should the stakeholders in primary health and social care be adequately motivated to seek it.

- **Managerialism 'versus' professionalism?**

Following on from the above, the managerial revolution that has to varying degrees occurred in developed country health services since the 1960s remains controversial, as is the role of non-clinical managers in directing the delivery of good quality care. To the extent that health professionals are not trusted to serve public interests in optimising the value derived from health care resources (Porter, 2009) or lack the organisational skills needed to achieve better service delivery, a competent managerial cadre is required. Yet non-clinical managerial groups can develop counter-productive vested interests and lack insight into key aspects of service provision. It is arguable, if also contestable, that only people involved directly in delivering care are genuinely well placed to coordinate the processes of interaction needed to achieve good medical and wider health and social outcomes.

In recent decades many commentators have stressed the need to closely involve health professionals and service users alike in care quality management in order to help make the NHS a responsive, learning, organisation (Berwick, 2013). New Federation/ Primary Care Home based approaches to the delivery of well-coordinated health and social care could help achieve this end, even though there can be no simple resolution to the challenges inherent in enabling skilled and highly motivated people to work together

¹² Community pharmacy is to an increasing degree provided via large private wholesaler owned chain pharmacies, which puts pharmacists in a different position from most GPs. Business processes can be designed at 'higher' organisational levels are performance managed through to delivery. However, such approaches may not be suitable for the provision of patient centred personal care in relatively complex situations.

¹³ From a constitutional perspective the primary mission of the NHS may be taken to be maximising public health, rather than assuring individuals' rights of access to effective treatments. Existing management and funding arrangements reflect this, albeit within a fragmented neo-liberal institutional level NHS governance framework. It could be suggested that optimally effective health and social care systems are likely to embody values that give priority to protecting the wellbeing and dignity of both patients and health care providers as individuals in society, rather than as units that collectively make up more important entities.

in ways that allow the resources collectively available to them to be used in ways that optimise outcomes for service users.

- **Population health ‘versus’ individual care?**

Despite the work of pioneers such as Julian Tudor Hart (1971), traditional medical and pharmaceutical care models can become unduly focused on treating individuals as distinct from addressing community wide determinants of health and illness. At the same time public health based approaches may on occasions be accused of sacrificing personal care standards and preferences in the pursuit of population level health improvement opportunities.

Such conflicts may be most likely to occur when resources are limited and multiple unmet health and social care needs exist, even if affluence can also be a cause of perverse behaviours. What can be said with confidence is that in developed nations like the UK good quality care for both individuals and the entire population should be achievable, despite claims it is in danger of becoming unaffordable. In reality perhaps the greatest risk is that failures to meet the experienced needs of all service users and community groups in fair and empathetic ways might in the long term undermine political support for the redistributive funding mechanisms required by universal health and social care systems.

Ensuring that care investment and delivery choices are as far as possible taken with, rather than for, communities, and are at the same time informed by the best available evidence and analysis, is likely to offer the most productive approach to assuring decision making that is perceived as reasonable and just. The extent to which this can be achieved by authorities that are remote from service users, or by groups that lack credibility as to their capacity to understand both the biological and psycho-social aspects of health and illness, is inevitably limited.

- **Self-care ‘versus’ professional care?** Traditional professional education can on occasions encourage beliefs to the effect that health and social care is something that is ‘done’ to passive patients by qualified staff. In reality, desired health and social care outcomes are normally co-produced by the combined efforts of service users and providers, coupled with informal inputs from other community members. This is as true in fields like, for instance, orthopaedic surgery and the effective use of anticancer medicines as it is in areas such as community nursing or the provision of smoking cessation support and other preventive interventions.

Free-standing community pharmacies are an important source of self-care products and advice. Failures to link pharmacy based work at the interface

between self-care and the professional treatment of illness more robustly to the ‘mainstream’ delivery of medical care by GPs and other health professionals could miss important opportunities for the further transformation of services and the better use of resources.

Dispensing medicines via the existing disseminated network of Community Pharmacies (at present 90 per cent of people in England live within 20 minutes walk of a pharmacy, rising to close to 100 per cent in urban areas – Todd et al, 2014) currently – along with related services – costs English taxpayers in the order of £2.5 billion per annum. Some commentators believe that this sum could be significantly reduced by computerising the transmission of prescriptions and concentrating dispensing in factory/warehouse-like facilities. Most medicines and allied products could, the proponents of this approach believe, be delivered directly to patients’ homes or to facilities like GP surgeries or collection centres in supermarkets or other retail outlets.

There is evidence that such strategies can save costs and/or release pharmacists’ time for clinical work. However, the net savings such measures are likely to generate are – assuming that an easily accessible capacity to provide the 25 per cent or so of all prescription items classified as ‘acute’ in a timely manner is preserved – likely to be considerably less than is sometimes suggested. Rather than weakening the existing Community Pharmacy service to a point where significant numbers of people lose good physical access to dispensing and other valued services a more cost effective strategy could be to move as rapidly as possible towards extending health care provision in local pharmacies, both to improve service access and reduce pressures elsewhere in the NHS.

Some decision makers may fear negative reactions to such policies, especially if more vigorously led attempts to realise this option were to be pursued, and some sectional interests may wish to exaggerate such concerns. But both doctors and patient representatives interviewed during the qualitative research undertaken for this report agreed that this way forward should now be pro-actively explored.

Towards value based care

To date NHS leaders have often taken a disappointingly binary (‘one side or the other’) approach to resolving the dichotomies outlined above. At the same time institutionally focused governance bodies such as Trust Boards and inadequately informed commissioning bodies have frequently lacked a comprehensive understanding of how best to serve public physical and mental health

interests. With the possible exception of more 'market led' care providers such as community pharmacists, it might also be said that service user 'wants' are too often seen as false signals that health and social care providers should ignore in order to concentrate on meeting 'legitimate needs'.

However, in October 2015 the Chief Executive of NHS England, Simon Stevens, endorsed a pilot programme for care delivery based on the 'Primary Care Home' model (Roberts, 2015). Pursued appropriately, such strategies could not only help to further develop better co-ordinated 'close to home' care for patients but in addition create opportunities for more sophisticated approaches to balancing individual and community requirements.

As already noted, NHS England has also recently announced funding for the experimental employment of several hundred clinical community pharmacists in General Practice. This is a desirable step forward that might in time help overcome some of the workforce problems currently affecting primary care provision. However, it should not be used to justify neglecting the wider development of Community Pharmacy, or discourage the addressing of questions like *'how can the existing body of community pharmacies and pharmacists be enabled to take a progressively more active part in local primary care Federations?'*

There is currently considerable interest in reforms such as what is (in some respects potentially misleadingly) termed the devolution of health and social policy making and service delivery responsibilities to local authority led regional bodies. The most notable example of this to date exists in the Greater Manchester area. Advocates of the budget and commissioning responsibility pooling that this will result in believe it will integrate health and social care, and give elected local councillors a stronger role in directing service developments.

This could permit innovative contracting or other forms of service funding and in theory at least allow service provision in England to become more like the system that exists in States such as Sweden (Box 8). The potential importance of such reforms should not therefore be ignored (McKenna and Dunn, 2015). However, simplistic attempts to introduce them in ways that ignore important cultural and allied success determinants must be guarded against.

Some critics warn that without explicit safeguards such steps might in the UK in future lead to stricter cash limits on overall health and social care spending (legally, local authorities cannot operate with annual deficits) while at the same time reducing national level pressures to increase public health and social care outlays on the care of people with conditions ranging from cancers to Alzheimer's Disease to advanced Western European

levels. Another cause for concern is that a strengthening of local political control in the health sphere could in some circumstances block the development of 'Primary Care Homes' and services provided directly by local professionals in ways that make them more directly and fully accountable to their individual users.

There are allied uncertainties surrounding the future role of CCGs. Some observers argue that they are not consistently fit for purpose in relation to commissioning secondary level hospital care, or community services other than, perhaps, narrowly defined primary medical care. Even in the General Practice context the ability of most CCGs to act has until recently been very limited.

Developments such as those in Manchester and recently in Cornwall might in time lead to new structures that will replace CCGs as they were established in 2013. Likewise, in some localities the emergence of fully integrated primary and secondary NHS provider organisations able to take comprehensive responsibility for developing services in their localities might also eventually lead to further reforms in, or even the abolition of, the current English NHS commissioning arrangements based on a purchaser/provider divide.

However, the past record of serial structural changes in the NHS is not encouraging. Removing or radically reshaping CCGs before they have had time to become more firmly established and define how best they can function might well have perverse consequences, not least because there are presently important opportunities for further extending their roles. The view taken here is therefore that the most productive approach from a health outcome improvement perspective will be to focus on developing Primary Care Federations in ways that will allow them to act effectively as budget holding comprehensive service delivery organisations, working with CCG support and secondary care hospital involvement as local conditions permit.

Achieving this will very probably demand a mixture of 'soft' and 'hard' interventions. Examples range from the further encouragement of public and professional debate about the future of primary care through to the financial incentivisation of better joint working between general practices and independently sited pharmacies. Important questions as to how this can best be done in ways consistent with patient and public interest in choice, as well as in technical, allocative and social efficiency and the improvement of professional motivation, remain to be resolved. But they are at least beginning to be more fully considered.

Even if each community pharmacy in England were only able – over and above their current contributions – to take on 10 per cent of the average general practice's existing clinical and allied workload over, say, the next five years,

Box 8. Health and Social Care in Sweden

As with the NHS in the UK, health care provision in Sweden (which in part because of its wartime neutrality established its modern era system before Britain was able to do so in the late 1940s) is a universal public service financed from taxation. As in this country and most other Western European nations, patient choice and competition between alternative providers have increasingly become seen as important priorities, while public monopoly provision is no longer regarded essential. But unlike the situation with the NHS, Swedish health care provision is based on the principle of subsidiarity. This requires responsibility for financing and ensuring appropriate standards to lie at the lowest possible local government administrative level (Bidgood, 2013).

Sweden spends 9-10 per cent of its GDP on its publicly supported health system. This is a little above the British level. About 70 per cent of this sum is raised by the 21 counties and 290 municipalities that together serve the country's 9 million people. Local charges are often levied at a flat rate, but central government grants funded by progressive national taxation serve to even out resource inequalities. Primary care is delivered by more than 1100 public (owned by the county councils) and private (mostly owned by companies or cooperatives) PCOs. Team-based primary care facilities with four to six GPs together with district nurses, nurses and depending on local needs physiotherapists, occupational therapists, psychologists, and social welfare counsellors represent the most common practice model in Sweden.

Another important characteristic is that, as opposed to the UK position, publicly supported social care in Sweden is better funded and of significantly higher quality across a range of areas, including – for instance – the provision of residential care for older people living with disabilities. Whereas Britain spends only about one per cent of its GDP on such support, the equivalent Swedish proportion is in the order of 3 per cent. Recent changes announced after the 2015 Comprehensive Spending Review may prove sufficient to check the relative decline in social care provision in England seen in recent years (see main text). But they will not contribute to closing the gap between Swedish and British public investment levels in this key area.

The extent to which such data are fully comparable is questionable. It would be wrong to over-emphasise

the extent to the Swedish welfare system as a whole has outperformed that of the UK over the last seventy years. In some areas, such as successfully assimilating large migrant populations with plural care and allied needs, Britain may have done relatively well. However, from an ageing population perspective a persistent weakness at the heart of the NHS and its partner agencies has been the inconsistency between 'free' medical and allied service provision and the fact that 'social' care for people with conditions such as (for example) dementias has typically been charged for until individual or sometimes family funds have in effect been exhausted. This has on occasions created perverse incentives to classify health care as social care, which perhaps helps explain the NHS's chequered record of community nursing service provision.

At other times it has either driven the avoidable use of, or 'blocking' of, relatively expensive hospital facilities. More adequate community provisions could moderate such problems, while simultaneously delivering better overall outcomes. It may be suggested that health and social care 'integration' could in future eliminate such problems in England, and there is evidence that the co-location of primary care workers of all types together with development of good personal relationships and cooperative cultures can generate important advantages. However, if no adequate solution to the underlying challenge of resolving the disparity between 'means tested' social care provision and 'free' health care is found, forming structurally unified provider-side agencies in the pursuit of better care coordination may in practice prove little more than 'magic thinking'.

It is also of note that in Sweden efforts have been made to distinguish between the provision of health care as a bio-medical function as compared to social care as being an activity aimed at enabling satisfactory ways of life to be maintained, and protecting individual choice and required levels of personal autonomy in every aspect of existence (Lindström Karlsson, 2015). The rhetoric of bio-psycho-social care may suggest that confusions between nursing and social care can easily be avoided. Yet inadequately informed attempts to conflate the two might have unwanted consequences that are more difficult to avoid than is commonly recognised.

this could release approaching 5,000 GP FTEs¹⁴ and similar amounts of practice staff time for other activities. Given the challenges facing the NHS, the possibility of gains of this magnitude should not be overlooked.

For some, the barriers still to be overcome in order to achieve such transformative progress may seem daunting. But the original NHS was effectively created

in the two bleak post-war years between the passage of the NHS Act in November 1946 and its establishment in July 1948. Seen from this standpoint, tasks like further improving joint working between General Practice and Community Pharmacy to provide better care access and open the way to enhanced health and social service coordination should not, in today's relatively benign social and economic environment, prove insuperable.

¹⁴ Full time equivalent workforce members

Conclusion

The NHS remains one of the better organised and resourced health care systems in the world. But to meet the twenty first century needs of people in England and the other UK nations as well as possible within the resources available it will have to improve its capacity to offer convenient access to preventive and 'common need' diagnostic and treatment services to people at all stages of their lives. There is in addition a growing requirement for well-coordinated social and health care to provide more complex personal support to patients at high risk of suffering avoidable episodes of serious illness and ultimately losing their independence. Although there is evidence that in international terms the current performance of the UK is already better than that of some other advanced countries, further improvements should be possible.

Enhancing primary health and social services offers an important key to raising the performance of the entire NHS. As the UK's demographic, epidemiological and social transitions continue, and innovative technologies offer new communication and therapeutic opportunities for both professionals and individuals seeking to maintain their own health, the balance of care provision will inevitably shift. But achieving optimal change will require good insight, careful planning and firm commitment to meeting personal and wider public requirements at all levels of the health and social care system, from those of families and local practitioner communities through to specialised hospital care and central policy making.

The unique universal care attributes of British general medical practice means that it can serve as a central plank for continuing NHS development, based on both trusting relationships with individuals and insight into the needs of local communities. There is also a large, if fragmented, body of evidence indicating that Community Pharmacy can beneficially play an extended part in delivering accessible health care, as well as in tasks such as reducing prescription errors and facilitating better medicines use amongst priority groups. If General Practice and Community Pharmacy can more effectively combine their contributions this would open the way to both better public health and significant overall NHS efficiency gains, whatever the uncertainties of the financial environment that lies ahead.

Some movement towards this end has already been achieved. However, no health service has yet achieved definitive system-wide progress towards realigning the working relationships between community pharmacists and doctors in ways that reflect the full levels of gain that pilot schemes and local examples of excellence show are possible.

In England and elsewhere the fundamental reasons for this apparent 'road block' include lagged consumer expectations, cultural differences between the

professions and historically rooted variations in the ways community pharmacists and GPs are educated and remunerated. These differences reflect important distinctions between the tasks of optimising medicines supply and use and that of delivering holistic clinical care. Yet barriers to closer joint working are now fading, along with some if not all of the traditional – in part social class defined – boundaries between medicine, pharmacy, nursing and social work inherited from the past.

The promise of the NAPC's Primary Care Home model is that it offers a route towards establishing better linked funding arrangements for local community medical, pharmacy and nursing services, and a platform for coordinating health and social service provisions. The extent to which progress towards this end could and should be facilitated by adaptive national contracts as distinct from multiple unique local agreements is presently uncertain. But constructive change will be possible if public and sectional managerial and professional interests are adequately aligned, and GPs and pharmacists are sufficiently motivated to take effective action. For independently sited community pharmacy in particular a failure to invest sufficient effort in establishing better integrated primary care provision would – whatever the perceived hazards of pro-actively seeking change – almost certainly result in reductions in its standing and role.

There is a need for individual health professionals to accept risk and lead purposeful service improvements. Undue dependency on central leadership is unlikely to generate viable new health care paradigms. Successful progress towards the formation of well aligned 'complete clinical communities' involving all primary care professionals will be a significant step in the ongoing evolution of this country's health and social care system. It might also help guide the development of cost effective universal health care in other nations.

However, having recognised the value of local innovation and enterprise, national recognition of the importance of supporting better primary care provision is also vital. One of the key conclusions of this report is that establishing more effectively linked financial incentives is a vital priority. Without these there is a danger the NHS will, despite repeated superficial changes, remain 'frozen in aspic' and – in some ways like health care in the Soviet Union in its last decades – ultimately fail, not because of its cost but through failures to evolve in ways that build on the inherent strengths of General Practice, Community Pharmacy and other community care resources.

Working together

Beyond the big issues of cultural change, relationship building and the appropriate financial support of health and (currently means tested) social care, prescribing

and dispensing lie close to the heart of what GPs and pharmacists provide the public. Taking medicines is alone rarely a complete way of resolving serious health problems, even when conditions are correctly diagnosed and effective drugs are appropriately used. Nevertheless, optimising the supply, prescribing and consumption of pharmaceutical products is a central part of good day-to-day health care.

In the past there were public interest focused reasons for strictly separating dispensing from the processes of diagnosis and therapy selection. Yet in the twenty first century advances in areas such as public understanding of health and disease, professional education, health sector regulation and the computerisation of not only health and social care record keeping but many other care related processes are creating a new environment. In the NHS, steps towards pharmacist prescribing have been taken since 2000. But the evidence presented in this analysis indicates once again that more could be achieved.

If in future the skills of pharmacists and the potential of the established NHS community pharmacy network are – as opposed to being lost or wasted – to more effectively boost the capacity of primary care as a whole and so allow the NHS hospital service to function as efficiently and effectively as possible, enabling all community pharmacists to be independent prescribers for ‘common cause’ complaints could well prove centrally important. A second central conclusion of this report is therefore that further extending pharmacy prescribing outside GP surgeries in ways that strengthen rather than weaken the ability of family doctors’ and their practice teams to provide first class individual and population care, and which also optimise the cost effectiveness and accessibility of community pharmacy medicines supply, should be seen as integral to the success of the future NHS.

In the final analysis, promoting new and more effective ways for local professionals to work together in order to provide services has much to offer not only service users, but also everyone working in health and social care. A great deal of the responsibility for developing more effective relationships lies with the immediate providers of such services, often because only they – in partnership with service users – can fully understand the tasks in which they are engaged. But individuals and groups such as GPs and pharmacists alone cannot facilitate the overall service transformation that is now required. Excellent national leadership and the establishment of more appropriate financial and governance systems is also vital for the success of services as a whole, including specialist hospital provision alongside that of community based care.

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This UCL School of Pharmacy report was researched and written by Professor David Colin-Thomé, Dr Jennifer Gill, Zahraa Jalal and Professor David Taylor. Professor Taylor is accountable for its content and any errors. It was funded by an unconditional grant from Pfizer Ltd as a contribution to pharmacy development. The authors thank all those who agreed to be interviewed during the research undertaken for this analysis.

