

# Public Health and Primary Care: Competition or Collaboration?

## INTRODUCTION

*Adalsteinn D. Brown, DPHIL*

Institute for Health Policy, Management and Evaluation  
Division of Public Health Policy, Dalla Lana School of Public Health  
University of Toronto  
Li Ka Shing Knowledge Institute  
St. Michael's Hospital

*Ross Upshur, MA, MD, MSC*

Department of Family and Community Medicine, Faculty of Medicine  
University of Toronto  
Division of Clinical Public Health, Dalla Lana School of Public Health  
University of Toronto  
Bridgepoint Active Healthcare

*Terrence J. Sullivan, PHD*

Institute for Health Policy, Management and Evaluation  
Division of Public Health Policy, Dalla Lana School of Public Health  
University of Toronto  
TJS Associates



## ABSTRACT

*In this commentary, the authors summarize and discuss some of the concerns presented in the papers herein, including issues of funding, skill sets and education. They present two key steps we could take across this country to ensure the long-term viability of public health within our healthcare system and ensure that public health and population goals are shared widely across our health systems.*

THE LEAD ARTICLE in this issue of *Healthcare Papers* (Millar et al. 2014) presents what many would take as a simple proposition. The authors of this paper argue for stronger integration between public health and primary care and raise a number of challenges around the willingness and preparedness of public health to do so. This is clearly an issue at the forefront of both the primary care and public health communities, as witnessed by two recent reports (Committee on Integrating Primary Care and Public Health et al. 2012; Valaitis 2012). Let us leave the issue of willingness and preparedness to other forums and focus on the question of whether and how public health and primary care should be integrated.

For many, the idea that public health and primary care should work together is both a simple and a natural proposition. One of us (A.D.B.) was trained in a Department of Public Health and Primary Care, and another (R.U.) trained as a public health physician and worked as a family physician while publishing in public and population health. All of us look to lights such as Julian Tudor Hart, who worked as a primary care physician *and* put forward a key insight into population health called the inverse care law. Yet as the commentaries that follow Miller and colleagues' paper illustrate, a closer relationship between public health and primary care is seen as neither simple nor natural nor even necessarily desirable. It may be useful to consider some of the objections raised to this proposition.

One general group of objections relates to resources. The argument runs that public health expenditure is already low and that lumping this expenditure with other parts of our health system would create further threats to the public health resource base. No one would argue that we spend too much

on public and population health, and most – including all of the authors in this edition of *Healthcare Papers* – would likely argue that we should spend more and intervene more effectively to promote health. On the books, expenditure on public and population health remains low in Canada compared with our peers and our aspirations for a healthier society. On the other hand, much of historic public health spending gets folded into one or another kind of social or infrastructure spending not posted in public accounts as public health spending, and it is very hard to illuminate the size or importance of such spending (Grogan 2012).

The more interesting question, perhaps, is *how* we should spend more on public health. The idea of merging public health and primary care provokes anxiety because it creates the risk that resources will be transferred from public health to primary care. This concern relates to the tyranny of the urgent; primary care's immediate needs for more and more service will overwhelm any arguments by public health for investments that will require years to pay off and involve greater uncertainties than the simple equation of more money now = more primary care visits now. Indeed, the refrain that improvements in population health are complex and take a long time is common and may be part of the challenge faced by public and population health advocates. It is also likely true of primary care's vulnerability to acute care. It is only recently that ministries of health across Canada have accepted primary care as a priority. Primary care and public health may be able to join for greater strength in advocating for resources.

However, if one searches for the best evidence of preventive intervention, one invariably turns up primary care practices that change patient behaviour, although this might

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be argued to be part of an *evidence trap*. This may in part be because of the bias favouring easily tested clinical interventions over more complex policy interventions when we look for evidence on what works.

This refrain focused on long-term benefits from population health may also tell only half of the story. There are countries that have seen large and rapid improvements or declines in health – for example, Portugal and Russia over the past two decades – as the broader determinants of health improved or declined. The payoff to some public health policies, such as reduced smoking or improved traffic safety in Portugal or a subsidy to the very poor in Brazil, can have an early return on results. If we could make a stronger case for the real and reasonably rapid payoff on public and population health investments, we would not have to create walls to protect what we spend in these areas and a tighter collaboration between public health and primary care might yield great health benefits.

A second set of objections relates to a lost perspective and underused skill sets. The epidemiological perspective, it is argued, is best deployed at a population level that is likely much larger than the standard primary care practice. If epidemiologists and public health experts find themselves mired in primary care practices, they will not be able to do the work that can identify and rectify serious risks to health. This argument is true, particularly when we want to be able to use larger and larger data sets to discover statistically significant and clinically important patterns. Leaving aside the influence of a long list of clinicians with huge public health

impact such as Hart or his countrymen Sir Douglas Black or Sir Richard Doll who were all clinicians (and even specialists), it could be a waste of epidemiological skills to force a focus down on the local populations where random variation overwhelms the ability to detect any patterns.

However, the value of large numbers should not be an argument against infusing a public health perspective into every clinician. As primary care practices consolidate into larger rostered populations supported by electronic health records, clinicians trained in epidemiology, health services research and population health can play a central role in analyzing practice-level data. As well, these clinicians could serve as liaisons to local public health units for the management of infectious disease outbreaks and health promotion initiatives. Just as Sackett and colleagues argued in *Clinical Epidemiology* (1991), the practice of observing the effectiveness of treatments and – in the case of public health – the role of populations, environments and the broader determinants of health should be part of every clinician’s skill set. Again, we might not be as concerned about underused skill sets if all clinicians had a public health perspective or, to paraphrase one of the authors in this issue, if public health really was everybody’s business.

The issue of perspective probably deserves deeper attention. Right now, public health is heavily organized along regional or municipal boundaries with additional agencies at a provincial and federal levels. Thus, regional units provide hugely valuable services but despite aspirational goals are largely in the wrong place to be able to affect the profound determinants of health such as equity, economic development and income distribution. The argument against integrating public health and primary care would be less worrisome if we had greater confidence that

public health had some input into the health consequences of tax policy, economic development programs and monetary policy decisions. Perhaps we should consider instead the integration of public health and higher-order policy making, including social transfers and industrial policy.

Some of the concerns raised by commentators may also be addressed by greater efforts to enhance educational opportunities that explore the large common ground and shared mission of public health and primary care. After all, both are interested in reducing disease burden, the public health physician at the level of primary prevention and the primary care practitioner at primary, secondary and tertiary prevention. Yet our modern primary care practitioners with few exceptions still have little intelligence with which to instrument the state of covered populations with preventive interventions (Glazier et al. 2009). Although some of the commentators look to better structured educational programs as a means of bridging the differences between primary care and public health, it is surprising that none of the commentators mention the Lancet Commission report on transforming education in the health professions for the 21st century (Frenk et al. 2010). This document outlines opportunities to reorient radically the education of healthcare professionals that include an argument for the imperative of integrating public health priorities and population health perspectives into clinical education.

In the Canadian context, many medical officers of health now combine two years of training in family medicine before continuing on to complete their Royal College specialty training. As the cohort of leaders in public health holding dual certification increases, the “two solitudes” mentality will likely break down. Enhancing training opportunities at

the interface of public health and clinical care in other health professions relevant to public health will help facilitate the type of transformative leadership the Lancet Commission argues is required by health professionals in order to best enhance the health of individuals and populations. Initiatives such as the newly created Division of Clinical Public Health at the University of Toronto are premised on developing these competencies.

A close reading of all of the papers in this edition shows one consistency. Public health should be part of our health system and should be strong enough to ensure our system focuses on health and not just the provision of care. But the debate opens up around the questions of where, when and how. Advocates and policy makers will undoubtedly have many options for the short term, but there are two key steps we could take across this country to ensure the long-term viability of public health within our healthcare system.

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The first is to start from the beginning. All healthcare professionals should see the public or population health perspective as part of their skill set and receive training in it from day one of their education. Advanced training programs such as graduate degrees and post-graduate training should try to bridge the disciplines, not reinforce professional silos. The second is to ensure that the goals for our health and healthcare systems include public and population health measures. There are

none of these right now in Canada in any serious way. Focusing on access to care is an excellent way to ensure that we never shift toward population health. Targeting measures of health that are amenable to clinical and population health interventions is the best way to start real collaborations where both perspectives can contribute. Perhaps the first key step in linking public and population health to the rest of our health system is to have measures that reflect improvements in health, a goal that would bring the entire system to public health's doorstep.

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