



Comprehensive Primary Health Care in Australia: findings from a narrative review of the literature

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RESEARCH

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Abstract

Objectives: To identify the extent to which the Alma Ata defined Comprehensive Primary Health Care (CPHC) approach is practised and evaluated in Australia and to describe the role that GPs and other medical practitioners play in it along with implications of this for future policy in light of the Health and Hospital Reform Commission (HHRC) and Primary Health Care taskforce reports, 2009 recommendations.

Methods: We conducted a narrative review of the literature (published and grey) from 1987 to mid 2007 as part of a global review carried out by teams of researchers in six regions in 2007.

Results: In Australia, the CPHC approach occurs chiefly in Aboriginal Controlled Community Health Services, state funded community health and in rural/remote and inner city areas. Participation by GPs in CPHC is limited by funding structures, workforce shortages and heavy workloads. Factors that facilitated the CPHC approach include flexibility in funding and service provision, cultural appropriateness of services, participation and ownership by local consumers and communities and willingness to address the social determinants of health.

Conclusions: The recent HHRC and Primary Health Care Taskforce reports recommend an expansion of CPHC services as a means of tackling health inequities. The findings of this

review suggest that resources will need to be directed beyond individual treatment to population health issues, cross-sector collaboration and consumer participation in order to realise the CPHC model. Without attention to these areas PHC will not be comprehensive and its ability to contribute to reducing inequities will be severely hampered. The absence of an evaluation culture supported with resources for CPHC programs and services also hinders the ability of practitioners and policy makers to assess the benefits of these programs and how their implementation can be improved. Funding structures, workforce issues and evaluation of programs will all need to be addressed if the health sector is to contribute to the goal of reducing health inequities.

Key words

Comprehensive primary health care; general practice; healthcare reform

Background

Comprehensive Primary Health Care (CPHC) has received renewed attention in health policy discussions in recent years. The thirtieth anniversary of the declaration of Alma Ata ^[1] in 2008 was a conduit for discussion of the original vision of CPHC and the extent to which it had or had not been achieved. The Alma Ata Declaration places an emphasis on health services that provide:

- universal accessibility and coverage on the basis of need
- vertical comprehensiveness with respect to access to secondary and tertiary services
- horizontal comprehensiveness with emphasis on disease prevention and health promotion
- active community and individual involvement in health services with an aim of self-reliance
- engagement in intersectoral actions on the determinants of health and
- use of appropriate technology and cost-effectiveness in relation to available resources

The Alma Ata Declaration was viewed as a blueprint for addressing the inequities in health that existed between richer and poorer nations and citizens within them.



A renewed research and policy focus on CPHC was also evident ^[2;3]. One such effort was the “Revitalising Health for All” (RHFA) research and capacity building project funded by the Canadian Global Health Research Initiative (http://www.idrc.ca/en/ev-114548-201-1-DO_TOPIC.html). The aim of this international four year research project has been to assess the extent to which CPHC as envisaged by Alma Ata ^[1] had been implemented around the world and what was still unknown about this approach. Six teams of researchers based in Europe, North America, Africa South America, South Asia and Australia were involved in the first phase of this project: A narrative review of the literature on CPHC and the extent to which it had been implemented and evaluated in each region. Preliminary findings from the global review are available ^[4].

The terms ‘Comprehensive Primary Health Care’ and ‘Primary Health Care’ are contested in the Australian context ^[7;8]. The most common definition sees primary health as a level of care provided at the first entry point to the health system by mainly General Practitioners and possibly some Nursing or Allied Health staff ^[8]. Others have broadened this definition to include first line services that move beyond individual treatment to incorporate measures that are preventative and have a population focus ^[9]. Systematic reviews using this definition of CPHC have been undertaken with a focus on accessibility, financing ^[9] and the various models delivered to Australians living in rural and remote areas ^[10;11]. However, this narrative review undertaken as part of the RHFA project is the first to examine CPHC across Australia as the approach outlined in Alma Ata ^[1] incorporating not only first line medical and allied health care with a range from treatment to prevention but also the other key elements of equity of access, collaboration across sectors beyond health and consumer and community empowerment and participation in the services. In examining the Australian literature, we sought examples of where CPHC was implemented with all these elements present, how it had been evaluated, to whom it was directed and what factors assisted in its implementation.

This paper reports on the findings of the Australian arm of the literature review with reference to the extent and coverage of CPHC. The role of General Practice as part of a CPHC approach is also examined along with the factors that facilitate and inhibit this approach. Results from this narrative review are particularly relevant in light of the current discussion of CPHC in the Health and Hospital Reform commission ^[5] and the Draft Primary Health Care Taskforce ^[6] reports

Methods

A search of online databases was conducted by the Canadian-based team in mid 2007 using an OVID interface for articles published in English between 1987 and mid 2007. Databases included Medline, EMBASE, HealthStar, CINAHL, the Cochrane register of online abstracts and Socio Abstracts. In addition, the Australian team searched the Informit database, performed Google searches and sought grey or unpublished literature from key informants in the primary health care research sector. A full description of the search terms is available from the corresponding author. Table 1 shows the breakdown of the published references from retrieval to inclusion in the final review. A total of 1894 references for Australia were sent to the authors in Reference Manager v11. One thousand, five hundred and twenty abstracts were reviewed using an agreed framework that had inclusion and exclusion criteria. Articles were excluded if there was no significant presence of CPHC as defined by Alma Ata ^[1]. That is, articles reporting only on primary medical care with no presence of addressing equity, multidisciplinary involvement, collaboration or consumer participation were not included in the review. The degree of comprehensiveness of the intervention described in the paper or report was rated on a scale from 0- not present, 1-minimally present to 2 strongly present. A paper needed to score at least 1 in most of these areas to be included in the review. Articles that described only needs assessment or stated that the target group were underserved without any intervention to address this were excluded. Likewise, preference was given to articles reporting some kind of evaluation data, while those that reported on a program, policy or service without data were classified as “commentaries” and included to provide context for CPHC in Australia.

The articles and reports included in the analysis were examined for the presence of a number of items according to the pre-determined framework. The presence or absence of these factors were recorded and analysis examined their strength and focus overall. Box 1 outlines the factors that were examined and analysed.



Box 1: Framework for analysis of articles and reports

Articles and reports were analysed for the following factors:

- Definition of CPHC
- Key questions the article/report addresses
- Site/date/population of program or intervention
- Study design and methods
- Degree of comprehensiveness of PHC
- Impacts/Results/Lessons learnt from the program
- Lessons learnt about CPHC research and the quality of the evidence

Study design and methods were classified according to whether they were experimental, cross sectional, reviews or case studies using quantitative or qualitative methods.

A sample of five articles included were checked via blind application of the framework by the research team in Canada and results compared with the screening done in Australia for levels of agreement. Sixty four scientific articles and eight grey literature reports were included in the final analysis. Twenty seven of these articles were commentaries only.

Table 1: Selection process for inclusion of published papers in Narrative Review Search

Number of published references retrieved from database search	1894
Articles with no abstracts discarded	374
Articles with Abstracts reviewed by first author (CH)	1520
Abstract excluded as not meeting inclusion criteria for CPHC	1273
Full text reviewed using framework by two reviewers (CH & JJ)	247
Articles excluded as not meeting inclusion criteria	183
Published articles included in narrative review	64
Articles including significant role for GPs or other medical practitioners	22

Results

The analysis was examined to answer a number of questions. In this paper, we present the findings on where CPHC is practiced in Australia, the extent of involvement of GPs in CPHC and the enablers and barriers to this involvement.

Where is CPHC practised in Australia?

The narrative review confirmed the findings of other related reviews^[9;12] that CPHC as outlined in Alma Ata^[1] is mainly occurring in Aboriginal Community Controlled Health Services (ACCHS), some state-funded community health services, particularly those serving inner-city populations^[13-15], in some rural and remote areas via multi-purpose services^[16] and other specifically funded initiatives designed to address the needs of isolated rural communities^[17]. Such services are provided for people experiencing disadvantage that makes accessing conventional general practice difficult for reasons including availability, cultural appropriateness and complex needs that require more than front-line medical care. Therefore, the studies reviewed described CPHC services for Aboriginal people, the homeless, people from low socio-economic backgrounds and people whose first language was not English. Those papers from rural and remote areas tended to report services that were accessed by communities rather than specific groups. Many of the studies described only one program or part of a program rather than a whole service and most were using time-limited funding.

Involvement of GPs in CPHC

Twenty two studies included in the review reported on programs or services that included a significant role for GPs or other medical practitioners. A number of these were descriptive commentaries on GPs as part of ACCHS^[18;19] while some studies included programs that had GPs operating as part of a multidisciplinary team^[16;20] or were specifically funded models of care such as the co-ordinated care trials^[21]. Very few studies reported CPHC programs or services initiated by GPs or hospital-based medical staff. Two exceptions^[14;22] are reported in Boxes 2 and 3.



Box 2: The Asthma Linking project

Lowe & O'Neill^[14], reported on an asthma management program targeting culturally and linguistically diverse and low income families collaboratively between a children's hospital outpatients, local GPs and a Community Health Centre (CHC) in inner city Melbourne. Asthma educators based in the CHC were assigned to families that presented frequently to the hospital with uncontrolled asthma in their child. Asthma educators also worked collaboratively with GPs and other professionals and the family on asthma control issues. Flexible appointments, interpreters and after hours work were used to make the service accessible to more families. Families also chose the most suitable venue for the appointments with most choosing home visits or the CHC. Support was given to some families in areas that contributed indirectly to asthma exacerbations where the family did not act preventatively due to other stressors. Help with a parent's illness, housing problems and unemployment were some examples of issues that required referral to other services. Some families reported improved asthma management as a result of better understanding, tailored education and culturally appropriate services and information. Improved coordination of care and appropriate accessing of services was another outcome for some families.

Box 3: The Wiradjuri General Practitioners and Aboriginal Health Workers Project

Andrews et al^[22] reported on a collaborative project in rural NSW undertaken by the Central West Division of General Practice, the Mid Western Area Health Service and the Midwest Wiradjuri Aboriginal Health Council. This program aimed to increase Aboriginal people's access to GP services. The project was overseen by a management committee with majority Aboriginal representation and chaired by a local Aboriginal person with regular reporting to the Aboriginal Health council. Three consultation meetings were held between GPs, Aboriginal Health Workers (AHWs) and community members. Project strategies included a list of AHWs, cross referral between them and GPs, outreach clinics and cultural awareness training. Both Aboriginal people and GPs benefited from meeting and working with each other in the project and this led to greater service uptake and greater awareness for both service providers and community members. Increased immunisation rates were another positive outcome.

Enablers and Barriers for CPHC in Australia

The review identified a number of factors that facilitated a fuller implementation of CPHC in the Australian context. These included providing culturally appropriate and accessible services, funding and staffing structures that allowed flexibility

of service provision in terms of location, appointment times and the range of staff providing services. Free or bulk-billed services were also an important feature of increasing access for the most disadvantaged groups^[13;22]. Often outreach activities enabled people to learn about what services were available and how to access them. It was also identified that if isolated or disadvantaged groups saw demonstrable benefits from the services provided they were more likely to continue to use them or to tell others about them. The use of culturally acceptable staff such as Aboriginal Health Workers or interpreters and peer workers also enabled access to PHC for some groups. A willingness to move beyond treatment to a focus on social determinants of health as described in the case study in Box 2 improved the impact of services and outcomes for some patients. Finally, active participation by consumers of health services and their communities was identified as a strong contributor not only to the uptake of services but also to the shaping and development of appropriate services for that particular group or region.

Barriers to CPHC in Australia found by the review concur with those identified by other studies^[9;10;23]. These include current funding structures that do not facilitate collaboration between health professionals and GPs, the State/Commonwealth divisions in funding between primary medical care and community and allied health services. There is also a problem of multiple funding sources and accountability mechanisms for ACCHS^[24] and an emphasis on short-term projects and trials set up to address access and complex health issues that are not subsequently fully evaluated or funded on an ongoing basis. This leads to a loss of goodwill among professionals and frustration among communities^[10]. A lack of services and funding to address acute needs, particularly in rural areas and among Aboriginal people also means that it is difficult to find time or money to address more long-term chronic health issues and the social determinants of these^[21;25]. Similarly, heavy workloads, staff shortages and funding structures prevent sustained participation of GPs in CPHC. Finally, the review found that few CPHC projects or services are properly evaluated with data being mainly descriptive in nature. Multiple factors account for this such as lack of time and skills (including in culturally appropriate research methods) among program staff, and absence of funding for the evaluation of services. Limited evaluation restricts the capacity of programs to assess what they are achieving and for others to assess how it might be applied elsewhere.



Discussion

Our review's findings that the CPHC approach in Australia is focussed mainly on marginalised and disadvantaged groups through small short term programs or community controlled or community health services with minimal evaluation has important implications. Health reviews undertaken since the federal election in November 2007 have argued to move health away from an emphasis on acute care provided in hospitals to focus on managing chronic and ongoing health issues in the community. Equity issues that prevent some groups from obtaining the health services they require and prevention of disease have also been emphasised. The Health and Hospitals Reform Commission Report ^[5] identified that one way to improve the performance of PHC was for the Commonwealth to take over funding of community health services as a way of addressing the divide between them and general practice services, and to encourage integration and collaboration between them in the management of complex and chronic patients and prevention. The report also proposed encouraging voluntary enrolment of such patients to allow them to access a package of medical and allied health services tailored to their needs. The evolution of Divisions of General Practice into something similar to New Zealand's Primary Health Care organisations ^[26] which are responsible for co-ordinating services and tailoring programs to address the health needs of their local populations was also suggested ^[5].

However, neither the HHRC report nor the Draft Primary Health Care Taskforce reports incorporate the full Comprehensive Primary Health Care approach as described in Alma Ata. While they consider improving equity of access and collaboration between health practitioners, cross sector collaboration to tackle the social determinants of health and empowerment of communities to have real participation in how services are distributed and operate are only minimally addressed. It has been suggested elsewhere ^[27;28] that both these factors are key to reducing health inequities and the results of this narrative review provide some support for this view. Without attention to these areas PHC will not be comprehensive and its ability to contribute to reducing inequities will be severely hampered. The absence of an evaluation culture supported with resources for CPHC programs and services also hinders the ability of practitioners and policy makers to assess the benefits of these and how their implementation can be improved.

The next stage of the RHFA project is funding the evaluation of CPHC services in twenty one projects around the world. In Australia, this evaluation research is focussed upon three ACCHS as the main exponents of CPHC in this country. In addition, a five year NHMRC project is investigating the evaluation of effectiveness of forms of CPHC in six primary

health care sites in South Australia and the Northern Territory (<http://som.flinders.edu.au/FUSA/SACHRU/Research/cphc/index.htm>) It is hoped that the findings will provide more knowledge and awareness of what enables a CPHC approach to provide well co-ordinated care, address the underlying determinants of health and what roles and structures are required to encourage GPs and other health professionals to work together effectively.

These findings will contribute to a stronger evidence base on how the comprehensive PHC model envisaged in Alma Ata (including intersectoral action, community participation and multi-disciplinary team work) can be further enhanced and implemented as part of mainstream health services. There are important lessons for the current health reform processes in Australia in terms of the need for all elements of PHC to be present for more effective health care delivery to be realised and health inequities addressed.

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CONFLICTS OF INTEREST

The authors declare that they have no competing interests