Primary Health Care

Policy Position Statement

Key messages:

Primary Health Care (PHC) is a whole-of-society approach founded on the premise that all people, have the right to achieve the highest attainable level of health. PHC is committed to the interconnecting principles of equity, access, empowerment, community self-determination and intersectoral collaboration. Public health informed models of PHC involve understanding the social, environmental, political, commercial, cultural, and economic determinants of health, supporting population health through a range of approaches including health promotion, prevention, and rehabilitation.

Key policy positions:

1. As described in the foundational 1978 Declaration of Alma Ata, PHC is essential for the health of individuals and communities. Models of PHC should seek to comprehensively address population health needs, with the focus of care expanding from a reactive to a planned approach.
2. PHC requires a multi-sectoral approach and involves partnering with all members of society who have the capacity to promote health and wellbeing.
3. Approaches to PHC should be equitable across the population; address local area health needs; embed community participation into decision-making; be sustainable; and be culturally competent.
4. Greater political effort is needed to develop and implement sustainable PHC funding models to promote health equity; recruit, train, develop and retain health workforce; embed multidisciplinary collaborations across the health care sector; prioritise action on social, environmental, commercial and political determinants of health; grow public health basics, including health promotion, prevention, screening and intervention; and enhance efficiencies in systems to support better performance in care delivery.

Audience: Individuals & communities involved in PHC; advocacy groups; Governments, policymakers; program managers; health professionals; Aboriginal community-controlled organisations; non-government organisations; PHAA members; media.

Responsibility: PHAA Primary Health Care Special Interest Group

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Contacts: PHAA Primary Health Care Special Interest Group: Shalomie Shadrach: doc_shalom@yahoo.co.in and Mary O'Loughlin: mary.oloughlin@jcu.edu.au

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PHAA affirms the following principles:

1. The foundation for this policy, is the vision of the World Health Organization's (WHO's) Alma Ata (now Almaty) Declaration which recognises that PHC is essential, community-based health care and is fundamental to the attainment of health for all. The delivery of health care must meet immediate and longer-term population health needs through health promotion, prevention, curative, and rehabilitation approaches.[1]
2. Universal access to PHC should be based on the right to enjoy a variety of goods, facilities, services and conditions necessary for health. It should contribute to improving the health of vulnerable groups and is an essential responsibility of governments. Investment in PHC promotes equity for individuals and communities and can strengthen and protect the health and wellbeing of all.[1]
3. A comprehensive PHC approach, that is based on a broader understanding of health, should be the foundation of a coordinated health system. This means the social, environmental, cultural, political, and economic context; alongside the capacity for individual and community participation in PHC decision-making, underpins universality, quality, equity, efficiency, and sustainability in PHC.[1,2]
4. Integrating public health approaches within PHC is a necessity. This includes actions to enhance equity, services based on the holistic needs of the population and building capacity for promotion, prevention, and early intervention in health care across the life course.[3]
5. Using a person-centred approach to PHC service delivery is vital. The importance of consumer lived experiences to develop and reform PHC, in partnership with health practitioners, service providers and funding entities, is recognised. Ongoing efforts are required to support and sustain consumer partnerships in all stages of health service planning, implementation, and evaluation.[4]
6. Individual and intersectoral collaboration is necessary for effective action in PHC with a health in all policies approach.[5] At local, national, and international levels this involves individuals, communities, health and non-health professionals and organisations.
7. A health system that is committed to continuous investment in PHC training, research and evaluation promotes accountability in funding, identifies opportunities to strengthen service delivery, and helps to build a sustainable, supported health workforce.

PHAA notes the following evidence:

8. Comprehensive PHC includes:
    a) Services and programs that are of an interdisciplinary nature in which accessibility, equity, sustainability, culturally competence, safety, effectiveness, and efficiency are enshrined.
    b) Person-centred services which recognise and develop approaches that value health consumers as central to their own self-care management.
    c) Illness prevention, health promotion and advocacy activities.

d) The provision of oral health services, both preventive and reactive, as an essential component of service delivery.

e) Community participation in the planning, organisation, operation, and evaluation of services.

f) Strategies to address the health needs of individuals and communities by improving health literacy.

g) Evidence-informed services and programs delivered by a range of health practitioners. [2]

9. Oral health is integral to overall health and well-being. Poor oral health is preventable by evidence informed public health measures including water fluoridation; healthy public policies including tobacco and nutrition policies; and behavioural approaches to mitigate risk factors. As an essential function of health, oral health care is best delivered, universally, in the PHC setting. [6]

10. Systemic structural barriers to the realisation of the principles of PHC include:

a) Parallel and inconsistent federal and state/territory involvements in health service delivery, leading to cost-shifting between the jurisdictions and uncoordinated systems and processes.

b) The complexity of a public-private delivery of PHC services in which many general practices, allied health services providers and pharmacies are privately owned businesses, whose income is reliant on a range of funders including governments, insurers, and individuals. Funding constraints influence the range and scope of service provision. [2,7]

c) The provision of reactive medical services is a key driver for PHC decision making. While the need for a preventative approach is acknowledged, there is an inadequate commitment to health promotion and preventative approaches, with limited priority and funding for prevention.[2,8]

d) Insufficient PHC resourcing across the sector. Inadequacies in PHC service provision leads to increases in morbidity and mortality, and additional, potentially avoidable costs in secondary and tertiary care. [9] Concomitantly, undue pressure on PHC services to meet the needs of hospital avoidance and post-acute care is at the expense of the delivery of comprehensive PHC.

e) Dominance of short-term project grants in funding of models to improve health outcomes through PHC and a lack of rigorous, publicly available longitudinal evaluations of successful models. [10]

f) Workforce challenges in PHC include an overburdened workforce, [11] struggling to meet the expanding needs of the population, especially in rural and remote areas; competition instead of collaboration between some health professional groups; barriers that prevent health professional groups working to their full scope of practice; and insufficient investment in research and workforce development.[8]

g) Insufficient funding for approaches that address the underlying determinants of health and well-being. Overcoming barriers to universal access to PHC services; improved access to affordable and functional, safe housing; meaningful employment; and social inclusion, will help to redress the current inequities in the population's health.[2]

h) A lack of reliable, effective digital infrastructure, digital health literacy and data sharing between PHC and the acute care hospital sector impedes data-led decision making.[12] This reduces individual and community capacity to make timely decisions about health care and limits continuity of care, as accessing an individual's own health data can be complex.[13]

11. In 2022, the Australian Government released a ten-year plan for PHC. Foundations for PHC reform identified in the plan include:

    a) Voluntary patient registration to promote person-centred, continuity of care in general practice.
    b) Funding reforms, including the advancement of blended payment models.
    c) Increased opportunities for the PHC workforce, including the medical, nursing, and allied health workforces.
    d) Digital health infrastructures, including improved data sharing mechanisms across service providers.
    e) The promotion of data linkages for evaluation and research to improve health and health service outcomes. [14]

12. Strong leadership is important in sustaining the implementation of policies and programs. Leadership in PHC policy and development involves of a wide array of actors including planners, providers, users, and communities. These stakeholders must work together to create a robust, comprehensive, fiscally responsible health care system that addresses the health needs of the community, including disadvantaged population groups.

PHAA seeks the following actions:

13. *Person-centred approach to care* - Implementation of the PHC reforms outlined in *Australia's Primary Health Care 10 Year Plan* should be with an authentically, person-centred focus; involving intersectoral collaboration between all stakeholders including individuals, communities, governments, health professional groups and private organisations. Individuals and community should be involved in all areas of health service planning, delivery, and evaluation.

14. *Prevention* - Health promotion, prevention, screening, and intervention are necessary activities to improve the health and well-being of individuals and communities and reduce health inequality and inequity across the population. Actions to address the determinants of health are requisite to underpin the preventative approach. Strengthening action to identify, implement, and evaluate strategies that prevent ill-health, including the underlying determinants of health, are required.

15. *Funding* – PHC requires extended and flexible funding models to support service delivery that improves equity, allocative efficiency, and distributional justice. This action includes:

    a. increasing core business funding (that is, an ongoing funding stream) for organisations engaging in essential PHC activities;
    b. exploring flexible funding arrangements to develop person-centred comprehensive PHC models, services and resources;
    c. providing funding to support self-management and community participation approaches in PHC, including strategies to promote digital health literacy; and,
    d. expanding health funding to universally embed access to preventative and reactive oral health care into PHC service delivery.

16. *Workforce* – Investment in research and workforce development is necessary to recruit, train, develop and retain the PHC workforce, particularly in regional, rural, and remote areas. Actions include:

    a. identifying barriers that prevent health professional groups working to their full scope of practice, and employing efforts to overcome these barriers; and,

b. developing strategies and providing funding to support team-based approaches to care, involving a range of health workforce disciplines, working collaboratively and effectively using their scope of practice.

17. *Care coordination, digital infrastructure, and data sharing* – Increased efforts are required to improve PHC coordination and data sharing across the wider health care system, especially with hospital-based care. With a focus on person-centred continuity of care, actions include:

    a. developing resources and processes that improve both the quality of, and access to, timely information;

    b. strengthening intersectoral digital infrastructure, including the requirement for publicly funded providers, including private organisations who receive Government funding, to share health information that is useful to individuals and communities for health care decision making;
    c. supporting the electronic health literacy of individuals, communities and the health workforce;
    d. strengthening the development and usage of person-focussed digital health record repositories, such as My Health Record; and,
    e. establishing publicly available health performance indicators that are understandable and useful to individuals and communities.

18. *Research and evaluation* - Strengthen PHC research capacity and funding. Actions include:

    a. providing resources to support innovation with respect to collaborative, intersectoral and community-informed models of PHC practice;

    b. supporting education and training initiatives that lead to wider implementation of PHC principles;
    c. increasing funding for research and evaluation of comprehensive PHC models of care, especially for those that involve preventative approaches;
    d. further developing evaluation methodology that measures person-centred outcomes; and
    e. ensuring that robust, appropriate, and timely evaluation methods are requisite as part of all PHC service and activity funding agreements.

PHAA resolves to:

19. Advocate for the above steps to be taken based on the principles in this position statement.
20. Actively promote the principles of comprehensive primary health care.
21. Actively support collaboration amongst primary health care stakeholders to achieve better outcomes for all.
22. Advocate to strengthen community participation in the design, implementation, and evaluation of primary health care services.

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