



The role of organised primary health care in addressing the social determinants of health

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A number of recent, high-profile reviews have recognised that Australia's health system needs to be reoriented: it must be much less geared towards acute care and much more prevention and primary health care focused.ⁱ⁻ⁱⁱⁱ The Government has responded with a number of commendable policy platforms including the National Primary Health Care Strategy and the National Preventative Health Strategy. At the highest level, the Council of Australian Governments (COAG) has endorsed a reform agenda designed to strengthen primary health care^{iv}. Against this backdrop, Australia is in the midst of forming primary health care organisations (PHCOs) – known as Medicare Locals – to improve coordination and integration of primary health care in local communities, address service gaps and make the health system easier for patients to navigate. Medicare Locals will be a form of organised primary health care similar to Primary Care Trusts in the UK and Primary Health Organisations in New Zealand. This essay discusses the relationship between the social determinants of health and contemporary Australian health care policy and addresses the question, 'what is the role of organised primary health care and the primary health care setting in addressing the social determinants of health?'

Introduction: what is health?

Medical science has made some commendable advances in treating disease over the last century – advances that can help with the diagnosis, prognosis and prolonged survival from serious disease. Yet even in wealthy countries that can afford to provide these medical treatments on a universal scale, a social gradient in health still operates whereby people who are less well-off have greater levels of morbidity and markedly shorter life expectancies than richer people. Scientific study shows that health status is extremely sensitive to the social and economic environment and is significantly affected by these so-called "social determinants" of health such as poverty, early childhood experience, education and health literacy, working conditions, unemployment, social support, illegal drug use, good food, transport, as well as access to health care.

The underlying message is that health is more than simply the absence of disease or infirmity. Attaining good health requires more than treating illness. More important for the health of the

population as a whole is the need to address the social and economic conditions that make people ill and in need of medical care in the first place. This concept has been encapsulated by the World Health Organisation (WHO) as comprehensive primary health care^v and has led to a broader definition of health as “a state of complete physical, mental and social well-being”.

Reiterated through the Alma-Ata Declaration (1978) the connection between health and its social determinants has led WHO to mandate that all its member nations address the social roots of health problems through health, social and economic action and to also call on all national and international stakeholders to develop and implement comprehensive primary health care throughout the world in order to achieve “Health for All”. The declaration specifies that, in addition to the health sector, comprehensive primary health care “involves, all related sectors and aspects of national and community development...[including] food, industry, education, housing, public works, communication, and other sectors; and demands the coordinated efforts of all these sectors”^{vi}.

A ‘wicked’ problem: why we need a new paradigm of health

This broader definition of health and the goal of comprehensive primary health care means that health policy must encompass much more than the provision, financing and regulation of medical care, because achieving wellbeing is a function of more than just the health sector. Moreover, the existence of the universal social gradient and the strong evidence between health and social factors means we are all affected to some extent - it is just a matter of degree. As a result, taking a comprehensive approach to health policy and practice that recognises and addresses the social determinants of health is essential to achieve overall population health improvement.

Australia has been slow to take this comprehensive view of health and the social and environmental factors that influence it, focussing instead on a more medical model of health. This is evident in the proportion of health spending devoted to prevention (ref).

It has concentrated its efforts and certainly its health expenditure either on the acute/hospital sector, or on cost-effective, short term, curative focussed interventions (selective primary health care). This has, in effect, diluted the social and political dimensions of the original WHO PHC vision³.

The adverse implications of this ‘bias’ in our health system have started to surface. The focus on acute, technologically driven, reactive care has exacerbated health inequities, creating what public health experts term “islands of excellence in a sea of mediocrity”, as well as contributing to rising

health costs. Yet evidence shows that more comprehensive primary health care oriented systems produce better outcomes, at lower costs, greater equity and with higher user satisfaction.^{vii}

Unless Australia quickly acts to implement a comprehensive primary health care agenda that incorporates policy objectives designed to improve health by addressing some of the determinants of poor health outcome, this has far reaching social and economic implications. Socially, in Australia and around the globe, people are increasingly holding governments to account on issues of fairness and social justice. Economically - poor health and well-being accounts for substantial productivity losses, reduced tax revenue, higher welfare payments and increased treatment costs. Moreover, in all OECD countries, total spending on healthcare is rising faster than economic growth^{viii}.

If we are serious about striving for WHO's vision of health for all in Australia, we need to make a concerted effort to balance and coordinate 'traditional' health policy set and implemented by health departments with policy and action to address social determinants by non-health government agencies and sectors is required. Achieving this cross-sectoral collaboration in Australia presents us with a 'wicked' problem. A 'wicked' problem is broadly considered as one highly resistant to resolution, and having a number of characteristics requiring multiple and unique remedies^{ix}. Health in a number of its facets can be described as a 'wicked' problem, but the social determinants of health are especially so as they encompass the complex and wide ranging dynamics of the social and environmental realms.

Australia's current opportunity

The notion of comprehensive primary health care (CPHC) in Australia is gaining renewed momentum as a means of achieving more equitable and affordable population health. Recognising the gains made in countries such as New Zealand and the UK through implementation of policy that takes into account the social and environmental factors influencing health, the time is ripe for Australia to set and drive a CPHC agenda. Limitations of a narrow medical model of health, an increasingly robust evidence base for the social determinants of health and the Federal Government's commitment to reform are all converging to create a policy window that has the potential to change the way we conceive health in this country and how we deliver health solutions.

Experts and key health stakeholders have recommended the need for organised primary health care at the regional level to deliver on this comprehensive model – this has included AGPN's Primary Health Care Position Statement and blueprint for Australian PHCOs. The Australian

Government has responded by designing Medicare Locals. Medicare Locals will be 'meso' level PHCO structures that will sit between governments and communities. The primary focus of these new organisations will be on population health planning with a view to addressing priority areas of need and service gaps within their regions. There will be a strong emphasis on partnership and collaboration. Mandates of Medicare Locals also require greater community engagement and input into primary health care service development and delivery.

Most significantly, the performance of Medicare Locals will be required to be transparent. Healthy Community Reports published by the proposed National Health Performance Authority will indicate the impact of Medicare Locals on key factors such as access to services, quality of services, patient outcomes and patient experience^x. It can be fully expected that in order to achieve their obligations and demonstrate health improvement in their communities, Medicare Locals will need to build links with other agencies beyond the traditional health sector - for example in education, housing, welfare and the like - to become a means through which health and social factors can be simultaneously addressed.

A comprehensive primary health care vision: the role of Medicare Locals

To do this, Medicare Locals must expand their scope of vision, action and responsibility to look beyond the boundaries that have, traditionally, neglected to view social, economic and environmental factors as core health business. This will especially require Medicare Locals to work collaboratively and synergistically across sectors and organisations - a way of working that demands innovative leaders and thinkers, flexibility and vision, daring and excellence. Health and social care leaders must 'think outside the square' to achieve this vision.

The Australian Public Service (APS) Commission has acknowledged the significant and far reaching problems that the APS has with tackling 'wicked' problems requiring highly complex solutions that are reliant on inter-sectoral team work and multi-faceted approaches^{ix}. Yet fundamentally, both at government and departmental levels, the APS is not structured to work in the manner that can necessarily and easily solve complex problems. The fact that we have a federal system creates divides between national and state governments; our democratic political system facilitates and promotes differences of view, and often fierce competition between those views; and the public finance system, perhaps as a result of this, is delivered in silos; all of which are barriers to innovative cross-sectoral collaboration and synergism.

To begin solving some of these 'wicked' health problems, we must therefore look beyond the hierarchical apex of bureaucracy to the grass roots actors, who do not – or at least not to the

same extent - operate in such a constrained environment. It is at this level that Medicare Locals can influence, innovate, shape and drive the way health is viewed and the way its services and interventions are thus delivered. These primary health care organisations will have ample opportunity, over time, to work synergistically with broad and varying sectors and stakeholders, in what will become joint efforts to address health problems at their 'socially determined' roots.

Advantages of building on the Divisions Network

As long as they have sufficient administrative and financial flexibility, a real advantage of Medicare Locals is that they are well placed to link the relevant agencies, sectors and levels of government together and bind them to a common agenda: the health needs of their particular community of interest. Moreover, by 'pooling' funding and actively coordinating effort at a regional level they could quickly become the main vehicles for driving the social determinants of health agenda in ways that are relevant to the particular characteristics of Australia's diverse population and geography and in ways that government agencies have never been able to do.

Medicare Locals have already been given the best start in their CPHC endeavours by being built on the existing Divisions of General Practice Network. Over the last 17 years, Divisions across Australia have increasingly implemented inter-sectoral approaches which reach beyond the traditional "health" sector to address the social factors in health. While such approaches will need to be expanded more universally across a Network of Medicare Locals, the foundations for this approach are undoubtedly already there within the Divisions Network. Such capacity has been long recognised. The Phillips Review of the Divisions of General Practice Program noted the logic of the Network evolving to operate under a comprehensive primary health care framework, building on and retaining its general practice roots^{xi}.

Many Divisions have already identified the need for a more comprehensive, whole-of-community approach by working across settings and partnering with social care stakeholders to deliver new models of care and community projects aimed at building social capital, and strengthening inter-sectoral linkages to improve peoples' living conditions – to impact on health through starting to address these fundamental social factors. Initiatives have included the development of market gardens in remote communities where access to good quality fresh food is limited; the instigation of community support workers in drought affected rural communities that can build community capacity and resilience and can link people with other non-traditional health sectors, such as financial counsellors to again address the underlying issues that impact on health. Further initiatives include new models of care such as **headspace** designed to provide 'wrap around' care and support for young people from a coordinated team of health, social services and vocational

advisers and new workforce in the form of care coordinators and outreach workers under the Closing the Gap initiative to assist Aboriginal and Torres Strait Islander peoples access care and overcome some of the structural barriers to access such as a lack of transport.

Conclusion

We must reconceptualise the way we think about health in Australia if we are to achieve the WHO's vision of "Health For All". This means looking beyond the traditional boundaries and models of care to the social and environmental factors that determine our health, rather than waiting for disease and infirmity to set in before treating it. To do this we need a strong, regionally responsive and locally governed primary health care sector to drive a comprehensive approach to improving health.

The policy landscape is looking promising: a number of reviews and expert opinion has converged on the need to reorient our system to one that is prevention and primary health care centric, a principle now embraced by all governments. As they are designed and mandated to do so, Medicare Locals will have an unprecedented opportunity to create innovative ways of working collaboratively and synergistically across sectors and organisational boundaries. This is what will be required to effectively address what are 'wicked' health problems, by targeting their causes at their roots. We are only in the early stages of what is going to be a long and challenging road ahead for equitable, efficient and effective health care - and the associated health outcomes that comes with it, but with a strong foundation on which to build, and the right creative and innovative clinical and local leaders steering it, the future of health care in Australia looks promising.

This article was written as part of a broader collection of essays and opinion pieces on the social determinants of health, composed by a range of Australian health and social care leaders and policy experts. The publication is titled "*Determining the Future: a Fair Go & Health for All*" and was produced and edited by Catholic Health Australia. More information is available at:

http://www.connorcourt.com/catalog1/index.php?main_page=product_info&cPath=7&products_id=169

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