
POLICY BRIEF

A Vision for Comprehensive Primary Health Care in Australia

The World Health Organization Alma-Ata Declaration (1978) presented a vision for comprehensive primary health care (PHC) which is being reaffirmed by WHO in 2018 with a focus on its relevance to reducing non-communicable diseases. Despite this, a disease-focused *clinical* PHC approach has dominated health system reform in most countries. By contrast *comprehensive* PHC:

- Acknowledges the socio-cultural and political characteristics of the community
- Adopts a holistic, social view of health
- Provides universal health care and equity in health care access and outcomes
- Ensures a continuum of care including treatment, rehabilitation, prevention, and health promotion
- Uses multi-disciplinary teams
- Recognises and supports community participation in decision making and empowers individuals and communities
- Uses intersectoral action and advocacy to address the impact of social determinants of health, including education, income, housing, transport, employment and racism.

The Southgate Ten Point Plan for Reform of PHC in Australia

1. **A national PHC policy and implementation plan** should be developed and complemented by a **national Social Determinants of Health policy and implementation plan**. These policies should be resourced and their development led by the Department of the Prime Minister and Cabinet and COAG.
2. The national PHC Plan should promote comprehensive PHC and **provide an overarching framework for a national approach to primary health care, rehabilitation, and community based disease prevention and health promotion**. It should pay particular attention to equity of access and outcomes.
3. **A national program of comprehensive community controlled PHC centres** in rural and urban settings should be funded and progressively rolled out in each jurisdiction. These centres should provide curative and rehabilitative multidisciplinary primary medical care services and be the focus of local disease prevention and health promotion activity conducted in partnership with local government and existing health services. They should also build community capacity through health promotion, partnerships and community development. The development of these centres should

be informed by the experiences of **community health and Aboriginal community controlled sectors**.

4. **The needs of groups who find PHC hard to access** including people in low socio-economic circumstances, refugees and Aboriginal and Torres Strait Islander peoples should be the focus of planning and service provision. Strategies to improve cultural safety and accessibility of 'mainstream' PHC services for Aboriginal and Torres Strait Islander service users and members of culturally and linguistically diverse communities should be strengthened in partnership with Aboriginal community controlled health organisations (ACCHOs).
5. **Training of health professionals** should include a focus on PHC, social determinants of health and health equity, and the principles of population health, so that they are equipped to work in these areas.
6. The **Aboriginal community controlled sector** should be strengthened and expanded with assured, simplified funding, including flexible funds for locally designed health promotion and community development activities.
7. These measures could be funded by **removing national subsidies for private health insurance** and redirecting savings into both a national community controlled PHC centres program and ACCHOs.
8. **Medicare** should be supported and strengthened as a progressive public health insurance scheme with an emphasis on equity of access and should not require co-payments for any services.
9. **The role of regional PHC organisations such as Primary Health Networks (PHNs) should extend beyond a primary focus on commissioning services to a strengthened role in planning for healthy communities** in partnership with local interests (including state and local governments, GPs, ACCHOs and community controlled services).
10. **Evaluation and monitoring of health and equity outcomes** should be factored into, and support, PHC reform in Australia.

These recommendations are based on key findings from the Southgate Institute's PHC research program:

- A range of World Health Organization (WHO) reports (including the 1978 Alma-Ata Declaration and the 2008 WHO Commission on the Social Determinants of Health) have highlighted the centrality of comprehensive PHC to a universal and equitable health system. A comprehensive approach to PHC would offer many benefits to Australia and, if fully implemented, would contribute to the prevention of disease, improved overall health and reduced health inequities, and the reduction of health care costs through upstream preventive and promotive action. However, our research indicates that Australian PHC is currently focused heavily on clinical treatment and chronic disease management, at the expense of population health and health promotion activities.
- While Medicare supports equitable access to general practice, the growing involvement of private health insurance in PHC is a risk for equity of access and health outcomes – this has already been demonstrated in the dental care sector.

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- Consideration of health equity in PHC policy is largely confined to improving *access* to health services, rather than a consideration of *outcomes*. Limited attention has been paid by governments to the social determinants of health equity, with the current approach largely focused on health and social service interventions targeting individuals, with little attention to structural drivers of socio-economic inequality.
 - In Australia, there has been a reduction in support for health promotion. Health promotion that is funded stresses individual responsibility rather than creating health choices for people.
 - A dominant policy idea of secondary prevention designed to reduce avoidable hospitalisations has detracted from a focus on health promotion. Socially determined health inequities are a major underlying cause of premature mortality, chronic disease and avoidable hospitalisations. New developments for coordinated care, such as Health Care Homes, are not based on comprehensive PHC principles, and the extent to which they address equity is unclear.
 - Despite the importance of population health planning, PHNs predominantly focus on commissioning and have limited resources and time to plan collaboratively for population health and equity. The quality of the PHNs' approach to partnerships with local government, state government funded local health networks, ACCHOs and other non-government organisations is highly variable.
 - Australian PHC policy encourages community participation, with some strategies in place to strengthen the role of community in PHC governance and decision-making. However, PHNs often struggle to balance professional and community perspectives, and private general practice does not generally involve community participation.
 - Community health services have been eroded in most jurisdictions in Australia and are no longer comprehensive. Our detailed case study of their demise in South Australia demonstrates the shift from comprehensive to highly selective service provision.
 - ACCHOs and community health services provide practical and effective models of holistic, comprehensive and culturally safe PHC.
 - Governments subject ACCHOs to complex, fragmented funding and accountability structures. These structures consume organisations' resources, favour remedial strategies and offer limited scope for culturally relevant health promotion strategies designed for local conditions. ACCHOs can also be disadvantaged by the competitive tendering process.

For further information visit [Stretton Health Equity](https://strettonhealth@adelaide.edu.au) at the University of Adelaide, or email: strettonhealth@adelaide.edu.au.

Or contact Professor Fran Baum, Director, Stretton Health Equity
fran.baum@adelaide.edu.au