

Staying true: navigating the opportunities and challenges of primary healthcare reform

Now is an ideal time to be considering the opportunities and challenges posed by primary healthcare (PHC) reform. The Second International Conference on Primary Health Care: Towards Universal Health Coverage and the Sustainable Development Goals will be held in Astana, Kazakhstan, in late October 2018 to mark the 40th anniversary of the original Alma-Ata declaration of 1978 (World Health Organization 1978).

As the 1978 Declaration makes clear, comprehensive PHC systems provide essential first-contact healthcare that is accessible and affordable, continuous and holistic, practical and scientifically sound. In particular, comprehensive PHC is participatory and based on a spirit of self-reliance and self-determination for individuals and communities. Less commonly cited is that the Declaration saw PHC as an integral part of the global community's commitment to human rights, to overcoming 'gross inequality in health status . . . between . . . as well as within countries', and to sustainable development. The link between health and income inequality is clear (Wilkinson and Pickett 2009), yet over this same 40 years, the share of national income held by the top 1% of earners in many high-income countries has increased substantially. Today we see growing global inequities (Piketty 2014). There is clearly a need for debate about policies directed towards greater equity, and PHC can play an integral role in that debate.

The implementation of PHC has been insufficient and uneven among and within countries. There has been a persisting tension between the medical- and community-orientated dimensions of comprehensive PHC. Some countries – predominantly low-income – focussed almost exclusively on the community-orientated public health and preventive aspects of PHC, driving the population to hospitals to meet needs for curative care. 'Selective primary care' providing universal access to only the most cost-effective medical interventions was proposed as an interim strategy (Walsh and Warren 1980), but, in reality, further development towards more comprehensive PHC was arrested at this stage in many countries.

Other countries – predominantly high-income – achieved more-comprehensive medical interventions but focussed almost exclusively on delivery of clinical services at the primary level within the formal health system. Comprehensiveness was limited to the scope of general practice: curative and preventive services; attending to mental and physical health; care for all ages.

The 25th anniversary of the Alma Ata Declaration of PHC was characterised by questioning whether the PHC movement had been a failure (Banerji 2003; Hall and Taylor 2003). But examples of PHC living up to its promise were found in a variety of income contexts and health systems, and where PHC was defined too narrowly or resourced inadequately, it did not reach its full potential (World Health Organization 2003; Starfield *et al.* 2005). The first decade of the 2000s saw a wave

of reforms to PHC, especially in industrialised countries, such as Australia, New Zealand and Canada. In 2008, the World Health Organization renewed its commitment that PHC is not just the concern of idealists and dreamers, recognising the critical role of PHC 'now more than ever' (Van Lerberghe 2008). Faced with rising costs, the growing burden of chronic illness and complex multimorbidity, an aging population, and corporate inroads into healthcare systems, funders and policy makers see PHC as a solution. These concerns are driving ongoing reforms in PHC internationally. The report's explicit acknowledgment of the critical role for the primary care team in providing comprehensive, continuous and coordinated care for individuals by trusted providers (World Health Organization 2008, Chapt. 3, pp. 41–60) made its recommendations relevant to policy-makers in industrialised countries who had too often dismissed the Declaration of PHC as irrelevant or unrealistic.

The establishment of Primary Health Networks has been a key reform to address Australia's fragmented care system. Primary Health Networks have the challenge of assessing local health needs and planning integrated system level responses. Two snapshots of the downstream effects of fragmentation in the care system are seen in this special issue. Longman *et al.* (2018) interviewed people recently hospitalised for an Ambulatory Sensitive Condition. The findings highlight the vulnerable state of people leading up to admission. They often lack easy access to social care and mental health care, and face barriers to accessing non-emergency specialist medical care. Their study also highlights the critical importance of social support and informal caregivers in managing complex care regimens, helping decide if complications are serious, and providing instrumental support to get timely access to needed services. Routine assessment of social support is an essential part of comprehensive PHC. Goode *et al.*'s (2018) review of homeless people's access to dental care describes the effects of fragmented high-cost care and a failure of public investment on a highly vulnerable population. Dental services are not considered as part of essential PHC services in many countries, but the authors make the case that they are part of a holistic response to the population needs, especially for the socially vulnerable. Importantly, their review pointed to the potential benefits of outreach, co-location, and linking clinical and social care, all important PHC principles.

Stitching our complex care system together is no easy task. Some light is shed on the challenges faced in such a complex task in the paper by Levesque *et al.* (2018) in this special issue, which describes the implementation of an innovative planning framework in a local regional Health Department to try to integrate social, population health and healthcare services. Historical and cultural attachments to the status quo within the bureaucracy, defended on the basis of specialist expertise and knowledge, proved hard to overcome. Yet the planning created

new opportunities for collaboration and exchange between previously siloed programs, and it achieved greater coordination around administrative elements like management of contracts. Foley (2018) provides a historical overview of reforms to PHC financing arrangements in New Zealand. The New Zealand reforms were unique and visionary, with a focus on social interventions, community development and reducing inequity and they achieved modest but varied success. Although important historical and cultural barriers including professional tensions were never fully resolved and remain today, the reforms have withstood changes of government, and provide a concrete case for how PHC payment reforms can contribute to equity (DeMeester *et al.* 2017).

Another current key reform in Australia has been the establishment of a pilot of the Health Care Home. The paper by McKittrick and McKenzie (2018) focuses on the roles of general practitioners (GPs) and practice nurses, specifically exploring the significant task shifting and redefining of roles that will be needed. They noted in a literature review and interviews with key stakeholders that 'improved outcomes for patients are likely to hinge on optimal use of the primary health care workforce in the HCH [Health Care Home]' but that resistance is high, and incentives are not seen as significant enough to shift entrenched behaviours. Medical dominance remains a key factor. Establishing a good collaboration between GPs and practice nurses will require investment in understanding how each other's skills and capacities can best serve the needs of the practice population. The dividend is better care for people and a PHC workforce using full extent of their professional skill set. The reflection by Reeve (2018) makes the case that the support of multidisciplinary primary care teams is critical to designing health systems that support person-centred care.

The paper by Reeve (2018) perhaps is a counterpoint to the power of medicine in PHC. She reflects on her sustained program of work over more than a decade exploring generalist practice. She suggests that complex needs of people's demand a new approach to strengthening person-centred practice at multiple levels (consultation, practice, health system). She suggests that empowering practitioners to engage in 'rigorous interpretive practice' as a balance to traditional evidence may generate truly person-centred care. Person-centred care goes beyond consideration of a patient's personal context. It empowers the patient to adapt health and treatment priorities to their needs and capacities, even when the choices run counter to clinical practice guidelines. Reeve speaks to the intellectual challenge, scholarship and sophistication involved in delivering this type of person-centred care.

System-level primary care reforms driven by notions of efficiency, accountability, risk management, standardisation and service integration can pose challenges to important principles and values of localism, community ownership and responsiveness that are at the heart of comprehensive PHC. Marsh *et al.*'s (2018) paper on a community-gardening initiative embodies the value of local and grounded, self-organising movements in true PHC. The model links health and place in a broad and empowering approach to individual and community health and wellbeing. Despite the assertion that 'It's not therapy; it's gardening' the authors found therapeutic effects for nutrition and physical fitness, and especially for

mental health. Community gardens can be part of the larger 'therapeutic landscape' created by comprehensive PHC. Supporting such innovation and localism requires adequate resourcing and skill development, suitable design, funding and policy support along with innovative partnerships with health professionals.

This special issue also highlights how reforms that include an indigenous perspective contribute innovatively to more comprehensive PHC. Harriss *et al.* (2018) report on a community-driven initiative to integrate mental-health screening in annual health checks for young people. The co-design of the screening event, with the far north Queensland Aboriginal community, led to high levels of acceptability and uptake that allowed for early referral of youth at risk of severe depression. The process created a safe space to discuss youth mental health. Nattabi *et al.* (2018) illustrate the successful integration of public health objectives in a primary care setting in northern Australian Aboriginal populations during a syphilis outbreak. Higher levels of syphilis testing occurred in clinics whose managers were actively involved in a continuous quality-improvement process focussed on enhancing client flow, continuity of care and cohesive team functioning. Their article highlights the often-ignored role of managers and also documents eloquently the public health outcomes of excellent comprehensive PHC. Finally, Foley's (2018) analysis of New Zealand's PHC reform suggests that a core orientation on provision of culturally appropriate care to, and community partnerships with, Maori and Pacific Islanders resulted in innovations in care delivery and a move away from targeted PHC towards a more universal and comprehensive approach.

The 1978 Alma-Ata declaration captured a spirit of the times; a vision of 'health for all by the year 2000'. We anticipate a new 2018 Declaration of PHC that reflects 40 years of experience and captures emerging trends and evidence: a re-affirmation of the importance of universal access to first-contact and community-orientated care but also a recognition of the importance of primary care that engages patients as partners, centres on their personal needs, and is integrated with other necessary services. We also look forward to the new Declaration to highlight the important role that truly comprehensive PHC can play in respecting and engaging with communities, standing up to address injustice and inequity. We believe the articles in this special issue provide inspiration and guidance to the important ongoing task of 'staying true', not only to the dream of comprehensive and person-centred primary care, but also to greater health and healthcare equity.

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