Recognising the Scope of Community Health

Welcome to this special edition of the *Australian Journal of Primary Health* (AJPH) that focuses on the broad context of community health. Communities are complex social systems bound together by interactive connecting links between organisations, neighbourhoods, families and friends. Authors of the papers in this special issue have contributed to a developing body of knowledge that will begin to provide some of the answers to the complex health issues confronting our communities.

A primary health care (PHC) focus and the provision of innovative and comprehensive health care in community settings are part of a long tradition in the Australian health system. A PHC approach emphasises working with people (as individuals or community) to facilitate decision-making about their needs and to develop ways to address them. The contribution of PHC in addressing many of the complex health problems currently facing individuals and communities is highlighted in this special issue. It is reinforced that health is more than the absence of disease, but shaped by socio-cultural and economic variables. Reflected in the papers is the diversity in the provision of PHC, illuminating the impact of geographical diversity and how the PHC approach varies within different communities, creating implications for practitioners and practice development.

The articles report community-based research and projects that inform our health practices and fuel our creativity in a high pressure health system. Innovative models of service delivery are reported that have developed ways of working with vulnerable people in our communities to build their personal capacity. These projects reflect the PHC philosophy of using approaches that are affordable, appropriate to community needs, and therefore sustainable (Wass, 2000). Importantly, research is reported that confirms investment in quality primary care and health promotion will achieve substantial cost savings through avoidance of hospitalisation. The evidence relevant to change management becomes critical if there is a genuine valuing of responsiveness to the changing needs of individuals and communities.

The PHC approach has inherent differences from what is sometimes described disdainfully as the medical model, in that it requires community service providers to take into account all the factors that can be seen to impact on a person’s wellbeing, or on the entire community in which they live, rather than focusing on one or more clinical conditions to be treated. For many service providers, however, the funding streams which support their work are based on input measures rather than outcomes. The extra time a community health worker may need to identify and deal with an issue of specific value in improving a person’s quality of life, but which is non-clinical, is not only discouraged by most funding systems, but penalised. Indeed, the quest for improvements in evidence-based care has not come from funders, but rather from community health agencies keen not only to provide better outcomes for clients, but also to ensure that their limited resources are being used to best effect. It is a responsibility of PHC agencies to use evidence and advocacy to argue successfully for change to funding systems to replace perverse incentives with ones that reward improvements to people’s quality of life. Attempts to measure community health outcomes that have a focus only on epidemiology and incidence of disease will spectacularly fail to reflect the broad range of complex issues that impact on community health.

The last decade has been a time of rapid change in community health; however, there has been one constant force and that is the presence of chronic disease and illness. The incidence of chronic disease is increasing worldwide; it is estimated that by 2020, chronic disease will account for nearly 80% of worldwide disease (NSW Department of Health, 2004). Chronic disease has a significant impact on hospital admissions, re-admissions and health care organisation and delivery in our communities. Evidence indicates that health outcomes are improved in a health system that is primary care orientated (Starfield, 1998); however, there are concerns that the push for evidence-based practice can simplify the impact of contextual issues on health outcomes (Weller & Veale, 1999).
Most health care for people with chronic disease occurs in the community setting in the context of their daily lives. Comprehensive knowledge and understanding of the context in which the person lives, family, carers, supporters, community and wider society is an important backdrop to successful chronic disease health care. People with one chronic disease often develop multiple illnesses which are referred to as co-morbidities. This adds another layer of complexity to a health system that is largely framed by a single disease model of care. Much research has also been disease- or symptom-specific, hence research is needed that will assist understanding of the impact of disease co-morbidity on individuals and communities. While there has been significant progress made in the clinical management of common chronic diseases, much less is known about the impact of co-morbidity, including physical and mental health co-morbidities, on disease management, clinical outcomes, quality of life and quality improvements.

The effective elements of a community health care system that promotes high-quality chronic disease care are population profiling of the community, development of processes that articulate community needs, consumer participation, person-centred care, self-management support, decision support and clinical information systems, and an emphasis on building effective multi-disciplinary teams. Within this context, evidence-based change concepts will further foster productive interactions between informed people in our communities who take an active part in their care and multi-disciplinary providers with resources and expertise. Our future research focus needs to progress systems that integrate preventive, acute, chronic co-morbidity, rehabilitative and long-term care for the purpose of reducing illness burden and improving health-related quality of life.

There is little doubt that primary care and community care will develop an even greater role during the years ahead. Funding in primary health care has a history of disadvantage when compared to the acute sector; hence the point that must concern us all is whether our crucial role in fostering the health of our communities will be adequately supported.

We trust that readers of the AJPH will find much of interest in this special edition, and wish to express our sincere appreciation for the assistance and support of the authors, reviewers and the editorial team.

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