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Improving life expectancy with primary health care

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As the population ages, the burden of multimorbidity (defined as two or more chronic conditions) grows, a process that is unfolding in both Aotearoa New Zealand (NZ)[1] and Australia.[2] In addition to the need for continuing health care and the risk of complications, multimorbidity can shorten life expectancy. The mortality burden, however, is not shared equally, but falls most heavily on the socioeconomically disadvantaged and several ethnic groups, notably Māori and Pacific peoples in NZ[1] and Aboriginal and Torres Strait Islander peoples in Australia.[3] Together, the multimorbidity of aging populations and persistent health inequities constitute the overriding challenges to health systems in high income countries.

Primary health care is critical in responding. It is key to preventing when possible, and managing when necessary, the chronic conditions of modern life. It can help reduce health inequities, although too often it fails to do so,[4] and can even exacerbate the problem; and it is no substitute for direct confrontation of the social determinants of health. Differences in life expectancy are one of the key indicators of health inequity. For example, life expectancy in 2017–2019 in NZ among those in the most deprived areas was 74.1 years among males and 78.5 among females, but in the least deprived areas was 84.7 and 87.5 years, respectively. For Māori, life expectancy for males was 73.4 and 77.1 years for females.[5]

One benefit of primary health care is its effect in reducing mortality and increasing life expectancy. Evidence of this effect dates back more than 20 years,[6] but a growing body of research in recent years has thrown considerable light on the mechanisms involved, and the findings are relevant to planning primary healthcare services capable of meeting the needs of aging populations and reducing health inequities.[7] Five groups of mechanisms that explain the effect of primary health care on population life expectancy can be identified:

1. Organisation (the levels of funding, the numbers of general practitioners, adoption of a public health perspective in the planning and delivery of services);
2. Access (the whole population is covered, equality of access for all population groups, and the use of outreach to engage marginalised groups),
3. Comprehensiveness (the service meets the needs of most patients, it covers both physical and mental health, provides physical, psychological, and social care for mothers and children, and offers care from conception to old age),
4. Clinical care (makes competent use of the clinical method, makes early diagnoses, provides illness prevention of communicable and non-communicable diseases, offers management of chronic non-communicable conditions, and prescribes safely);
5. The therapeutic relationship (earning the confidence and trust of individuals and communities, offering continuity, and promoting adherence to effective interventions).

Patients of primary healthcare services with these characteristics tend to have longer lives than patients of services without them. Too often, it is assumed that hospitals are responsible for the effect of health care in saving lives, and it is undeniable that they do reduce deaths. The heroic work of respiratory specialists in the recent pandemic is but one recent example. But primary health care saves lives too. Whether it is primary preventive care for populations, vaccination for example, or the care of complex multimorbidity in individuals, the powerful effect of primary health care on population mortality is key to the overall effect of health systems. But today's improved understanding of the mechanisms by which primary health care reduces mortality brings with it a responsibility to plan and deliver services in ways that maximise the benefits for all in the population. We are obliged to act on the evidence to improve health.

Although some of the mechanisms are under the control of individual practices or practitioners, many are not. It will be difficult, therefore, for already busy front-line practices to take on this new agenda unaided. The leading responsibilities lie with policymakers and primary health organisations (PHOs) or their successor locality networks. Policymakers need to set goals and target resources according to population needs using allocation formulae that take account of the costs of implementing the mechanisms of primary health care in different contexts. The locality networks will need to develop plans to reduce mortality. They should be able to explain the reasons for the observed life expectancies of the population groups in their care and implement strategies for improvement informed by the mechanisms of primary health care. The focus should be on supporting practices and practitioners in making effective changes, for example, in using outreach schemes to improve access, or improving the physical health of people with serious mental illness. They will also need help in interpreting the mortality data relating to their own populations and in monitoring the impact of efforts to reduce mortality.

The care of the whole population, from before conception until the last days of life, gives primary health care a special role in reducing inequity and reducing the burden of multimorbidity. The life course theory of health inequalities argues that our experiences early in life influence our ability to respond to later adversity.[8] This means that the care of mothers and children is therefore key to future health. The outcome of a primary healthcare nurse discussing a woman's health with her before she embarks on a pregnancy may well be delayed until long after the nurse's own life has been completed. Although the attention of policymakers may be firmly fixed on middle-aged and older people with multimorbidity, the needs of mothers and children must receive equal attention if the tide of chronic disease is to be slowed among future generations.

Primary health care could also do more to reduce inequities in life expectancy. It is, of course, true that the biggest drivers of inequity are the social determinants of health, and national policies to address these are essential. But this does not mean that primary health care has little or no role to play. The mechanisms of primary health care make clear the importance of extending effective care to everyone, especially those with greatest need and facing the most barriers to access. They show how a proactive service is more effective than a reactive one limited to responding to requests from patients. An example is the targeting by primary health care of the cardiovascular risk factors of high blood pressure and high low-density lipoprotein cholesterol in whole populations,[9] a policy that has been associated with reduced mortality rates in two United Kingdom primary care networks.[10,11]

It is time policymakers and governments stopped underestimating the importance of primary health care to population health. They need to be more ambitious about the role of primary health care and build services that play a full role, along with other sectors, in improving health and reducing inequities. With the necessary support, primary health care can improve the life expectancy of disadvantaged populations.

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