INTRODUCTION

There is a critical lack of evidence regarding the effectiveness of Comprehensive Primary Health Care (CPHC) as a health care delivery system, particularly ‘whole of service’ level evaluations. This study is examining the effectiveness of CPHC in Australia and its contribution to stemming increasing health care costs.

The CPHC focus on equity means it is especially suited to developing population health approaches that address the needs of population groups who have worse health status, including people living on low incomes and Aboriginal and Torres Strait Islander peoples.

The research is a 5 year program of work, 2009-2013. This poster presents findings from Stage 1 which was conducted in 2009-2010.

THE PHC CASE STUDY SITES

The study comprises 6 case studies of PHC services, each providing differing models of service and demonstrating a mix of funding and management models. Three of these are State government managed health services. Previously these had Boards of Management, including community representation, and serviced a local population. Restructuring of health services in South Australia has led to creation of larger regions and a move to departmental rather than local control. A State government managed Aboriginal Health Service is situated within one of the health regions. The remaining two sites are non-government organisations; one is a sexual health service with a management board, the other is an Aboriginal community-controlled health service which is governed by a community cabinet.

Accessibility

Services are either located in areas of identified need providing local access to services (eg low socio-economic areas) or service population groups with poorer health status (eg Aboriginal Australians). The Aboriginal community-controlled health service is able to focus on making its services accessible to Aboriginal people.

Current centrally-driven health service restructuring in the State-managed services will result in some services being moved from hospital outpatients to more accessible multi-service community sites.

A social view of health

Practitioners and managers in the State-managed services suggest a social view of health appears to be of less importance as a driver of health reform than a focus on hospital avoidance and chronic disease management. This is leading to an emphasis on disease-centred services and a shift toward medical and behavioural approaches to prevention and promotion, away from socio-environmental and community development approaches. A social view of health appears to be more prominent in the two non-government services.

Community driven services and community participation

Community participation strategies ranged from surveys of clients to a community-controlled organisation governed by a community cabinet.

More community participation was evident in the non-government services compared to the government managed services. For the government managed services the responsibility for community engagement strategies has shifted from locally-based services to the much larger regional level. Interviewees in these services reported a decline in local community input and participation and less capacity to interact with local communities.

Barriers identified included lack of service autonomy which hinders responsiveness to local issues, and community reluctance to attend meetings. Other difficulties noted were local issues, community reluctance to attend meetings and privileging some voices over others.

Advocacy

Responses to questions about advocacy fell along the following continuum:

- “not part of my role” (clinical/project worker with specific responsibilities)
- advocacy for individual clients eg writing letters of support to other agencies
- membership of committees and networks, eg advocating for importance of addressing women’s health/migrant health for a particular issue
- broader, more active advocacy, such as organising a forum to address a particular issue, or contributing to shaping policy affecting the social determinants of health, such as alcohol or housing.

Barriers to advocacy work, particularly in the government managed services, were ‘role legitimacy’, a perceived conflict with role as public servant; the burden and precedence of clinical work and lack of staff resources. Intersectoral work in the State-managed services has moved to regional level as services have been consolidated into regions, resulting in strategic partnerships at the regional level but reduced opportunity for individual workers to engage in advocacy. The Aboriginal community controlled service reported very effective advocacy on policies relating to the control of alcohol and redevelopment of the town. The other NGO service was also active in advocacy related to sexual health, for example in relation to the inclusion of sexual health in school curricula.

Equity

Equity was an unequivocal cornerstone, endorsed by practitioners through to government funders. Access to services (mainly in terms of the location of services in an area of high disadvantage) was a key strategy to achieve equity.

Non-Aboriginal services all had priority populations eg Aboriginal, newly arrived migrants, low income families eligible for free health care, people with disabilities. Equity was operationalised through priority of access for defined groups, although services differed in how actively they engaged with the defined groups. Some services have developed specific services or programs eg special clinic days for particular migrant groups.

The existence of Aboriginal specific services is a response to the significant health inequities experienced by Aboriginal people in Australia. The community-controlled service explicitly seeks to address the social and economic determinants of the poor health experienced by Aboriginal people as well as provide equitable access to services. The sexual health NGO has identified ‘communities of interest’ that are identified as being those with most need and least resources in terms of sexual health.

Multi-disciplinary care

Multi-disciplinary care was expressed differently at the various sites. All sites employed people from multiple disciplines, with the exception of the State government managed Aboriginal Health Service (which employed youth workers, men’s workers). Only two of the sites employ doctors, other sites interact with local ‘fee-for-service’ general practitioners. The mix of other disciplines varies partly in response to local priorities, partly as an historical artifact.

The extent and ways of working together varied between services with particularly strong multi-disciplinary work in early childhood teams.

DISCUSSION

We are able to draw some tentative conclusions from the first stage of our research.

1. All the services we have studied provide multidisciplinary care and more than other parts of the health system have a focus on disease prevention and health promotion.
2. The PHC services in the study all demonstrate a concern with the priority of access for defined groups, although services differed in how actively they engaged with the defined groups.
3. The work of the PHC services is shaped and determined by the work of other agencies and the nature of the priority of access for defined groups.
4. More community participation was evident in the non-government services compared to the government managed services. For the government managed services the responsibility for community engagement strategies has shifted from locally-based services to the much larger regional level.
5. In addition, the Australian National Health and Medical Research Council funded this research.
6. Our early findings suggest that governance structures have a very real impact on the style and content of services provided. The non-government PHC services have maintained a greater focus on social determinants and are more easily able to involve their communities in planning and management decision making.

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Further information about the methodology of this research is shown in the poster ‘Researching comprehensive primary health care in Australia: the development of a program logic model and evaluation framework to assess the effectiveness of services’.