SA Health and Community Complaints Commissioner

Discussion paper

on

Primary Health Care in South Australia

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Dr Angela Lawless & Professor Fran Baum

Southgate Institute for Health, Society and Equity
Flinders University, South Australia
Executive summary

- Primary health care is seen internationally as crucial to the provision of a responsive, effective, high quality and efficient health system. Internationally, and in Australia, successive reviews of health systems have recommended that governments should reorientate their health systems towards primary health care.

- Despite strong evidence and recommendations, this has failed to happen. In South Australia the Generation Health Review (2004) also recommended a much greater emphasis on primary health care. While there were some moves towards this including the drafting of a policy, recent policy decisions have done the opposite and reduced funding to State government managed primary health care services, especially those directed at disease prevention and health promotion.

- The 2013 McCann review concluded that there was insufficient evidence to support aspects of primary health care services. The South Australian Government responded to this review by cutting some health promotion services completely and changing the emphasis of primary health care services so that they now concentrate on intermediate care and ‘hospital avoidance’ strategies. This has been at the detriment of their community engagement strategies, disease prevention and health promotion, cultural safety, and action on the social determinants of health.

- The system of community health and women’s health centres in South Australia no longer exists and has been undermined by successive policy initiatives, including the move to GP Plus Health Care Centres and the government’s response to the McCann Review.

- Funding to primary health care has been reduced as a result of a perceived crisis in health sector funding which has resulted from falling State government revenues and determination to maintain a balanced budget. Yet aspects of the health sector have been exempt from the cost containment. Thus in 2013 salary increases of 9% were given to medical staff and increases over recent years have exceeded inflation. We recommend that detailed analysis of the cost pressures on the State’s health budget be examined transparently to inform a public debate on the priorities within the health budget.

- The Charter of Health and Community Services Rights identifies the rights of consumers in regard to services in terms of access; safety; quality; respect; information; participation; privacy and comment and we show that in each of these areas the policy and funding changes to primary health care services have resulted in State government managed services being less able to uphold these rights, especially for people who are already facing disadvantage.
Recent changes to primary health care in South Australia

In 2012 Warren McCann from the Office of Public Employment and Review was appointed to conduct a Review of Non-Hospital Based Services (McCann, 2012). The review signalled a shift away from state government investment in comprehensive primary health care (see Box 1 for definition) especially health promotion activities. The review assumed that the Commonwealth through Medicare Locals, and local government would fill the gap created by the state government’s withdrawal from health promotion. The Government response to that review (SA Health, 2013) has resulted in a contraction of state-funded primary health care in South Australia particularly in disease prevention, community capacity-building and health promotion. The services now take a narrow approach which focuses on chronic disease management.

Five years ago the Generational Health Review (GHR), also commissioned by the Labour Government, developed a 20 year framework for the South Australian health care system. (Government of South Australia, 2003a). The report was authored by John Menadue¹ and was based on comprehensive consultation process with key health system actors. The GHR stated that, “The objectives are that the health care system, in partnerships with governments and stakeholders will:

- strive to maintain and improve the health of the population with an emphasis on addressing health inequalities
- ensure safe, accessible, efficient and effective health care.” (p3 summary report)

A major recommendation of the GHR was reorientation of the health system to primary health care.

“The principles of primary health care not only underpin system reform, they also provide strategies and ways of working in the proposed primary health care focused system. (p11 summary report)”

The evidence from the GHR appears not to have been considered by the McCann Review given its recommendations that primary health care services be cut. Two factors appear to have driven the McCann recommendations: an intention to reduce the burgeoning state health budget; and national health reform which has resulted in the development of Medicare Locals.

International evidence indicates that a strong, comprehensive primary health care sector is an important means of controlling health costs – evidence that appears not to have been considered in the McCann review. The World Health Organisation and many health

¹ John Menadue was formerly Secretary of the Department of Immigration in the Fraser Government 1980–83, Secretary of Prime Minister and Cabinet under Prime Ministers Whitlam and Fraser, Ambassador to Japan, and CEO of QANTAS. He chaired the South Australian Generational Health Review 2003.
policy authorities have seen primary health care as a solution to spiralling health care costs rather than the problem and have strengthened rather than weakened these services.

The second issue seems a classic case of Federal–State cost shifting. In the longer term the new Medicare Locals might offer the primary health care system Australia needs but at this stage of their development they are not in a position to take up the gaps resulting from the cuts to our community health services. It is also highly likely that for the state funded hospital and other health services a cadre of workers who understand primary health care would be required to integrate the state services with the activities of the Medicare Locals. 61 Medicare Locals were established nationally, 5 in South Australia by the Gillard Labor Government. They are currently under review by the Abbott Coalition Government. They have a remit for improving primary health care and identifying and addressing health needs and service gaps in their local communities. They have objectives relating to health promotion, prevention and social determinants of health. The Medicare Local accountability framework notes that aspects of standards on health promotion are ‘developmental’ because it will be some time before Medicare Locals are able to formalise their approach and have the information, capacity, partnerships and programs to meet the standards. (Commonwealth of Australia, 2013).

Medicare Locals are very much in the early stages and are struggling to move beyond narrow primary medical care (which reflects their origins in Divisions of General Practice which focused on selective primary medical care) to a role that includes health promotion, population health and social determinants action (Doggett, 2012). The Disease Prevention and Health Promotion in Medicare Locals Program funding is very minimal – $5m nationwide (Australian Medicare Local Alliance, 2012).

Local government also reports that it does not have the resources to pick up services and programs the state government is withdrawing from. SA Health has also abolished the Health Promotion Branch and while some of its functions continue, this represents a serious downgrading of policy and planning attention to health promotion. A further dent in capacity was the withdrawal of support for the Primary Prevention Plan. This Plan had wide support and provided a very sound strategic planning framework for disease prevention and health promotion in South Australia.

For South Australia the cost shifting represented by the government’s response to the McCann recommendations appears likely to create many cracks for people to fall through and has already resulted in a depletion of SA Health expertise in disease prevention and health promotion. Cutting primary health care services may result in short-term savings to the South Australian government but, in the longer term, there is evidence to support the prediction that cuts will see increased pressure on the hospital system. When people, especially those facing multiple disadvantage in their lives, don’t have local supports or services, problems are likely to compound leading to more serious outcomes for the individual and higher health costs.

The retreat from comprehensive primary health care is accompanied by a loss of infrastructure, workforce, skills and knowledge. The result for community is loss of services and resources for health with particular impacts on those with fewer resources for health.

Health reform in SA is being driven by budget considerations yet the contribution primary health care can make to containing costs appears to be largely overlooked. This is happening at a time when governments and the World Health Organisation are calling for a renewal of primary health care.
What is primary health care?

What do we mean when we use the term primary health care? (See Box1 for definitions.) The concept of primary health care was central to the World Health Organisation’s (WHO) Alma Ata Declaration of 1978 (World Health Organization, 1978). This seminal Declaration and the Health for All strategy positioned primary health care as one of the most important means by which population health and health equity could be advanced.

Primary health care is based on a social view of health. In western society the biomedical perspective of health and illness has been dominant in health systems. The biomedical model puts forward a mechanistic understanding of the human body. A healthy body is akin to a "well-oiled machine", disease occurs when the body "breaks down" in some way. A social view of health challenges the traditional biomedical model by considering the impact of social and environmental factors on health.

Primary health care is the first level of health service delivery and an approach to health care that is underpinned by five basic principles:

- Equitable distribution of resources
- Community involvement
- Emphasis on prevention
- Use of appropriate technology
- An intersectoral approach

Primary health care emphasises the social determinants of health and incorporates a continuum of activities for prevention, health promotion, cure and rehabilitation developed in partnership with communities (International Conference on Primary Health Care, 1978, Tarimo and Webster, 1994).

There has been considerable debate about the implementation of primary health care and in practice it has often focused on ‘downstream’ work emphasising direct work with individuals rather than the ‘upstream’ prevention and health promotion approaches.

In this paper we use the term primary health care to refer to a comprehensive approach in the Alma Ata tradition as captured in this Australian definition:

Primary health care is socially appropriate, universally accessible, scientifically sound, first level care provided by health services and systems with a suitably trained workforce comprised of multidisciplinary teams supported by integrated referral systems in a way that: gives priority to those most in need and addresses health inequalities; maximises community and individual self-reliance, participation and control and; involves collaboration and partnership with other sectors to promote public health. Comprehensive primary health care includes health promotion, illness prevention, treatment and care of the sick, community development, advocacy and rehabilitation. (Australian Divisions of General Practice, 2005).
Primary health care is a contested term so it is important to address definitions. The term primary Health Care has been used to describe both a level, and an approach to care. The broader sense of the term, as a description of an approach to health care, was used by the World Health Organisation (WHO) in the Alma Ata declaration of 1978. Primary health care is underpinned by a number of concepts which provides a philosophical framework rather than simply describing a particular type of health service. The Declaration of Alma Ata includes calls for:

- Equity
- Community participation
- Socially acceptable technology
- Health promotion and disease prevention
- Intersectoral action (Wass, 2000)

Comprehensive PRIMARY HEALTH CARE vs Selective PRIMARY HEALTH CARE

The intent of Alma Ata was fairly quickly compromised by a retreat from the comprehensive strategies originally outlined to more selective and disease oriented approaches (Walsh and Warren, 1979). Fundamental principles espoused at Alma Ata - equity, intersectoral action and community involvement - were discarded in the name of technical feasibility and cost-effectiveness (Baum and Sanders, 1995). Selective PRIMARY HEALTH CARE focused on reduction of specific diseases privileging medical intervention and overriding the consideration of the social determinants of health and a social view of health.

Primary health care and primary (medical) care

The terms primary health care and primary (medical) care are sometimes used interchangeably but this masks differences in philosophies and practices. Keleher (2001) argues that this slippage in language disguises important differences between primary care and primary health care, particularly the potential of the latter to address issues of inequity. The matter of definition is far more than a matter of pedantry. It reflects a conservative policy environment actively narrowing the reforming intent of the primary health care agenda.

Primary (medical) care is of fundamental importance in primary health care but is not equivalent to primary health care. For example, any service providing primary care will undertake individual treatment sessions, but if the service is a comprehensive primary health care service then the incorporation of PRIMARY HEALTH CARE principles should be evident. We would ask how PRIMARY HEALTH CARE’s concern with equity figures in treatment activities – it might be through the presence of a priority of access scheme, outreach sessions for particular population groups or strategies to ensure culturally respectful interactions.

Community health

In Australia the primary health care approach has underpinned much of the work of community health centres and for many people the term community health has more resonance than primary health care. For the authors part we believe the term community health is more accessible to lay people and puts community front and centre in the health system.
Primary health care reform

Across the globe governments are interested in ways of making health systems more effective, more efficient, and more responsive. Debates about equity, rights and access are entwined with discussions regarding cost containment and efficiency (De Voe and Short, 2003, Duckett, 1984). Health systems act not only to provide health care to those who are ill; they are an important determinant of health and equity in their own right. Getting health policy settings right is difficult and the governance of health is a complex task (Leppo and Tangcharoensathien, 2013). Health care is brimming with ‘wicked problems’ and action in one area will have impacts, not always be positive, on other inter-connected issues (Duckett, 2014).

In an increasingly complex environment the health sector must work across sectors in and outside government in order to improve health (Leppo and Tangcharoensathien, 2013). Health systems require political leadership and supportive social and policy environments if they are to operate effectively, sustainably and equitably. Experience shows that much can be achieved in terms of equity and health status given such conditions. In the 1980s and 90s South Australia was lauded as an example of this:

“Throughout the 1980s and early 1990s, South Australia produced examples of collaboration for health that extended beyond institutional, sectoral and professional boundaries and achieved outstanding results in terms of equity, health status and quality of life (Kickbusch, 1995 p xi).

Health care sectors, with their roots in medicine, often fail to engage with the evidence on the social determinants of health in terms of how services are delivered or in engaging with other sectors to promote health and equity (Baum et al., 2009a). It has long been understood that the organization of health care directly affects health by providing differential access to and exclusion from services. In the 1970s Tudor Hart (1971) described the ‘inverse care law’ whereby the need for care varied inversely with the care provided. Baum, Begin et al (2009b) argue that the growing evidence regarding the social determinants of health highlights the role of the health care sector as a determinant of health in itself and call for recognition and reversal of the sector’s “propensity to generate health inequity.” A primary care orientation of health systems has been demonstrated to result in greater improvement in population health and more equitable distribution of health (Starfield, 2009). A primary care orientation needs to be evident both in policies and in clinical service characteristics. Where both system policies and the clinical characteristics are in place significantly lower total costs of care are achieved alongside a range of better health outcomes. (Starfield, 2009)

The World Health Report (2008) identified three disturbing trends that have a negative influence on population health outcomes and equity:

*Today, it is clear that left to their own devices, health systems do not gravitate naturally towards the goals of health for all through primary health care as articulated in the Declaration of Alma-Ata. Health systems are developing in directions that contribute little to equity and social justice and fail to get the best health outcomes for their money. World Health Report 2008*
- a disproportionate focus on specialised curative care
- a command-and-control approach to disease control, focused on short term results
- unregulated commercialisation of health has been allowed to flourish.

These trends pull and push systems into configurations that sacrifice comprehensiveness, pay little attention to disease prevention and health promotion, fragment care, are disease-centred rather than person-centred and are not responsive to community needs. These movements represent a failure of government and health systems to respond to evidence about ‘what works’ in improving health and equity. Countries with strong primary infrastructure have been found to have lower costs and better performance on major aspects of health (Starfield and Shi, 2002, Commission on Social Determinants of Health, 2008).

Primary medical care, as opposed to specialty care, has been shown to be more effective in prevention of illness and death and is associated with more equitable distribution of health (Starfield et al., 2005).

Higher health care spending is not necessarily associated with better outcomes. An examination of health care spending reveals increases in spending across the OECD member states:

“In 2006, the vast majority of these countries spent between 8% and 10.5% of their gross domestic product on health care …Thirty years ago, the same OECD countries were spending between 5% and 7%.43 (Baum, Begin et al p 1969).”

Despite the increased expenditure health gains were often relatively small and distributed unevenly across the population and in any case health improvement is primarily about the broader social determinants of health rather than health service use.

For four decades primary health care has been promoted as a health care system able to meet the needs of individuals, improve population health and health equity outcomes whilst also delivering increased efficiency and reduced costs. Yet accumulated evidence of effectiveness has not been able to sway political decision-makers and primary health care’s potential contribution to population health remains unrealised (Wise and Nutbeam, 2007). In addition implementation of a comprehensive primary health care approach has been patchy at best and the original vision first promulgated in 1978 at the International Conference on Primary Health Care, Alma-Ata has never been fully realised (Baum 2002). For a range of reasons more selective individual and disease based approaches proved more palatable to many decision-makers and more easily implemented than the more comprehensive primary health care agenda.

The increasing burden of non-communicable diseases represents a global crisis. In developed countries the mixed progress in improving health and especially in addressing chronic disease has led to a re-examination of comprehensive primary health care approaches (Evans et al., 2001, World Health Organization, 2004). In order to address chronic disease person-centred care with a strengthened primary health care sector to provide critical prevention and treatment is required
(Beaglehole et al., 2011). As a result of this realisation the WHO devoted the World Health report to primary health care in 2008 and the Commission on the Social Determinants of Health recommended it as the basis for national health systems in order to achieve health equity. The 2008 WHO report *Primary Health Care: Now more than ever* calls for substantial reorientation and reform of health systems – a renewal of primary health care - if progress towards health for all is to be achieved. Since 2008, in several World Health Assembly resolutions, Member States’ have “[s]trongly reaffirm[ed] the values and principles of primary health care” and confirmed their commitment to primary health care, including health system strengthening (World Health Organization, 2009) and action (Beaglehole et al., 2011). The UN High-Level Meeting on Non-Communicable Diseases in 2011 recommended as one of the five priority actions the strengthening of health systems to provide patient-centred care, starting with primary care. The shortcomings of selective, vertical and disease centred approaches have become apparent with the development of a patchwork of health interventions lacking coordination and sustainability (Buse et al., 2005, Pogge, 2004).

Health policy experts noting the increasing inequities in wealth and health over the last two decades are calling for action on the social determinants of health to help reduce these (Adeyi et al., 1997, Cornia, 2001, Labonte et al., 2004, Commission on Social Determinants of Health, 2008). In the past decades there has been increasing recognition that the causes of health and illness and the root of health inequities largely lie outside of the health sector in the conditions of people’s everyday lives. The conditions in which people grow, work, love, live and play are termed the social determinants of health (see Box 2). In 2009 the World Health Assembly endorsed the Commission on the Social Determinants of Health and adopted a resolution on reducing health inequities through action on the social determinants of health. Amongst other measures the resolution highlighted aligning action on the social determinants of health with a renewal of primary health care (World Health Organisation, 2011). Margaret Chan, Director General of the WHO noted that health services “delivered according to the values, principles and approaches of primary health care” were well placed to improve equity.

**Box 2: The Social Determinants of Health**

The social determinants of health are the conditions in which people are born, grow, live, work and age, including the health system. These circumstances are shaped by the distribution of money, power and resources at global, national and local levels, which are themselves influenced by policy choices. The social determinants of health are mostly responsible for health inequities - the unfair and avoidable differences in health status seen within and between countries.

Source WHO: [www.who.int/social_determinants/en/](http://www.who.int/social_determinants/en/).

Source: (Dahlgren and Whitehead, 1991)
The available evidence confirms improved population health outcomes and equity, more appropriate utilization of services, user satisfaction and lower costs in health systems with a strong primary care orientation.

WHO Regional Office for Europe’s Health Evidence Network (HEN) January 2004

Australian policy responses

A series of Federal and State reviews of health systems have been consistent in suggesting that the primary health care system needed to be strengthened (Dwyer, 2004). Accessibility, increased focus on preventive care and chronic disease management, multi-disciplinary and coordinated care, effective technology and data systems, local flexibility and promotion of an evidence base have been identified as key elements in health reform by both Labor and Coalition governments (Gardner, Douglas et al 2008). The December 2007 COAG Communiqué on Health and Ageing confirmed health system reform as a priority for governments across Australia, including a focus on preventative health care, general practice and links between health and disadvantage. A Primary Health Care Strategy (Australian Government Department of Health and Ageing, 2010) was also adopted in 2010 with 4 priority directions for change:

- Improving access and reducing inequity
- Better management of chronic conditions
- Increasing the focus on prevention
- Improving quality, safety, performance and accountability

In this paper we examine the impact of national and state health reform on the scope and potential of primary health care in South Australia. We look back to our recent history to provide context to the current position and explore what we have lost and stand to lose. In particular we examine the likely impact on South Australians, especially those with poorer health status and fewer resources for health.
Community health services

Community based health services have long been part of the Australian health care landscape. Major health reforms were relatively rare in the twentieth century with the introduction of universal health insurance (Medibank) in 1975 figuring as the first significant Australian health policy change in the twentieth century (Palmer & Short, 2000). During this era of reform community based health services were also a focus of policy attention and expansion. A policy designed to give federal grant assistance for the establishment of community health centres was implemented. Community health advocates believed that community health centres could provide a platform for a new system of health care delivery (De Voe, 2003). Duckett (1984) writing on the development of the Community Health Program notes that the reform represents a coincidence of interests between corporate rationalists seeking technocratic solutions to institutional health service problems and equal health advocates.

‘The coincidence of interests is apparent: on the one hand, equal health advocates were to get ‘high quality, readily accessible services... available equally to all’ and on the other hand corporate rationalists were offered ‘coordinated’ services with ‘efficient management’ (p. 960)

The chief objective of the national program was to:

…..encourage the provision of high quality, readily assessable, reasonably comprehensive, coordinated and efficient health and welfare services at local, regional, State and national levels. Such services should be developed in consultation with, and where appropriate, the involvement of, the community to be served (Hospitals and Health Services Commission 1973, p4).

Whilst the Community Health Program was ambitious and could possibly have become the foundation for a new system of health system delivery, the Program was not fully implemented and its potential never realised or assessed. Nevertheless the Community Health Program left a legacy of community health services and health professionals committed to a social view of health and primary health care principles (Raftery, 1995).

The 1970s and 1980s provided relatively favourable conditions for the development of community health. Although federal funding for the program was absorbed into global grants to the states, South Australia continued to develop the infrastructure established by the 1973 Program. Across metropolitan Adelaide a number of community health centres and women’s health centres delivered a range of treatment, prevention and health promotion activities. Despite opposition from the AMA some centres included primary medical care delivered by salaried doctors. These centres employed a range of health professionals and although there was always a strong emphasis on curative care (Milio 1988) innovative programs were also included - food cooperatives, domestic violence support and action groups, parenting programs, health promotion in schools, child protection, peer education, anti-tobacco and sun smart programs to name a few. By the 1990s South Australia had a network of community and women’s health centres, managed by local people, focused on needs of local population, providing treatment services and undertaking a wide range of prevention and promotion strategies including community development. The achievements of the SA community health sector were summarized in a book of edited chapters on many aspects of the program (Baum, 1995).
A 1998 study of medical services in 3 western suburbs community health centres demonstrated consumers valued services implementing primary health care principles. Almost half of the participants who attended medical services at community health centres were regular users of other services at their centre. Services cited included dental, immunisation, counselling, podiatry, physiotherapy screening, health information, health education groups, community action groups, massage, exercise classes, child care facilities, shared care with the Queen Elizabeth Hospital, financial advice, speech therapy and Spanish-speaking mornings. Below are some direct quotes from participants in the study:

I think the other [non-medical] services are very good ...because whatever area in people's lives is not right- the physical and emotional and spiritual it makes sense to have all the services there for the whole of the person -not a fragmented service.

I don't like the concept of private practice, whereas at women's and community health centres there is access to other services and supports, and it's free ...it's handy ...it's easy to access, they're friendly ...particularly over at Dale St....I know them and I've been in there sometimes in tears and they'll give me a hug- it's good...I feel like a total stranger.

I think the CHC plays a lot of roles because it has a lot of facilities. It has a lot of courses- you can learn about looking after your feet and doing massage, health awareness for different things they have for older people or whatever ...they have groups there for single mums to
The commitment to primary health care principles was still evident in the operation of the services in the last decade. In a 2004 report regarding the effectiveness of community health and women's health in Adelaide, the philosophy underpinning community health described clearly echoes the principles of comprehensive primary health care:

*Positive health as a distinct concept from that of absence of disease. The latter is concerned more with a physical or psychological definition whereas a positive view of health concerns culture, spirituality, community connectedness as well as physical and behavioural factors. This means that community health services can be concerned with many aspects of the factors that affect health, and the areas with which they are concerned will extend well beyond the confines of health services.*

*The comprehensiveness of services is crucial. Community health services should offer curative, rehabilitative, disease prevention and health promotion interventions. Wherever possible the emphasis should be on disease prevention and health promotion.*

*Multidisciplinary teams are the basis for community health work and no particular professional group is assumed to take leadership.*

*Community involvement in the management and planning of programs within community health services is an essential part of good practice. The aim of community health is to enable communities to take greater control of the social, economic and physical environments that influence their health.*

*Working in partnership with other sectors is a crucial part of community health work.*

*Equity and a social a view of health are fundamental to the operation and decision-making within the services (Jolley et al., 2004)*

**Changing policy context in South Australia**

Community health centres, whilst playing an important role in their local communities and providing a model of care that differed significantly to fee-for-service general practice, have remained a small part of the health system. The governance and infrastructure of primary health care is complex and the primary health care system includes a range of different services and programs with differing funding sources and accountabilities. There has however been a national commitment to primary health care since April 2013 with the Commonwealth, states and territories agreeing to the following vision for primary health care:

*A strong, responsive and sustainable primary health care system that improves health care for all Australians, especially those who currently experience inequitable health outcomes, by keeping people healthy, preventing illness, reducing the need for hospital services and improving management of chronic conditions. (Standing Council on Health, 2013 p 11).*

Despite a cohesive vision for primary health care, the division of powers with funding and management split between the Commonwealth and State and Territory governments has in some ways given rise to distinct and parallel systems: Medicare supported fee-for-service general practice
funded by the Commonwealth; and the state funded and managed providers such as community health services (Wiese et al., 2010). There are few links between the systems of fee-for-service primary care delivered in general practice and state government funded and managed primary health care services. (Wiese et al., 2010, Baum et al., 1996). Whilst general practice has reoriented to include more individual preventive care and emphasised improving access in recent years, fee-for-service general practice still focuses on individual instances of care, has little multidisciplinary team work, and does not provide groups of community capacity building.

The primary health care landscape also includes other significant non-government players such as Aboriginal controlled health services, private allied health providers, church and community based organisations or issue based organisations such as AIDS, substance abuse, or sexual health services. At the beginning of this century the political and policy conditions appeared favourable for primary health care. In May 2002 the South Australian government commissioned a ‘root and branch’ review of the health system to guide health reform for the next twenty years, the most comprehensive review in thirty years. In April 2003 the final report of the Generational Health Review was presented to the Government following an extensive consultative process with health service users and providers. The Report made some 74 recommendations in areas such as population health and governance, promoting primary health care, accountability and transparency, workforce development, and health inequities.

A key message of the report was:

‘there needs to be a significant shift from system focused on illness to a health system reoriented towards health promotion, illness prevention and early intervention.’

The then Treasurer committed the Government to funding health reforms. He said:,

It is about ... more money into health, ensuring that in the primary sector, out in the community, we do have a strong health system that gives all of us an alternative to hospital.’

This review and the South Australian Government’s response First Steps Forward promised to make community health services a better resourced and more mainstream part of the health system. The government developed a new Primary Health Care policy to mark the 25th anniversary of the WHO Alma Ata Declaration for Primary Health Care.

Community health and primary health care advocates were heartened by the government’s explicit commitment to primary health care and looked forward to further investment in state-funded services.
The reforms unravel

The intention to strengthen primary health care and health promotion from the Federal and State Governments in policy and strategic planning documents has struggled in its implementation. Federally, while the Medicare Locals have much promise they did not receive anything like the level of funding to achieve that promise. Review of the Medicare Locals has been commissioned and early indications suggest that the outcome of this review will be an increased focus on general medical practice and a winding back of the broader mandate the Medicare Locals were given. This means that the McCann assumption that the Medicare Locals would take up the work lost through the implementation of the review’s recommendations relating to the state-managed primary health care service will likely not be realised.

Despite the strengthening of comprehensive primary health care and health promotion suggested by the 2003 Generational Health Review and the primary health care policy (Government of South Australia, 2003b), almost immediately the focus was being diverted to a more selective approach with an emphasis on chronic disease. The SA Health Strategic Plan primary health care strategies implemented were focussed on individual clinical care.

The policies designed to strengthen primary health care have not translated into increased resources and investment in primary healthcare services. Instead there has been a reduction in funding for health promotion and community capacity building activities and an increased focus on individualised approaches to chronic disease. This was first noted when some community health services were replaced with “GP Plus health services” which began the process of moving from a more comprehensive to a far more selective form of primary health care.

In 2009 a five year NHMRC funded research project on comprehensive primary health care was commenced by staff in the Southgate Institute, Flinders University. The project was conducted in partnership with six primary health care services – four state funded and managed services including one Aboriginal and Torres Strait Islander health service and two non-government services, SHine SA and Central Australian Aboriginal Congress Aboriginal Corporation NT. Originally designed as a project examining the effectiveness of comprehensive primary health care the project has also been able to document a contraction of the state-funded and retreat from primary health care principles and staff responses to these changes. In the next section we draw on the results of this research to document some of the effects of these changes to primary health care.
Consequences of changes

Access

Whilst increasing access and reducing inequity was identified as a priority direction in the National primary health care Strategy, recent changes in to primary health care in South Australia appear to have impeded access. Optimising access to services is more than simply addressing availability – geography, affordability, acceptability can all form barriers to access (see Figure 1).

Figure 1 Equity Evaluation Tool

![Image of Equity Evaluation Tool]

Source: Jolley, Lawless and Hurley (2008)

To tackle inequitable access, health services must improve the ‘potential access’ of those most in need to achieve ‘realised access’, where they actually use the service (Aday and Anderson, 1981). The primary health care services in our study universally endorsed equity of access as a principle that should underpin health services. Most services operated a ‘priority of access strategy’ whereby priority populations (typically Aboriginal and Torres Strait Islander people, newly arrived migrants, children under Guardianship of the Minister, and families with healthcare cards) move up the waiting list. Such strategies increase potential access but may have no impact on realised access. This was the case at one study site where children under the Guardianship of the Minister and Aboriginal children were ‘top priority’ under the priority of access strategy but few such clients actually used the service.

Our study identified that engagement with the community was an important means used by services to overcome the gap between potential access and realised access. Approaches which raised the community’s awareness of the service established trusting relationships between the community and the service and provided multiple entry points encouraged use by those for whom the services
were hard to reach. For example one service ran a community garden which successfully engaged people in supported residential facilities and acted as an entry point to services and another service run regular lunches at which service providers could talk about their services in an informal and supportive atmosphere.

Many of the on-the-ground health workers we spoke to reflected that despite the success of such approaches changes in the organisational environment and priorities of the health system were reducing their ability to undertake engagement strategies. Instead of flexible, locally responsive strategies, there was a trend to centrally imposed state-wide programs focused on chronic disease management which did not always suit their local communities. An increasing focus on individualised clinical care has been accompanied by a significant move away from community development and engagement strategies.

The way services are delivered will in part, determine who gets to use them. This doesn’t always reflect need within the population as we can see with the example of high priority groups such as Guardianship of the Minister children and Aboriginal children being less likely to use the service. The demographics of a population and the needs of the community should be reflected in the usage of the service. This will often require significant reshaping of those services to include strategies to engage the community actively and to make them more culturally appropriate. A service that is engaged with its community is linked into a range of networks and works cooperatively and collaboratively with other agencies and sectors will encourage different people to walk through its doors than a service that operates in isolation from such networks. As one of the study interviewees put it:

> ... we end up with a generic health service that isn’t really designed for the community it’s in, isn’t really connected to the community that it’s in. And services like that tend to be okay for some people, they might even be okay for the majority of people. But for the people that are most vulnerable - they’re just not the best at being accessible to those people.

(See Freeman et al., 2011 for more detail)

**Community Development, Access and Patient Safety**

The retreat from community development and engagement strategies has relevance to another of the national priorities – improving quality, safety, performance and accountability. As discussed above, community development has been employed in community health services for many years as a means of engaging people who, for a range of reasons, are reluctant to use services. Cuts to these activities can be seen as a threat to patient safety. Traditionally, patient safety was a technical issue concerned with errors in diagnostics and treatment but more recently the notion was broadened to include breakdowns in access (Kuzel et al., 2004). Lee (2002) added underuse as a threat to safety. As already discussed community development and engagement strategies can act to make services more accessible. Rather than focusing on hard to reach populations, the onus for action is on the hard to reach service. Examples are the use of a youth participation strategy - Youth Action Teams – in a sexual health service and a living skills initiative for a new migrant group. These proactive strategies which reach out to individuals and community groups are not ‘added extras’ – they are an
important part of a service which seeks to ensure the quality and safety of all those in the population it serves.

(See Baum et al., 2012 for more detail)

**Health promotion in primary health care**

The study also examined what happened to the health promotion activity of the primary health care services. By 2012 the health promotion undertaken in the study sites related primarily to chronic disease management and prevention – reflecting the National Priorities ‘Better management of chronic conditions’ and ‘Increasing the focus on prevention’. However the focus of health promotion is heavily skewed to individualised and behavioural change strategies rather than addressing social determinants affecting whole communities. This is despite the evidence that in order to improve the health of populations activities need to address these factors rather than focus on the small group of people with diseases. Most health promotion dealt with: parenting and child development, chronic disease prevention and a limited amount mental health. There was little health promotion work that aimed at the promotion of good health rather than simply the prevention of disease. The absence of this broader work in the SA Health units contrasted with the non-government organisations which were part of our study who also reported advocacy on social determinants. The changing policy environment and organisational restructures were seen to reduce the ability of services to undertake health promotion. In 2013 when the cuts resulting from the McCann review were instituted programs such as the Community Foodies were targeted. This was a community development program which used a network of community volunteers who worked with other community members to increase knowledge about healthy food and the means of preparing and providing on a low budget. One manager put it this way:

> “Well broadly what you’ve seen is, and certainly culminating in the McCann review - you’ve seen a reduction of emphasis on any health promotion and illness prevention, and that includes social determinants of health. A reduction of that down and down until now I’ve been told that’s not our work. So health promotion is not in our work ... it’s come down just to clinical work really. So they’re calling it intermediate care rather than primary care.”

Manager, state government service, Oct 2013.

(See Baum et al., 2013a for more detail)

**Cultural respect**

Cultural respect is an important element in achieving realised access to services. Cultural respect has been defined as, ‘the recognition, protection and continued advancement of the inherent rights, cultures and traditions of Aboriginal and Torres Strait Islander Peoples’ (Australian Health Ministers’ Advisory Council’s Standing Committee on ATSI Health Working Party, 2004 p 7). The two Aboriginal health services in our study identified a range of strategies used to ensure culturally respectful service provision. These ranged from making the services welcoming and encouraging a sense of belonging to employment of Aboriginal and Torres Strait Islander staff. Strategies were underpinned by an understanding the social determinants of clients’ health and included advocacy and action on
the social determinants. Clients were able to articulate how these strategies supported their health and wellbeing.

Strategies to ensure culturally respectful practice were also noted in the mainstream services which served both Aboriginal and culturally diverse communities. For example, special clinic days were held for cultural groups, literature was available in languages other than English, cultural workers were employed and activities such as community lunches were held to make the community familiar with the service.

Cultural respect is congruent with a social view of health which takes into account the conditions and circumstances of people’s lives. Comprehensive primary health care, with its focus on the social determinants of health, such as poverty, early life, living conditions, and transport that contribute to ill health (Hayman et al., 2009, Baum et al., 2013b) is well-placed to deliver culturally respectful services. The findings from the NHMRC study also highlighted the need for service, flexibility and agility in order to respond to local needs. For Aboriginal people the argument has been made that comprehensive primary health enables Aboriginal health services to be responsive to the complex health needs of Aboriginal peoples and local communities and to operate in ways that improve access (Peiris et al., 2008, NACCHO, 2013).

Again our findings suggest the ability of services to ensure culturally respectful health care is constrained by organisational, system, funding, and policy factors.

(See Freeman et al., (2014) for more detail)

Case Study: Aboriginal and Torres Strait Islander Health Team

5 years ago this team had a number of strategies and programs based on a social view of health that promoted social connectedness, increased access to services, information and resources and ensured these were culturally respectful. These were highly valued by staff and clients.

A transport service supported clients attending appointments with the team and other health services. Clients reported found this invaluable:

“It’s the transport for me, yeah. It helps me get down to see the doctor, and medications and that.” (Client)

“I get in the bus, “How are you going? How you are today? How you been? What’s going on brother?” And it makes your entire insides feel good, and so you know you’re going to start off with a good day.” (Client)

A community lunch program with speakers on health issues that brought people together and provided regular free, healthy lunches:
“With the Nunga lunches that is the most important gathering for the community people ... it’s an opportunity for us to promote our health professionals in this area as well and so that the community can put faces to names.” (Manager)

Lunches also provided a means of following up clients. The team leader noted that at another health service in the north of Adelaide where the lunches were cut, the caseload of workers had fallen, in effect, reducing access to the services.

**Health promotion groups** (Men’s Health, Women’s Health, Mums and Bubs) met weekly. Clients reported great benefits from these groups, and used them as stepping stones to seeking further health care.

Contributions to **cultural events** such as NAIDOC week and reconciliation activities.

**Bush camps**, where staff would take community members on bush trips, and include health promotion content, e.g. on alcohol and other drug issues. Clients highly valued these camps:

> “Camps are good - like it was really good man, because we’re stuck in the city for a long time... We’re black fellas man, and we need to escape. We’re sick you know. We’re sitting in a state for white fellas looking at us – you know, we jump on the bus full of white fellas and all that, and you just want to escape sometimes.” (Client)

Over the course of the project, a **learning centre** was established that provided access to courses, including literacy and numeracy programs.

Recent reforms and changes in funding in South Australian primary health care have heavily affected this Aboriginal and Torres Strait Islander Health Team. All of these listed strategies - the lunch program, health promotion groups, organisation of cultural events, learning centre, and transport have all been scaled back, in terms of frequency, access criteria, and reorientation towards chronic conditions. Staff are concerned with the implications of this for the health and wellbeing of the community, and their access to services. There has also been significant reduction in staffing. The following quote shows the extent of this reorientation:

> “Nunga lunch will continue, it’ll be monthly, but from a more strategic perspective where we will include well health checks in the Nunga lunches ... that’s dependent on the availability of the community centre. Our men’s and women’s group that we used to have individually, again that will happen monthly, but it’ll be strategically where we will have women’s health days with well health checks and screening and the same for the men. Our mums and bubs program that we used to have will be linked in with our clinical area around early childhood. We don’t have youth programs anymore.” (Manager).

The reflections on the change and reorientation by this worker were typical:

> “It was deadly back then. It was, being able to get up and go and if there was that, had enough hours you know, where you go and you take the woman to a woman’s shelter, you know, her and her children. Being able to go and do that, and run late back to work, 5:30 pm or 5:45 pm, and say ‘out doing this’. Yeah, can’t do that. You always get told, ‘knock off at 5 o’clock, and you’re not getting no time.’ That’s that. Yeah we’re an Aboriginal health service, yeah. It’s not nice “ (Staff member)
Addressing the social determinants of health inequity

Primary health care involves activities that can be characterised as treatment and rehabilitation, disease prevention and health promotion. Activities in one area can and should inform activities in other areas. Legge and colleagues identified what they called ‘Integration of the macro and micro’ as best practice in primary health care. This refers to addressing immediate health needs whilst also addressing the determinants of health. Individual issues are linked with an analysis of the contributing social, economic and political factors (Legge et al., 1996).

The style of service delivery, the relationship between services and the communities they serve, provision of transport or child care to overcome access barriers – these are all tangible ways in which services take the social determinants of health into account. Although there is strong evidence that the social determinants of health are key to improving population health and equity (Commission on Social Determinants of Health, 2008), the organisational climate in primary health care services was perceived as becoming less amenable to action on the determinants of health. The study highlighted the importance of supportive policies and practice in enabling such action. In the absence of a supportive environment services are constrained in their ability to act on the Commission on the Social Determinants of Health’s recommendations regarding the role of primary health care in taking action on social determinants.

(SeeBaum et al., 2013b for more detail)

The study tracked the impact of the policy changes and reduction in funding and has demonstrated that they have resulted in a much more selective primary health care system. This has meant the primary health care services have been less able to incorporate community participation, build community relationships, involve partnerships across agencies and sectors, promote equity of access and outcome and undertake proactive health promotion.

The study developed a program logic model for comprehensive primary health care (see Appendix 1). This demonstrates the ways in which comprehensive primary health care is dependent on organisational and political context, relies on mechanisms that are underpinned by social justice principles which lead to a set of service qualities that should imbue all activities. If all these building blocks are in place then the evidence is strong that they will lead to improved health and its more equitable distribution.

In South Australia the mechanisms, the service qualities and the activities underpinning comprehensive primary health care have been eroded in the past 5 years despite the fact that many of the principles of primary health care are reflected in the State’s Health Care Act (2008). Cultural respect, the promotion and development of healthy communities and individuals, accessibility, recognition of communities with particular health needs, and community engagement are all incorporated in the principles of the Act.
Primary Health Care and the broader South Australian health system

In this discussion paper we have cited the international evidence that primary health care should form the backbone of a health system and that policy should be directed towards bringing about a reorientation towards and strengthening of primary health care. We have seen that despite policy statements that this should happen the opposite appears to have happened in recent years in South Australia. The reason for this cited by SA Health is that the system is under significant cost pressure and the focus has to be on immediate measures to reduce the demand for hospitals.

Like other developed countries, Australia faces questions about the sustainability of current health systems. In recent decades all states and territories have undertaken health system reviews to address common issues: the need to constrain health spending, service fragmentation, the increasing cost of intervention technologies, increasing incidence of chronic disease, the ageing population and a weak primary health care system. Despite strong political will to reduce health care costs it does not appear to extend to the sufficient political will to confront powerful vested interests that drive increased costs. In relation to these John Menadue noted:

“to reduce waste and costs requires political will to stare down the powerful interests and rent seekers that are determined to protect their territory and their high costs –e.g. the AMA, the Private Health Insurance firms, the Pharmacy Guild of Australia and Medicines Australia. In the past no government has been game to tackle these vested interests.”
(Menadue, 2014).

The strength of these vested interests and their power to control the direction of health systems has been noted in a study of former health ministers (Baum et al., 2013c) which reported the consistent stories from both Labor and Liberal former ministers of health concerning the power of the medical lobby to demand more hospital beds despite evidence about the need to reduce their supply and increase investment in primary health care. What appears to have happened in South Australia is that the historical pressures to maintain medical and hospital power have continued but have been accentuated by a budget crisis brought about by falling state revenues and a government determined to reduce state debt.

We note, however, that despite the “budget crisis”, salary increases to medical staff of 9% were given in 2013 and over recent years have exceeded inflation. This appears to be a significant cost driver within the health system which receives very little attention in political, bureaucratic or media concern about health costs. Most commonly increasing health costs are portrayed as resulting from an ageing population and an increase in chronic disease. While these factors do contribute the data we have examined appears to suggest that above average salary increases are a major factor.

Given this we recommend that the failure of the government to follow international advice (and its own earlier policy statements) and increase investment in comprehensive primary health care cannot simply be seen as a result of cost pressures and the need to reduce budgets. It also has to be reviewed in light of what aspects of the health budget have been protected from cuts and indeed appear likely to have received an increased share of the budget. We recommend that detailed analysis of the cost pressures on the State’s health budget be examined transparently to inform a public debate on the priorities within the health budget. It is likely to surprise many in the community that at a time when a health funding crisis is presented and our health services are under
considerable pressures, groups of staff within the system have received seemingly every generous pay rises. We further recommend assessment of the likely future costs of cutting disease prevention and health promotion services in terms of likely future health burden and associated costs.

**Discussion of trends in relation to role and charter of HCSCC**

The Charter of Health and Community Services Rights identifies the rights of consumers in regard to services in terms of access; safety; quality; respect; information; participation; privacy and comment. These rights are closely inter-related. Factors that support access are closely linked to those that guarantee other rights. Respectful, safe service provision underpins good access. Information is critical for people to participate in sound decision-making about their health and to navigate health systems. The ability for people to participate in their own care and contribute to service planning as well as being able to comment and complain is critical to the responsiveness of services to individuals and to communities. We examine some of these rights in relation to the current state of primary health care.

**ACCESS:** Supporting people’s rights to access services requires a service response that recognises and addresses both barriers and enablers to access. Primary health care services have in the past engaged with their communities proactively, particularly those with the greatest health needs, through outreach and community development strategies. This engagement is an important factor in enabling access for those who for many reasons otherwise remain excluded from services. It is an example of progressive universalism - ‘providing support for all and more for those who need it most, through both financial support and access to services’ (Her Majesty’s Treasury, 2006p 108).

The community engagement activities of services have been largely curtailed as a result of policy and organisational change. This is likely to reinforce the inverse care law with the largest impact of changes on those with greatest need and least access.

**SAFETY:** Reframing breakdowns in access or underuse of services as a patient safety issue also leads us to reframe our responses. Too often it is people who are defined as the problem rather than the service. The notion of ‘hard to reach’ services, rather than people, places responsibility on services to ensure access and safety and address processes of exclusion such as discrimination.

**QUALITY:** Findings from our research suggest that primary health care services work well in providing multi-disciplinary, coordinated individual care. The comprehensive suite of services once a hallmark of primary health care is, however, diminishing. The groups and programs that complemented individual treatment, promoted health literacy and encouraged social connectedness have been hard hit by recent changes. The balance of services between treatment, disease prevention and health promotion is heavily weighted to the treatment end of the spectrum.

**RESPECT:** The provision of respectful services that take into account the circumstances of people’s everyday lives is a key quality of primary health care. This quality has in the past been supported by community engagement and development strategies and encouragement of community participation in service development. Again the retreat from community engagement strategies compromises the service’s understanding of its communities and its ability to respond to local and cultural needs.
INFORMATION: Use of health information requires the ability to seek out information and navigate systems of increasing complexity alongside “a growing delegation of risk management to the individual, the family and the community” (Kickbusch, 2008). As health literacy and health outcomes both follow a social gradient this constitutes a potential ‘double inequity’ where those with fewer advantages experience worse health and are least able to gain information about health or navigate the health system. Again services require innovative, participative strategies to address this double inequity. Successful examples of such strategies, for example the Community Foodies program, were targeted for cuts in the McCann review.

COMMENT: Whilst most services have comment and complaint systems, consumers do not always have the knowledge or ability of people to engage with these. Again we see a double inequity with those most likely to have encountered discrimination or barriers to access often least likely to understand the systems or feel empowered to comment.

A participant in one of our research workshops said, ‘I reckon like today is the first time I’ve been approached that I can actually put in a complaint. I didn’t know who to go to before.’

Laverack and Labonte (2000) point out that marginalised groups are those in most need with limited access to resources and who exist outside power structures. They also note that “the most marginalised populations are often unable to articulate their interests or needs”.

Primary health care as a philosophy and a system can act to integrate and support consumer rights. A comprehensive model of primary health care is an inclusive one that seeks to uphold these rights for all, including those who are less empowered. As implementation of a comprehensive primary health care model of service is constrained by unsupportive policy and organisational environments so too are these rights compromised, particularly for those most in need.

Conclusion

In recent years South Australia has lost its international position as a leader in primary health care and health promotion. Despite the evidence that primary health care can provide an effective, high quality and efficient health system, policy decisions in South Australia have resulted the dismantling of comprehensive primary health care services and programs. This is happening rapidly and represents a u-turn from the strategic direction set out in the Generational Health Review only a decade ago. Community engagement strategies, disease prevention and health promotion, cultural safety, and action on the social determinants of health have all faced significant cuts to the point where the state-managed primary health care services no longer perform those functions. The impact of these cuts will be most heavily borne by those already disadvantaged with fewer resources for health and poorer health status.

The funding cuts to primary health care are driven by burgeoning health sector spending and falling State government revenues. The wisdom of cutting prevention and promotion activities whilst other parts of health sector have not been subject to the same cost constraint (including well above-average pay increases for salaried medical staff) is highly questionable as it is the part of the sector which most promises to constrain costs in the future.

Consumer rights require health systems that are fit for purpose. In order to fulfil the Charter of Health and Community Services Rights, especially for those in disadvantaged circumstances, health
services need a supportive political and administrative environment, an understanding of strategies which contribute to community engagement and positive health outcomes and organisational structures and culture capable of promoting this understanding. On all counts the policy direction of primary health care in South Australia is undermining rather than supporting these aspects of the health system.

Appendix 1 Program Logic for Comprehensive Primary Health Care
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