PART I

Theory

Community and primary health care

1

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LEARNING OBJECTIVES

At the completion of this chapter you should be able to:

- Describe the principles of primary health care.
- Explain how primary health care principles are linked to improving the health of individuals and communities.
- Differentiate between primary health care and primary care.
- Identify the principles that underpin health promotion, and the strategies used to promote health.
- Explain the principles of advocacy, mediation, enabling, community participation and community development in relation to health promotion.

Introduction

Primary health care (PHC) is a philosophy or approach to health care where health is acknowledged as a fundamental right, as well as an individual and collective responsibility. The PHC approach is founded on the social model of health, which recognises that a person's health is shaped by their biology, social group and family influences, community factors, economic and environmental influences, as well as broader public policy. Social justice, equity, community participation and health promotion are key principles of PHC. In a just society, everyone is supported to achieve and maintain her or his optimum level of health and well-being. Health improvement and well-being are achieved through addressing the social and environmental determinants of health, along with reduction in the burden of preventable disease and medical treatment.

The social model of health

Most health care systems have been developed to respond to illness, rather than to create and support wellness. Advances in science have entrenched the biomedical model of health as the pinnacle of health care for over a century. However, this view has been challenged in the face of mounting evidence, which demonstrates that health and health care are far more complex than this model allows. The social model of health takes a broader view of the complex interactions, which occur within a society, that influence individual and community health. A range of factors which can positively or negatively influence achieving and maintaining good health and well-being have been identified. These factors are collectively referred to as the **social determinants of health**.

Social determinants of health – the circumstances of daily living that determine a person's chances of maintaining good health.

The social determinants of health are simply the circumstances of daily living that influence a person's health. Lists of social determinants may vary, but fundamentally they will relate to economic, social, political and environmental conditions, and are frequently interrelated (Marmot & Wilkinson, 2006). For example, economic factors refer to the level of a person's income as well as her or his opportunities for employment. People may be employed, but not necessarily at the level they would like to be – known as being 'underemployed' – and they may also be unemployed. Employment opportunities can be influenced by numerous factors, including level of education, geographic location and political conditions (Keleher & MacDougall, 2011). Generally the level of education a person receives influences the type of employment they obtain, which influences how much they may earn. Income can impact on a range of life issues, such as food choices, recreational and social opportunities, housing options, access to health care services and educational opportunities. Houses that are further away from resources such as schools, shopping centres and health care facilities are usually cheaper to rent or buy. This means that access to transportation to reach these resources and potential employment opportunities become very important. If access to affordable public transport – or the cost of purchasing a car and the expenses of keeping it running safely – is difficult, people on low incomes may prioritise funding transportation or keeping a car over spending money on food, heating, lighting or recreation activities.

Economic factors, and how they influence a person's well-being, are often more visible than social factors. Yet these too can be interrelated. Lack of income or transportation may limit a person's opportunity to go out with friends, or participate in sporting or other social activities, making them feel isolated or excluded. Other social factors may be less tangible, but have similar outcomes. A person's gender or ethnicity may contribute to prejudice leading to social exclusion, or may limit educational or employment opportunities

(Keleher & MacDougall, 2011; Marmot & Wilkinson, 2006). Social exclusion may contribute to stress and how well stress is managed. Early life development and experiences can impact on health in a number of ways, particularly learned behaviours for stress management. Poorly managed stress may lead to problem behaviours such as substance misuse or may negatively influence mental health. This could then impact on income, employment, housing and so on.

Extreme political conditions such as the presence of civil conflict have an obvious impact on health, as do less obvious political factors such as government policy on the provision of social support, or models of taxation. Social support provided by governments may include public housing for low-income families, free or subsidised education and universal health care. Socially cohesive societies with welfare structures that provide high-quality education and health services demonstrate significant improvements in health, which are not apparent in equally affluent but less socially cohesive nations, with substantial health inequities (Marmot et al., 2012).

Both the built and natural environments can contribute or be detrimental to the health of individuals and communities. The natural environment may influence people's health through extremes in weather conditions such as flood, drought and temperature; and events such as earthquakes, tsunamis, cyclones and bushfires influence housing, employment and other opportunities. The built environment may relate to access to green spaces, noise pollution, road traffic and sanitation. Access to basics such as safe food and water supplies, adequate housing and transportation systems, clean air and recreational facilities can be considered environmental factors that impact on health (Keleher & MacDougall, 2011).

In 1998 the World Health Organization (WHO) first published a document that identified 10 determinants of health called *The Social Determinants of Health: The Solid Facts*. This document was revolutionary at the time, clearly acknowledging the following factors beyond biology and physiology relevant to health outcomes:

1. the social gradient
2. stress
3. early life
4. social exclusion
5. work
6. unemployment
7. social support
8. addiction
9. food
10. transport.

At a similar time, the Public Health Agency of Canada (PHAC) published its findings on the determinants of health (Keleher & MacDougall, 2011).

These are:

1. income and social status
2. social support networks
3. education and literacy
4. employment/working conditions
5. social environments
6. social inclusion
7. physical environments
8. personal health practices and coping skills
9. healthy child development
10. biology and genetic endowment

11. health services
12. gender
13. culture.

A quick comparison of the two lists demonstrates considerable agreement regarding economic, social, political and environmental factors that influence health outcomes, although the terms used may differ slightly. These lists demonstrate in a very simple way the multiple and complex influences on health, beyond human anatomy and physiology. The inclusion of biology and genetic endowment in the list produced by the PHAC reinforces recognition that these are only a small component of factors that influence health status and outcomes.

Social justice

Social justice – an ethical principle that requires the outcome of an action to be equality for all.

A key principle underpinning the social model of health is **social justice**. Social justice is an ethical principle that requires the outcome of action to be equality for all. In health, as in many other areas, equality is achieved by adopting an equitable approach. It is essential not to confuse equity with equality. Health equality refers to all people having the same health outcome – ideally this is to achieve their full health potential – while health equity refers to the process used to achieve health equality. This does not mean that everyone receives exactly the same resources, but rather that those who need more receive more. Some individuals and communities – and even some countries – are disadvantaged. Therefore, to achieve the same health outcomes as those who are not disadvantaged, a greater amount of resources and assistance is required in order to achieve health equality.

To achieve social justice we must act to reduce social inequity (Keleher & MacDougall, 2011). Inequities can be reduced by addressing the broader determinants of health, by empowering individuals and communities, and facilitating access to appropriate and sustainable health care (Marmot et al., 2012). As health outcomes are influenced by economic, social, political and environmental conditions, the financial sector, industrial sector, educational sector, transport sector, government sector and so on all have a role to play. The health care sector alone is not able to achieve the changes that need to be made.

The social gradient

Some groups in society have less chance than others in the same society of achieving their full health potential, due to the circumstances of their lives. The most disadvantaged groups in a society are found to have the poorest health, and are more likely to have greater exposure to health-damaging risk factors (Marmot et al., 2012). Put simply, the greater the disadvantage people face, the harder it becomes to make healthy choices. An individual, group or community may move in either direction along an imaginary line of advantage or disadvantage, as life circumstances change. This is referred to as 'the social gradient', which should really be considered as a continuum rather than two extremes. This concept is represented in Figure 1.1.

REFLECTION

Consider how you would explain the difference between health equity and health equality to someone who believes that it is not fair if they do not receive exactly the same resources as those given to someone else.

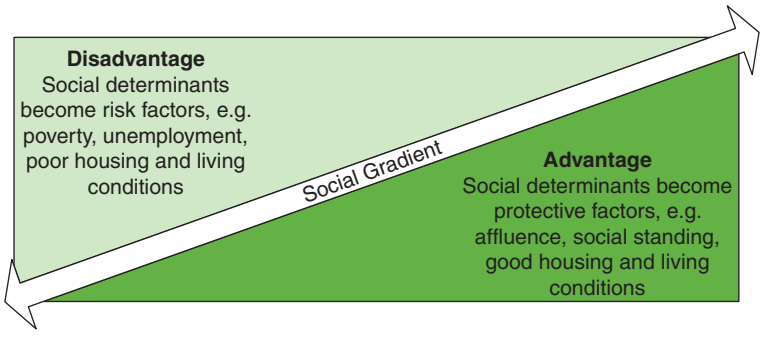

Figure 1.1 The social gradient

Promoting health

Health promotion is another core principle of PHC. In 1978, the WHO held the International Conference on Primary Health Care in Almaty (formerly Alma-Ata), in Kazakhstan. One of the significant outcomes of this conference was a declaration expressing the need for urgent national and international action to protect and promote the health of all people. This declaration, known as the 'Declaration of Alma-Ata', stated that primary health care was the key to attaining health for all.

Following on from this, the WHO held its First International Conference on Health Promotion in Ottawa, Canada, in 1986. It was here that the international agreement referred to as the Ottawa Charter for Health Promotion was signed. The charter details a series of strategies, set out under five core activities, that called for action in health promotion to achieve the goal of 'Health for All by the Year 2000' (WHO, 1981; 1986). These areas for action are designed to improve and maintain the health and well-being of individuals and communities. In order for individuals and communities to make positive changes to their health status, they must be empowered and supported. This is achieved using the primary principles of health promotion activity to advocate, mediate and enable.

The principles of health promotion

The principles of health promotion activity to advocate, mediate and enable, presented in this order, represent a continuum of intervention required to facilitate better health outcomes. Health advocacy is undertaken to change policy and systems to create favourable conditions for better health choices and health outcomes (Dorfman & Krasnow, 2014). When we advocate for health, we take a stand on behalf of others who are not in a position to take this stand for themselves. This may be due to a lack of knowledge or understanding, having little power or authority in the situation or perhaps due to lack of skill and confidence. Advocacy involves some form of effort on behalf of others, whether through speaking, writing or even protesting. Advocacy may be required to protect people's rights, to challenge organisational policy, procedure and practice, or possibly to gain political commitment and social acceptance for change (Keleher & MacDougall, 2011).

Historic, cultural and economic interests often shape our physical and social environments, which we acknowledge contribute towards and influence the health of individuals, families and communities. Mediation between these differing interests in society, and prioritising better health outcomes for all, relies on cooperation between governments and non-government organisations (WHO, 1986). Health professionals have a responsibility to ensure that good health remains the priority outcome when competing

interests may be detrimental to this. They also have a responsibility to mediate at the local level, such as when competing care requirements or patient values might create barriers to better health. Health promotion activity works towards creating a reality in which every person experiences an equal opportunity to reach her or his full health potential.

To enable individuals, families and communities to achieve optimum health outcomes, they must be knowledgeable, skilled and appropriately resourced. The five strategies outlined in the Ottawa Charter are designed to enable individuals, families and communities achieve optimal health.

The strategies for action in health promotion

The five strategies for action in health promotion distinguished in the Ottawa Charter provide a comprehensive framework, particularly when multiple strategies are used simultaneously. These are:

1. building healthy public policy
2. strengthening community resources and action for health
3. creating supportive environments for health
4. developing personal skills
5. reorienting health systems towards illness prevention and health promotion.

Building healthy public policy

The first strategy for health promotion noted in Ottawa Charter is to build healthy public policy. This is directly linked to the concept articulated in the Constitution of the WHO, that governments have a responsibility for the health of their peoples. The main way that governments address health is through legislation, fiscal measures and taxation. Public policy devised and enacted by government directly affects the availability and accessibility of health care services, as well as influencing the sectors that affect health in less obvious ways. Examples of such public policy include decisions involving housing regulations, importation of food and public transport. Healthy public policy requires the examination of all policy decisions in relation to their potential to affect health. Non-government organisations are also accountable and have a shared responsibility for health (Potvin & Jones, 2011). The effects of their decisions on health must be consciously considered. Those responsible for making policy decisions across all sectors, and at all levels, have to work together to achieve health improvement (Allender et al., 2012). Intersectoral collaboration requires both government and non-government organisations to work together to achieve optimal health outcomes, rather than simply placing the responsibility for accomplishing this solely on those working in the health sector.

Strengthening community resources and action for health

Strengthening community action involves bringing the community together to use the existing human and material resources to escalate self-help through self-reliance. Central to the strengthen community action strategy is the belief that people have the ability to identify their own needs, to determine how these needs are best addressed and to bring about the required change in their community to achieve better health (Racher & Annis, 2008; Talbot & Verrinder, 2005; WHO, 1986). This results in individual and community participation, the development of mutually supportive relationships and the encouragement of cooperation in decision making. Community participation and community development are fundamental aspects of this health promotion strategy, which focuses on enabling people to make knowledgeable and informed choices relating to their health.

Creating supportive environments for health

The emphasis on the environment in the Ottawa Charter reflects the commitment to the underlying principle of enabling. A supportive environment facilitates individuals, groups and communities to make informed choices and take action to optimise their health. When we consider the concept of the environment for health, it is important to view this as more than the physical, built and natural environments. Although they are undeniably important in promoting and detracting from health, we must also acknowledge the influence of the social and emotional environments (Allender et al., 2012). Good urban planning for recreation, transportation, health services and educational facilities demonstrate how the built environment can positively support health (Jackson et al., 2006; Scriven & Speller, 2007). Conservation of the natural environment also facilitates better health, through clean air and water, minimising the effect of climate change and maintaining biodiversity (McMurray, 2007; Talbot & Verrinder, 2005). The social environment is enhanced through **community participation**, the empowering process of partnership requiring the active consideration of choices and involvement in decision making, and **community development**, which is the strengthening of mutually beneficial relationships within social networks to build individual and community capacity and to promote citizen voice within community groups. The emotional environment is enhanced through social inclusion and resilience.

Community participation – engaging and building relationships within the community that result in enhanced community capacity, ownership and sustainability.

Community development – the empowerment of individuals, groups and communities by strengthening their networks and enhancing their capacities to identify and respond to issues.

Developing personal skills

The health promotion strategy to develop personal skills focuses on enabling people to take responsibility for their own health through the provision of relevant information, health education and the development of appropriate life skills (Jackson et al., 2006; Scriven & Speller, 2007; WHO, 1986). Developing personal skills provides people with the necessary tools to cope when faced with illness or injury (WHO, 1986), and assists their capacity to make wise health choices for the future. The result is confidence to make informed decisions and adjust as needed to manage all life stages, thereby facilitating a sense of control over one's life.

Reorienting health systems

Reorienting health services is a necessary response to the burgeoning health budget, the significant increase in chronic conditions and an aging population (King, Ogle & Bethune, 2010; National Health and Hospitals Reform Commission, 2009; St John, 2007; van Loon, 2011). The prime focus of the health care sector has traditionally been to manage illness through provision of clinical services; however, current health care reform in Australia and New Zealand highlights the need to shift health care from a reactive, acute care focus to one with a greater emphasis on proactive, preventative and health promotion action (Australian Government, 2011; Ministry of Health, 2002; National Health and Hospitals Reform Commission, 2009). A long history of inadequate funding has greatly inhibited the success of health promotion activity. In order to make the true potential of health promotion a reality, a genuine reorientation in health care funding is required (Acosta-Mendez, Mariscal-Servitje & Santos-Burgoa, 2007; Scriven & Speller, 2007). An associated reorientation in the education of health professionals and health research is also required for health promotion to be successfully integrated into the health care system (Talbot & Verrinder, 2005).

PHC, primary care and health promotion

The term PHC is commonly misunderstood by many health care providers and health consumers. It is frequently and erroneously used interchangeably with the term 'primary care'.

Intervention is the core activity of primary care provision, the focus of care being early diagnosis, effective treatment and disease management of an individual. Primary care can be considered a component of PHC and primary care services may be delivered within a PHC service. A PHC service must fulfil the principles of equity, universal access, sustainability, and cultural and financial appropriateness (meaning no or minimal cost).

In primary care, health promotion activity focuses on prevention. Prevention refers to health promotion interventions that are aimed at minimising the risks associated with poor health. Depending on where activity is taking place along an illness trajectory, the preventative action may be described as primary, secondary or tertiary prevention. Primary prevention activities relate to risk factors and risk conditions, therefore the focus of primary prevention is staying healthy. Social marketing and the provision of health information, health education and skill development, community action and creating supportive environments are common health promotion activities associated with primary prevention.

Secondary prevention is associated with early treatment to minimise complications of an existing health issue, recovery from the health concern and prevention of further problems. Health promotion activities focus on screening and individual risk-factor assessment, personalised health education and skills development. Community action and the creation of supportive environments tend to relate to specific illness concerns, such as the creation of support groups for people with the same health problems.

Tertiary prevention is concerned with maximising the quality of life of an individual with an established health issue. Rehabilitation is at the crux of tertiary prevention. Condition-specific health education, skills development and creation of a supportive environment are required.

Primary health care nursing

As with many nursing roles, the titles relating to practice may vary across and within states and countries, and the scope of practice within a role with the same title may vary. It is therefore important to consider the fundamental purpose of a role and whether it is practised within a PHC framework. As identified earlier, a number of terms are used, misused and interpreted in a range of ways by people with different perspectives and professional backgrounds. The reality of practice often requires an overlap between what some may view as separate areas of practice. It may help to conceptualise this as a 'patchwork' of practice. The unifying concept that is most consistently identified is PHC. Figure 1.2 demonstrates one way in which multiple concepts can be integrated coherently under a PHC approach.

There is no consistent or shared terminology internationally in relation to community nursing, as titles vary within and between countries, from public health nurse (PHN) to community health nurse (CHN), health visitor and community nurse – all contributing to confusion about these roles (Edgecombe, 2001). Solheim, McElmurry and Kim (2007) have noted that due to the overlap between primary health care, primary care, community health and public health, discussing them as separate roles is difficult, and that the terms are frequently confused. The PHC patchwork illustrated by Figure 1.2 attempts to assist in differentiation.

What we collectively do as a society to create the conditions in which people can be healthy, prevent disease and promote health is described as public health by Solheim and colleagues (2007). This could be conceptualised as activities undertaken on behalf of, or 'for', the community. The process of health promotion and disease prevention incorporating multisectoral or intersectoral interventions, community development and community participation is identified as community health (Solheim, McElmurry & Kim,

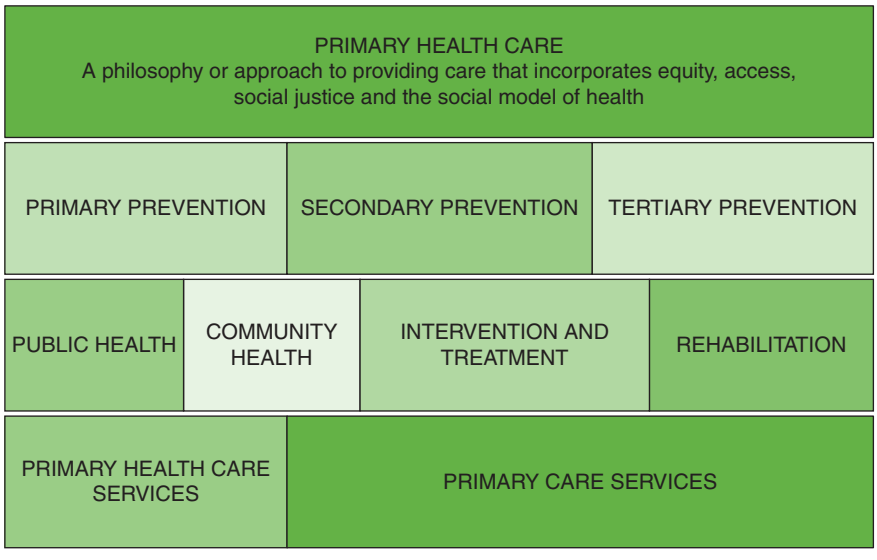

Figure 1.2 The PHC patchwork

2007). This describes activity that focuses on working with the community. Clearly, the two concepts are closely interwoven, and the differentiation relates to the focus of the activities and processes being undertaken. Community health nursing emphasises working with high-risk groups or populations, adopting preventative rather than restorative or health maintenance activities, and with health promotion the mainstay of practice (Lind & Smith, 2008; St John, 2007). This distinction suggests that working with the community is a subset of public health practice, whereas clinical practice in the community is not. Figure 1.3 illustrates this in relation to community nursing practice.

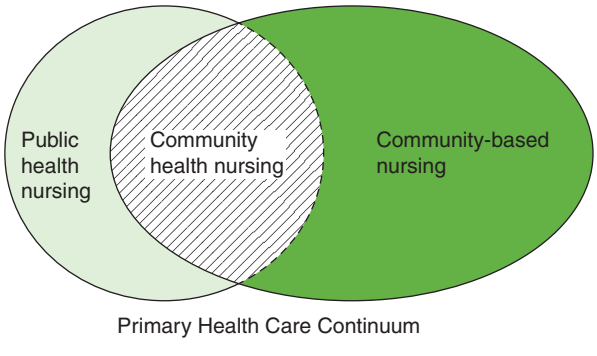

Figure 1.3 Community and public health nursing practice

Community health and public health, in particular, are terms that are frequently used interchangeably. As illustrated in Figure 1.3, while community health nursing predominantly sits within a public health model, there are activities that some community health nurses are involved in that may not be considered 'public health', particularly when focusing on individuals or families rather than populations or groups. It should also be noted, however, that public health and community nursing practice all occur within the framework of the primary health care continuum. In Australia and New Zealand, public health has been broadly defined as the organised response by society to protect and promote health and to prevent illness, injury and disability (National Public Health Partnership, 1998; Williams, Garbutt & Peters, 2015).