The Primary Health Care Workforce and Population Health Activities: Scope and Potential

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Introduction

The overlaps and synergies between Primary Health Care (PHC) and Population Health have been evident since the drafting of the seminal World Health Organisation Alma Ata Declaration and Health for All strategy (WHO, 1978) which saw PHC as one of the most important means by which population health could be advanced. While some of this potential has been realised in Australia, there is considerable scope to enhance the role of the PHC workforce in population health work. The researchers concur with the conclusions of Fry and Furler (2000) that in the last 15 years, policy and funding frameworks for PHC and population health "have occurred with little cross-reference". This means there is considerable scope to improve the interface between PHC and population health.

This paper seeks to define the scope of the PHC workforce, describe its current involvement in population health work and explore its potential to increase its contribution to population health including, planning, health promotion, and community development.

What is a Population Health Approach?

The term "population health" has come into use in Australia in recent years. Its meaning overlaps significantly with public health. Part of the preference for the term "population health" comes from the tendency for people to use the term "public health" to refer to publicly funded health services.

Drawing on earlier definitions of public health (Baum, 1998, Public Health Association of Australia, 1997, Beaglehole and Bonita, 1997), we offer the following working definition of population health as comprising the following elements:

- Focus on populations as entities (as opposed to a focus on individuals who comprise the population)
- Emphasis on health promotion and disease prevention strategies at a population level
- Concern with the underlying social, economic, biological, genetic environmental and cultural determinants of health of whole populations

Grasping the difference between a population health or public health approach and a clinical or individual approach is not easy. People assume that because interventions with individuals aim to improve health, then they must be good for the health of the population. To some extent this is true. But the essential thing about population health is the level of analysis, and the level at which intervention is aimed. The difference between the perspectives was detailed in a seminal paper by Rose (1985) in which he explained the crucial difference between considering sick individuals, and

sick populations. He noted that the question 'Why did this particular individual develop disease X?' is fundamentally different from the question 'Why does the population have an unusually high (or low) rate of disease X?'.

Population health approaches are concerned with interventions that address the later question. They also typically go "upstream" to consider causes of ill-health that are fundamental aspects of the social, political, economic or cultural aspects of society. Most other health service provision focuses "downstream" on dealing with individuals who have become sick or injured.

Generally, population health deals with causes of ill health that are less immediately evident than the downstream factors that readily manifest themselves in illness in individuals.

Some examples may help explain the difference and these are provided in Table 1

Issue	***Individual/clinical perspective***	***Population health***
Care for chronically ill	Provision of care and ensuring co-ordinated system	Working to prevent causes of chronic illness
Falls in older people	Mending fractures Providing physiotherapy and OT support to those who have suffered falls to assist with rehabilitation	Preventing falls through legislation, better housing design, population level education
Inappropriate drug use	Assist individuals who have suffered harm as a result (eg treatments for lung cancer, dealing with heroine overdose)	Prevent inappropriate drug use through legislation, population wide education, measures to reduce supply of illegal drugs
Domestic violence	Provision of services to people who have suffered violence or who want to deal with their violent behaviour	Legislation to make domestic violence illegal, population based education about effects and alternatives to violence Changing social attitudes about the legitimacy of violence
Tuberculois	Treatment of infected people	Improve living conditions that lead to TB infection Increase nutritional status of a population

Table 1

While all the measures in the individual/clinical care column may contribute to the health status of individuals, they do not necessarily contribute to improved overall

population health[1]. The measures in the population health column all are designed to improve population health overall.

What is Primary Health Care?

Primary Health Care was used by the World Health Organisation in its Alma Ata Declaration of 1978 to describe its approach to addressing inequalities in health status between, and within, nations. The WHO Health For All by the Year 2000 Strategy saw PHC as the first level of service delivery and also as an approach to health care that incorporates five basic principles:

- Equitable distribution of resources
- Community involvement
- Emphasis on prevention
- Use of appropriate technology
- A multisectoral approach (including sectors such as agriculture, water supply, environmental planning, education whose activities affects health)

There has been considerable debate about how PHC should be implemented. In most cases the implementation of PHC has focused on the downstream work and emphasised direct work with individuals rather than the upstream population health approaches (Sanders, 1998). Community health services have strived for a comprehensive approach to health based on the philosophical underpinnings of the Health for All strategy but have been unable to achieve it. The strategies espoused in the Ottawa charter provide a fairly accurate picture of the work undertaken in community health (Baum 2001).

There is no national PHC policy in Australia. The following definition of PHC has been adopted by the Commonwealth on two occasions:

> Primary Health Care seeks to extend the first level of the health system from sick care to the development of health. It seeks to protect and promote the health of defined communities and to address individual and population health problems at an early stage. Primary Health care services involve continuity of care, health promotion and education, integration or prevention with sick care, a concern for population as well as individual health, community involvement and the use of appropriate technology.
> (Australian Health Ministers Council, 1988; Commonwealth Department of Health and Family services, 1998)

This definition is compatible with the WHO definition and clearly sees a strong role for PHC in population health.

This paper is based on a view of PHC that at its heart, emphasizes the social and economic determinants that influence health, and incorporates a continuum of activities for prevention, health promotion, cure and rehabilitation developed in partnership with communities. (WHO 1978, Tarimo & Webster 1997)

[1] For those who want to follow the logic of the difference between the individual/clinical approach and the population health approach we would recommend McMichael,T (2001) Human Frontiers, environments and disease, Cambridge University Press. In this book he argues cogently and persuasively for the difference between the two perspectives and demonstrates the value of population-based approaches in reducing disease across societies.

PHC may be thought of as incorporating four key elements: values, activities, settings and people. The interactive relationship between these elements and health outcomes is described in Figure 1.

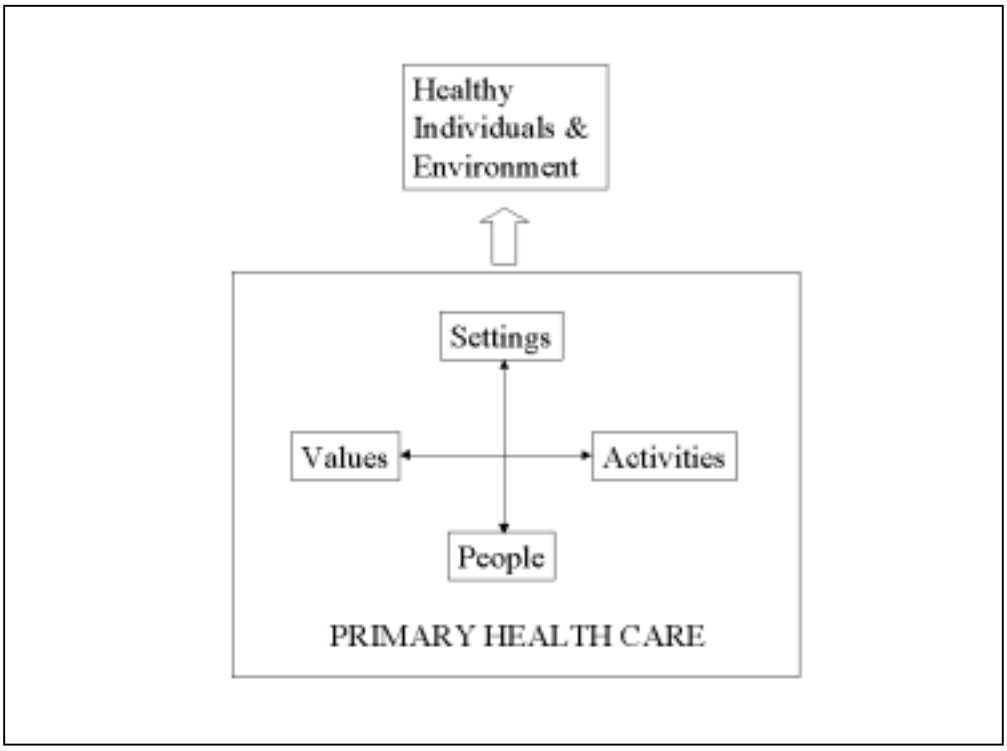

Figure 1

The *values* of primary health care emphasize that health is determined by personal, social, environmental and economic factors. Individuals and communities are seen as democratic partners in defining health needs and designing and implementing solutions to meet them. Achieving healthy individuals and communities and equity in health status is the ultimate goal of PHC.

Primary health care *activities* are conceptualized on a continuum which includes restorative and rehabilitative services provided for individuals with health problems, early intervention and prevention for those experiencing health risks, health promotion to assist individuals and communities to maintain and enhance their health and well being and planning, monitoring, regulatory, legislative and institutional action to maintain and improve population health outcomes.

Primary health care is delivered in range of community *settings.* These may include local community health services, schools, work places, community organizations and places where recreational activities occur.

There is considerable overlap between Primary Health Care and Population Health approaches. It is this interface, where the primary health care workforce employs (or has the potential to employ) population health strategies that we are interested in exploring. (Figure 2)

In the Australian context the relationship between PHC and population health is influenced, and complicated by, the methods of funding and organisation of health services. General practice is largely funded through Medicare rebates and organized on a fee-for service basis. Other private PHC practitioners operate entirely within the

private health care market (especially physiotherapists, speech pathologists and psychologists). States provide community health services and the organisation and function of these differ from State to State. Public and environmental health services have yet another form of organisation. Consequently the interface between PHC and population health is, inevitably complex and at times confusing.

This paper will attempt to explain some of the complexity and distill the potential of PHC in population health.

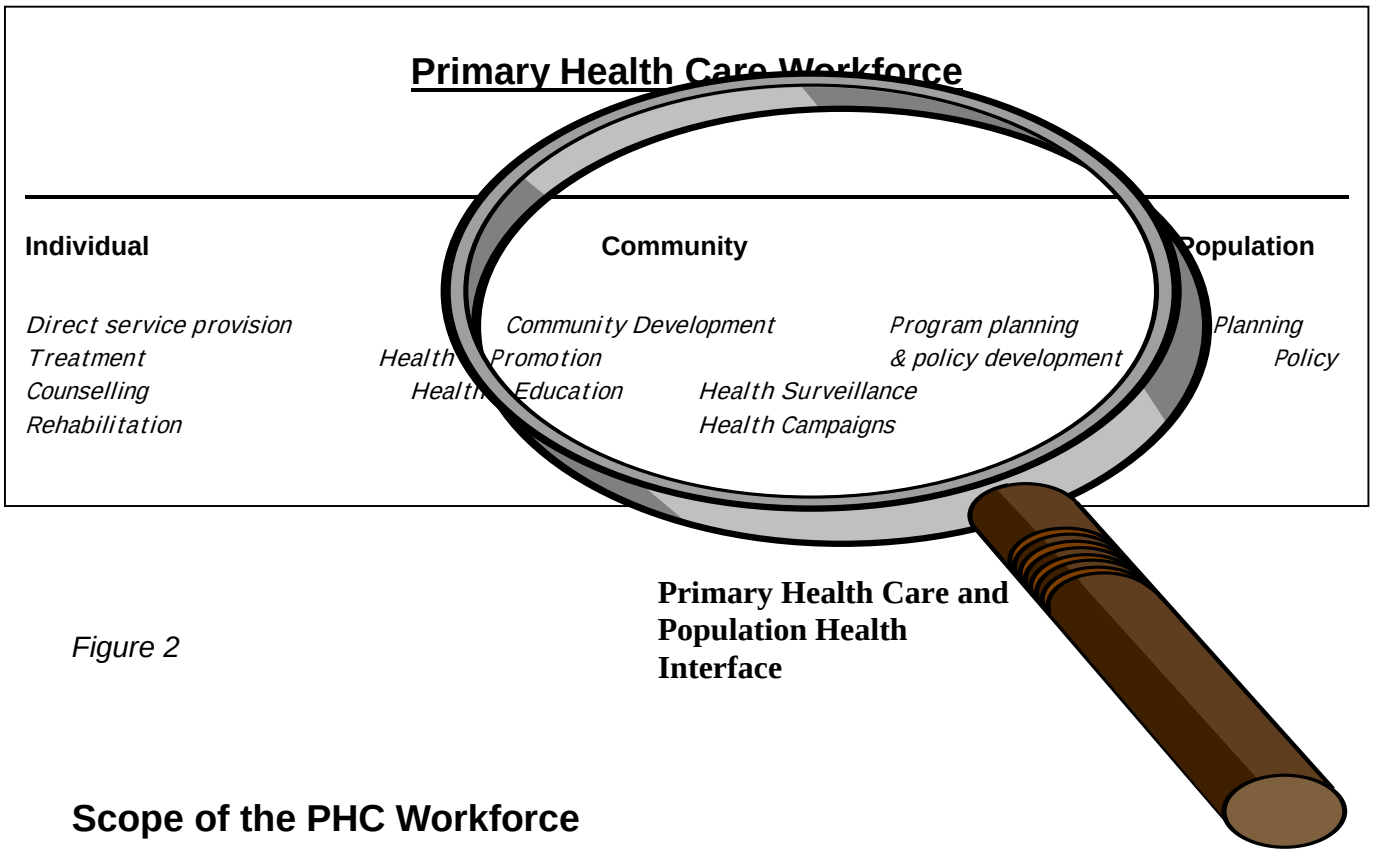

Figure 2

Scope of the PHC Workforce

The PHC workforce is involved in provision of services which exhibit some or all of the following characteristics:

- Treating health problems at an early stage of development
- Emphasising illness prevention and health promotion
- Emphasising community participation in decision making
- Concerned with issues of access and equity in health care
- Involving intersectoral collaboration
- Addressing broad social, economic and environmental determinants of health and illness

The following groups comprise the main workforce with which this paper is concerned:

1. Private fee for service practitioners

- GPs[2]
- Physiotherapists

[2] The brief of this project is to consider the scope and potential of the non-GP primary health care workforce because significant earlier work has been undertaken on GPs

- Occupational therapists
- Speech pathologists
- Psychologists
- Pharmacists
- Dietitians / Nutritionists

2. Public Sector

a) Community Health

Public sector services usually comprise community health services, consisting of multi-disciplinary teams of salaried health professionals who aim to protect and promote the health of defined communities:

- Domiciliary nursing services
- Early childhood and child health services
- Aged and frail services
- Services for people with disabilities
- Dental health services (provided by community health services)
- Women's health
- Aboriginal health services
- Remote health nurses
- Family planning services
- Alcohol and drug rehabilitation programs not involving admission
- Etc.

b) Local government based health related services
e.g. community development workers with a health focus

c) Educational institutions (schools)
e.g. Speech pathologists and psychologists employed by the Education Department

d) Prisons/corrections
Health care staff employed in these institutions

e.) Environmental Health Services

3. Non-government Sector

- Aboriginal and Torres Strait Islander controlled services
- Large NGOs e.g. church based, Aids Council, Family Planning Association, etc.

Population Health Activities

Population health activities broadly fall into three categories: Screening and immunization; activities to encourage and assist individuals to take health promoting action; and social and environmental change strategies.

Screening and Immunisation:

Screening: Screening involves the systematic use of a test or investigatory tool to detect individuals at risk of developing a specific disease that is amenable to prevention or treatment. It is a population based strategy to identify specific conditions in targeted groups before any symptoms appear.

Immunisation: Immunisation aims to prevent the spread of vaccine preventable disease across targeted population groups.

Encouraging individuals to take health promoting action

Health Information: Health information interventions aim to increase people's capacity to make informed choices about their health and wellbeing, including opportunities for preventive care by improving their understanding about the causes of health and illness, the services and support available to help maintain or improve health, and personal responsibility for actions affecting their health.

Health education and skills development: Health education, and skills development may be offered as part of a planned program at a local level or in conjunction with state-wide or national initiatives This action can also includeeducation and skills development in a "train the trainer" model or the development of peer education networks.

Social marketing: Social marketing involves programs designed to influence the voluntary behaviour of target audiences to benefit this audience and society as a whole. It typically uses persuasive communication (not just information) and cultural change processes. Social marketing is not restricted to the use of mass media but can involve a wide range of media, from radio and television to highly targeted messages delivered through low technology media.

Strategies for social and environmental change

Community action: Community action aims to encourage and empower communities (both geographical areas and communities of interest) to build their capacity to develop and sustain improvements in their social and physical environments that are conducive to improved health outcomes.

Organisational development: Organisational development aims to create a supportive environment for health promotion activities within organisations such as schools, local businesses and sporting clubs. It involves ensuring that policy, service directions, priorities and practices integrate health promotion principles.

Economic and regulatory activities: Economic and regulatory activities apply to regulatory or financial incentives or disincentives to support healthy choices. These interventions typically focus on pricing, availability, restrictions and enforcement.

Primary health care professionals engaged in these activities require population health knowledge, skills and competencies beyond those usually required for clinical practice. Apart from the specific knowledge and skills required to design and conduct the activities described above, more generally, they require skills in needs assessment, program planning and implementation and evaluation and monitoring. Recently, there has also been considerable interest in primary health care staff having skills in building the capacity of other professionals and community members in the development, implementation and evaluation of population health activities.

The implementation of population health approaches also requires understanding and commitment on behalf of the management of health services. In particular the strategic planning processes that underpin successful population health strategies will require significant organisational support and resources. The reorientation of health services required to incorporate population health approaches is unlikely to occur unless management of the service is both committed to such approaches and provides the infrastructure necessary to implement them. (Sanderson and Alexander, 1995)

This paper recognises that there is significant overlap between those in the primary health workforce who are involved in population health activities and those who

provide services to individuals who present with specific needs. The PHC workforce committed to restorative, rehabilitation and support services have significant potential to assist in the delivery of population health programs.

It is also clear that the health care setting in which different professionals work affect the extent of their involvement in population health activities. For example, it seems that those employed by state funded agencies are more likely to engage in population health activities than those in private practice. Settings which hold more potential for population health approaches are community health services and Divisions of General Practice. Such settings are funded to work on population health issues and so systematic planning is possible. This planning enables the agency or institution to conduct some form of needs assessment and then to establish priorities appropriate to the local community. These settings are also able to engage with local communities in meaningful ways. Funding models that permit this type of planning and engagement are essential if the PHC workforce is to engage in population health work.

The following sections of the paper will identify the number and type of professionals involved in population health activities across different settings, the programs and services they provide, and the models of practice that are embodied in a primary health care approach to population health. This will involve the documentation of available data on relevant workforce characteristics a consideration of the potential for occupations to contribute to population health work and through a set of illustrative case studies that demonstrate the potential for the PHC workforce to become engaged in population health work.

Employers and occupations

Empirical information on the national primary health care workforce involved in population health activity is relatively sparse. The Australian Institute of Health and Welfare[3] has compiled data on persons employed in health and community services for 1996 based the Australian Bureau of Statistics Census. These data were used in this report to describe the primary health workforce. As described above, data are reported for those occupational categories which predominately practice in primary health settings.

The data do not allow analysis of the extent to which occupations practicing in primary health settings are directly involved in population health activities or the degree to which primary health approaches are actually adopted. In this sense the primary health occupations reported here represent the potential pool of occupations and individuals which might be involved in the application of primary health care and population health approaches. We have addressed this issue in part by separately reporting data for those employed in community health services. It is arguable, that community health services are both more likely to encourage staff to practice within a primary health framework and to address population health issues.

Community health services

Community health services have differed over time and differ between States and Territories. As already noted there are no comprehensive databases that describe

[3] AIHW (2001) Health and Community Services Labour Force.

the activities of community health. Community health, undertakes a diverse range of activities and differs between services and States.
There are three main areas of activity within community health services:

- One-to-one services
- Group
- Community Development and Social Action

The comprehensive nature of community health means that services would normally have some activities in each of these areas. (Baum 2001)

Community health should be understood as having two broad functional service groups or types: population health (ie, health promotion and community development), and individual services. Population health activities would usually fall within the sphere of “Group” or more often “Community Development and Social Action”.

Population health programs are differentiated from other service types in that these activities are not provided as client services. Activities of this sort are usually organised as programs which seek to strengthen community capacity to promote health and well-being. These programs have their own internal logic with specific objectives, activities and outcomes which are related to community processes, information, skills, policy development and so forth. Performance indicators for population health will be qualitatively different from those for individual services.

A recent review[1] of South Australian community health services found that staff spent some 45% of their contact time in “community initiatives”. Community initiatives were those activities involving program support, community support, community consultation and interagency liaison. Population health activities are likely to be categorised as “community initiatives” although not all community initiatives will be population health activities.

Community health is diverse and complex and considerable further work on the development workforce data and performance measurement is needed. The experience of the casemix process in hospitals shows that it is vital to develop the community health workforce to become more oriented towards evaluation and performance measurement. In relation to performance indicators, population health and individual services of community health need to be treated as separate areas Such a process will raise knowledge and skills and will build a group of people within community health committed to improved performance and allow a more sophisticated analysis of the workforce and its activity.

Core services in community health

A recent review of metropolitan Community Health Services in South Australia defined the core services offered by those services. Service models included 1:1 services, group programs and community development.

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- **Community development and community capacity building**
  - ✓ Working with community groups
  - ✓ Social action activities
  - ✓ Information and resource provision
  - ✓ Collaborative action
  - ✓ Extensive community participation
  - ✓ Advocacy

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- **Early Childhood Development**
  - ✓ 1:1 services
  - ✓ counselling
  - ✓ immunisation
  - ✓ infrormation and education for parents
  - ✓ health promotion
  - ✓ Interagency coordination
  - ✓ Early intervention therapy
  - ✓ Advocacy

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- **Mental Health**
  - ✓ Counselling
  - ✓ Range of groups
  - ✓ Health information and education
  - ✓ Information about services and referral
  - ✓ Advocacy

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- **Sexual and reproductive health**
  - ✓ Counselling
  - ✓ Groups
  - ✓ Health information and education
  - ✓ Advocacy
  - ✓ Develop community awareness
  - ✓ Information about services and referral
  - ✓ screening

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- **Physical Health**
  - ✓ Doctor and nurse clinics
  - ✓ Health information and education
  - ✓ Screening as part of medical consultation
  - ✓ Information about services and referral
  - ✓ Advocacy
  - ✓ Prevention
  - ✓ Health promotion
  - ✓ 1:1 allied health services

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- **Drug and Alcohol**
  - ✓ Needle exchange
  - ✓ Information and education
  - ✓ Counselling
  - ✓ Information about services and referral
  - ✓ Community action
  - ✓ Access to methadone program

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- **Interpersonal Violence**
  - ✓ Counselling
  - ✓ Groups
  - ✓ Information and education
  - ✓ Advocacy
  - ✓ Develop community awareness
  - ✓ Prevention

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Facts and Figures

Table 1 (appendix 1) estimates that there were approximately 182,000 people employed in primary health settings in Australia in 1996. These estimates were derived by adjusting data on the total number of people employed in these occupations independent of setting presented in table 2 (appendix 1). In a number of cases, such as nursing a significant proportion of people work in non primary health settings such as hospitals and nursing homes. Data were available for people employed in health industries (settings) by qualification (table 3 in appendix 1). These were used to adjust the total numbers employed in each occupation presented in table 2. For example this involved adjusting the number of people employed in health science occupations by adjusting down the relevant occupational numbers by excluding those employed in hospitals, nursing homes, specialist medical services, pathology services, ambulance services and 'other health industry settings'. Overall, for the occupations presented in tables 1 and 2, those employed in primary health care comprise about 45% of the total, although this proportion falls to about 30% if community service occupations are excluded. When the estimate for health occupations employed in primary health settings derived here is compared to the total number of people working in health occupations in all settings[4] the primary health workforce is about 25% of the total health workforce.

It is clear from table 1 (appendix 1) that general practitioners are the largest single group employed in primary health settings, followed by nurses, community workers, allied health staff, dentists, retail pharmacists and other community services workers. However, as table 4 (appendix 1) indicates general practitioners, dentists and retail pharmacists are much more likely to be privately employed than other occupational groups working in primary health settings.

Table 5 (appendix 1) indicates that community health services employed 31,916 people across Australia. Of these about 10,000 of these were professional health workers, about 4,700 were employed in professional social, arts or miscellaneous occupations and about 3,000 were employed as associate professionals in health and welfare occupations. By comparison, GP medical services employed about 57,000 people, of which most were GPs, 25,000 were other health professionals and only a small minority were from non-health occupational categories. It is important to note that community health center employment varies across states and territories depending on the organizational structures adopted for state health services. For example, in 1996 more than a third of all community health staff were employed in Victoria and only about 19 percent were employed in New South Wales. This reflects the predominance of autonomous community health centers in Victoria compared to the incorporation of similar staff in Area Health Services in NSW[5].

Similarly, caution must be exercised in making direct comparisons between table 1 and table 5 (appendix 1) because the occupational categories are not strictly comparable. Nevertheless, it would seem likely that about 10 percent of the professional and associate professional primary health workforce (approximately 18,000) is employed in community health centers across Australia.

Expenditure on health services represents another source of information for analyzing the relative contribution of primary health. Table 6 (appendix 1) presents total health services expenditure for 1998-99. Total expenditure on community and public health was $2.8 billion. This represents 5.5% of total health expenditure.

[4] See AIHW (2001) Health and Community Services Labour force 1996 table 2 p23.
[5] See AIHW (2001) Health and Community Services Labour force 1996 table 16, p55-56

However, it is important to note that this expenditure does not include payments for medical services (including GPs) and dental services which comprise approximately $8.5 billion or a further 16% of expenditure. When these expenditures are included the total is about 21% which is comparable to the estimates derived for the proportion of people employed in primary health settings.

Overall, these workforce data are only indicative of the involvement of different occupational groups in primary health activities. Current collections are only partially useful in investigating the involvement of different occupations in primary health settings. Apart from the use of employment in community health centers as a proxy measure for direct engagement in a primary health approach, there is little information on the relative effort directly devoted to a primary health approach and there is virtually no information on the involvement of the primary health workforce in population health activities.

In order to address the issues more fully we conducted a more qualitative investigation of population health activities in community health settings.

Population Health Approaches – some examples

To illustrate a range of the population health approaches undertaken by primary health care workers and organisations we have compiled vignettes of existing practice. The examples each illustrate aspects of the intersection of primary health care and population health approaches.

"Don't Bet On It" provides an illustration of a prevention program developed in response to a local health issue.

"Noarlunga Health Village" is an example of an organisation which explicitly attempts to support primary health care and population health approaches.

"The City of Prospect Mental Health Project" is an example of these approaches being adopted in local government.

"Women of the West for Safe Families" illustrates the involvement of a primary health care worker across a continuum of health services - from direct service provision to social action and advocacy.

"Reorientation of a Speech Pathology Service" describes an individual practitioner's attempts to incorporate population health strategies into her practice.

"Families First" is a "top-down" example, where government policy has facilitated the development of population approaches to the health of families with young children.

These vignettes are not intended to be a comprehensive picture of population health approaches in primary health care. Nor are they necessarily "benchmarks" for future practice. They do however, provide real-life examples of population health approaches in primary health care.

“Don’t Bet On It” - a gambling problems prevention program

The psychologists at Noarlunga Health Village noticed an increase in the number of people with gambling-related mental health issues “walking through their doors”. This led to a discussion of ways to prevent gambling related problems in the wider community.

Given that 80% of Australian children have had their first gambling experience by age 13, the team decided to target children in the middle school years using the existing good relations with local schools.

The Australian context was important in deciding the nature of the program. Some overseas programs sought to “prevent gambling” promoting abstinence. In the local context this was seen as unrealistic and instead the aim of the program is to “prevent gambling-related problems”, a harm minimisation approach.

By a happy coincidence a small ad in the newspaper announced there were funds available from the Gambling Rehabilitation Fund for programs addressing gambling issues.

The grant application for $7,000 was successful and a working party of two psychologists from the health service and four teachers from local schools undertook the tasks of project design and development. The grant money allowed the program to provide teacher relief time, allowing the teachers to be released from the schools to participate in meetings and planning sessions. This was a crucial element in facilitating a successful collaboration between the health service and the schools.

The product of the project is a “Don’t Bet On It!” board game and accompanying lessons which can be embedded in the middle school curricula. Aimed at Years 6-9 the game provides a learning experience regarding the realities of gambling that is engaging and accessible.

Teams of students start the game with “$20” in hand and the object of reaching the supermarket at the end of the board with enough money still in hand to buy the necessities on their “Shopping List”. Just as real life, there are a distractions along the way and the opportunity to take your chances in various gambling scenarios. There are winners and losers and those who break even. For those who try their hand in the “casino” and lose, there is a loop which brings then into the casino again, presenting them with the opportunity of perhaps winning back what they have lost. There are those who lose a lot more trying to make back their losses.

The debriefing session explores issues such as what do you do if there is no money left when you reach the supermarket door, how did you reach agreement on whether to gamble or not, was there pressure to have a go?

To date the program has been trialled in local schools with 200 children and has met with enthusiasm on the part of students and teachers alike. Evaluation to date suggests children have made small but significant changes in their attitudes to gambling.

The project team has won a further $7,000 grant pilot the program in the south, and make the teaching program compatible with the South Australian Curriculum Standards and Accountability framework.

Lessons for Improved Population health practice within PHC

- Links can be made between clinical observations and your role in "Population Health"
- You need an organisation that supports your role in prevention
- Partners in a collaborative project need to be supported in their participation (in this case through funding teacher relief time)
- Look at what others are doing in the area but it may not always be directly applicable because the local context needs to be considered
- Consider what settings may be useful in reaching your target population.
- Use existing networks
- If you are working in a controversial area (gambling is in SA) be prepared for a lot of interest in your work. A small media release on the launch of the project resulted in several radio interviews and contact from the SA's "No Pokies" MP's office. (There was even a mention on Roy And HG!)
- Intersectoral collaboration can be tricky even when it works well at the local level e.g.. Education and Health have very different organisational cultures.
- Be prepared to let it go. Sometimes projects will gain a momentum of their own. There is the possibility that if the trial is successful the Education Department will incorporate the program into their curriculum

Hallmarks of a "population health" approach from the "Don't bet on it" example

- Identification of an issue at a population level
- Focus on Prevention, "upstream thinking"
- Intersectoral collaboration to ensure appropriate input in planning and implementation
- Planning process underpinning the reorientation of practice

Noarlunga Health Village

Noarlunga Health Services was incorporated in 1985 and encompassed a broad vision of health supported and articulated by the then State Minister for Health, John Cornwall. "…many illnesses can be attributed to the social and economic conditions in which people live…The Noarlunga Health Village seeks to offer services which are based on this wider understanding of health." (Cornwall 1985)

Noarlunga Health Village has had a number of contextual advantages that have supported primary health care workers working in innovative ways. The community health services were established prior to the establishment of the Noarlunga Hospital. Thus, quite unusually, the Heads of Allied Health are located in community health but also manage the hospital-based professionals. This has facilitated hospital–community links e.g. the hospital-based Speech Pathologist ran a highly successful preventive health program in schools targeting teachers (who comprise some 70% of clients presenting with voice disorders).

Noarlunga has also been part of the Healthy Cities program since 1987 providing a framework for intersectoral collaboration and encouraging a "settings" approach to health issues.

At the beginning of the 21st century this underpinning has been the basis for the ongoing development of an organisation that produced many examples of both primary health care and population health approaches.

From its inception there has been a recognition that the organisational culture and structures must support the workforce in adopting primary health care and population health approaches. Some of these are outlined below:

- A Director with a clear understanding of, and commitment to, primary health and population health approaches.
- Supportive team structures. In this case a dual team structure; professional discipline teams with a Head of Discipline (e.g. Occupational therapy), and multi-disciplinary teams
- An explicit commitment to the Ottawa Charter as the basis of the way the organisation works.
- Job descriptions mandating a "blending" of one to one client services, educational and groupwork strategies, and community development approaches (nominally a third of any disciplines work would be in each category)
- Agency and Board support for the development and reorientation of roles
- Use of a settings approach to health issues allowing programs to target sometimes hard to reach populations e.g. Workplace safety programs have targeted blue-collar male workers.
- Strong links with other agencies and networks e.g. Noarlunga Healthy City project and the Onkaparinga Crime Strategy

Hallmarks of a "population health" approach from the Noarlunga Health Village example

- A commitment to reduce inequalities in health status
- An understanding of the social, economic and biological basis of health
- A focus on prevention and early intervention
- Intersectoral collaboration to ensure appropriate input to planning implementation and evaluation, and the development of a comprehensive network of services
- A focus on accessibility of services
- Multi-disciplinary teamwork to ensure a range of perspectives, knowledge and skills
- Use of Health Promotion Strategies

The City of Prospect Mental Health Project

The City of Prospect, an inner city area of Adelaide, has been involved in a mental health project during the last two years. The impetus for the project came from the council's community development officer who identified mental health issues as an area of need in the local community.

"The aim of the project is to, build a healthier community through social, recreational and educational programs, with the focus being specifically on promoting mental health. Its aim is also to strengthen existing community networks by linking people to these."

The project has attempted to address issues in their local community at three levels:

- People in the community with mental health problems
- People in the wider community with an interest in mental health issues

- Whole of community, health promotion

The council employs a part-time project officer whose coordinates project activities, develops and maintains networks and oversees the planning of future developments. She is also involved in some "hands-on" delivery in the "Live It Up" sessions, a social program for those with mental health problems. The current project officer is an Occupational Therapist with a particular interest in population health approaches fostered by postgraduate study (MPH).

The council has provided infrastructure support by way of project support, transport for participants, venues etc. but a key characteristic of the project is the bringing together of various community groups and agencies with an interest in mental health issues.

The project links non-government organisations, community health agencies, mental health organisations providing a network of services and support in the local community. Even the local Aussie Rules club has been involved in a successful collaboration with the project, involving individuals with mental health problems in the clubs activities.

Some of the successful activities developed through the project are:
- Living it Up! A social and recreational program for those with mental health problems, with a focus on linking with local community activities
- Depression Workshops
- Volunteer program for those in supported accommodation
- Games Days An opportunity for those with mental health problems to experience social and recreational activities in a supportive environment
- Information and Education sessions
- Panic/Anxiety Information session and workshops
- Coping and Personal Skill Development Workshops
- Public mental health promotion displays

The program breaks down traditional barriers by providing programs at no cost, providing transport and holding activities in community venues which lack the stigma of clinical services.

The participation of organisations in the various aspects of the project has been facilitated by the independence of the project from any service provision agency or medicalised notion of mental illness. Agencies have come to the project with a willingness to collaborate and agreement on a preventative focus.

Hallmarks of a "population approach" from the City of Prospect example

- Focus on issues at a population level
- Intersectoral and interagency collaboration to ensure a coordinated network of services
- Community involvement ensuring issues and projects are defined with the community not by the professionals
- Community Development strategies
- Health Education and Health Promotion strategies

Women of the West for Safe Families

Women of the West for Safe Families (WOWsafe) is an example of a program that has sought to address domestic violence as a community issue, as part of a continuum of services that includes individual and group services.

The Psychologist at the Parks Community Health Service has been involved in a range of activities addressing Domestic Violence including individual counselling, group work and community development activities.

A Women's Group for victims of domestic violence has been running weekly at the Parks Community Health Service since 1985. The group developed as a response to the needs of women in, or separating from, domestic violence situations. The Women's Group operates as a support and self-help group providing a safe environment in which victims and survivors can share experiences, offer support and celebrate changes.

From this group a second group, WOWsafe, has developed and operates in parallel with the Women's Group. The focus of WOWsafe is on domestic violence as a larger issue rather than on individual needs. It explicitly seeks to broaden the agenda from the personal to the political.

WOWsafe incorporates peer support activities, community education initiatives and advocacy on domestic violence related issues.

Personal stories are seen as part of a wider context and are often translated into action for change. For example the daughter of a WOWsafe member was not taken seriously when she reported the abusive behaviour of her father to the police. The police did not make a formal record of the report and returned the children to the care of the father. WOWsafe identified the issue as a need for police education and training, to sensitise them to dealing with such situations.

One woman noted that WOWsafe provided a venue for action even when the individual woman involved did not have the time, skills or confidence to do so. *"There's always someone ready to take action"*

WOWsafe's explicit involvement in identification of Domestic Violence as a wider issue, its links with other agencies and services, and its commitment to social action sets this group apart from many other groups for victims or survivors of domestic violence. The Women's Group and WOWsafe continue to inform and support each other whilst adopting differing approaches to the issue of domestic violence.

Hallmarks of a "population approach" from the WOWsafe example

- Focus on issues at a population level
- Community involvement ensuring issues and projects are defined with the community not by the professionals
- Community Development strategies involving the women in collective action to tackle issues
- Focus on education and health promotion
- Intersectoral collaboration
- Social advocacy

Speech Pathology

Like many Speech Pathologists, the sole practitioner in a community health service was faced with a long, and growing, waiting list. The health service was in an area of socioeconomic disadvantage. The Speech Pathologist caseload had traditionally been a generalist one, treating a range of communication problems across all age groups. Clients were seen on a one-to-one basis or occasionally in treatment groups. There was little hope of additional funding, but even had another position been created the likelihood was that the extra capacity would have been quickly absorbed and a waiting list again created.

The community health service was attempting to reorient services in line with the principles espoused in the community health program and the Ottawa charter. This provided a framework in which the Speech Pathologist was able to explore other ways of working. A number of steps were taken in an attempt to change the nature of the Speech Pathology service.

- Pre-school and early primary age children were identified as a high priority group with difficulty accessing services. This was also in keeping with the agency's focus on prevention and early intervention
- Links were made with other agencies dealing with these groups e.g. education department and pre-school Speech Pathologists. Agreements to work in cooperation were made.
- Appropriate settings were identified in which activities aimed at promoting speech and language development could be developed e.g. early childhood centres
- Programs for parents were developed, sometimes in conjunction with Speech Pathologists from other agencies. Parents (almost exclusively Mums) learnt about communication development and how to foster it. Some went on to play a peer education role in their local community. Some even appeared on a TV program giving suggestions for fostering speech and language development.
- Links with other disciplines inside and outside the agency were fostered and resulted in joint planning and delivery of services. Eventually a multi-disciplinary "Child Development Team" was formed.
- Liasion with the local community nurse undertaking "well baby" checks led to an increasing number of very young children being referred, providing opportunities for preventive and early intervention work.
- Existing structures such as routine four and a half year old screening were used. The Speech Pathologist participated in screening sessions, making contact with all children identified with speech and language problems or possible hearing loss, and available for parents to chat to about concerns regarding their child's communication.
- Sessions for Family Day care workers and child care centre workers were held emphasising ways to foster speech and language.
- Community resources such as the Library were used with the Childrens' Librarian giving individual input to families where books were not part of the family's usual routine and linking them with story-telling sessions and other community events
- The association of family violence and developmental problems in children noted in clinical practice led to the Speech Pathologist's involvement in a child abuse prevention network and program.

Therapy with individuals, families or groups continued to comprise about half the Speech Pathologist's caseload. There was still a waiting list (!) but half the time and effort was now directed at targeted groups within the community aiming at prevention of, and early intervention in speech and language developmental problems.

Hallmarks of a population health approach from the Speech Pathology example

- Focus on prevention and early intervention
- Intersectoral and interagency communication
- Multi-disciplinary team work
- Health education strategies
- Planning process

Families First

"Families First" is an initiative of the NSW government using a "whole of government approach" to support families and young and children. Families First is based on the premise that no one agency or service can provide the resources or services to support and strengthen families. It draws on research that demonstrates early intervention services produce a sustained improvement in children's health, education and welfare.

Families First seeks to develop a network of services, bringing together Health, Community Services, Ageing and Disability, Education and NGOs at a regional level.

Families First seeks to: support women during pregnancy; provide support for families; coordinate support services; and facilitate community development. This strategy underpins the development of programs but implementation may differ from area to area in response to local needs.

Families First has been government led, providing a structure that has allowed disparate organisations to be brought together in a network of services. Each region has a Project Lead, unattached to any individual organisation,

The **South West Sydney Area Health Service** was one of the first areas to implement the "Families First" strategy and their program has been up and running for some three years.

A cornerstone of the initiative is the universal home-visiting service offered to all new families. Identifying families through an obstetric database, community nurses contact and visit new families in the home in the first two weeks after birth. They provide support to some 12,000 families per year. Community response to the program has been very positive with a very low refusal rate. The aboriginal community has also responded positively with only 6 refusals in over 90 families offered visits.

Community nurses have embraced the project seeing it as building on previous work.

Implementation of the Families first strategy has led to changes in the service system with emphasis on flexibility of services to meet family needs rather than services maintaining strict boundaries. There has been an allocation of resources in order to implement the strategy and in some cases a reallocation of existing resources.

The mandate for inter-sectoral collaboration has facilitated development of service networks although these are still emerging. The "fit" of theFamilies First strategy with some sectors and organisations has been more comfortable than others. Sectors

such as Education are finding an emerging role as the strategy has develops. In Health, community-based organisations have been more involved and responsive although it is recognised that the strategy needs to be inclusive of services such as hospital based ante-natal and maternity services.

Hallmarks of a population approach from the Families First example

- Intersectoral and interagency collaborationcollaboration
- Focus on prevention and early intervention
- Strategic planning process

Discussion

In this overview of the scope of the primary health care workforce and its intersection with population health approaches we have noted the lack of available data to assist in defining the precise extent and types of roles and activities. Despite this inadequacy, it is clear that the number of people working in primary health occupations and settings represents approximately 20-25% of the total health workforce. Based on the numbers employed in community health centres, it is further estimated that at least 10% of the potential primary health workforce has an explicit commitment to the application of a primary health approach to population health issues. Nevertheless, there is currently no available data showing the actual level of involvement of the primary health care workforce in addressing population health issues, or the extent to which primary health approaches, including the values and activities outlined above, are adopted in practice.

In the absence of such data, the vignettes (above) show that there exist some good examples of effective implementation of a primary health care approach to population health issues, and suggest directions for future development of potential. Collectively the vignettes highlight a number of crucial factors influencing the effectiveness of such interventions. These can be summarised in terms of the following principles:

- An underlying understanding that social (including cultural, political and economic) factors determine the health and wellbeing of populations and individuals
- A commitment to reducing inequalities in health status and improving access to services
- Identification of issues using populations as the ‘unit of analysis’ in order to determine the kinds of questions to be asked and therefore the strategies to be implemented
- A focus on ‘upstream’ interventions and preventive strategies
- A multidisciplinary approach, involving a range of professional groups in order to respond to complex social factors
- Collaboration across sectors in defining and responding to issues, based on recognition that creation of health and wellbeing is not the exclusive domain of the health sector
- Involvement of communities in planning, implementation and evaluation
- Appropriate strategies aimed at building capacity within population groups to address health issues (eg community development approaches)
- Building into workplace practices the need for flexibility; careful planning, monitoring and evaluation of strategies; and negotiation of roles, as

requirements of working in multidisciplinary and intersectoral teams and involving communities.

While representing actual examples of practice, the vignettes nevertheless provide snapshots of isolated, localised initiatives, suggesting that there remains considerable untapped potential for application of more effective and sustainable approaches to population health.

Developing potential

In addition to developing the vignettes, discussions were held with key contact people representing a number of the professional groups identified during the collection of workforce data. These people reported that they perceived several main issues affecting the ability of the workforce to take a population health focus in their work. In general they saw evidence among their colleagues of a:

- lack of understanding and information about 'population health approaches' and what they mean in practice, and confusion about the differences between 'population' and 'public' health;
- general impression that these approaches are incompatible with private practice in so far as the latter is geared towards generating income through fees;
- perceived lack of organisational support for a population focus;
- high level of demand for one-to-one services leaving little time for planning and implementing alternative approaches;
- lack of training in these approaches, and/or where a population focus was included in undergraduate curricula, there were limited opportunities to practice skills and knowledge in the workplace.

Together with the vignettes, such anecdotal evidence emphasises the importance of the wider structural context. From a population perspective, the infrastructure and policy environment in which the primary health care workforce operates determines its ability to apply the primary health care principles. International research has demonstrated that the distribution and organisation of resources to *support* primary health care approaches are directly related to the achievement of better health outcomes (Starfield 1996 cited in Fry and Furler 2000). In Australia, a lack of structural support has been identified as a major barrier to achievement of collaboration between the primary health care workforce and other sectors and communities (Fry and Furler 2000, Baum, Kalucy et al 1996).

Barriers to improved role of Primary Health Care in Population Health

Specifically, the following issues have been identified as structural barriers to the adoption of a population health focus by the primary health care workforce:

- a lack of integration of the primary health care workforce (outside of general practitioners) within the overall health system
- policies and guidelines have a narrow rather than comprehensive focus
- professional specialisation and differential treatment in terms of resources and accountability inhibits collaboration and intersectoral work
- funding arrangements tend to be inconsistent and inflexible and restrict the ability of the workforce to work across services and sectors
- different funding and administrative arrangements among the States inhibit a concerted national approach

- access to professional training and education in population health is limited and lacks a specific focus on skills and knowledge relevant to work in multidisciplinary teams
- a lack of organisational infrastructure to support the planning and evaluation cycles critical for population health strategies
- communities have inadequate resources to facilitate their involvement in planning and setting priorities
- health services are subject to variable political and organisational requirements, including administrative procedures and public accountability.

Two of the issue areas highlighted here are addressed in detail in the following two papers produced by this project. The first is the transparent need for appropriate Education and Training. This review of the primary health care workforce suggests that to fulfil its considerable potential there are a number of crucial areas of knowledge and skill which will need to be developed. These include: an understanding of the social determinants of health inequalities; the difference between a population health and clinical approach in practice (eg multidisciplinary teams, community based); specific skills in working with consumers and community groups; skills in planning, evaluation, needs assessment and, priority setting; and clarification of underlying values (eg principles of equity, socio-environmental approaches to health promotion). (See paper 2)

The second issue is the requirement for efficient and effective processes and structures for dissemination of information among the workforce to support an integrated and coordinated approach to population health. (See paper 3)

Opportunities to improve the role of PHC in population health

There exist in each state particular conditions and initiatives in the current policy environment suggesting that the time is ripe to move in the direction of expanding the potential of the phc workforce. It is anticipated that such opportunities will be identified during the state-based workshops. The following are a few examples of these:

1. State based policies, initiatives and strategies promoting intersectoral collaboration (eg in South Australia DHS explicitly supports this, and in NSW it is evident in the 'Families First' program etc.)

2. Existing arrangements which may be drawn on to develop funding models (eg a funding scheme for Divisions of Primary Health Care (based on the Commonwealth's General Practice Program) that encourages collaboration between GPs and community health services by funding demonstration projects that develop trust and networks necessary for effective collaboration between the partners. (SACHRU 1996).

3. Locality based policy and practice frameworks (eg Integrated community based intersectoral initiatives that begin with population level analysis and approaches including Healthy Cities and LA 21.) The establishment of such frameworks can facilitate the development of collaborative arrangements and intersectoral partnerships around specific issues.

Proposal/Recommendations

There is clearly a need for leadership at a national level to enable the primary health care workforce to fulfil its potential to focus on population health issues. The authors of this report support the conclusions drawn by Fry and Furler (2000 p.214) in arguing for an integrated approach to policy and program development in this area:

> Before the conceptual and operational relationships at the interfaces of general practice, primary health care and population health can be strengthened and developed the three components need to be seen as necessary and complementary parts of a comprehensive system.

For collaboration to become common practice at the community level, a comprehensive National Primary Health Care/Population Health Policy and Implementation Plan is therefore called for, which will enshrine the following:

- A strong policy framework to support a reorientation of the health system to incorporate a population health focus in Australia complementary to direct service provision
- A coordinated approach to policy and program planning and development in population health which accommodates differences between States
- A model of practice based on a cooperative partnership among the many professional groups represented in the primary health care workforce (including general practice)
- New service and funding arrangements to reflect this cooperative partnership
- A comprehensive plan for promoting the benefits of reorienting the health system to the general public, professional groups and Commonwealth and State government etc.
- A revised infrastructure supporting research and evaluation in population health based on the new partnership model of practice.

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