Health promotion and primary care: finding common ground

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Introduction

Although there appears to be some ambivalence on the part of health promotion practitioners as to the importance of the health system, the weight of evidence concerning the potential impact on population health, and the continuing central role of the health system as an anchor for public health programs in most countries means that we cannot afford to ignore this health promotion ‘sleeping giant’. There is no doubt that health services (systems or sectors) have vital roles to play in promoting the health of populations and individuals (Wise & Nutbeam, 2007, p.26).

In many health systems, including that of New Zealand, health promotion and health care tend to operate independently. Health promoters have often been resistant to engaging with health care services, yet – as identified in the quote above – health services have a largely untapped potential to promote health at the individual and population levels. The planning, funding and implementation of each is largely separate from the other. Health promotion usually remains the domain of public health practitioners and health care the domain of clinical practitioners. Despite the distinctions, health promotion has formally entered the health services arena in recent times. In New Zealand, primary health organisations (PHOs) are responsible for not only delivering clinical services but also health promotion. The Ottawa Charter for Health Promotion (WHO, Health & Welfare Canada, & Canadian Public Health Association, 1986) identified the importance of orienting health systems towards more comprehensive health care. Comprehensive health care includes not only the diagnosis and treatment of illness, as is the focus of hospital-based care, but also the prevention of illness and injury, along with the promotion of health in its widest sense.

This paper presents an argument for the promotion of health through the delivery of primary care. It outlines the historical common roots of health promotion and comprehensive primary health care, explores the distinctions between primary health care and primary care, and identifies how health promoters can close the conceptual gaps between primary care and health promotion.

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Historical Roots: Health Promotion and Comprehensive Primary Health Care

Traditionally, health promotion and primary care each have its own focus, funding sources, model of care, leadership, ownership and epistemology and culture. Yet, a historical perspective is required for one to fully understand that modern health promotion and comprehensive primary health care share common roots and principles (see Table 1).

The notion of primary health care, as a comprehensive approach to health needs, surfaced in the 20th century as an outcome of the changing discourse of health and health care. During the 1960s and 1970s, health planners and development workers translated the growing global inequalities in health status and in access to health care into a development issue (Werner & Sanders, 1997). A basic needs approach to health and development emerged during that time, incorporating a health determinants perspective. This basic needs approach built on the small but important successes achieved by grassroots health initiatives in developing countries from the 1940s onwards. These initiatives were often the joint effort of clinicians and community organisers or early health promoters, and were later known as primary health care initiatives (Newell, 1975; Werner & Sanders, 1997; WHO, 1977).

The concept of comprehensive primary health care owes its official origin to the 1978 International Conference on Primary Health Care, which produced the Declaration on Primary Health Care, known as the Alma-Ata Declaration (WHO & UNICEF, 1978). The international delegates from 134 governments, including New Zealand, adopted a strong, collective vision of comprehensive primary health care as the strategy to reduce health inequalities within and between countries to achieve the goal of ‘health for all’. The core principles of comprehensive primary health care have been summarised by MacDonald (1992) as:

- a concern for equitable access to health services;
- the involvement of individuals and communities in developing strategies to improve their health; and
- a concern for addressing the social and environmental determinants of people’s ill-health.

Comprehensive primary health care and health promotion are both grounded in these principles, whereas primary medical care (known as primary care) is not explicitly (Neuwelt et al., 2009).

Table 1: Contrasting paradigms of health promotion, primary care and comprehensive primary health care.

<table>
<thead>
<tr>
<th>Focus</th>
<th>Health Promotion</th>
<th>Primary Care</th>
<th>Comprehensive Primary Health Care</th>
</tr>
</thead>
<tbody>
<tr>
<td>Populations (communities, whānau groups, etc.)</td>
<td>Populations and individuals</td>
<td>Individuals (patients and families)</td>
<td>Only populations and individuals</td>
</tr>
<tr>
<td>Funding</td>
<td>Public / population health</td>
<td>Personal health</td>
<td>Both personal health and population health</td>
</tr>
<tr>
<td>Model of care</td>
<td>Usually NGO model (with some government-funded)</td>
<td>Usually business model (with some NGO model)</td>
<td>NGO model</td>
</tr>
<tr>
<td>Leadership</td>
<td>Public health practitioners / health promoters</td>
<td>General medical practitioners (GPs)</td>
<td>Leadership from communities, with health professional input</td>
</tr>
<tr>
<td>Ownership</td>
<td>Public</td>
<td>Private (mostly GP owners)</td>
<td>Community</td>
</tr>
<tr>
<td>Language and culture</td>
<td>Population health</td>
<td>Clinical</td>
<td>Combines population health with clinical</td>
</tr>
</tbody>
</table>

Comprehensive primary health care is not a level of health care but an approach that incorporates both disease prevention and health promotion (Sanders, Schaay, & Mohamed, 2008). In defining primary health care as a comprehensive approach for establishing equitable health and social outcomes, the Alma-Ata Declaration, it has been argued, set the scene for the modern health promotion movement (Talbot & Verrinder, 2005). In fact, it has been said that one of the driving forces behind the development of the Ottawa Charter was the failure of industrialised countries to adopt the strategy outlined in the Alma-Ata Declaration (Baum, 2002).

Primary Care in New Zealand

New Zealand’s primary care sector has historically been organised around GP-owned practices in both urban and rural areas. GPs have employed nursing and reception staff, and worked either in solo or group practices. Prior to 2001, general practices had little involvement in the delivery of health promotion at a population level (Helford, Crampton, & Foley, 2005). General practitioners and practice nurses offer personal and family health care, including preventive care in the form of childhood immunisations, screening and individual health education. The funding of general practice has been based on receiving fees, both from the government and from patients, for services provided; a funding model known as ‘fee-for-service’. GPs have received government funding, in the form of subsidies, for patient consultations and have charged patients fees to complement those subsidies. As business owners, GPs have relied on making a profit in order to earn a living. Their ability to charge fees to patients is a privilege which doctors’ organisations have held tightly to over many decades in New Zealand, despite government attempts to limit this privilege (Brown & Crampton, 1997).

Alongside small business general practices have been alternative models of primary care. The most notable is the third sector model, which first emerged in the 1980s in urban areas in the form of the Union Health Centres. They developed through the collaborative efforts of labour union organisers, health professionals and community activists, as a direct response to observed inequitable access to quality primary care services for low-income families and especially Māori and Pacific peoples (Crampton, 1999). In the early 1990s, Māori organisations also became involved in delivering primary care, out of a desire to better meet the health care needs of Māori (Crengle, 2000). Crengle (2000) purports the distinguishing features of Māori primary health care services to be their basis in a Māori understanding of health, their emphasis on the determinants of health as key to Māori development, and their utilisation of Māori values and processes in service planning and delivery. During the 1990s, a number of Pacific primary care providers were also established, to improve access to primary care for Pacific peoples (Tukuitonga, 1999).

These ‘third sector primary care organisations’ (non-government, non-profit) tended to adopt comprehensive primary health care as their ideal. In contrast to general practice businesses, many adopted community governance models, worked within a community development framework, and employed clinicians on salary (Crampton, 1999). They were found to be more likely than for-profit general practices to deliver group health promotion services (Crampton et al., 2005) and to better meet the needs of less privileged populations in New Zealand (Crampton, Lay-Yee, & Davis, 2004). Yet, in 2000-2001, only one fifth of all Māori primary care consultations were with Māori providers, while the majority were with mainstream general practices (Crengle, 2007). The challenge for health promoters, then, must be learning to work with mainstream general practices.

In 2001, the Primary Health Care Strategy (King, 2001) was released, which aimed to...
reduce health inequalities and brought health promotion formally into the primary care sector. The Strategy, which adopted the Alma-Ata Declaration’s definition of primary health care, called for the establishment of not-for-profit organisations, known as primary health organisations (PHOs), responsible for delivering both clinical and health promotion services to enrolled populations. PHO clinical and health promotion funding was tagged to the size and demographic make-up of the enrolled populations of the general practices within them. As a result, large PHOs (those derived from GP organisations known as IPAs) had the means to employ qualified health promoters to develop substantial programmes (Lovell & Neuwelt, 2011), while smaller PHOs often allied themselves with other organisations to engage in health promotion activities.

In a review of health promotion initiatives, Thomas (2010) found that most PHOs used their health promotion funding to provide health education and healthy lifestyle programmes either within general practices or at the PHO level. The report of a 2006 national meeting on health promotion in primary care identified that most health promotion activity within PHOs operated separately from treatment services (Winnard, 2006). To further support this finding, an evaluation of the implementation of the Strategy stated that PHOs have carried out health promotion activities, without tackling general practices’ approach to service delivery (Smith, 2009). Thus, with the exception of the PHOs derived from third sector organisations, the reorientation of primary care has remained elusive in New Zealand, in spite of the government’s attempt through the 2001 Primary Health Care Strategy.

**Implications for Health Promotion**

The focus of New Zealand general practice is still individual clinical care. Starfield and colleagues (2005) argue strongly for collaboration between public health (including health promotion) and primary care, in order to transition health care from being totally individually centred to being more people-centred and population-based. There remains untapped potential for health promotion within primary care settings. Some small practical steps for health promoters and other health practitioners are offered next.

If health promoters are to gain traction in the primary care sector, then language that incorporates a clinical perspective is critical. The shared principles of comprehensive primary health care and health promotion (health equity; community participation and action on the determinants of health) can be translated into the language of general practice, as outlined in Table 2.

Equity is often deemed to be a challenging concept to general practitioners; yet, it relates directly to the practice of triage. In health care, patients with acute and serious health need are given priority over those who are less ill. This practice, known as triage, is in place to ensure that people with the most urgent health need are treated before those with a less urgent need. Triage decisions, often carried out by receptionists and nurses in the general practice setting, are evidence-based. For example, a middle-aged man with acute chest pain is given priority treatment over patients already waiting to be seen, since evidence has demonstrated that men of this age have high rates of heart disease in New Zealand. To extend this triage practice to the wider concept of improving health equity is not difficult. For example, evidence has demonstrated that Māori, who are known to die prematurely relative to non-Māori in New Zealand, tend to underutilise primary care relative to their level of health need. This same argument can be made for others with high health need, such as Pacific peoples, new migrants, youth and mental health consumers.

Community participation is related to the primary care notion of patient-centred care (Weston & Belle Brown, 2003), in which patients set the agenda for doctor-patient interactions. Community involvement in primary care can assist general practice teams in agenda setting for service planning (Neuwelt, 2012). For example, in response to community input a practice might offer outreach clinics, employ Māori and Pacific staff, ensure the clinic waiting room is welcoming or run drop-in clinics for acute care, to better meet community needs. Community involvement could also lead to the inclusion of a community health worker (CHW) to a practice team. CHWs have been demonstrated, in New Zealand and elsewhere, to reduce access barriers for people from disadvantaged communities (Forrest, Neuwelt, Gotty, & Crengle, 2011; Lehmann & Sanders, 2007).

The third health promotion principle that requires translating for general practice is that of action on the determinants of health. The determinants are commonly known as ‘lifestyle issues’ in general practice. Practitioners know well that housing, income, diet and exercise levels all contribute to poor or good health for their individual patients. Research has demonstrated that members of less privileged communities recognise the futility of maintaining a purely clinical focus in the primary care setting (Neuwelt, 2012). Members of these communities clearly want support from primary care practitioners on issues such as housing, transportation, income and education. Working intersectorally, with organisations and agencies outside of the health sector to improve these key determinants of health, appears to be a distinguishing feature of primary health care organisations which engage communities (Neuwelt, 2008). If health promoters and clinicians communicate these individual and collective concerns to each other, practices would be in a strong position to act. Action might involve such things as advocacy on housing or urban planning issues, including contributing to select committee submissions, and health promotion activities focused on determinants rather than on disease.

**Conclusions**

The health care sector is important to health promotion, and the New Zealand primary care sector provides evidence to support that claim. Health promoters often assume that primary care practitioners simply ‘don’t get health promotion’. Yet, many health promoters struggle to understand the drivers of professional practice in primary care. Health promotion models, such as the Ottawa Charter (WHO et al., 1986) and Te Pae Mahutonga (Durie, 1999), draw on the discipline of collective or sociological understandings. They incorporate notions of working with whānau and communities, not only individuals. Primary care practitioners are trained to work with individuals, and may draw more naturally on psychological models of behaviour change. We can develop shared language most effectively if we can develop shared understandings. There is work to be done to better understand how psychological models of behaviour change and more collectivist health promotion models can complement one another. Otherwise, primary care practitioners and HP practitioners may talk past one another.

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Third sector primary care organisations, many of which are Māori-led and Pacific-led, have demonstrated that comprehensive primary health care meets the needs of less-advantaged populations better than mainstream general practice care. Yet, most high needs populations are served by mainstream primary care. ‘Better, Sooner; More Convenient (BSMC) Primary Health Care is the current government’s initiative to deliver a more ‘personalised’ primary health care system that provides services closer to home (Ryall, 2007). PHOs have been asked to demonstrate how they will help to reduce acute demand pressure on hospitals by better managing chronic conditions through clinical pathways, flexible services and shifting some secondary services to primary care. Although this strategy appears to support a move away from health promotion towards a clinical approach (with a focus on designing health delivery systems, self management programmes, decision support and information systems), the potential to support health promotion in primary care may lie within BSMC’s call for PHOs to deliver services that are consistent with Whānau Ora approaches (Ryall, 2007).

Whānau Ora, is defined as Māori families being supported to achieve their maximum health and wellbeing (Te Puni Kokiri, Ministry of Social Development, & Ministry of Health, 2009). The Ministry of Health, Te Puni Kōkiri and the Ministry of Social Development endorse the Whānau Ora approach and support agencies and providers to work with families as they achieve self determination, live healthy lifestyles, participate fully in society and become economically secure. In doing so, Whānau Ora has the potential to advance the health promotion cause, particularly in terms of empowering families and communities to be more involved in their own health and future wellbeing and in addressing the wider health determinants. Those committed to promoting population health need to utilise these new opportunities to strengthen health promotion in primary care.

Health promotion in the health care context must not replace broad health promotion programmes. Evidence suggests that both are needed. Health promotion funding is vulnerable to political and economic change. As a consequence, advocacy for a strong policy commitment to health promotion is as critical in the health care setting as in the public health setting. But, in the words of Wise and Nutbeam quoted previously, the health care sector remains a “health promotion ‘sleeping giant’” (Wise & Nutbeam, 2007, p.26). Community-governed third sector primary care organisations and Whānau Ora initiatives have much to teach us about the translation of health promotion principles into primary health care action.

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“Adapted from NEUWELT, P and M. Harwood (in press) “Promoting Health through the Health Care Sector: health promoting primary care” in Signal, L and M. Ratima (Eds), Promoting Health in Aotearoa New Zealand, Routledge, Wellington.”