Comprehensive Primary Health Care in Theory and Practice

Now more than ever!

Donna Ah Chee
Chief Executive Officer
Central Australian Aboriginal Congress
The Struggle for Health in the Early Years

• Infant mortality 120 /1000 live births (now 10/1000)

• Life Expectancy for Aboriginal men 52 years (now 63), women 54 years (now 69)
WHO/UNICEF Alma Ata Conference (1978) ‘Health for All by the Year 2000’
Key elements of the Declaration of Alma Ata

• There should be total coverage of the population with basic, but essential health care, with particular attention being given to needy, vulnerable groups.

• Services should focus on the major health problems, should be affordable, employ technologies that are locally appropriate as well as acceptable.

• Health is more than the absence of disease or infirmity, it is a state of complete physical, mental and social wellbeing -- it is a fundamental human right.
Key elements of the Declaration of Alma Ata (cont)

• It requires the concerted efforts of all social and economic sectors, not just the health sector.

• Gross inequalities in the health status of people, both between and within countries are politically, socially and economically unacceptable and requires a new world economic order dedicated to achieving more equitable health outcomes.

• People have the right and responsibility to participate individually and collectively in the planning and implementation of their health care.

• Governments have a responsibility to ensure that their citizens enjoy the best standard of health by providing adequate health and social measures.
The 4 pillars of care

<table>
<thead>
<tr>
<th>Primarily Individually Focussed</th>
<th>Primarily Population Focussed</th>
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<tbody>
<tr>
<td>Rehabilitative approach</td>
<td>Preventive approach</td>
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<td>Curative approach</td>
<td>Promotive approach</td>
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The Comprehensive Primary Health Care equation - *David Sanders* (South Africa)

Primary Medical Care \( + \) plus Public Health - old \( + \) plus Public Health - new \( = \) Primary Health Care
WHO Ottawa Charter on Health Promotion (WHO 1986)

• develop healthy public policy

• create supportive environments

• strengthen community action

• develop personal skills, and

• re-orient health services.
Southgate Model for Comprehensive Primary Health Care: Central Australian Aboriginal Congress

**Mechanisms**
- Social Justice and Social View of Health
  - Accessible, locally delivered
  - Community driven (Community controlled)
  - Mix of prevention, promotion, treatment, and rehabilitation
  - Multi-disciplinary teamwork (inc. AHWs)
  - Intersectoral and interagency collaboration
  - Cultural respect
  - Promote economic paradigm consistent with public health

**Activities**
- Service planning, monitoring, management, administration, development, capacity building for remote health, research, Continuous Quality improvement
- AHW training, registrar program, supporting medical, social work, psych, midwifery, nurse, AHW students, supporting junior and OS doctors, encourage local doctors
- Support development of ACC PHCs, improve models of ACC PHCs, Intersectoral committees eg AS Transformation Plan, PAAC, early childhood
- GP, pharmacy, chronic disease, hearing, children’s programs, frail aged & disabled, dental, specialists, immunisation, health checks, sexual health, allied health, preschool program, School Health/Trachoma Program, Renal Outreach Program, Healthy Lifestyle Program
- Antenatal care, birth, sexual health, ANVIP program, specialist clinic, dispensary, health checks, cultural program, YWCHEP
- Health checks, drop in centre, violence, sexual health, Men’s shed, hygiene, cultural program, Numungra, health summits, community liaison
- Headspace, youth advisory group, GP, psych services, community development
- Remote health services (direct and auspiced) inc. podiatrist, diabetic nurse, nutritionist, GPs, nurses, AHWs, ACD
- Long daycare

**Service Qualities**
- Individuals
  - CPHC mechanisms embedded in processes, systems and structures
  - Skilled, accountable, satisfied workforce
- Family
  - Services that are:
    - Encouraging of individual and community empowerment and dignity
    - Responsive to community needs
    - Holistic
    - Efficient and Effective
    - Universal and used by those most in need
    - Culturally respectful
    - Compassionate

**Activity Outcomes**
- Health for All
  - Community participation
  - Build capacity of remote PHCs
  - Local community health profs Stable, skilled workforce
  - Achieved change in SDH Strengthened ACC PHC field
  - Reduced rates of disease and disability
  - Reduced progress and impact of disease and disability
  - People feel cared for
  - Increased child and mental health
  - Increased and promote women’s health
  - Increased rate of healthy weight babies
  - Reduced rates of STIs
  - Reduced rates of violence
  - Increased men’s health and wellbeing
  - Reduced rates of suicide
  - Increased social and emotional wellbeing
  - Reduced rates of suicide
  - Increased health, wellbeing of Aboriginal and non aboriginal adolescents
  - Improved health, wellbeing, access to health care in remote NT
  - Improved outcomes for children

**Community Outcomes**
- Sustainable CPHC oriented health system
  - Full Aboriginal employment at Congress
  - Achieved Aboriginal community controlled PHCs in all communities
  - Improved health and wellbeing of individuals and the community
  - Improved quality of life in our community
  - Increased dignity in the community (through true holistic service that encompasses social, emotional, self-worth, empowerment)
  - Reduced avoidable premature mortality
  - Increased equity in health, housing, income, employment, and tertiary qualifications

**Organisational Operating Environment**
- Physical work environment, infrastructure
- Complexity of interaction between Indigenous knowledge & culture and Western styles of professional practice in the context of 21st Century life

**Socio-political context**
- Political environment
- Close the Gap
- Northern Territory Emergency Response

Central Australian Aboriginal Congress
ABORIGINAL CORPORATION | ICN 7823
Congress Urban and Remote Clinics Total Episodes of Care over Time

(includes residents and visitors; Aboriginal and non-Aboriginal)

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<thead>
<tr>
<th>Year</th>
<th>Wallace Rockhole</th>
<th>Hermannsburg</th>
<th>Amoonguna</th>
<th>Mutitjulu</th>
<th>Santa Teresa</th>
<th>Areyonga</th>
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<td>5716</td>
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<td>8652</td>
<td>6054</td>
<td>89328</td>
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<td>6712</td>
<td>87699</td>
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<td>2012/13</td>
<td>316</td>
<td>8779</td>
<td>5519</td>
<td>6127</td>
<td>5406</td>
<td>7113</td>
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<td>2013</td>
<td>195</td>
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<td>6953</td>
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<td>5856</td>
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<td>8605</td>
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<td>6072</td>
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<td>6004</td>
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<td>5522</td>
<td>7476</td>
<td>8617</td>
<td>13160</td>
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<td></td>
<td>6405</td>
<td></td>
<td>8506</td>
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• Pathways to Community Control Working Group
• Primary Health Care Working Group
• Needs Based Funding Working Group

Remote AOD  Workforce  Eye Health  Oral Health  Hearing  e-Health
Needs based planning

• per capita PHC funding
• population/staffing ratios
• existing health infrastructure
• capacity to benefit
• core functions of PHC
Core functions of primary health care: a framework for the Northern Territory
Domain 1: Clinical Services

Services delivered to individual clients and/or families, in both clinic and home/community settings, including treatment, prevention and early detection, rehabilitation and recovery, and clinical support systems.

1.1 Treatment
1.2 Prevention & early intervention
1.3 Rehabilitation and recovery
1.4 Clinical support systems
Domain 2: Health Promotion

Non-clinical measures aimed to improve the health of the community as a whole. Health promotion includes a range of activities from building healthy public policy to providing appropriate health information and education, and encourages community development approaches that emphasise community agency and ownership.

2.1 Building healthy public policy
2.2 Creating supportive environments
2.3 Supporting community action and development
2.4 Health information, education and skills development
2.5 Orienting health services towards health promotion
2.6 Evidence and evaluation in health promotion
Domain 3: Corporate Services & Infrastructure

Functions to support the provision of health services, including the availability and support of well-trained staff, financial management, infrastructure, information technology, administration, management and leadership, and systems for quality improvement across the organisation

- 3.1 Management and leadership
- 3.2 Workforce and HR management
- 3.3 Staff development, training and education
- 3.4 Financial management
- 3.5 Administrative, legal & other services
- 3.6 Infrastructure and infrastructure management
- 3.7 Information technology
- 3.8 Quality systems
DOMAIN 4: Advocacy, Knowledge & Research, Policy & Planning

Includes health advocacy on behalf of individual clients, on local or regional issues, or for system-wide change; the use of research to inform health service delivery as well as participation in research projects; and participation in policy and planning processes (at the local / regional / Northern Territory and national levels)

- 4.1 Advocacy
- 4.2 Knowledge and research
- 4.3 Policy and planning
Domain 5: Community Engagement, Control & Cultural Safety

Processes to ensure cultural safety throughout the organisation, engagement of individual clients & families with their own health & care, participation of communities in priority setting, program design & delivery, and structures of community control & governance.

- 5.1 Engaging individual clients with their health and care
- 5.2 Supporting community participation
- 5.3 Governance and community control
- 5.4 Cultural safety
Specific areas for further development

The project was also asked to look at four ‘specific areas’ that have not generally been well-integrated into comprehensive primary health care and/or not well resourced at the primary care level. These are:

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<table>
<thead>
<tr>
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<tbody>
<tr>
<td>A</td>
<td>Alcohol, tobacco and other drugs</td>
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<tr>
<td>B</td>
<td>Early childhood development and family support</td>
</tr>
<tr>
<td>C</td>
<td>Aged and disability</td>
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<tr>
<td>D</td>
<td>Mental health / social &amp; emotional health &amp; well being</td>
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</table>
“Today’s readers are tomorrow’s leaders, that’s what we say,”
Mary Edwards
Community Facilitator for Enningonia Campaign

The socio economic determinants of health
CULTURE
Aboriginal and Torres Strait Islander peoples have the right to live a healthy, safe and empowered life with a healthy strong connection to culture and country.

- Continually striving to improve accessibility, appropriateness and impact
- A robust, strong, vibrant and effective community controlled health sector
- Based on the best possible evidence
- Free of racism and inequality
- Supported by housing, education, employment and other programs focused on eliminating the causes of health inequality
- Mothers and babies get the best possible care and support for a good start to life
- Growth and development of children lays the basis for long, healthy lives
- Youth get the services and support they need to thrive and grow into healthy young adults
- Adults have the health care, support and resources to manage their health and have long, productive lives
- Older people are able to live out their lives as active, healthy, culturally secure and comfortable as possible
- Individuals and communities actively engage in decision making and control
- Social and emotional wellbeing as a central platform for prevention and clinical care
Early Childhood
<table>
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<tr>
<th></th>
<th>Primary Prevention</th>
<th>Secondary Prevention</th>
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<tr>
<td></td>
<td>Targets children with no current problems but who are at risk of developing problems – identified risk usually based on low SES or maternal education level</td>
<td>Targets children with current problems identified early in life when most likely to respond to intervention and before gets worse – determined by screening or referral to services</td>
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<tr>
<td><strong>Centre Based</strong></td>
<td><strong>Child Focus</strong>&lt;br&gt;- Abecedarian educational day care&lt;br&gt;- Immunisations&lt;br&gt;- Child health checks&lt;br&gt;- Developmental screening</td>
<td><strong>Carer Focus</strong>&lt;br&gt;- Health advice to parents in clinic (e.g. nutrition, brushing teeth, toilet training)</td>
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<td><strong>Child Focus</strong>&lt;br&gt;- Child-centred play therapy&lt;br&gt;- Therapeutic day care&lt;br&gt;- Preschool Readiness Program&lt;br&gt;- Antibiotics</td>
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<td></td>
<td></td>
<td><strong>Carer Focus</strong>&lt;br&gt;- Filial therapy&lt;br&gt;- Circle of security&lt;br&gt;- Parenting advice / programs&lt;br&gt;- Parent support groups</td>
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<tr>
<td><strong>Home Visitation</strong></td>
<td><strong>Child Focus</strong>&lt;br&gt;- Mobile play groups</td>
<td><strong>Child Focus</strong>&lt;br&gt;- Nurse home visitation&lt;br&gt;- Families as first teachers (home visiting learning activities)</td>
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<td><strong>Carer Focus</strong>&lt;br&gt;- Child Health Outreach Program&lt;br&gt;- Ear mopping</td>
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<td><strong>Carer Focus</strong>&lt;br&gt;- Targeted Family Support&lt;br&gt;- Intensive Family Support&lt;br&gt;- Case management models for children at risk&lt;br&gt;- Parents under Pressure (PUPS)</td>
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Towards an integrated model for child and family services in central Australia

Donna Ah Chee, John D Boffa and Edward Tilton

doi: 10.5694/mja16.00385
<table>
<thead>
<tr>
<th>Rehabilitation</th>
<th>Treatment</th>
<th>Prevention</th>
<th>Promotion</th>
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<tr>
<td>Safe and Sober program</td>
<td>Safe and Sober program</td>
<td>Social and emotional wellbeing services – counselling, youth outreach</td>
<td>People’s Alcohol Action Coalition</td>
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<tr>
<td></td>
<td>Treatment of alcohol-related harms in medical clinic</td>
<td>and drop in centre</td>
<td>Alukura prenatal and antenatal care, Family Partnership Program</td>
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<td>Pharmacy – dispensing medications</td>
<td>Medical clinic – adult health checks</td>
<td>Early childhood and family support services, inc. Intensive Family Support,</td>
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<td>childcare, preschool readiness, Healthy Kids school outreach, community workers</td>
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<td>Youth Outreach team</td>
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<td></td>
<td>Social and emotional wellbeing services, including community wellbeing team</td>
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<td>Community Health Education</td>
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<td>Ingkintja – job skills, health promotion and community development, anti-violence campaign</td>
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<td>Intersectoral collaboration on housing, Office of Families and Communities</td>
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<td>Supporting cultural determinants through community events eg NAIDOC, bush trips,</td>
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<td>Alukura cultural advisory council</td>
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<td>Self-determination through community control, employment of Aboriginal staff, AHW training</td>
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TURNING DOWN THE TAP TO BRING DOWN THE HARM

LATEST NEWS

22 Aug 16  Giles needs to get a handle on grog prices

10 Aug 16  Pre-election Alcohol forum Alice Springs

2 Aug 16  Pre-election alcohol policy forum in Alice Springs – quiz the candidates?

14 Feb 16  Rise in Alice Springs assault numbers exposes gaps in policing

PEOPLE’S ALCOHOL ACTION COALITION

PAAC is an unincorporated association based in Alice Springs. Membership is open both to individuals and organisations that support its aims.

PAAC’s current supporters includes medical and welfare organisations, churches, community groups and concerned individuals.

What Works is What We Want

Click here for a Summary of PAAC’s Position

Follow PAAC on Facebook

LINKS

Temporary Beat Locations

Central Australian Aboriginal Congress
ABORIGINAL CORPORATION | ICN 7823
Figure 1: Estimated Per Capita Consumption of Alcohol – Northern Territory
Boyer Lectures: Sir Michael Marmot highlights health inequalities and 'causes of the causes'

Australians do not have to look far to find dramatic inequalities in health.

The life expectancy gap between Indigenous and non-Indigenous Australians is about 11 years. Aboriginal men are six times more likely — and Aboriginal women 11 times more likely — to die of ischaemic heart disease than non-Indigenous men and women.

Incarceration rates, too, are gravely disproportionate. Indigenous people make up 2.5 per cent of the population and yet account for 25 per...
Income Inequality, low social status and self esteem and poor health and well being in Alice Springs
...but life expectancy is related to income differences within rich societies

Growing gap between rich and poor

$56.2b
Wealth of Australia’s seven richest people.

$54b
Approximate wealth of the poorest 20% of households.

1. Gina Rinehart: $22b
2. Frank Lowy: $6.87b
3. James Packer: $6b
4. Anthony Pratt and family: $5.95b
5. Ivan Glasenberg: $5.61b
6. Harry Triguboff: $4.95b
7. Hui Wing Mau: $4.82b

Source: BRW, ABS
World Economic Forum: Income Inequality biggest risk to economy

Income disparity world's chief risk
World Economic Forum survey

Judith Sloan and Sid Maher

The Australian, January 13, 2012
CHART 1: TAX REVENUE TO GDP RATIOS, OECD 2010

Per cent of GDP

Per cent of GDP

Mexico, Chile, United States, Korea, Turkey, Australia, Japan, Ireland, Slovak Republic, Switzerland, Greece, Canada, Portugal, New Zealand, Spain, Poland, Israel, Estonia, Czech Republic, United Kingdom, Iceland, Germany, Luxembourg, Hungary, Slovenia, Netherlands, Austria, Finland, Norway, France, Italy, Belgium, Sweden, Denmark.
An analysis of wealth and income data beyond two centuries in France and Britain.

Over the long term, the wealth tied up in capital - assets such as property and finance - accumulates more rapidly than economies grow.

In broad terms, this means inheritance trumps merit, and wealth concentrates.

His research upends an article of faith of neoclassical, "trickle-down" economics: that inequality will decrease as nations' incomes continue to rise.
Economist Thomas Piketty suggests Australia introduce inheritance tax to address wealth inequality

Lateline  By Emma Alberici
Updated 25 Oct 2016, 8:18am
“Over my career in public health which started in the mid-1980s I have researched community health centres and become an admirer of the ways in which they have been able to put the principles of the WHO’s Alma Ata Declaration on comprehensive primary health care into action. I have had the opportunity to observe primary health care in many settings around the world and it is evident that Congress is an extraordinary model of good practice”

Prof Fran Baum
WHO Reform: Call for a global mobilization around the democratization of global health governance

Posted on: 28 November, 2016

This new paper, prepared by David Legge, of PHM's WHO Watch project, describes the current program of ‘WHO reform’; identifies the main problems being addressed and evaluates the strategies of reform. This analysis is contextualised within the contemporary structures and dynamics of global governance. The purpose of this analysis is to inform policy and advocacy around the directions of reform and of global health governance more broadly.

The role and reach of the World Health Organisation was fiercely debated when it was created in 1948 and has been subject to recurring controversy since then. Current debate around the functions, structures and governance has been focused around the reform program which was launched in 2010 following (yet another) a budget crisis.

Clearly there have been shortfalls in performance; the delay in mounting an effective response to the 2014 Ebola outbreak in West Africa is an undisputed example. What is contested are the causes and how WHO should be reformed.

At the centre of the debate around WHO reform is the freeze on mandatory contributions by member states (also 'assessed contributions' or ACs) and the tight earmarking of voluntary contributions by various national, international and private donors.

Undoubtedly the purpose of the freeze and the tight earmarking is to control WHO; to prevent it from implementing many of the policies and programs mandated by the governing bodies (the World Health Assembly, the Executive Board, and the regional committees). The fig leaf with which the freeze is rationalised is that, because WHO is so inefficient and unaccountable, it cannot be trusted with more than...