



Comprehensive primary health care, Health systems and workforce program statement

February 2005

Goal of the Comprehensive primary health care, Health systems and workforce program

To improve the performance of health systems with a particular focus on comprehensive primary health care services in order to maximise health gains for Aboriginal people

The CRC for Aboriginal Health is committed to carrying out research that will improve Aboriginal health. To do this, we know we must have strong partnerships between research, industry, Aboriginal community partners and organisations in the broader community. We also know that our research must be directed towards priorities identified by Aboriginal people and by those industry partners such as health services which can make use of the research. We must also incorporate capacity development and research transfer throughout our work. This program statement sets out how we will do these things in the Comprehensive Primary Health Care, Health Systems and Workforce Program.

For the purposes of this research program the term **comprehensive primary health care** refers to primary medical care for the individual, plus a more holistic approach which includes prevention, support services such as staffing, management and infrastructure, and supports outside the health service such as education (see Appendix B for more details).

1. Background

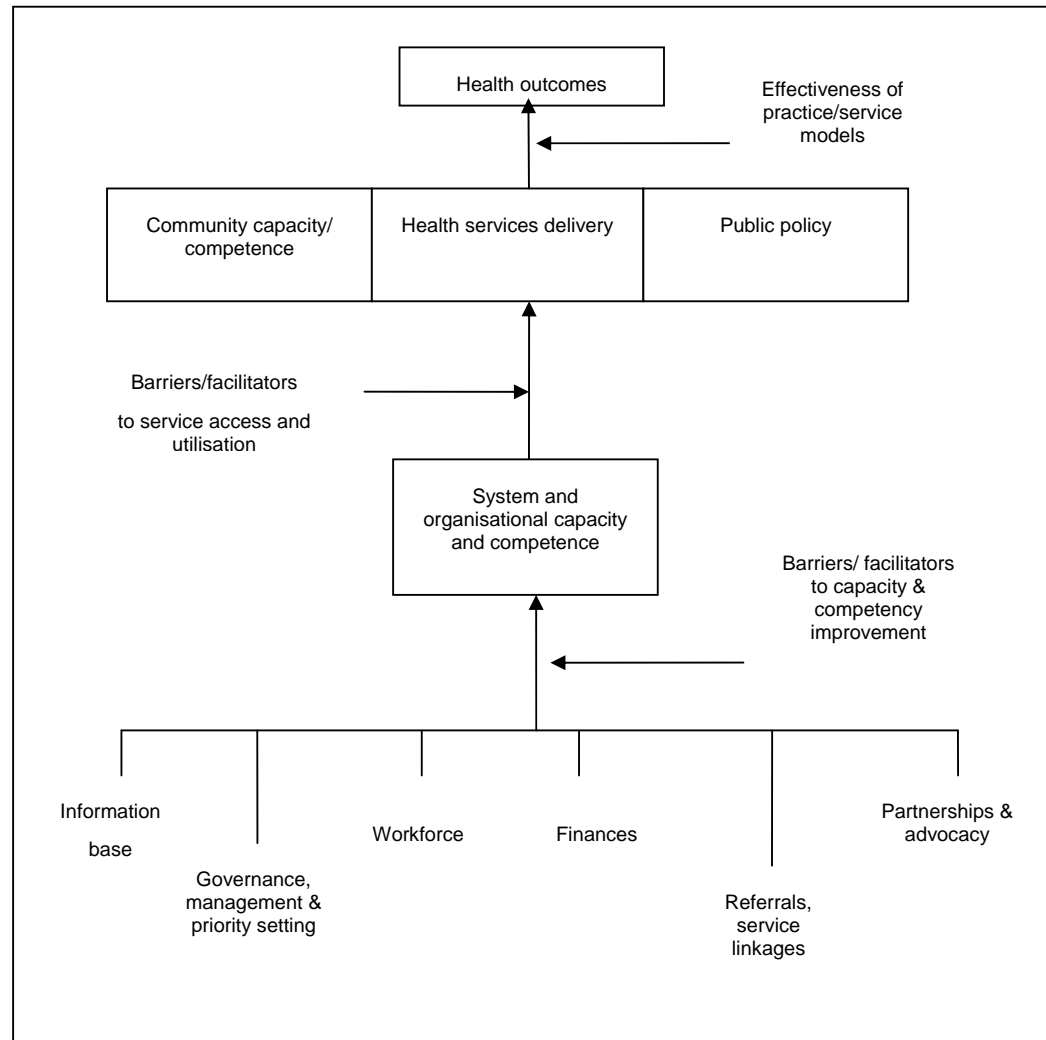
The Comprehensive Primary Health Care, Health Systems and Workforce Program is one of a small number of programs through which research development within the CRC is organised. The CRC intends that this programmatic approach will enable a more strategic, coherent and integrated approach to research development, transfer and capacity building. The purpose of the program statement is to set out the parameters within which the program will be developed and implemented, for consideration by the Board and communication to the CRCAH community.

2. Program Scope

The focus of this program will be on health services and health systems (including workforce issues). In particular, the program will be centred on comprehensive primary health care, including relationships within and between the primary, secondary and tertiary sectors of health care and with other sectors. This program will also consider components of primary health care such as governance and management, funding and accountability, workforce models, IT systems, and quality improvement processes.

This systems approach may be conceptualized as in Diagram 1.

Diagram 1: Components of health systems



Research in this area will address gaps in knowledge critical to reform and development in policy, service delivery and practice that will maximise the achievable health gain for Aboriginal people.

Research design and implementation will be undertaken in ways that recognise Aboriginal authority in framing problems, setting priorities and valuing outcomes.

All aspects of the Comprehensive Primary Health Care, Health Systems and Workforce Program are subject to national and local ethical guidelines appropriate to research with Indigenous communities.

3. Outcomes

3.1. Health outcomes

Comprehensive primary health care provision that improves the health of Aboriginal people.

This health outcome will be achieved through the combination of research, policy and practice, and capacity development outcomes outlined below.

3.2. Research outcomes

Research in this program will result in evidence that can be used by policy makers and service providers about:

efficient and effective models of comprehensive primary health care and health systems, which can contribute to health gain for Aboriginal people;

policy and resource allocation choices for comprehensive primary health care delivery in Aboriginal populations at national, state/territory and local levels and their impact on Aboriginal health, particularly within the context of a whole of government strategy to address Aboriginal health and social disadvantage;

the role of comprehensive primary health care services and systems in addressing social determinants to maximise health gain in the short and long term;

sentinel indicators around quality improvement in chronic disease prevention, early detection and management;

sustainable workforce models in Aboriginal comprehensive primary health care which recognise the value of Indigenous knowledge and practices;

models of community control and governance.

3.3. Policy and practice outcomes

Policy and practice outcomes will be achieved through the combined efforts of the CRCAH's research and industry partners. These include:

the identification and application of strategies to produce sustainable change in order to improve effectiveness and efficiency in PHC, at the practitioner, community and organisational levels;

evidence is used to influence the development and implementation of strategies and policies about comprehensive primary health care services and health systems at national, state/territory and local levels;

researchers work together with managers and practitioners in Aboriginal PHC to identify important knowledge practice gaps and develop culturally effective ways of addressing such gaps;

improved access to and uptake of evidence (in policy, service development and practice).


3.4. Capacity development outcomes

sustainable workforce models for Aboriginal primary health care are identified and applied;

Aboriginal primary health care develops a strong culture of inquiry and problem-solving;

pathways for Indigenous health practitioners to acquire research training are identified and strengthened;

research capacity in Aboriginal health care – particularly among managers - is strengthened through the use of action research, evaluation, practitioner-based research and cooperative benchmarking;



more Indigenous researchers are attracted into and skilled in health services and health policy research;

non-Indigenous researchers learn to work appropriately and effectively with Aboriginal communities and agencies; bridging the gaps (in language and experience) between researchers and industry, between Indigenous and non-Indigenous partners;

increased Indigenous research capacity through scholarships, traineeships, professional development strategies and/or cadetships;

curriculum for both Indigenous and non-Indigenous practitioners is improved.

4. What we don't know – knowledge and implementation gaps

Existing CRCAH projects – both funded and in-kind – begin to address the outcomes listed above. Current projects, students and opportunities are listed on our website. However much of this work involves one-off studies of the application of particular service or workforce models or theories. The key gaps in this program are:

comparative work that examines the effectiveness and efficiency of health service models and particularly the impact of different models on health improvement;

analysis of Aboriginal comprehensive primary health care in the context of a broader, multi-faceted health and intersectoral systems (including general practice);

effective strategies for implementing evidence-based policy and practice (how to bring about change) in the health system, health services and the workforce;

the identification of and strategies for implementing sustainable workforce models in Aboriginal comprehensive primary health care which recognise the value of Indigenous knowledge and practices.

increased capacity of the Aboriginal comprehensive primary health care sector, and of Aboriginal researchers, particularly in management, leadership and governance.

It is these gaps to which the CRCAH's resources should be targeted.

5. Indicative research questions

In seeking to provoke and facilitate a discussion within the network of researchers and practitioners participating in this program we are proposing to focus in on 'indicative research questions'. Indicative research questions in this context are stepping stones as we move from the identified priority areas to rigorous and productive research proposals. The philosophy behind the programmatic approach to formulating indicative research questions to achieve identified outcomes is discussed in Appendix A.

The following research questions are indicative and will require further development through an iterative process:

- 1) What primary health care services are currently utilised by Aboriginal people? What are the patterns of service utilisation?
- 2) What are the current trends in program and service development in Aboriginal health services? What are the most efficient and effective models and strategies, particularly in the delivery of high quality care for the prevention and management of chronic diseases?
- 3) What are the structures and processes in Aboriginal health care which currently support innovation, evaluation, organisational learning and system-wide learning for improved effectiveness? What are the barriers to program and service development in Aboriginal health care?
- 4) What kinds of system reforms and infrastructure provision might facilitate more innovation and evaluation and the development of organisational learning across Aboriginal health care?
- 5) How are Aboriginal PHC services funded? How do multiple funding pathways with different accountability requirements affect health service provision? What kinds of accounting and information systems do PHC organisations require to manage these different funding sources? Where does best practice lie in accounting and information systems for Aboriginal health services?
- 6) How are primary health care services addressing the social determinants of Aboriginal health? What strategies and models of practice appear to be most effective? What are the lessons from the accumulated experience of community development in Aboriginal health care? Can these lessons be more widely applied?
- 7) What are the current trends in inter-organisational relationships, among PHC organisations and between PHC organisations and more specialised secondary and

tertiary organisations? Are there models which are working particularly well? What are the barriers to more effective system wide coordination?

- 8) How significant is institutionalised racism as a barrier to accessing mainstream services? What models exist and what experience has been accumulated of successfully addressing institutionalised racism in health care? What kinds of strategies can be put into place to help to confront and eliminate institutional racism in health services?
- 9) What are the characteristics of the current workforce in Aboriginal health and what are the gaps, weaknesses in the face of current and future challenges?
- 10) What are the current arrangements through which the Aboriginal health workforce is reproduced and maintained in different regions, program areas and levels and what are the more promising strategies and models which could be adapted more widely?
- 11) Describe and develop successful models of workforce development that integrate Aboriginal and non-Aboriginal knowledge and approaches to health care?
- 12) What are the critical issues in the education and career development of health professionals that need to be addressed in order recruit and retain a high quality Aboriginal health workforce? What steps need to be taken at school, institution and workplace levels?

6. Development and implementation of the program

6.1. Program management

Working in collaborative groups such as those proposed in the CRCAH programmatic approach will require some innovative approaches to research program management. A team will be established to manage and implement program and will include:

Program Leaders

This role will provide leadership in the development of the program proposal and implementation, ensuring research, transfer, communications and capacity development activity are integrated within the program (normally an in-kind role). Each program should have both an industry and research leader, and these program leaders should be nominated through a transparent process. Wherever possible, Indigenous research capacity should be built through the involvement of Indigenous people in the senior roles in each program.

Program manager

The program manager is the key operational role to ensure the program's implementation and partnerships, and the effective delivery of its outcomes in research, transfer and capacity development. Program managers will be recruited and funded by the CRCAH.

6.2. Facilitated collaborative research development

This program will achieve its outcomes by drawing together existing funded and in-kind research projects, and where necessary, undertaking additional research.

Developing a robust and productive research plan involves articulating specific questions that can be answered by research, identifying methods of data collection and analysis, negotiating settings and partners. This is commonly a highly iterative process, visiting and revisiting the questions, methods, data and settings until a tight powerful protocol has been developed.

In the context of CRCAH research this cycle of iterations will also include questions about community involvement, transfer and dissemination and education and training.

The CRCAH is keen to encourage the community of researchers and the wider CRC community to participate cooperatively, not just in identifying research priorities but also in the shaping of the projects themselves. This is a marked change from customary practice; research planning is often a quite private activity involving a small group of colleagues. This is partly because of the traditionally competitive process for evaluating research proposals.

This program will be supported by appropriate information systems to retrieve and review current information about previous and current research. These resources will ensure that the network of

researchers participating in this program will be aware of the opportunities for building on what has gone before.

6.3. Integrating research, research transfer and capacity building

The program will also include provision for research transfer and capacity building, including education and training, in accordance with the CRC's broad objectives in these areas.

Provision for transfer and dissemination will be incorporated into research design from the earliest stages. This will include push strategies (offering resources and opportunities) as well as pull strategies (responding to and supporting practitioners who are asking questions and looking for better ways of doing things). It will include all avenues from accredited training to outreach to the internet.

Opportunities for capacity building, including education and training, will be incorporated into research design. Capacity refers to health research as well as health policy and health care delivery. Capacity building includes organisational development as well as workforce development.

Research transfer and capacity building will be facilitated by building close links with Aboriginal health care organisations and communities in the design and implementation of the research.

6.4. Network of interest

Critical to the development and implementation of this Program Statement will be the formation of a network of interested researchers and practitioners from across the CRCAH community who will work together to develop and undertake a series of fundable projects and linked groups of projects. The network will include:

- researchers and practitioners associated with projects already funded by the CRCAH in this program area;

- researchers and practitioners from CRC member organisations who have an interest in this program area (including RDG members);

- relevant experts (people from outside the CRCAH may be invited if necessary);

- industry representatives including people from the SME forum.

It is a responsibility of the program leaders and manager to build this network of interest and support its involvement in developing and implementing the program.

Communication within and across the network will involve:

- face to face meetings at convocation, at round table meetings and also at other times as needed;

- teleconferences (including VOIP1 teleconferencing – chat rooms);

- webpage, listserv and bulletin board.

- a CRCAH information system that can support program development and management.

6.5. Program development strategy

- circulate the Program Statement across the CRCAH community and invite researchers and practitioners to join the program network and engage in the program discussions.

- refine the indicative research questions and develop concept plans for research required, transfer and capacity development activities.

- prioritise and timetable the rollout of potential research projects or other activities (having regard to the limited resources and the breadth of the agenda sketched above).

- facilitate research proposal development to a level of peer review fundability (including fundability in external programs). This facilitation will involve the RDG and may involve

¹. VOIP (voice over internet protocol) teleconferencing is much cheaper than phone mediated teleconferencing

recruiting mentors to work with particular researchers and groups. These mentors will be the kind of people who might be asked to be peer reviewers.

proposals peer reviewed and recommended to Board.

6.6. Budget for program development

Budget for program development to include administrative support for program planning and management, and provision for seed funding for research proposal development.

6.7. Program Evaluation

Monitoring and evaluation strategies will be established and implemented to ensure each program regularly reports on research details, transfer and capacity development outcomes achieved, and strategic plans for any additional strategies required to promote research uptake.

7. Linkages with other programs

All of the CRCAH's programs will have a strong foundation in comprehensive primary health care. These include:

Healthy Skin – centred around health promotion and service provision at the community level;

Chronic Conditions – a focus on particular chronic diseases such as diabetes, cardiovascular and renal disease in comprehensive primary health care contexts;

Social and Emotional Wellbeing – boosting resilience of children and families in a comprehensive primary health care context;

Social Determinants of Aboriginal Health – how social determinants of health can be addressed through interventions beyond the health system.

The Comprehensive Primary Health Care, Health Systems and Workforce program focuses on systems and workforce issues that will be of importance to the success of all other program areas. For example, the issue of appropriate models of community-based employment is key to the achievement of primary health outcomes in Chronic Diseases, Social and Emotional Wellbeing, Social Determinants and the Physical Environment, and Healthy Skin. In another example, institutionalized racism and its impact on health is a key component of both the comprehensive primary health care and social determinants programs and should be worked on jointly. Similarly, the quality improvement systems work currently being undertaken through the ABCD project can contribute to the systemizing of chronic disease, mental health and healthy skin practices within clinics. It is vital that there is a close inter-relationship between programs to maximize the opportunities for such integration.

APPENDIX A

The Programmatic Approach: Underpinning Philosophy

We have in place an existing body of knowledge about Aboriginal health, descriptive, explanatory and prescriptive; and a range of customary ways of working, including government policies, organisational strategies and clinical practices. We also live amidst a range of debates and variations in practice many of which flag important uncertainties about causes, policies, strategies and practices.

Some of this conventional wisdom and best practice is referenced in the various policy documents that have been produced at federal and state levels, in the indexed literature and in the grey literature, much of which is produced through industry organisations. However much of the conventional wisdom is carried in the current understandings and practices of Aboriginal health practitioners and managers as well as policy makers, funders and educators.

It is this assemblage of conventional wisdom, best practice and debate with which the research sponsored through this program will engage. This includes:

- clarifying causes,
- evaluating existing policies, strategies, models and practices,
- developing and evaluating better policies, strategies, models and practices, and
- clarify the conditions for their implementation.

This kind of research is not and cannot be value free. In defining problems, setting priorities and steering implementation the research sponsored or funded through the CRCAH will be oriented around the concerns, interpretations and aspirations of Aboriginal people. The continuing influence of Aboriginal perspectives will be effected through the increasing role of Indigenous researchers and the active partnership role played by community organisations and practitioners in all facets and stages of research development and implementation.

Building on previous and current CRCAH sponsored research

Research planning within this program will build on previous and current research sponsored through the CRC. This will include following promising leads, filling in gaps, harnessing synergies and complementarities and capitalising on existing relationships and methods.

Developing specific research questions

The processes and arrangements adopted for this program are designed to support conversations among the researchers and practitioners who are involved in this program; conversations about research questions which address the identified research priorities and about the methods, data and settings through which such questions can be addressed.

Ideally the list of indicative research questions would in aggregate represent a comprehensive approach to addressing the identified research priorities. This is clearly not the case for the indicative research questions as they stand but they do represent a starting point.

We are hoping that the indicative research questions (as developed over time) will provide starting points from which researchers (including practitioners) can proceed to develop interlinked project proposals which in sum will comprise the work of this program.

APPENDIX B: What is Comprehensive Primary Health Care?

Selective versus Comprehensive Primary Health Care.

Table 1: The contrast between selective and comprehensive Primary Health Care

Characteristic	Selective	Comprehensive
Main aim	Reduction of specific disease	Improvement in overall health of the community and individuals
Strategies	Focus on curative care, with some attention to prevention and promotion	Comprehensive strategy with curative, rehabilitative, preventive and health promotion that seeks to remove root causes of health
Planning and strategy development	External, often 'global', programmes with little tailoring to local circumstances	Local and reflecting community priorities professional 'on tap not on top'
Participation	Limited engagement, based on terms of outside experts and tending to be sporadic	Engaged participation that starts with community strengths and the community's assessment of health issues, is ongoing and aims for community control
Engagement with politics	Professional and claims to be apolitical	Acknowledges that PHC is inevitably political and engages with local political structures
Forms of evidence	Limited to assessment of disease prevention strategy based on traditional epidemiological methods, usually conducted out of context and extrapolated to situation	Complex and varied research methods including epidemiology and qualitative and participatory methods

From Baum, F, 'Primary health care: can the dream be revived?', Development in Practice, Vol 13, No. 5. November 2003.

Aboriginal Primary Health Care Services

From: Aboriginal Medical Services Alliance Northern Territory,
<http://www.amsant.com.au/amsant/what-is-primary-health-care.html>

WHAT IS PRIMARY HEALTH CARE?

Primary health care has two meanings. The narrow definition (sometimes called primary medical care) focuses on the provision of medical services treating individual, generally acute medical conditions. It forms only a part of **comprehensive primary health care** which is the broader, holistic approach to health problems. As well as primary medical care, comprehensive primary health care addresses a range of health concerns that have no specific medical intervention.

In 2000, the Northern Territory Health Forum partners endorsed a definition of a well resourced Aboriginal comprehensive primary health care service.

The NT Aboriginal Health Forum endorsed definition reads:

Aboriginal primary health care services refers to all services delivering health care in accordance with the holistic definition of health and includes the following core services:

A) CLINICAL SERVICES

1. Primary clinical care

- treatment of illness using standard treatment protocols
- 24 hour emergency care
- 24 hour access to the advice of a doctor either on site or via telecommunications
- provision of essential drugs including provision of medicine kits to designated holders
- continuing management of chronic illness

2. Preventative care

- immunisation
- antenatal care
- appropriate screening and early intervention (this includes activities such as growth monitoring, well women's checks and well men's checks)
- STD and other communicable diseases control
- secondary prevention of complications of chronic diseases

To achieve these core functions there also needs to be clinical support systems such as pharmaceutical supply system and a comprehensive health information system which will include:

- a population register and recall system to support population health activities;
- a chronic disease register and recall system to support the ongoing management of chronic disease;
- collection of data to enhance evaluation and quality assurance.

B) SUPPORT SERVICES

Internal to the health service:

1. Staff training and support


- Aboriginal health worker education,
- orientation of new staff in the management and presentation of major illnesses and in cross cultural and other issues;
- continuing education opportunities for all staff

2. Management systems

- Financially accountable and include effective recruitment and termination practices.
- Where primary health care is managed by a community controlled health service the organisation must be adequately resourced to implement and maintain good management systems
- Political advocacy

3. Adequate infrastructure at the community level

- staff housing and clinic facilities
- functional transport facilities to allow access to appropriate health care when needed. This includes the availability of roads and airstrips as well as the use of road and air transport where needed.



External to the health service:

- appropriate visiting specialists and allied health professionals including dental services, mental health services, physician services and others.
- medical evacuation services where needed
- access to hospital facilities
- costs of transport and accommodation to access specialist and ancillary care where needed
- education and training i.e. TAFE, university level etc.

C) SPECIAL PROGRAMS

Resources should be made available for community initiated activities dealing with the underlying causes of ill health. This could include areas such as substance misuse, nutrition, environmental health and others. It could also include special services aimed at particular target groups such as youth, frail aged and disabled people, young mothers, schoolchildren etc. Communities should determine their own priorities. These programs require community action or agency to have any chance of success.

D) AVOCACY AND POLICY DEVELOPMENT