GLOBAL CONFERENCE
ON PRIMARY HEALTH CARE
ASTANA, KAZAKHSTAN **25-26 OCTOBER 2018**

COMMUNITY HEALTH CENTRES: Linking primary health care, universal health coverage, Sustainable Development Goals and social determinants of health in action around the world

OCTOBER 25, 2018 - IFCHC PRESENTATION at Astana 2018 by:

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PRESENTATION FRAMEWORK

Concepts and Connections

Connections and gaps between PHC, SDOH, UHC, SDGs

Role of Community Health Centres (CHCs)

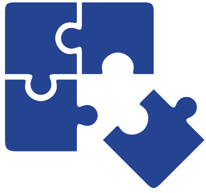
What they are. How they connect PHC, SDOH, UHC, SDGs in practice

Implementing CHCs: Important Steps

Key guidance at macro, meso and micro levels

Call to Action

Let's realize the full potential of primary health care



PHC as Critical Piece of Bigger Puzzle

Primary Health Care (PHC)
Social Determinants of Health (SDOH)
Universal Health Coverage (UHC)
Sustainable Development Goals (SDGs)

Four separate global strategies, with some distinct and some intersecting lines of action at policy level and within the global community (UN agencies, etc)

To a large extent, the success of efforts related to SDOH, UHC and SDGs depends on us *getting it right* when it comes to PHC policy, planning and funding

...primary health care is so integral to the path towards the SDGs that reference in a [single] goal or target would undermine its cross-cutting role...

National governments and other stakeholders need to be ambitious in measuring progress towards delivery of primary health care that will address the SDGs. This monitoring includes the use of indicators that can capture the principles of equity, community participation, prevention, appropriate technology, and inter-sectoral collaboration underpinning the Alma-Ata declaration, and which can also document the elements of first contact, continuity, comprehensiveness, coordination, and family and community orientation which, evidence suggests, make primary care services successful...

Comment

THELANCET-D-15-07234
S0140-6736(15)00949-6

Primary health care and the Sustainable Development Goals

After the eight Millennium Development Goals that have shaped progress in the past 15 years, 17 Sustainable Development Goals (SDGs) were adopted by governments at the UN General Assembly in September, 2015. SDG3 explicitly relates to health—to "Ensure healthy lives and promote well-being for all at all ages". This goal is translated into 13 targets: three relate to reproductive and child health; three to communicable diseases, non-communicable diseases, and addiction; two to environmental health; and one to achieving universal health coverage (UHC). Four further targets relate to tobacco control, vaccines and medicines, health financing and workforce, and global health risk preparedness.

When supported by strong public health policies and with aligned efforts across social, economic, and political domains, primary health care has a central role in achievement of sustainable development. Although differences are inevitable between countries in the organisation of primary health care and the human resources available, many of the challenges outlined in SDG3—related to reproductive and child health, communicable diseases, chronic illnesses (including multimorbidity), addiction, and other mental health problems—can be addressed through a person-centred and population-based approach to primary health care.[1–5] Delivery of vaccines and drugs needs a functioning primary care system. Well integrated and prepared primary health care has a key role in health emergency responsiveness and it is essential for the achievement of UHC equitably and cost-effectively.[6–8]

Moreover, primary health care can contribute to the achievement of many of the 16 other SDGs; for example, its role in addressing the social determinants of health was underlined in the report Closing the Gap in a Generation. Primary care teams worldwide can provide examples from daily practice that illustrate their contribution across the SDGs, including helping to end poverty, improve nutrition, provide health education and promote lifelong learning, empower individuals and communities to reduce inequities and promote justice, enable access to safe water and sanitation, encourage productive and sustainable employment, foster innovation, advocate for healthy and sustainable living environments, and promote peaceful communities.

Yet, investment in realising the full potential of primary health care still seems elusive to many governments, policy makers, funders, and health-care providers. Therefore, 7 years after the World Health Report and *The Lancet* Series on primary health care, and 37 years since the Alma-Ata declaration, the absence of reference to primary health care in the SDGs and their targets seems a serious oversight. Two conclusions could be drawn: first, that primary health care is dispensable and peripheral to achieving sustainable development; or, second, that primary health care is so integral to the path towards the SDGs that reference in a goal or target would undermine its cross-cutting role.

We opt for the second conclusion, yet do so with apprehension, because one of the contributing factors to the documented failure of primary health care in many settings since the Alma-Ata declaration was "the scarcity of a proposed strategy for implementation and its monitoring for accountability and scale-up purposes".[9] This issue needs to be addressed in the development of implementation strategies for the SDGs. If the agenda is not explicit about how health systems with good-quality comprehensive primary care can be achieved, or how to measure progress towards this goal, we risk repeating the failures of the past.

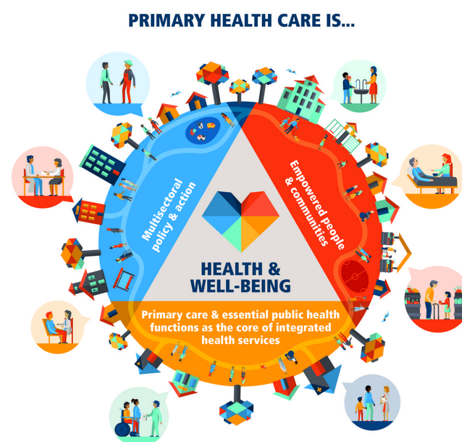
National governments and other stakeholders need to be ambitious in measuring progress towards delivery of primary health care that will address the SDGs. This monitoring includes the use of indicators that can capture the principles of equity, community participation,

Countries need strong political will, sound economic policies, and coordinated international efforts to achieve UHC. Measuring progress towards the implementation of primary health care is no easy task, yet it is the lynchpin to achieving UHC and is pivotal across the SDGs.

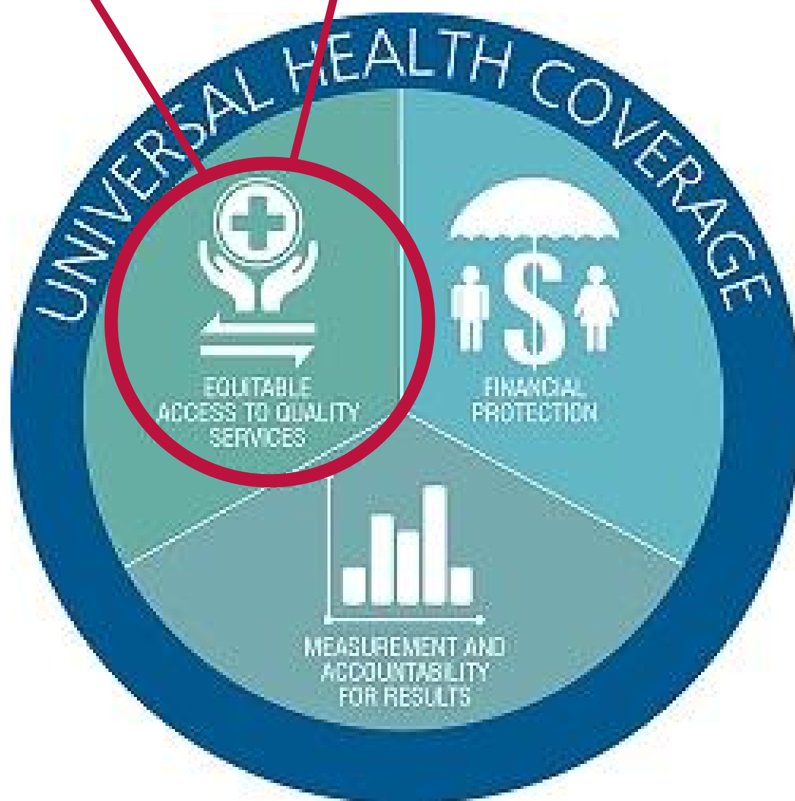
The Lancet - VOLUME 386, ISSUE 10009, P2119-2121, NOVEMBER 28, 2015

PHC and Universal Health Coverage

WHO: "Primary health care covers the majority of a person's health needs – promotion, prevention, treatment, rehabilitation, palliation – from birth to final days of life. Primary health care is: multi-sector policy and action; empowered people and communities; primary care and essential public health functions as the core of integrated health



WHO's framework for UHC recognizes equity as an essential component of UHC. If we truly want PHC to accelerate UHC, then PHC policy, planning and funding must be done with a health equity approach. Why does this matter?



Without a health equity approach, both UHC and PHC efforts will replicate and perpetuate existing forms of Vulnerable and marginalized groups -- often those who carry greatest burden of risk factors and illness -- will be left out of health "coverage". PHC services will not be appropriate to the health and social needs, or the lived realities of diverse individuals and groups.

PHC and Sustainable Dev Goals

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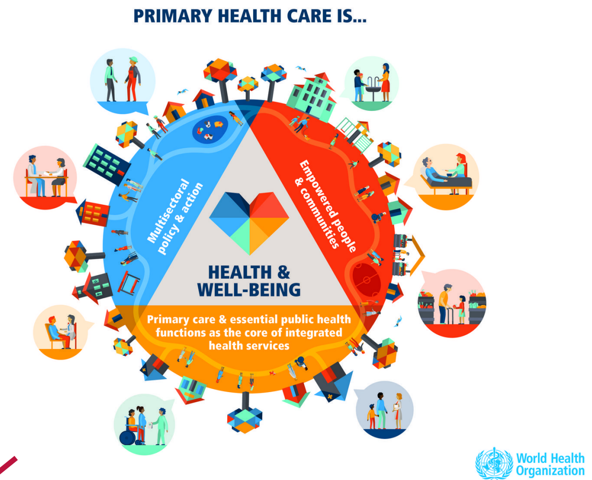


80%

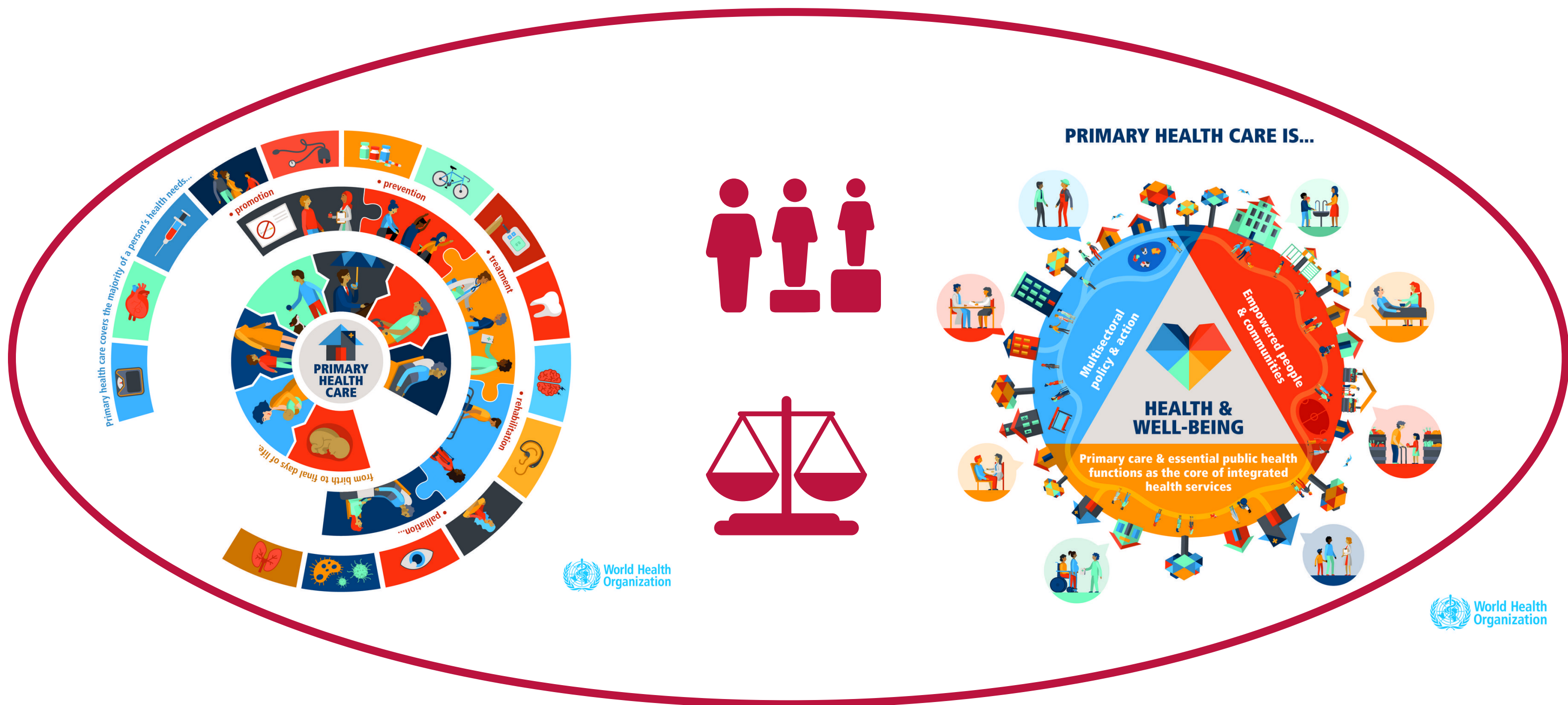
These ingredients are about 80% of the PHC recipe to achieve high impact on the Sustainable Development Goals.

So what's missing?

SUSTAINABLE DEVELOPMENT GOALS

1 NO POVERTY
2 ZERO HUNGER
3 GOOD HEALTH AND WELL-BEING
4 QUALITY EDUCATION
5 GENDER EQUALITY
6 CLEAN WATER AND SANITATION
7 AFFORDABLE AND CLEAN ENERGY
8 DECENT WORK AND ECONOMIC GROWTH
9 INDUSTRY, INNOVATION AND INFRASTRUCTURE
10 REDUCED INEQUALITIES
11 SUSTAINABLE CITIES AND COMMUNITIES
12 RESPONSIBLE CONSUMPTION AND PRODUCTION
13 CLIMATE ACTION
14 LIFE BELOW WATER
15 LIFE ON LAND
16 PEACE, JUSTICE AND STRONG INSTITUTIONS
17 PARTNERSHIPS FOR THE GOALS
SUSTAINABLE DEVELOPMENT GOALS

Health Equity & Socio-Economic Justice are the Missing Ingredients



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High Impact at Level of PHC

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SUSTAINABLE DEVELOPMENT GOALS

Health Equity & Socio-Economic Justice

HEALTH EQUITY refers to efforts to eliminate socially and institutionally structured health inequalities and differential health outcomes. Health equity explicitly recognizes that these structured health inequalities are not natural. They are avoidable, unfair and systematically related to social inequality and disadvantage.

SOCIO-ECONOMIC JUSTICE may be broadly understood as the fair and compassionate distribution of the fruits of economic growth (*Social Justice in an Open World: The Role of the United Nations, 2006*). Social justice assigns rights and duties within the institutions of society which enable people to participate in the basic benefits and burdens of cooperative society. These relevant institutions often include taxation, social insurance, public healthcare, public schooling, public services, labour law, and the regulation of markets to ensure fair distribution of wealth, equal opportunity and equality of outcome. Social justice does not preclude charity (e.g., civic organizations receiving charitable funding or providing charitable services), but it demands commitment to root causes of inequity and participation in collective efforts to achieve systemic change rather than simply focusing on addressing short-term needs.

We cannot achieve universal health coverage or the sustainable development goals without **primary health care.**

World Health Organization

...and primary health care cannot achieve its potential if it does not have health equity and social justice at its core.

[a friendly amendment]

Community Health Centres

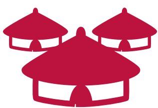
Community-oriented primary health care organizations that connect the dots between PHC, SDOH, UHC, SDGs. Several common, core attributes:

Interprofessional: team-based care and support from a diverse range of clinicians, allied health professionals, program staff and administrative staff

Subsidiarity in delivery of services: the right care, by the most appropriate care provider, at the right time for individuals, families and groups

Whole-person care and support: address risk factors and root causes of illness (social, economic, environmental) through direct services, programs and partnerships that address social determinants of health

Navigation and support for patients/clients: staff including social workers, community health workers and others tasked with helping clients access services and resources within the CHC and in the broader community



Community participation: involve community members in diverse aspects of the organization (eg, governance, service planning and evaluation)

Health equity: appropriate services (eg, culturally-relevant, prioritized) planned and delivered to address health inequities experienced by diverse individuals and groups due to social inequities

Population health: Responsible for a defined local population, either geographical or by population group(s); work to improve the health not only of individuals and families, but also groups and population, informed by commitment to social justice

CHCs in Action

Boyle McCauley Health Centre - Edmonton, Alberta, Canada

www.bmhc.net

Bernie's Story

Bernie is an Indigenous senior in Edmonton who first came into contact with Boyle McCauley Health Centre through the CHC's Miyowayawin Clinic. The clinic is a service provided by Boyle McCauley Health Centre (BMHC) onsite at a local partner agency, the Edmonton Native Healing Centre.

Bernie accessed the centre's foot care program for the first time in 2016. After having the wound on his foot attended to, he became a regular at the foot care program and gradually became comfortable enough to talk a bit more openly with Donna, one of BMHC's nurses.

Bernie had been homeless, living on the streets for the past 6 years. He had multiple chronic illnesses including diabetes and heart disease; he was having challenges controlling his alcohol use; and, he had no access to routine primary care. Building on the trust she had established, Donna connected Bernie with Sandi, one of BMHC's Nurse Practitioners from whom he now receives regular primary care. Sandi recently referred Bernie to an ophthalmologist and he has now had cataract surgery. Bernie has also been referred to a detox program and is many months sober. Through BMHC, Bernie has also been connected to permanent housing with an inner city seniors housing program. As a regular client of multiple services provided by BMHC, Bernie is at the centre of a circle of care and support that is there for him when and where he needs it.

Like Bernie, the 13,000-plus clients that access services and programs at BMHC have access to wrap-around care through an interprofessional team. Chronic disease management, mental illness and addictions care, HIV care, Hepatitis C care are all integrated as part of regular primary health care services. The care team is comprised of nurse practitioners, nurses, social workers, family doctors, psychiatrists, mental health and addictions counsellors, dentists, and outreach workers who work together with BMHC's clients to address needs at the right time, in the right place, by the most appropriate provider.

BMHC also has a dedicated Health Advocate on staff. The Health Advocate acts as a resource for both the staff and clients at the centre in regard to housing, financial and legal issues, food and clothing issues, educational and employment opportunities, applications for government assistance, and more. In addition to BMHC's Health Advocate, social workers play an essential role. Social workers are always on site at BMHC's main location, and are always able to help line someone up with services or to navigate services from a government or other social agency.

If a client needs help with income tax, as part of addressing poverty or low-income, the Health Advocate connects the client to a volunteer who can help with that. If a client is interested in finding work or going back to school, BMHC provides support for resume writing, mock job interviews, and other tools. As needed, BMHC will also work with its clients on government assistance to establish third party payment plans in order to guarantee that a client's rent gets paid when benefits checks go out. This helps mitigate the precariousness of housing.

BMHC also works actively to address food insecurity. They have two drop-in programs that provide a lunch and/or snacks, 5 days a week. One is the Kindred House program for women in the sex-trade to come in, be safe, and have a lunch. The other is the HAART House program for clients with HIV who are homeless. They come in for a nutritious lunch, prepared by a skilled, professional cook, and to take their medications with the support of one of BMHC's nurses.

In BMHC's Pathways to Housing program, staff work on skill building with individual clients. This includes development of budgeting skills and helping them to plan meals and grocery shop. And, on an ongoing basis, clients in need are also actively connected to a local food co-op called WECAN. This is just a short list of some of the services and programs, across sectors, that are provided through BMHC. And Bernie is one of the 13,000-plus Edmonton residents that are able to benefit each year.

CHCs in Action

Chiawelo Community Practice - Soweto, Johannesburg, South Africa

https://afrocp.wordpress.com/chiawelo-cp/about-ccp

Renewing COPC in South Africa

In 1939, Drs Sydney and Emily Kark set out to pilot a service model for the planned National Health Services under the liberal government of General Jan Smuts. In the rural village of Pholela, in Kwa-Zulu Natal province, they established Pholela Health Centre to serve the local population of 30,000.

Primary care was delivered from a house converted into a clinic, through a clinical team with strong task-shifting involving nurses, medical aides and physicians. The CHC applied a COPC approach. Community Health Workers (CHWs) were deployed to do screening and health assessments in the community and diverse community stakeholders were engaged in development of health promotion services.

The CHC's work was informed by robust data collection and analysis. Pholela CHC attracted a lot of attention and, by 1948, more than 40 CHCs had been set up across South Africa. Unfortunately, the National Party took power in 1948 and introduced apartheid shortly thereafter. The Karks fled South Africa for Israel in the 1950s and during the apartheid era CHCs and COPC withered in South Africa.

The post-apartheid government of South Africa implemented District Health Services with what they called "CHCs" as a key feature. However, these co-called CHCs are in fact narrow, biomedical services that do not truly reflect the CHC model of COPC.

In contrast, Chiawelo Community Practice (CCP) was set up in 2013, in a small section of Chiawelo CHC (one of five CHCs within Soweto, Johannesburg) as a model to re-claim COPC and the true CHC model. It serves a community of ±22,000 people and is staffed by a part-time family physician, a clinical associate, two intern doctors rotating weekly, and 20 CHWs who work under the guidance of a junior nurse team leader.

The CCP team delivers people-centred care to ±1,000 patients per month. Promising outcomes have been documented: lower wait times than at general primary care services; reduced rates of avoidable utilisation of primary care and hospital services; high satisfaction rates among patients; and, a high compliance rate (83%) with national standards for chronic disease management.

Community members are frequently engaged, and the information and guidance that is received is supporting a growing intersectoral health promotion programme. The centre's CHWs have set up five health clubs in the community with ±150 elderly chronic patients involved in daily exercise and social sessions to combat social isolation and increase social cohesion. This has become a base to address diet and food security, with cooking classes set up in the community and joint efforts at providing mental health care support to patients in the community.

CCP has renewed COPC in South Africa. Students rotating through CCP are motivated to re-consider some negative perceptions of primary care and family medicine, and CCP is also influencing national policy: COPC is being explored as the core model in design of the new primary health care capitation contract under South Africa's National Health Insurance System.

CHCs in Action

Community Health Centre Botermarkt - Ledeberg, Ghent, Belgium
www.wgcbotermarkt.be

Key developments

1978: family practice in poor neighbourhood
1980: first nurse, social worker and foundation of the Community Health Centre, a not-for-profit organisation
1986: interprofessional team; inter-sectoral platform for health and wellbeing
1995: established capitation financing system
1996: community oriented primary care
2006: teaching platform for Ghent University
Today: 6200 residents from 95 countries

INTEGRATED, PERSON-CENTRED PRIMARY CARE & HEALTH PROMOTION

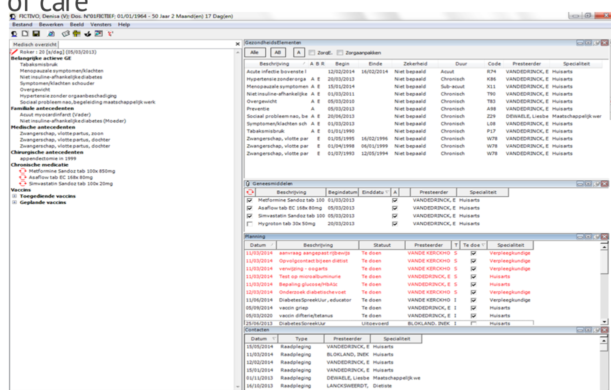
Interprofessional Team: family physicians, nurses, social workers, health promotion worker, dietitian, dentists, ancillary staff, administrative staff and receptionists. All collaborate with core principle of subsidiarity: Care is provided by the person most equipped for the task and most knowledgeable about the subject.

Family Physicians (24/7 coverage)
During the day 08.00-19.00: Consultations and appointments; Home visits (12%)
At night from 19.00 until 08.00: Organised night-duty with other GPs in Ghent
During the weekend (Friday 19.00 pm to Monday 08.00 a.m.): One "on call" GP-post per 100.000 inhabitants in Ghent

Nursing
Immediate (walk-ins) appointments available: care substitution; Home care for patients with mobility limitations
Curative care: wound care, ear irrigation, wart treatments, palliative care; Prevention: flu vaccinations, contraceptive injection; Diagnostic Procedures: ECG, blood tests, spirometry.; Empowerment: Diabetes Clinic, inhaler-training appointments

Social Workers
Social work in the health centre includes: first intake, exploring the problem; information and counseling; advocating, mediating; supporting, psychosocial guidance; supporting undocumented residents; administrative support, application for allowances, budget-planning; establishing patient centered networks of care

Shared Electronic Patient Record
One electronic platform shared by patient, family physician, nurse, dietitian, social worker. International Classification of Primary Care-2 (ICPC-2) coding



CHCs in Action

Community Health Centre Botermarkt - Ghent, Belgium

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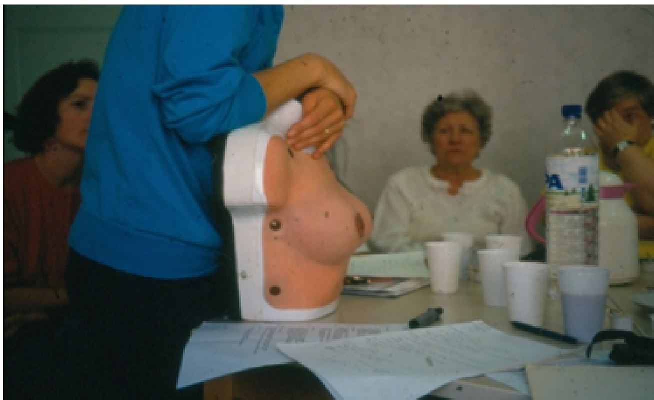
Shift from problem-oriented care to goal-oriented care

	Problem-oriented	Goal-oriented
Definition of health	Absence of disease as defined by the healthcare system	Maximum desirable and achievable quality and/or quantity of life as defined by each individual
Evaluator of success	Care provider	Patient

What really matters to people is functional status and meaningful social participation. Health promotion, illness prevention and community health programs and interventions are key... Individual, group-based, and community-level



Implementing CHCs: Important Steps

Macro-level

...Support dialogue and public policy development across sectors (healthcare, housing, employment, social services, etc) to enable integrated planning and funding of Community Health Centres as primary health care organizations aligned with WHO vision

...Create financing mechanisms e.g. "integrated risk-adjusted capitation" or "global funding" to ensure appropriate care based on patients' health and social complexity and to reduce barriers to team-based care

...Develop research on social determinants of health (SDH), community participation in PHC, and health equity

...Support data collection and service evaluation across levels of healthcare system and across sectors

Meso-level

...Create "Primary Care Zones" that are accountable for 100,000-250,000 people (or less in rural/remote areas), and that provide actions to support development of Community Health Centres in these zones

...Support data collection and participation in international systems such as International Classification of Primary Care-2 (ICPC-2) and International Classification of Functioning, Disability and Health (ICF), to facilitate community/population level diagnoses and appropriate service planning

...Implement and expand interprofessional health education to induce more inter-professional cooperation and more integration of PHC, public health services and social care

Micro-level

...Conduct local community needs assessments (health services, social services, other), involving members of the community and identify mechanisms for ongoing community participation (governance, committees, etc)

...Ensure appropriate clinical team is coupled with appropriate mixture of staff with focus on health promotion and community development to guarantee COPC approach, upstream action on SDOH, and multi-sector partnerships

...Create clear accountability between team of providers and a defined population (empanelment)

...Integrate primary care services with public and community health services (e.g. health promotion, prevention, and social services) and strengthen community involvement

Call to Action

Put Equity and Socio-Economic Justice at Core of PHC policy, planning and funding

Invest in Community Health Centres as a universal model for PHC delivery, but with special attention for vulnerable people, experiencing health inequities

Implement mechanisms for multi-sector policy and planning and tools to measure impact of PHC across health system and other sectors

Support increased interprofessional education to advance team-based care and optimize health human resources

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