

Primary Health Care – The Time Has Come

The Canadian health system is undergoing massive change. Reform and restructuring is on everyone's lips. Much of this reform is reflective of an attempt to reduce costs, but some of this is truly an attempt to make the system function better. In this past year alone, there have been two major national assessments presented – the Romanow Commission and Kirby Commission – as well as significant provincial reports including the Fyke Report in Saskatchewan, the Mazankowski Report from Alberta and the Clair Commission from Quebec. In many of these reports and commissions, primary health care (PHC) has been put forward as a solution and a logical path to follow. Since the 1980s, the Canadian Nurses Association (CNA) has advocated for a health system based on the principles of PHC.

What is primary health care?

Both a philosophy and a model for improving health care, PHC has been internationally accepted as the most effective way of meeting the health needs of people in communities around the world.

The focus of PHC is preventing illness and promoting health. It

means being attentive to, and addressing, the many issues in people's lives that make them sick – from issues like diet, income and schooling to relationships, housing, workplaces and environmental toxins. PHC involves citizens and patients on an equal footing with professionals.

PHC includes basic medical and curative care (primary care), but it is much more than just treating disease. PHC is:

- a commitment to providing essential health care (preventive, promotive, curative, rehabilitative and supportive);
- an equitable distribution of care; and
- optimal individual and community involvement (Munro, Gallant, MacKinnon, Dell, Herbert, MacNutt, et al., 2000).

The five basic principles that are usually equated with PHC programs include:

- public participation
- health promotion
- appropriate skills and technology
- accessibility
- intersectoral collaboration.

Many programs in Canada model these principles quite successfully. Pages 2 and 3 include examples of these programs.

What does PHC mean for nurses?

CNA has been advocating for more than 20 years for a health system in Canada that embodies PHC principles. Why? Mainly because we believe that a system based on PHC principles will be the most equitable and appropriate for all Canadians. In a PHC system, we see hospitals better linked to community resources. We see a system that has a focus on people and communities – not just diseases. We see a system where health professionals, social services professionals, educators and others truly collaborate with community members; we see a system where health professionals are working to their fullest capacity.

When the World Health Organization (WHO) adopted the PHC approach as the basis for effective health care delivery in 1978, nurses were seen as being the key to attaining health for all (World Health Organization, 1988). Nurses have a vital role to play not only in understanding what PHC means to their individual practices but also in advocating for a health system based on PHC principles.

PHC is really a reflection of nursing practice. Nurses interact every day with Canadians from all cultures and socio-economic backgrounds. They see, first hand, the issues related to



accessibility of services and the need to integrate health services with social services. Nursing in a PHC system involves the person, family and community. It starts where the person is at and acknowledges the many factors affecting that person's health or illness. Nursing works with the resources the person has. Nurses have the knowledge and skills to make PHC the way of the future in Canada.

Dr. Mahler, the former director general of WHO, issued a challenge to nurses to move forward the PHC agenda "...by 1985 it was obvious that physicians were not providing leadership for PHC" (Ogilvie and Reutter, 2002). He felt that nurses, because of their professional capacity and commitment, could best support and promote a broader approach to health – one actively involving patients, families and communities.

Where to from here?

PHC makes sense; it is cost-effective and has the capacity to benefit people in greatest need. For example, research has shown that every dollar invested in nutritional counselling for pregnant women saves more than three dollars in hospital care for low birth weight babies (Wahl, 1993).

If PHC is such a good approach, why haven't we adopted and embraced it as the health care system?

While nursing has adopted PHC as a method to improve the health of Canadians, it has not become the focus of the Canadian health system. Many Canadians see the health system as an "illness care" system that will be there when they need it. Although there has been greater interest and focus on prevention and promotion over the last two decades, many Canadians value expensive technology and "quick-fix" cures. Canadians still see appoint-

ments with a physician and access to diagnostic technology as indicators of a good health system. The attention of the public and policy-makers has been on the curative elements and dismissive of the preventive components of the health system.

PHC has been difficult to understand because of the number of words used to describe it and other similar concepts – primary care, health promotion, population health, etc. There is ambiguity about what PHC really means, who should be involved and how to implement it. The distinction between PHC and primary care is particularly difficult for many people. While access to primary care is an important and necessary element of PHC, it is clearly not sufficient for attaining the total intent of PHC (Ogilvie and Reutter, 2002).

However, the tide may be turning.

Speaking at the CNA convention in June 2002, Commissioner Roy Romanow, who was responsible for the influential Commission on the Future of Health Care in Canada, stated, "Primary health care is the single most important basis from which to renew the health care system" (Canadian Nurses Association, 2002).

Romanow insisted that collaborative practices, illness prevention and health promotion are part and parcel of the solution to the system's failures and that new ways must be found to maximize the skills of all health care team members. When the Romanow Report was tabled in late 2002, support for system reform based on PHC was a major theme.

Over the next few years, we will experience major shifts in the health system. With the advent of SARS and West Nile virus, our health system is being tested. CNA firmly believes a system based on PHC will best serve the Canadian public.

Working in a PHC system

In PHC the theory is important, but it needs to be supplemented with the practical experiences from people trying to make PHC work. The following stories are a few examples of PHC programs in action.

Accessibility

Health of homeless and "out-of-the-mainstream people" are a reality and priority for many nurses working in large urban centres. Street health teams, which are active in most of the cities across the country, are made up of nurses, physicians, nutritionists, social workers, lawyers and other professionals, as well as the housing and criminal justice sectors. The health of these people is often challenged by poor diets, lack of housing and poor sanitation. Many suffer from diseases such as tuberculosis, HIV/AIDS and Hepatitis C; yet, they cannot access the health system. The street health teams bring varied expertise to those living on the streets. However, all of the nurses focus on caring for individuals as well as addressing the challenges that these populations face – the challenges that determine their health status.

Intersectoral collaboration

The work of the Northeast Community Health Centre in Edmonton embraces the PHC approach. Community Health Centres (CHCs) are not a new concept. In 2002 there were approximately 300 CHCs across Canada. The Northeast Community Health Centre provides a full range of services including community health promotion, chronic disease management, emergency services, laboratory services and diagnostic imaging. With the advice of a community advisory committee, the centre plans services to address the health care needs of new immigrants, seniors, children, adolescents and women. The centre is located on major bus routes and close to schools. The centre's staff includes nutritionists, audiologists,

social workers, public health nurses, emergency nurses, physicians, cultural workers and nurse practitioners. The staff works together to ensure effective responses to individual and family needs. There is an integrated information system that allows the various professionals to access and share files and information. This centre has strong links with other resources in the community such as schools, social housing and local workplaces.

Health promotion

In Southern Ontario, a PHN was working with a group of low-income people who were benefiting from her professional skill and knowledge with respect to nutrition, child development and community action. The group shared, with each other, how to best stretch their limited budgets to meet the nutritional requirements of their families. They were distressed to learn that a national bakery was planning to close the local day old bread outlet. The nurse coached the mothers to contact the local newspaper reporter who in turn contacted the president of the bakery. The encouragement of the PHN who had become a trusted community resource through action on various community and health issues had the desired effect of keeping the outlet open. (CNA, 2003, p.4)

Appropriate skills and technology

Telephone triage systems across the country are an example of appropriate utilization of health care resources. Ontario, Quebec and New Brunswick have province-wide systems. Nurses in the New Brunswick program, for example, are able to respond to the questions and concerns of almost 75 per cent of the callers. This means

the program has reduced the demands on, and inappropriate use of, emergency rooms.

Nurse practitioners are also an excellent example of using appropriate skills and abilities in a clinical and preventive capacity.

Public participation

A wonderful example of community participation in a PHC program occurred in James Bay, located close to downtown Victoria, British Columbia. This small residential community is comprised of mostly low income, single parent families and seniors.

The James Bay Community Project (JBPC) is widely viewed as a very innovative model of PHC delivery. JBPC integrates clinical services with self-care and social support concepts. It features a volunteer program with 200 volunteers, a youth clinic that reaches out to those most at risk, a women's clinic that fosters informed decision-making and a men's health project in its initial stages.

JBPC is also considered a pioneer of multidisciplinary practice, particularly in the blending of nursing services with general practitioner services, thus expanding the scope of practice for nurses. In addition, the clinic integrates independent health practitioners such as a midwife, naturopathic physician and podiatrist.

How does PHC integrate into my practice?

In order to practise within a PHC framework, we need to continually assess our actions, questions and solutions. The following are some questions to consider:

Relating to accessibility

- How does the client get here? How much does parking cost and does the client have sufficient money? How does the family get here?

- Are services and programs available in needed languages? If not, are interpreters available?
- Are the hours "user friendly"?
- Is any print material in "literacy appropriate" language?
- How much do the treatments cost? How much do drugs cost (and can lower priced options be suggested or offered)?
- Is the site wheelchair accessible?

Relating to health promotion

- What community resources are available to clients you deal with?
- How are clients involved in the preparation and implementation of your health education/promotion programs?
- Do the health education and health promotion programs include a focus on the determinants of health and illness (social, environmental and cultural)?
- Is there a focus on enabling people to increase control over and improve their health?

Relating to interdisciplinary collaboration

- What other professional colleagues should be involved in supporting this person?
- What community information, services and referrals does this person need?
- What services are available in this community and how does the client access them?

Relating to appropriate skills and technology

- Is this the most cost effective way of dealing with this issue?
- Does the client know how to use the equipment safely?
- Is the most appropriate professional working with the person?

- Are professionals being used in the most cost effective ways?

Relating to community involvement

- How has the community been involved in determining whether this program is needed/performing as it should?
- Is this program or treatment plan reflective of a need or problem identified by the client or community, or is this a professionally defined need/issue?
- Is the community working in partnership, or are they just implementing what professionals tell them to?

How can nurses influence PHC implementation across Canada?

Nursing is a political act, so is PHC (CNA, 2000)!

Influencing the implementation of PHC across Canada will take concerted action on the part of Canadian nurses. With PHC cur-

rently being discussed profusely, nurses continue to play a major role in ensuring that our health system reflects the values and realities of Canadians.

What can you do to ensure that the changes taking place will reflect a PHC model?

- Educate politicians, community members and other health workers about PHC and the vital role that nurses play in PHC;
- Invite politicians and bureaucrats to your workplace to demonstrate and discuss what you do;
- Lobby your local politicians to ensure that health plans reflect the realities of your community;
- Write letters to the editor based on your experiences – tell your story and point of view;
- Volunteer to be on decision-making bodies, both at work and in the community – ensure that a nursing voice is heard;

- Participate on planning committees at your workplace looking at restructuring, evaluating, etc.;
- Write about your PHC experiences and submit them for publication in journals or magazines; and
- Learn about resources available in your community.

If we want to be sure that we have a health system based on PHC principles, nurses need to be sitting at the decision-making tables. There is no doubt about it: things are going to change. Nurses are well positioned to play a pivotal role in health care reform, but we need to be there and be prepared to participate.

Resources to learn more about PHC

- ☑ The Canadian Nurses Association (CNA) has a number of documents related to PHC on its web site (www.cna-aiic.ca):

Fact sheet: The Primary Health Care Approach

Primary Health Care: A New Approach to Health Care Reform

Position Statement: Framework for Canada's Health System

Press Release: Why is Canada So Slow at Implementing Primary Health Care? CNA Identifies Barriers

- ☑ The Canadian Health Network (www.canadian-health-network.ca) has in-depth information on 26 key health topics and population groups, with resources on how to stay healthy and prevent disease and injury. It also provides information on societal health issues such as violence prevention, environmental health and workplace safety.

- ☑ The Canadian Health Services Research Foundation (www.chsrf.ca) has released a report analyzing PHC systems in several industrialized nations. The report aims to help identify the models that are best suited to Canada's health care system.

Canadian Nurses Association. (2000, May). Nursing is a political act – The bigger picture. *Nursing Now*, 8, 4-8.

Canadian Nurses Association. (2003). *The value of nurses in the community*. Ottawa: Author.

Commission on the Future of Health Care in Canada. (2002). *Building on values: The future of health care in Canada*. Ottawa: Author.

Commission for the Study of Health and Social Services. (2000). *The Clair Commission report: Emerging solutions – Report and recommendations*. Government of Quebec: Author.

Munro, M., Gallant, M., MacKinnon, M., Dell, G., Herbert, R., MacNutt, G., et al. (2000). The Prince Edward Island conceptual model for nursing: A nursing perspective of primary health care. *Canadian Journal of Nursing Research*, 32(1), 40.

Ogilvie, L. & Reutter, L. (2003). Primary health care: Complexities and possibilities from a nursing perspective. In J. Ross-Kerr & M. Wood (Eds.), *Canadian Nursing: Issues and Perspectives* (pp. 450-451). Toronto: Mosby.

Premier's Advisory Council on Health. (2001). *A framework for reform*. Edmonton, AB: Government of Alberta.

Saskatchewan Commission on Medicare. (2000). *Caring for medicare: Sustaining a quality system*. Regina, SK: Government of Saskatchewan.

Standing Senate Committee on Social Affairs, Science and Technology. (2002). *Volume five: Principles and recommendations for reform – Part I*. Ottawa: Author.

Wahl, B. (1993). We'll save money by maintaining public health programs. *Ontario Nurses Association News*, 20(2), 8.

World Health Organization. (1988). *From Alma-Ata to the year 2000: Reflections at the midpoint*. Geneva: Author.