PHABC Position Paper:

The Role of Public health in Community-based primary healthcare

[In response to the BC Ministry of Health Paper:

‘Primary and Community Care in BC: A Strategic Policy Framework 2015’]

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May 19, 2015
Introduction & Purpose

The recent Ministry of Health paper ‘Primary and Community care in BC: A strategic Policy Framework 2015’ (PCCdoc) outlines a progressive vision for addressing the longstanding shortcomings of primary health care in BC. It affirms the need to ‘improve population health’ and to include health promotion and disease prevention in the development of policy and system re-design. But astonishingly, the paper fails to identify the critical role of public health professionals in realizing this vision.

The purpose of this paper is to draw attention to the very important role of public health professionals (Medical Health Officers, Public Health Nurses, Environmental Health Officers, Epidemiologists, Nutritionists, Audiologists, Speech/language Pathologists and others) in improving population health through health promotion and disease prevention interventions for which they are specifically trained. It is intended to be helpful to public health professionals who are working in Health Authorities and communities undergoing a transformation to community-based primary healthcare. Much of the process of primary and community health care transformation will take place at the grassroots, community level. BC Public Health professionals should ensure their voices are heard at the local level (particularly at Divisions of Family Practice) where there will be a mandate, and resources to drive progressive, positive change. The transformation of primary health care to community-based primary healthcare cannot be achieved without your full participation.
Basic requirements for community-based primary health care

The MOH PCCdoc incorporates much of the evidence as to what is needed to transform primary and community health.

Extensive review of the health care literature has identified the following basic requirements for transformative change in primary healthcare¹

1. Serving a **defined geographic population**,  
2. Providing a **comprehensive array of services which must include upstream prevention** (addressing the socioeconomic determinants of health), clinical prevention and care especially for those with chronic co-morbidities (including urgent acute care and specialist care), hospital care, home and long term care, mental health and addictions, palliative and end-of-life care;  
3. **Interprofessional teams** including physicians, nurses, nurse practitioners, midwives, physiotherapists, OTs, pharmacists, mental health and addictions workers, public health professionals, specialists, home and long term care professionals as well as navigators and care managers;  
4. **Appropriate financial incentives and supports**;  
5. **Electronic data systems** (EHRs) and telehealth technology that allow data sharing as appropriate and secure across clinical teams. These data must be also analyzed and be made available to clinical teams for quality improvement purposes and accountability. Population level data must also be available, analyzed and reported;  
6. A **governance** mechanism that enables patient and community engagement in both co-designing the system and in quality improvement.

Of particular note, are items 2 and 3: comprehensive service including **upstream prevention addressing social, economic and environmental determinants of health** and **integrated interprofessional teams including public health expertise**.
Public Health Core Functions

Although the PCCdoc reaffirms that the BC Ministry of health is directing its efforts toward the **Triple Aim**, the first of which is *improving the health of the population* and states that *integrated and comprehensive patient-centered health care including health promotion and disease prevention drives all policy and system re-design*, there is absolutely no mention of public health programs or professionals within this context. The ministry does recognize the importance of public health in the ‘Health Service Delivery Performance management Framework to Drive Continuous Improvement’ (see Fig 1).
The PCCdoc rightly recognizes that BC still has a considerable burden of disease related to smoking, poor diet, physical inactivity and obesity and that up to 80% of heart disease, stroke and type 3 diabetes and over 30% of cancers can be prevented by eliminating tobacco, unhealthy diet, physical inactivity and the harmful use of alcohol. Importantly the paper also recognizes that these behavioural risk factors are embedded in the social and economic determinants of health (the ‘causes of the causes’). The burden of most chronic diseases (obesity, diabetes, heart disease, stroke, cancer, mental health and addictions problems and others) are projected to continue to rise over the next decades driven by the underlying behavioural risk factors and the social and economic determinants of health, so in order to achieve the third Triple Aim: ‘reducing the per capita cost of health care’ it will be very important to coordinate effective health promotion and disease prevention programs at the provincial and community levels The PCCdoc fails to recognize that the above, are the very issues that public health professionals are trained to address and have had much success with over the past decades (particularly smoking and reductions in cardiac disease burden).

The importance of public health core functions is not addressed in the PCCdoc. This omission is hopefully an oversight that this PHABC paper will help to correct and at the same time point out to public health professionals in the field how public health is essential to realizing the vision. The challenge now for public health is to ensure that public health expertise is integrated into the process of the transformation of primary and community care in order to attain the goal of improving the health of the population and reducing health inequities.

At a very high, simplifying overview level, basic functions of public health include but are not limited to:

1. Surveillance, monitoring and reporting – through data collection and analysis, epidemiologists, medical Health Officers and other professionals are trained to develop community health profiles and identify epidemics and adverse trends in disease.

2. Health promotion – the promotion of healthy behavioral choices in tobacco, diet, physical activity and alcohol use; and addressing the
‘upstream’ social and economic determinants of health including poverty, growing income and wealth inequities, reproductive health, early child development, education (primary, secondary and post-secondary as well as skills and trades training), food security, housing, transport, environmental protection and so forth.

3. Disease prevention – communicable disease/epidemic control, immunization, cancer screening

4. Protection – ensuring clean water supplies, effective sewage disposal, environmental protection and restoration.

5. Disaster planning – earthquakes, floods extreme weather events, violence and so forth

6. Advocacy – for societal conditions and social justice, peace and shared prosperity to improve health.

These are represented in the schematic below (BC MOH 20130: ‘Promote, Protect, Prevent, Our Health begins Here, A Guiding Framework for Public Health (2013)
For those, particularly public health professionals requiring a detailed explanation of the complex spectrum of expertise and skills offered by public health please see: **A Framework for Core functions in Public Health** available at: http://www.health.gov.bc.ca/library/publications/year/2005/core_functions.pdf

Consider emerging evidence from the US

The PCCdoc (pp108-113) refers to UK NHS transformative initiatives which generally have not integrated public health personnel or expertise. It may be helpful to consider in addition recent US initiatives emerging under the Accountable Care Act (Obamacare). Accountable Care organisations and Communities are being established based on a policy ‘focused on the health of the population as a vehicle for bringing health care delivery systems, **public**
**health agencies**, behavioural health, social services and other entities together to improve health outcomes in their communities’. There are now a number of these initiatives that have been established in the US that have shown significant reductions in health care costs as well as improved outcomes².

Public and population health practitioners understand the vision of the Ottawa Charter, the impact of the social determinants of health on the wellness of populations and have traditionally worked closely with primary care practitioners, whether in youth clinics, early childhood development or seniors’ support services and, as importantly, have a longstanding expertise in the engagement of community partners.

**Conclusion**

There is much more detail that could be provided but this perhaps suffices to show that the skills and training of public health professionals are key to improving population health. It will be essential that public health professionals are included in the inter-professional teams that will be developed to provide a comprehensive array of prevention and promotion health services in a transformed community-based primary healthcare system.

**References:**

1. Millar, J. (2014). *Healthcare sustainability: how can we create a cost-effective system of primary and community care around interdisciplinary teams?*, 2014. PHABC.