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CENTRE FOR PRIMARY HEALTH CARE AND EQUITY, UNIVERSITY OF NEW SOUTH WALES & THE DEPARTMENT OF GENERAL PRACTICE, UNIVERSITY OF MELBOURNE

Designing community-based health programs to address the needs of marginalised and disadvantaged communities

APHCRI INTENATIONAL VISITING FELLOWSHIP

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Prof Mark Harris
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Mr Terry Findlay
Ms Elizabeth Harris
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We would like to thank the Australian Primary Health care Research Institute for agreeing to fund Dr Julie Will's visit. We would also like to thank Dr Will for coming to Australia and for sharing with us her expertise and experiences both formally in the seminars and workshops and in informal discussions with researchers at both research centres.

We would also like to thank the 100 or so people who participated in the seminars and workshops. Their thoughtful questions and comments contributed to a learning environment which was beneficial to us all.

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INTRODUCTION

The focus of the visit by Dr Julie Will was to explore evidence based approaches for improving access and equity in primary health care, with a particular emphasis on preventing and managing chronic conditions and health problems of people who are unemployed. Dr Will is a senior epidemiologist in the Division for Heart Disease and Stroke Prevention at the Centers for Disease Control and Prevention. For the past 13 years, she served as the WISEWOMAN Team Leader, Acting Team Lead for the Applied Research and Translation Team, and Senior Epidemiologist for Health Services Research and Registry Team.

The visit was co-hosted by a partnership of the Centre for Primary Health Care and Equity (CPHCE), University of NSW and the Department of General Practice, University of Melbourne. Primary health care is an important area of health services development within Australia and ensuring greater equity of access and health outcomes is an important focus of future reform [1]. The visit builds on previous collaboration between the two research centres addressing health inequity in the general practice setting [2-11] This partnership also co-convened the Health Inequalities Research Collaboration's (HIRC) PHC Network, which was funded by the Commonwealth Department of Health and Ageing from 1999-2003 to develop a health inequalities research agenda within Australia [12]. The PHC Network maintains links between researchers, policy makers and practitioners across Australia and internationally with an interest in addressing health inequity through action within a comprehensive PHC system. The Network continues to advocate for ongoing research into these areas and the translation of research and evaluation into policy and practice that focuses on what works in real world settings for disadvantaged communities1.

The program for Dr Will's visit included a series of one-day seminars and workshops that targeted researchers, policy makers and practitioners working in the area of primary and community health. The seminars included presentations on programs and approaches with an explicit equity focus and workshops provided an opportunity to apply models in the design of prevention programs.

[1] Eg at the 2009 GP&PHC Conference: "Addressing health inequalities through primary care. Progress over 10 years. Opportunities for renewal"

Dr Julie Will spoke about the WISEWOMAN program which targets low-income, underinsured, and uninsured women aged 40-64 years for screening and interventions aimed at reducing the risk of heart disease, stroke, and other chronic diseases. Mr Terry Findlay spoke about his experience leading practice and system redesign in Glasgow, through a case study of children's services. Dr John Furler spoke on an approach to a systematic review on initiatives to improve equity of access to preventive care for disadvantaged groups. Ms Elizabeth Harris and Prof Mark Harris spoke about the evidence on inequity in preventive care in the Australian context, and through two case studies demonstrated the continuing operation of the inverse care law amongst programs specifically targeting disadvantaged communities. The presentations are available on the CPHCE web page under Designing prevention: programs to improve access and reach for disadvantaged communities.
http://notes.med.unsw.edu.au/CPHCEWeb.nsf/page/News+and+Events

KEY LEARNINGS AND OUTCOMES

The presentations and workshops generated a great deal of thoughtful and considered discussions which were distilled into three major interrelated themes:

- The continued salience resilience of the inverse care law
- The importance of research and evaluation in developing effective prevention programs that will benefit disadvantaged communities and reduce inequities
- The need for multi-component and multi-level approaches

The continued salience of the inverse care law

The inverse law was first articulated in the 1970s by Dr Tudor Hart, an English GP, who argued that that there is an inverse relationship between need and the level of care available [13]. The widening socio economic gradients in relation to smoking are a clear illustration of the inverse care law in operation. Both Mark Harris and John Furler presented evidence of the continuing evidence to practice gap in relation to preventive care in Australia. Using the example of

common risk factors they compared the prevalence in the community, with their prevalence identified in general practice and the prevalence of GP interventions. Liz Harris also provided evidence from home visiting programs for mothers and babies showing that socioeconomically better off women were more likely to receive home visits and care that met the guidelines than vulnerable women with identified risk factors. In her presentation Liz also highlighted the systemic nature of the inverse care law and that even in programs specifically designed to improve access for disadvantaged and vulnerable populations, the most marginalised and vulnerable are less likely to receive the service. These findings suggest there is a need to identify and address both patient and provider factors in the design of preventive programs, link individually focused to community focused interventions, and to link a provider focus to more system level approaches.

The importance of research and evaluation

All the speakers stressed the importance of research and evaluation in the design, development and implementation of programs and for assessing their reach and effectiveness.

The WISEWOMAN program has drawn on multiple theoretical frameworks and models including the socio-ecological model; behavioural, organisational and community change theories; and public health impact models that focus on both reach and effectiveness. There are multiple program components all of which are based on the evidence of what works. The program has evolved over three major stages: a 10 year research and evaluation based demonstration phase, a two year transition phase and since 2008, a dissemination phase which has seen the program implemented more broadly across the US. The demonstration phase involved a number of RCTs, nonrandomized group assigned trials, quasi-experimental studies and descriptive studies, the learnings from which contributed to the program's development [14]. The transition phase involved translating research into practice through developing tools and resources that are based on evidence reviews. These resources include implementation templates that identify core elements that must be implemented to maintain the program's fidelity, whilst allowing some flexibility to meet local circumstances. They help to identify what to do and how to do it and are available via a web page (http://www.center-trt.org/index.cfm?fa=wisewoman.overview). Partly this initiative was in response to evaluations which found considerable variability in the implementation of the components. There were concerns that the empirical basis of the program linking the components to demonstrated outcomes was

being diluted. This underlines the importance and value of conducting ongoing process evaluations of any preventive programs to ensure that the core evidence based components are implemented as designed.

From a management perspective Terry Findlay reinforced the importance of demonstration projects to test and evaluate the effectiveness of interventions developed elsewhere and their appropriateness for local contexts. His presentation also reminded us that while demonstration projects may achieve sufficient positive results to warrant their broader implementation, the continuing problems of widening health inequalities indicate that system change and redesign is required. This illustrates that individual program approaches might not be sufficient to close the gaps in health status.

The need for multi-component and multi-level approaches

The resilience of the inverse care law and the social determinants of health suggest that addressing health inequalities in preventive programs requires a multifaceted approach. A strength of the WISEWOMAN program is that it comprises screening, lifestyle interventions, access to treatment services, and follow up. Another strength is that it built on an existing national screening program for disadvantaged women which assisted with recruitment of women to the program.

Three major challenges for systematically addressing health inequalities emerged from the presentations: the need for culture change, system change and changes to the way resources are allocated. A lack of understanding about inequalities in a health care context was highlighted. Much of the communication about health inequalities is focused on particular population groups where the health gap is particularly visible. The general improvements in population health masks a more nuanced understanding of health inequalities and the widening gaps between the most and least well off in our society. This was well illustrated in Mark's presentation on the health inequalities associated with colorectal and cervical cancer screening rates and the differential GP consultation times by SEIFA quintiles[2] and by Liz's evidence on differential patterns of early childhood home visits. Linked to this need for what might be called improved 'health literacy' across the health system is the conflict between medical and social models of health as the drivers of change. In Glasgow, the joining up of the NHS and Local Authorities through establishing Community

[2] An index of socio economic status

Health and Care Partnerships better links the health of individuals to a broader primary and population health approach that emphasis health and well being.

Finding the common ground between the medical and social views of health remains a persistent challenge. Julie Will commented that a limitation of linking the WISEWOMAN program to an existing screening program was that it tended to be implemented within a medical model, which might go some way to explain the loss of women to follow up. From a social health perspective, stronger links need to be made with "... partners who can make policy, environmental and system changes that support the adoption and maintenance of heart-healthy behaviours by underserved populations where they live, work and play." [14]. These tensions regarding a medical versus social model of health also came up as an issue in the workshops and influenced the ways in which participants approached the design of preventive programs. Acknowledging that health care practitioners come from different backgrounds and perspectives, each with a tradition of what's considered evidence-based is an important first step. Using these differences to design interventions and programs that link clinical interventions to community-based interventions and community development approaches can assist with the achievement of long term outcomes and reducing the health gaps.

Outcomes

The intended outcomes of the visit were: a) facilitate the uptake of evidence into policy and practice; b) strengthen the links between PHC related researchers, policy makers and practitioners; and c) strengthen the linkage and exchange between researchers working to build capacity and innovation in this important under-researched area.

These outcomes were achieved through organising a program of seminars/workshops that were held in Sydney, Melbourne and Canberra which attracted over 100 participants. They came from a mix of research, policy, management, clinical, and health promotion backgrounds, and from the public and community sectors as well as divisions of general practice. The workshops focused on applying theoretically based models to the design of preventive programs and supporting literature was provided to all participants as part of their registration. The informal meetings between Julie Will and researchers at both research centres provided a fertile environment for an exchange of ideas and experiences. A tangible outcome has been the development of an NHMRC research proposal for enhancing the role of general practice in preventive care in disadvantaged communities. This research proposal draws on the experience of the WISEWOMAN program in the design of the intervention and one particular evidence-based component.

CONCLUSION: IMPLICATIONS FOR APHCRI'S STRATEGIC WORK PROGRAM

The international visiting fellows program makes an important contribution to two of APHCRI's strategic goals.

Uptake of research evidence (Goal 2)

Dr Will's visit was used as an opportunity to organise a seminar and workshop program that included other case studies of equity focused programs and research and for participants to explore the application of theoretical models in the design of programs. Resources were made available to participants to assist them to incorporate theory and evidence in future policy and practice. The high number of registrations at particularly the Sydney seminar illustrates the potential to broaden the reach of visiting fellows through linking their visits with other activities.

The transition phase of the WISEWOMAN program illustrates the comprehensive and detailed strategy CDC used to promote the take up and use of evidence based approaches. There are few examples of this approach being undertaken in Australia, and it would be useful for APHCRI and perhaps also PHCRIS to explore the opportunities for this type of approach within the Australian context.

Enhanced research capacity (Goal 3)

The success of the visit by Dr Will shows that the program of visiting fellows can lead to both formal and informal research collaborations and a productive exchange of ideas and experiences. It is recommended that they continue.

APPENDICIES

PROGRAM OF ACTIVITIES

Date	Activities	Location
29th Oct 2009	Informal meetings with researchers Lunchtime seminar	Centre for Primary Health Care & Equity, UNSW
30th Oct 2009	Informal meetings with researchers involved in disadvantaged communities	Centre for Health Education, Training, Research and Evaluation, Liverpool
2nd Nov 2009	One day seminar and workshop	Sydney
4th Nov 2009	One day seminar and workshop	Melbourne
5th Nov	½ day seminar and workshop	Canberra

SEMINAR PROGRAM

Time	Agenda	Speakers/facilitators
45m	Registration & Coffee Welcome	Ms Julie McDonald, Research Fellow, CPHCE
1 hour	Key note address: The WISEWOMAN Program: Designing a prevention program for disadvantaged women in the US	Dr Julie Will, Senior Epidemiologist, CDC
20 m	Morning tea	
25 m	Addressing the challenges of growing health inequalities in Glasgow through structural and service delivery changes: an early childhood and parenting program	Mr Terry Findlay, Honorary Visiting Fellow, CPHCE, UNSW
25 m	Systematic review of primary health care initiatives to improve access to preventive care for disadvantaged groups & communities	Dr John Furler, Senior Research Fellow, University of Melbourne
20 m	Discussion	Ms Julie McDonald, Research Fellow, CPHCE
45m	Lunch	
30 m	Reflections on the themes from the morning. Access to primary health care and the 'Inverse Care Law'. Current policies and initiatives for improving equitable access to primary health care	Prof Mark Harris, Executive Director, CPHCE Ms Elizabeth Harris, Director, Centre for Health Equity, Training, Research & Evaluation
1 hr	Workshop focus: Designing programs to improve access to primary health care for marginalised groups Introduction to models for improving access to PHC How can these models be used to design programs	
1 hr	Feedback & discussion close	

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