THE ROLE OF PRIMARY HEALTH CARE IN CHANGING LIFESTYLES

Report on a WHO Working Group

WORLD HEALTH ORGANIZATION
Regional Office for Europe
COPENHAGEN

TARGET 28

Content of primary health care

By 1990, the primary health care system of all Member States should provide a wide range of health-promotive, curative, rehabilitative and supportive services to meet the basic health needs of the population and give special attention to high-risk, vulnerable and underserved individuals and groups.

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LIFE STYLE
HEALTH PROMOTION - methods
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Note

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Introduction

The Working Group on the Role of Primary Health Care in Changing Lifestyles met in Rovigo, Italy, from 13 to 16 June 1989. The Group was convened by the WHO Regional Office for Europe in collaboration with Local Health Unit N.30 of the Veneto Region. The participants are listed in Annex 1.

In recent years health promotion has received increasing attention both inside and outside WHO. The emphasis has been on its content, on approaches to implementation, and on the role of the public and the individual.

Health services naturally have a particularly important part to play in health promotion; general practitioners/family doctors, community nurses and other health professionals are particularly well placed to carry out health promotion activities because of their daily contact with the community.

The Working Group's main task was to review the ways in which primary health care providers, especially general practitioners/family doctors, are involved in health promotion. The Group was asked to describe the role of the main primary health care providers in health promotion and on this basis to specify the requirements for undergraduate and postgraduate training. Bearing in mind that the providers' contribution to health promotion is only one part of the input needed, although an important one, the participants were also asked to look specifically at the possibilities for collaboration with other sectors, other professions and the community. Finally, they were expected to make recommendations to the professions concerned, governments and WHO as to where future efforts to strengthen the involvement of primary health care providers in health promotion should be directed.

The Working Group accepted the definition of health promotion generally used by the WHO Regional Office for Europe: "Health promotion is the process of enabling individuals and communities to increase control over the determinants of health and thereby improve their health".

Health promotion in primary health care in the European Region

The Working Group recognized that although the full potential scope of primary health care was defined at the Alma-Ata Conference in 1978, its actual scope at the present time varies considerably from country to country. In many Member States of the European Region, services are provided by general practitioners, nurses, midwives and other professional staff working in small local units located in the community, but this is not always the case. In the German Democratic Republic, for example, primary health care is defined as "all medical services - preventive, diagnostic, treatment and rehabilitation - that are available to the residents of every district and that are used most frequently by them". Thus the accepted definition in the German Democratic Republic, and indeed service management, includes the provision of a wide range of specialist services, including inpatient facilities.

The Working Group therefore decided that, to aid discussion, they should concentrate on the roles of general practitioners, primary health care nurses and midwives, who are referred to collectively as "primary health care providers".

The position of the general practitioner in Europe today is very variable. In Italy, Austria and most of Spain, general practitioners work largely on their own. In other countries, however, such as the Netherlands, the

United Kingdom and Yugoslavia, teams of general practitioners and nurses customarily work together.

In Greece, a major new development is taking place in that some parts of the country are establishing a generalist primary health care service. In most areas of Greece, primary medical care has hitherto taken the form of direct access by patients to a variety of medical specialists. Now, however, a small number of accredited general practitioners (some 200) are providing preventive, treatment and rehabilitative services from health centres staffed by teams of generalist primary health care professionals.

The position of nurses in the European Region varies to an even greater extent. Their training ranges from the very basic to university-level education. In some countries, nurses work exclusively as assistants to physicians. In others, they work independently and are considered the professional equals of general practitioners.

The Alma-Ata Declaration stated that primary health care was the key to achieving health for all, yet there are still considerable variations in the amount of progress made as regards incorporating health promotion into the provision of primary health care.

The participants gave some examples of progress, although most concerned preventive services.

In Italy, general practitioners are concerned almost entirely with diagnosis and therapy. At present the family doctor has no obligation in respect of either prevention or health education. Some do undertake health education on their own personal initiative, however, and a proposed change in doctors' contracts is soon likely to oblige all general practitioners to perform preventive care.

In those countries where general practitioners and nurses work together in teams, preventive activities seem to be more common. For example, in Yugoslavia, doctors and nurses work together in health centres, and the majority of doctors provide preventive services for early detection of chronic disease. Interesting experimental projects are also taking place in both the Lithuanian SSR and in Barcelona, Spain. In the former, a project called Lithinterhealth aims to improve the preventive services provided by doctors and nurses working from polyclinics in certain areas. In Barcelona, general practitioners traditionally worked in an isolated and demand-oriented fashion. A new system is now being set up, whereby teams of physicians and nurses work from primary health care centres. Specific prevention projects have followed this reform, for example an attempt to improve immunization rates, and another project in which nurses offer smoking cessation advice at the centres.

In the United Kingdom, preventive services are increasingly being offered in those practices where the doctors employ nurses specifically to carry out regular check-ups on adult patients. Maternal and child health advice, however, forms a routine part of the primary health care services offered throughout the United Kingdom by health visitors attached to primary health care facilities.

The concept of "lifestyle"

In considering the role of primary health care in changing lifestyles, the Group expressed agreement with the definition of lifestyle proposed by Nutbeam: "The term lifestyle is taken to mean a general way of living based on the interplay between living conditions in the wide sense, and individual patterns of behaviour as determined by sociocultural factors and personal characteristics".

They noted that in some countries the word lifestyle is sometimes used to describe personal health behaviour: for example, it has been suggested that primary health care providers should give "lifestyle advice", in other words that they should be able to influence lifestyle by direct advice to patients. However such statements, implying interchangeability between the terms lifestyle and health behaviour, fail to take account of the true range of determinants of lifestyle. These include on the one hand personal health behaviour but on the other the individual's "ecosphere": the family, community, culture, societal structure, physical environment, financial situation, and so on. Determinants of lifestyle must be seen as a combination of internal and external forces, in continuous interaction. The Alma-Ata report stated that health promotion seeks to "enable individuals and communities to increase control over the determinants of health and thereby improve their health ... It is therefore concerned not only with enabling the development of lifestyles and individual competence to influence factors determining health, but is also concerned with environmental intervention to reinforce factors supporting health lifestyles and to change those factors preventing or prohibiting healthy lifestyles".

From prevention to health promotion

The participants presented evidence showing that in many Member States the primary health care services are increasingly carrying out important disease prevention activities, increasing immunization coverage, for example, setting up screening programmes for the early detection of chronic disease, and so on. Several participants also suggested that some primary health care providers are giving personal advice to patients as the opportunity arises during routine patient-initiated consultations, in an attempt to influence health behaviour.

However, such activity is mainly directed at maintaining the status quo, rather than providing a broad positive approach to health promotion which accepts the importance of the ecosphere as a major determinant of lifestyle. Seen in the broader perspective, implicit in the definition used by the Regional Office, health promotion aims to influence lifestyles by a combined approach of influencing not only personal health behaviour but also the general health environment.

A key question for the Working Group, therefore, was to consider how far primary health care providers could become involved in interventions aimed at improving the health environment. It was agreed that it was legitimate for them to take an interest in the health environment and seek to influence it, while at the same time promoting appropriate personal health behaviour by individuals and families. A multidisciplinary team was more likely to be able to carry out broad-based health promotion activities than individual, isolated practitioners. The skills of primary health care nurses (public health nurses or health visitors, for example) would often be valuable in local action focusing on the health environment.

Implementing the health promotion approach in primary health care

The Working Group felt that a broad health promotion approach in primary health care should be firmly rooted in a commitment to preventive care. Although by and large trained in curative medicine, primary health care providers have in recent years begun to accept greater responsibility for this other area. Increasingly they are working with district and community physicians, developing coherent local prevention strategies. Yet concentrating on prevention and individual health behaviour to the exclusion of the ecosphere can easily

lead to "victim blaming", unless the strategy adopted by the primary health care team is a broader one of health promotion. Once the essential importance of the ecosphere in determining lifestyle is accepted, it is natural to progress from a traditional preventive service to broader health promotion initiatives.

The role of primary health care providers in such initiatives can be summarized under the headings used in the Ottawa Charter for Health Promotion - enabling, mediating and advocacy. The challenge for them will be to start looking beyond the confines of the one-to-one consultation, or even of family care, and to accept that their role is to work with others to enable the community as a whole to increase its control over the determinants of health. Locally, primary health care teams will clearly need to deal with local issues, but they could join with other primary health care workers to initiate and support regional and national health promotion initiatives.

Leadership from professional and national organizations is essential to give credibility and impetus to health promotion programmes in primary health care. The Group also felt that local demonstration projects were of crucial importance. For example, in Thessalonika, Greece, primary health care centres have been set up, not only to provide curative and preventive services but also to work in the locality to develop community programmes. In one centre, the primary health care providers mounted a road safety campaign following a spate of serious road accidents, and also a community-based antismoking initiative.

Demonstration projects must be accurately described and evaluated; others can learn from their success (or failure). It is important, therefore, to have effective networking, so that providers in Member States can be informed of health promotion projects going on elsewhere.

Primary health care providers could also be encouraged to become more active in health promotion as a result of national or local public debate, and if governmental organizations provided the leadership. Professional bodies could set up consensus panels, produce guidelines and suggest suitable quality control and audit procedures. National and regional conferences could also aid discussion and encourage new projects.

Bodies which fund primary health care services in Member States will need to accept the obligation to provide a proper economic framework and funding for health promotion activities.

Difficulties will inevitably be encountered in moving towards a health promotion approach. In particular, traditional attitudes towards health education as a didactic activity may need to be modified, and professional roles may need to be re-examined. Some professionals may believe that the task of trying to influence the ecosphere is beyond them. Nevertheless, many of these difficulties can be overcome by developing specific objectives for local programmes and activities, by step-wise progression towards new ways of working, and by making use of all the skills available in a multidisciplinary primary health care team.

Intersectoral collaboration

One of the implications of the move from prevention to health promotion is the need to accept that the health sector must move away from its present position of sole responsibility towards a policy of intersectoral collaboration. In some Member States, primary health care providers are already involved in examples of intersectoral collaboration. The Working Group endorsed the importance of collaboration between primary health care teams and other sectors, but also pointed out that

these other sectors often ignore the teams and fail to collaborate, despite the fact that the teams are usually working closely with the community. The Group felt it was important for goals to be set in order to activate intersectoral collaboration; this process would involve public debate and should give the population as active a role as possible.

Collaboration may take place at a number of levels: the regional and district levels are probably the most important in terms of the organization and administration of primary health care, since these two tend to deal with policy issues and can most easily liaise with local authorities. However, this should not preclude local collaboration where appropriate, especially with the voluntary sector or with local branches of nongovernmental organizations, which may be particularly productive. Other sectors which should be involved include sports organizations, schools, local industry, pharmacists and the media.

The Group identified several potential problems in connection with intersectoral collaboration:

- intolerance of other organizations or sectors;
- the lack of a common language;
- variations between sectors in objectives and targets;
- variations between sectors in concepts, priorities and values;
- variations between sectors in administrative arrangements and methods of work;
- variable access to resources.

Overcoming such problems would require a commitment to the principle of intersectoral collaboration and frank discussion of any difficulties. It would also be very helpful to have national and regional leadership by professional organizations, to set up demonstration projects, to disseminate information on good practice and, above all, to gain further experience of various collaborative initiatives.

Ethical issues

Quite a few primary health care providers have difficulty accepting the concepts used in health promotion programmes because of their own reservations about the ethics of such programmes. They may, for example, feel that certain activities constitute an unwarranted interference in their patients' everyday lives. Some, on the other hand, would say that for policy-makers not to allocate funds and resources to health promotion activities is itself unethical on the grounds of social justice. The question of equity in health can also be seen as a matter of social justice, while yet another ethical issue concerns the desirability of appropriate personal health behaviour on the part of primary health care practitioners themselves.

If providers become firmly committed to a broad health promotion approach, the nature of the relationship between them and the community they serve is bound to change. The patients' expectations may also need to change, as the style of service becomes less demand-led (demand-led services being often associated with unnecessarily high prescribing rates). The ethical implications of such changes must be considered.

A provider with respect for a patient's autonomy will presumably agree that the patient should be able to

take control over his or her health. One who feels beneficient towards the patient, however, may seek to exert excessive control.

The Working Group felt that these and other ethical issues should be examined further in some detail.

Education of health care providers for health promotion

At present, many education and training curricula for primary health care providers neglect health promotion. The approach is often sickness oriented, instead of health oriented, the social and behavioural sciences are relatively neglected, and the educational setting is often restricted to institutions, with little opportunity for experience in the community. When educational priorities are being set, the health needs of the population are often ignored, whereas an analysis of these needs must inevitably lead to much greater concentration on the teaching of health promotion.

However, the Working Group also accepted that few attempts have yet been made to define the special knowledge and skills needed for broad-based health promotion action in primary health care, although these would clearly include the social determinants of health and illness and other aspects of the behavioural sciences, a knowledge of community resources and community dynamics, essential skills in communication, and also, taking into account the difficulties mentioned earlier, the skills needed to work successfully with members of other professions.

The Group felt that professional bodies and academic institutions would be in the best position to define the knowledge, skills and attitudes needed. However, not all Member States yet have academic departments or institutes devoted to primary health care, which would need to be an

essential part of any strategy for improving training, and a major part of whose work should consist of health promotion studies.

Once educational institutions have been set up and curricula devised, rational plans can then be made for step-wise progression in undergraduate, postgraduate and continuing education. It was emphasized, however, that any training organization should have links with active health promotion programmes or demonstration projects, to make the training practical as well as theoretical. It was also felt that the teachers should include practising primary health care providers.

At undergraduate level, all nurses and doctors should be given a grounding in the health promotion approach. While the Working Group had no mandate to undertake a comprehensive review of medical and nursing education, they nevertheless felt strongly that medical and nursing training schools almost entirely neglected this subject and that a major reorientation of the curricula and of training methods might be desirable.

Postgraduate education should concentrate on the practical aspects of health promotion programmes, using examples of local and national projects.

Continuing professional education should deal with the management of health promotion projects, with skills (especially those required for collaboration with other professions) and possibly with problems of implementation.

Academic institutions would also have an important part to play both in formulating research questions concerning health promotion action, and in conducting research into such subjects as the effectiveness of health promotion methods and activities, and policy development.

Conclusions and recommendations

Health promotion and primary health care

1. The WHO Regional Office, Member States and health districts should recognize and affirm that primary health care has a central role to play in changing the lifestyles of individuals, families and populations. Changing lifestyles will involve primary health care providers in considering and influencing people's personal health behaviour; but it is important to recognize that they will also need to develop a complementary and legitimate interest in seeking to reduce inequities in society, and in seeking to improve living conditions and the health environment. They will require skills for enabling, mediating and advocacy, and will need to involve themselves actively in intersectoral collaboration.

2. Member States should ensure not only that primary health care is given an appropriate priority in the development of health services, but also that funding is provided for health promotion action by primary health care providers.

3. Member States, and professional organizations within Member States, should develop strategies for using contacts between providers and patients as opportunities to influence personal health behaviour for the better. These strategies will be a first step towards a comprehensive approach to health promotion by primary health care providers.

4. WHO, Member States and health districts should set up and develop a network of demonstration projects in health centres, clinics and other primary health care facilities in order to develop, refine and test model practice in health promotion and to initiate programmes of intersectoral collaboration involving primary health

care providers. WHO should monitor these developments and provide a networking and information service in order to disseminate information on good practice.

Training and research

5. Member States should ensure that, where they do not already exist, academic institutions or departments for both primary health care and health promotion are established, properly staffed and funded. These institutions or departments should give priority to identifying and evaluating methods for health promotion in primary health care.

6. Member States and professional organizatons should ensure that suitable curricula and teaching methods for health promotion in primary health care are developed and implemented in undergraduate, postgraduate and continuing professional education.

7. WHO, Member States and professional organizations should organize national and district conferences on primary health care and health promotion, leading to plans for future activities.

8. WHO and Member States should determine the appropriate mechanisms for considering the ethical implications of practising health promotion in primary health care.

Promoting intersectoral collaboration

9. WHO, Member States, health districts and primary health care providers themselves should recognize the importance of intersectoral collaboration which involves providers in attempts to change lifestyles. Public participation and community involvement are essential prerequisites for productive collaboration.

10. Member States and health districts must develop planning mechanisms and policies for active collaboration between primary health care providers and sectors such as the voluntary or lay organizations, education, local industry, local planning authorities and the media.

Annex 1

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