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Short Report

Community, equity, access: core geographic concepts in primary health care

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While the use of appropriate technologies, an opposition to medical elitism, and achieving health for social development have been repeatedly cited as ideas important to both the Declaration of Alma-Ata and primary health care more generally, we believe that key geographic concepts are equally as foundational. More specifically, notions of 'community', 'equity', and 'access' are consistent definitional elements of primary health care across systems; each of these possesses inherently geographic components and, thus, to truly effectuate the most relevant primary health care research and practice, we must think geographically about them. Our objective in this short paper is to introduce readers to the geographic nature of primary health care and to encourage researchers and clinicians alike to engage with applying a 'geographic lens' to relevant enquiry and practice. To achieve this, we overview the geographic nature of community, equity, and access as these concepts relate to primary health care and also outline the fundamental geographic concepts of scale, space, and place.

Key words: access; community; equity; geography; place; primary health care

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Regular readers of this journal will be in no need of convincing that primary health care (PHC) is an absolutely vital form of health care delivered around the world. Since its early conceptualization by the World Health Organization (WHO) via the Declaration of Alma-Ata, such care has been envisioned as a way to overcome health disparities operating at numerous scales through the provision of equitable and accessible care by, in, and for communities. While the use of appropriate technologies, an opposition to medical elitism, and achieving health for social development have been repeatedly cited as ideas important to both the Declaration and PHC (Cueto, 2004), we believe that key geographic concepts are equally foundational. More specifically, notions of 'community', 'equity', and 'access' are consistent definitional elements of PHC across systems; each of these possesses inherently geographic components and, thus, to truly effectuate the most relevant PHC research and practice, we must think geographically about them. Our objective in this short paper is to introduce readers to the geographic nature of PHC and to encourage researchers and clinicians alike to engage with applying a 'geographic lens' to relevant inquiry and practice.

Community

In reviewing the Declaration, it is clear that the WHO placed the idea of community at the centre

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of its vision for PHC. This is demonstrated by the inclusion of comments such as '[PHC] reflects and evolves from the economic conditions and sociocultural and political characteristics of the country and community' and 'requires and promotes maximum community…participation in the planning, organization, operation and control' (WHO, 1978). In fact, the emphasis on community within PHC is what sets it apart from other health service delivery models (Litsios, 2004). This focus on community in PHC has been translated into the very practices of health care systems. A recent Delphi process undertaken with experts identified four operational community-oriented dimensions of PHC: (1) client/community participation, (2) equity, (3) intersectoral team practice, and (4) population orientation (Haggerty *et al*., 2007). That community was raised here as a defining element of PHC further indicates that this concept rests at the core of what such care can and should be.

Community is a fundamentally geographic concept. Communities host the places from which care is delivered (eg, clinics) and are made up of spatial phenomenon such as neighbourhoods. Family medicine is a primary discipline for PHC given its focus on first-contact care provision. Agarwal (2009), while reflecting on her practice as a family doctor and its geographic nature, notes that part of what makes its practice community-based is that many providers and consumers live close by, thus allowing doctors to become intimately familiar with patients' local contexts. The practice of PHC must also be responsive to the highly localized needs of community residents while addressing regional and national, if not international, priorities. Such a reality references the geographic concept of scale, which is often used to explain relationships among systems and across places. In considering the practice of PHC in Canada, Wiles and Rosenberg (2009) contend that geographical scale underpins the organization and delivery of care for many reasons, including that how PHC is conceptualized at one scale (eg, in a provincial budget) has implications for how it may be delivered or received at another (eg, in a particular community clinic). The outcomes of such a reality are numerous and can include a mismatch between national, regional, and local priorities, or a push at the national level for a PHC initiative that has little or no relevance to a local community.

Equity

Central to conceptualizations of PHC is that such care must be offered equitably (Hall and Taylor, 2003), which pertains to the 'extent to which access to health care and quality services are provided on the basis of health needs, without systematic differences on the basis of individual or social characteristics' (Haggerty *et al*., 2007: 304). The WHO initially forwarded the PHC agenda in order to achieve 'health for all' (Pappas and Moss, 2001), which, by its very nature, requires meeting the needs of everyone and hence evokes equity. Haines *et al*. (2007) suggest that ensuring equitable and affordable first-contact care is how many developed nations, in particular, have infused the PHC mandate into their systems. Importantly, equity in health outcomes is also of great importance to PHC, in that its effective delivery may ultimately positively affect the distribution of health across populations (Broemeling *et al*., 2006).

Equity can be interpreted in numerous ways, one of which is from a geographic perspective. Concern with issues of equity tends to bring about a focus on difference, such as in the standards of care provided across patients or clinics and in people's abilities to access needed care (Bowen, 2001). Examining the ways in which these and other important differences are manifested across space and how they, in turn, affect the provision of PHC is an example of how a geographic lens can be applied. Hanlon (2009), in reflecting on how PHC is accessed and utilized, points out that 'distributional equity' is a core issue, in that people can reasonably expect that such care will be distributed across space in a way that is sensitive to where people are located. Such a focus on equity necessitates consideration of the foundational geographic concept of 'space', which can be thought of as that which contains the flows of everyday life (Gregory, 2000). Drawing on the findings of an ethnographic study conducted in Perú, Gold (2009), for example, demonstrates that the presence of user fees negatively affects the equitable provisioning of such care across space. Furthermore, Yantzi and Skinner (2009) use the results of two qualitative studies focused on the provision of home and community care in Ontario, Canada to suggest that equity in PHC relates also to the differential valuing of those who provide care across settings throughout

space, whereby formal care providers in the home are typically paid less than those in institutional settings. At the more macro-scale, another deeply spatial issue related to equity in PHC provision pertains to the acknowledgement and appropriate accommodation of differences – in population size, health status, and health service provisioning – across rural and urban spaces.

Access

The need for PHC to be accessible to all was written into the Declaration through its call for 'universally accessible' care and has since been translated into system priorities across jurisdictions (WHO, 1978). Haggerty *et al*. (2007) suggest that first-contact accessibility in PHC relates to 'the ease with which a person can obtain needed care (including advice and support) from the practitioner of choice within a time frame appropriate to the urgency of the problem.' Accessibility further relates to services accommodating the needs held by diverse patients (Haggerty *et al*., 2007). Access is also inherently related to equity. For example, barriers such as lack of geographic access to services, to money to pay for care, to culturally appropriate care, and to needed health treatments decrease the equitability with which PHC is offered (Bowen, 2001).

In thinking geographically about access to PHC, the issue of proximity, as in one's physical location relative to services, becomes apparent. There are, however, numerous other ways in which access is a core geographic concept. Conradson and Moon (2009), in drawing on research conducted on walk-in centres in two coastal communities in England, suggest that putting services in places where marginalized individuals reside does not necessarily ensure that they will ultimately decide to access such care. They make the point that providing care that is local is not the same as providing care that meets the needs of, and thus is accessible to, marginalized individuals in a particular location. Related to this, Kearns and Neuwelt (2009) draw upon their observations of PHC practice in New Zealand to demonstrate that accessibility must also be considered as it relates to effectively encouraging communities in particular places to participate in PHC. Both of these examples draw on the geographic concept of place, which pertains to 'bounded settings in which social relations and identity are constituted' (Duncan, 2000) (ie, places are physical locations). Place is relevant to the practice of PHC in numerous ways; for example, the environment of a clinic, such as whether or not the place is understood to be welcoming or inviting, may enhance people's decisions regarding accessing care. Considering the implications of people's movement between places, such as through the process of immigration, in delivering culturally accessible care is also important when providing PHC.

Revisiting importance

Perhaps the best way to summarize the importance of applying a geographic perspective in PHC research and practice is to consider what happens when geography is ignored. Based on what we have argued above, this would lead to care most likely not being offered in the most equitable and accessible ways possible in, by, and for communities. In practice, we would see things such as PHC providers in rural and urban areas working from the same care models, patients from cultural minority communities being assumed to have the same access to care as other citizens, and decision-makers siting services based upon political will or citizen demand with no consideration given to factors such as population change or transportation routes. While these examples may seem extreme, though certainly not impossible or implausible, they do serve to demonstrate the importance of applying a geographic lens to PHC research and practice. If more PHC researchers were to take seriously its geographic nature, including thinking about issues such as space, place, and scale in their studies, then we would surely have more responsive care systems.

Conclusion: where do we go from here?

At the outset of this short paper we stated that our objective was to introduce the geographic nature of PHC. To achieve this we have overviewed the ways in which community, equity, and access are core geographic concepts related to PHC and also outlined the concepts of scale,

space, and place, which are fundamental to the discipline of geography. A long-term objective is to have researchers and clinicians alike engage with applying a geographic lens to their work. There is no singular way to go about doing this. We have outlined a detailed research agenda for geographic inquiry into PHC elsewhere and so shall not repeat ourselves here (see Crooks and Andrews, 2009). Beyond this, useful entry points – methodological, empirical, and theoretical – are provided by key reviews of health geography (eg Kearns and Moon, 2002; Parr, 2003). In summary, researchers must integrate multiple perspectives, including those of the social science and health service disciplines, in order to usefully address the more socio-spatial aspects of how PHC is delivered, consumed, and practiced in particular places and across space at all scales. The findings of this research will then be well-positioned to inform PHC practice and administration that is geographically sensitive to issues of community, equity, and access.

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[1] We heavily draw upon this book in the present paper as it explicitly addresses the geographic nature of PHC and, thus, is highly relevant to our arguments. It should be noted that all contributions were carefully reviewed by the editors. Further, a number of the chapters present, in new ways, the findings of studies, which have also been published in highly regarded peer-reviewed journals.