

**Ms. Denise Fry BA (Hons)**  
**(government and public administration, USyd)** \_\_\_\_\_

*Since 1976 has worked in many areas of primary health care, including health promotion, community health services, policy analysis and evaluation. She has also published in these areas. She has been involved in the General Practice Strategy as a member of the Divisions Evaluation Advisory Group (1994-98) and the Divisions Development Advisory Committee (1998-2000). She is a member of the Pharmaceutical Health and Rational Use of Medicines Committee. Since 1997 she has worked as a consultant in the areas of primary health care and general practice development.*

**Dr. John Furler MBBS MRCGP GradDipPubHlth** \_\_\_\_\_

*Is a general practitioner at North Richmond Community Health Centre, working in the cultural diversity of inner Melbourne. He also works half time as a senior lecturer in the Department of General Practice and Public Health at the University of Melbourne. He has provided support to Divisions in the area of access and equity, and is involved in evaluation of Divisional activity in addressing health issues for disadvantaged groups. He has worked in a range of primary health care systems from the NHS in the UK to Aboriginal community controlled health services in remote Australia.*

**Denise Fry and John Furler**

# **General practice, primary health care and population health interface**

## **11.1 Introduction**

This chapter seeks to explore the interface between general practice, primary health care and population health in Australia. To do so, the chapter will:

- explore definitions of key terms, and refer to the debate over meaning and interpretation;
- locate Australian debates and approaches within an international context;
- briefly describe the national policies and programs relevant to these areas;
- propose a framework that describes the interface between general practice, primary health care and population health;
- identify current issues; and
- comment on future directions that may assist general practice and primary health care to contribute more strongly to population health.

At first glance, the conventional interpretations of primary health care (treating individuals who are seeking care) and population health (program-wide activities that protect the health of the whole population) seem to be far apart. Indeed, this chapter will argue that in Australia in the last 15 years policy and funding frameworks for these two areas have occurred with little cross-reference. Despite this, an international debate is now rethinking the interface and the relationships between population health and primary health care, including general medical practice. This rethinking is influenced by an analysis of general practice in a wider primary health care context, by the identification of barriers to the improvement of the health of the population and by considering strengths and weaknesses of population health practice within broader health systems (Bhopal 1995; Boppard Conference 1997; Sanders 1998; Beaglehole & Bonita 1997).

In Australia, the debate on the relationship between primary health care and population health is influenced and complicated by concerns about the place of general practice in the health system, the sustainability and effectiveness of current health care arrangements and relationships between Commonwealth and State governments.

## 11.2 Methodology

An international literature review was undertaken to gather material for this chapter. Given our brief to ‘identify current issues and hot topics and to comment on how they might influence future directions for general practice’, we searched the Medline database and the Australasian Medical Index from 1990 onwards. Three searches were conducted. The first combined terms for general practice with terms for public health and terms for primary health care. The second combined terms for primary health care with terms for health care reform. The third combined preventive medicine and terms for general practice with terms for primary health care. Abstracts were then reviewed and selected for their relevance to the chapter topic. Additional key materials published before 1990 supplemented this literature review.

## 11.3 Background and definitions

This section will explore definitions and some key terms and consider the background to the development of these definitions. It will also describe components of the primary health care sector in Australia.

### 11.3.1 Public health, new public health and population health

Approaches to health that are concerned with the health of populations rather than individuals have a long history and go back to Hippocratic Greek traditions (Rosen 1958; Porter 1997; Porter 1999). Like all important terms, the definition and scope of population health has been contested.

A number of writers (Baum 1998; Beaglehole & Bonita 1997) have shown how the term ‘public health’ has been used in different ways over different periods of time depending on the paradigm that dominated medical practice and social thought at the time. Some historians of public health have traced this process specifically for the United Kingdom (UK) (Acheson 1991; Lewis 1991) and the United States (US) (Fee 1991) and other countries (Porter 1994). A detailed history of Australian public health debate, practice and achievements is yet to be written (Lewis & Leeder 1998).

Beaglehole and Bonita note that the term ‘new public health’ was first used by H.W. Hill in the US in 1916 to denote changed public health responses following advances in bacteriology (Hill 1916). Acknowledgement of the importance of social, economic and political factors on the health of populations is a continuing theme in public health discourse, as is the debate on the need to ensure its practice addresses these factors. Baum argues for the use of the term ‘new public health’ as an ‘all-embracing term [signifying] an interest in the broad range of social, economic and political activities implied by the Ottawa Charter [see below] and a commitment to community participation’ (Baum 1998:512).

Central elements of the definitions of public health proposed by several key groups and writers, and which we include in our understanding of the term population health, are:

- collective responsibility for health and a prime role for government in carrying this out;
- a focus on whole populations;
- an emphasis on prevention;
- concern for underlying social, economic and cultural determinants of health;
- a multidisciplinary approach that uses quantitative and qualitative methods as appropriate; and
- partnership with the populations served (Beaglehole & Bonita 1997; Acheson Report 1988 Baum 1998; Public Health Association of Australia 1997).

We agree that recognising the impact of these factors is important for both clinical practice and population health practice in improving and maintaining the health of populations.

Public health strategies include legislation, surveillance, control of infectious diseases, programs designed for whole populations (for example, mothers and children) and the collection and analysis of epidemiological information. These strategies are usually encouraged, directed and/or funded by governments in order to safeguard the health of the whole population or nation. In contrast, clinical medicine has traditionally focused on the problems of individuals.

In this chapter, we have used the term ‘population health’ rather than ‘public health’ to indicate that we are concerned with how general practice and broader primary health care programs can contribute to improving the health of whole populations. In addition, as some people interpret ‘public health’ to mean health services for the already sick funded by public money (such as hospitals), the use of the term ‘population health’ may avoid this kind of confusion.

### 11.3.2 Primary health care

‘Primary health care’ is another contested term. Debate around its scope and intent has reflected confusion between a description of current approaches and the advocacy of possible developments (Fry & Baum 1992; Mullan 1998).

The World Health Organization (WHO) was largely responsible for giving the term ‘primary health care’ new meaning and currency in 1978 with its Alma Ata Declaration on Primary Health Care (WHO 1978). The World Health Organization was seeking a conceptual approach to health care that could address the problem of serious health inequalities within populations and between nations (Newell 1987; Roemer 1994). The addition of ‘health’ to the term ‘primary care’ signalled an extension in the scope of care from illness treatment to health development and an extension from medical practice to broader multidisciplinary approaches that include the active engagement of the populations served (Sanders 1998).

The World Health Organization’s policy on primary health care conceptualises it as both the first level of care (that is, first contact care) and a particular approach to health care (Mahler 1998). A key element of the WHO policy and its Alma Ata Declaration on Primary Health Care (WHO 1978) is the importance of a primary health care infrastructure capable of reaching all members of communities, at individual and population level, and of involving them in accessible health programs relevant to their needs. (Tarimo and Webster 1994; Werner & Sanders 1997). Twenty years later, at the second WHO primary health care conference in Almaty in 1998, the strategies of strengthening local primary health care infrastructure, involving communities and including actions beyond the health sector, were seen by the WHO as more important than ever in improving the health of populations. (WHO 1998; Sanders 1998). Throughout this chapter we use the term ‘primary health care’ in this broader definition; that is, we mean both first level care (primary care) and a conceptual approach as outlined by the WHO. The essential elements of this approach are a concern with coverage and accessibility, the involvement of people in strategies to address problems, and partnerships within and beyond the health sector in order to address the determinants of health.

### 11.3.3 A spectrum of approaches

WHO's Ottawa Charter for Health Promotion (1986) subtitled 'Towards a new public health', brought together the conceptual approaches of public health and primary health care. The Ottawa Charter recognised the interaction of individual and social determinants of health and therefore encouraged the use of multiple strategies to improve health. Five types of strategies were encouraged:

- the development of personal skills;
- the reorientation of health systems;
- the strengthening of community action;
- the creation of supportive environments; and
- the development of healthy public policies, within and beyond the health sector, including education, agriculture, transport and environmental safety et cetera.

The Healthy Cities movement is an example of this broad approach (Ashton 1992) and includes several Australian examples (Baum 1993; Baum 1998). Health professionals, including medical practitioners, will be one of many groups who contribute to population health.

A spectrum of approaches to primary health care can be identified within the extensive literature that is available. A more narrow view would focus on providing the first point of contact within the health system for individuals and on responding to the already developed health problems of individuals. At the other end of the spectrum is the broader WHO view of primary health care as a model for health system development that extends to the health promotion of populations (Rifkin & Walt 1986; Tarimo & Webster 1994).

A definition of primary health care developed in Australia to suit the needs of this country is:

Primary health care seeks to extend the first level of the health system from sick care to the development of health. It seeks to protect and promote the health of defined communities and to address individual and population health problems at an early stage. Primary health care services involve continuity of care, health promotion and education, integration of prevention with sick care, a concern for population as well as individual health, community involvement and the use of appropriate technology (Australian Health Ministers' Council 1988; Commonwealth Department of Health and Family Services 1998).

This definition implies the involvement of medical practitioners, other health professionals and the community itself.

The spectrum of views on primary health care mirrors the range of interpretations of public health noted by Beaglehole and Bonita (1997). In their words 'public health has always been pulled in two directions: towards a broad focus on the underlying social and economic causes of health and disease and towards a narrow medical focus' (Beaglehole & Bonita, 1997:212). But between the ends of the spectrum there is room for activities which can keep individual people healthy in an immediate way and for programs that address broader social and economic determinants of health in a longer term way.

A number of key population health activities, such as immunisation, pap smears and antenatal care, require personal interaction between individuals and health professionals. Health education and promotion needs to be tailored for individuals and for groups in the community. A broad view of population health incorporates disease prevention, health education, health policy, environmental concern and community empowerment (Beaglehole & Bonita 1997).

A primary health care sector that can reach all of the population in a regular and ongoing way is needed if all members of the population are to benefit from contemporary knowledge in disease prevention, early detection, evidence-based care and health promotion. Population health strategies (such as legislation, policy development, surveillance and national data analysis) need to be supplemented by the interaction between health professionals and people, which is the core of primary health care.

### 11.3.4 General practice

A key development of the last 15 to 20 years has been the emergence of general practice as a specialist discipline of medicine in its own right with a specific postgraduate training program, ongoing quality assurance requirements and academic infrastructure. The Health Insurance Commission requires doctors who wish to be 'recognised general practitioners (GPs)' for the purpose of reimbursement to be either trainees in the Royal Australian College of General Practitioners (RACGP) General Practice Training Program, fellows of the college or to be vocationally registered.

The Royal Australian College of General Practitioners uses the following definition:

a general practitioner is a doctor who provides primary, continuing, comprehensive whole person care to individuals, families and to the community (Royal Australian College of General Practitioners 1999).

Starfield has identified cardinal and associated features of primary medical care. Cardinal features are first contact access, longitudinality, comprehensiveness and coordination. Associated features are community orientation, cultural sensitivity and family centredness (Starfield 1996; Starfield 1992). These are similar to those features identified by the RACGP.

'Primary care', meaning simply the system of first contact care, is a term falling into disuse to some degree, although it is often used interchangeably with 'primary health care'. We take it to mean the system of health care workers which provides locally-based first contact care and health promotion to communities and includes GPs, pharmacists and community health practitioners. 'Primary medical care' is also a term used to specify the role of general practice within the primary care system.

From our discussion, we acknowledge that there is a tension between the way that primary care (first contact) services, including general practice, operate and the limited extent to which they are able to use a conceptual framework informed by broader primary health care principles.

It is worth noting that this discussion over the definition of general practice and its place in the broader health system has taken place relatively recently within Australia. Perhaps before this time GPs and others presumed the purpose and parameters of general practice were obvious and therefore did not require definition or delineation from other types of health care. The National Centre for Epidemiology and Population Health discussion paper 'W(h)ither Australian general practice?' noted the lack of an accepted definition of general practice while exploring the possibilities of one (Douglas & Saltman 1991). A subsequent report discussed a range of options for GP financing without raising the question of 'financing what?' (Douglas 1991). The public funding of both medical education and the majority of spending on general practice, as well as changing consumer and community expectations, mean that the degree to which general practice contributes to the improved health of both individuals and populations will increasingly come under scrutiny. It is in this context that general practice needs to examine its interface with, and contribution to, primary health care and population health.

### 11.3.5 Australia's primary health care sector

Australia's primary health care sector is a complex mix of public and private services and of Commonwealth and State government funded programs.

Its main components are:

- general medical practice;
- community health services, staffed by mainly non-medical health professionals, in programs mainly funded and managed by State governments and/or their area regional health services and some non-government agencies; and
- community care programs to support frail aged and disabled people—these programs are mainly funded by the Home and Community Care Program (with Commonwealth/State cost sharing) through State-based human services/community services and/or some health departments, and are usually run by local government and non-government agencies.

General medical practice is provided by approximately 17,000 recognised general practitioners and about 5,000 other doctors within a fee-for-service framework. This makes consultations with individuals the main 'unit of currency' that structures general practice work and reimbursement. Divisions of general practice and the Practice Incentives Program offer some opportunities to GPs to be paid in other ways for other kinds of activities, but, generally, individual consultations provide the bulk of their work and income. GPs conducted 102.5 million consultations in 1998–99, with an average of 5.4 consultations per head of population per year. GP items accounted for \$2.39 billion of Medical Benefits Schedule (MBS) expenditure in 1998–99. This accounted for 36 per cent of total MBS spending in that year (Commonwealth Department of Health and Aged Care 1999a).

Community health services consist mostly of multidisciplinary teams of salaried non-medical health professionals and are by and large funded by State governments. These teams have responsibility for protecting and promoting the health of defined populations. Service components variously include health promotion, aged care, home nursing, mental health, the screening of school children, maternal and child health, counselling for social and emotional problems, drug and alcohol services, palliative care, women's health, sexual health services, programs for non English-speaking people and community development projects. Services for individuals include home visits, and programs for groups and community organisations are provided.

Compiling national and current data about community health services is difficult due to the complexity of the sector and its diverse organisation. Data collected by the Australian Community Health Association in 1993 identified approximately 23,500 staff based in 4,760 centres/services (Australian Community Health Association 1993). Since that time there has been a considerable expansion of post hospital discharge programs (called variously 'hospital in the home', 'post acute care', 'ambulatory care' and by other titles). Some are administered by hospitals, some by community health services. There is insufficient information at national and State level to accurately describe the size and scope of these services and their relationship to more primary health care oriented services.

Deeble, Mathers et al (1998) have reported on State and Territory spending on community health services during 1995–96. Their findings are contained in Table 11.01. These figures indicate a large sector comparable in size, if not expenditure, to general practice.

Because of their salaried nature, community health practitioners are able to be involved in a wide variety of individual, group and community-wide programs, unconstrained by a fee-for-service structure (Sindall 1992; Legge, Wilson et al 1996; Baum 1998).

**Table 11.01 State/Territory Expenditure on Community Health Services (1995-96)**

	Total Spending \$ million	% of total state health expenditure
NSW	553.1	10.8
VIC	200.5	5.9
QLD	265.7	10.9
WA	154.8	10.4
SA	173.6	14.1
TAS	20.7	5.4
ACT	12.7	4.8
NT	52.2	18.4
Total	1,533.30	1,395

Source: Tables A4: 5-A4.12 pp120-123, Deeble, Mathers et al 1998

General medical practice and community health services have generally had a tradition of ‘separate development’ due to a range of differences in service organisation, funding systems, management styles, services offered and approach. There is evidence of growing collaboration, especially between divisions and general practice and community health services (McMaugh, Fry & Dougan 1998; Swerrisen 1998).

The community care sector is complex and includes services such as home nursing, home help, community transport, allied health services, delivered meals, personal care, home maintenance, day care centres, respite care services and information and counselling services. There are about 3,000 services across Australia funded by \$823.4 million (costs shared by the Commonwealth and the States are 60% and 40% respectively). They are increasingly important services for improving the health and wellbeing in the aged and disabled population and in assisting them to live independently in their own homes. In an average month, the HACC program provides support for over 275,000 people (Commonwealth Department of Health and Aged Care 1999b).

### 11.3.6 Summary of the debate on definitions

The diversity of the Australian primary health care sector is reflected in the range of interpretations of the scope and practice of primary health care and population health. Discussion over interpretations continues to centre on the relative dominance played by biomedical and epidemiological concepts and by the medical profession. There is also debate on the role of broader social, economic and environmental factors and the place of community education, development and participation strategies.

Debate over definitions and implications of meaning will continue, as words that involve important and strongly held values are particularly prone to transformations and interpretations. This is why they have been called ‘key words’: keys to certain values, traditions and cultures (Williams 1983). Indeed, individuals and groups need to have this debate to explore their ideas and values in order to develop, in Ted Marmor’s words, their own ‘treaties of words’ which reflect purposes and values (Mullan 1998). The important thing is to acknowledge these purposes and values and make them explicit.

**Table 11.02 From nations to individuals: a health spectrum**

Population Health	Primary Health Care	General Practice
Responsible for :	Responsible for :	Responsible for :
Nations and states	Regions and communities, families and individuals	Communities, families and individuals
<ul style="list-style-type: none"> <li>● Laws and policies to support a healthy society</li> <li>● Funds progress to protect/promote the health of the population.</li> </ul>	<ul style="list-style-type: none"> <li>● Developing health communities</li> <li>● Early detection of health problems in communities</li> <li>● Assess and management of health problems of individuals</li> </ul>	<ul style="list-style-type: none"> <li>● Health promotion and information</li> <li>● Diagnosis and management of health problems of individuals</li> <li>● Referral to specialists</li> <li>● Collaboration with other health services</li> </ul>

Figure 11.01 seeks to illustrate the interface between population health, primary health care and general practice. All three areas overlap, but each has an area that remains distinctive from the others.

## 11.4 Locating the Australian debate in the international context

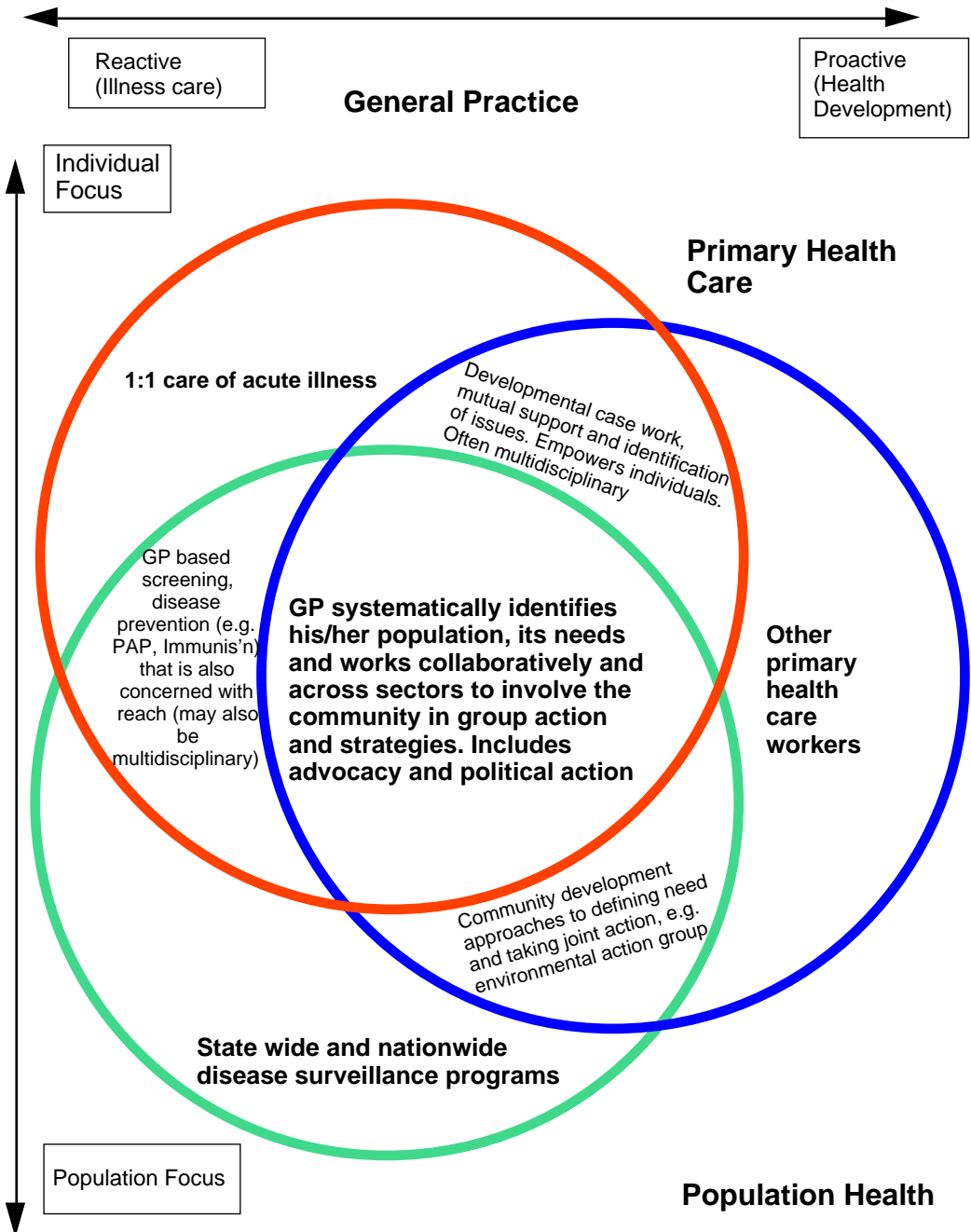
This section seeks to locate the debates about general practice, primary health care and population health in an international context. There is a large contemporary literature on these subjects, and the debate is international and lively. Due to pressures of space, this chapter will not give a full review of the literature. However, we wish to outline some key points.

### 11.4.1 Population health

There is an international debate regarding the scope and capacity of population health and of the role of epidemiology within it. General practitioners and others developing an interest in population health should be aware of the parameters of the debate in order to assess which aspects of population health are feasible and appropriate to apply in a primary health care setting.

Beaglehole and Bonita (1997) note the ongoing discussion on the definition, scope and nature of population health. They argue that part of the problem is that many governments espouse a broad definition and then apply minimalist strategies, thus making it difficult for population health to achieve its ambitious aims. For all countries, the resources devoted by the state to population health are only a tiny fraction of those spent on medical care (Beaglehole and Bonita 1997:152). The political pressure for governments to respond to what are seen as more pressing priorities in health and other policy fields often results in population health issues being moved down the agenda.

**Figure 11.01 Diagrammatic representation of the interface between GP, PHC and Population Health. Based in part on Centre for Health Equity Training Research and Evaluation 1998**



The techniques of epidemiology and its place in population health have also received attention in the international debate (Pearce 1996; Susser & Susser 1996). The development and application of clinical epidemiology has produced much valuable evaluation of medical services. However it has meant that some epidemiologists have moved away from the population perspective and instead focus on groups of patients and outcomes of treatments (Last 1988). This type of epidemiology ignores the unique feature of populations (the interaction between inhabitants and their environment) and instead isolates individual characteristics and risk factors from their social context (Beaglehole & Bonita 1997:120; Krieger 1994).

Epidemiology as a discipline and profession needs to regain its population perspective; this means focusing on the main health issues that affect the population and seeking to apply this knowledge to health and other public policies to improve the health of all the population (Scott-Samuel 1995; Remington 1990).

Health systems can be evaluated from a population perspective; that is, their degree of effectiveness in improving the health of the whole population.

For instance, in a comparison of population health outcomes in 11 Western industrialised nations, Starfield concluded that countries with a strong primary health care infrastructure achieve better health outcomes, as found in statistics related to mortality, morbidity and preventive care (Starfield 1996; Starfield 1992). Starfield commented that the different effects of the health services across these countries can be explained by the way in which resources are distributed, the degree to which resources are organised to achieve the function of primary health care and the clarity of roles and interrelationships between GPs and medical specialists.

This brief sketch of the international debate indicates the global nature of the issues that Australian policy makers and primary care practitioners are addressing. There are no neat answers, but the literature points to the need to take a broad view of major health determinants rather than a narrow focus on individual health issues. There is also a need to see population health as a multidisciplinary practice that requires the collaboration of population health researchers, medical and other health professionals and the public. Population health is a broad scientific and social enterprise that aims to improve the health of all people. It includes, but goes beyond, a set of specialised professional techniques.

#### 11.4.2 Primary health care

The international debate on primary health care has focused on the experience of countries in implementing the WHO Alma Ata declaration, on major factors that have hindered the development of primary health care led health systems and on the extent to which it is desirable or possible to influence determinants of health beyond the health system.

Tarimo and Webster (1994) reviewed international responses to the implementation of primary health care by governments since the Alma Ata declaration. They concluded that six major misinterpretations, or incomplete understandings, of the meaning and implications of primary health care have influenced the development of health systems by governments. These misinterpretations, and Tarimo and Webster's response to them, are listed below:

- *Primary health care is simply community based care.*  
The creation of community based programs alone, without changes in other supporting health structures and in the overall allocation of resources, is not sufficient to improve the health of all the population;

- *Primary health care is simply first level contact care.*  
Primary health care includes first contact care but needs to go beyond it to include the development of health;
- *Primary health care is only for poor people in developing countries.*  
Primary health care is indeed health and cost effective for developing countries. However, richer and more technologically developed countries also need to make difficult choices about resource allocation. With an enormous increase in demand for health services and technological capacity, considering cost and effectiveness is even more important. Reconsideration of primary medical services (general practice) will occur in this context;
- *Primary health care is a core set of health services.*  
The Alma Ata declaration defined a number of essential elements of primary health care as the minimum range of activities. However, some countries have selected elements and discarded other key elements, such as essential drugs and the treatment of common illnesses. A comprehensive approach is needed;
- *Primary health care is concerned with rural areas and is opposed to technology.*  
Primary health care recognises the value of technology, particularly in appropriate and cost effective forms. Problems of coverage and comprehensiveness may show up more starkly in rural areas, but they have general applicability in urban and rural areas;
- *Primary health care is cheap.*  
Some countries view primary health care as desirable because they presume it requires a minimum of resources. Primary health care is better described as 'cost effective' rather than cheap. Countries whose populations have high morbidity and mortality and/or who have not previously had access to health services need to invest money in health and in social and economic development to improve health.

Tarimo and Webster concluded that many countries have successfully implemented some elements of primary health care and that in these countries there has been a more equitable distribution of health resources and the development of new types of health workers.

However, major problems remain, particularly where fragmented vertical programs have narrowed the scope of primary health care to specific issues and technical interventions. The political commitment and financial resources allocated to primary health care by governments have not been adequate (WHO 1998). Some countries have made choices between the essential elements of primary health care and implemented piecemeal programs. Similarly, many countries have made choices between preventive and curative services, between basic and applied research and between hospitals and frontline units. The point is not to make 'either/or' choices but to decide on an appropriate mix (Sanders 1998).

Parts of this critique of the implementation of primary health care can be applied to the Australian situation. While Australia has developed a series of national strategies for some health issues (for example, mental health, HIV/AIDS), for some population groups (women, Aboriginal people) and for parts of the health system (general practice), an integrated Commonwealth/State strategy for primary health care is yet to be developed (Milio 1992; Fry 1994; Baum 1998).

However, Australia does have many innovative multidisciplinary primary health care programs that mobilise a range of skills to provide curative, preventive and educative programs to communities. Non-fee-for-service structures enable flexibility of function. Many community health centres have developed the long term collaborative relationships needed to foster community and organisational development (Furler 1997; Baum et al 1999).

Australian community health services have some innovative approaches to increasing partnerships with communities, particularly within Aboriginal community controlled health services (Couzos & Murray 1998; Saggars & Gray 1991). These services are managed by Aboriginal community organisations and provide clinical, education, community development and population and environmental health programs. The services have included primary medical care as an essential component of their work. Doctors working in these services are encouraged to be actively involved in needs assessment, 'community owned' disease prevention programs and community development projects. They also work as part of multidisciplinary teams and collaborate with Aboriginal health workers. This flexibility of function is enabled by medical practitioners receiving a salary rather than fee-for-service payment as well as having medical staff work under the management of the community.

Other examples of comprehensive primary health care are the community health centres and women's health centres that retain medical staff. These centres are found most frequently in Victoria and South Australia. The history and practice of this model has been studied by Baum et al (1996), who concluded that the inclusion of GPs within these centres enabled the integration of clinical care and health promotion as well as fostered an emergence of socio-environmental understandings of health. Baum et al (1996) called for the establishment of a national primary health care policy that would facilitate the development of this alternative model of general practice. So far, the General Practice Strategy has not chosen to develop this model of multidisciplinary teamwork. A number of key writers (Werner & Sanders 1997; Tarimo & Webster 1994; Baum 1995; Baum 1998) agree that primary health care needs to:

- reach all the population;
- include curative, preventive and community development activities;
- be based on partnership with communities;
- be multidisciplinary; and
- be a well-supported part of the overall health system.

### 11.4.3 General practice

This section looks at some of the literature that has considered how general practice might go beyond the care of individual patients and develop its interface with population health.

One UK based model of care has been developed by Julian Tudor-Hart. He describes it as 'anticipatory care', whereby the GP takes on responsibility for actively seeking out and treating risk factors within a defined population. Anticipatory care seeks out health problems in individuals coming to a general practice and is guided by epidemiological information about the main health issues in the community (Hart 1988; Hart et al 1991). But Tudor-Hart notes that screening and case finding, however skilfully done, are insufficient without planned follow-ups. He comments that, in order to have good anticipatory care with follow-up, 'divisions of labour and a much larger and more diverse primary care team are essential: there is no way one doctor can possibly cover all the tasks of anticipatory care for even the smallest population' (Hart 1988:10).

Population-based anticipatory care is more applicable to the UK, where GPs have responsibility for definable populations (the practice list). More recent developments in the UK have built on the model of anticipatory care and included principles of broader primary health care. They focus on social, environmental and economic determinants of health, including local unmet need, and a strengthening of both community participation and intersectoral action. Major elements of the reforms include:

- the formation of primary care groups (PCGs) led by GPs and nurses (They cover areas of about 100,000 people and aim to develop primary and community health care. Since April 1999, involvement in a PCG has been mandatory for all GP practices. PCGs may exist as advisory bodies, but it is envisaged that ultimately they will all reach a level of independence allowing them to act as trusts and to commission care and manage services) ;
- personal medical pilots, in which a range of alternative employment models for GPs have been suggested, including salaried employees of trusts with contracted public health responsibilities;
- professional development plans, in which responsibility for quality and professional education is seen as a practice responsibility with a clear multidisciplinary focus;
- health improvement programs, in which PCGs, hospital trusts, local government, consumers and a range of other organisations (including private) are charged with improving health outcomes in national health priority areas;
- health action zones, which seek to improve the health of disadvantaged communities; and
- clinical governance, which is a framework for ensuring high quality care through the key concepts of protecting patients, reflective practice and the development of people, teams and systems (Department of Health 1997).

These initiatives are at an early stage of development, and their success will depend on the degree of involvement and enthusiasm from GPs and other health professionals. The response of the profession is not yet clear.

The second major framework developed for improving the population health impact of general practice is known as Community Oriented Primary Care (COPC). COPC was developed by S. and E. Kark in South Africa and Israel and has been implemented to some degree in parts of the US (Kark & Kark 1983; Geiger 1993; Wright 1993). Its key features are:

- a primary care centre based in the community (that is, not hospital-based primary care) ;
- an identifiable population or community for which the practice assumes responsibility;
- a planning, monitoring and evaluation process for identifying and assessing local health problems; and
- liaison and collaboration with local communities.

**Table 11.03 The elements of Community Oriented Primary Care**

The shift from primary care to COPC

Clinical function	Primary care	+	Community approach	= COPC
View of patient population	Individuals (in particular, active users of services)	+	Members of a population (in particular, includes users and non-users of service)	
Method to assess health need	Patient oriented	+	Epidemiological tools	
Planning	Utilisation of service by users	+	Health need of the population, including unmet need	
Use of workforce	Professional specialties and office staff	+	Multiple community participants with a range of skills	
Environmental change	Individualised patient education	+	Community involvement	

Source: Gair et al 1993

The requirements of the model have been summarised by Garr et al (1993) in Table 11.03.

COPC has been implemented in a number of health centres and health maintenance organisations in the US. Its effectiveness depends on increases in the resources of these services to implement an epidemiologically informed model of care and the better educational preparation of doctors and others in social/epidemiological concepts of health (Sapir 1994).

The Centre for the Advancement of Collaborative Strategies in Health, in the New York Academy of Medicine, has recently considered how medicine can better contribute to population health. This centre has published a monograph of over 400 case studies of collaboration between medicine and public health. The purpose of the monograph was to capture what was seen as an increasing synergy between the two sectors.

The academy classified such collaboration by the type of ‘synergy’ produced. These included:

- improving health care by coordinating services for individuals;
- improving access to care by the un/underinsured;
- improving the quality and cost effectiveness of care by applying a population perspective to medical practice;
- using clinical practice to identify and address community health needs;
- strengthening health promotion by mobilising community campaigns; and
- shaping the future of the health system by collaborating on policy, training and research (New York Academy of Medicine 1999).

Very few of the case studies included the work of GPs.

In the last decade, several writers have referred to a ‘crisis in general practice’ (Douglas & Saltman 1991; Rosenblatt 1990; Richards 1993). In general, they are referring to a perceived lack of recognition and remuneration of general practitioners, the marginalisation of general practice in a specialised medical world located within hospitals and a growing number of other practitioners from whom the public increasingly seek help. Roy Porter, a distinguished historian of medicine, has noted the public’s changing expectations of primary care and the subsequent tensions between scientific methods and the solace sought by many patients from the doctor. While science is associated with superior diagnosis and better treatment, it also ‘demystifies, .... creates impersonality, clinical detachment and modes of mechanisation, all of which may seem remote and uncaring’ (Porter 1997:671).

A challenge for general practice in the next century is to apply contemporary scientific knowledge in a way that respectfully acknowledges the patient’s concerns and needs.

## **11.5 A proposed framework linking general practice, primary health care and population health**

Bhopal has summarised the characteristics of primary health care and population health in terms of perspectives, attitudes, knowledge, skills and resources (Bhopal 1995). These, he says, are complementary, as they form part of a comprehensive system. Bhopal’s description of primary health care is essentially taken from the current role of general practice in the UK. We have added a central column to Bhopal’s table (Table 11.04), in which we outline the characteristics of primary health care aimed at improving the health of a community. This additional column encapsulates the areas where we see the interface of general practice and population health. The

**Table 11.04 A Framework linking population health and General Practice**

	<b>Population Health</b>	<b>Primary Health Care at a community level</b>	<b>General Practice (primary medical care)</b>
<b>Perspective</b>	<ul style="list-style-type: none"> <li>Care of populations</li> <li>Environmental, social, organisational and legislative interventions are of dominant importance</li> </ul>	<ul style="list-style-type: none"> <li>Care of individuals, groups and communities</li> <li>Early intervention prevention, education and skills development of the community, tailored to meet local needs and conditions</li> </ul>	<ul style="list-style-type: none"> <li>Care of individuals</li> <li>Medical interventions are of dominant importance</li> </ul>
<b>Professional attitudes</b>	<ul style="list-style-type: none"> <li>Health requires the organised efforts of society</li> <li>Prevention is better than cure</li> </ul>	<ul style="list-style-type: none"> <li>Health development requires applying public health concepts at a local level, as well as providing high quality and integrated individual care</li> <li>Partnership with the community is essential</li> </ul>	<ul style="list-style-type: none"> <li>The consultation is the basis of health care</li> <li>The care of the sick is the prime role, and prevention has a role</li> </ul>
<b>Knowledge</b>	<ul style="list-style-type: none"> <li>Public Health sciences, eg. epidemiology, statistics)</li> <li>Organisational and management issues</li> <li>Policy making &amp; policy analysis</li> <li>Administrative networks</li> <li>Health status of large populations</li> </ul>	<ul style="list-style-type: none"> <li>Population health, epidemiological and social analysis, local area data, qualitative information</li> <li>Community networks, and experience of communicating and working with the community</li> </ul>	<ul style="list-style-type: none"> <li>Broad clinical knowledge</li> <li>Local patterns of disease</li> <li>Communication with individuals</li> <li>Personal circumstances of families/individuals</li> <li>Local community and its services</li> </ul>
<b>Skills</b>	<ul style="list-style-type: none"> <li>Epidemiological and health services</li> <li>Report and policy writing</li> <li>Administration</li> <li>Communication with professional services</li> <li>Committee work</li> </ul>	<ul style="list-style-type: none"> <li>Multidisciplinary cooperative work practices, across individuals and organisations</li> <li>Health promotion and education</li> <li>Advocacy</li> <li>Identification and analysis of health issues</li> <li>Program planning and evaluation</li> <li>Management and coordination</li> </ul>	<ul style="list-style-type: none"> <li>Investigation and management of clinical problems</li> <li>Consultation and communication</li> <li>Small group leadership skills</li> <li>Practice management</li> <li>Medical audit</li> </ul>
<b>Information and material</b>	<ul style="list-style-type: none"> <li>Information on populations and their health in large areas</li> <li>Access to Health Authority resources</li> <li>Access to non-medical staff eg finance, computing etc.</li> </ul>	<ul style="list-style-type: none"> <li>High quality local area data (including access to services data) and well researched community needs,</li> <li>Work infrastructure that supports collaboration between local community and health professionals</li> <li>Pathways for local evaluation and analysis to inform larger policy/funding decisions</li> </ul>	<ul style="list-style-type: none"> <li>Practice register</li> <li>Information on individuals</li> <li>Access to local networks and primary care teams</li> </ul>

(Adapted from Bhopal (1995) by Fry & Furler)

future of work at this interface lies in population health, primary health care and general practice recasting aspects of their work within a broader framework and seeing what they do in a spectrum of health activity. This spectrum links the range of health actions, from the national to the individual level, in an interdependent way.

A recast middle ground between general practice and population health, what we have called primary health care at the community level, with its broad definition of determinants of health and its emphasis on community involvement, may help GPs and other primary health care professionals bridge the gap between ‘big picture’ population health analysis and the ‘real life’ expression of population health issues at the community and practice level. Working ‘in the middle ground’ requires collaboration among a range of groups.

Table 11.05 attempts to describe how general practice currently contributes to population health as well as raises some immediate challenges to the expansion of this work.

Table 11.05 Activities of General Practice that contribute to population health		
<p><b>Activities within individual consultations</b></p> <p><b>1:1 prevention and health promotion</b> (includes Immunisation, Shared Antenatal Care, Shared Mental Health care, Support for breast feeding, Health education (information and advice), Referral to other health promotion programs)</p> <p><b>Disease and risk factor screening and management</b> (includes Cervix and Breast screening, CVD/hypertension screening, Familial cancer screening, Familial diabetes detection, promotion of physical activity)</p> <p><b>STD/communicable disease identification, management and contact tracing</b></p> <p><b>Evidence based management via clinical guidelines</b> (Includes diabetes, hypertension, asthma, quality use of medicines, Hep C etc.)</p>	<p><b>Contribution to surveillance activity</b></p> <p><b>Communicable</b> disease identification and notification</p> <p><b>Immunisation</b> and notification</p> <p><b>Contribution</b> to division wide recall and data systems</p>	<p><b>Contribution to broader population health program</b></p> <p><b>Broader</b> health promotion through involvement to other education and community development programs</p> <p><b>Collaborative</b> activity through involvement in planning and developing programs in divisions</p>
<p><b>Challenge</b></p> <p>How well is this done currently?</p> <p>What are the barriers to improving it?</p> <p>What mix of incentives could be used to improve performance?</p>	<p><b>Challenge</b></p> <p>What could be the potential GP contribution here?</p> <p>What would be the need for IT/IM investment?</p>	<p><b>Challenge</b></p> <p>What is the role of divisions here with regard to advocacy, local needs assessment, community health promotion, and intersectoral action?</p> <p>What is the role of individual GPs within their community vis a vis these activities?</p> <p>What is the potential of a more integrated and well-linked GP system here?</p>

Adapted from Wilson 1999

This section briefly reviews the development and implementation of national policies and programs on population health, primary health care and general practice in Australia in the last 25 years. To date, policies and programs for these three issues have been divergent or parallel rather than coordinated.

### 11.6.1 Population health

At the beginning of the century, State governments were responsible for most aspects of traditional public health practice (ensuring clean water, control of infectious diseases, food inspection, maternal and child health et cetera). Australia did not establish a Commonwealth Department of Health until 1921, twenty years after the nation's federation. The department's first head, Dr J.H.L. Cumpston, Director-General from 1921 to 1945, had ambitious plans to protect and promote the nation's health, but the Depression of the 1930s intervened and only parts of the plan were implemented, including the National Health and Medical Research Council (1936) and the School of Public Health at the University of Sydney (1931) (Lewis 1989).

The postwar period was marked by the dominance of curative medicine in health policy and by the federal subsidisation of private health insurance. In the 1960s, there was growing public and professional awareness of the health impacts of tobacco smoking, road accidents and excessive drug and alcohol use, but preventive efforts were directed at individuals rather than populations (Lewis & Leeder 1998).

In 1985, the Commonwealth Government commissioned Professor Kerr White, a US physician and academic, to review public health and tropical medicine teaching and research and to identify new directions. The subsequent initiatives included the decentralisation of postgraduate public health teaching from the School of Public Health and Tropical Medicine at the University of Sydney to other universities across Australia, and the establishment of the Public Health Research and Development Committee of the NHMRC, the National Centre for Epidemiology and Population Health at the Australian National University (ANU) in Canberra and the Australian Institute of Health, also in Canberra (Blewett 1988). A national infrastructure for postgraduate training, for research and development and for population-wide data analysis was thus in place.

State governments, too, were slowly re-establishing some kind of public health capacity (often in response to the emergence of HIV/AIDS) at this time after a general preoccupation with clinical and funding issues (Palmer & Short 1994).

The Better Health Commission, set up by the federal minister Dr Blewett in 1985, conducted extensive public consultations in its attempt to refocus Australia's health system toward a more preventive approach. Its report recommended that priority be given to cardiovascular diseases, nutrition and injury, but it did not include strategies to effectively re-allocate policy or funds to health promoting activities (Better Health Commission 1986).

As a next step, a Health Targets and Implementation (Health for All) Committee, involving the Commonwealth and States, was established to develop a national strategy to address national health priorities. The Committee's report, *Health for all Australians*, identified national goals, discussed health inequalities and made a series of recommendations for action, including a national primary health care strategy. (Health Targets & Implementation Committee 1988) A National Better Health Program (NBHP) provided funds for innovative health programs at

national and State level for five years. An evaluation of the NBHP found that it stimulated useful and promising programs but that the funding program in isolation could not address the systemic factors that keep health promotion programs a marginal part of the Australian health system (Commonwealth Department of Health and Community Services 1993; Leeder 1999).

There were some examples of a preliminary, if implicit, coming together of concepts of population health and service orientated primary health care. The 1992 National Centre for Epidemiology and Population Health report on health promotion and the role of primary health care noted the lack of links between health promotion programs and primary health care as provided by general practice and community health services (National Centre for Epidemiology and Population Health 1992). The 1988 *Health for all Australians* report recommended a number of wideranging strategies, including Commonwealth/State cooperation to address both health system issues and the underlying determinants of population health (McPherson 1992). State initiatives, such as South Australian Primary Health Care and the Social Health Policy Statements, also sought to apply primary health care strategies on a population basis (Baum 1995; Raftery 1995).

Australia's community health sector has long had proponents keen to apply population health concepts to its work, particularly in relation to health promotion and intersectoral collaboration (Australian Community Health Association 1986; Owen & Lennie 1992; Baum 1995). However, a general policy emphasis by funding bodies on curative services for individuals has not provided a 'favourable milieu' for community health services to extend their health promotion and community development work to all people of their defined communities (Fry 1995).

Since 1987, the Commonwealth has funded the Public Health Education and Research Program (PHERP), which assists universities across Australia to run masters and PhD programs in public health. A 1999 independent review of PHERP commented that 'PHERP investment ... has built a substantial public health workforce' and that, in addition, PHERP should provide a vehicle for funding innovation and development and improved research capacity (Nolan, Bryson & Lashof 1999).

The National Public Health Partnership, established in 1996 by the Commonwealth Department of Health, seeks to revitalise public health and to foster coordination and collaboration between the Commonwealth and the States. It seeks to strengthen public health infrastructure and capacity and to enable a greater 'whole of system' approach to be taken.

There are over 20 national strategies on public health issues. The partnership has established a National Strategies Coordination Working Group to improve the collaboration and adoption of best practice (National Public Health Partnership, 1999).

### 11.6.2 Primary health care

Until the 1970s, the Commonwealth Government had played a lesser part in health policy, funding and program delivery in comparison with the State Governments. A new government in late 1972 brought fresh policy ideas, more funds and a larger role for the Commonwealth Department of Health in both policy and program implementation.

While the term 'primary health care' was not yet part of the discourse (these developments predated the World Health Organization's policy declarations), the government emphasised the importance of universal access to medical (GPs and specialists) and hospital care through the establishment of Medibank in 1974. Professorships in community medicine at a number of

universities were established to further develop general practice as an academic discipline. The Royal Australian College of General Practitioners received funds to devise and conduct the Family Medicine Program, the precursor to the college's current postgraduate training program in general practice (Walpole 1979).

The Commonwealth also funded the Community Health Program, which established an infrastructure of multidisciplinary health centres, staffed by salaried health professionals, with a responsibility to provide curative and preventive programs to a defined population (Milio 1988; Sax 1984; Owen & Lennie 1992). GPs were included in a few of these multidisciplinary centres, mainly in Victoria, South Australia, the Northern Territory and Queensland (Copeman 1992). In an overall sense, general practice has been a small proportion of community health services but important in enabling some primary medical care to be delivered in a multidisciplinary context (Copeman, Sangster & Lennie, 1988; Baum et al 1996).

Following a change of government in 1975, responsibility for the Community Health Program was transferred to the State Governments in 1976. The Commonwealth maintained a nascent interest in health promotion and funded programs emphasising individual behaviour change, such as the 'Life—Be in It' campaign (Davidson, Chapman & Hull 1979).

In 1981, Australia also became a signatory to the World Health Organization's Health for All by the Year 2000 Global Strategy. The WHO Strategy's overall goal is to reduce health inequalities by the development of community-based primary health care systems that can address the main health problems in the population (WHO 1978; WHO 1981). With regard to its domestic health policies, Australia's second version of a national health insurance scheme, Medicare, was in place by 1984. In the mid-1980s, the Commonwealth focused its attention on the health of specific groups and developed national policies and funding programs for women's health, HIV/AIDS and frail aged and disabled people. A national health strategy for Aboriginal and Torres Strait Islander peoples was launched in 1989 (Anderson 1997). This 'many strategies' approach could be seen as Australia's own version of 'selective primary health care' (Rifkin & Walt 1986).

Changes to the community health sector in the last five to 10 years have been stimulated by changes in the broader health system, such as earlier discharge from hospital, new funding systems and organisational restructuring. Many services are now providing more postacute care and report fewer resources and incentives to do health promotion and early intervention work (Fry 1997). Despite these funding and policy limitations, many community health services continue to conduct innovative health promotion and primary health care programs for their communities (Legge, Wilson et al 1996; Baum 1998).

### **11.6.3 The General Practice Strategy**

Since 1991, the Commonwealth has chosen to direct policy and resources to developing the general practice component of primary health care. The General Practice Strategy grew out of a number of political, professional, bureaucratic and public debates about general medical practice and its future directions (Douglas & Saltman 1991; National Centre for Epidemiology and Population Health 1992; Senate Select Committee on Health Legislation and Health Insurance 1989).

The strategy was based on a negotiated consensus between the government and the key medical professional bodies. Its stated goal was ‘to enhance the role of general medical practitioners beyond individual patient care, and to promote better integration of GPs with the rest of the health system (General Practice Consultative Committee, 1992:2). The key initial components of the strategy were:

- the use of practice grants to complement fee-for-service payments;
- standards and accreditation of general practices;
- improved distribution of the medical workforce; and
- development of information technology (Commonwealth of Australia 1991).

A Demonstration Practice Grants Program was part of the initial budget allocation in 1991–92. With a budget of \$10.45 million, this program funded 320 projects, including 10 demonstration divisions of general practice. These projects were funded to ‘foster new ideas for the delivery and funding of general practice services, unconstrained by fee-for-service arrangements’ (Commonwealth Department of Human Services and Health 1995).

Divisions were defined as local networks of general practitioners, operating within a specified geographic area, and aiming to assist GPs to work more closely with each other and the rest of the health system. Divisions are perhaps the component of the General Practice Strategy that have the greatest potential to link general practice with population health concepts and practices. Their geographic focus enables GPs to identify population-based health issues and develop approaches both within and beyond the individual consultation to address these issues. The role of divisions in the broader General Practice Strategy has grown as 123 divisions have been established across Australia and the program has developed (McNally et al 1995; Pegram et al 1995).

Significant changes to the administration of the divisions program occurred in late 1997, with a shift from annual funding (an infrastructure grant plus project funds) to a three-year budget guided by a strategic plan and specific health outcomes to be achieved. State offices of the Commonwealth Department of Health became responsible for the administration of contracts with divisions, and State-based organisations (SBOs) replaced field support services.

A review of the General Practice Strategy was commissioned by the Minister for Health in 1997. A committee of 16 members (representatives of GP organisations, bureaucrats, academics and one consumer) received submissions, conducted consultations and produced a report in March 1998. Overall, the review report continues the general direction and budget of the strategy. The report contains 174 detailed recommendations, including those in relation to divisions (Recommendations 141 to 148) and those that seek to assist GPs to have a broader role in population health (Recommendations 21 to 24).

These specific recommendations state:

- that GPs be assisted to have a broader role in public health;
- that divisions of general practice facilitate and undertake a range of public health activities as part of core business;
- that the public health workforce working group of the National Public Partnership identify measures that will enable trained public health practitioners to work in close relationships with divisions of general practice on local public health initiatives; and
- that a dedicated pool of funds be established and made available to divisions specifically to fund GPs to develop and apply skills in public health initiatives, GPs to be remunerated on a sessional or hourly basis, and that the program be evaluated within 18 months (General Practice Strategy Review Group 1998: xxiv).

Baum (1998) sees the development of the General Practice Strategy as a missed opportunity for the significant strengthening of a broader multidisciplinary primary health care sector which could contribute to a 'new public health' agenda. This is because the strategy gives considerable resources to one part of the primary health care sector (general practice) but does not include other, multidisciplinary components. On the other hand, she acknowledges that 'for the first time in Australia [the General Practice Strategy] has encouraged GPs to come together, and take a population view of the community they serve, opening opportunities for them to integrate more effectively with hospitals and community based health services' (Baum 1998: 47).

The General Practice Strategy suggests new funding arrangements be considered to promote an expanded population health role for GPs, implying acknowledgement of the difficulties in promoting population health in a predominantly fee-for-service funding system. (General Practice Strategy Review Group 1998:90–2). Other national reviews of general practice have noted this tension (National Centre for Epidemiology and Population Health 1992; National Health Strategy 1992).

A further component of the General Practice Strategy has been the General Practice Evaluation Program (GPEP), which has funded evaluation studies and programs of general practice. GPEP was initially established in 1990 to evaluate changes to general practice and the impact of such changes on quality and value for money. A recent study by the National Information Service has evaluated the population health findings and implications of studies funded by GPEP from 1992–98 (Rogers, Veale & Weller 1999). The report recommended that the links between general practice and population health be strengthened and that future general practice evaluation funding programs include a population health perspective to assess the implications of future research.

A range of initiatives in the Commonwealth Department of Health and Aged Care are currently identifying ways in which GPs and divisions can extend their population health roles. A joint advisory group (JAG) on general practice and population health has been established as a collaborative exercise between the National Public Health Partnership and the General Practice Partnership Advisory Council (GPPAC). The JAG has also considered an issues and options paper, which looked at how GPs could extend their population health roles, and recommended options by which this could happen. This paper suggests that various strategies may be possible and includes support for GPs via divisions, more training in public health for GPs, GPs engaging other trained staff to conduct population health and funding incentives (Bollen 1999).

A later issues paper published by the JAG seeks to develop a consensus statement and national policy on general practice and population health. The paper proposes that GPs and general practices are ideally placed to improve the health of Australians through engaging in a systematic and best practice approach to disease prevention, early detection, health education and illness management via evidence-based guidelines. It suggests that financing incentives, education and training and structural support will be needed to extend the role of GPs in population health. A national symposium is planned in 2000 to discuss these issues and to gain national endorsement (Joint Advisory Group 1999).

An additional report from the general practice financing section of the Commonwealth Department of Health also looks at how to extend the population health role of GPs (Towler 1999). The report recommends developing a national policy framework, stimulating debate in order to agree on the exact nature of GP population health activities, developing program funding for general practice population health and recruiting general practice population health coordinators for State-based organisations.

## 11.7 Current issues in Australia

There are many issues in the current professional and policy environment that affect the interface between general practice, primary health care and population health. This section identifies what we see as the key issues and activities and comments on how they may act as both facilitators of, and barriers to, improved population health.

### 11.7.1 The role of divisions of general practice

The first ten demonstration divisions of general practice were funded in 1992. At the end of 1999, there are 123 divisions, and all areas of Australia are included in a division. Divisions have developed and conducted a wide range of activities, funded from 1993–97 with specific project grants and from 1997 onwards with outcomes-based and block grant funding linked to three-year strategic and business plans. The National Information Service keeps a database listing the projects and is in the process of developing a database of divisional strategic plans. While descriptions and analyses of subsets of these projects have been undertaken (for example, Access SERU 1996; Centre for General Practice Integration Studies 1996), there has been no global analysis of the content and outcomes of these projects. Todd and Sibthorpe found the most frequently reported activities included shared care (palliative care, mental health, diabetes, aged care, hospital liaison, women's health, health promotion, general practice, organisational issues, immunisation, continuing medical education, drug and alcohol and local area health need assessment (Todd & Sibthorpe 1995). Divisional activities as listed on the National Information Service Database are shown in Table 11.06.

Rogers and Veale (1999a) have described the changes occurring in divisions' priorities and activities associated with the change to outcomes-based funding. Their evaluation compared the activities and expenditure of 27 divisions in 1996–97 with activities and expenditure in 1998–99. Rogers and Veale found important changes in patterns of expenditure, with increases in expenditure on GP issues (workforce, continuing medical education, management), information technology and immunisation, and decreases in expenditure on needs assessment, all areas of the national health priorities (except immunisation), aged care, and community access and liaison. The authors note 'the central dilemma facing divisions is that of reconciling and balancing the potentially competing demands of providing services and support to GPs while also achieving identifiable outcomes in public health' (Rogers & Veale, 1999a:50).

**Table 11.06 National Information Service Database on divisional activities**

Key word	Divisions database (n = 1452)
Public Health	95
Population Health	32
Primary Health Care	129
Health Promotion	438
Community Development	21
Community Liaison	73
Collaboration and Community	67

The most recent overview of the activities of divisions can be gained from the results of the 1997–98 annual survey (National Information Service 1999). It is important to note that this survey used self-reported data and does not include detailed qualitative information on aspects of divisional activity. The data indicates that the majority of divisions continue to improve their working structures and working relationships to enable them to function as important members of the broader health system. The National Information Service (NIS) report on the annual survey of divisions recommends improved data quality, a better integration of information collected from divisions, a review of the use of evaluation expertise by divisions and further training in management.

At the 1999 divisions forum, three strategic aims for the divisions movement were identified by the Commonwealth Department of Health and Aged Care. They were:

- the improvement of poor health outcomes via a population health approach;
- identifying and implementing cost effective best practice; and
- building a more cost effective system through a commitment to an integrated primary care framework (Furler 1999).

It remains difficult to gain a systemic overview of the degree to which divisional activity addresses population health issues. Nevertheless, divisions remain important structures for improving the interface between general practice and population health as they link general practitioners and other health services within a defined geographic area, thus enabling a population perspective to inform the identification of health issues and the strategies chosen to address them. Several reports have called for greater policy direction for divisions on the balance between the key functions of services to GPs and population health activities (Sibthorpe & Fry 1998; Rogers & Veale 1999; National Information Service 1999).

### **11.7.2 Interaction between divisions and other national health strategies**

Several national strategies initiated by the Commonwealth Department of Health and Aged Care are providing funds to divisions as a way of implementing programs and linking with GPs.

Several of these strategies have population health goals. These strategies include:

- National Immunisation Strategy, in which each division was given funds to improve immunisation levels in its population;
- National Mental Health Strategy, in which \$3 million has been provided to develop primary mental health care programs. Divisions will be assisting GPs to provide this care;
- The National Prescribing Service (NPS), which has funded approximately 30 divisions to undertake activities that assist GPs to carry out quality prescribing. The NPS also provides practice visits; independent expert information to GPs, specialists, pharmacists, consumers and others, and prescribing feedback to GPs;
- National Diabetes Strategy, which is supporting divisions and GPs in the early diagnosis of diabetes and in the application of evidence-based clinical guidelines;
- The Rural Incentives Program, which assists rural and remote areas to retain and recruit doctors to work in their local areas;
- The Divisions and Hospitals Integration Program, which has funded seven divisions to establish programs that help to integrate GPs and hospitals; and
- The National Public Health Partnership and the General Practice Partnership Advisory Council (GPPAC), which have established the Joint Advisory Group in General Practice and Population Health. The JAG is seeking to stimulate debate on how general practice can contribute to population health (Joint Advisory Group 1999).

It is important for evaluation systems to describe and analyse the interaction of all these programs in order to gain an overall picture of their combined efforts and their impact on the health of the population.

### 11.7.3 Coverage of the population

The coverage and accessibility of services are important if general practice-based programs are to contribute to the improved health of the whole population. Problems with the distribution of GPs across Australia mean that some groups, particularly people in remote and rural areas and some indigenous Australians, have inadequate access to primary medical care (National Rural Health Alliance 1997). In some rural areas that do have GPs, long waiting lists can make prompt access a problem (Consumers Health Forum 1998). While there is a large number of bulk-billing GPs in city areas, in some country towns no doctors bulk-bill, thus increasing financial barriers for some groups.

Programs such as immunisation and pap smears require optimal coverage in order to be effective at a population level. If these programs are to be primarily delivered via general practice, the barriers of geographic accessibility, timeliness and financial disincentives need to be addressed.

Community health services are also not distributed in a comprehensive way to all communities. Rural services often have a shortage of physiotherapists, speech pathologists and social workers as well as mental health professionals (National Rural Health Alliance 1997). Some large urban services have had difficulty matching the growing demand for services with their limited supply (Western Sydney Area Health Service 1995).

Achieving optimal general practice coverage in rural areas has been the aim of the Rural Incentives Program, now delivered through State-based rural workforce agencies, with a remit to address 'sustainable GP and support services...., to meet rural community needs' (Rural Workforce Agency of Victoria 1999), through workforce support, supply and training. The National Rural Health Alliance is a larger umbrella organisation formed from twenty member organisations covering GPs, pharmacists, nurses, Aboriginal and Torres Strait Islander health workers and allied health workers. It lobbies for improved rural health under a multidisciplinary, intersectoral, population health framework and sees access to GP services as an element of this (National Rural Health Alliance 1999).

Other emerging policies are attempting to improve coverage in rural areas through the recruitment of overseas-trained doctors and the development of models in which nurse practitioners work independently to provide primary health care services. It has been suggested that GP registrars should undertake a compulsory rural placement during or after their training. Many of these strategies have been strongly opposed by the medical profession.

Within urban areas, ensuring adequate coverage is made problematic by the lack of any GP-patient linkage or registration system.

### 11.7.4 Financing issues

Financing in general practice continues to be the subject of much debate. Details of the shifts in GP financing since the introduction of Medicare and the General Practice Strategy can be found elsewhere in this book and have been extensively detailed in the General Practice Strategy Review.

At the heart of the debate lies an understanding of the perverse incentives provided by the fee-for-service system of Australian general practice, with its rewards for high throughput care (with little evidence of clinical benefit) and disincentive to provide the care and case management of people with complex chronic conditions.

From the point of view of the interface between general practice, primary health care and population health, the fee-for-service system, until recently, has discouraged GPs from consulting with other primary health care colleagues or from taking on a case management role as a part of a multidisciplinary team. The enhanced primary care Medicare Benefits Schedule (MBS) items announced in the 1999–2000 budget allocated \$171 million to enable this kind of activity.

Other budget initiatives included \$200 million to the Practice Incentives Program, the GP immunisation incentives scheme and the GP links scheme (aimed at practice amalgamations).

The General Practice Strategy Review stated a commitment to the fee-for-service system as the main funding source for GPs (General Practice Strategy Review 1998:235). It specifically recommended against compulsory patient linkage to a practice (General Practice Strategy Review 1998:74), which might underpin a capitation-based payment system. The review also recommended an enhanced population health role for GPs. Other commentators have indicated that this precludes the possible use of a powerful strategy for linking GPs more closely to their communities and that this option ought to be revisited (despite the current legal complexities) (Mooney 1998).

The general practice memorandum of understanding (MOU), described elsewhere, provides a framework agreement for general practice that covers an ongoing commitment to divisions, the enhanced primary care MBS items and a commitment to examine other quality initiatives. The General Practice Financing Group (GPF) will be overseeing the \$7.7 billion budget underpinning this. All members of the group would have to agree to any cashing out of sections of the \$7.7 billion for specific population health activities. If this were not possible, other sources of funding for GP involvement in population health would need to be considered. An evaluation of the MOU in this regard would be valuable.

### 11.7.5 Collaboration

‘Collaboration’ has a range of meanings and is usually defined as ‘working together or jointly’ (Fry & Baum 1992).

GPs, other primary health practitioners and population health professionals all need to collaborate with each other. However, there are major structural barriers to collaboration and partnership within Australia’s complex health system. Five major barriers to collaboration within health systems have been identified and are described in the following categories:

- political—health services are subject to different kinds of political control and public accountability;
- financial—the services are differently financed and have different budgetary procedures;
- organisational—the services have different funding structures and administrative procedures;
- professional—there are different professional perspectives and traditions; and
- planning—there are different demands on resources and often different perspectives on what the most urgent problems are (Hudson 1990).

This listing of issues represents a useful summary of some of the differences between GPs, other primary health practitioners and population health specialists.

Australian research on collaboration between GPs and other primary health care practitioners has grown in the last decade. Several studies have shown that cooperation and coordination is possible when policy and funding opportunities enable and stimulate understanding of each others' roles (Craig & Della Putta 1995; South Australian Community Health Research Unit 1994). Effective service coordination develops when time has been invested in developing personal networks that enable mutual trust and respect and an understanding of working styles and contexts. A national study by the Centre for General Practice Integration Studies found that collaboration between GPs and hospitals and community health services takes place but was frequently complicated and, in some cases, undermined by issues of trust and status (Harris et al 1997).

A study of collaboration between divisions of general practice and community health services found a considerable amount of joint activities between the two groups (McMaugh, Fry & Dougan, 1998; Royal Australian College of General Practitioners 1999a). It concluded that while collaboration is possible, it is not straightforward and requires negotiation in order to be successful, particularly in light of the differing policy funding and professional perspectives of the groups. Factors that helped collaboration included a shared set of goals, the ability of collaborating organisations to include goals relevant to their skills and values, formal coordination structures and the early involvement of all players. Hindering factors included inadequate or a lack of timely funding, a lack of formal coordinating structures, differences in perceptions and/or values in relation to teamwork, and a lack of experience in working collaboratively.

A Victorian study has also identified collaborative models between GPs and community health services (Swerrison et al 1998) and recommended a range of strategies that could increase collaboration with regard to policy issues, funding issues, information provision and the removal of structural barriers to improved relationships.

While multidisciplinary teamwork continues to take place in community health services (particularly in relation to health promotion), there have been comparatively few funding or research programs in Australia that have explicitly encouraged multidisciplinary teamwork or sought to uncover its dynamics, beyond some early work in South Australia (Furler 1982). The new MBS item numbers for GPs to carry out care planning, case conferencing and health assessments may encourage greater coordination with other health professionals, if not teamwork.

### **11.7.6 Workforce and education**

The size of the broader population health workforce is difficult to estimate because it includes many occupations, such as GPs, nurses, Aboriginal and Torres Strait Islander health workers, teachers and others, all of which involve some degree of population health activity. Specialist population health occupations, such as epidemiologists, are too small to be enumerated in the national census. Among occupations with some relevance to population health, the 1996 census identified 5,127 environmental health officers, 704 Aboriginal and Torres Strait Islander health workers, 5,501 primary products inspectors and 3,659 safety inspectors. In December 1997, the annual medical workforce survey counted 466 practising public health physicians in Australia, without specifying their work activities (Harding, personal communication).

While all these groups contribute to population health, they have varying professional traditions and, in some cases, little opportunity to work collaboratively.

Legge et al (1996) have estimated that in an average district of 100,000 people there were approximately 130 GPs out of a total of 560 paid primary health care workers. In addition, there were 2,000 non-paid primary health care workers, essentially carers at home looking after sick or

disabled relatives. This report concluded that there was no urgent need for an increase in resources to the primary health care sector but rather a need for skills training, education, integration and other strategies to develop a 'shared consciousness' (National Centre for Epidemiology and Population Health 1992). Similarly, the estimate of the community health sector referred to earlier in this chapter shows a substantial workforce sector comparable in size and with a wide range of health professionals.

The RACGP Training Program recognises population health and the context of general practice as one of five domains in which training should occur. The RACGP's curriculum document aims to produce graduates who are not only competent GPs but also able to meet the needs of communities (Royal Australian College of General Practitioners 1999b). This means training GPs not only in the skills of needs assessment, epidemiology, population health planning and evaluation but also in the skills and attitudes essential for multidisciplinary teamwork and for facilitating community participation. The first cohort from this curriculum will complete their training in three to four years.

Conventionally, education in public health has been conducted at postgraduate level in the form of a masters or doctoral degree in public health and has not generally been incorporated into medical undergraduate training. Internationally, there have been different degrees by which public health has been perceived as a medical specialty, such as in the United Kingdom (Scally 1996a), or as a multidisciplinary domain with a broad body of knowledge and including some professional sub-specialties, such as in the USA (Fee and Acheson 1991). Australia can be seen as about halfway between these two traditions.

It is probable that collaboration within Australia's broad population health workforce has been discouraged by separate education traditions and workforce practices. Wider education in population health principles and multidisciplinary teamwork may assist in improving cohesion and collaboration (Australian Institute for Primary Care 1999).

### **11.7.7 Health inequalities**

There is renewed focus internationally on the existence of continued and widening health inequalities and new empirical evidence supporting social and economic factors as major determinants of these inequalities. In particular, there is growing interest in the role of widening income disparity as a powerful cause of such inequalities as well as the role played by a cluster of factors associated with social inclusion, social capital and a sense of control over the environment (Marmot 1997; Syme 1997; Kawachi et al 1997). This causative link has also been highlighted in a number of recent reports internationally (Acheson 1999; World Health Organization 1998; Access SERU 1999; Royal Australian College of Physicians 1999).

The most important requirement for health is sufficient resources to meet essential needs such as food, shelter, clothing, warmth and security from war. Inequalities in health are derived from inequalities in wealth, power and social resources, which determine the social circumstances in which people live and work. Underlying socioeconomic causes of ill-health include poverty, inadequate housing, poor water supply, insufficient food, a lack of literacy, unemployment and occupational and environmental hazards.

Societies wishing to improve the health of the population need to initiate policies and programs that address the above factors as well as ensure that appropriate health care is available to all. Collaborative work between general practice, primary health care, population health and other public policies beyond the health sector is needed to deal with the complex relationships between the social and economic characteristics of societies, health and disease (Draper 1991; Beaglehole & Bonita 1997).

Population health and primary health care programs can address health inequalities by directing resources and services to groups with specific needs either by providing services that are free of charge and/or geographically and culturally accessible or facilitating organisational and community development activities that can address the factors contributing to health inequalities. Their strength is that they can go beyond the health professional/patient consultation as the main mode of activity.

The National Research Collaboration on Health Inequalities published a framework assessment in June 1999 that is strongly multidisciplinary in focus. The document recognises the role for collaboration with GPs and other health practitioners (Interim National Reference Group 1999).

Traditionally, tackling the issue of health inequalities has not been a concern of GPs or other professionals working in predominantly one-to-one clinical settings. This is partly because such inequalities are 'really only visible at the aggregate level rather than at the individual level' (Bhopal 1995). It is also because acting to reduce health inequalities implies an understanding of the powerful influence of social determinants as well as embracing ways of working collaboratively with other providers, patients and communities and outside the health sector. Nevertheless, there is a growing interest in the role GPs can play in addressing health inequalities in their communities.

However, to substantially involve GPs requires a supportive remuneration structure that both permits and frees them to undertake this work.

In Australia, key general practice organisations have a stated interest in the issue of health inequalities. The General Practice Strategy Review Group noted that GPs 'should become involved in population and public health campaigns aimed at disadvantaged groups (General Practice Strategy Review Group, 1998:133) and recommended that each aspect of the General Practice Strategy be evaluated in terms of its effectiveness in meeting the needs of disadvantaged groups (Recommendation 45). Currently, divisions of general practice are charged with improving health outcomes at the local level. The draft principles document developed recently by the Divisions Development Advisory Committee (which advised the Commonwealth Department of Health and Aged Care) highlighted equity, in particular for disadvantaged groups, as one of the three main principles of the divisions program (Divisions Development Advisory Committee 1999). At a divisional level, improving health outcomes at the local level will involve developing their knowledge of the relationship between social and economic determinants and health. It will also involve acting collaboratively with communities, as part of primary health care teams, and across sectors. They will need skills in local needs assessment and the prioritisation of action.

The RACGP is committed to a general practice workforce with an understanding of national health priority areas, including health inequalities, while recommending that GPs 'work with others to reduce the inequalities in health outcomes for disadvantaged groups' (Royal Australian College of General Practitioners website 1999).

A discussion paper on how general practice can address health inequalities has been published recently (Access SERU, Integration SERU & CHETRE 1999a). The Access SERU has also held workshops on health inequalities at the general practice evaluation conferences in 1998 and 1999. The 1999 GPEP workshop concluded that divisions, State-based organisations and the Commonwealth Department of Health all had a role in assisting the capacity of general practice to address health inequalities (Access SERU, Integration SERU & CHETRE 1999b).

Over the last twenty years, GPs have responded to evidence about the role played by smoking, alcohol, diet and physical activity in health. Responding to the evidence of the social and economic determinants of health inequalities is a more complex task and requires action within the consultation as well as the need for collaboration within and beyond the health sector.

Strategies at both divisional and GP level fall largely into the categories of access, empowerment and participation, and advocacy. Access to care is an important factor in addressing health inequalities. Financial, cultural and geographic barriers to accessing care result in delayed help seeking, less use of preventive measures and more expensive and complex health interventions. On the other hand, increased access to primary health care, in particular the general practice component, is not of itself sufficient. It may be of particular importance to specific population groups with particularly poor health outcomes who currently have no access to such care, such as indigenous groups, but improved health outcomes for the wider population requires broader action.

Empowering communities to solve problems was a concept strong in the 1970s and 1980s (Labonte 1997). Aboriginal health services have worked from a population health perspective based on community control and have provided a platform for thinking broadly about health and social policy in Australia throughout recent decades. Divisions may need to embrace lessons from these organisations, and models of practice ought to be considered for their more wide applicability.

### **11.7.8 Evidence-based practice and guidelines**

Evidence-based medicine is discussed in detail elsewhere in this book. Nevertheless, it is important to discuss the impact that evidence-based practice and guidelines can have on the interface between GPs, primary health care and population health. The aim of evidence-based guidelines is to incorporate research findings about the impacts and outcomes of health care into everyday practice, thereby improving clinical decision-making and health outcomes.

With regard to general practice, Silagy et al (1997) have identified barriers to GPs adopting and applying evidence-based guidelines in their practice. Silagy et al emphasise that the dissemination and implementation strategies should be multifaceted, participatory and integrated into the process of care. In circumstances where research about evidence-based guidelines indicates improved outcomes, it is reasonable to expect that widespread application by the majority of GPs will result in the better health of the population.

The role of divisions in promoting national guidelines, implementing them amongst GP members, evaluating the uptake of the guidelines and monitoring use will be a major area of development for the divisions over the next few years. Certainly the Commonwealth is keen to see the divisions play a role in this (Furler 1999).

The widespread use of poorly developed guidelines can have the effect of divisions competing for scarce health dollars or of displacing resources and time from other more effective activities. Examples include the conflicting evidence about the effectiveness of brief lifestyle interventions in general practice (Ashenden & Silagy 1997) and of prostate and bowel cancer screening (Weller 1997).

The development and uptake of guidelines has been the subject of much debate, focusing not only on factors that facilitate their adoption by practitioners (local ownership being vital) but also on the potential harms that can result due to having a poor evidence base, inflexibility and restricting access to care (Langley et al 1998; Gupta et al 1997; Rice 1995; West & Newton 1995; Woolf et al 1999; Shekelle 1999; Feder 1999). The RACGP has published guidelines for preventive activities in general practice (Royal Australian College of General Practitioners 1998), and it reinforces their use through the entry standards for the accreditation of general practices (Royal Australian College of General Practitioners 1996).

There are moves to make evidence-based practice more readily available to GPs through information services or direct computer access to databases. Rigorous adherence to the national consensus on the development and implementation of guidelines is important (National Health and Medical Research Council 1998).

### **11.7.9 Partnerships with consumers and communities**

Collaborative partnerships between consumers and communities, GPs and other primary health practitioners and population health specialists are essential if general practice, primary health care and population health are to improve people's health. While broad policy statements such as the WHO Ottawa Charter for Health Promotion emphasise the importance of people's involvement, the implementation of most programs includes few or no resources to encourage community participation, or places it lower down the list of priorities. However, there are instances of ongoing community or consumer involvement in some program areas. Consumer groups have been keen to contribute to the General Practice Strategy, and they have been involved in a wide range of projects with the divisions (Mott & Fry, in press; Consumers' Health Forum 1996; Walker, Adam & Lewis 1997). The population health strategies that are most applicable to general practice are aspects of health promotion and early detection/intervention (for example, pap smears and health education) that can only be effective if there is an active partnership based on mutual respect and understanding between the GP and the patient/consumer. GPs will need to understand the social and cultural contexts of these patients' everyday lives in order to encourage feasible health promoting activities and to design effective programs (Bury 1994). This means that broader research paradigms are needed to complement traditional epidemiological studies (Matrice & Brown 1990; Wadsworth 1998). Such research should enable consumers and community members to 'name their experiences, and have that naming heard and respected by others' (Labonte 1997:31).

Public participation is the key to a vigorous population health movement and to effective primary health care (Beaglehole & Bonita 1997:222). Unless people perceive population health as being relevant to their needs and beneficial to their everyday lives, they will be reluctant to participate in programs or to support the broad policy changes needed to promote the health of all members of the population. This applies to a wide range of public health strategies, such as immunisation, the restriction of smoking in public places and the reduction of greenhouse gas emissions. Two-way consultation and joint ownership of programs is needed to achieve participation and effectiveness (Scally 1996b).

### 11.7.10 Data collection and surveillance

Better collection, analysis and application of health data is needed to assess the contribution of general practice and primary health care to improving the health of the population.

In relation to general practice, there are two major national data collections in progress. The first is the Australian Sentinel Practice Research Network (administered by RACGP), which collects data from a network of general practitioners on encounters for a range of infectious and other diseases. The second is Bettering the Evaluation and Care of Health (BEACH), which grew out of the Australian Morbidity and Treatment Survey in the early 1990s. This survey collects data on a range of GP, patient, management and population characteristics. Data includes demographic details of patients encountered, reasons for the encounter and management undertaken. There is the potential for this data to include socio-economic indicators (Britt et al 1999). The first report of the project gave details of 100,000 encounters from 1,000 GPs. The project is able to provide an 'enhanced' report to divisions, where 40 GPs are sampled from the postcodes of the particular divisions.

The collection and use of data by divisions has been the subject of an extensive process of discussion associated with the introduction of outcome and block grant funding. In their evaluation of the transition to outcomes and block grant funding, Rogers and Veale (1999) found that some divisions reported problems in identifying and collecting data that could accurately describe the processes and outcomes of their programs. The study recommends that 'policy be developed which critically examines the ways in which outcomes may be used as evaluation indicators for Divisions' programs' (Rogers & Veale, 1999: 47).

As part of the National Outcomes Based Funding Support Program, the Integration SERU and others held workshops and surveyed divisions regarding the collection, management and use of data. The subsequent report recommended:

- building capacity and encouraging the development of an evaluation and quality improvement culture among GPs and divisions;
- including data collection as an item in schemes such as the Practice Incentives Program and accreditation;
- strengthening reporting requirements; and
- clarifying the objectives of the divisions program and the expectations of divisions (Integration SERU 1999).

With regard to primary health care more generally, many services collect some kinds of service and program evaluation data, but there is insufficient State and national capacity to aggregate and interpret data at a broader scale. In addition, there are no specific national funding programs to develop this kind of infrastructure in multidisciplinary primary health care.

More recently, there have been efforts to involve divisions in more collaborative models of data collection. The Victorian Department of Human Services' Public Health Division has embarked on a regular computer assisted telephone interview designed to collect core population health information, particularly that related to morbidity in the community. The department is keen to work with the divisions to make the data locally relevant (Ackland 1999). In the northwestern suburbs of Melbourne, a project is currently underway to develop a 'partnership model' of utilising available data from a range of sources, interpreting them within a multidisciplinary framework and developing meaningful ways of presenting them to the divisions and a range of other health service providers in the area (Ruth & Suleiman 1999).

## 11.8 Future directions

In this chapter we have attempted to describe a conceptual and program interface between population health, primary health care, and general practice.

We have argued that primary health care and general practice have the capacity to go beyond a narrow interpretation of primary care (responding to the health problems of presenting individuals) in order to contribute to the larger goals of population health. This will be so if their infrastructure and operation include the following key elements:

- population-wide coverage;
- focus on protection and promotion of health;
- identification, analysis and direction of resources to the main health issues of the population;
- application of guidelines that improve population health; and
- engagement of communities in partnership.

We have also noted the relatively separate policy and program development of general practice, primary health care and population health in Australia. Before the conceptual and operational relationships at the interfaces of general practice, primary health care and population health can be strengthened and developed, the three components need to be seen as necessary and complementary parts of a comprehensive system.

Further development is required to achieve this kind of comprehensive system. Some strategies likely to assist are:

- policies and programs that encourage greater collaboration between general practice, primary health care and population health (kinds of collaborative activity could include demonstration projects, multidisciplinary academic programs and joint evaluation activities.);
- a strengthened research, evaluation and development infrastructure informed by the complementary relationships between general practice, primary health care and population health;
- innovative service and funding models across the three elements of the interface;
- greater policy development and coordination; and
- workforce and education development, which could include innovations in undergraduate and postgraduate education, fellowships to develop new skills, possible joint appointments between universities, divisions and community health centres, and opportunities for non-medical health professionals.

Greater collaboration between all three groups, especially in relation to implementing primary health care principles at a community level, is likely to lead to more comprehensive and well designed programs that can improve the health of the population as a whole. Working in this 'middle ground' will also demonstrate a more explicit continuum between individual and population concepts of health.

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