**Keynote and plenary abstracts**

**Nurses in general practice: an evolution in primary care?**

**B Sibbald**, Professor of Health Services Research, and Deputy Director, National Primary Care Research and Development Centre, University of Manchester, England

Nurses increasingly work alongside family doctors in the provision of primary care. Their roles vary from assisting doctors with simple clinical tasks such as taking blood samples or syringing ears, to more advanced roles in health care promotion and the management of patients with stable chronic conditions such as asthma, diabetes and cardiovascular disease. In some countries, nurses are able to undertake advanced training in diagnostics and therapeutics which enable them to function as substitutes for family doctors.

This paper examines the rationale for extending nurse roles in general practice. Does the addition of nurses to general practice teams enhance the effectiveness or efficiency of health care provision? Can nurses reduce doctors’ workload? What are the unintended effects of change?

These questions are addressed with reference to systematic reviews of available research and illustrated by examples from UK primary care. The evidence suggests that policy makers need to weigh up and make tradeoffs between potential costs and benefits. Multiprofessional general practice teams may enhance efficiency through improvements in the quality of clinical care, economies of scale and scope, and reduced waiting times for patients. However this may also increase transactions costs, and reduce the continuity of care and patient satisfaction with the interpersonal quality of care.

**General practice and primary health care research in Australia—on the crest of a wave?**

**J Beilby**, Department of General Practice, University of Adelaide

The presentation will examine the history and evolution of primary health care research in Australia since the late eighties. The initiatives that have been crucial to the development will be outlined and lessons identified. The presentation will then explore the value and importance of this development and will draw on such issues of the ecology of medical care and the growth of publication and research grants that have occurred in the last ten years. Discussion will take place on some of the strengths of the current research being completed in primary care and some of the weaknesses and difficulties that need to be solved to further foster this development.

Six areas will be discussed in detail

- the issue of advocacy,
- the value of the Fellows and Scholars and their need to be protected
- the need for a more mature sharing of ideas and reflections across institutions
- the importance and vulnerability of the practice-based research networks
- the important role of the new Primary Care Research Centre and
- the need to measure, summarise and reflect on what we’ve actually achieved in the last ten years.

Lessons from other countries will be used to suggest models to strengthen the momentum that’s currently taken place in Australia around primary health care research. The final section will challenge the conference to look at areas around health outcomes, the family, equity and the incentives for primary health care personnel to be part of this research momentum.
Disease management and prevention and primary health care: finding the balance

G Powell Davies, Centre for General Practice Integration Studies, School of Public Health and Community Medicine, University of New South Wales

The growing burden of chronic illness and the strain this can place on health services has started to change the way that we think about primary care and primary health care. In particular, we are looking increasingly to this sector for evidence based management and prevention of chronic illness.

This is a worthy goal. The question is how to pursue it. There are at least two broad approaches, differing in scope, approach to management and approach to prevention.

What might be called the specialist model tends to work back from the end stage disease, defining the problem in medical terms, providing earlier stage care based on evidence of what slows progression to the end stage and reduces complications, and seeking to reduce the individual risk factors that contribute to that condition in those considered at risk.

The primary health care model works forward from the circumstances in which people find themselves as they move from being not at risk to at risk, living with the condition and perhaps needing more comprehensive care over time. The problem here is defined as a problem of quality of life as well as a medical problem, the focus is on the combination of strengths and vulnerabilities that the person and their environment bring to maintaining and then to managing their health. Treatment is usually for multiple conditions, and while provision is made for good end stage care, this does not dominate the course of treatment and prevention at earlier stages of life.

This clash of ideas is not new. However recent developments have strengthened the appeal of the specialist approach within community based care. These include the trend to providing more acute care in the community, the growth of clinical evidence about disease management, and the emergence of clinical streaming as a way of organising services in the community. This has turned a clash of ideas into something of practical importance to patients, service providers, funders and policy makers.

Both approaches have strengths. This presentation will use evidence about prevention and disease management to highlight the difference between these approaches and explore what is at stake in choosing between them or seeking to combine them, and suggest where the balance might lie.

Maintaining health or preventing illness: using depression to explore the evolution of a disease led approach in primary care?

J Gunn, Department of General Practice, University of Melbourne

Background

There is an increasing push for primary care to implement chronic illness management and collaborative care models. These models of care are heavily influenced by a ‘disease-based focus’. Depression diagnosis and management provides a useful starting point to explore the implications of a disease led approach to primary care. Australian primary health care has experienced major policy change in the area of depression management in recent years: the establishment of Primary Mental Health Teams ($22m over 3 years in Victoria), the Federal Government’s ‘Better Outcomes in Mental Health Care’ Program and the National Depression Campaign (Beyond Blue). Depression is the single largest cause of disability burden in Australia and is mainly managed in general practice yet little is known about the context of care delivery.

Methods

This presentation will explore the recent trends in recommendations for the diagnosis and management of depression in primary care and weigh up the evidence that informs the introduction of a disease led approach to this major public health problem.
Discussion/implications
A disease led approach to the management of common health problems in primary health care brings with it many complex challenges for the primary health care system.

Frontiers of the revolution: learning from spectacular failure in health promotion

P Hawe, Department Community Health Sciences, University of Calgary, Canada

Fear of failure is a reason why many of us avoid evaluating our programs. Sometimes our attention to evaluation is so cursory, that nothing likely to shake our world view of our program will arise from our enquiry. This session takes examples from major and celebrated preventive intervention trials in the field and reassesses the difference between program failure and evaluation failure. We interrogate the proper role of theory in intervention design and evaluation. The context into which a program is introduced can be a major predictor of the success of a program. Examples of context-level evaluation using inter-organisational network analysis methods are given.

Three critical questions: regarding general practice, primary health care and Aboriginal and Torres Strait Islander health

I Anderson, Koori Health Research and Community Development Program, VicHealth

There is a focus currently on developing the capacity of primary health care services to effectively and efficiently respond to the health disadvantage in Aboriginal and Torres Strait Islander communities. A number of strategies have also been recently put in place to refocus research in Aboriginal health onto those questions for which new knowledge is strategically important to reform in health policy and practice. In general terms, this places a high priority on research into Aboriginal primary health care. In this presentation I want to outline a broad agenda for primary health care research in Aboriginal and Torres Strait Islander health and consider some of the key process and capacity issues that need to be addressed in order to develop this agenda.

Access to quality PHC in Australia: challenges and opportunities

E Harris, Centre for Health Equity Training Research and Evaluation, University of NSW

Australia is one of the healthiest countries in the world as demonstrated by rapidly declining mortality rates and increased life expectancy. Unfortunately health is not equally distributed in our community. The gap between life expectancy at birth between Indigenous and non-Indigenous Australians remains an unacceptable 20 years, while the difference in life expectancy between those from the most and least advantaged communities in this country are as great as the north–south divide in the United Kingdom.

Although many causes of poor health status lie outside the direct control of the health system there is increasing evidence that countries that have strong primary care systems have better health and less health inequalities. Health systems have an important role in the prevention and management of health problems and as advocates of their patients and populations. However unless there is a conscious effort to address the needs of those who are most socially disadvantaged there are real dangers that the ‘inverse care law’—where those who need treatment most are least likely to get it—will emerge. As pressure on Medicare as a universal health insurance system increases issues of access to quality PHC services will come increasingly into focus.

This presentation will explore the current challenges and opportunities in Australia in ensuring that all our citizens have access to quality PHC. What is the evidence that access to PHC can make a difference? What is the evidence that there are problems in accessing quality PHC services? What are some of the levers for change? How urgent is the need to ensure that we maintain and develop a universal health system? What can we as researchers contribute to this debate?
Addressing inequalities in New Zealand through the Primary Health Care Strategy

J Marwick, Clinical Services Directorate, Ministry of Health, New Zealand

Although general health status in New Zealand has improved over recent years, Māori and Pacific people and the socioeconomically deprived have much worse mortality and morbidity than the rest of the population. In particular, there is evidence that some groups have higher rates of hospitalisations avoidable by primary health care. This may be related to the fact that, in New Zealand, there are comparatively high financial barriers to general medical practice.

The Primary Health Care Strategy aims to tackle these issues by making significant changes in the way that primary health care services are funded, organised and delivered.

The Government’s part in funding access to health care services will increase very substantially over the next few years and change from being income-targeted to a universal scheme with much reduced co-payments. Payment will shift from a fee-for-service subsidy that practitioners claim, to payment of a Primary Health Organisation according to the expected needs of the population enrolled with the PHO’s providers.

PHOs are required to know their enrolled population and to involve the community as well as providers in governance. They will be funded to provide some health promotion services and to address non-financial barriers that lead to people not accessing care that could improve their health.

Although the Strategy builds existing developments, it is a challenging change and has met some opposition. Involving the community and a range of providers threatens some existing power bases. The moves to capitation funding and to agreements on patient fees have met resistance. The gradual introduction of higher funding in some higher need PHOs before others has raised concerns. There are questions about whether there will be sufficient incentives, monitoring and sanctions to ensure success.

Addressing health inequalities in Scotland: the Starting Well demonstration project in child health

W Rogers, Department of General Practice, Flinders University

Scotland has the highest infant mortality rate in the UK and one of the worst life expectancy rates in the developed world. Child health is of particular concern. Thirty per cent of Scottish children are currently born into relative poverty. These children are more likely to have increased perinatal and infant mortality, low birth weight, sudden infant death, respiratory diseases, infectious diseases and childhood behavioural difficulties.

Against this background, the Scottish Executive Health Department has funded a three year demonstration project in child health, which started in late 2000. The aim of Starting Well is to demonstrate that child health in Glasgow can be improved by a program of activities which both supports families and provides them with access to enhanced community-based resources. The project consists of home-based support through a program of intensive home visiting, together with the development of a network of community-based support services.

Implementing this project has raised a number of ethical issues, both for management staff and for individual practitioners. The relationship between evidence and service delivery poses challenges. Policy requirements for evidence-based interventions are in tension with the unique circumstances in Glasgow and the commitment to involve communities in decision making. As we would expect, this three million pound project is being rigorously evaluated. This has led to some ethical dilemmas for practitioners who have to balance service delivery with following project protocols and meeting evaluation requirements. Procedures for community
consultation and consent have proved difficult to implement, in part because it is not clear what force the community voice may have in shaping services. Targeting vulnerable communities rather than individuals has avoided stigmatising individuals, but may be having an adverse effect on inequalities across the city.

These issues identified from the Starting Well project have implications for health inequalities research, policy and practice.