The National Information Service
Linking primary health care research with policy and practice

With the aim to inform primary health care policy and practice in Australia this bi-monthly publication summarises examples of key recent research findings identified by the editor. Over 30 journals - most with a focus on primary health care, general practice or public health - are monitored, along with conference proceedings and other health and medical media. The journals include Academic Medicine, American Family Physician, Australian Health Review, Australian Journal of Primary Health -Interchange, British Journal of General Practice, British Medical Journal, Family Practice, Journal of Epidemiology & Community Health, Journal of Public Health Policy, Preventive Medicine, and Social Science & Medicine.

Note that editorial comments are provided in italics.

Primary health care issues which will be addressed in JournalWatch publications include:

- support for primary health care research
- research evaluation
- capacity building
- quality care
- integration
- GP wellbeing
- corporatisation of medicine.

This issue considers QUALITY in primary health care

The Institute of Medicine definition of quality, which is recommended by the General Practice Strategy Review Group (GPSRG), is: “Quality is the degree to which health services to individuals and the population increase the likelihood of desired health outcomes and are consistent with current professional knowledge.” (GPSRG, 1998, 187).
In their 1997 report on GPEP projects investigating quality in general practice, Veale & Fahy conclude that further improvement in quality in general practice will require research on the consultation itself, extensive use of best practice principles and attention to the structural issues affecting general practice. Thirty-eight percent of GPEP studies include a quality of care component, and the PHCRED program will provide further opportunities for research into quality in primary health care.

But are research findings a major determinant of primary health care policy? Lomas (1990) and Kushner (2000) (see below) argue that they are not. Kushner concludes that it is rather the values and beliefs of a particular society which heavily influence health policy development. Where misconceptions exist, relevant information is more likely to be ignored and the views of dominant structural interests are more likely to prevail. Moreover, to what extent are research findings translated into practice? Grol, in the International Journal for Quality in Health Care, observes: "Huge sums of money are spent on publishing new research findings or spreading them through education, often without any impact on patient care." (Grol, 2000). Awareness that evidence-based guidelines for practice need to be complemented by evidence-based implementation is, however, growing.

"...health replaces salvation, said Guardia. This is because medicine offers modern man the obstinate, yet reassuring face of his finitude; in it, death is endlessly repeated, but it is also exorcised; and although it ceaselessly reminds man of the limit that he bears within him, it also speaks to him of that technical world that is the armed, positive, full form of his finitude."

Michel Foucault, The Birth of the Clinic 1973

Implicit in Foucault's metaphysics of modern medicine is the role of evidence-based quality care, which itself depends on high quality, relevant research. In primary health care this requires the establishment of sustainable partnerships in order to conduct the research in appropriate settings. In the Medical Journal of Australia, David Weller notes that partnerships will ultimately determine the success of the new Primary Health Care Research, Evaluation and Development (PHCRED) strategy in Australia. Further, "from Government, we need carefully planned, sustainable investment in research infrastructure, and a capacity to formulate primary care policy based on evidence and previous experience." (Weller, 2000).

The following articles provide insights on quality in primary health care which have relevance for Australia. In our Feature Article Barbara Starfield emphasises the importance of a strong primary health care system as a key determinant of population health and cost-effective
health care. She argues that due to increasing co-morbidity, iatrogenesis and other factors, most existing methods for assessing quality of care are inadequate at present.

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Co-morbidity and iatrogenesis force changes to quality assessment


Evidence-based medicine is surely a desirable approach to improving the quality of practice, but existing evidence is not, for the most part, appropriate for primary care. Most current approaches to assessing quality of care are based on models developed fifty years ago. At that time, the techniques of medical audit of the processes of care were developed to assess the extent to which generally recognised features of care, such as preventive procedures, screening tests and appropriate management strategies for specific conditions were performed by practitioners. These remain at the core of most quality assessment schemes today.

There are good reasons for moving beyond conventional approaches to assessing quality of care, and tools are now available to focus on the new challenges that face health services systems in general and primary care in particular. These challenges include:

- The increasing importance of person-focused assessments rather than disease-focused assessments. Co-morbidity is the rule rather than the exception, and discomfort, dysfunction and disability result not only from specific medical conditions but from a variety of circumstances, including social conditions.
- The increasing dangers of medical interventions, including diagnostic and therapeutic technology and medications, with consequent increased health risks.
- The increasingly recognised effect of the mode of delivery of health services on the health of individuals and populations.
- Increasing interest in equity as an important outcome of health services systems.

Increasing likelihood of survival due to scientific and technological advances will result in larger proportions of people with continuing morbidity and disability and with more co-morbidity as new diseases are accrued on top of already existing ones. For example, in a population of Canadian hypertensives, only one-third of annual visits are for that condition. The next most common reason was diabetes, which accounted for 3% of visits. Thus 63% of visits made by patients with hypertension are for a large number of reasons, none of which account for more than 1% of visits. Thus it is not sensible to limit considerations of quality of care for hypertensives to care of their hypertension, or even to care of their hypertension and diabetes. In the US the average number of diagnosed conditions in adults over 60 years is
two. Over 80% of females aged 65-85 have at least one chronic condition; 50% have more than one, and 25% have three or more.

Clearly, a disease-by-disease focus, which has predominated until now, will not continue to serve us well. Existing clinical guidelines apply to individual diagnoses, and even the best ones derive from clinical trials that exclude people with co-existing conditions.

On the increasing danger of medical interventions: since 1990 the rate of introduction of new medications has increased significantly, with most adding little to improve overall health but much to increased costs of health care systems. Adverse effects of medications - due to unanticipated ill effects - is calculated to be around the fifth leading cause of death in the US. When this is added to deaths associated with unnecessary surgery, errors in medication administration, other errors in hospital care, and nosocomial infections, then iatrogenic causes amount to the third leading cause of death - 225,000 deaths annually - in the US, after heart disease and cancer, and ahead of cerebrovascular diseases and all other causes.

Primary care adequacy is very important in influencing health. Countries with strong primary care have lower costs and generally healthier populations. Even within countries the impact of primary care remains strong on various health parameters. A recent US study found a strong and significant inverse association between family physician to population ratio and hospitalisation rate for a range of preventable conditions. Furthermore, primary care has an equity-producing effect on health, at least for those measures that are especially responsive to primary care, such as postneonatal mortality, stroke mortality, and self-perceived health.

The increasing recognition of the multiple causes of illness, the predominance of co-morbidity, and the dangers of medical interventions should make us aware of more than just the processes of clinical care for specific conditions. We have much to do to prepare for the new challenges to primary care. The necessary tools are available, for example:

- Co-morbidity can be described by techniques such as the Adjusted Clinical Group system developed at Johns Hopkins University.
- The International Classification of Primary Care is a proven system of coding and classifying symptoms and signs, which could be useful in documenting and monitoring the occurrence of adverse effects of interventions, including medications.
- All evaluations of the quality of care should include consideration of the adequacy of primary care characteristics as well as clinical characteristics. Validated instruments such as the Primary Care Assessment Tool make it possible to do this in a standard way. (refer to Starfield, 1998).
The author integrates the paradoxical dual primacy of the individual consumer and population health that exists in primary health care. The article by Rosen (below) mentions conflicts which may arise from this dual focus. Starfield acknowledges the complexity of assessing quality in primary health care, and proposes proven methods to deal with this.

Co-morbidity levels in Australia - given our relatively old population - are likely to be similar to those of the US, although studies are sparse. As for adverse medical events, in Australia it has been shown that 1% of hospitalisations are likely to lead to death or serious disability as a result of a preventable adverse event (Duckett, 2000) (see below). Walsh (2000) takes it further: US studies, replicated and broadly supported in Australia, suggest that 3-4% of hospitalised patients sustain an adverse event. “Now at my hospital, that means that there are around 2,000 patients a year that sustain such an adverse event...About one in 10 of these adverse events results in death. At my hospital, this means an astonishing 200 deaths per year out of a total of 800...To me, these figures seem almost unbelievable...Even if [the problem] is only half as big, it is still enormous.”

Rigby & Litt (2000) found the cost of just 12 iatrogenic injuries was significant (US$0.25m). They recommend an ongoing national database to assist in identifying iatrogenic injuries, monitoring trends, and providing data for cost estimates and economic evaluations. Walsh (2000) suggests that we should concentrate on the big problems first: adverse drug events and nosocomial infection together constitute around 50% of hospital adverse events.

Another Australian study involving 324 doctors from 1993 to 1995 collected data on incidents of potential or actual harm to general practice patients: 805 incidents were reported, of which 76% were preventable and 27% had the potential for severe harm. The most common contributory factors were poor communication between patients and healthcare professionals, and errors in judgement (Bhasale et al, 1998). Kitson (2000) advises that the way evidence is generated to evaluate the safety of health care delivery systems is as important as the search for a new treatment for a particular disease.

Starfield stresses the importance of strong primary health care as an equity enhancer in health. This view is reinforced by Illich:

"The level of public health corresponds to the degree to which the means and responsibility for coping with illness are distributed among the total population...That society which can reduce professional intervention to the minimum will provide the best conditions for health."

Ivan Illich, *Limits to Medicine* 1976
A new framework for evaluating national quality initiatives
The Wimpole Street Group was formed as a collaboration of individuals and organisations in the UK with commitment to quality in the National Health Service. The findings of a series of meetings held at the Royal Society of Medicine, Wimpole Street were formed into a framework by which new national initiatives might be tested before or after they are enacted. The draft framework was then tested against the green paper A First Class Service (Department of Health, 1998).

The framework comprises four domains: policy, organisation, methods, and resources.

Policy: comprehensive and consistent
All elements of quality are embraced within integrated approaches at local and national level; the framework is able to provide national consistency of purpose and priority in quality improvement; it is relevant to patients in independent, voluntary and social care, as well as in the public sector; potential conflicts are addressed between differing perceptions of quality by patients, professions and organisations; proposed new quality initiatives link with or explicitly replace existing priorities and structures; responsibilities and accountabilities of public, private and professional bodies are defined; implementation of national guidance is followed up through performance management or independent review; proposals ensure that quality will become and remain visible on every management agenda.

Organisation: integration and accountability
Integration of quality initiatives within regional/state/national Departments of Health is consistent and evident to the health care system; the scope for support for quality improvement is visible and consistent within and between regional agencies which are accountable to a single authority; clear and workable mechanisms provide continuity of quality management between primary, secondary and tertiary care, and between statutory, independent and voluntary agencies; quality management structures and mechanisms are integrated within each provider and commissioning organisation.

Methods: coordinated, cost-effective and achieving change
Adoption of demonstrated effective quality methods is recognised and rewarded in organisations and individuals; the development and dissemination of clinical standards is
coordinated nationally to avoid duplication and to ensure that they are coherent, affordable and cost-effective; organisational standards are clinically relevant and coordinated through an identified national mechanism; national organisational and clinical standards are consistently applied and/or monitored by statutory and/or voluntary mechanisms through the health care system; priority is given to research and development to identify and implement incentives and mechanisms which are shown to effect behavioural change; universal indicators for performance management avoid duplication of data collection and presentation.

Resources: realistic and accessible
National quality resources are catalogued, signposted and accessible to intended users across the nation; there are clear mechanisms to demonstrate and improve the quality of health service data and to support their use for quality assessment; responsibility is identified for national integration and provision of training in quality management in all health disciplines; local resource allocation mechanisms respond to deficits demonstrated by quality management programs; proposals for the establishment or modification of national structures recognise the need for realistic funding and support.

But would it work for Australia?
Quality expectations have previously not been explicit as they have often been seen to be within the provider's exclusive domain or because quality of care has been implicitly assumed to be good. Questioning of the adequacy of quality of care has occurred in many countries: in Australia it has been shown that 1% of hospitalisations are likely to lead to death or serious disability as a result of a highly preventable adverse event.

A common line of reasoning assumes that unless quality is intrinsic then externally imposed quality standards are likely to be subverted. However, recent evidence suggests that Total Quality Management, Continuous Quality Improvement and the like have had little impact on improving quality. Quality of care is complex with a variety of different stakeholders, each needing to be involved in the quality management process.

The Wimpole Street (UK) principles (Shaw & Nichol, 2000) propose a framework to evaluate government quality initiatives against a "perfect policy" paradigm using 24 items. The principles are based on the goal that successive quality policies represent incremental
improvements rather than proposing strategies which are likely to fail. Australia has suffered from policy swings in this area and thus achieving the Wimpole Street goal would be welcomed here.

However, the Wimpole Street principles assume an organised health system where national guidance and policy direction provide a framework for local implementation. They appear less relevant in a multi-centric system like Australia with the Commonwealth, eight states and territories, and many private hospital systems and other providers each pursuing their own policy independently. In the Australian version there needs to be more emphasis on the centrality of the consumer and on the importance of evaluating progress on a regular basis.

Formulating national, state, regional or even local policies on quality is complex, and involves many different stakeholders. These include GPs, allied health professionals, consumers, academics, and the governing body of the organisation.

What does quality mean to patients?

Haddad S, Potvin L, Roberge D et al 2000 Patient perception of quality following a visit to a doctor in a primary care unit Family Practice 17(1): 21-29 (abstract only cited)

Assessment of the quality of primary care services may be enhanced by including patient perceptions as well as professional evaluation of quality. There is a need for reliable and valid instruments to measure these perceptions.

A survey was conducted on 473 patients who visited a physician in 11 primary care units in the Montreal region. Randomly selected patients received mailed questionnaires a week after their visit. The scale comprises 22 items divided into three sub-scales referring to the patient-physician relationship (5 items), the technical aspects of care (12 items) and the outcomes of the visit (5 items). The scale focuses on patients’ opinions about quality rather than on satisfaction, and includes items related to outcomes of the visit. The scale was found to be valid and reliable and the authors concluded that it would be useful for physicians and primary health care units and has a wide range of applications.

Patients’ evaluations of their care can provide valid quality indicators, as evidenced by this and other studies. Moreover, the duration and nature of the relationship between the practitioner and the patient have been demonstrated to strongly influence the outcome of care. Research shows that the interpersonal skills and personal qualities of the GP, provision of information by the GP, the length of the consultation, and technical competence are rated
highly by consumers when they are asked to identify what is important to them in defining quality in general practice (General Practice Strategy Review Group, 1998, 70).

Integration essential for quality care

This article by a health policy analyst provides an overview of the state of primary care reform in Canada and lists several important facilitators for reform.

The importance of integrated health services as a vital component of quality care is highlighted. To achieve an integrated primary health care system, the public needs to understand why it is better for them than the existing unintegrated service options. For those in good health this lack of integration may not matter as their contact with the system is centred on episodic visits to the family doctor and there is minimal use of other services. For the vulnerable, however, an unintegrated system is complex, inconvenient and costly. The frail elderly, homeless people, those with mental illness and substance abuse problems, those with chronic conditions such as heart disease, cancer, diabetes and asthma, and the dying often do not get what they need from the system...because they tend to be difficult to treat, may be hard to deal with, and require too much time in busy family practices. A superior communications strategy may be required to explain the deficiencies of the current system and the benefits of proposed changes.

The reinvestment in primary health care needs to be transparent, so consumers and practitioners can be confident that the strategy is being implemented. There has generally been a lack of consumer input in new models for primary care in Canada. Early success was shown with shared care in mental health, involving linkage between a psychiatrist and GPs working in group practices and Community Health Centres (CHCs). The program improved access to services for those with serious mental conditions in Ontario. However, a recent review shows no increase in the number of GPs working in shared care models between 1993 and 1998.

It is vital to get "organised medicine" onside. In Canada (except for Ontario) a single organisation represents all doctors, regardless of their different interests and roles in the system. This may be a key factor in making it more difficult to achieve consensus and meaningful, as opposed to rhetorical, support from organised medicine. Financial and professional concerns must be addressed: attractive levels of reimbursement and benefits,
reasonable on-call arrangements, access to continuing medical education, and teamwork facilitation.

There is a need to concentrate on functions that are likely to improve the timely delivery of appropriate, cost-effective care as these are likely to have the greatest impact on reducing reliance on hospital and specialist care. The current fee-for-service system tends to limit doctors' ability to deliver effective preventive care. Few practices have recall systems for patients who do not attend, and quick response and after-hours service are difficult for doctors in a busy solo practice.

Efficient and effective information systems are vital to carrying out many of these functions. Computerised systems make it easier to identify patients with specific chronic conditions and follow their care. Electronic records also improve information exchange on patients' admission to and discharge from hospital.

Improved primary care can also be more cost-effective by involving providers other than doctors in patient care. These professionals are paid less and have specialised training in specific areas. Moreover, allied health workers can free up the doctor to see patients who require the skills of a medically trained practitioner.

Excellence in clinical care is an important objective. This requires attention to both the content and process of care. The content of care can be guided by evidence, for example, by using cost-effectiveness research on various diagnostic and treatment interventions and clinical practice guidelines, such as those produced by the Canadian Task Force on Preventive Health Care. Adopting quality improvement programs can help processes in the delivery of care. A meta-analysis on the impact of anticipatory care (that is, the evidence for identifying, and actively monitoring those at high risk, ensuring rapid response at the first signs of deterioration) found a 22% decline in mortality among those who had access to anticipatory care (Feightner & Hutchison, 1994).

The CHC model provides effective primary health care delivery. CHCs have defined populations (usually by territory), salaried staff, a focus on health promotion and disease prevention, integration and coordination of services, and opportunities for community participation. Compared to fee-for-service practice and capitated medical practices, CHCs provide more health promotion and disease prevention services, make greater use of allied health workers, and CHC patients use fewer specialist and hospital services. Good models take time to become established. It is desirable to set achievable goals and ensure some early successes. The critical element in any primary health care model is
teamwork. This does not come without effort. Each profession trains separately, and bringing together providers from different disciplines, founded on different philosophies, can provide a challenge. Mutual respect and perseverance are key requirements for success.

Community health has a low profile in the Canadian system. Although primary care is the foundation of the system, and although its functioning has a direct impact on the resources needed by secondary and tertiary care, its role remains poorly understood by the mainstream press and the public. To attain their potential, "community based services need to capture the imagination of the public. People need to know they can avoid problems through timely prevention and treatment by primary care. They need to know they can effect changes in their communities through advocacy and local initiative."

Effective information management and communication have been identified by the General Practice Strategy Review Group as central to improving the quality of GPs' care: "Finding ways to promote the rapid adoption of information technology to improve information management is seen by many as the single most important step that could be taken to enhance the quality of general practice." (GPSRG, 1998, 221).

Most of the points made are applicable to Australia, although it would appear that primary health care reform may be proceeding along a smoother path in Australia. Commonwealth Government policy, the General Practice Strategy, Divisions of general practice, the General Practice Evaluation Program, the Consumers' Health Forum and the General Practice Partnership Advisory Council have all played a part in strengthening Australia's primary health care system. Current initiatives, including the Coordinated Care Trials, PHCREd and the More Allied Health Services (MAHS) programs, with their commitment to evidence-based practice, integration, partnerships and consumer input, should advance the process further.

An integration framework for quality primary care

Miles G 2000 Clinical pathways: the care link between primary health services Australian Journal of Primary Health-Interchange 6(3&4): 84-90

The author works for the Royal District Nursing Service, Melbourne, Australia.

Clinical pathways are an innovative process that provides a framework for the management of coordinated care. Effective management is achieved by organising and integrating all levels of health care delivered by different providers from a number of different disciplines.
They are management plans which identify desired consumer outcomes and specify the sequence of events necessary to achieve these outcomes.

The components of a clinical pathway include timelines, interventions, care activities, expected outcomes and variance. Timelines are documented across the top and can be recorded in hours, days, treatment phases or visit schedules. Interventions are listed down the left side of the pathway and either reflect the broad categories of care or the contribution made by each health professional. Care activities represent the minimum level or extent and type of care provided. They ensure consistency of care is provided to similarly classified clients. Expected outcomes can be documented in relation to a timeline or a discharge goal and they reflect the anticipated status of the consumer following an intervention or discharge. Variation is the difference between what is expected to happen and what actually happens.

At the Royal District Nursing Service in Australia, clinical pathways have been developed for the management of patients with diabetes and venous leg ulcers. Although they have not yet been fully implemented, a pilot study has shown that staff favourably received pathways and that a number of patients were able to achieve the desired outcomes within the specified time. It was found that it was necessary to consider patient characteristics during pathway development.

Clinical pathways enhance communication by providing a mechanism for health professionals to work together bringing specific skills to achieve shared goals. They are an effective quality management tool which establish standards of care based on evidence-based practice.

Clinical pathways appear to provide a practical, flexible means of managing coordinated care. They create a consumer-focused link between service providers, which otherwise can be elusive.

Integrated care needed for diabetes management
The authors are health professionals who work with people with diabetes in New South Wales, Australia, and their article defines the characteristics of an integrated model of care for people with diabetes.

Integration of effort is likely to be the best way of ensuring optimal outcomes of management both for clinicians and consumers. The current health system pressures have led to an hypothesis: the impact on the system of chronic disease could be reduced by the provision of well organised care founded on agreed, evidence-based guidelines for best practice, which incorporates patient education and early detection of complications. While there is plenty of guideline material, developed by numerous organisations, the major challenges are the incorporation of this expert knowledge into clinical practice, and the monitoring of the effectiveness of these guidelines in improving health outcomes for specific diseases.

Integrated care, which incorporates the use of clinical management guidelines, is a systematic approach to service delivery that recognises the central role of the consumer in chronic disease management, the crucial role of the GP, and the importance of population health science.

Diabetes consumes significant proportions of the health budget, especially in the management of diabetes-related complications. There is now evidence that improved metabolic control of blood glucose and blood lipids will delay or prevent the progression and development of diabetic complications. However, improved metabolic control requires patients to have both knowledge of, and direct involvement in, the management of their condition. Changes are thus occurring in diabetes treatment with a focus on patient empowerment through education and increased autonomy. However, many people with diabetes still do not have access to appropriate care.

Integrated care comprises:

- established systems for communication between providers (referral letters, computer networks and shared clinical databases).
- cooperation between providers in providing care and in the planning of health services. This cooperation needs to be based on trust and respect for other professionals’ territory.
- agreed guidelines and standards of care, and appropriate training.
- implementation of agreed policies and procedures.

Diabetes shared care has been widely adopted by Divisions, providing structured, community-based care for people with diabetes by GPs, allied health professionals and diabetes services. In 1997 the National Divisions Diabetes Program was established to
coordinate a best practice approach by providing information to Divisions on guidelines, GP education, IMIT and program evaluation. The programs included prevention and early detection, GP education and clinical audit based on management guidelines, GP clinical record forms that prompt for care and data collection, and patient education and access to integrated care (CDHAC, 2000).

Coordination of services can be difficult in areas where outcomes are currently poorer or services less accessible, such as in parts of rural Australia. Some Division programs have addressed the needs of disadvantaged or high-risk groups such as Aboriginals or people from non-English speaking backgrounds.

Simmons (2000) describes a New Zealand case study of how “care-mapping” (a process which precedes the development of referral pathways, which are similar to the clinical pathways described in the Miles article above) was used to develop a population-based integrated care approach to diabetes, involving integration of primary and secondary care. A key feature was the role of a Diabetes Care Promoter, the person responsible for coordinating care. This person differs according to the clinical setting and could be a GP, practice nurse, diabetes nurse specialist or podiatrist.

A UK study showed that success in improving diabetes care is associated with certain organisational features of primary health care teams. Success was more likely in teams in which: the GP or nurse felt personally involved in quality improvement such as an audit, they perceived their teamwork as good, they had recognised the need for systematic plans to address obstacles to quality improvement, and the teams had a positive attitude to continued monitoring of care (Stevenson et al, 2001).

How to implement clinical governance in fragmented primary care?
The term clinical governance covers the range of activities required to improve the quality of health services. These include the requirement for all National Health Service organisations to develop processes for continuously monitoring and improving the quality of health care and to develop systems of accountability for the quality of care that they provide.

Evidence-based practice, audit, risk management, mechanisms to monitor the outcomes of care, lifelong learning among clinicians, and systems for managing poor performance will all
contribute to the development of effective clinical governance. Primary care groups and trusts are the organisations through which clinical governance will be developed at a local level and local priorities identified.

Quality improvement systems for general practice exist, but there have been few attempts to involve all primary care team members in quality improvement work. Clinical governance in primary care must focus on individual patients and whole populations; this creates tensions between a concept of good practice based on individual rights and a population approach focused on equitable distribution of services. If, for example, a primary care group chooses diabetes as a priority area it will still need to decide between individually focused priorities such as implementing evidence based treatment protocols and population goals such as reducing inequalities in access and use by different groups.

Primary care services are fragmented across multiple providers, with no clear managerial or professional hierarchy through which to implement clinical governance. Primary care groups and trusts are taking various approaches to clinical governance, but there is some common ground: a recent survey found that 70% will conduct inter-practice audits and work to improve data for monitoring the quality of care. However, another survey of clinical governance leaders revealed concerns about implementation at a local level. These included lack of resources for the job, the size of the workload created by clinical governance, and the difficulties of moving primary care professionals toward an open, participative culture.

The introduction of clinical governance raises further research questions. What are effective mechanisms for developing accountability in primary care, and what incentives will increase participation in clinical governance? What are the advantages and disadvantages of different methods of public involvement in clinical governance? What are the most effective methods for education and training in multidisciplinary primary care teams and for managing underperforming colleagues?

Australia’s Divisions of General Practice structure provides an effective framework for provision of primary health care. The majority of Divisions have active integration, ITIM, audit, community/consumer liaison programs, and health promotion; also, disease prevention programs (focused on the National Health Priority Areas of cancer, mental health, diabetes, cardiovascular disease, injury, asthma and immunisation) are widespread. These programs generally involve - and often constitute - clinical governance. Divisions of general practice, with their capacity to provide locally relevant community health programs, are well placed to provide the link between individual patient care and population health. The research
questions raised above could be addressed under the PHCREd program. The tensions between individual and population approaches in general practice are being investigated by Wendy Rogers, a consultant with the National Information Service.

**Improvement through evaluation**

Brazil K 1999 A framework for developing evaluation capacity in health care settings


Demands for results-oriented accountability have heightened the importance of evaluating quality in health care. Quality has been described and measured in terms of timeliness, appropriateness, responsiveness, efficiency and effectiveness. Consequently, an evaluation framework needs to be comprehensive enough to accommodate the complexity of quality in health care. This article summarises current trends toward developing effective evaluation practices within health care settings.

Relevant evaluation methods for different stages of a program: planning (needs assessment, using surveys, population statistics and structured groups), design (evaluability assessment, using interviews and document reviews), program implementation (program monitoring, using performance measurement systems), and program accountability (outcome evaluation, using experimental and quasi-experimental designs).

Program evaluation has become more focused on helping programs to become self-improving. Program managers need to see evaluation as a fundamental component to decision making whereby it can promote evidence-based organisational change. To facilitate this, evaluators need to actively plan for the dissemination and implementation of their findings. It is important to identify primary users: the more involved the user becomes with the evaluation, the more targeted the evaluation will be, and thus the more likely the recommendations will be adopted.

*The goal is gradual, sustainable improvement...here, in health care services; in the Duckett article above, in quality policy.*
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National Information Service  
Flinders University, Adelaide  
Ph: (08) 8204 5399  
Email: gpnis@flinders.edu.au