

Health Inequalities Research Collaboration

Primary Health Care Network

Discussion Paper:  
Research priorities and capacity  
building issues

Julie McDonald  
Elizabeth Harris  
John Furler

September 2002

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

Department of General Practice, University of Melbourne

ISBN: 0 7334 1970 4

© This report is copyright. It may be reproduced and distributed for educational purposes with acknowledgement to the authors and the Health Inequalities Research Collaboration.

This report has been produced for the Health Inequalities Research Collaboration – a Commonwealth initiative through the Department of Health and Ageing.

For further copies please contact Julie McDonald on

Phone: 02 4236 0225

Email: [maclyle@leearth.net](mailto:maclyle@leearth.net)

# Contents

Acknowledgements .....	i
Abbreviations .....	iii
Executive summary .....	v
<b>1 Introduction &amp; context setting .....</b>	<b>1</b>
1.1 Purpose & scope of this document and its development .....	1
1.2 Definitions .....	1
1.3 The Health Inequalities Research Collaboration (HIRC) .....	3
1.4 Primary Health Care Research Network .....	4
1.5 Patterns of health inequalities .....	5
1.6 The contribution of PHC in addressing health inequalities .....	8
<b>2 Research priority areas in primary health care .....</b>	<b>11</b>
2.1 The effectiveness of PHC approaches .....	11
2.2 Access to PHC services and programs .....	12
2.3 Indigenous health .....	12
2.4 Rural Health .....	14
2.5 Oral health .....	15
<b>3 The context of research funding &amp; support in primary health care.....</b>	<b>17</b>
3.1 GPEP .....	17
3.2 PHCRED .....	17
3.3 NHMRC .....	20
3.4 National Health Priority Areas .....	22
3.5 State Commonwealth Research Issues forum (SCRIF) .....	23
3.6 State research priorities and investment .....	24
3.7 Implications for PHC health inequalities research .....	26
<b>4 Building research capacity in primary health care .....</b>	<b>27</b>
4.1 The fragmentation of PHC in Australia .....	27
4.2 Lack of a research infrastructure & capacity .....	27
4.3 Methodological issues .....	28
4.4 Conceptual frameworks for PHC inequalities research .....	29
4.5 Capacity building .....	30
4.6 Future directions .....	33
4.7 Recommendations .....	36
<b>5 Appendix 1: HIRC Board &amp; PHC Network Steering Committee membership .....</b>	<b>37</b>
<b>6 References .....</b>	<b>39</b>



## **Acknowledgements**

A number of people have contributed to the development of this discussion paper. In particular the authors would like to thank:

- the people who participated in the consultation workshops and who gave their wisdom and experience in identifying research priorities and capacity building issues;
- the members of the Steering Committee who provided overall guidance, and who read and gave valuable input into the drafts of the discussion paper;
- Professor John Spencer and Ms Anne Sanders who largely wrote the section on oral health research priorities
- Mr Graham Hill who to a large extent wrote the section on rural health priorities.



## Abbreviations

Abbreviation	Full name
AAAGP	Australian Association of Academic General Practitioners
ABS	Australian Bureau of Statistics
ACCCHS	Aboriginal Community Controlled Health Services
AHMAC	Australian Health Ministers' Advisory Council
AIHW	Australian Institute for Health & Welfare
AIPC	Australian Institute for Primary Care
ARIA	Accessibility/Remoteness Index for Australia
CHETRE	Centre for Health Equity, Training, Research & Evaluation
CRCATH	Cooperative Research Centre for Aboriginal and Tropical Health (Northern Territory)
DALY	Disability Adjusted Life Year
DGP	Divisions of General Practice
DSRU	Dental Statistic and Research Unit
FFS	Fee-For-Service
GP	General Practitioner
GPPAC	General Practice Partnership Advisory Council
GPEP	General Practice Evaluation Program
HIC	Health Insurance Commission
HIRC	Health Inequalities Research Collaboration
LGA	Local Government Area
NACCHO	National Aboriginal Community Controlled Health Organisation
NRHA	National Rural Health Alliance
NHMRC	National Health & Medical Research Council
NHPA	National Health Priority Area
NHS	National Health Service (UK)
NHPAC	National Health Priority Action Council
NHS	National Health Service
NPHP	National Public Health Partnership
PHC	Primary Health Care
PHCAP	Primary Health Care Access Program
PHERP	Public Health Education and Research Partnership
PHCRED	Primary Health Care Research, Evaluation & Development
PHCRIS	Primary Health Care Research & Information Service
RAWG	(Aboriginal & Torres Strait Islander) Research Agenda Working Group
R&D	Research & Development
RCT	Random Controlled Trial
RRMA	Rural, Remote and Metropolitan Areas Classification
SACHRU	The South Australian Community Health Research Unit
SCRIF	State Commonwealth Research Issues Forum
SDRC	Strategic Development Research Committee
SEIFA	Socio Economic Indices for Area (ABS)
SES	Socio Economic Status
SLA	Statistical Local Area
UNSW	University of New South Wales
YLL	Years of Life Lost



## Executive summary

The large differences between the health of the most and least advantaged Australians have been well documented and there is increased interest in identifying action that can be taken to reduce these inequalities. The establishment of the Health Inequalities Research Collaboration (HIRC) has provided an important means of supporting research into understanding health inequalities and action that can be taken to address them. The Primary Health Care (PHC) Network is one of three research and development networks funded through the HIRC, the others dealing with children, youth and families, and with sustainable communities. Each network emphasises Indigenous and remote and rural populations, in collaboration with organisations involved in Indigenous health research. The networks aim to enhance Australia's knowledge on the causes of and effective responses to health inequalities, and to promote vigorously the application of this evidence to reduce health inequalities in Australia.

There is increasing evidence that PHC has an important role in addressing and reducing health inequalities and strengthening PHC has been identified as a key intervention strategy to reduce health inequalities in the UK, New Zealand and in New South Wales. In order to advise the HIRC Board on priority issues for the PHC Network and for HIRC an extensive consultation was undertaken across Australia. The findings of these consultations form the basis for this discussion paper.

The paper has three purposes:

- identification of PHC research priorities;
- placing these priority areas within the context of research funding and support;
- identification of actions to increase research capacity.

**The purpose and scope of the paper** are discussed in **Section 1**. This section also considers some of the key patterns of health inequality, and how these may be addressed in a primary health care setting.

### **Identifying key research priority areas.**

This is discussed in **Section 2**. Five research priority areas have been identified:

- The effectiveness of PHC approaches in reducing health inequality
- Access to PHC Services
- Indigenous health
- Rural health
- Oral Health.

### **Placing PHC research priorities within the context of research funding and support.**

This is discussed in **Section 3**. This section examines the HIRC in relation to the role and focus of key research programs and agencies such as GPEP, PHCRED, the NHMRC and State/Territory initiatives. There appears to be a high level of alignment between the HIRC PHC research priority areas and the priorities of these programs and agencies.

### **Building research capacity**

Capacity building issues that will assist in the implementation of the HIRC primary health care research agenda are discussed in **Section 4**. It is argued here that the lack of a national PHC policy and fragmentation of the PHC system reduces the capacity of PHC to develop a systematic research agenda and this includes research into interventions to reduce health inequality.

It is suggested that given resource constraints, future activity of the PHC Network in regard to the five research priority areas should take three key forms:

- leadership and advocacy;
- capacity building; and
- information exchange and support.

We suggest that ‘capacity building’ is a central concern, and one which must be addressed nationally. An effective and appropriate evidence base for reducing health inequality through primary health care cannot be developed without the active participation of primary health care workers, in an environment that recognises and values a culture of research.

On this basis, our recommendations to the HIRC Board are:

1. Endorse the five priority areas discussed in **Section 2** of this paper (PHC approaches, Access, Indigenous health, Rural health and Oral health).
2. Endorse the three areas of future activity within these priority areas discussed in **Section 4** of this paper (advocacy & leadership, capacity building, and information exchange & support).
3. Support the development of a national Primary Health Care policy which supports research into health inequality.
4. Acknowledge the role of the HIRC in monitoring the level of investment in PHC and health inequality research.
5. Review the extent to which the PHCRED Program is:
  - Funding PHC and equity related research through the NHMRC grants process, including a focus on health inequalities within the National Institute of PHC Research
  - Fostering state based PHCRED programs to increase capacity for PHC and equity research
  - Fostering debate between policy makers, practitioners, researchers and the community on equity related PHC research and research capacity building.
6. Advocate for a recognition of the challenges of undertaking PHC intervention research especially in dealing with health inequality.

# 1 Introduction & context setting

## 1.1 Purpose & scope of this document and its development

The purpose of this discussion paper is to:

- identify key areas of Primary Health Care (PHC) health inequality research that should be supported by the Health Inequalities Research Collaboration (HIRC) PHC Network and the HIRC Board;
- place these research priorities within the context of Primary Health Care, Research, Education and Development (PHCRED) and other research funding or support bodies in Australia; and
- identify capacity building issues that will enable the PHC health inequalities research agenda to be progressed.

The scope of the paper is limited to the contribution of PHC approaches to reducing health inequalities. The authors acknowledge that most of the reductions in health inequalities will be brought about by changes in macro-economic policies that shape the society we live in and provide the conditions under which health inequalities continue to exist. However, there are two main areas where PHC can make an important contribution:

- firstly, access to health services as the first point of entry into the health system; and
- secondly, access to opportunities for health and wellbeing, particularly in relation to prevention and early intervention.

During April 2002, workshops were held in NSW, Victoria, Tasmania, South Australia, Western Australia and Northern Territory with researchers, policy makers and practitioners. The aims of the workshops were to consider a draft of this discussion paper and make recommendations on research priorities and action to improve the capacity of the PHC system to actively engage in PHC inequality research.

Prior to the workshops the discussion paper was circulated to registrants and other people who expressed an interest but who were unable to attend, inviting their comments.

Following the consultation period, comments from the workshops and written comments received were reviewed. The discussion paper was then revised and circulated to the steering committee for their final input and endorsement.

The final version was forwarded to the HIRC Board in September 2002. Over the next twelve months the HIRC PHC Network will progress the recommendations and report back on progress in another round of national workshops in 2003.

## 1.2 Definitions

### *Primary Health Care*

There is considerable debate around the scope of primary health care and also its intent. For the purposes of this discussion paper, primary health care is conceptualised as a continuum from primary care that focuses on assessment and management of health problems of individuals through to population based approaches that focus on the underlying determinants of health through intersectoral action.

While there are many definitions of Primary Health Care (PHC), the following has been used, as it has been endorsed by the Australian Health Ministers:

*“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.”<sup>1</sup>*

This definition sees PHC as a level of care and also an approach to health care. The essential elements of a comprehensive PHC approach include:

- a mix of treatment, prevention and health promotion services;
- a focus on populations;
- multidisciplinary approaches;
- participation of individuals and communities in decision-making;
- equitable and accessible services; and
- intersectoral partnerships.

The major components of the primary health care sector include privately funded general practice and allied health practitioners, and publicly funded community health services and community care programs. Other groups actively involved in the delivery of PHC are Aboriginal Community Controlled Health Services (ACCHS), pharmacists, many non-government organisations, consumer and self help groups.

### **Health equity**

Equity is about enabling people to have equal access to services for equal need; that there is equal use of services for equal need and equal quality of care or services for all is provided with a focus on health outcomes. An equity approach recognises that not every one has the same level of health or level of resources to deal with their health problems and it may therefore be important to deal with people differently in order to work towards equal outcomes.<sup>2</sup>

Margaret Whitehead has summarised these ideas:

*“Equity in health implies that ideally everyone should have a fair opportunity to attain their full potential and, more pragmatically, that no one should be disadvantaged from achieving this potential, if it can be avoided. Based on this definition the aim of policy for equity and health is not to eliminate all health differences so that everyone has the same level of health, but rather to reduce or eliminate those, which result from factors which are considered to be both avoidable and unfair. Equity is therefore concerned with creating opportunities for health and with bringing health differentials down to the lowest levels possible.”<sup>3</sup>*

### **Inverse care law**

The ‘inverse care’ law implies that those in greatest need receive less care. This law was first proposed by Julian Tudor Hart in the early 1970s in relation to the availability of good medical care.<sup>4</sup> The implications of this may be that this ‘law’ operates in the following ways:

- the unequal distribution of health resources and services, with less availability of services in areas of greatest geographic and social need;

- whilst disadvantaged people make a greater use of some health services, for example emergency departments, they make less use of preventive services and have shorter consultation times;
- the application of ‘standard interventions’ contribute to widening health differentials as they fail to take into consideration the needs and capacities of disadvantaged groups; and
- disadvantaged groups experience cultural and attitudinal barriers to accessing health care services, independent of ethnicity.

### 1.3 The Health Inequalities Research Collaboration (HIRC)

HIRC was established in 1999 to develop a health inequalities research agenda within Australia and aims to be intersectoral and multidisciplinary. Its strategic objectives are to:

- increase national focus on reducing health inequalities;
- build national capacity and support for research and development in health inequalities;
- establish close collaboration among researchers, practitioners and policy developers; and
- promote the uptake of research findings in policy, practice and evaluation.

As one initiative to meet its goal and strategic objectives, HIRC has funded the development of three research and development networks. The networks are funded for two years. These networks relate to:

- primary health care;
- child, youth and families; and
- sustainable communities.

Each network is to emphasise Indigenous and rural and remote populations. HIRC will not run a separate Indigenous research agenda, but will collaborate with organisations engaged in Indigenous health research.

The **Sustainable Communities Research Network** will focus on three working areas, each of which will result in a working paper to be presented to HIRC. These are:

- the impact of government policy on service delivery, resource allocation and community development;
- environmental justice, environmental risk and the experiences of vulnerable communities; and
- resilience and community capacity in relation to health and socio-economic change.

The network will highlight the need for a trans-disciplinary, inter-sectoral and participatory approach and will base its understanding of health inequality on the notion that the range of determinants of health inequalities in rural and Indigenous communities includes geographical, environmental, cultural, age, gender and socio-economic differences. The development of interventions will be guided by the principles of sustainability, such as inclusivity, connectivity, equity, prudence and security as they can be applied in communities to reduce health inequalities.

The focus of the **Child, Youth and Families Research Network** recognises the imperative to understand and redress health inequalities for children and adolescents, with population statistics showing that young people are making up an increasing proportion of the disadvantaged in Australia. Their focus will include:

- facilitation of intersectoral and multi-disciplinary partnerships, fostering interaction between researchers, service providers and policy makers;
- provision of opportunities for skills development in critical areas, such as program evaluation;
- facilitation of strategic research to address current gaps in knowledge and practice;
- the development of effective mechanisms for collating, interpreting and disseminating existing research evidence.

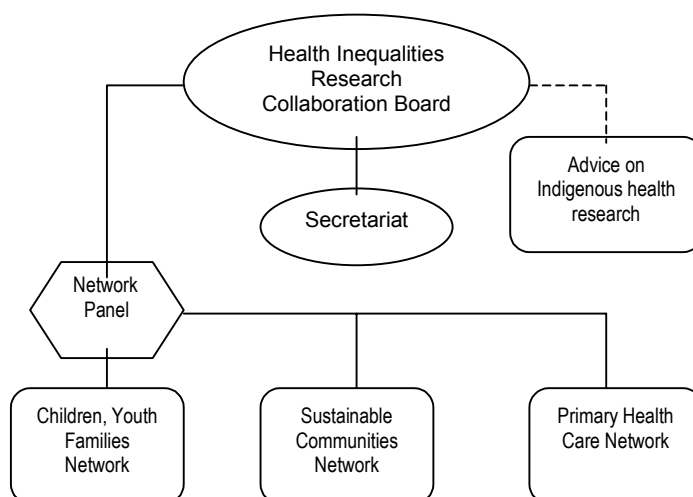
An annual report will be produced on issues in child, youth and family health inequalities, with an initial focus on the evidence for effective intervention and prevention.

The **Primary Health Care Research Network** is discussed at 1.4 below.

There are teleconferences between the networks, as a network panel, to share information about activities and members and to strengthen coordination. The commonality between the PHC and Child, Youth and Families networks particularly requires a coordinated approach. Each network reports to HIRC annually through the network panel.

The following chart outlines the HIRC structure.

### ***The relationship between the 3 networks and HIRC***



## **1.4 Primary Health Care Research Network**

Prior to establishment of the PHC Network, HIRC commissioned the Centre for Health Equity, Training Research and Evaluation (CHETRE) at UNSW and the Department of General Practice, University of Melbourne to produce a discussion paper, a draft of which was presented at a workshop held in July 2000. Thirty people participated from across Australia, representing general practice, community health, policy, practice and research and community. There was overwhelming support and enthusiasm for the concept of a network.

There was agreement that an initial goal of the network would be to build a culture of evaluation, research and development and a focus on health equity within the PHC sector. This goal acknowledges that such a culture is not yet in place and without it there is little likelihood that isolated and unevaluated activities will substantially influence policy and practice to reduce health inequalities through PHC approaches.

In mid 2001, HIRC advertised for tenders to run each of the three networks. The PHC tender was awarded to CHETRE & University of Melbourne. The Network is open to all researchers, policy makers and practitioners with a commitment to addressing health inequalities through PHC.

***The Network aims to:***

- provide leadership and champion a focus on health inequality through PHC;
- develop a broad consensus of priority issues for the PHC Research Network and HIRC;
- build the capacity of PHC health equity research and development; and
- provide a range of mechanisms for information exchange and support.

***The Network's objectives are to:***

- establish and maintain a comprehensive and viable research network;
- provide expert advice to the HIRC Board on priority research topics, questions and related matters;
- facilitate communication and collaboration between network members and other individuals and groups;
- undertake activities to build capacity in research concerning health inequalities; and
- lobby existing funding bodies to fund relevant PHC health inequalities capacity building research.

## **1.5 Patterns of health inequalities**

### ***Health status***

Patterns of health inequalities have been well documented in Australia.<sup>1</sup> There is growing and convincing evidence that differences in health status are associated with gender, family composition, income, education, occupational status and prestige and place of residence.<sup>5</sup> There is also evidence of a relationship between health and a sense of control (for example a lack of control over work and home life<sup>6</sup>), continuing anxiety, insecurity, low self-esteem and social isolation. All these have powerful effects on health, and the effects accumulate throughout life.<sup>7</sup> There is concern that while there has been an overall improvement of the health of Australians, these improvements have not been equally shared. There is nowhere where this is more apparent than in the life expectancy and burden of disease of Indigenous people.<sup>8</sup>

Whilst gains have been made in reduced childhood mortality and communicable diseases, the mortality rate for all causes of death is higher for Indigenous people compared with the general population; and the pattern of age-specific death rates is significantly higher.<sup>9</sup> Four major health conditions - circulatory, respiratory and endocrine diseases and injury/poisoning, account for two-thirds of all excess deaths.<sup>10</sup>

Work undertaken in 1992 and reported in *“Enough to make you sick: How income and environment affect health”* showed clear social gradients in mortality, morbidity and health service use. For example, men from the most disadvantaged groups were 67% more likely to die prematurely than men from the least disadvantaged backgrounds.<sup>11</sup> More recently *“The Australian Burden of Disease Study”* has published data on both mortality and morbidity differences across the social gradient (that is, between the most and least disadvantaged groups).<sup>12</sup>

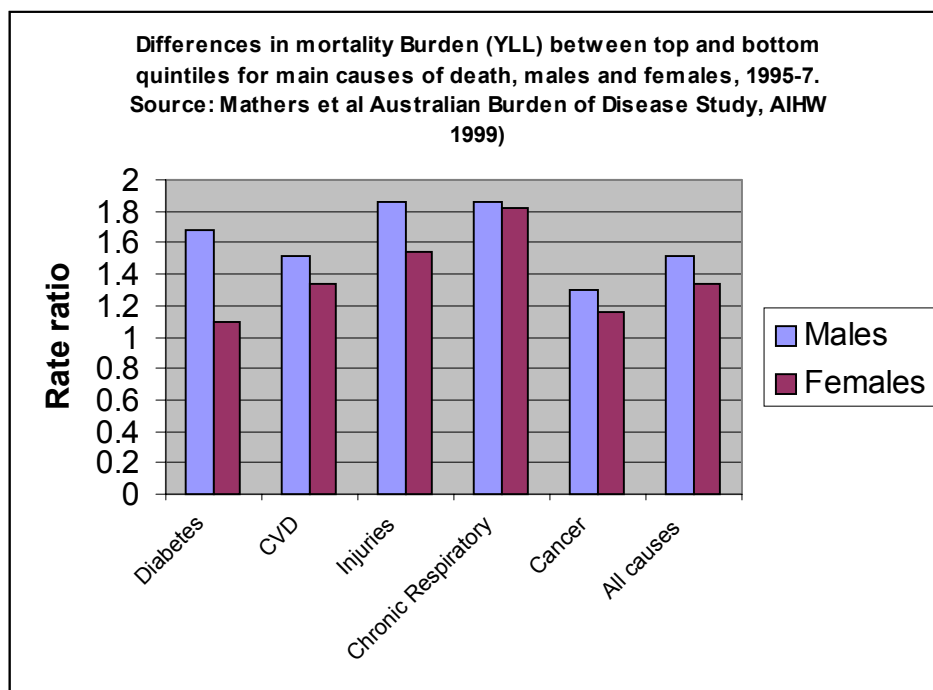
Significant inequalities exist in most main causes of death, particularly for males. The “attributable” excess mortality burden from socio-economic status is thought to be 19% for males and 12% for females. This is greater than the attributable mortality burden from risk factors such as smoking, hypertension and physical inactivity (although some of the socio-economic burden will be mediated by such risk factors). Comparisons over a ten year period (1985-7 to 1995-7) showed no lessening of these differentials.

---

<sup>i</sup> See, for example, Maher et al's series of 4 publications that detail health differentials amongst Australian children, young adults, working aged adults and older persons; and publication entitled *The burden of disease and injury in Australia*.

Highly significant differences have been found between poor and rich areas in Victoria, in both urban and rural settings. Use has been made of Disability Adjusted Life Year measures (DALYs) to estimate the burden of a range of diseases both from mortality and years lived in disability. Poor inner and outer metropolitan and rural areas have DALY scores of up to 28% higher than the Victorian state average and 67% higher than the most advantaged LGAs.<sup>13</sup>

**Graph 1: Differences in mortality burden**



Recently reported data over a three year period has shown that the gap in mortality (as measured by Years of Life Lost - YLL) between the most and least disadvantaged quintiles of women and men narrowed between 1996 and 1999 (from 25.2 to 14.9 per 1,000 for men, and from 14.5 to 10.6 per 1,000 for women).<sup>14</sup> The reason for the improvement is thought to be at least in part due to reductions in smoking prevalence, particularly amongst people from manual occupational groups.

**Table 1: Life Expectance at Birth in NSW 1994-1998**

	Area of Residence	Males	Females
<b>Rural</b>	Most disadvantaged	66	73
	Least disadvantaged	80	83
<b>Urban</b>	Most disadvantaged	70	79
	Least disadvantaged	80	86

In NSW, data presented in the *Draft Health and Equity Statement* reported males born during the 1990s from the most disadvantaged urban areas could expect 70 years of life compared to 80 years in the least disadvantaged areas. In rural NSW, males from the most disadvantaged areas could expect to live only 66 years. Females from the most disadvantaged areas could expect a longer life than in comparison to males; with females in the most disadvantaged rural

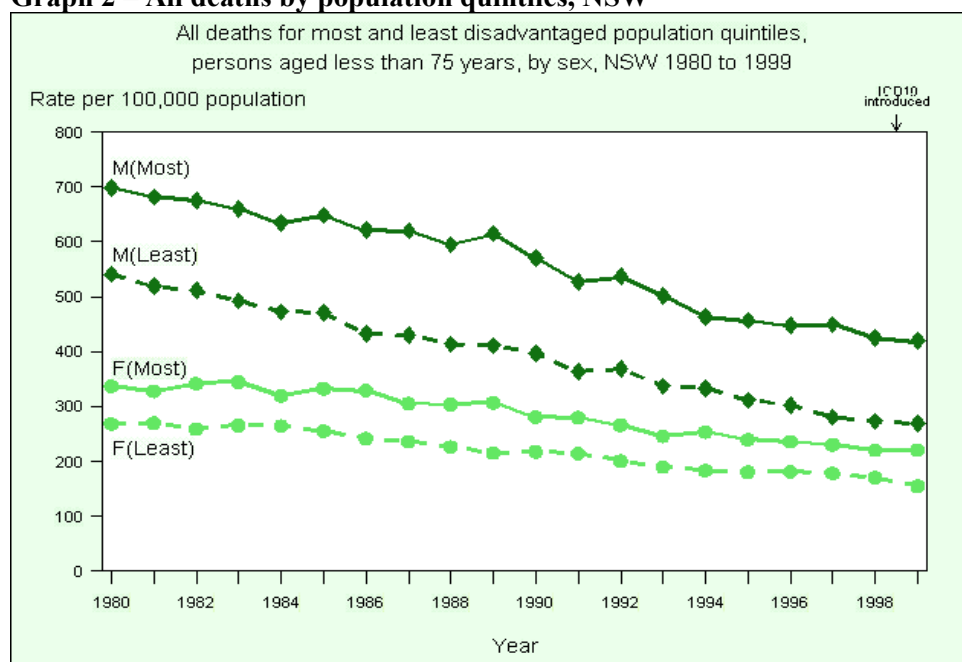
areas expected to live until 73 years and females from most disadvantaged urban areas to 79 years.

The data for females from the least disadvantaged areas was even more pronounced, with females from the least disadvantaged rural areas expected to live to 83 years, and least disadvantaged urban areas to 86 years.

Between 1980 and 2000, death rates declined across the highest (least disadvantaged) and lowest (most disadvantaged) socioeconomic groups:

- for males, this decline was from 543 to 256 per 100,000 in the highest Socio-Economic Status (SES) group, and from 698 to 392 per 100,000 in the lowest group; and
- for females, the decline was from 270 to 149 per 100,000 in the highest SES group, and from 337 to 213 per 100,000 in the lowest group.<sup>15</sup>

**Graph 2 – All deaths by population quintiles, NSW**



In absolute terms, the gap between the most and least disadvantaged groups narrowed, with the difference in death rates between the highest and lowest SES groups decreasing from 155 to 135 per 100,000 in males, and from 110 to 64 per 100,000 in females.

However, in relative terms, the gap actually increased. In 1980, death rates for males in the lowest SES group were 30% higher than in the highest SES group. By 2000, this had increased to 52% higher. This gradual increase of 22% over the twenty-year period was highly significant ( $p < 0.0001$ ). For females, in 1980, the death rates were 24% higher in the lowest compared with highest SES groups and 32% higher in 2000. This gradual increase of 12% in the gap between low and high SES groups over 20 years for females was moderately significant ( $p < 0.05$ ).<sup>7</sup>

These patterns of difference between people living in the most and least disadvantaged areas can be seen across many indicators of health and well being in NSW. One of the greatest differences is in the rates of teenage pregnancy, with the proportion of teenagers giving birth each year ranging from less than 1 in 1,000 teenagers in the least disadvantaged areas to more than 1 in 10 in the most disadvantaged areas.

## **Primary health care utilisation**

Data on the distribution of the broader PHC workforce across differing socio-economic areas is not available. GP numbers and work activity data is available, some in the public domain.<sup>16</sup> Data obtained from the Health Insurance Commission (HIC) suggest that population GP ratios are much higher in disadvantaged areas, and that those GPs see a significantly higher number of patients, generally for shorter consultations.<sup>17</sup>

The *Social Health Atlas* reports standardised rates of GP services across quintiles of SES disadvantage and shows very little variation between the groups for both men and women. This is despite the above data on substantially increased disease burden.

While there is a sizable non-GP primary health care workforce and some data is collected, it is not routinely analysed or reported on in a systematic manner at either state or national levels. Recent analysis of AIHW data on Health and Community Services Labour force undertaken by Baum et al illustrates the challenges in scoping the non-GP primary health care workforce.<sup>18</sup>

## **Quality of care**

The *Social Health Atlas* reports hospital admission data that in general shows higher rates of admission for all causes amongst people from the most disadvantaged areas, with some notable exceptions where the trend is reversed, including private hospital admissions, and admissions for hip replacement, lens insertion and endoscopy.

Again, data on the type of care people of differing SES receive when they access GP services is not widespread. Some studies have looked at this question and found, for example, unemployed patients were 2-3 times as likely to receive a prescription for their symptoms than employed people, despite reporting greater desire to be more informed about the use of medication and to explore their symptoms in more detail.<sup>19</sup>

The concept of 'inverse care' is supported by data from Wiggers who found that patients of low occupational status received significantly less GP consultation time (21% less) than patients from higher occupational groups.<sup>20</sup>

In summary:

- There is consistent evidence of substantial inequalities in health outcomes across the SES gradient in Australia, but reports using area measures (such as the *Social Health Atlas*) probably underestimate the extent of this.
- Evidence as to whether these inequalities are widening or not is conflicting;
- There is less data on primary health use across the SES gradient, although what does exist suggests that primary care access does not match need.
- However, less is understood about the causes of these associations and effective action that can be taken to address health inequality.

## **1.6 The contribution of PHC in addressing health inequalities**

There was considerable debate about the contribution of PHC in addressing health inequalities during the consultations on this discussion paper. In their report to HIRC, Turrell et al concluded that<sup>21</sup>

*“... there are some actions, approaches and principles relevant to reducing socio-economic health inequalities for which a combination of empirically-and theory-based evidence is at least moderately compelling.”*

These are:

- *Macro-economic and social policies*: investment in infrastructure and social assets.
- *Living and working conditions*: community development programs in disadvantaged areas, focussing on creating supportive community networks.
- *Behavioural risk factors*: behavioural change programs that are sensitive to the context of peoples lives and their capacity and abilities to make sustained changes.
- *The health care system*: universal and free health care system funded through taxation, the provision of accessible health care systems, redistribution of resources that support primary health care, and the development of intersectoral collaboration.

While it can be argued that most of the reductions in health inequalities will be brought about through a focus on upstream and system changes, PHC has an important contribution to play in the latter three areas.

The role of primary medical care in addressing health inequalities is supported by international research showing an independent effect of primary medical care on improving health status and reducing health inequalities.<sup>22</sup> Other research shows that primary medical care may mitigate the adverse effect of income inequality on health status.<sup>23</sup> Countries with strong primary care infrastructure have lower costs and generally healthier populations,<sup>24 25</sup> and are characterised by:

- more equitable distribution of resources;
- fewer barriers to access (such as co-payments);
- choice of primary care provider;
- long-term relationships between patients, families, communities and providers; and
- integration of services.<sup>26</sup>

There is a growing body of evidence that suggests access to PHC services is a key factor in meeting the health needs of disadvantaged groups. A recent literature review on the effectiveness of community health services identified aspects of accessibility that enhanced utilisation by disadvantaged populations and contributed to their effectiveness. These included:

- location;
- community-based settings;
- home visiting;
- affordability; and
- single point of entry.<sup>27</sup>

Multidisciplinary teams in community settings have been shown to improve accessibility and uptake of services, enhance communication between providers and the community and improve consumer satisfaction.<sup>28 29</sup> A UK study comparing antenatal care outcomes provided by community versus hospital-based multidisciplinary teams found that community-based teams achieved better outcomes and client satisfaction compared with traditional hospital-based teams.<sup>30</sup>

A USA study found that vulnerable populations were more likely to visit community health centres than use hospital outpatient departments and physicians' offices; established that patients at community health centres were more likely to present with new health problems compared with the other sites; and visits made to outpatient departments were made by sicker people and were characterised by less continuity than other sites.<sup>31</sup>

In systematic overview of the effectiveness of home nursing<sup>32</sup> it was found that interventions (including assessment, case management, and counselling and teaching) had more impact on 'high risk' clients (defined as unmarried, low income or teen mothers) than on those at moderate or low risk.

Results from an outcome evaluation of a series of nurse run health-screening clinics suggest that these appear to be an effective approach to disease prevention in a homeless population. Abnormalities were identified in 22% of clients screened, and of these, 80% received follow up.<sup>33</sup>

In addition to providing accessible services, another major element of PHC is a focus on prevention and early intervention. From the preceding section on patterns of health inequalities, it is evident that disadvantaged populations share an unequal burden of disease in relation to the national health priority areas (NHPAs) and that disadvantaged groups are more likely report higher levels of smoking, alcohol consumption and physical inactivity. These behavioural risk factors are common to a number of the NHPAs, are amenable to interventions predominantly delivered in PHC settings and make up a large proportion of the preventative and health promotion work within the PHC sector.

In the draft discussion paper on dealing with disadvantage in the NHPAs, the NHPAC reiterates the importance of considering the circumstances in which people live in any risk factor reduction interventions as there is evidence that traditional behavioural change programs have not been as effective in disadvantaged groups.<sup>34</sup> A comprehensive PHC approach that embodies a social view of health and embraces multiple and systematic strategies, including a focus on creating supportive environments, therefore plays an important contribution to reducing health inequalities.

PHC gives a framework for understanding that health is a resource for life rather than being a primary goal. It enables a shift from a focus on individual health behaviour to understanding health in the context of people's lives. Implicit in this social view of health is that in order to address health inequalities, research, policy and practice need to embrace intersectoral and multidisciplinary approaches.

In response to the increasing evidence, accessible and proactive PHC systems have been identified in both the UK and New Zealand as key strategies in addressing health inequality. The New Zealand government recently announced an additional \$400 million in new funding into PHC over the next 3 years. The new funding will be targeted firstly at low income people with high health needs.<sup>35</sup>

In summary it is evident that:

- PHC can make an important contribution to reducing health inequalities, particularly through a focus on early intervention and access to a range of health care services.
- Upstream action is also required to bring about sustained health improvements for disadvantaged populations.

## **2 Research priority areas in primary health care**

The initial discussion paper commissioned by HIRC in July 2000 identified four research priorities, two have an intervention focus – primary health care approaches and access to PHC services; one has a population focus – Indigenous health; and one has a focus on oral health. The consultations held across Australia in April 2002 confirmed these priorities and added a fifth priority area with a population focus – rural health. A specific focus on rural health was felt to be warranted to enable the relationship between rurality and inequality to be explored in greater detail.

There was considerable commonality in the specific research priorities within each of the five priority areas. Major themes and issues that cut across all five areas were:

- understanding the contribution of PHC approaches to reducing health inequalities and hence the priority given to an intervention focussed research agenda; and
- ensuring that all PHC related research projects are required (and funded) to include a focus on implications for policy and practice and a strategy for dissemination of research findings.

The rationale and research priorities for each priority areas are summarised below.

### **2.1 The effectiveness of PHC approaches**

Section 1.6 summarises some of the international evidence on the contribution of PHC approaches to meeting the health needs of disadvantaged groups and achieving positive health outcomes. However there has been little Australian research that explores the nature and extent of these contributions.

Research priorities include:

- research that draws together international and Australian evidence on the contribution of PHC approaches to addressing health inequalities and the implications for policy and practice;
- interstate/cross-regional comparisons and analysis of PHC systems (including their level of integration) and their effectiveness in meeting the health needs of disadvantaged populations;
- applied PHC research into interventions that have been found to be effective in different countries, settings, communities and sectors for disadvantaged groups;
- research on the role of multidisciplinary approaches in improving continuity of care for people from socio-economic disadvantaged backgrounds with complex needs;
- examining whether the use of evidence-based guidelines in PHC effectively address health inequality issues;
- development and evaluation of models of community participation that engage disadvantaged groups, including models of community control and empowerment, citizen engagement;
- development, evaluation and dissemination of results of community capacity building initiatives in disadvantaged communities; and
- piloting and evaluating prevention, health promotion and population health models within community settings for the NHPAs that are appropriate and relevant for people from disadvantaged backgrounds.

## 2.2 Access to PHC services and programs

In Australia notions of access and equity are diffused throughout the health system but it is often unclear how effectively current policies and programs reach those who need their services most. The concept of access to PHC services is complex and multilevel. It has traditionally been conceived as reflected in access to *resources* for comprehensive health service development, access to affordable and appropriate *services*, and access to services based *on need*. An equity analysis would look at the way in which resources for PHC were distributed and controlled and whether there was a fair balance between acute and community-based services, prevention and treatment activities.

A focus on access would identify if there were any groups in the community that were systematically marginalised from the delivery of PHC services and what action could be taken to ensure that these groups had access to a range of high quality, appropriate services that met their needs. Finally it would be important to identify if people were receiving services in proportion to need and if there were differences in the outcomes of these interventions across population groups.

Research priority areas include:

- the range of primary health care service delivery processes and their outcomes (one-on-one clinical consultations, group work, programs delivered in the community);
- the organisation and delivery of PHC services (geographic distribution of services and workforce by differing socio economic areas, utilisation of PHC services by SES, levels of funding);
- the identification of factors that enhance or inhibit integration between primary medical care and community health services, especially in relation to complex conditions requiring well coordinated care, and policy implications;
- the relationship between PHC services and other parts of the health system. This includes the balance between investment in acute and community based services, and investment in management structures and relationships, and whether funding allocation processes support integration in relation to health inequality issues (for example in areas such as mental health);
- the impact of PHC funding models on access to PHC services by socio-economically disadvantaged groups; and
- the identification of forces outside the health system that are impacting on the delivery and effectiveness of PHC services (for example, the dismantling of rural infrastructure, fiscal and funding decisions, changing government priorities and so on).

## 2.3 Indigenous health

Historically, there has been only a modest research investment in Indigenous health and the major focus of that research has been on describing the health status.

This is despite the fact that Indigenous people in Australia continue to have:

- life expectancies 15-20 years below that of the non-Indigenous population;
- low use of primary care services;
- high (but still underrepresented) rates of hospitalisation; and
- low representation amongst health care professions.

An obstacle to the improved health status of Aboriginal and Torres Strait Islander peoples has been poor access to appropriate health services, including PHC services.

Barriers include:

- the lack of provision of PHC services particularly in rural and remote areas;
- poor linkages (both horizontal and vertical linkages) between the different parts of the health system;
- lack of a population health focus;
- poverty, which limits access to private health services, including FFS general practitioners;
- cultural and social factors, such as cultural misunderstandings, poor communication and discrimination.<sup>36</sup>

These barriers underlie the importance of partnership approaches between Indigenous specific health services and mainstream health services to achieve health gains for Indigenous communities.

GPs have an important role in the delivery of primary care services for Indigenous communities, whether this be through their private clinical practice, involvement in Aboriginal Medical Services or in population health initiatives through Divisions of General Practice.<sup>37 38</sup> A recent review of Divisions of General Practice showed that the majority of these recognised the need to work with the local Indigenous community on improving access to primary care. Nevertheless, few divisions have skills in working with community controlled services. Similarly Divisions had difficulty linking local needs assessment with a sustainable planned program or intervention<sup>39</sup>.

State/Territory health departments employ Aboriginal Health Workers who are involved in the delivery of PHC services, including early detection, health promotion and community development. In addition, they provide an important link between Indigenous communities and mainstream health services.

Aboriginal community controlled health services (ACCHS) are “*culturally appropriate, autonomous primary health care services, initiated, planned and governed by local Aboriginal communities through their elected Aboriginal board of directors.*”<sup>40</sup>

Improved access to health services has been identified as a major benefit of ACCHS for Indigenous communities for reasons that include:

- local community ownership and control of the service;
- flexible and responsive service delivery, including the provision of outreach services;
- integrated and holistic service delivery through PHC approaches;
- cultural appropriateness of services, including information and education, that cater to the social and cultural needs of Indigenous peoples in ways that are sensitive and inclusive.<sup>41</sup>

ACCHS have maintained a strong commitment to the principles of PHC. However, with a focus on service delivery they are limited in being able to undertake research into the role of PHC interventions and their impact on health outcomes.

There are a number of important issues in undertaking Aboriginal health research that are as relevant today as they were 13 years ago when they were described in the National Aboriginal Health Strategy. Aboriginal health research has often been undertaken with little/proper consultation with communities; communities have had little or no control over the research been undertaken; and rarely has research provided benefits to the Indigenous participants<sup>42</sup>. Despite a considerable body Aboriginal health research, it does not appear to be contributing to an improvement in Indigenous health status, a point recognised by the Aboriginal and Torres Strait Islander Research Agenda working Group (RAWG) and has led to RAWG providing a structure through which research, policy and practice can be more effectively addressed and linked<sup>43</sup>.

The central issues of Aboriginal self-determination and partnership apply to the conception and conduct of Aboriginal health research<sup>44</sup>. It is recognised that any systematic approach to researching Indigenous health issues must be led by Indigenous people and that it is inappropriate for the PHC Network to develop priorities for Indigenous PHC research. The Network will need to be guided by Indigenous researchers and Indigenous organisations, including NACCHO. The Network sees its role in supporting the efforts by Indigenous researchers and organisations and in building capacity across the PHC system to support local Indigenous communities in undertaking research and evaluation activities.

## 2.4 Rural Health <sup>ii</sup>

As noted above, rural health was added as a fifth priority area as a result of the consultation process, as a specific focus on rural health would enable the relationship between rurality and inequality to be explored in greater detail.

The Australian Institute of Health and Welfare (AIHW) has concluded that the health of people living in rural and remote areas is poorer than that of their metropolitan counterparts with respect to some health indicators, and that in general census data shows an increasing socio-economic disadvantage aligned to increasing distance from a major urban centre. This is evident in respect of mortality and hospitalisation rates (as an indicator of morbidity), poorer population health status in a number of areas (such as rates for diabetes), and higher rates for injury and suicide. The report also notes the impact of Indigenous health status on these figures, particularly in more remote areas, and in relation to rates for respiratory and circulatory disease. There are clear differences in health status between metropolitan and non-metropolitan communities evident in both the burden of disease and across population groups and a number of age cohorts.<sup>45 46 47</sup> There is also evidence of different patterns of use of general practice services in remote areas.<sup>48</sup>

There is clear evidence that many non-metropolitan communities are relatively disadvantaged in terms of access to health services as a result of physical isolation, the capacity of health care services, and the distribution or profile of the health workforce. A wide range of government programs have been developed over many years to address this disadvantage in the PHC area, ranging from strategies and incentives to attract and retain a primary medical care workforce in rural areas, and the development of programs which have a specific focus on rural health needs.

However, both 'rurality' and 'rural health' can be problematic concepts. Over recent years it might appear that the concepts of rurality, inequality and relative disadvantage have become to some extent synonymous in the political discourse. However the experience of living in rural areas varies widely in terms of remoteness from services, underlying social and economic conditions and whether the area is growing or declining. The interaction of these factors and general issues of socioeconomic status (such as level of education or income) are poorly understood. A more sophisticated understanding of the interplay between rurality, socioeconomic status and health service issues is required.

Fragar has also proposed a classification system based on the primary agricultural commodity produced in any given region.<sup>49</sup> A single concentration on the concept of rurality in itself can mask a wide range of other research agendas, which need to identify both the determinants of health inequality and the capacity of rural PHC systems to address inequality in both relative and absolute terms.<sup>50 51 52 53</sup>

---

<sup>ii</sup> This section was largely written by Graham Hill, from OCHRE consulting

*Healthy Horizons*, a report by the National Rural Health Policy Forum and the National Health Rural Alliance (NHRA) for AHMAC suggested that broad level research should be conducted. The following issues have been supported through the consultation process:

- provide a better understanding of the health status of rural, regional and remote Australians and the social, economic, environmental and political factors that contribute to health status;
- include research about local health issues and priorities in order to evaluate the success of local interventions; and
- include the development of health status and related risk factors which reflect diversity of conditions and people in rural, regional and remote areas, measure changes in health and well being, and provide guidance for the allocation of the workforce, research and funding to areas with poorer health outcomes.

## 2.5 Oral health <sup>iii</sup>

The burden of oral diseases in Australia represents a significant challenge for consumers, policy makers, health service managers, educators, clinicians and public health professionals. Throughout the 1990s, population-level surveillance conducted by the Dental Statistics and Research Unit (DSRU) provided a systematic collection of nationally representative oral health data. Core surveillance activities addressed disease estimates and access to dental care. Analyses of datasets revealed persistent inequity with a greater burden of disease among vulnerable subgroups including Indigenous Australians,<sup>54</sup> rural and remote dwellers,<sup>55</sup> migrants,<sup>56</sup> elderly in residential care,<sup>57 58</sup> and publicly funded adults.<sup>59</sup> Not only do these adults have comparatively poorer oral health outcomes, they also face structural, social and economic barriers to timely and appropriate care.

Of the 4.7 million Australian adults eligible for public dental care, ten percent are currently on waiting lists for general dental services. Institutional resource scarcity and severe rationing of services mean that many adults are pressured to seek private dental care beyond their means or access emergency public dental care.<sup>60</sup> Both of these options are likely to result in quick-fix solutions such as dental extractions, rather than a comprehensive program of prevention and maintenance. Criticism of problem-oriented visiting behaviour blames those already disadvantaged by their circumstances, and incorrectly makes the assumption that dental disease is entirely preventable.

A number of obstacles restrict the ability of the present system to reduce social inequality in oral health. These include the uncoordinated and fragmented nature of dental services, inequitable distribution of resources, limited scope of insurance coverage, and clinical (rather than preventive) orientation to oral health.<sup>61</sup> Other constraints are the separateness of oral health from general health, the lack of consumer involvement, and inadequate understanding of the underlying determinants of oral health to inform interventions to reduce inequality.

Overcoming these obstacles requires a focus on addressing “upstream” factors. Ideally, a reorganised approach would aim to achieve a balance in responsibility between levels of government, community and individual commitment. Recognition of oral health as an integral aspect of overall wellness is important with dental care being a component of health care. Within public dental care emphases would be on shifting visiting patterns from emergency to general dental care, and from extraction to restoration, and ultimately from a treatment philosophy to a preventive orientation.<sup>62</sup>

---

<sup>iii</sup> This section was largely written by Professor John Spencer and Ms Anne Sanders from the Australian Research Centre for Population Oral Health at the University of Adelaide, SA.

Nevertheless, the principles of primary health care outlined in the World Health Organisation's Alma-Ata Declaration<sup>63</sup> can be applied to priority areas for oral health research.

Research priority areas include:

- research into the socio-cultural and politico-economic determinants of oral health. This will improve the understanding of how environments differentially support groups, clarify factors that shape oral health behaviour, and highlight opportunities for innovative interventions;
- methodological research into methods of preventing and controlling prevailing oral health problems specific to defined communities. This includes the improved identification of individuals at risk of oral conditions. It supports a reorientation of oral health care to greater emphasis on disease prevention and health promotion;
- building supportive communities, with a focus on informing, educating and empowering members. Greater emphasis needs to be placed on maternal education for the infant and preschool child and the extension of school-based dental programs;
- multidisciplinary, and multilevel research into ways of collecting contextual data in order to maximise appropriate action at a community level. New ways are needed to incorporate self-help, community empowerment, and health behaviour change as priorities in education;
- greater integration of oral health with general health activity. This includes a sharing of resources for mutual benefit and a common risk factor approach to health and illness; and
- mobilisation of a unified approach in the roles and responsibilities of health care educators, providers, agencies, administrators and policy makers. It endorses the establishment of an appropriately trained and coordinated oral health care workforce.

## 3 The context of research funding & support in primary health care

Historically, there has been little research into PHC in Australia. There is an ongoing debate over whether research funding is best driven by investigator, priority or policy agendas. In the UK, the *Research and Development Strategic Review: Primary Care* advocates that to be of value to the National Health Service (NHS), primary care research must impact on quality of care and achieve this by:

- establishing a reflective evidence-based culture; and
- producing research output which fills the evidence gap.<sup>64</sup>

These challenges have been taken up in Australia through initially the General Practice Evaluation Program (GPEP) and now the PHC Research, Evaluation and Development program (PHCRED). Both these initiatives have come out of the general practice branch and reflect a primary medical care orientation. There is no other national initiative that extends the research focus to include other aspects of PHC. At a state/territory level, NSW, Northern Territory, Queensland, South Australia and Victoria have PHC research and development centres associated with universities.<sup>iv</sup>

### 3.1 GPEP

As part of its general practice reform strategy, the Commonwealth established the GPEP in 1990. During a 10 year period over \$12 million dollars was invested in general practice related research.

A recent study of all GPEP projects completed between January 1999-September 2001 found that of the 52 projects, health inequalities and the determinants of health were not researched as a main area of interest but were covered as part of only four projects in association with areas such as evidence-based practice and quality of care. The authors concluded that this may reflect the orientation of the program towards primary medical care rather than comprehensive primary health care which has a stronger focus on health inequalities and health promotion.<sup>65</sup>

### 3.2 PHCRED

The Commonwealth has recently moved to consolidate research, evaluation and development funding for primary care in Australia through a restructuring of GPEP as PHCRED program. The focus of this substantial program (\$50 million over 5 years) will be the development of research and evaluation capacity in the field, with a particular focus on linking general practice with other primary health care providers.

The strategy is to address:

- a pressing need for the development of evidence to support clinical and primary health care decision making, development of service models and economic evaluation for policy and planning purposes;

---

<sup>iv</sup> The NSW based Centre for Health Equity, Training Research and Evaluation; the NT based Cooperative Research Centre for Aboriginal and Tropical Health; The South Australian Community Health Research Unit (SACHRU); the Victorian based Australian Institute for Primary Care and the Queensland based Centre for Primary Health Care.

- the development of capacity for research into Primary Health Care by expanding:
  - (a) the number of primary health care researchers and the number of practitioners trained in, and undertaking, research;
  - (b) better engagement with and uptake of research and evaluation by development of stakeholder critical analysis skills, receptiveness to participation in research through data collection and good record keeping, and the number of practitioners delivering evidence-based care through, for example, better use of guidelines;
  - (c) high level research skills through improving quality of primary health care scholarship.<sup>66</sup>

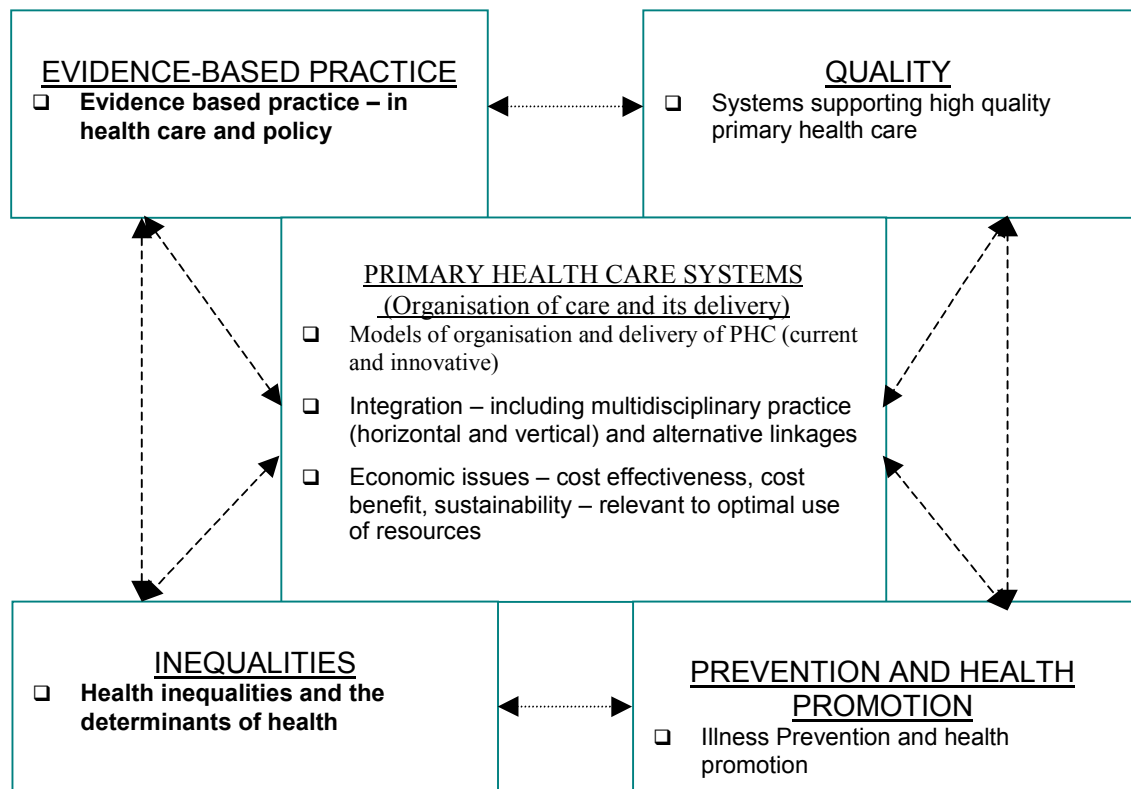
Major initiatives and priorities include:

- priority setting, with Stage 1 report produced;
- researcher development program – placements;
- scholarships for higher degrees and fellowships, through NHMRC which have been announced;
- Primary Health Care Grants, administered through NHMRC have been announced;
- University capacity building program (through 18 Departments of General Practice & Rural Health), now in place; and
- National Primary Care Research Institute, now in development.

Seven inter-related thematic areas for PHC research and development were identified through Stage 1 priority setting process which involved a structured and systematic consultation with key stakeholders including PHC providers, researchers, consumers and government representatives. These include:

- a) evidence based practice;
- b) systems for supporting high quality PHC;
- c) models of organisation and delivery of PHC;
- d) integration;
- e) economic issues;
- f) inequalities and the social determinants of health; and
- g) illness prevention/ health promotion.

The framework of the thematic priority areas has been developed to illustrate the inter-relationships between the priority areas.



Priority research, evaluation and development focus is also on rural and remote populations, Aboriginal and Torres Strait Islander communities, and people who are disadvantaged or ‘hard to reach’ due to their health or other social, economic or environmental factors.<sup>67</sup>

Within the priority area of *health inequalities and social determinants of health*, five priority research areas have been identified:

1. The development of PHC interventions which break the cycle of socio-economic disadvantage (levers for change; effectiveness of the involvement of PHC providers in intersectoral approaches);
2. The development of strategies to improve access and overcome systematic, professional, cultural and economic barriers;
3. Assessment of the impact of cultural differences on access and effectiveness;
4. Oral health care services; and
5. The management of chronic disease in Aboriginal and Torres Strait Islander peoples.

In December 2001, requests for research proposals were advertised. The research grants process has been run through the NHMRC and concern has been expressed as to their capacity to respond to the challenges into undertaking research in the PHC context and the need for methodologies that are not those traditionally valued in the NHMRC grant process. Furthermore, as the research proposals are investigator driven, there is no requirement that proposals address the identified priority areas. In fact, no proposals were successful in

obtaining funding through the NHMRC, and have been referred back to the PHCRED program area in the Department of Health and Ageing for further consideration.

From the consultations on the draft discussion paper, it is clear that the major focus of PHCRED remains on general practice. Few of the PHCRED capacity building initiatives have been able to systematically engage other PHC workers in R&D training, education and support initiatives. The exceptions are in some rural areas, where there is active participation of community health staff in the program. There has been little consultation with state health departments to examine ways in which state funded PHC staff could be facilitated to participate in initiatives and only in South Australia is there is a comparable structure (SACHRU) to build the research and evaluation capacity of community health workers.

### **3.3 NHMRC**

In 2001, one primary health grant of \$141,975 was awarded. In 2002, this increased to fourteen primary health grants totalling \$783,393, four of which have an explicit health inequalities focus; ten of which are scholarships/fellowships; and two of which are tied to strategic research priorities. The total number of grants that had a health inequalities focus in 2001 was twelve, totalling \$1,622,052; and in 2002 was twenty three, totalling \$1,753,572.<sup>v</sup> This summary information provides a stark illustration of the paucity of PHC research that is being funded through the NHMRC.

#### ***NHMRC strategic research priorities***

Since 1997, the NHMRC has set aside funding to develop strategic capability in areas where the research effort is not commensurate with the magnitude of its importance to health care in Australia. This research funding is administered by the Strategic Research Development Committee (SRDC). A strategic framework has been developed to guide its activities. The framework is organised in three tiers:

- research priority areas;
- related research areas; and
- approaches to developing strategic research.

The new priority areas in tier one for 2000-2003 are:

- Indigenous health;
- ageing;
- mental health;
- oral health; and
- systems of care for chronic diseases.

The second tier of the framework focuses on research priority areas as they relate to health services research, socio-economic determinants, rural health and palliative care. This tier assists in refining and defining the focus.

The third tier identifies various approaches to develop strategic research, including scoping, capacity building and targeted research.<sup>68</sup>

---

<sup>v</sup> This information is based on data provided by NHMRC on all grant types except block funded institutes and using 'primary health' and 'disadvantage', 'access', 'socioeconomic', and 'equity' as key words.

## SRDC priorities

The following table summarises the initiatives in each SRDC priority area.

Priority area	Summary of initiatives
Indigenous Health	<ul style="list-style-type: none"> <li>◆ Established RAWG – collaborative structure through which Aboriginal health research, policy &amp; practice can be linked &amp; addressed.</li> <li>◆ RAWG has outlined 6 research themes as part of its Road Map that are considered critical to achieving substantial health gain for Aboriginal and Torres Strait Islander peoples:               <ul style="list-style-type: none"> <li>▪ The factors and processes that promote resilience and wellness.</li> <li>▪ Patterns of risk, disease, death.</li> <li>▪ Non-health sector interventions that address determinants of health.</li> <li>▪ Research that enhances research practice.</li> <li>▪ Research into gaps in demographic knowledge eg: previously under-researched Aboriginal and Torres Strait Islander populations and communities.</li> <li>▪ Research that has a focus on the delivery of health services to Aboriginal and Torres Strait Islander people eg: priorities in the delivery and enhancement of primary health care, health system analysis and financing models.</li> </ul> </li> </ul>
Ageing	<ul style="list-style-type: none"> <li>◆ Funding of up to \$2 million will be available for projects researching the biomedical and psychosocial aspects of healthy ageing.</li> <li>◆ EOI called for projects to address following areas:               <ul style="list-style-type: none"> <li>○ <b>Strategic Research</b> – addressing dementia, neurodegenerative disorders, musculoskeletal disorders, mental health or wound healing</li> <li>○ <b>Developmental Research</b> – including geriatric pharmacology or nutrition</li> <li>○ <b>Fundamental Research</b> – addressing the genetics of human ageing, oxidative stress or mitochondrial dysfunction</li> <li>○ <b>Aboriginal and Torres Strait Islander Research</b> – issues relevant to ageing and premature death in Aboriginal and Torres Strait Islander peoples.</li> </ul> </li> </ul>
Mental Health	<ul style="list-style-type: none"> <li>◆ Funding of up to \$100,000 for health services research that contributes to filling the research gaps in mental health.</li> <li>◆ EOI for multidisciplinary evaluation of innovative mental health services. Aim is to evaluate the effectiveness of mental health services in terms of outcomes &amp; sustainability. Multidisciplinary : either in team's composition and/or services it evaluates.</li> </ul>

Priority area	Summary of initiatives
Oral Health	<ul style="list-style-type: none"> <li>◆ Focus on research that fills knowledge gaps &amp; interplay between oral health &amp; systematic health.</li> <li>◆ Priority areas include:               <ul style="list-style-type: none"> <li>○ Basic research - "What are the cellular, molecular and genetic risk factors for disease of the oral tissues and fluids?"</li> <li>○ Clinical research - "What are the best methods for treatment of oral disease and for improving the health of oral tissues and fluids, including natural methods?"</li> <li>○ Public health research - "What are the health gains of continued or expanded systemic and/or topical fluoridation in the Australian community?"</li> <li>○ Health services and practices - "How can community initiated and/or driven interventions improve access and equity in oral health?"</li> </ul> </li> <li>◆ Funding of up to \$100,000 has been allocated for PHC related research</li> </ul>
Systems of Care for Chronic Diseases	<ul style="list-style-type: none"> <li>◆ Funding of up to \$3mill available for research on 6 identified research topics (in consultation with Population Health Division).</li> <li>◆ EOI called for one area : 'Unified systems of care' – coordinated care, incentive provision, outcome monitoring &amp; system monitoring, plus systems of care that reduce the burden on carers.</li> </ul>

### 3.4 National Health Priority Areas

The research implications arising from the National Health Priority Areas (NHPAs) are integrated into the SDRC priorities of in relation to systems of care for chronic diseases and mental health. This is important, as there is clear evidence of a social gradient in each of the priority health issues.<sup>69</sup>

Moreover, as a substantial proportion of care and management of people with chronic disease occurs within PHC settings, it is important that any PHC research agenda addresses and informs the chronic disease research agenda and conversely that the chronic disease research agenda has not only a health inequalities focus but also a focus on PHC settings.

The major research gap is in relation to prevention and early identification of risk factors in relation to the NHPAs, as this is not part of the SRDC research agenda.

The National Health Priority Action Council (NHPAC) has been established to progress action on the NHPAs. The Council is currently developing its strategic directions and these will be informed by a paper that examines disadvantage in relation to the NHPAs and action required. The areas for action to address disadvantage in the NHPAs suggested by the NHPAC<sup>70</sup> include a focus on interventions, PHC related approaches (including self management, consumer education and community awareness, multidisciplinary approaches and coordination of care) and access and cross over the priority areas identified in this discussion paper. This is an important initiative as the areas for action rely on a PHC system and research agenda to deliver.

### 3.5 State Commonwealth Research Issues forum (SCRIF)<sup>vi</sup>

SCRIF is a joint initiative of the Departments of Health of the Commonwealth, States and Territories, under the auspices of the Australian Health Ministers' Advisory Council. Through the Australian Health Minister's Advisory Council (AHMAC) SCRIF has responsibility for a program to address a range of important research themes. The NHMRC is assisting in administering the research component of the Program, on behalf of the SCRIF. In the first round of priority-driven research \$3.9 million was allocated under 4 themes: health services, health economics, health of individuals and health of populations. There are several PHC related research projects.

#### **Health services:**

*The Centre for Health Service Development* [the University of Wollongong, NSW] will receive \$264,137 over three years to examine why patients attend Emergency Departments, and whether the availability of primary care community services (such as GPs and after hours medical services) influences the number and type of patients who attend hospital Emergency Departments.

#### **Health of individuals:**

*The Menzies School of Health Research* [Northern Territory] has been granted \$300,000 for a three year project that seeks to improve the framework to be applied in evaluating community-directed Aboriginal diabetes prevention programs in remote Northern Territory and rural Victoria. It responds to a need to develop and implement, together with Aboriginal people, culturally sensitive diabetes prevention and control programs.

*The Murdoch Children's Research Institute* [Victoria] has been granted \$294,137 over three years to conduct a randomised controlled trial of a brief GP intervention to reduce overweight in Victorian primary school children.

#### **Health of populations:**

*The Menzies School of Health Research* [Northern Territory] will receive \$458,500 over five years for a study entitled "Community Health Centre Organisation and Quality of Care for the Prevention and Management of Chronic Disease" which will focus on improving care for Indigenous Australians in rural and remote areas. This project will investigate the use and impact of system changes in remote and rural health centres, while at the same time implementing, and monitoring the impact of, a process of continuous quality improvement in the health centres.

*The Flinders Medical Centre* [South Australia] has received a grant of \$348,857 over four years to establish and evaluate an Integrated Cardiac Assessment Regional Network in the south-east region of South Australia. This study will evaluate the effectiveness of a new system supporting rural GPs in the delivery of up-to-date evidence-based management of patients possibly suffering a heart attack.

---

<sup>vi</sup> This information is taken from a SCRIF Joint release: Health Minister's fund new priority-driven research programs.

## **3.6 State research priorities and investment**

### ***Northern Territory***

The Cooperative Research Centre for Aboriginal and Tropical Health (CRCATH) is based in the Northern Territory. It is a partnership between two universities, a research institute, NT health and two Aboriginal controlled health services. It receives funding from the Department of Education, Science and Technology and a number of other sources. Its major research focus is on improving the health of Aboriginal peoples through strategic research, capacity exchange (including education, training, research information dissemination, providing skill development and employment opportunities for Aboriginal peoples), collaborative approaches and partnerships with Aboriginal communities. Much of its work is concerned with intervention and PHC research.

The NT Department of Health in partnership with the Commonwealth Department of Health is currently implementing the Primary Health Care Access Program (PHCAP) in remote areas. PHCAP provides a mechanism to improve local health systems which include both mainstream and Indigenous-specific health services. It involves cashing out existing commonwealth and territory funds for the development and expansion of comprehensive primary health care services in a planned and coordinated manner in partnership with local communities. The implementation of PHCAP includes an evaluation component.

### ***New South Wales***

The NSW Health Research and Development Infrastructure Grants Program targets public health research as one of its target groups. Organisations funded in this stream between 1999-2002 included CHETRE, one of the Centres for PHC associated with the UNSW. The centre also receives funding from a number of other sources, including the Commonwealth Department of Health and Ageing. CHETRE has been involved in the development and evaluation of interventions by PHC systems to:

- Address health inequalities
- Workforce needs assessment of health workers in disadvantaged communities
- Identifying ways in which GPs and Divisions can address the needs of disadvantaged communities.
- The provision of research support for community health services.

### ***Queensland***

The Centre for Primary Health Care was established in 1994 as a joint initiative of The University of Queensland and Queensland Health. The Centre works with Health Districts, community organisations and professional groups to research and develop ways of advancing the health and wellbeing of communities. The Centre supports several research projects particularly in the areas of:

- Health inequalities
- Measuring community engagement and community capacity building (with SACHRU)
- Working in effective collaborations and partnerships
- Mental health and mental health promotion
- Consumers and community organisations role in health care
- An evaluation of community public health planning in rural and remote areas.

The Centre also initiated a Graduate Health Studies Program (GHSP), a postgraduate distance education program for primary health care workers, which aims to enhance the knowledge and skills of mid-career health professionals

## **South Australia**

The Community Health Research Unit (SACHRU) receives core funding from the Department of Human Services to provide a PHC research and evaluation service for community health services across South Australia. Its work program includes:

- Social capital research with a health equity focus
- A systematic review of the effectiveness of locational interventions to reduce socio-economic inequities in health
- Workforce training and education; and dissemination of research findings.

The Department of Human Services is also funding several health inequalities related PHC research initiatives including:

- exploring approaches to mental health care in remote and rural areas; and
- a comparative analysis of the different approaches to mental health promotion and treatment.

## **Victoria**

The Department of Human Services Primary Care Partnerships represent a significant investment in primary care reform. While this major program does have a significant development approach in relation to communities and building multidisciplinary teams, it does not have a specific research component or an overt aim of addressing health inequalities. Other relevant initiatives include:

- The Primary Care Knowledge Base, which can provide online access to demographic and service utilisation data
- The Burden of Disease study, which provides descriptive data on inequalities in health status across the regions and LGAs of Victoria.

The Latrobe University based Australian Institute for Primary Care (AIPC) provides a focus for PHC R&D activity within the state. The Institute has a strong focus on evaluation and support of PHC and Community Health Services, particularly through the work of the Centre for Development and Innovation in Health (CDIH). Also co-located at the AIPC is the Health Issues Centre, with a focus on consumer responsive equitable health service and the National Resource Centre Consumer Participation in Health. The Institute provides expert consultancy and project management, research and development, information, education and training services, and accreditation and standards reviews for primary care and community service providers.

### 3.7 Implications for PHC health inequalities research

As the following table illustrates, there is good alignment between the research priorities identified by the PHC Network with the research priorities identified for PHCRED and some alignment with the NHMRC's SRDC 1<sup>st</sup> and 2<sup>nd</sup> tiers.

Priority area/who	PHC Network	PHCRED	NHMRC
Rural	X	X	X
Indigenous	X	X	X
Oral	X	X	X
Access & quality	X	X	
PHC interventions, inc EBP	X	X	
Mental health			X
Systems of care for chronic disease			X

Two of the tier one SRDC priority areas – Indigenous and oral health - are consistent with the health inequality research priority areas identified in the PHCRED Stage 1 priority setting process and also the PHC Network priorities. The SRDC Indigenous health priority area has a clear PHC and health inequality focus and oral health has a specific allocation and focus on community-based interventions to improve access and equity in oral health.

In summary:

- There is a growing awareness by government of the need to invest in PHC related research and capacity building.
- This has not yet been translated into a specific PHC and health inequalities research focus within the NHMRC.
- PHC research through PHCRED is investigator driven rather than driven by policy or priority agendas
- There is a good alignment between the research priorities identified in this discussion paper and research priorities identified through other research priority setting processes.

## **4 Building research capacity in primary health care**

### **4.1 The fragmentation of PHC in Australia**

Primary health care systems in Australia are the front line of health service delivery in the country and represent a significant level of health resource investment. Future strategic directions within the health system that are focusing on decreased length of hospital stay, development of ambulatory care systems, improved management of chronic and complex health problems and a focus on early intervention are increasing pressure for the development of an integrated primary health care system. At the same time, the pressure to allocate primary health care resources to reduce the burden of the hospital sector poses a threat to developing a sustainable and equitable primary health care system for other health issues.

The complexity and differing jurisdictional responsibilities has resulted in a PHC system that is fragmented and as a result, vertical and horizontal links within the system and between the PHC and other sectors are poorly developed and services are less effective than they might be. It can be argued that whilst a PHC approach offers a framework for addressing health inequalities, in reality the fragmentation limits the possibilities.

There are also long standing tensions within the major components of the PHC sector, particularly general practice and community health services. Partly these are to do with the differences in their training, lack of agreement about the scope of PHC and also competition over resources and power.

The lack of clear national policy frameworks for the development of primary health care systems has only served to exacerbate the tensions.

It is within this above context that the challenges of undertaking research within PHC on health inequality needs to be understood.

### **4.2 Lack of a research infrastructure & capacity**

The Commonwealth has recognised the need to improve the research and development (R&D) infrastructure within PHC through the GPEP and more recently PHCRED, and AHMAC has developed a mechanism to look into the development of a national PHC policy framework.

The lack of capacity across the system is reflected in a number of ways:

- Research is not seen as part of the routine work of GPs or other PHC professional groups and there is therefore no time / resources routinely allocated for R&D activities.
- The structure of PHC means that there is often not a critical mass of people working together to support the development and implementation of R&D activities. This is a particular issue in general practice.
- There is no strong culture of R&D and in fact many parts of the workforce of suspicious of research or evaluation activities if they feel they will be used to 'judge' their performance.
- Basic information technology infrastructure that will allow R&D activities to be built into practice is absent in many places.
- Clients are unused to research being undertaken within PHC settings and often practitioners are concerned that their clients may be upset by being asked to participate in studies. There are also difficulties in developing and processing ethics applications and

deciding on when and how consent should be obtained. Navigating through ethics applications is particularly an issue for relatively inexperienced PHC researchers.

- In many places there are weak links between Universities and practitioners. There are also difficulties in attracting researchers in PHC settings where research may be seen as more difficult to organise and conduct.
- Until recently there has been little emphasis placed on evidence-based practice in many PHC settings and the lack of a research or reflective culture limits the ease with which projects can be developed.

These issues are compounded when attempting to undertake PHC research in the area of health inequalities, as issues to be studied may be sensitive and client groups difficult to reach.

### 4.3 Methodological issues

There is growing interest in the area of health inequalities research in moving from the description of problems or patterns of disadvantage to taking action. Turrell et al argue that research into health inequalities needs to focus on individuals, groups, communities and systems and that intervention-based research needs to be informed by the following four approaches:<sup>71</sup>

- *A social ecological approach* (which implies a relationship between people and their environments – focus on contexts in which people live and work & how this impacts on psychosocial functioning and health-related behaviour).
- *A targeted approach* that specifically targets disadvantaged groups & taken into consideration the structural, material, economic and contextual constraints.
- *An intersectoral approach*, involving community participation in recognition that health is influenced by other sectors than health.
- *A multi-level approach* –i.e. that focuses on upstream, mid stream and downstream levels.

The scope of the interventions that have been identified as effective and the approaches to be followed require the development of capacity in a wide range of methodologies. As well as developing capacity in the more traditional research approaches, PHC research needs to develop skill in multi-level interventions and tracking of complex interventions. An emphasis on understanding and developing interventions will also require skills in qualitative methods.

These issues have been identified in other countries. New Zealand has identified

*“a clear need for research into the nature and patterns of environmental, social, economic and lifestyle determinants of health, the ways in which these determinants interact to influence health and disease, and potential interventions to improve individual and population health and reduce health inequalities. While identifying causal factors and relationships is important, research that contributes to solutions and interventions is essential. It is also essential that the research is undertaken with appropriate regard to social and cultural context. There is also another overarching issue around the need to encourage and foster more multidisciplinary intervention research.”<sup>72</sup>*

## 4.4 Conceptual frameworks for PHC inequalities research

There has been no overall framework for PHC research and development, and little resource investment. This has been compounded by the lack of a national PHC policy within which a research agenda can sit and be reflected. Consequently R&D in PHC has been limited and piecemeal. The work of PHCRED, while limited is important in providing a structure within which PHC R&D can be contextualised and further refined.

The UK has developed a primary care research framework that identifies 4 areas of evidence gap that could be used to identify research priorities.<sup>73</sup> These ‘evidence gaps’ are:

- ◆ **basic science gap:** applies to both social and clinical science
- ◆ **effectiveness gap:** relate to a range of interventions, including promotion, prevention, diagnosis, treatment, and includes impact, outcomes & cost effectiveness
- ◆ **applicability gap:** application of evidence from trials/pilots to practice, delivery and organisational systems and community contexts
- ◆ **implementation gap:** most common gap, where there is good evidence about what is effective & who it should be offered to, but adoption has been patchy and incomplete (service development gap).

The *applicability* and *implementation* areas are the focus of health services research and are particularly pertinent for health inequalities. For instance, the applicability and implementation of interventions for Indigenous or refugee communities, or for unemployed people with low literacy, or in rural settings.

Within the UK framework, a number of levels at which research needs to focus have been identified:

### **Clinical care**

- access
- quality of care: continuity of care
- integration of care
- participatory care

### **Delivery of care:**

- practice/service level
- organisation level
- system level

### **Intersectoral action:**

- addressing underlying social determinants of health
- social policy
- partnerships with others

What is missing from this framework is the community level that is the focus of much of community health and community care service provision. In developing a PHC Health Inequality R&D conceptual framework that incorporates a wider population perspective, the proposed National Public Health Partnership (NPHP) schema may be useful.

The schema has been developed to assist in evaluating evidence on public health interventions that contributes to increased confidence in and acceptance of research. When finalised it is intended to inform the NHMRC in its public health research agenda. Their schema is:

- ◆ Focus on evaluating the strengths, weaknesses and gaps in the available evidence;
- ◆ Build on existing approaches for evaluating different types of health research;
- ◆ Reflect the complexity of public health program evaluations, while supporting the principles of evidence-based practice;
- ◆ Help to assess what is known about the benefits and harms of public health interventions, and the degree of uncertainty about them;
- ◆ Distinguish between questions about the intervention, the methods that were used to evaluate the intervention and the evaluation findings;
- ◆ Assist in determining the gaps in evidence;
- ◆ Identify the features of an intervention that should be reported to enable a meaningful interpretation to be made about the findings;
- ◆ Enable the overall credibility of the reported outcomes to be assessed; and
- ◆ Guide the appraisal of the importance and relevance of reported outcomes.<sup>74</sup>

It is not within the scope of this report to develop a conceptual framework but this will be an important step in developing a comprehensive approach to PHC health inequality research in Australia. It will also be important to consider capacity building issues and enabling factors as part of any PHC inequalities research framework.

## 4.5 Capacity building

The need to develop PHC research capacity has been identified as a major issue. The PHCRED program represents the most comprehensive attempt to develop research capacity in this area in Australia. This section of the report examines the types of capacity issues that need to be addressed in developing capacity in health inequality research within PHC.

Capacity building is defined as an approach to

*“the development of sustainable skills, structures, resources and commitment to health improvement in health and other sectors to prolong and multiply health gains many times over”.*<sup>75</sup>

One way of looking at what’s required to build research capacity within the PHC sector is to use the conceptual model for building capacity to improve health developed by NSW Health.<sup>76</sup> This model identifies a number of key areas where action is required. These action areas are:

- organisational development,
- workforce development,
- resource allocation,
- partnerships, and
- leadership.

These five areas were used in the consultations for this discussion paper to help identify capacity building issues that will enable the PHC health inequalities research agenda to be

progressed. The following two tables summarise the major strategies identified in the consultations for each of the action areas.

Table two summarises the areas of action required. These address issues at the national, state and local level. A national PHC policy incorporating a commitment to reducing health inequalities will be important for underpinning efforts to build research capacity in this area. For example, it provides the context for ensuring that PHC research funding programs and agencies both commit funds to reducing health inequalities and are accountable within their performance agreements for those funds.

The development of multidisciplinary teams in PHC health inequalities research is important, and requires joint training as well as collaborative working structures. The availability of accessible and appropriate data ensures research is focused on identified and emergent need, and dissemination of findings performs the same task at the end of the cycle.

Above all, the commitment of increased funds at a joint Commonwealth and State level to multidisciplinary PHC structures and training for research within that is important. This will involve nurturing and rewarding research effort as well as formal training input.

**Table 2: Summary of strategies for 3 key action areas**

<b>Organisational Development</b>	<b>Skilled staff</b>	<b>Resources</b>
<ul style="list-style-type: none"> <li>• Develop national PHC policy</li> <li>• Develop ethical frameworks for PHC research</li> <li>• Incorporate PHC &amp; health inequalities research into performance agreements &amp; other accountability mechanisms</li> <li>• Establish structures that support research priorities (e.g. multidisciplinary research groups/networks, links with universities)</li> <li>• Establish a Health Inequalities Unit within the proposed National Institute for PHC Research</li> <li>• Develop systems to support multidisciplinary &amp; collaborative research</li> <li>• Develop quality data sets that incorporate SES</li> <li>• Define &amp; build better data collection &amp; Information systems</li> <li>• Foster/build research culture within State jurisdictions &amp; DGP</li> </ul>	<ul style="list-style-type: none"> <li>• Enhance education &amp; training opportunities for new cohort of PHC researchers</li> <li>• Provide accessible professional development &amp; training opportunities for PHC practitioners on research methods, data collection &amp; use</li> <li>• Expand opportunities for training Indigenous health researchers</li> <li>• Expand opportunities for multidisciplinary research education &amp; training (that involves researchers, policy makers, consumers, practitioners)</li> <li>• Provide access to expert advice on research, appropriate interventions for disadvantaged groups, health inequalities issues</li> <li>• Build multidisciplinary &amp; collaborative research teams</li> </ul>	<ul style="list-style-type: none"> <li>• Increased funding for PHC &amp; health inequalities research through NHMRC, State health dept's</li> <li>• Increase numbers of NHMRC PHC scholarships &amp; fellowships</li> <li>• Allocate funds to enable practitioners to participate in research activities</li> <li>• Fund community health research in each state/territory to match PHCRED funding</li> <li>• Establish a critical mass of PHC research positions</li> <li>• Establish long term funding to encourage continuity of research, achieve institutional stability, develop expertise (implications for NHMRC, state/territory health dept's)</li> <li>• Funding to enable systematic dissemination of research findings</li> </ul>

**Table 3: Summary of strategies for 2 key contextual elements**

Partnerships	Leadership
<ul style="list-style-type: none"> <li>• Develop partnerships between each state/territory health dept' and state-based PHCRED capacity building programs</li> <li>• Enhance research &amp; health inequalities focus of strategic relationships between key stakeholders across PHC system, (eg Commonwealth &amp; State jurisdictions, including AHMAC, GPPAC)</li> <li>• Foster, nurture &amp; support partnerships between researchers, policy makers &amp; practitioners – develop understanding &amp; experience about how to do this well</li> <li>• Engage disadvantaged communities to actively participate in research</li> <li>• Engage other government departments with health inequalities research agenda</li> <li>• Support health inequalities research focus of existing PHC networks (eg PHCRED, AAAGP)</li> <li>• Encourage the development of research partnerships with Indigenous researchers</li> </ul>	<ul style="list-style-type: none"> <li>• Identify, nurture &amp; support champions to drive the PHC &amp; health inequalities research agenda (within &amp; outside the health sector)</li> <li>• Nurture &amp; support the development of research collaborations</li> <li>• Provide rewards &amp; incentives in recognition of PHC &amp; health inequalities research</li> <li>• Show case innovative research projects (especially those that have significantly contributed to greater understanding about what works for disadvantaged communities)</li> <li>• Promote opportunities to develop a reflective culture &amp; practice</li> <li>• Advocate for senior management commitment to PHC &amp; health inequalities research</li> <li>• Lobby for development of national PHC policy</li> <li>• Leaders to model trust &amp; respect for the knowledge, skills &amp; experience of the different PHC stakeholders (eg general practice, community health)</li> </ul>

## 4.6 Future directions

There are a number of issues that need to be addressed as part of building a national PHC health inequalities research agenda.

- Historically there has been a lack of resource investment in PHC research and the investment that has been made through GPEP has been focussed on general practice. This lack of investment has meant that a culture of research has not developed or been nurtured beyond small pockets within some universities. There is also little capacity or incentive for practitioners to become engaged in research in partnerships with researchers.
- The difficulties of doing research in this area and the need for innovative and flexible approaches have not been recognised. Traditional scientific base methodologies, such as RCTs may not be feasible for many important areas of PHC research. A range of methodologies are required including qualitative and observational studies as well as clinical trials to answer a wide range of research questions. New methodologies which combine qualitative and quantitative methods may also need to be developed. Multi-levelled, multi-focussed and multidisciplinary research is required.
- A need for recognition of the importance and value of intervention research in any PHC and health equity research agenda. There is limited evidence of the effectiveness of the applicability of interventions developed in other populations, contexts, settings or the contribution of PHC approaches and interventions in reducing health inequalities. The

five research priority areas identified in this discussion paper highlights this evidence gap as do other priority setting processes (eg PHCRED) and action areas for tackling disadvantage (eg NHPAC) and was also a major theme in the consultation workshops.

- There is no national PHC policy within which to embed a research agenda. This is important because of the lack of clarity about the scope of PHC, and by extension the scope of a research agenda, and also because of the fragmentation and competition within the sector.

There are two fundamental preconditions for a PHC health inequalities research agenda:

- a) a cohesive PHC system on to which to build research; and
- b) resources and capacity to undertake research.

Given these preconditions and the limited resources of the PHC research network, the work of the network will need to be strategic and focussed to have any impact or influence on a PHC health inequalities research agenda. One way will be to focus on the five identified research priority areas in relation to:

- Advocacy & leadership;
- Capacity building; and
- Information exchange & support.

Collaborations with other key organisations and individuals who are doing work that relates to the research priorities will be important to extend the work of the network. Such collaborations include:

<b>Priority area</b>	<b>Role of network</b>
Access to quality PHC care & PHC approaches	<ul style="list-style-type: none"> <li>◆ Collaborate with the National Institute for Primary Care Research (at ANU), although this will be limited as Institute will not be in a position to collaborate over next 12 months.</li> <li>◆ Link with PHCRED strategy &amp; research agenda (ie through NHMRC &amp; GP Branch)</li> <li>◆ Link with PHERP: through Network Steering Committee members; through QUT PHERP project on strengthening health inequalities R&amp;D capacity &amp; infrastructure</li> <li>◆ Collaborate with PHCRIS</li> </ul>
Indigenous	<ul style="list-style-type: none"> <li>◆ Collaborate with RAWG</li> <li>◆ Collaborate with the NT Cooperative Research Centre on Aboriginal &amp; Tropical Health</li> </ul>
Rural	<ul style="list-style-type: none"> <li>◆ Collaborate with researchers within University Departments of Rural Health</li> </ul>
Oral	<ul style="list-style-type: none"> <li>◆ Collaborate with the Australian Research Centre for Population Oral Health</li> <li>◆ Collaborate with the Oral Health Alliance of the Public Health Association</li> </ul>

## ***Leadership and advocacy***

The network has a major role to play through discussion and consultation in a number of areas. This includes lobbying for the development of a comprehensive national PHC policy, and lobbying the NHMRC to significantly enhance its funding allocations and criteria to include a health inequalities focus, in partnership with the other two HIRC research networks.

The network also needs to advocate for the development of a framework for conceptualising PHC research, that embeds health inequalities research within it, while at the same time enhancing and supporting existing groups and organisations.

Where there is no focussed research effort in the priority research areas (such as PHC approaches and access to quality health care), the network will advocate for funding for establishment of an equity unit within the National Institute for Primary Care Research, and advocate for funding for the network to auspice the development of research collaborations.

In recognition of NACCHO's role as a lead national advocacy organisation in relation to Aboriginal and Torres Strait Islander people's self determination, the PHC network will (in conjunction with the other two networks), continue to advocate for the development of a partnership between NACHHO and the HIRC Board as a key strategy in addressing the health inequalities suffered by Aboriginal and Torres Strait Islander peoples.

## ***Capacity building***

This will be done through partnerships that can help extend and enhance the network's limited resources and will focus at three levels:

- ◆ **The HIRC** itself, and by extension to PHCRED to influence capacity building projects to incorporate a comprehensive PHC approach & health inequality focus; to the NHMRC to recognise that much of the research needed is fundamentally health services research; and to various other priority setting processes and funding bodies (eg NHPAC).
- ◆ **The PHC Network** through ongoing work in the dissemination of information on relevant developments in health inequalities related research, and maintaining and making accessible a database of researchers and policy makers active in the area of health inequalities. The network will also work to identify and respond to opportunities for building capacity, through workshops, lobbying and advocating for resources for the priority areas, and for equity to become a priority within PHC research.
- ◆ **Work with other stakeholders**, including the Commonwealth and state funders of PHC services for an increased investment in developing a PHC evidence base, including the role of PHC in addressing health inequalities.

## ***Information exchange and support***

This will be done through developing links and references to other health equity related web sites & the PHCRIS web site, the production and distribution of two newsletters per year and the dissemination of articles, papers etc between network members on the basis of the five research priority areas.

## 4.7 Recommendations

1. Endorse the five priority areas discussed in **Section 2** of this paper (PHC approaches, Access, Indigenous health, Rural health, and Oral health).
2. Endorse the three areas of future activity within these priority areas discussed in **Section 4** of this paper (advocacy & leadership, capacity building, and information exchange & support).
3. Support the development of a national Primary Health Care policy which supports research into health inequality.
4. Acknowledge the role of the HIRC in monitoring the level of investment in PHC and health inequality research.
5. Review the extent to which the PHCRED Program is:
  - Funding PHC and equity related research through the NHMRC grants process, including a focus on health inequalities within the National Institute of PHC Research
  - Fostering state based PHCRED programs to increase capacity for PHC and equity research
  - Fostering debate between policy makers, practitioners, researchers and the community on equity related PHC research and research capacity building.
6. Advocate for a recognition of the challenges of undertaking PHC intervention research especially in dealing with health inequality.

## 5 Appendix 1: HIRC Board & PHC Network Steering Committee membership

### ***HIRC Board***

#### **Chair:**

Prof Stephen Leeder, Dean Faculty of Medicine University of Sydney

#### **Members:**

- Prof Adele Green, Deputy Director, Queensland Institute of Medical Research, Brisbane
- Prof John Catford, Director of Public Health & Development Division, Dep't of Human Services, Victoria
- Dr Jack Best, Chair, Strategic Research Development Committee, NHMRC
- Dr David Mildenhall, President, Rural doctors Association of Australia
- Prof Margot Prior, Director of Psychology, Royal Children's Hospital & University of Melbourne
- Prof Richard Smallwood, Chief Medical Officer, Dep't of Health & Aged Care

### ***PHC Network Steering Committee***

#### **Convenors:**

- Ms Elizabeth Harris, Director, Centre for Health Equity Training, Research & Evaluation, UNSW
- Dr John Furler, Senior Lecturer, Department of General Practice and Public Health, University of Melbourne

#### **Members:**

- Prof Fran Baum, Professor and Head, Department of Public Health Flinders University, Director South Australian Community Health Research Unit
- Dr Ian Cameron, CEO NSW Rural Doctors Network representing Newcastle Institute of Public Health
- Prof Mark Harris, Professor of General Practice, School of Public Health and Community Medicine, UNSW
- Ms Terry Dunbar, Deputy Director, Cooperative Research Centre for Aboriginal and Tropical Health, NT
- Ms Libby Kalucy, Co-Director, Primary Health Care Research and Information Service, Flinders University.
- Ms Pat Kopusar, representing the Consumers Health Forum
- Ms Clare Shuttleworth, representing the Public Health Association
- Ms Gai Wilson, Director, CDIH, representing the Australian Institute of Primary Care, Latrobe University
- Ms Laurann Yen, Executive Director, Primary and Integrated Care, ACT Community Care
- Mr Ian Watts, RACGP



## 6 References

- <sup>1</sup> Australian Health Ministers' Council, 1988, Commonwealth Department of Health and Family Services, 1988.
- <sup>2</sup> NSW Health, *NSW Health and Equity Statement*. 2002
- <sup>3</sup> Whitehead M. *The concepts and principles of equity and health*. Europe: World Health Organisation, Regional Office, 1990.
- <sup>4</sup> Tudor Hart, J. The Inverse Care Law. *The Lancet*, Saturday 27<sup>th</sup> February 1971  
<http://www.sochealth.co.uk/history/inversecare.htm>
- <sup>5</sup> See Turrell G, Oldenburg B, McGuffog I, Dent R (1999) *Socioeconomic determinants of health: towards a national research program and a policy and intervention agenda* Queensland University of Technology, School of Public Health, Ausinfo, Canberra – which contains a review of Australian research on socioeconomic health inequalities.
- <sup>6</sup> Marmot M et al (1997) Contribution of job control and other risk factors to social variations in coronary heart disease incidence *Lancet* 350 (9073):1404-5
- <sup>7</sup> Wilkinson and Marmot M, *The Solid Facts*. WHO Regional Office for Europe: 1998
- <sup>8</sup> Australian Institute of Health and Welfare 2002, *Australia's Health 2002*, Canberra, AIHW
- <sup>9</sup> Cunningham J and Paraides Y. *Occasional Paper: Mortality of Aboriginal and Torres Strait Islander Australians 1997*, Australian Bureau of Statistics, Canberra. 2000. Cited in The Office for Aboriginal and Torres Strait Islander Health. *Better Health Care: Studies in the Successful Delivery of Primary Health Care Services for Aboriginal and Torres Strait Islander Australians*. Commonwealth Department of Health and Aged Care 2001
- <sup>10</sup> The Office for Aboriginal and Torres Strait Islander Health. *Better Health Care: Studies in the Successful Delivery of Primary Health Care Services for Aboriginal and Torres Strait Islander Australians*. Commonwealth Department of Health and Aged Care 2001
- <sup>11</sup> National Health Strategy. *Enough to make you sick: how income and environment affect health*. National Health Strategy Research Paper; AGPS, Canberra; 1992.
- <sup>12</sup> Mathers C, Vos T, Stevenson C. *The burden of disease and injury in Australia*; Canberra: Australian Institute of Health and Welfare; 1999.
- <sup>13</sup> Vos T, Begg S. *Victorian Burden of Disease Study: Mortality*. Health Intelligence Series; Melbourne: Public Health Division, Department of Human Services, Victoria; 1999.
- <sup>14</sup> Catford J. *Health Inequalities in Victoria: A new agenda for research, policy and services*. *The Health of Victorians: The Chief Health Officers Bulletin*; 2001.
- <sup>15</sup> Australian Bureau Statistics mortality data (HOIST). Epidemiology & Surveillance Branch, NSW Health Department.
- <sup>16</sup> Prometheus Information. *HealthWiz: The National Social Health database*. Canberra, ACT: Prometheus Information; 2000.
- <sup>17</sup> Furler J, Harris E, Chondros P, Powell Davies G, Harris M, Young D. The inverse care law revisited: Impact of disadvantaged location on GP consultation times. *MJA* 2002;177(2):80-3.

- 
- <sup>18</sup> Australian Institute for Primary Care, LaTrobe University and the Department of Public Health, Flinders University of South Australia. *The Primary Health Care Workforce and Population Health Activities: Scope and Potential. A discussion paper prepared by the for the PHERP Project "Providing Population Health Sector Support for the Primary Health Care Research Institute."* March 2002.
- <sup>19</sup> Comino E, Harris E, Silove D, Manicavasagar V, Harris M. Prevalence, detection and management of anxiety and depressive symptoms in unemployed patients attending general practitioners. *Australian and New Zealand Journal of Psychiatry*; 2000;34: 107-113.
- <sup>20</sup> Wiggers JH, Sanson-Fisher R. Duration of General Practice Consultations: Associations with Patient Occupational and Educational Status. *Social Science & Medicine*; 1997;44: 925-934.
- <sup>21</sup> Turrell et al (1999)
- <sup>22</sup> Starfield B. Primary care: is it essential? *Lancet*; 1994; 344: 1129-1133
- <sup>23</sup> Bunker j, Frazier H, Mosteller F. Improving Health: Measuring the effect of medical care. *Millbank Quarterly*. 1994; 72: 225-58
- <sup>24</sup> Starfield B. New paradigms for quality in primary care. *British Journal of General Practice*, April 2001; 303-309.
- <sup>25</sup> Shi L, Starfield B, Kennedy BP, Kawachi I. Income inequality, primary care and health indicators. *Journal of Family Practice* 1999; 48(4): 275-284
- <sup>26</sup> Starfield B. 1996. Public health and primary care: a framework for proposed linkages. *American Journal of Public Health* 86:1365-9.
- <sup>27</sup> McDonald J. *The effectiveness of community health services. A literature review.* South Western Sydney Area Health service. 2001
- <sup>28</sup> Marshall, J. & Craft, K. *New Vision for Community Health for the Future report: Overview.* Perth, Western Australia: Health Department of Western Australia. 2000
- <sup>29</sup> *Better Access to Services: An information resource, PCP, Aged, Community and Mental Health,* Department of Human Services, Victoria. 2000.
- <sup>30</sup> Wood, J. A review of antenatal care initiatives in primary care settings. *British Journal of General Practice* 1991; 41: 26-30.
- <sup>31</sup> Forrest C, Whelan EM. Primary Care Safety-Net Delivery Sites in the United States. A Comparison of Community Health Centers, Hospital Outpatient Departments and Physicians' Offices. *JAMA*, 2000; 284; (16):2077-2083
- <sup>32</sup> Ciliska D, Hayward S, Thomas H, Mitchell A, Dobbins M, Underwood J, Rafael A, Martin E A Systematic Overview of the Effectiveness of Home Visiting as a Delivery Strategy for Public Health Nursing Interventions. *Canadian Journal of Public Health*. May-June 1996 87 (3):193-198.
- <sup>33</sup> Macnee CL, Hemphill JC, Letran J Screening clinics for the homeless: evaluating outcomes. *Journal of Community Health nursing*. 1996;13 (3): 167-77
- <sup>34</sup> *Dealing with disadvantage in the National Health Priority Areas. A Discussion Paper for the National Health Priority Action Council (DRAFT).* Prepared by the NHPAC Secretariat, January 2002.
- <sup>35</sup> New Zealand Government Press Release *Funding for Primary Health Care Strategy*, 13<sup>th</sup> March, 2002 <http://www.scoop.co.nz/archive/scoop/stories/90/50/200203130012.28b05796.html>

- 
- <sup>36</sup> The Office for Aboriginal and Torres Strait Islander Health. *Better Health Care: Studies in the Successful Delivery of Primary Health Care Services for Aboriginal and Torres Strait Islander Australians*. Commonwealth Department of Health and Aged Care 2001.
- <sup>37</sup> Access SERU, Centre for Health Equity Training, Research and Evaluation, Integration SERU, *Action on Health Inequalities through General Practice: Discussion Paper*, 1998.
- <sup>38</sup> Harris E, Traynor V, Furler J, Powell Davies PG, Harris M, Young D, *Action on Health Inequalities II: the role of Divisions of General Practice*, 2000.
- <sup>39</sup> Access SERU, Centre for Health Equity Training, Research and Evaluation, Integration SERU, *Action on Health Inequalities through General Practice 2: The role of Divisions of General Practice*. August 2000
- <sup>40</sup> Bell K, Couzos S, Daniels J, Hunter P, Mayers N, Murray R. Aboriginal community controlled health services, in *General Practice in Australia 2000*. Commonwealth Department of Health and Aged Care. 2000.
- <sup>41</sup> Bell K Op. Cit.
- <sup>42</sup> Bell K Op. Cit.
- <sup>43</sup> [Http://www.health.gov.au/nhmrc/research/srdc/indigenous.htm](http://www.health.gov.au/nhmrc/research/srdc/indigenous.htm)
- <sup>44</sup> Bell K Op. Cit.
- <sup>45</sup> Australian Institute of Health and Welfare (AIHW), *Health in rural and remote Australia*, AIHW Cat. No. PHE 6, 1998. The three indicators of socio-economic wellbeing are 'economic resources', 'education and occupation' and 'disadvantage', and are measured through the SEIFA indices across a range of ABS geographical classifications, with the SLA accepted as the standard geographical unit for purposes of relative comparison.
- <sup>46</sup> AIHW, *The Health and Welfare of Australia's Aboriginal and Torres Strait Islander Peoples*, 2001.
- <sup>47</sup> Mathers C, *Health differentials among Australian children*, AIHW, *Health Differentials among young Australian adults*, AIHW, F Al-Yaman et al, *Australia's children: their health and wellbeing*, AIHW 2002, AIHW Cat No PHE 36
- <sup>48</sup> Commonwealth Department of Health and Aged Care. *General Practice in Australia 2000*. Canberra: Commonwealth Department of Health and Aged Care, 2000.
- <sup>49</sup> Fragar I, *A Picture of Health?* National Rural Public Health Forum Proceedings, 1997.
- <sup>50</sup> Welch N, *Towards an Understanding of the determinants of rural health*, National Rural Health Alliance, 2000.
- <sup>51</sup> Humphreys J, 'Delimiting "rural": implications of an agreed "rurality" index for health care planning and resource allocation', *The Australian Journal of Health*, 1998, 6 (4).
- <sup>52</sup> Humphreys J et al, 'Factors in accessibility of general practice in rural Australia', *Medical Journal of Australia*, 1997, 166.
- <sup>53</sup> Keleher H, 'Rural public health matters', *Australian and New Zealand Journal of Public Health*, 1999, 23 (4)
- <sup>54</sup> Brennan DS, Carter KD, (1998) *Adult access to dental care- Indigenous Australians*. AIHW Dental Statistics and Research Series No.16, The University of Adelaide, Adelaide.

- 
- <sup>55</sup> Stewart JF, Carter KD, Brennan DS (1998) *Adult access to dental care – rural and remote dwellers*. AIHW Dental statistics and Research Series No. 17. The University of Adelaide, Adelaide.
- <sup>56</sup> Carter KD, Brennan DS, Stewart JF. (1998) *Adult access to dental care – Migrants*. AIHW Dental statistics and Research Series No. 15. The University of Adelaide, Adelaide.
- <sup>57</sup> Chalmers JM, Hodge CP, Fuss JM, Spencer AJ, Carter KD 2000. *The Adelaide Dental Study of Nursing Homes 1998*. AIHW Dental Statistics and Research Unit Series No. 22. The University of Adelaide, Adelaide.
- <sup>58</sup> Chalmers JM, Carter KD, Hodge CP, Fuss JM, Spencer AJ. 2001. *The Adelaide Dental Study of Nursing Homes One-year Follow-up 1999*. AIHW Dental Statistics and Research Unit Research Series No. 23. The University of Adelaide, Adelaide.
- <sup>59</sup> Australian Institute of Health and Welfare, Dental Statistics and Research Unit. *Oral health and access to dental care—the gap between the ‘deprived’ and ‘privileged’*. Research Report. Adelaide: AIHW Dental Statistics and Research Unit, Adelaide University, 2001.
- <sup>60</sup> Spencer AJ. What options do we have for organising, providing and funding better public dental care? Australian Health Policy Institute Commissioned Paper Series 2001-02. The Australian Health Policy Institute at the University of Sydney, NSW, Australia.
- <sup>61</sup> Australian Health Ministers’ Advisory Council. Steering Committee for National Planning for Oral Health. *Oral health of Australians: National planning for oral health improvement: final report*. August 2001.
- <sup>62</sup> Spencer AJ. *Costs of dental care*. In: AIHW Dental Statistics and Research Unit. *Dental care for adults in Australia*. Adelaide: AIHW Dental Statistics and Research Unit, The University of Adelaide, 1993; pp61–67.
- <sup>63</sup> World Health Organization, 1978. Declaration of Alma-Ata. International Conference on Primary Health Care, Alma-Ata, USSR, 6-12 September.
- <sup>64</sup> NHS R&D Strategic Review Primary Care, 1999. Report of the Topic working Group.
- <sup>65</sup> Beacham B, Kalucy L, and Lowcay B. 2001. *Foundations for future research: The relevance of GPEP projects (1999-2001) to priorities for research, evaluation and development in the area of primary health care*, Primary Health Care Research and Information Service, Department of General Practice, Flinders University Adelaide.
- <sup>66</sup> [www.health.gov.au/hsdd/gp/phcresch.htm](http://www.health.gov.au/hsdd/gp/phcresch.htm)
- <sup>67</sup> Kalucy L, Beacham B, Raupach J, Dwyer J, Pilotto L., June 2001. *Priorities for Primary Health Care Research, Evaluation and Development in Australia. Summary Priority Setting Process: Stage One*. Primary Health care Research & Information Service. Department of General Practice, Flinders Press Adelaide.
- <sup>68</sup> This information was taken from the NHMRC website: <http://www.health.gov.au/nhmrc>
- <sup>69</sup> AIHW, *Australia’s Health 2000*.
- <sup>70</sup> *Dealing with disadvantage in the National Health Priority Areas. A Discussion Paper for the National Health Priority Action Council (DRAFT)*. Prepared by the NHPAC Secretariat, January 2002.
- <sup>71</sup> Turrell G, Oldenburg B, McGuffog I, Dent R, 1999. *Socioeconomic determinants of health: towards a national research program and a policy and intervention agenda* Queensland University of Technology, School of Public Health, Ausinfo, Canberra
- <sup>72</sup> New Zealand HRC *Research Portfolio: Determinants of Health*

---

<sup>73</sup> NHS R&D Strategic Review Primary Care, 1999. Report of the Topic working Group.

<sup>74</sup> Rachitic, L. & M. Former May 2000, A proposed schema for evaluating evidence on public health interventions, A discussion paper prepared for the National Public Health Partnership, National Public Health Partnership, Melbourne, p. vi. [www.nphp.gov.au](http://www.nphp.gov.au)

<sup>75</sup> Hawe P, King L, Noort M, Jordans C, Lloyd B (2000) *Indicators to Help with Capacity Building in Health Promotion*. NSW Health Department, Sydney. Cited in NSW Health (2001) *A Framework for Building Capacity to Improve Health* NSW Health Department.

<sup>76</sup> NSW Health (2001) *A Framework for Building Capacity to Improve Health* NSW Health Department