ARTICLES

Best Practice in Primary Health Care[1]

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Abstract

The purpose of the work reported here was to delineate the strategies of practice which are associated with excellent outcomes in contemporary primary health care in Australia, and to provide wider access to exemplary and illustrative cases. One hundred and eighty five published accounts of primary health care practice were collected and abstracted. Ninety nine of these cases were evaluated, each by a panel of two or three reviewers, and the 25 most highly rated cases were studied in more detail through interviews with the authors and other protagonists. Eight broad strategies of primary health care practice were identified which appeared to have contributed to excellent outcomes in the cases studied: consumer and community involvement; collaborative local networking; strong vertical partnerships; intersectoral collaboration; integration of the macro and micro; organisational learning; policy participation; and good management. Some of the finer elements of practice which are encompassed by each of these broad strategies and some of the dynamics through which they appear to contribute to good outcomes are delineated. Illustrative cases are cited which might serve as benchmarks to inspire and guide the wider pursuit of excellence in primary health care.

Key words: primary health care, outcomes, best practice, strategies

Challenges to Primary Health Care

The starting point for this research was the finding (National Centre for Epidemiology and Population Health (NCEPH), 1992) that although the principles of primary health care (World Health Organization (WHO) & United.Nations Children's Fund (UNICEF), 1978) are widely endorsed and there are documented case studies of these principles being realised in practice (e.g., Baum, 1995; NCEPH, 1991), nonetheless, there are significant shortfalls between the norms of the primary health care model and generally prevailing patterns of practice in Australia.

On one hand, despite a number of positive state initiatives (South Australian Health Commission, 1993; Queensland Health, 1992), the health policy climate in Australia is becoming less, rather than more supportive of the primary health care model, in particular with the introduction of market-based models of health funding. On the other hand, the policy model promulgated at Alma-Ata should not be viewed as a comprehensive, universal and timeless prescription. The policy slogans of the new market environment address real problems; they have their own logic and deserve careful consideration. It might be that there are insights and strategies signalled by these slogans which could complement the strategies of the primary health care model in the current circumstances.

The present research was conceived as an engagement between the older visions of primary health care and some of the newer strategies of the market-oriented environment. In particular, the practice of primary health care is re-examined in the light of the increasing public policy emphasis on 'outcomes' and 'evidence-based practice', and new thinking in corporate management about best practice and the creation of learning organisations.

The outcomes movement and evidence-based practice

The ascendancy of market models in public policy has contributed to an increasing focus on the measurement of health outcomes; the notion of outcomes offers a way of describing what is being purchased (Australian Health Ministers Advisory Council (AHMAC), 1993).

Primary health care has traditionally focused on organisational arrangements (such as community involvement and district level co-ordination) and on the principles of practice, but the outcomes of primary health care have not been so clearly delineated. If advocates of primary health care are to engage with the discourses of outcomes and the purchase of health gain, there is a need for a clearer focus on the outcomes which are presently being achieved in primary health care.

It is also evident that there are many outcomes which are not measurable in routine practice, owing to the cost of data collection or the difficulties of attribution. Calls for 'evidence-based practice' reflect this. It is argued that if funders have to purchase on the basis of episodes or items of service (rather than outcomes), at least they should be able to restrict their purchases to services (or program strategies) which are demonstrably effective. However, enthusiasm for evidence-based practice needs to be tempered by a recognition of the contingency of practice.

Best practice and organisational learning

In searching for resources which might be useful in adapting the primary health care model to new circumstances, the challenge is from new thinking in corporate management, from strategies of best practice for the pursuit of excellence, and from the concept of organisational learning as a frame for thinking about managing change.

The traditional standards-based approach to quality improvement in health care presumes a domain of knowledge about what works; known relationships between structure, process and outcomes; and knowledge which is independent of the settings in which practice takes place. The applicability of this expert-based standards approach in the primary health care field is limited. To be relevant across different settings of practice such standards have to be cast in general terms which leaves a wide margin for individual judgement.

The focus of the best practice movement is on creating organisational cultures which are directed to the pursuit of excellence (Lansbury, 1994). Any use of formal standards is subordinated to this larger vision. In a best practice environment

practitioners are looking continuously for instances where other people are doing similar things but using different models of practice. Documenting episodes of practice encourages critical reflection and the consideration of alternative strategies, and creates a database for others to refer to in developing their practice.

One of the most destabilising aspects of the current environment is the continuing onrush of social and institutional change. The primary health care narrative neither addresses the management of change nor does it provide guidance for practitioners seeking to exercise some influence over the direction of such change.

Rapid economic and technological change also presents problems for business organisations. One approach which has attracted considerable attention in business circles is known as organisational learning (Kempin, 1994; Senge, 1992); creating organisations which deal pro-actively with change and which take part in determining its directions. The concept of organisational learning evokes a culture, a set of expectations and practices which encourage continuing reflection on what we are doing and why; and a continuing awareness of trends in the external environment. Organisational learning offers us a fresh way of viewing our work in evaluation, planning, research and education (Legge, Rotem, & Walters, 1996).

Objectives

The purpose of this project was to take a fresh look at primary health care practice in the light of the challenges discussed above: to define outcomes and to demonstrate the effectiveness of the core strategies of primary health care; and to consider new ways of thinking about achieving excellence and managing change.

The main strategy was to collect a number of cases where excellent outcomes are currently being achieved and to look for commonalities. It was hoped that these would shed light on how some agencies are realising the ideals of primary health care in their practice and to derive generalisations which might inform policy making and better practice. It was also hoped that vignettes of good practice would be found, which would serve as benchmarks for agencies and practitioners striving to achieve better practice.

Methods

One hundred and eighty-five published accounts of primary health care practice were collected and abstracted; reviewer evaluations of 99 of these cases were organised, and an interview-based analysis of 25 highly rated cases was conducted. Details of methods are described in the full project report (Legge, Wilson et al., 1996). These are summarised below.

Collection, dissemination and analysis

In the first phase of the study, as large a sample as possible (within the limits of resources) of recent, well documented accounts of episodes of primary health care practice in Australia, focussing on the social health, networking and developmental aspects of primary health care, was identified. A wide range of health journals, recent monographs, conference proceedings and bibliographic sources were scanned.

One hundred and eighty five published (or public domain) reports in accordance with four selection criteria, were identified. To be included, case studies needed to:

- describe passages of practice undertaken within the primary health care sector in Australia;
- be reasonably well documented with respect to process and outcomes;
- be recent (1990-1994); and
- include the networking, social health or developmental aspects of primary health care practice (as distinct from purely clinical or single discipline professional work).

Abstracts and bibliographic details of these 185 cases have been published (Butler Legge, Wilson, & Wright, 1995) and placed upon the HEAPS database.2 These 185 stories include reports of projects, descriptions of episodes of organisational development, and evaluations of models of program delivery. A descriptive analysis of the 185 case studies collected is presented in the full project report (Legge, Wilson et al., 1996).

Reviewer evaluation study

The objectives of the next phase of the study were, first, to explore the relationships between project outcomes and selected aspects of practice and, second, to select, through a peer review process, a subset of 25 cases of excellent practice for more intensive study.

Five criteria were established for including cases in this phase of the study. These criteria corresponded to the networking, social health and developmental aspects of primary health care practice. These criteria were cast as aspects of practice and comprised:

- **consumer and community involvement;**
- **collaborative local networking;**
- **vertical networking;**
- **macro/micro balance (integrating a concern for the micro or immediate issues with the longer term or macro issues); and**
- **change consciousness.**

For inclusion in the sample for this reviewer evaluation study at least three of these study criteria had to be judged to be present in significant degree in the case study. Ninety-nine case studies were selected from the larger data base and were despatched, each to a panel of three reviewers. Reviewers were asked to provide a single global outcomes rating (in relation to the case as a single entity) and to comment on the relevance, to the outcomes achieved, of each of the five aspects of practice listed. Details with respect to the methods and findings of this study are presented in the full project report (Legge, Wilson et al., 1996).

Interview study

Twenty five cases[3] which had been rated most highly in the reviewer evaluation study were identified, and at least two people who had been associated with each case, were interviewed in seeking to clarify:

- **the outcomes which had been achieved;**
- **the strategies of practice associated with the achievement of those outcomes; and**
- **the pre-conditions for those strategies of practice.**

All of the documentation on each of the 25 cases was then analysed with a view to drawing together a coherent account of the outcomes achieved, the strategies of practice deployed and the pre-conditions for those forms of practice. A detailed account of the method of analysis and findings with respect to outcomes and pre-conditions is presented in the full project report.

Strategies and Vignettes of Good Practice in Primary Health Care

The findings of the interview study in relation to strategies of practice which constitute good practice in primary health care are presented below. The description of practice was structured around eight broad strategies:

- **consumer and community involvement;**
- **collaborative local networking;**
- **strong vertical partnerships;**
- **intersectoral collaboration;**
- **integration of the macro and micro;**
- **organisational learning;**
- **policy participation; and**
- **good management.**

The finer elements and dynamics which constitute each of these broad strategies are described but owing to limits on space, only one or two cases to illustrate each point are able to be cited; more case material is referred to in the full project report.

Consumer and community involvement

Both in the reviewer evaluation study and in the interview study, consumer and community involvement was strongly associated with good outcomes.

Levels of involvement

The power relations which shape consumer and community involvement vary widely and these variations are associated with different patterns of involvement; ranging from overt community control, through good consultation, to the interpretive skills of agencies and practitioners who are particularly responsive to consumer and community priorities. In general, the stronger patterns of involvement subsume the features of the less strong. On one hand, where consumer and community participation depends wholly on the good offices of practitioners (through consultation and responsiveness), it seems clear that some consumer and community concerns and understandings will be silenced. On the other hand, good consultation and a high level of responsiveness can lead to more powerful forms o fparticipation in the next round.

The case studies from Aboriginal health services illustrate most clearly the workings of community control. Redfern Aboriginal Medical Service (Foley, 1991) was controlled by a community board and employed Aboriginal $taff where possible.4 This allowed the service to its outspoken and to advocate on behalf of be community in a sometimes hostile bureaucratic and political environment. There had been a high level of community participation in decision making and in advocacy and political action. This provided political support for the service and strengthened the service's position in relation to policy and individual issues taken up. Concerns raised by community members over the years have been responded to with the development of new services and advocacy, both for individuals and collectively. This commitment helped to maintain the confidence and trust of the community.

There are formal provisions for community involvement in management at the Parks Community Health Centre (CHC) in Adelaide, which included the clean up and redevelopment of a previously neglected local reserve, the Wilson Reserve, (Tesoriero, 1990); and Nutrition in the Parks, which was a program of initiatives from health education to nutritional research addressing nutritional issues for low income people (Spurr, Ward, & Payton, 1993). The Parks CHC is controlled by a committee of management consisting of local residents and others. Action groups, consisting of residents and some staff, undertook projects with delegated authority and budget control from the committee.

The third level of consumer and community involvement turns upon the responsiveness of particular agencies and practitioners. In the case of the Far West Mental Health Service (Hemming, 1993), new directions in psychiatric service delivery were based on the community mental health model and a commitment by staff to developing a partnership relationship with clients. It was a model which valued the client's view and understanding of his or her illness and sought to construct the psychiatric help around the context of that person's life.

Dynamics

Three dynamics which appear to mediate the influence of community involvement on the achievement of good outcomes (in this study) were identified:

- determining the priorities;
- exercising power; and
- acquiring ownership of professional knowledge, methods and skills.

The most obvious ways in which consumer and community involvement contributes to better outcomes are in putting issues on the agenda and setting priorities. This is more than just moving items on to or higher up an agenda; it is also about the framing of issues, setting the terms of the story which says what matters and why.

A holistic story about needs, causes and strategies will generally draw upon community and professional perspectives. However, the construction of such shared stories must negotiate comprehension difficulties and resistances associated with different world views. The power relations prevailing in the settings where such negotiations take place will determine to some extent the outcome of such negotiations.

Nganampa Health Council (Pholeros Rainow, & Torzillo, 1993) is controlled by the Aboriginal people it serves, the Pitjantjatjara people. The Housing for Health project was located in the Pipalyatjara community. The project was initiated and approved and staff were selected by the council. The project involved a complex negotiation between technical and community perspectives in determining a program which reflected community priorities.

A second dynamic, through which consumer and community participation appears to contribute to best practice and good outcomes, we have labelled 'exercising power'. This dynamic brings together a number of cases where the political power associated with consumer and community support for a particular movement appear to have determined administrative decisions or the mobilisation of resources. Such exercise of political power is not always deliberate or overt. It is the particular skill of politicians and politically sensitive administrators to be aware of the sensibilities of particular constituencies.

The Onkaparinga project (Lewin, 1992) illustrates the influence of such understated political power. The project was part of the Noarlunga Healthy Cities project and was run by a community committee with the involvement of a range of health and environment groups. This allowed for wide involvement and ownership and advocacy across sectors. The project responded to widely held concerns about the pollution in the river and its environmental and health impact. The issue had legitimacy with community, institutions, developers and government. The project brought together individuals and groups who had been active in campaigning to clean up the river at different places and times. The coalition under the name of the Water Quality Group gave broader support and showed political strength.

The third dynamic through which consumer and community involvement appears to contribute to best practice and excellent outcomes is through acquiring a sense of ownership, by consumers and community members, of knowledge, methods and skills previously restricted to the professionals and acquiring confidence in their use or disposition. It is not simply a matter of acquiring knowledge and skills. More generally, it is about ownership; about being able to speak as the knowing subject within these professional discourses rather than appearing as the silent object about whom such knowledges speak, upon whom such skills are practised.

Paps I Should (Farnan & Gray, 1994) illustrates this dynamic well. This was a project on cervical screening f r and by women with disability. One of the major transitions effected by this project was the acquisition of ownership by networks of

women with disabilities of some of the knowledge and technologies underpinning cervical screening. In the process these women added value to this knowledge with innovative work on methods for taking Pap smears from, for example, wheelchair-bound women.

The Home Oxygen Support Group (Stefanovski, 1993) was a self-help group controlled and managed by its members. Membership was restricted to people requiring oxygen therapy. The work of the group involved an integration of technical information concerned with the delivery of oxygen, therapeutic information about the role of oxygen therapy and the indigenous knowledge and skills of the people who were using the equipment.

Collaboration

The networking functions that emerged in the interview study are described in terms of three different kinds of collaboration:

- local networking;
- vertical partnerships; and
- intersectoral collaboration.

Collaborative local networking refers to collaborative links between practitioners, health service agencies and community organisations at the local level. Collaboration with practitioners and organisations whose main identification is with other sectors of social practice is categorised as intersectoral collaboration.

Vertical partnerships refers to collaborations and co-operative arrangements between practitioners and organisations operating at the primary health care level and more specialised health practitioners or agencies at the secondary or tertiary levels, including public health agencies and practitioners. Collaborations which involve more specialised or more centralised resources in other sectors are discussed under the heading, intersectoral collaboration.

Intersectoral collaboration refers to linkages between practitioners and agencies which identify as operating within the health sector and practitioners and agencies which identify as operating in other sectors of social practice, such as housing, environment, or education. Intersectoral collaboration as used here operates at a local level or with more centrally located resources.

Four dynamics through which collaboration appears to contribute to better health outcomes were identified:

- building a broader story;
- a story that coordinates different playefs;
- mobilising additional resources; and
- capability-building.

Collaboration involves building a broader story; sharing different perspectives about the nature of the problems that we are confronting, about causes and about strategies for their solution. Mobilising different understandings will help to produce a broader story; one that a broader range of players will find useful.

Sharing a common story about the problems, causes and strategies can help to orient the responses of a number of people with different skills and knowledge to act in complementary ways. Players who stand in a different relation to the problem might nonetheless respond in complementary and mutually reinforcing ways if they are orienting their action around a common story. Involving a wider range of players generally also means mobilising additional resources of various kinds. In many cases this will help to ensure a more enduring or more definitive response to the problem(s).

The experience of successful collaboration puts in place a greater capacity for similar collaboration in the future. Such experiences might contribute to reorienting individuals, organisations, even wider networks to the possibility of different ways of working.

Collaborative local networking

Networking at the local level was evident in almost all of the 25 cases included in the interview study and in just under half of the cases it was judged to have been particularly important in contributing to the outcomes achieved.

The Horizons Service, a community managed support service for people with psychiatric disability (Cox, 1994), illustrates the way a shared story helps to co-ordinate the contributions of different players. This project originated in discussions among a range of local services which were supportive of the association. These discussions included community groups, people from the local psychiatric hospital, consumers and family members. The story underpinning the development of the service helped to weave a complementarity in the contributions of this wide range of other players in providing services to, and with, people with psychiatric illnesses.

Local collaboration can assist in mobilising additional resources, not necessarily financial. The Patchwork story (Millicer, 1993) tells of the co-operation of the whole meals-on-wheels network to recruit local co-ordinators and to distribute fire safety information to the public. In the Brisbane Women's Cancer Screening project (Prasad & Shinwari, 1993) the links with pre-existing ethnic community networks led to a much more effective information provision and recruitment to screening.

The Rural Outreach project (Webster & Wilson, 1993a) included the establishment of advisory groups involving key people and organisations in local towns. A number of specific projects developed through partnerships with a range of local organisations, services and groups. Much of this work continued after the Loddon-Campaspe Women's Health Service reduced its resource commitment in these towns.

Collaboration within organisations

The initial focus in exploring collaborative local networking was on collaboration between local providers, operating as separate autonomous agents, since this had been identified in the 1992 Primary Health Care Review (NCEPH, 1992) as being a particular weakness of the primary health care system.

However, in analysing the 25 cases in the interview study, collaboration within larger institutions also emerged as an important issue. In around 20% of cases good practice with respect to intra-organisational collaboration, appeared to have made an important contribution to the achievement of good outcomes.

This is well illustrated by the two schools projects, Billanook (Fensham, 1991) and WASH (McBride, Midford, James, & Cameron, 1994). In each of these cases, individuals from different parts of the same organisation came together in a team to collaborate around agreed goals and objectives. The contribution made by having different parts of the organisation represented appeared to contribute far more than could have been achieved by any part of the organisation acting alone.

Strong vertical partnerships

'Vertical partnerships' refers to local-central relationships between agencies which identify as lying within the health sector. We have analysed the contribution of strong vertical partnerships to good outcomes in terms of the same four dynamics listed above.

Several of the vertical partnerships in our interview cases illustrate experts from the tertiary sector working with family members and local primary health care personnel to develop a shared story which weaves together knowledge and strategies at the family and community level with knowledge

and strategies which focus more on disease process and treatment and prevention. By creating a story which all of the different players find useful, within which they can each locate their own agency, they set the conditions for complementary and mutually reinforcing action.

In the case of the Child Development Unit project (Taylor, 1993), family members, general practitioners and specialists from the Adelaide Children's Hospital came together to create a shared story about the needs of particular children. The Far West Mental Health Service (Hemming, 1993) similarly had families, clients and local community mental health staff working with visiting psychiatrists, sharing different perspectives and knowledge, and building a shared understanding of people's troubles and needs.

Reclaiming the Womb (Webster & Wilson, 1993b) illustrates a collaboration between women's health activists, academic specialists, two royal colleges and a range of clinicians in various Melbourne hospitals who shared the concern of the project about inappropriate hysterectomy.

In the case of the Babinda Hospital (Barker & May, 1993), building vertical partnerships led to new sources of money including Home and Community Care (HACC) program funding and new services. This was also associated with decisions taken at the regional health department level to delegate budgetary discretion to Babinda management, enabling them to use existing resources more flexibly.

It is inevitable that only some of the effort which goes into building new relationships and reorienting the thinking of consumers, local practitioners and specialists, feeds directly into the present project, into measurable and immediate outcomes. Of comparable importance are the processes of capability building, putting in place a readiness and a capacity to act more effectively at some stage in the future. Projects such as the Horizons Living Skills Program (Cox, 1994), Paps I Should (Farnan & Gray, 1994) and Rural Outreach (Webster & Wilson, 1993a) have contributed to capability-building for future engagements, and in ways which would have been difficult to specify prospectively.

Intersectoral collaboration

Intersectoral collaboration was identified as being present in around 80% of the interview cases. It was judged to be particularly outstanding in around half of the 25 cases. These included intersectoral collaboration at the local level, and also collaboration with agencies working in other sectors at a more centralised level. The Wilson Reserve project (Tesoriero, 1990) involved Parks CHC people working together with local council personnel to improve safety and usefulness of a local park and thereby improve the physical and social conditions for better health.

Several of the cases in the interview study drew upon more centralised expertise across intersectoral boundaries. The Onkaparinga project (Lewin, 1992) brought together residents groups, recreation groups and tourist interests with health people, local environmentalists and other individuals concerned about water quality in the estuary. It also involved collaboration between local people and more central experts and authorities.

Macro/micro balance

Integrating the macro and the micro is a key aspect of the primary health care model; addressing immediate health issues in ways that also contribute to redressing the underlying conditions which reproduce those patterns of need. Such patterns of practice were associated with good outcomes in the reviewer study and were judged to be outstanding in around half of the cases in the interview study.

Redfern (Foley, 1991) had always operated at a range of levels in addressing the immediate health needs of individual clients and families, and in addressing the public health needs of the local community and the wider community of Aboriginal people in Sydney and beyond. However, the historical, political, cultural and economic issues which constituted the circumstances of Aboriginal health were also an everyday reality in terms of discrimination in mainstream health services and the longer term circumstances of disadvantage. Awareness of these aspects and how these might be overcome, were also present in shaping the health care and preventive strategies adopted by the Service.

Taking the Message (Webster & Wilson, 1993c) was similarly based on an analysis of the circumstances of women from non-English speaking backgrounds working in factories and the complex of problems including access to health information, particularly information about contraception and occupational safety. The strategies of the organisation drew upon insights from feminism and industrial relations and from the cultural experience of migration.

Paps I Should (Farnan & Gray, 1994) began with a focus on access to cervical cancer screening for disabled women. However, the project was also informed by a related analysis about the rights of people with disabilities to participate fully in society. The project responded in an integrated way to issues identified at different levels.

Organisational learning

Organisations with a structured capacity for learning how to do their work better are more likely to produce better practice and improve outcomes than organisations without such a capacity. A deliberate approach to organisational learning was evident in around half of the 25 interview cases but it was judged to be outstanding in only six or seven cases.

We identified three main dynamics which supported organisational learning in these agencies. These were:

- **evaluation and critical reflection upon practice;**
- **linking practice with theory and research; and**
- **investing in personnel training.**

Many of the projects included in this study have collected data for accountability and reporting purposes but the evaluative strategies which appear to be contributing to excellent outcomes are as much about creating a culture of critical reflection as they are about measuring performance indicators.

The story of the Far West Mental Health Service (Hemming, 1993) tells of an organisation where staff were encouraged to justify their strategies and practices at team meetings and other staff discussions; where programs were evaluated, and papers were written and presented at appropriate conferences.

A significant number of the cases in this study have been associated with active theorising and research in their development. The picture which emerges, of an active interplay between theory and practice, is impressive.

The WASH project (McBride et al., 1994) was conceived from the start as a model for piloting and if successful for wider emulation. This entailed a comprehensive review of the literature and relevant theoretical issues. The role of the National Centre for Research into the Prevention of Drug Abuse in the evaluation and related research was influential throughout the project.

The Parks CHC (Tesoriero, 1990) and Nutrition in the Parks {Spurr et al., 1993) had developed a culture in which staff were encouraged to undertake further study including research, programs were evaluated, papers written and conferences attended and papers presented. Most basic,

by way of creating learning organisations, must be the investment in personnel training. This includes training opportunities for consumers and community activists as well as professional development opportunities for staff.

The success of the Gagudju alcohol project (Furler & Bulliwana, 1993) depended in part on the training for the Aboriginal health worker as the mainspring of the project, which was provided in Alice Springs through an Aboriginal run training program for alcohol workers and at the local Training and Further Education college (TAFE}. He gained access to knowledge, skills and experience in other indigenous settings in tackling alcohol issues which contributed to the success of the program that he developed at Jabiru.

Policy participation

Participation in the policy cycle, for example, through research or advocacy, did not emerge as a prominent strategy of practice in the analysis although the prominence of 'supportive policy and program environment' as a pre-condition for good practice highlighted the absence of a corresponding strategy of practice {policy participation) and a corresponding outcome (policy development}.

To some degree the absence of policy participation from the results of the analysis was artefactual. Policy participation had been a strong feature of several of the case studies, for example, Redfern (Foley, 1991}, Reclaiming the Womb (Webster & Wilson, 1993b), aiid the Onkaparinga Estuary (Lewin, 1992) but the analysis had not been sensitive to it. Part of the reason for underplaying policy participation in the analysis might be that policy participation, like the management of change generally, does not figure strongly in traditional accounts of primary health care as a policy model.

In the reviewer evaluation study 'change consciousness' was one of the three process variables studied which was associated with good outcomes (details are presented in the full project report). Clearly, the pro active management of change in health care must include participating in the policy process.

Good management

Good management was not one of the initial foci of attention in this project but clearly emerged as important in the interview study. There is a wide overlap between the notion of good management and the other aspects of good practice which have been already discussed in this paper However, there are four aspects of good management which emerged in this study and are not adequately covered by the preceding headings and which warrant brief mention. These are:

- flexibility and risk taking;
- effective personnel selection;
- using available information resources; and
- mobilising financial resources.

A willingness and ability to take unforeseen opportunities, and risks in some cases, was present in most of the cases in this study and was judged to have been particularly important in contributing to the outcomes achieved in about a quarter of cases. The Rural Outreach project (Webster & Wilson, 1993c) is a good example. This project was based from the start on the requests and interests of women from small towns in the region. It was not tightly planned and was able to identify opportunities and needs and to respond flexibly as the project unfolded in the different towns.

Effective personnel selection was identified as a feature of around half of the 25 cases, but it was scored as particularly contributory in only two cases. For example, Women in Community Health (WICH), the source agency of Taking the Message (Webster & Wilson, 1993c), developed a very careful approach to staff selection to ensure that language and cultural

background needs were addressed and the range of skills were maintained for the needs of the factory visits program.

A sensitivity to appropriate information resources was evident in many of the interviews. Health Sharing Women's Health Resource Service (Webster & Wilson, 1993d) and Reclaiming the Womb (Webster & Wilson, 1993b), had a systematic approach to the use of published literature and a range of other information sources. Further access to information was facilitated by a network of links to specialists, women with specific experiences related to particular health issues, other health professionals and other women's health services.

The mobilisation of financial resources is a key contribution to excellent outcomes. It was recorded as a key feature in more than half of our 25 cases and as an important contribution to the outcomes achieved in around one quarter of cases. In the case of Gagudju (Furler & Bulliwana, 1993) the procurement of demonstration money from the Commonwealth's General Practice Reform Program for a service that the Territory Department had not been able to fund, was a key achievement. It led in due course to the Department supporting Aboriginal Health Workers' positions at Jabiru. The mobilisation of more than $1 million from local, state and Commonwealth governments_to build the Onkaparinga wetlands (Lewin, 1992) was a major achievement of this project.

Conclusions

The patterns of practice which were associated with excellent outcomes in 25 case studies of primary health care, and some of the dynamics involved in producing these outcomes, have been reported. These patterns and dynamics, with vignettes from some of the case studies, have been illustrated. It is hoped that a clearer delineation of the elements of good practice and the identification of contemporary benchmark cases, illustrating how these can be achieved, should facilitate the wider achievement of good practice and excellent outcomes in primary health care.

It should be noted that this study was designed to focus on the social health, networking, and developmental functions of the primary health care model. Case studies which were solely clinical and/or which remained solely within one discipline were not included in the survey. The data reported in this paper are abstracted from the results of a larger study which also included a detailed analysis of outcomes, of the associations between process and outcomes, and of the pre-conditions associated with patterns of good practice.

The conclusions and recommendations from the larger study deal with priorities for educational support (programs to support consumer and community activists as well as professionals), and directions for policy and program development. It is recommended that the Commonwealth government establishes a national network of primary health care reference centres to provide infrastructure support for human resource development in primary health care in Australia. The Commonwealt_h should take the lead in developing a national primary health care policy and action plan, and a number of policy directions which should be incorporated within such a plan, have been suggested.

The problem of measuring the outcomes of primary health care has not been solved, and it is doubtful that the problem can be solved. Many of the outcomes of today's practice constitute the pre-conditions for better practice tomorrow, although not always predictably. It is important that these longer term outcomes are valued as well as the immediate health gains.

Epidemiological evidence about the effectiveness of the different elements of practice described, has not been produced. However, the findings will contribute to a clearer delineation of the kinds.of dynamics and strategies through which excellent

outcomes are produced and, perhaps, to a clearer delineation of the boundaries between universal guidelines and local judgement.

The best practice approach to achieving excellence in primary health care is impressive. Building a culture of critical reflection and searching for better ways of doing things must be a high priority within the primary health care field. It is hoped that the benchmarks of best practice publicised through this project will contribute to this.

The notion of iearning organisations as a way of thinking about the pro-active management of change, and as a rubric which brings together the previously separate activities of planning, research, evaluation and education, linked by an overriding commitment to building a learning organisation, is also impressive. Perhaps it is time to go beyond organisational learning and look towards building a capacity for system-wide learning across the whole primary health care field.

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Footnotes

1. The findings which we report in this paper are taken from a larger study, the Best Practice in Primary Health Care project, which was funded through the National Health Advancement Program of the Commonwealth Department of Human Services and Health. The full report of the project (Legge, Wilson et al, 1996) is available from the Centre for Development and Innovation in Health.
2. HEAPS (the Health Education and Promotion System) is a database of health promotion programs and resources, designed for personal computers and produced and maintained for the Commonwealth Department of Human Services and Health by Prometheus Information, PO Box 2319, Canberra, 2601 (phone: 06 257 7356; fax: 06 241 5284)
3. An abstract of each of the 25 cases is included in Appendix 1 in the full project report.
4. As a general convention the past tense is used to describe the cases since it is based on documents and interviews which refer to periods past. This does not imply that the situations described do not continue to prevail.

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