

Much of the material in this issue is concerned with communication, but communication is much more than simply a means whereby information and knowledge is transferred between people. It is influenced by culture and by the social and policy contexts in which it takes place. In the primary health care area, meaningful communication is possibly even more important and more difficult than in any other area of the health system. It is more difficult, for example, because of the principles of primary health care to which practitioners subscribe, including the empowerment of those who would seek access to the system, re-orienting the health sector, and intersectoral co-operation in attempting to improve health and health services. The contributors demonstrate that in primary health care and in thinking about what is health, what influences it, how is it perceived, and how is it to be improved, there are theoretical and practical ways of approaching such issues.

Weeramanthri in 'Knowledge, language and mortality: Communicating health information in Aboriginal communities' argues that communication between professional and community groups is often difficult from a lack of overlapping values and differences in knowledge and skills, and that the same difficulties exist for Aboriginal people and professionals. To improve communication, the first questions which could be asked are not 'What do people need?' or 'What are their problems and how can they be addressed?' but 'What do people know?' and 'What do people value?'.

Such an approach could encompass a number of the other papers. For example, the role of general practitioners has been subject to review in the previous decade and Peterson presents for discussion an analysis of how general practice has been viewed by policy makers and how the role might be changed. Polgar, McGartland and Hales discuss the limitations of the generally welcome attempts to assist people to quit smoking but argue that from a biopsychosocial view, this might not be the appropriate response for people with schizophrenia who also smoke. Is it

sufficient simply to treat people who have suffered road accidents or are there other consequences, including social and occupational ones, which require a much longer follow-up than is generally available? How do people themselves report these consequences? Jeavons, Greenwood and Horne explore this little-researched area.

How do policy makers understand, use and value the concept of 'community'. Both Smith and Wilkin, and Rissel analyse the re-orienting of health services and the role of communities and how the term 'community' is understood by policy makers. The value of taking group processes into account in the design and implementation of programs is argued by McGartland and Hammond to be increasingly important as many health and education programs are based on groupwork. They explore approaches to the development of interpersonal skills while maintaining the independence of the members of the group.

Swanborough examines 'group processes' in a different way in an innovative approach to structural advocacy for homeless people, where she argues that the intersectoral complexity of homelessness requires more than advocacy related to individual client outcomes. Client outcomes are the focus of an evaluation by Adams et al. of consumer satisfaction with Child Health Services in a community setting. Pentland and Drostens' paper is also about client outcomes but their discussion is about how close collaboration between different professionals with different skills can improve those outcomes in problem gamblers. Salisbury and Follent compare the levels of stress experienced by Aboriginal and Torres Strait Islanders and non-Aboriginal and Torres Strait Islanders, and the barriers which exist in accessing services, and conclude that a partnership is required to develop a health service which is acceptable and useful to Aboriginal and Torres Strait Islanders.

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