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What is going on here?

A striking characteristic of this issue is the number of papers reporting on the experience and attitudes of patients and providers, the people involved most closely in primary health care. Five papers examine the experience of patients and potential users of services, three examine the perspective of those delivering services and a further three papers include the perspectives of both patients and service deliverers in their evaluations of pilot programs. Research studies like these are undertaken because researchers who are often clinicians themselves want to understand what is going on (or not) and what is needed to improve the situation. Such studies can help providers, organisations and policy makers to design and provide care appropriate to the diverse contexts of primary health care.

Several of the papers challenge the prevailing orthodoxies. Well-integrated multidisciplinary care can be of great value for people with chronic conditions, but Maneze et al. report few patients in their study felt that having many health professionals involved in their care improved their diabetes control. Bonney et al. used different methodology to discern patients’ views of multidisciplinary care and concluded that interpersonal continuity of care must not be lost in health care reform. By examining patient experience, descriptive studies like these remind us to look deeper than the terminology, which becomes so familiar it can be meaningless, and to question whether coordination, patient-centred care or multidisciplinary care is delivering what it is meant to. Research provides a more accurate basis for knowledge of patients’ preferences, needs and values than assumption, and without this knowledge primary health care cannot be effective.

Knowledge of patients is only part of the equation in delivering care – knowledge of the attitudes, experience and behaviour of providers is needed to develop systems of effective care that support rather than hinder the providers. Looking at care of newly arrived refugees from different perspectives, two papers arrive at compatible conclusions. Farley et al. found that despite recent improvements resulting from a new specialised refugee health service, providers in Brisbane still felt isolated, needed greater supports and a more coordinated approach to care. Clark et al. report that refugee women in South Australia identified language and lack of use of interpreter services as the main barriers to access, and concluded that education, training and support were required for the refugees, support organisations, GPs, pharmacists and their staff.

Is it normal for children to have dirty faces? This confronting question takes the journal reader to remote Indigenous Northern Territory communities and the problem of eliminating trachoma. Here health promotion is the role of staff in clinics, schools and community workplaces. Lange et al. found that more than one-third of staff considered dirty faces normal and a substantial proportion were unaware they lived and worked in a trachoma-endemic area. This study forms the basis of the trachoma-elimination health promotion to increase awareness and take action to promote clean faces and good hygiene practices. Changing staff attitudes to dirty faces is a first step in taking action.

Descriptive research studies like these cannot provide the definitive answers that are possible through conducting a double-blind randomised controlled trial of an intervention. However, with the knowledge gained by such descriptive studies we have more chance of designing interventions appropriate to the diverse contexts in which people work and live. Such knowledge also helps us to interpret the findings of larger scale studies such as Skinner et al.’s review and meta-analysis of the effect of health insurance on utilisation of allied health services, or Harris et al.’s study on the factors associated with routine use of guidelines in general practice. The latter paper demonstrates the value and efficiency of conducting secondary analysis on a dataset derived from a Commonwealth Fund survey of primary care practitioners.

Building research capacity in primary health care has been a feature of Federal and State government funding over the past decade. Friesen et al. describe one approach to building research capacity to help generate the evidence to underpin clinical activities, while Brown and McIntyre examine the contribution of research supported by the national Primary Health Care Research Evaluation and Development program. Sustaining the primary health care research workforce requires ongoing funding for different types of research, an issue being vigorously discussed at present in Australian academic primary care circles. It is essential to be able to continue performing the descriptive and intervention research relevant to the wide variety of primary health care practitioners and patients, as well as conducting the implementation and health services research that is important for policy development at high levels. As a vital and essential component of health services, primary health care requires a body of knowledge to match its diversity and complexity.

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