This is the first occasion the Journal has published a special issue on safety and quality in primary health, although of course individual articles on the subject have appeared in its pages. The timing of the issue reflects significant world-wide interest evidenced in a growth of specialist safety and quality-related journals, conferences, World Health Organization programs, as well as policy initiatives by governments all over the world.

Research into, and public inquiries following, deaths and injuries in public hospitals have been major drivers for this focus on safety and quality. The community sector, however, has not been uppermost in the minds of policy-makers as they channel programs and resources towards system improvement. Indeed, in Australia, responsibility for, and even definition of, primary health are so contested, it is not surprising that its profile regarding safety and quality has been barely visible. The review of the former Australian Council on Safety and Quality in Health Care in 2005, for example, pointed out that, in five years, the Council—Australia's peak body in this area—simply failed to address safety and quality in primary health care provision altogether, even though it was a key platform for health care delivery (Paterson, 2005).

Clearly, it would be better if improvements in health care safety and quality were not driven by disastrous and costly injuries to service users, but rather by a sustained system-wide quest for outstanding consumer-focused outcomes.

This issue of the Journal throws some light on what is happening in safety and quality improvement across the spectrum of primary health. It is clear from the range of contributions that there has been a great deal of energy and experimentation with quality improvement methodology, using techniques adapted to the smaller organisational scale—particularity of service type—and community culture distinctive of primary health. Evident in the articles is a growing partnership between service providers, consumers and government.

As stated in an editorial in the 2002 special issue of this Journal, primary health is defined more by values, setting, scale and purpose rather than by service types or models. It includes a complex array of forms, including home-based services and both generalist and specialist community-based services such as mental health, drug and alcohol, and sexual health services as well as general medical practice.

Australia-wide, there is now over 20 years' experience in policy development, design, implementation, evaluation and administration of quality initiatives in primary health. However, remaining gaps in our understanding should be addressed with targeted research.

Government has played a major role in development and introduction of quality initiatives. It has been left to each government funding body or regulatory agency to decide upon their nature and timing, and risk management has been a prominent, though not exclusive, driver. Improved outcomes and other objectives have also motivated these initiatives.

Another factor shaping quality initiatives in primary health has been the division of responsibility for health services quality between state and Commonwealth governments. "Quality frameworks" abound between program silos at any given level of government. The frameworks frequently involve complex and competing reporting requirements.

Primary health services tend to be particularly vulnerable to the resulting workload because, increasingly, they are platforms for a range of diversely funded programs. Concern about complexity, contradiction, duplication and compliance costs in quality initiatives is widespread in the sector.

This theme of competing public imperatives is picked up in this issue by Cameron, who describes the plight of disability services trying to steer a course between the "dignity of risk" for disabled people attending supported employment services, and the services' absolute liability under occupational health and safety legislation.

The news is not altogether grim, however. Some of the more integrated initiatives have truly engaged the targeted sector to generate a strong sense of partnership and ownership. Examples of engagement processes can be seen particularly in Brown et al. (community health sector), and Booth et al. (general practice).

Accreditation has been an important contributor to the fostering of quality improvement in primary care. The Community Health Accreditation and Standards Program (CHASP), born 24 years ago, has evolved into a broad health and community services quality improvement vehicle, serving some 30 service sectors, and now auspiced by the Quality Improvement Council (QIC). Elmer and Kilpatrick's contribution observes the QIC accreditation program in action from the perspective of the culture of participating organisations.

Likewise, the Royal College of General Practitioners Standards used for accreditation by AGPAL and GPA in some 4000 general medical practices has made a contribution to promoting quality improvement in those settings.

As the contributions in this issue show, there is a great deal of vitality in the field. The next step will surely be to build up a base of evidence regarding the efficacy and sustainability of interventions. Biuso and Newton give us a glimpse of how this might occur in the evaluation of GP Collaboratives.

A significant investment has been made in compliance-based strategies as a means of reducing risk and the associated harm. This has occurred particularly in the acute and aged care sectors where mistakes can overtly lead to death and injury. To date, research into the effectiveness of these compliance-based initiatives suggests they are no more effective than quality initiatives that promote cultural reform in line with the principles of CQI. Notwithstanding the limitations outlined above, there is increasing interest in this latter approach, particularly among primary health services. Examples can be found in articles by Rose, Bailie et al., Holst and Walsh, Rennau et al., and Teshuva et al.

Primary health places a strong emphasis on partnerships between communities, consumers and practitioners. Quality initiatives have developed accordingly, with consumer experience being central to the quality assessment and improvement process. For an account of innovative consumer-focused quality improvement, see Hoodless et al.

One strategy directed towards realisable consumer goals is care planning. In her contribution Kirsner describes the use of this strategy in palliative care.

To support continuity of care, primary health and other community services—as well as acute care services—should be well coordinated. It follows that consumer-centred quality improvement should also be coordinated. One example of a coordinated quality initiative engaging a range of relevant services can be found in Holst and Walsh, who describe the effectiveness of a Local Area Service Network program for services in the homeless sector.

The articles in this issue show a great deal of accumulated experience and learning has been acquired by the primary health sector. There are, however, several research priorities that arise from gaps in our understanding of quality improvement in primary health.

Primary health, like any other level of health service, is capable of harming those it is charged with healing; for example, through misdiagnosis, poor communication or unsafe treatment. Research into the nature of harm of this type is needed; in particular, in the higher risk areas such as general practice and community-based medication programs. At present, there is not even a common language to describe harm in the wider primary health field. A taxonomy of harm in primary health, therefore, would be a useful start.

In primary health, increasing engagement of consumer partnership in interventions (e.g., self-management of chronic illnesses) makes identifying the nature and extent of harm that arises from this kind of work an important research topic.

Poor service integration is also believed to generate harm to consumers. Further research could explore the nature of and risk associated with service fragmentation and disjointed information transfer.

International literature on the efficacy of accreditation, especially in primary health, remains insubstantial. Little evidence is available, for example, about factors critical to accreditation's success. Such work would necessitate a clear statement of the program logic of accreditation,

especially the balancing of compliance, with quality improvement. It would also need to take account of organisational change theory.

The evaluation of accreditation—a particular quality initiative—should sit within a wider inquiry into the cost benefit of quality initiatives in primary health and their key success factors. Findings from such research could make a major contribution to the evidence base for policy-making and service investment.

We hope this special issue stimulates policy debate and research effort that will strengthen primary health practice and encourage continued evolution of quality and safety initiatives tailored to it. We thank the authors for their contribution—they have made this special issue possible—and the reviewers for their helpful advice.

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