

The Role of Physiotherapy in the Provision of Primary Health Care

Introduction

This background paper aims to bring together evidence from both national and international sources in support of a primary health care approach to the Australian health care system, and the important role physiotherapy can (and must) play in the delivery of this approach.

Background

Currently, there is no universally accepted meaning of the term “primary health care” (Doggett, 2007; Centre for Primary Health Care & Equity, 2006; Rogers & Veale, 2003). Disagreements persist over the values and goals it encompasses (Powell Davies, Hu, McDonald, Furler, Harris & Harris, 2006).

It is important to acknowledge from the outset these differences in conceptualisation because of their recognised potential to lead to misunderstandings between stakeholders, and subsequently to impede collaborative efforts (Powell Davies et al., 2006; Centre for Primary Health Care & Equity, 2006).

The term was popularised when the World Health Organization (WHO) Alma-Ata Declaration was signed by 134 health ministers attending the International Conference on Primary Health Care in 1978 (Lin, Smith & Fawkes, 2007; Corbin, 2005; Australian Primary Health Care Research Institute, undated). The Declaration represented a global commitment to a ‘Health for All’ policy; and to primary health care as the most appropriate strategy to achieve this goal by the beginning of the 21st century (Corbin, 2005; Rogers & Veale, 2003).

The Declaration “strongly reaffirms that health, which is a state of complete physical, mental and social wellbeing, and not merely the absence of disease or infirmity, is a fundamental human right and that the attainment of the highest possible level of health is a most important world-wide social goal whose realisation requires the action of many other social and economic sectors in addition to the health sector. The existing gross inequality in the health status of the people particularly between developed and developing countries as well as within countries is politically, socially and economically unacceptable and is, therefore, of common concern to all countries” (WHO, 1978, cited in Corbin, 2005, p.78).

The definition adopted by delegates – known as Comprehensive Primary Health Care (CPHC) – embraced a social justice approach, supporting equity, community participation, integration, intersectoral collaboration, multidisciplinary teamwork and health promotion. This was considered by some to be too difficult to attain, instead choosing to pursue a more medically focused approach. This came to be known as Selective Primary Health Care [SPHC] (Centre for Primary Health Care & Equity, 2006; Corbin, 2005; Rogers & Veale, 2003).

The differences in the two approaches have been summarised in terms of the following:

 Their conceptualisation of health - positive wellbeing (CPHC) compared with absence of disease (SPHC)

 Locus of control over health – rests with communities and individuals (CPHC) rather than with health professionals (SPHC)

 Major focus - health through equity and community empowerment (CPHC) compared with health through medical interventions (SPHC)

Provision of health care – via multidisciplinary teams (CPHC) compared with via general practitioners (GPs) plus other health professionals (SPCH)

Health strategies – multi-sectoral collaboration (CPHC) rather than medical interventions [SPHC] (Rogers & Veale, 2003, p.18).

According to Rogers and Veale (2003), the Australian interpretation of primary health care fits somewhere between Comprehensive Primary Health Care and Selective Primary Health Care. It fails to acknowledge the importance of intersectoral collaboration, to explicitly commit to equity, and to place population health methods and approaches at the centre of primary health care.

The Australian Primary Health Care Research Institute (undated) provides a definition of primary health care to which Australian governments and service providers should aspire in the new millennium. It incorporates the *Declaration of Alma Ata* (WHO 1978) and the *Primary Health Care: A Framework for Future Strategic Directions* (WHO 2003):

Socially appropriate, universally accessible, scientifically sound first level care provided by a suitably trained workforce supported by integrated referral systems and in a way that gives priority to those in most need, maximises community and individual self-reliance and participation and involves collaboration with other sectors. It includes the following:

health promotion
illness prevention
care of the sick
advocacy
community development.

Summary Statement:

There is no universally accepted definition of Primary Health Care. As a starting point for ongoing dialogue with other stakeholders, it is important to obtain clarity around the term and work towards a commonly agreed definition.

The APA considers that the Australian Primary Health Care Research Institute (undated) provides a definition of primary health care to which Australian governments and service providers should aspire in the new millennium. It incorporates the *Declaration of Alma Ata* (WHO 1978) and the *Primary Health Care: A Framework for Future Strategic Directions* (WHO 2003):

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- Health promotion
- Illness prevention
- Care of the sick
- Advocacy
- Community development.

Why Primary Health Care?

As acknowledged by Australian Labor Party (2007) in their pre-election paper, both the cost of health care provision and the demand for it are on the increase. On current projections, health care

spending will rise from 3.8 per cent of GDP in 2006-07 to 7.3 per cent by the middle of the 21st century.

Many countries are suffering economic and social pressures caused by longer life expectancies, increases in chronic illnesses¹, advances in health care technologies, high consumer and community expectations, changing patterns in diseases and increasing inequalities in health outcomes (Doggett, 2007; Lin et al., 2007; Australian Labor Party, 2007; Powell Davies et al., 2006; Sibthorpe, Glasgow & Wells, 2005; Australian Divisions of General Practice, 2005; McAvoy & Coster, 2005).

Although the major driver to change may well be economics (McAvoy & Coster, 2005), it is acknowledged that primary health care also has the capacity to improve population health outcomes and reduce health inequalities and many countries are reorienting their health care system in line with this evidence (McDonald, Powell Davies, Cumming & Harris, 2007; Australian Labor Party, 2007; Powell Davies et al., 2006; McDonald & Hare, 2004; Glasgow, Sibthorpe & Gear, undated).

It has been found that nations with a strong primary care infrastructure — which supports equitable access of services (both in terms of geographical spread and cultural sensitivity), a consumer orientation, early detection and intervention practices that emphasise health promotion as well as disease and injury prevention, better management of chronic conditions, continuity and coordination of care, a population health focus and improved information management of health needs and outcomes — have lower healthcare costs and generally healthier populations than those concentrating their efforts on the tertiary end of healthcare (College of Physical Therapists of Alberta, Alberta Physiotherapy Association & Canadian Physiotherapy Association, 2007; Doggett, 2007; McDonald & Hare, 2004).

Summary Statement:

In times of increasing demand and economic pressures, primary health care represents an effective approach to improving service efficiency, coordination, and continuity so that consumers' health needs can be met equitably and appropriately (Soever, 2006).

Primary Health Care and the Australian Context

Despite Australia being counted among those nations currently undertaking health care and social welfare reforms (e.g., South Africa, New Zealand, and countries from Europe and North America), a recent report that surveyed six industrialised nations regarding their performance in preventative and chronic disease care ranked Australia fifth (Australian Labor Party, 2007; McAvoy & Coster, 2005).

Reasons for this poor performance are likely to include:

1. No National Policy on Primary Health Care

Although there have been many large-scale programs (e.g., the national Coordinated Care Trials of funds pooling and care planning, the Indigenous health Primary Health Care Access Program and the Australian Primary Care Collaboratives Program) and small-scale, local programs aimed at strengthening primary health care, there is no national policy (Sibthorpe et al., 2005).

1. *The Split between State/Territory and Commonwealth Government Responsibilities*

The current divide between State/Territory and Commonwealth responsibilities for funding, policy directions and the organisation of health services has led to service fragmentation, cost-shifting and duplications. It has also made the system unnecessarily onerous for providers and consumers to use. The community health sector and hospitals are the responsibility of State/Territory Governments; while the Commonwealth Government is responsible for general practice, which supplies the primary medical care component of primary health care in Australia (Australian Labor Party, 2007; McDonald et al., 2007; Powell Davies et al., 2006; Jolley, Braun, Hurley & Fry, undated).

1. *Emphasis on Late-Stage Biomedical Care*

The health system is oriented towards late-stage biomedical care, with hospitals receiving the bulk of available funding (Jolley et al., undated). The emphasis on biomedical care is reflected in the relatively low expenditure on primary health care nationally. Only 1.7 per cent of recurrent national health expenditure in 2004-05 was spent on health promotion and prevention (Australian Labor Party, 2007).

1. *Programs Oriented towards Individual Care, Not Population Health*

Powell Davies et al.'s (2006) study revealed that there has tended to be an orientation towards individual care, rather than towards population health. This has been particularly the case with programs designed to manage chronic conditions. In addition, there has been little evidence of integration across programs.

1. *Inadequate and/or Misdirected Funding*

Despite the rhetoric from both Commonwealth and State/Territory Governments in support of a primary health care approach, funding often has been short-term and not necessarily in keeping with the model of primary health care (Powell Davies et al., 2006; Rogers, Barton, Pekarsky, Lawless, Oddy, Hepworth & Beilby, 2005).

1. *Failure to Encourage Multidisciplinary Care*

An example of this failure can be seen in the Enhanced Primary Care Program (a payment scheme introduced in the late 1990s designed to support continuity of care and health checks for older Australians). This program has failed both to encourage GPs to embrace multidisciplinary care; and to significantly engage other primary health care professionals (Lin et al., 2007; Powell Davies et al., 2006).

. *Inadequacy of Divisions of General Practice (DGPs) to Facilitate the Delivery of Primary Health Care Services*

. Limitations to role

Although according to a 2002 Commonwealth Government review, DGPs were playing an important role in the coordination of health service delivery and the improvement of population health outcomes (Lin et al., 2007), the absence of direct leverage over funding places significant limitations on what they can achieve and restricts them to various State/Territory Government funded initiatives (McDonald et al., 2007).

Failure to engage allied health professionals and consumers

DGPs have largely failed to engage other health professionals, consumers or community groups in governance (McDonald et al., 2007).

1. *Inadequacy of Primary Health Care Networks or Partnerships (PCN/Ps) to Improve Service Coordination*

PCN/Ps have been set up as voluntary alliances of predominantly State/Territory Government funded primary and community health care agencies. These have met with varying degrees of success and there has not been a consistency of engagement with general practice (McDonald et al., 2007).

In response to the current shortfalls in health care, the new Australian Labor Party (ALP) Government is promoting a dual role for the Australian health system: maintenance of good health as well as treatment and management of illness (Doggett, 2007; Australian Labor Party, 2007). To this end, it has promised to promote preventative health as a “first order economic issue” (Australian Labor Party, 2007, p. 4).

Pre-election statements promise the adoption of a staged approach, starting with:

- . *[The establishment of] ... a **National Preventative Healthcare Strategy** ... supported by a permanent taskforce to provide evidence-based advice to government and health providers – both public and private – on preventative health programs and strategies.*

- . *[The provision of] incentives for GPs to practice preventative health care and an increased focus on multi-disciplinary care from primary care teams.*

- . *Broadening the focus of the major health care agreements between the Commonwealth and the States and Territories, to include more than just hospital funding*

- . *Commissioning Treasury to produce a series of **reports outlining the economic impacts of chronic disease** and the economic benefits of a greater focus on prevention in health care* (Australian Labor Party, 2007, p.4).

Summary Statement:

Despite Australia being counted among those nations currently undertaking health care and social welfare reforms (e.g., South Africa, New Zealand, and countries from Europe and North America), a recent report that surveyed six industrialised nations regarding their performance in preventative and chronic disease care ranked Australia fifth (Australian Labor Party, 2007; McAvoy & Coster, 2005).

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Lessons from International Experience

The success of the countries that originally inspired the ‘Health for All’ model of primary health care was due to their intersectoral activities and their high level of community participation (Corbin, 2005).

It should be stated from the outset that, internationally, primary health care providers and consumers continue to experience poorly coordinated and duplicated care (McDonald et al., 2007). Clearly, there is still considerable work to be done globally in the pursuit of an effective and comprehensive primary health care system. This caveat notwithstanding, the success of some countries in reorienting their health systems (e.g., UK and NZ) provide salutary lessons (Sibthorpe et al., 2005).

Of course, differences in the structure, funding and organisation of each nation’s health system need to be taken into account when deriving learnings from other countries’ experiences (McDonald et al., 2007).

In the UK, New Zealand and Canada, current primary health care reform has been accompanied by significant new funding across the sector. Although there have been substantial investments in Australia, these have been directed at general practice not at primary health care more broadly (Powell Davies et al., 2006).

In a number of countries, a major strategy to address health challenges has been the development of primary care organisations (PCOs). These act as intermediaries between government and local primary health care providers, planning, coordinating, supporting, and, in some cases managing services. Successful implementation of such organisations appears to relate to their capacity to commission services, being underpinned by a capitation-based funding system and having an appropriate patient enrolment process (McDonald et al., 2007).

In the UK, PCOs are known as Primary Care Trusts. They are positioned between government and local primary health care providers, integrating general practice with other primary care providers (and in some cases social support services) including nurses, allied health professionals, mental health practitioners and social workers (Doggett, 2007; McDonald et al., 2007).

In New Zealand, PCOs are known as Primary Health Organisations (PHOs). They are governed by a combination of elected community representatives and ministerial appointments. This has facilitated wide-ranging stakeholder input, rather than dominance from a single stakeholder group. PHOs aim to work collaboratively and with community involvement in the pursuit of local solutions to issues of local concern (Doggett, 2007; McDonald et al., 2007; McAvoy & Coster, 2005).

Summary Statement:

Although primary health care providers and consumers continue to experience poorly coordinated and duplicated care internationally learnings can be derived from the success of some countries in reorienting their health systems (McDonald et al., 2007), Sibthorpe et al., 2005):

- In UK, New Zealand and Canada primary health care reform has been accompanied by significant new funding across the sector
- In UK and New Zealand regionally-based primary care organisations have been set up, which plan coordinate, support, and, in some cases manage services (Powell Davies et al., 2006; McDonald et al., 2007).

The Practice of Primary Health Care

Both international and Australian reforms have placed general practice at the centre of primary health care activities (McDonald & Hare, 2004).

Some, however, question how well general practice fits within the philosophy of Comprehensive Primary Health Care. Jolley et al. (undated), argue that general practice is a more individually-focussed approach to health care; and, although there are areas of philosophical convergence (e.g., holistic view of health, use of research-based methods, and some health promotion and prevention), there are also areas of divergence [e.g., GPs remain silent on issues of equity in health care, acceptability of technology, community control over health services] (Rogers & Veale, 2003).

Certainly, AMA (undated) considers general practice to be “pivotal to the success of primary health care (PHC) in Australia ... [saying, it] must be delivered through general practice” (3rd page). Given this claim, it is interesting to note the findings of a study undertaken by Shortus, McKenzie, Kemp, Proudfoot & Harris, 2007³. They found that GPs rarely collaborated with other health care providers when preparing multidisciplinary care plans, most asserting that collaboration would not improve patient care in the majority of cases, even for those with complex needs. Many contended that sufficient collaboration occurs through referral and feedback letters.

A scan of the literature points to a number of contributors to the effective provision of primary health care.

1. Community Participation

The Alma-Ata Declaration places community participation at the heart of addressing health inequities (Corbin, 2005).

1. Intersectoral Collaboration

The Declaration also highlights the importance of intersectoral collaboration, acknowledging that health outcomes are determined by activities and policies beyond medical and health sectors (Corbin, 2005). Cooperation must occur at all levels, “from government planning through to local implementation, across traditional departmental boundaries” (Rogers & Veale, 2003, p.5).

1. Multidisciplinary Team Effort

There is now strong evidence in support of the benefits of teamwork over individually provided services. There remains, however, some confusion within the health care literature over the meaning of the term. “Teamwork” has been variously defined and a number of distinct terms are often used interchangeably: multidisciplinary, interdisciplinary, interprofessional, and transdisciplinary (College of Physical Therapists of Alberta et al., 2007).

The term most commonly used in relation to primary health care is *multidisciplinary team*. College of Physical Therapists of Alberta et al. (2007) define multidisciplinary teamwork as “include[ing] several disciplines with various knowledge and skill bases that are drawn together in a structure to provide services” (p.19).

Because primary health care balances health promotion, preventive care and illness treatment, a team approach is most appropriate. Teams should be drawn from a variety of professions, including: GPs, nurses, allied health professionals, community workers, population health professionals, health promotion workers and educators, Indigenous health workers and multicultural health workers. The services that teams deliver should reflect local community/population health needs (Doggett, 2007; Soever, 2006; McDonald & Hare, 2004; Rogers & Veale, 2003).

Both consumers and professionals stand to benefit from the multidisciplinary team approach. Service delivery to consumers is improved because the expertise of various professionals is more effectively utilised; and collaborative working arrangements — where professionals share responsibility for problem solving and planning patient care — can help address professionals’ work/life balance issues (College of Physical Therapists of Alberta et al., 2007; *Canadian Pharmacists Journal*, 2007).

Linked to effective teamwork are the following concepts:

Interdisciplinary trust and respect

It is well-established that effective teamwork in health care is often hampered by clashes in health care professionals’ world views. As the College of Physical Therapists of Alberta et al. (2007) point out, considering others’ world views requires being open to change and being prepared to trust in others.

Effective communication

Effective communication is central to the partnership approach that characterises primary health care (Vowles & Williams, 2000). It involves discourse not just at the interpersonal level but also at the organisational level (*Canadian Pharmacists Journal*, 2007).

Cooperation and leadership

It is likely that leadership within multidisciplinary teams will not be static, as flexible work practices aim to meet the needs of both consumers and team members. Case management responsibility must be designed to meet consumer needs, and this may change on a case-by-case basis (College of Physical Therapists of Alberta et al., 2007). Although the AMA (undated) supports a team-based approach, it insists that the GP must always be the team leader.

Summary Statement:

A scan of the literature points to a number of contributors to the effective provision of primary health care.

- Community participation to address health inequities
- Intersectoral collaboration
- Multidisciplinary team effort, which requires interdisciplinary trust and respect, effective communication, and cooperation and leadership (Corbin, 2005; College of Physical Therapists of Alberta et al., 2007; *Canadian Pharmacists Journal*, 2007; Vowles & Williams, 2000).

Primary Health Care and Physiotherapy

Across the world, rehabilitation providers, including physiotherapists, are playing an important part in primary health care teams (College of Physical Therapists of Alberta et al., 2007; Soever, 2006).

The skills and training of physiotherapists mean they are capable of working with a wide variety of conditions and disabilities and they are able to improve the health status of individuals across the lifespan. In addition, they are able to positively impact on population health in the local areas where they practise (Soever, 2006).

Physiotherapists are valuable members of multidisciplinary teams, making an important contribution to primary health care through their health promotion, prevention, screening, as well as triage, assessment and treatment activities (College of Physical Therapists of Alberta et al., 2007; Soever, 2006).

Apart from the treatment of musculoskeletal conditions, physiotherapists have a well-established role to play in the treatment and maintenance of chronic conditions such as cardiovascular disease, chronic obstructive pulmonary disease, diabetes, osteoporosis, obesity, and hypertension. The educative focus they adopt in areas such as chronic disease management, self-management techniques and lifestyle and physical activity counselling aligns well with the primary health care philosophy of consumer and community empowerment (Soever, 2006).

The training and experiences of physiotherapists make them valuable members of multidisciplinary teams in primary health care settings. They are trained in anatomy, pathology, physiology and rehabilitation techniques. They are superior problem solvers, skilled in clinical reasoning. They are educators and practiced communicators. They are competent researchers, able to plan, implement and evaluate interventions. As circumstances dictate, they can be independent autonomous practitioners or committed team players (Soever, 2006).

The skills and experience, together with the philosophical underpinnings of the profession, with its consumer focus, ideally place physiotherapists as active participants in primary health care service delivery models.

Summary Statement:

Physiotherapists can make an important contribution to primary health care through their health promotion, prevention, screening, as well as triage, assessment and treatment activities (College of Physical Therapists of Alberta et al., 2007; Soever, 2006).

The training and experiences of physiotherapists make them valuable members of multidisciplinary teams in primary health care settings. They are trained in anatomy, pathology, physiology and rehabilitation techniques. They are superior problem solvers, skilled in clinical reasoning. They are educators and practiced communicators. They are competent researchers, able to plan, implement and evaluate interventions. As circumstances dictate, they can be independent autonomous practitioners or committed team players (Soever, 2006).

The philosophical underpinnings of the profession, with its consumer focus, ideally place physiotherapy as an active participant in primary health care service delivery models.

Issues for Consideration

A number of key issues for Australia, requiring urgent consideration and action, have been identified in the literature.

1. *The need for a national policy and framework*

In the lead-up to the 2007 Australian election, the ALP acknowledged the need for a national position on primary health care (a view shared by many):

Given the international evidence, it would seem that Australia is poorly served by having no national strategy for primary health care and no strategy for more effectively harnessing the benefits primary care could provide for prevention and better management of chronic disease (Australian Labor Party, 2007, p25).

A national position on primary health care will need to make an explicit commitment to the equitable provision of services, community participation and empowerment, intersectoral collaboration and multidisciplinary teamwork. It will also need to review the accessibility, affordability and acceptability of technology in the delivery of health care (Doggett, 2007; Rogers and Veale, 2003). It must reflect a shared vision from all the major stakeholders, including consumers. It must also be based on a commonly agreed definition of primary health care (Powell Davies et al., 2006).

1. *The need for a single authority responsible for primary health care (Powell Davies et al., 2006)*
2. *A commitment to the primary health care workforce*

In addition to addressing workforce shortages, ongoing training needs of the existing workforce must be met. This should include the development of new skills and ways of working to encourage effective multidisciplinary teamwork and population health approaches (Powell Davies et al., 2006; Soever, 2006; McDonald & Hare, 2004).

1. *Appropriate levels of funding*

As Powell Davies et al. (2006) point out, system reform will not be possible under the existing funding arrangements. A reorientation of funding will need to include incentives to build the collaborative relationships that are required for effective multidisciplinary teamwork (College of Physical Therapists of Alberta et al., 2007; McDonald & Hare, 2004).

1. *The need for information systems to support integration of services (McDonald & Hare, 2004)*

Currently, infrastructure in this area remains under-developed (Powell Davies et al., 2006).

1. *Support for organisational changes designed to strengthen primary health care*

This must include the establishment of a series of formal structures that facilitate community and consumer involvement, decrease competition between providers, and establish multidisciplinary teams as functional units (Rogers & Veale, 2003).

1. *Support for research and development*

Research and development activities that guide the primary health care agenda in a systematic way must be supported (Powell Davies et al., 2006).

Advocating for physiotherapists' role in primary health care

The ALP has promised to "work in partnership with the states and territories, health professionals, and the community to help build a better preventative front end to our health system" (Australian

Labor Party, 2007, p. 26). It is important that all stakeholders (including consumers) are heard equally.

As one of the many stakeholders, the physiotherapy profession needs to clearly define its role in the primary health care system and establish the scope and boundaries of its role in multidisciplinary teamwork. It must advocate for its role by demonstrating to other health care providers, governments and policy makers how physiotherapy can contribute to the primary health care approach (College of Physical Therapists of Alberta et al., 2007; Soever, 2006). In the words of Soever (2006); "... physiotherapists need to demonstrate how they have the potential to contribute to the sum of the parts" (p.13) so that the skills and knowledge of physiotherapists are fully utilised in any reshaping of Australia's primary health care system.

Summary Statement:

A number of key issues for Australia, requiring urgent consideration and action, have been identified in the literature:

1. The need for a national position on primary health care
2. The need for a single authority responsible for primary health care
3. A commitment to the primary health care workforce
3. Appropriate levels of funding
4. The need for information systems to support integration of services
5. Support for organisational changes designed to strengthen primary health care
6. Support for research and development activities to guide the primary health care agenda (Australian Labor Party, 2007; Doggett, 2007; Rogers & Veale, 2003; Powell Davies et al., 2006; Soever, 2006; McDonald & Hare, 2004; College of Physical Therapists of Alberta et al., 2007).

The ALP has promised to "work in partnership with the states and territories, health professionals, and the community to help build a better preventative front end to our health system" (Australian Labor Party, 2007, p. 26). It is important that all stakeholders (including consumers) are heard equally. As one of the many stakeholders, the physiotherapy profession needs to clearly define its role in the primary health care system so that the skills and knowledge of physiotherapists are fully utilised in any reshaping of Australia's primary health care system.

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