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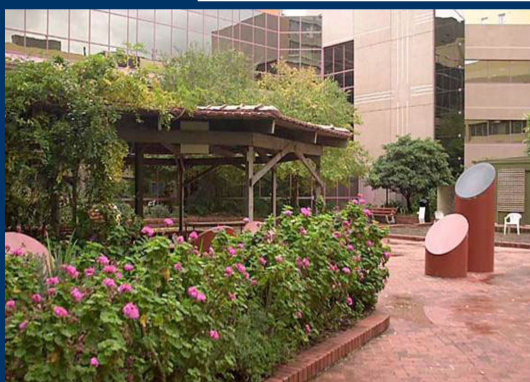
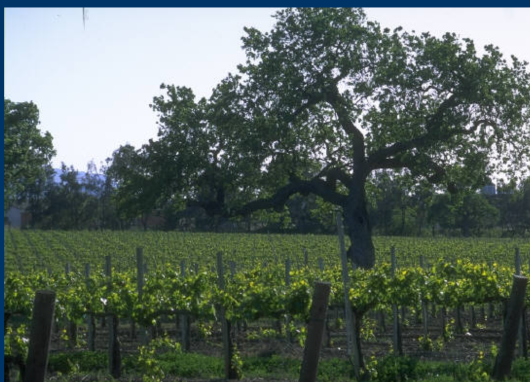
Governance change in the southern metropolitan Adelaide health region: implications for Primary Health Care





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Executive summary

The aim of the study was to begin an assessment of the impact of the new regional health structure in southern metropolitan Adelaide on commitment to, and implementation of, primary health care (PHC), including allocation of resources. The study addressed the questions: What is the most effective way to organise health service governance in order to promote and strengthen primary health care as a key focus of the health system? How does a change in health service governance affect the position of primary health care in relation to acute care health services?

This project was funded by the Flinders Institute of Health & Medical Research (FIHMR) with a grant of $20,000 for completion by December 2005.

Method

A Project Advisory Group was established to monitor progress of the study and to provide stakeholder advice on data collection and analysis, assistance with dissemination and support for further funding applications.

Base line quantitative data planned to be obtained for CHS provided PHC included:

- funding – the amount of core and grant funding
- governance – constitution, Board membership
- workforce – number, level and characteristics of workforce, job descriptions
- services – activity statistics, types of service, unmet need

Documentation from the PHC policy, the Generational Health Review and the subsequent response from the SA government and DHS were reviewed to provide an historical record of the policy development process and to help establish, and allow future review of, the stated goals and strategies arising from the policy as it is implemented in the southern region.

Semi-structured face-to-face interviews were conducted with key informants (service providers, DH funders and policy people). Two focus groups were held with community health staff. Interview and focus group data were collated and analysed to produce a table of key themes, goals and potential indicators for PHC. Interview respondents and other stakeholders were invited to a forum to get consensus on a vision for PHC in the region for the next 3 –5 years. Comments and suggestions were collated and used by the research team to revise the final PHC Goals Framework.

Findings

Interview respondents' vision for PHC in the SAHS region included:

- Access and quality
- Improved health
- Coordination and links
- Less demand/chronic disease management
- Focus on health and wellness
- Community empowerment

Goals for improving health based on a stronger PHC system were:

- Increased integration and continuity of care
- Better data collection and data connectivity
- Decreased hospital presentations and admissions, particularly for chronic diseases.
- Increased resources going to PHC
- Increase in prevention, maintenance, early intervention and screening services;
- Health service users having more 'ownership' of their health and involvement in health service planning and evaluation activities.

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The following were suggested as necessary to bring about reform

- Resources and funding mechanisms linked to reform and a willingness to reallocate resources to achieve a PHC focussed system
- Clearer population and health data for the region
- Recruitment, training and workforce development that supports the re-orientation to PHC by increasing health professionals' understanding of public health and community strategies
- Breakdown of professional barriers and hierarchies within the health workforce

Staff responses to the regionalisation and reform process ranged from outright pessimism to cautious optimism. Positive impacts included:

- the Aboriginal health framework;
- some increase in communication and links across services
- development of the consumer participation framework.

Potential benefits could be:

- regional strategies to address the social determinants of health,
- workforce development related to PHC,
- increased visibility and weight of primary health care in decision-making forums that could result in a shift of resources to the primary health care sector.

Negative reactions were based on perceived:

- Lack of implementation and change management strategy;
- Lack of adequate communication between executive and service staff;
- Devaluing of primary health care experience and expertise particularly that related to the health promotion, community development and public health activities;
- Emphasis on clinical and quantitative data;
- 'Slippage' of language and values (primary health care equated with primary medical care);
- Reduction in the visibility of social justice and health equity in the reform agenda.

Discussion

The study addressed the questions: What is the most effective way to organise health service governance in order to promote and strengthen primary health care as a key focus of the health system? How does a change in health service governance affect the position of primary health care in relation to acute care health services? In order to assess the strength of PHC and how this relates to health service governance, information in two main areas is needed:

1. An agreed definition and understanding of PHC and its goals
2. Ways to measure the strength of PHC and how this changes over time.

This pilot project has made some headway in both of these areas. The framework was developed from empirical and theoretical data. It links comprehensive PHC with considerations of equity and the social determinants of health and therefore clearly differentiates comprehensive PHC from primary medial care or selective PHC. The overarching goal, sub-goals and strategies reflect this value base. The resulting indicators and measuring tools still have a long way to go before they are sufficiently specific and robust for practical use and this research will continue.

An attempt has been made to establish baseline data for PHC in order to follow changes over time. Baseline data were collected and analysed but with difficulty. Some of the challenges include:

- deciding what 'counts' as PHC eg. resources provided to general practice to build community-based chronic care programs with the aim of reducing avoidable hospital admissions
- changing structures eg DASC is now administered by SAHS but was previously a separate service provider. Some of DASC's services would be classified as PHC.

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- different ways of recording data eg ISCHS and community health at NHS use different ways to record and present data on workforce and service provision; in 2003 the CHSS data collection program changed to CHIS; inconsistencies between budget and service data from different sources
- data not able to be made available to the project eg. minutes of Board meetings, level of unmet need

The next step in this research is to refine the framework by testing its appropriateness with other regional health services. This work will occur during 2006 and should result in a set of robust goals, strategies and indicators with which to assess PHC and its place in the South Australian health system.

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1. Introduction

1. 1 Project funding

This project was funded by the Flinders Institute of Health & Medical Research (FIHMR) with a grant of $20,000 for completion by December 2005. FIHMR grants are intended as seeding grants to assist in the development of larger funding applications. This study was limited in scope (to one health service region in southern Adelaide) and time (a 12 month time frame). This funding enabled evaluation to begin at the same time as the change process, the development of a research method to assess the impact of governance changes and regionalisation on primary health care across the metropolitan regions, and the development of an application to gain further funding under the ARC Linkage scheme.

1.2 Aim

The aim of the study was to begin an assessment of the impact of the new regional health structure in southern metropolitan Adelaide on commitment to, and implementation of, primary health care (PHC), including allocation of resources. The Inner Southern Community Health Service and Noarlunga Health Services are two of the main providers of primary health care in the southern metropolitan region of Adelaide. As part of the State Government reforms announced in response to the Generational Health Review, these services have become part of a new regional health structure: Southern Adelaide Health Service. One of the intentions of the reform is to strengthen the focus on primary health care. This study began an evaluation of the impact of regionalisation and new governance structures on primary health care.

The study addressed the questions: What is the most effective way to organise health service governance in order to promote and strengthen primary health care as a key focus of the health system? How does a change in health service governance affect the position of primary health care in relation to acute care health services?

1.3 Background

Despite constant change and reform in health systems across the world, these health care reforms remain largely unevaluated (Pollitt, 1995; Ferlie et al, 1996; Shaw 1999). Further, research and evaluation rarely take place concurrently with changes in policy and this makes the development of an evidence base for health policy decisions very difficult (Klein 1998). In the past ten years in particular, the literature has contained many examples where health care reform efforts in the UK, Canada, the USA, New Zealand and Australia have been discussed and analysed in some aspects but there have been few systematic evaluations of agency level organisational changes (Pollitt 1997). The work done in the southern area of Adelaide from 1998-2001 is one of the few systematic studies of local and regional health care reform (van Eyk, Baum & Blandford, 2001; van Eyk, Baum & Houghton 2001; Hurley, van Eyk & Baum 2002; van Eyk and Baum 2002). This application will be ideally placed to build on the existing findings from that study and to add an emphasis on PHC services.

Organisational change

To date, most studies of organisational change of a ‘transformational’ nature have focused upon the private, corporate sector (Ferlie et al.1996). It has been suggested that successful change is much more difficult for the public sector for a number of reasons including the fact that such organisations have to answer to a range of stakeholders, not just shareholders. The rationale for change is nearly always to reduce or control costs, improve service efficiency and population health outcomes (Braithwaite et al, 2005) although there is little or no evidence to date that health care reforms have substantially achieved any of these objectives (Braithwaite et al, 2006; Fulop et al, 2002). Also, the political context into which such changes are introduced has a significant impact. In some cases, changes will occur in the health system without reform while some reform efforts fail to lead to significant changes (Hacker, 2004). Also, lower level incremental changes may have more impact on the health system than the high level transformational efforts (Ashton, 2005)

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Many of the health care reform efforts of recent years have included a call to strengthen the primary health care sector as a way of reducing costs and improving outcomes (Macinko, Starfield & Shi, 2003; Dwyer, 2004; Dwyer, 2005, Green, 2004). However, there has been limited success and a number of challenges in implementing PHC reform. Some of the problems identified include: entrenched modes of working, resolving funding issues and responsibilities and the managerial implications of health care reform. Also, the inherently political nature of health care reform (Becker et al, 1998) means that the arrival of new leaders into the public sector, often as the result of electoral cycles, frequently results in more changes, in some cases reversing reforms that have already been undertaken or taking the reform in new directions. Continuous changes of this kind can lead to high anxiety and low morale amongst non-managerial staff (Southon 1996; van Eyk, Baum and Houghton, 2001).

Reviewing the ten years of multiple health system reforms in New Zealand, Ashton (2001) stated that the lessons learned from this process included the need for: clear goals and strategies to achieve them; early and frequent consultation with stakeholders; establishing trust with stakeholders and using opinion leaders to help promote change; and that substantial reform takes time and structures should be evaluated for their effectiveness before they are reformed or replaced (Ashton, 2001; Braithwaite et al, 2005). Recent Canadian experience with regionalisation and other reforms supports this view (Marchildon 2005).

Kotter (1995, 1996) outlines requirements for transformational change as follows:

- An agreement among staff and managers that change is needed
- A powerful coalition of leaders to drive the change
- A simple statement of goals and vision for change that is easily and widely communicated
- 'Small wins' along the way toward the final goal
- The willingness to confront and overcome barriers to change
- Consolidating the improvements by ensuring that progress is not linked to the presence of key people
- Institutionalising new approaches through checking that the changes have permeated the organisations culture (Kotter 1995; Kotter 1996).

Members of our group used this framework previously to analyse a failed attempt at reform in the state health system and found it a useful mechanism with which to analyse reasons for the failure (Hurley, Baum, & van Eyk, 2004). While some theorists, including Dunphy and Stace (2001), have questioned the effectiveness of the transformational change model, emphasising instead the importance of directive approaches when organisations need radical change but have little stomach for it, for the public sector, with its complex stakeholding and power relationships, Kotter's framework remains a useful tool.

SA Health Reform

The issues raised in the organisational change literature are reflected in events in SA where health 'reform' has shifted with the political agenda. In the early 1990s, the State government department responsible for health pursued regionalisation at the level of health service policy and planning. The major southern Adelaide health care agencies met at a strategic planning conference in November 1994 and resolved to pursue an integrated regional health service that would promote the idea of a 'teaching region' and develop a framework for linking clinical services across the south. An initiative – 'Designing Better Health Care' – arose from these discussions with the support of the SA Health Commission. The aim of the initiative was to improve agency integration and collaboration in order to enhance the way that services were provided to people in the catchment area. Political and bureaucratic changes however meant that the initiative did not proceed to establish a regional health service as planned (Hurley, Baum & van Eyk, 2004) and a modified project and detailed evaluation were conducted which involved two of the current CIs (FB, CH) and one of the partner investigators (HvE) (Baum et al. 2002).

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In 2002, a new State government commissioned the 'Generational Health Review' (Government of South Australia 2003a) as one of its first actions. It recommended sweeping reform of health service organisation including an increased focus on primary health care and a change to regional health structures and governance. The government's response to this review confirms health care reforms including new governance structures and strengthening primary health care (Government of South Australia 2003b). As a result, two geographic regions (Central Northern Adelaide Health Service and Southern Adelaide Health Service) and one population based region (Child, Youth and Women's Health Service) have been created. Health unit boards of management have been disbanded and new regional boards established.

This research provided an opportunity to assess the impact of these changes on the State government funded PHC services which are planned to become a far more central plank of the reformed health system. It will also contribute to the gap in knowledge about public sector reform processes, with a focus on the often difficult pathway from policy to implementation, and from structure to strategy. It makes use of lessons described in the academic literature about the need for clear goals, feasible strategies, consultation and trust, and sufficient time.

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2. Methods

2.1 Ethical approval
Ethical approval was obtained for the study from the Flinders University Social and Behavioural Research Ethics Committee.

2.2 Advisory Group
A Project Advisory Group was established to monitor progress of the study and to provide stakeholder advice on data collection and analysis, assistance with dissemination and support for further funding applications. The Advisory Group members, with their positions at the start of the research were:
- Sue Foster, Director of Inner Southern CHS
- Richard Hicks, Director of Community and Allied Health, NHS
- Clare Shuttleworth, Primary Health Care, SAHS
- Helen van Eyk, Research and Evaluation Branch, DH
- Juli Ferguson and Denise Nitschke, consumer representatives recruited through the Health Consumers Alliance

2.3 Baseline data
The focus of this study was to gather base line data on PHC services provided by CHS and to trial a Goal Attainment Scaling approach to determining a vision for PHC in the SAHS.

Base line quantitative data planned to be obtained for CHS provided PHC included:
- funding – the amount of core and grant funding
- governance – constitution, Board membership
- workforce – number, level and characteristics of workforce, job descriptions
- services – activity statistics, types of service, unmet need

The quantitative data aimed to give a base line measure with which to compare the results of policy implementation as it proceeds.

2.4 Policy documentation
Documentation from the PHC policy, the Generational Health Review and the subsequent response from the SA government and DHS were reviewed to provide an historical record of the policy development process and to help establish, and allow future review of, the stated goals and strategies arising from the policy as it is implemented in the southern region. During the course of the study the SA State Strategic Plan was released and this document contains a number of goals and indicators relevant to health and well-being.

2.5 Interviews and focus groups
Semi-structured face-to-face interviews were conducted with 10 key informants (service providers, DH funders and policy people). Questions were based on Kotter's framework, to gain information on perceptions of the reform changes/re-orientation to PHC in the region. Interviews were audio-taped and transcribed for analysis.

Two focus groups were held with community health staff, one each at Noarlunga Health Village and Inner Southern Community Health Service. Respondents were asked about their perceptions of changes since regionalisation and the impact on primary health care. Notes from these sessions were recorded on an electronic whiteboard and typed summaries sent back to respondents.

2.6 Initial analysis and reporting
Interview and focus group data were collated and analysed to produce a table of key themes, goals and potential indicators for PHC. As this resulted in a very large number of indicators, the document was sent to interview respondents with a request to choose priority themes and indicators, or to make any other comments. Following this, the revised framework was presented to the advisory group for

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further feedback and suggestions. Using this draft document, knowledge of the literature and PHC research experience the research team then developed and refined the framework to determine an overarching goal, three major goals and associated strategies and indicators of achievement at one and five years.

2.7 Forum

Interview respondents and other stakeholders were invited to a forum to get consensus on a vision for PHC in the region for the next 3 –5 years. About 50 people from across South Australia attended. The project to date and early results were described and speakers from the Department of Health, the Southern Adelaide Health Service and one of the consumer representatives on the advisory group presented their perspectives on PHC.

Participants then worked in small, facilitated groups commenting on and modifying the draft strategies and indicators that had been developed by the research team. Comments and suggestions were collated and used by the research team to revise the final PHC Goals Framework.

A draft report was prepared describing the study and the outcomes and circulated to stakeholders for comment. The final report was written following this feedback. Other dissemination methods i.e. journal articles and conference presentations will be written and submitted as appropriate.

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3. Findings

3.1 Baseline data
Two community health services, Noarlunga Health Services (NHS) and Inner Southern Community Health Service (ISCHS) were operating in the region before the formation of SAHS in July 2004. Baseline data consists of financial years 2002/03 and 2003/04 for these two services.

PHC Funding
Revenue from core funding, capital, and grants and contributions for 2002/2003 and 2003/2004 are shown in the tables below. Core includes base budget plus ongoing budget variations; capital funding covers funds for buildings and major projects; grants include project funding and once-off budget variations. Carry-over funding from the previous financial year is not included.

Community health service funding ($'000)[1]

2002/03	Core	Capital	Grants	Total
ISCHS	1,583	35	315	1,933
NHS	4,992	-	446	5,438
Total	**6,575**	**35**	**761**	**7,371**

2003/04	Core	Capital	Grants	Total
ISCHS	1,820	137	482	2,439
NHS	5,662	-	518	6,180
Total	**7,482**	**137**	**1,000**	**8,619**

The total PHC budget in 03/04 was 16.9% increase on the 02/03 budget. Core budget (including recurrent budget variations) increased by 13.8%.

Workforce and population

2002/2003	Population[2]	CHS Budget ($'000)	Staff (FTE)
ISCHS	213,328	1,933	25
NHS	152,945	5,438	76.49
Total	**366,273**	**7,371**	**101.49**

2003/2004	Population[3]	CHS Budget ($'000)*	Staff (FTE)
ISCHS	213, 487	2,439	23.16
NHS	153,496	6,180	52.78
Total	**366,983**	**8,619**	**75.94**
% Difference 02/03 and 03/04	**+ 0.2%**	**+ 16.9%**	**- 25.2%**

The population showed a very small increase of 0.2%. Full-time equivalent positions appear to have decreased by 25%. The data show that Inner Southern Community Health Service serves a larger population with one third of the budget of Noarlunga.

[1] From annual reports and personal communications
[2] http://abs.gov.au/Websitedbs/c311215.nsf/20564c23f3183fdaca25672100813ef1/3c556306c6a3b803ca256b5500799b10!OpenDocument#Untitled%20Section_2
[3] http://abs.gov.au/AUSSTATS/abs@.nsf/Previousproducts/3218.0Main%20Features52003-04?opendocument&tabname=Summary&prodno=3218.0&issue=2003-04&num=&view=

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Job descriptions
Full job and person specifications were not available at the time of this report, however extracts were provided by SAHS Human Resources. These extracts are from executive positions in PHC, not all executive positions in SAHS and are listed in more detail in Appendix A.

Role requirements include ensuring an appropriate balance of service delivery responsibilities within the PHC context (eg., clinical, health promotion, community development) and collaboration with stakeholders at the local, regional and state level to improve the health and social status of the community. Essential person requirements include a commitment to social health philosophy and a clear understanding of primary health care practice,
knowledge of primary health care, its relationship to social justice and the range of factors influencing health status and implications for service delivery, and sound knowledge of objectives and principles of early intervention and health promotion program development.

Services
A list of services provided by NHS and ISCHS is contained in Appendix A with details of client and program data for 2002/03 and 2003/04.

A summary of activity across the two services is provided below.

Table: Numbers of clients and occasions of service

2002/03	Group programs	One to one registered clients	Total
Number of unique clients	1,712	3,489	5,201
Number of attendances/ occasions of service	19,484	14,144	33,628

2003/04	Group programs	One to one registered clients	Total
Number of unique clients	1,392	3,673	5,065
Number of attendances/ occasions of service	41,669	19,143	60,812

In addition, 76,082 informal one-to-one occasions of service were recorded for 2002/03 and 76,313 informal one-to-one occasions of service for 2003/04.

From 2002/03 to 2003/04, overall numbers of unique clients fell slightly although there was an increase in numbers of one-to-one registered clients. Group client numbers decreased. Occasions of service nearly doubled with most of this increase in attendance at group programs.

Table: Numbers of group and community initiative programs

2002/03	Group programs	Community initiative programs
Number of programs/initiatives	517	287

2003/04	Group programs	Community initiative programs
Number of programs/initiatives	95	180

There is a large fall in the number of group programs from 2002/03 to 2003/04 which coupled with increases in attendance (Table above) suggests that those group programs that were run attracted more people, or that a different method of recording the data has been used. The number of community initiative programs also fell. Numbers of participants in community initiatives is difficult for services

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to record accurately and this data has been collected by CHIS only since mid-2003. Aggregated data from NHS and ISCHS indicate 45,901 people attended community initiatives in 2002/03 and 59,887 attended in 2003/04.

Governance

A list of the SAHS Board as at February 2006 is contained in appendix A. The SAHS constitution states that there should be an even gender balance on the board. Currently there are 6 male and 4 female board members. Seven of the original (2004) board members describe themselves as having a commitment to PHC, health promotion, social justice or community participation, although the constitution does not require board members to have skills or expertise in this area.

3.2 Policy documents

First Steps Forward 2003, the SA Government response to the GHR, lists statements of intent on health reform.

'The South Australian Government's reform of the health system will:

- provide services closer to home; and increase prevention, early intervention and health promotion
- strengthen primary health care services by creating greater opportunities for health professionals to work in local teams (GP's, allied health workers and nurses)
- improve health services for the most vulnerable populations in the community (Aboriginal people, children and young people, people with mental illness, frail aged
- develop a health workforce to support the new system with the right skill balance, the required training, recruitment and retention strategies
- sustain the current system while reforms are developed and implemented
- produce new structures that focus on the needs of the population rather than the health institution by creating, new governance structures, new models of funding services, new methods of sharing information
- broaden the involvement of practitioners and the community in health planning and policy decision-making'.

Some of these strategies are being implemented in the region – two new service sites planned, PHC network, new governance model. Some are at the planning stage – improving health services for vulnerable populations, new funding models and information sharing, community participation framework. Little action is apparent on workforce apart from the transfer of some positions from the central DH office.

PHC Policy 2003 includes a PHC Action List, 2003 – 2005. There are two main areas of actions for the regions, with DH as the driver.

Regional action plans:

> 'Ensure that regions have PHC action plans that are consistent with the DHS's PHC policy, and involve communities, General Practice, other agencies and departments and other primary health care providers.'
>
> 'Ensure that regions have sufficient PHC leadership and delegated authority to enable them to develop 'local solutions to local problems'.'
>
> 'Establish regional panning mechanisms that link with the Aboriginal Health Advisory Councils.'

Primary health care networks:

> 'Assist regions to develop PHC services and networks that better organise, integrate and deliver services, and enhance access to a comprehensive range of services. This will be in partnership

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> with General Practice, hospitals, other private practitioners, carers, volunteers, non government agencies and Local Government.'

At the time of data collection for this project, a regional health plan was still being drafted. The PHC plan was expected to fall under the regional plan. By June 2006 the regional plan had not been released.

A PHC network was being established at the time of this project with SAHS and the Southern Division of General Practice. The network provides coordinated and integrated care access for people with complex chronic disease and includes General Practice, hospitals and allied health services.

The PHC policy also promised an annual report card on PHC by the Minister for Health, however this had not eventuated at the time of this research.

SA Strategic Plan 2004, contains goals, targets, measuring tools and priority actions for whole of the state. While not specifically mentioning primary health care the section on health and wellbeing lists a number of relevant targets:

- Quality of life (Mercer QOL Index) in top 20 cities in 10 years
- Increase healthy life expectancy to lead Australia in 10 years
- Infant mortality – best performing state
- Psychological distress – equal or less Australian average in 10 years
- Reduce young smokers by 10% in 10 years
- Reduce overweight/obesity by 10% in 10 years
- Exceed Australian average in sport and physical activity in 10 years

Implementation strategies and the role of regional health services are not yet clear.

3.3 Interview data

Interviews were conducted with 12 respondents who were involved in health reform and regionalisation as members of the SAHS Board, or executive and management positions within SAHS health services (acute and community-based) or linked to the Department of Health.

> ***What outcomes for primary health care in the South do you want to achieve through the current health reform and regionalisation process?***

Most respondents stated that increased integration and continuity of care was a key outcome sought. This was described as a major potential benefit from the regionalisation process. One respondent particularly mentioned the integration of community health in relation to the strategic plan. Integration with other human services agencies outside the health sector was also seen as important.

Better data collection, a set of indicators and data connectivity between services and providers was also seen by most as an outcome that would lead to identification and measurement of key performance indicators.

About half of the respondents proposed an outcome of decreased hospital presentations and admissions, particularly for chronic diseases. About half also wanted to see increased resources going to PHC.

Other outcomes stated by several respondents were: improved health; an increase in prevention, maintenance, early intervention and screening services; and a move to health service users having more 'ownership' of their health. One respondent summed up a five year goal - there should be a strong primary health care focus in the region, measured by the engagement of communities and work within priority areas eg violence, early childhood. A healthy cities approach should have been established across the region with strong partnerships across sectors and with communities.

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Three people suggested outcomes related to an increased focus on evidence and evaluation, for example, the need for a clear understanding and recognition of the role community health and PHC plays in contributing to improved health outcomes for the population. This was believed to be relevant across metropolitan and country regions and needed further analysis of the effectiveness of PHC and prevention interventions.

Two respondents wanted to see people within particular population groups (one respondent named men and people of ATSI background) to be more engaged in prevention and in taking more responsibility for their health and health behaviours.

One person discussed outcomes for the workforce – by the end of the first year staff working in community health and primary health care should feel the region is a good place to work.

Who do you think are the key people in achieving a reorientation toward primary health care in the South?

Key people listed by at least half the respondents were SAHS Executive, general practice and the SDGP, and the community. Several people included DH and the SAHS Board. Other health providers (including the acute sector and community health managers and senior discipline staff), professional groups, other government sectors (eg. local government, DECS, Housing Trust), NGOs and the media were also mentioned.

The SAHS Executive and Board and the SDGP were generally believed to understand and be committed to the reform agenda although one respondent believed they still had some way to go in understanding a primary health care approach fully. Individual GPs were described as 'somewhat of a challenge'. Senior clinicians and some people in DH were also believed to have an understanding of the reform agenda. One respondent believed that while most people in the health sector understood the need for reorientation to PHC, for other governments and departments and NGOs, health and health reform was only thought of in terms of hospitals.

No respondents thought the community understood the need for change or was engaged in the change process.

Some suggestions for engaging key stakeholders were to engage the Board and Executive through the Population Health and Health Reform Committee, increase public relations and communication strategies, use a change management process to help people see how they would benefit, develop strategic partnerships, work at making health service users central to the health encounter with GPs, and increasing awareness of the work of groups such as HRSA and SACHRU.

What major changes are needed in the region for the outcomes you envision to be achieved?

Most respondents described resources and funding mechanisms linked to reform as a key mechanisms of change. It was noted that there will be a single line budget for each of the regions that they can allocate to services. That will allow funding to be shifted over time. Ensuring an increased funding and resource base for primary health care and the priority areas of the strategic plan was also mentioned.

Next most common change needed was in information technology and management. This included clearer population and health data for the southern region, and more data sharing and connectivity between service providers. This was seen as essential for improving the ways in which people with chronic conditions, in particular, could received an improved primary health care service.

The crucial importance of workforce development was mentioned by several people. This included the need to train different professional groups to work together in multidisciplinary teams, the

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establishment of new types of health professionals and the inclusion of PHC in undergraduate curriculum for health professionals such as doctors , nurses and allied health workers.

There were a number of other individual responses about the need for leadership, agreed vision, strategic planning and structures, consumer participation, tools to measure change and the need for primary health care to be clearly on the Board's agenda. One person also noted the need for good examples of primary health care practice to be promoted.

The main barrier to change according to about half the respondents are vested interests and professional differences/hierarchies that lead to 'silo' approaches to health care. Four people described the difficulty of providing long term investment to PHC when the acute sector is perceived to be under constant pressure and features in the media. It was recognised that this issue is heavily political and will require a government that is prepared to resist the 'health crisis' mentality and which directs its Treasury to invest in primary health care.
.
Other barriers mentioned were the lack of technology in PHC sector, community focus on hospitals and doctors, political expediency and insufficient political will, and workforce shortages.

What are the values you think should underpin health reform and primary health care in the region?

Equity issues and community engagement were the two most common values identified by respondents. Equity was described in terms of focussing on where there was most gain to be made and targeting those most in need. This included equitable distribution of resources to services according to the communities they served. Community engagement encompassed empowerment, partnerships with patients, and a system designed at all levels to focus on patients or communities.

Efficiency – making best use of resources – and effectiveness – doing the right things – were mentioned by two people each.

Individual responses included shared goals underpinned by partnerships, evidence and rigour so that PHC is more widely understood and can drive the political process, commitment to making hard resource allocation decisions and the need to value PHC work and the people who use the health system. One respondent noted that primary health care must be seen not only as a level of care but also an approach informed by comprehensive primary health care principles (WHO, 1978) and the Ottawa Charter for Health Promotion (WHO, 1986).

What aspects of organizations or services and cultures are critical to protect and preserve

About half the respondents described the NHS model of hospital and CH integration as something to be preserved and replicated. This was due to the culture of PHC that included the hospital, and encompassed an holistic approach which recognising the importance of the social determinants of health, and intersectoral partnerships. One respondent noted the need to reaffirm support for community health staff to pursue this comprehensive primary health care approach. It was felt that an important role of the Directors would be to encourage and reinforce the balance between one-to-one, group, community development and health promotion work.

Three respondents also talked about the community participation and empowerment approach within Onkaparinga and NHS, and one the importance of the international work and link to WHO through Healthy Cities Noarlunga.

Three people believed the good links with SDGP needed to be preserved and developed.

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Providing services close to where people live and work and the commitment of staff were also valued. Specific areas of where good work in the region was mentioned were early intervention, indigenous health and women's health.

Is there a region-wide change strategy for accomplishing the various initiatives and outcomes you have outlined?

Most people talked about the SAHS strategic plan, which is due to be released shortly. Under this will sit a PHC strategic plan and an acute services strategic plan. These are both in the process of being drafted. Also mentioned as underway are business plans for each of the six population groups identified as priorities (people with mental illness, people from Aboriginal backgrounds, people experiencing violence, chronic disease, older people, and children and families). It is too early to say if these strategic plans are understood and accepted as they are still being drafted. However, there does not appear to be any additional resources for implementing any of these plans.

A Health Atlas for the south is being prepared and should be ready in 2006.

Those responsible for driving the plan were identified as SAHS executive and Board, including the Population and Health Reform sub-committee. Some respondents stated that staff and community organisations (eg SDGP) had been consulted about the strategic plan while others believed that consultation had been minimal. PHC staff and agencies could contribute to the change management process.

How will all of the various initiatives afoot in the region be integrated and orchestrated?

The main way that integration will occur was thought to be through management, the strategic plan and priorities groups. Sub-group of stakeholders will be established on these population groups; the Children's Roundtable was described as an example.

In terms of ensuring sustainability for the reform changes, two people talked about the importance of government and political allegiance, including the Premier and Treasury, and the opposition. One respondent noted the need to engage people 'at the coalface' so that reform can survive changes in leadership or politics and one respondent noted that there is a strong history of sustained primary health care experience and expertise to build upon.

Leadership (including the role of Directors and senior staff), good governance and building up systems and relationships were also mentioned as important to ensuring sustainability.

What are you and your team planning to do to prepare staff and key stakeholders, to succeed in making this change as quickly and effectively as possible

Most of the responses focussed on communication strategies. These included newsletters, Board meetings as different sites, talking and meetings to promote the change process and a road show around the region to present the strategic plan. However some respondents thought that communication channels across the region and at different levels could be improved. One respondent mentioned the need to build opportunities for staff to be involved in regional working parties and new initiatives.

For one respondent, rewarding reform changes with investment funding was seen as a way to encourage change.

Tertiary training programs on chronic disease self-management are being planned.

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How will you assess your progress and change your plans when you need to? How will you ensure getting accurate and timely feedback regarding the changes?

About half the respondents discussed the need for targets, indicators and other information, both qualitative and quantitative, and from a broad range of people. These could be assessed against the strategic plan. One person noted the need for a range of process goals and indicators eg establishing regional reference groups, contact with and engagement of the community, establishment of an implementation plan for each of the strategic plan areas. Another indicator suggested was a measure of attendance at prevention activities.

Two people nominated improved health as an outcome measure, but acknowledged this was long term. Others specified the need for indicators on decreased hospital use, decreased service use by people with chronic disease, better early intervention and increased perception of ownership of own health. These sorts of outcomes from the introduction of systematic chronic disease management were thought to be measurable in a much shorter time frame than actual changes in health status.

Two people talked about evaluating PHC interventions. One stressed the need for formal evaluations with control groups to increase the rigour of evidence. The other person focussed on the need for clear objectives and a program logic eg Is poor nutrition in children an issue because it leads to obesity later in life or because it effects brain development early on? What indicators are measured will depend on what rationale the program is built on.

How are you going to model the required personal changes you are asking of the organization?

Most responses were about being engaged and talking with people - promoting change and acting as change agents. Several respondents noted the need to support staff during the change process. The various strategic plans, the HSA and performance management will contribute to modelling change. The Board was reported to have a positive attitude towards PHC and there are plans for committing increased resources to PHC next year. Clarity will be needed about this investment and how the outcomes from it will be measured.

Now that we have spent sometime asking you to think about the reform process and regionalisation, can you describe your vision for primary health care in the Southern Adelaide Health Service region in as simple and succinct terms as possible?

Responses have been grouped into key themes and illustrated with extracts from transcriptions. All responses reflected more than one theme.

Access and quality

people with mental health problems have equal access to the healthcare system in terms of prevention and management

health as an integrated network that is close to where people live and work with clear pathways that people can enter at various points and feel secure that they are doing something about their health

more people getting better services more quickly in a way that makes them feel good about their life, family and how they want to live

the best care in the best place at the best time by the best provider, but clearly primary health care is a lot more than that …

getting service closer to home

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Improved health

improved health status of community

initiatives in PHC will improve health significantly

a healthier community, healthier individuals

Coordination and links

strong involvement of community health and other primary health care initiatives, driven by community members and links with NGOs and government agencies to achieve integrated, collaborative primary health care

links to GPs and NGOs

measures of better coordination between GPs and hospitals and others

also that there are integrated teams working in the health system

Less demand/chronic disease management

lessen demand on acute services, measures include decrease in chronic disease related admission, mortality rates, hospital admissions

people managing their conditions better, less reliance on the formal health system

better health outcomes will result from better chronic condition management

Focus on health and wellness

health is everybody's business

we will be a community that believes in wellness

increasing prevention, early intervention, health promotion,. It's about making health a part of life …

Demonstration of value

we are able to demonstrate what we do as being the best way to contribute towards the health and well being of the population with the resources we have got and be able to describe that in clear terms

Resources

integrated and increased resources for community based services focussed on important areas

Workforce

… getting people to work as teams, develop a workforce …

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Community empowerment

> *a system where people have control and are able to feel empowered enough to make decision that are right for them, which may or may not be about access to health services … so it's a community where we look after each other*

3.4 Focus group data

All staff were familiar with the Primary Health Care policy. Just under half were familiar with the *First steps forward* document and the *Every chance for Every Child* framework. Staff had some knowledge of the community consultation framework and some staff had provided input to the framework.

Staff responses to the regionalisation and reform process ranged from outright pessimism to cautious optimism. All expressed a high degree of uncertainty within the health services regarding the impact of regionalisation. Negative reactions were based on: the lack of an implementation and change management strategy; lack of adequate communication between the executive and service staff; a perceived devaluing of primary health care experience and expertise; an emphasis on clinical and quantitative data; a growth in bureaucracy; 'slippage' of language and values (primary health care equated with primary medical care); and reduction in the visibility of social justice and health equity in the reform agenda.

Positive impacts of regionalisation cited included: work on the Aboriginal health framework; some increase in communication and links across services; and the development of the consumer participation framework.

A number of *potential* positive impacts were identified by some staff. It was felt that the regionalisation and reform process could provide a platform for a number of positive developments e.g. regional strategies addressing the social determinants of health, workforce development, mental health etc. Increased visibility and weight of primary health care in decision-making forums could result in a shift of resources to the primary health care sector.

There was a dichotomy of opinion on the nature of leadership provided by the Executive. Some characterised the leadership as 'committed to primary health care', 'open to learning' and 'accessible', others felt there was 'little or no understanding of primary health care' and that the leadership had little commitment to consultation.

3.5 Reflection on the framework development process

It was hoped that the interviews with key executives, Board members and community health staff would provide data from which clear goals, indicators and strategies for strengthening PHC could be drawn. This proved less straightforward than planned as most respondents found it difficult to be precise in terms of goals for PHC and how they could be best achieved. The interview data reflect the ongoing debate about definitions and understandings of (comprehensive) PHC and unrealistic notions about impact and outcome evaluation capacity in the health sector. The interview data were analysed in light of the research team's expertise and reading of the relevant literature. This enabled a draft framework to be constructed. The number of goals, indicators and strategies means that the framework is large and complex, however attempts to simplify it risk losing important ideas. As the framework has undergone various iterations following consultation and further analysis, it has become clear that stakeholders will continue to debate the relevance and realism of the contents according to their own interests and areas of expertise.

4. Draft framework for PHC

Appendix B contains the full framework as it was updated following the forum. The framework was initially developed by the research team on the basis of the data from the interviews and focus groups. Discussion and development of it formed the basis of a workshop held at the end of 2005 and this

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event resulted in a number of changes and refinements of the framework. The framework consists of an overarching goal and three sub-goals. For each sub-goal, a number of strategies are listed along with indicators of achievement at 1-2 years, 3-5 years and 5-10 years. Potential measurement tools are also listed. The framework should be treated as a ‘work in progress’. It will be developed and refined further during 2006 through another round of action research that will take the framework developed in this research focused in southern Adelaide and determine its applicability to the whole of the metropolitan region..

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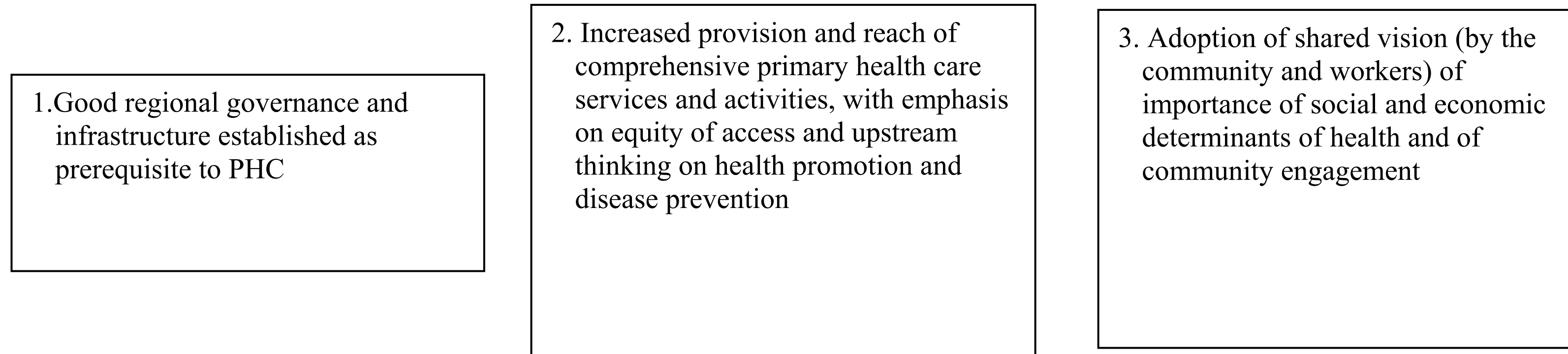
Governance change in the southern metropolitan Adelaide health region: implications for Primary Health Care Developing goals and indicators for PHC



Over-arching goal strengthening PHC in South Australian Health System: Improvement and greater equity in population health status

Strategy	Indicator 5 years	Indicator 10 years	Measurement tools
Strengthen PHC system through sub-goals and related strategies as stated below	Infant Mortality rates by population groups such as ATSI and SES Chronic disease rates especially in children Injury rates across population groups such as ATSI and SES Avoidable hospital admissions	Life expectancy across population groups by ATSI status and SES. Prevalence of chronic disease	Health Omnibus survey Health Monitor survey Mortality Statistics State Strategic Plan

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5. Discussion

The study addressed the questions: What is the most effective way to organise health service governance in order to promote and strengthen primary health care as a key focus of the health system? How does a change in health service governance affect the position of primary health care in relation to acute care health services? In order to assess the strength of PHC and how this relates to health service governance, information in two main areas is needed:

1. An agreed definition and understanding of PHC and its goals
2. Ways to measure the strength of PHC and how this changes over time.

This pilot project has made some headway in both of these areas. The framework was developed from empirical and theoretical data. It links comprehensive PHC with considerations of equity and the social determinants of health and therefore clearly differentiates comprehensive PHC from primary medial care or selective PHC. The overarching goal, sub-goals and strategies reflect this value base. The resulting indicators and measuring tools still have a long way to go before they are sufficiently specific and robust for practical use and this research will continue.

An attempt has been made to establish baseline data for PHC in order to follow changes over time. Baseline data were collected and analysed but with difficulty. Some of the challenges include:

- deciding what 'counts' as PHC eg. resources provided to general practice to build community-based chronic care programs with the aim of reducing avoidable hospital admissions
- changing structures eg DASC is now administered by SAHS but was previously a separate service provider. Some of DASC's services would be classified as PHC.
- different ways of recording data eg ISCHS and community health at NHS use different ways to record and present data on workforce and service provision; in 2003 the CHSS data collection program changed to CHIS; inconsistencies between budget and service data from different sources
- data not able to be made available to the project eg. minutes of Board meetings, level of unmet need

The Kotter framework described in the introduction section lists a number of requirements for achieving transformational change of the type envisaged by the GHR and subsequent policy documents. These are now reviewed against the data from this study.

An agreement among staff and managers that change is needed

The need for change is agreed by executives, managers and community health practitioners and to a lesser extent by other stakeholders, including the wider community. The specific changes needed and ways to achieve these are more open to debate. We found evidence that the staff from community health services were fearful that their model of PHC would be undermined by a focus on more medical and chronic disease focussed approaches that did not use the significant skills and experience in community development and health promotion that have developed in the south over many years. Thus we identified a significant policy tension between different understandings of PHC. We suggest there is need to understand these tensions further, particularly as the SA Government PHC policy does present a more comprehensive view of PHC that would imply the use of the wide range of strategies typically associated with the community health model. The research team finds it surprising that the community health model is not rating more highly in the current debates. Its comprehensive approach is seen to have a good fit with best practice in PHC (Legge et al. 1996). It would enable a focus on many health issues, including a range of chronic disease but do so in a way that was not just focussed on management of health issues but also on primary prevention and positive health promotion which will be essential if the goals of the SA Strategic Plan are to be met. It is an area of health service delivery that South Australia has a reputation for and would seem to us that the health reform process needs to be careful not to throw this particular baby out with the bathwater.

There was some suggestion of 'change fatigue' and a belief that the change underway was not fundamental system change but rearranging on the surface.

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A powerful coalition of leaders to drive the change
Some powerful leaders driving change were identified in the executives and the Board of Management. While the importance of primary health care was articulated by these respondents it is not clear if they have a comprehensive understanding of the complexities of primary health care as an approach as well as a first line of service provision. Other leaders, closer to the practice of comprehensive primary health care, have been lost, moved aside or resigned as a result of the regionalisation process. It is also unclear how much of a 'coalition' has been established. Some respondents believed power plays and silo approaches were still evident.

A simple statement of goals and vision for change that is easily and widely communicated
Respondents put much faith in the upcoming regional strategic plan and sub-plans. However, the expected staff and community consultation did not occur and, at the time of writing, it appears that this plan has been redesigned into a business plan rather than one describing goals and strategic directions and providing the crucially important vision of a change process. This vision, in Kotter's view, should capture the excitement of the change process and be a central part of winning support for it.

One of the challenges in this study has been to balance the desire for simplicity in the framework and the complexity of primary health care and its evaluation. A simple statement of goals and vision for change seems unrealistic given the many different stakeholders and interests within a regional health service. Different philosophical and value bases and different uses of language are obstacles to the establishment of a simple goal and vision statement but there does need to be a vision that provides a philosophical framework and inspiration to guide what will be a challenging process of changing a complex system.

'Small wins' along the way toward the final goal
Some 'small wins' have been identified, such as the community participation framework and increased integration of discipline-specific services across the region.

The willingness to confront and overcome barriers to change
The main barrier to change identified was professional differences and hierarchies leading to protection of bases of power and resources. Many of the strategies to overcome this lie outside the regional health service or the state health system and relate to the recruitment, training and professional development of health service providers. Some respondents stressed that shifting resources from acute to community care, in the short term, was not feasible given the current State Government emphasis on maintaining a 'triple A' credit rating and the politically sensitive nature of health. These respondents believed the focus should be on long term shifts or more funding overall to the health system.

Consolidating the improvements by ensuring that progress is not linked to the presence of key people
It is too early in the regionalisation process to comment on the achievement of this requirement. However, given the inherently political nature of health reform it seems likely that progress and direction will change as key leaders in the Department of Health and regional health service change. As this report was being finalised (mid way through 2006), rumours were rife about impending re-structuring of the health system, These rumours appear to be adding to the sense of cynicism that workers feel and a despair that any reform process will be followed through.

Institutionalising new approaches through checking that the changes have permeated the organisation's culture
Again it is too early to make much comment here. Primary health care staff were less optimistic than executives and Board members about changes becoming institutionalised. Some were fairly cynical in their belief that the proposed reforms were not sufficiently radical and did not have the commitment of politicians to be fully developed and sustained.

Indicators from the framework relating to job descriptions and professional development may be helpful. Primary health care knowledge and experience is required for management positions within

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the primary health care/population health portfolio but not elsewhere. Staff outside this portfolio are not required to have any understanding of primary health care or to undertake professional development in this area. This would be one way of consolidating the place of primary health care within the service

The next step in this research is to refine the framework by testing its appropriateness with other regional health services. This work will occur during 2006 and should result in a set of robust goals, strategies and indicators with which to assess PHC and its place in the South Australian health system.

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Appendix A: Baseline data for Primary Health Care (PHC): service activity and management in the Southern Adelaide Health Service

PHC Services

The following services were provided in 2004

Inner Southern Community Health Service	Noarlunga Health Service
Aboriginal Health	Aboriginal Health Services
Counselling and Referral	Clinical Psychology Services
Cardiac Counselling	Physiotherapy Services
Diabetes	Diabetes Services
Podiatry	Podiatry Services
Nutrition and Dietetics	Nutrition and Dietetics Services
Mental Health	Occupational Therapy Services
Men's Health	Social Work Services
Speech Pathology	Speech Pathology Services
Domestic Violence	
Clean Needle Program (Marion Youth Site)	
Older Persons	
Youth	

Service Activity

Inner Southern Community Health Service

Summary Statistics	2002/03 Financial Year	2003/04 Financial Year
REGISTERED CLIENTS		
New Registrations to Inner Southern CHS	1045	875
Registered Clients with Activity	n/a	1092
Registered Clients attending 1 to 1 services	1093	915
Registered Clients attending Group services	363	309
SERVICES		
Formal One to One Services	2876	3718
Additional Number Seen*	728	n/a
Informal One to One Services	3784	5038
Total One to One Services	**7388**	**8756**
Group Services	1887	3811
Community Initiative Services	6692	23664
TOTAL SERVICES	**15967**	**36231**
PROGRAMS		
Group Programs Held	143	43
Community Initiative Programs	39	86
Group Sessions Held	234	336
Community Initiative Sessions Held	572	2105

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Noarlunga Health Service

Summary Statistics	2002/03 Financial Year	2003/04 Financial Year
REGISTERED CLIENTS		
New Registrations to Noarlunga CHS	2494	3563
Registered Clients with Activity	n/a	3937
Registered Clients attending 1 to 1 services	2653	3145
Registered Clients attending Group services	1300	1317
SERVICES		
Formal One to One Services	7447	12568
Additional Number Seen*	1766	n/a
Informal One to One Services	72298	71275
Total One to One Services	**81511**	**83843**
Group Services	7003	34102
Community Initiative Services	39209	36223
TOTAL SERVICES	**127723**	**154168**
PROGRAMS		
Group Programs Held	374	52
Community Initiative Programs	248	94
Group Sessions Held	724	901
Community Initiative Sessions Held	10651	5387

SAHS Executive Positions

While the full job and person specifications are not available these extracts demonstrate the standard PHC requirements of executive positions in SAHS:

Role Requirements, examples of which include:
Monitoring and reviewing workload of all staff and ensuring an appropriate balance of service delivery responsibilities within the PHC context (eg., clinical, health promotion, community development)
As an authority in the discipline within a Primary Health Care (PHC) context, ensure the provision of innovative, state of the art, specialist professional services at the discipline and corporate levels
As an authority in the discipline within a Primary Health Care context collaborate with stakeholders at the local, regional and state level to improve the health and social status of the community

Essential Person Requirements which include:
Commitment to social health philosophy and a clear understanding of primary health care practice
Minimum 5 years experience in the discipline *with at least 2 years working in a primary health care setting*
Sound knowledge of the discipline in a range of areas including individual and group therapy, health education/promotion and preventative health.
Knowledge of Primary health care, its relationship to social justice and the range of factors influencing health status and implications for service delivery
Sound knowledge of objectives and principles of early intervention and health promotion program development
A demonstrated ability to establish services with a comprehensive health service with a major emphasis on preventative health programs/focus

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SAHS Board

As at December 2004, the board of the Southern Adelaide Health Service (SAHS) consisted of:
Chair, Mr. Basil Scarsella
Deputy Chair, Mr. Ray Blight *
Mr Bevin Wilson *
Mr. Ross Haslam
Ms Noelene Wadham
Dr Richard (Dick) Wilson *
Mr. Ian Yates *
Professor Anne Edwards
Ms. Robyn Pak-Poy
Ms. Catherine Miller *
Dr Helena Williams *

* self-identified commitment to PHC/health promotion/population health/community participation

The SAHS constitution states that there should be an even gender balance on the board. As at December 2004 there were 6 male and 5 female board members. Although six members have self-identified as having commitment to PHC or some aspect of PHC, the constitution does not require board members to have skills or expertise in this area.

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Appendix B

Governance change in the southern metropolitan Adelaide health region: implications for Primary Health Care Developing goals and indicators for PHC

Overarching goal: Improvement and greater equity in population health status

1. Good regional governance and infrastructure established as prerequisite to PHC

2. Increased provision and reach of comprehensive primary health care services and activities, with emphasis on equity of access and upstream thinking on health promotion and disease prevention

3. Adoption of shared vision (by the community and workers) of importance of social and economic determinants of health and of community engagement

Over-arching goal strengthening PHC in South Australian Health System: Improvement and greater equity in population health status

Strategy	Indicator 5 years	Indicator 10 years	Measurement tools
Strengthen PHC system through sub-goals and related strategies as stated below	Infant Mortality rates by population groups such as ATSI and SES Chronic disease rates especially in children Injury rates across population groups such as ATSI and SES Avoidable hospital admissions	Life expectancy across population groups by ATSI status and SES. Prevalence of chronic disease	Health Omnibus survey Health Monitor survey Mortality Statistics State Strategic Plan

NB. Glossary of terms to be added

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1. Establish good regional governance and infrastructure as prerequisite to primary health care

Strategy	Indicator 1-2 years	Indicators 3-4 years	Indicator 5-10 years	Measurement tools
1.1 Clarify roles, management and accountability structures within region and with DH	• Clear organisational chart, role descriptions and lines of responsibility (regions and DH) developed and disseminated by July 06 • 100% of EDs/Managers have clear understanding of key roles and responsibilities • Staff have a clear understanding of their key roles and responsibilities and an understanding of how their role relates to the regional vision	• 100% staff and ED/managers have clear understanding of key roles and responsibilities and an understanding of how their role relates to the regional vision	• Key stakeholders (e.g. SDGP, RDNS, metro dom care etc) have an overview of the organisation and understand relationships	Document audit Staff interviews Survey Monitor changes to organisational structures
1.2 Establish and consolidate regional planning structures and processes which include community and staff participation	• Clear documentation of community and staff participation frameworks • Opportunities for, and level of community & staff participation, made explicit in Regional strategic plan(s) • % staff aware of regional planning process • (Establish) baseline of staff & community satisfaction with participation process & outcomes	• On-going structures to support & foster community & staff participation in planning • Number and diversity of community members in formal participation roles • Community & staff participation structures and processes have been implemented as per Regional strategic plan(s) • 50% staff & community express satisfaction with participation process and outcomes	• Number & diversity of community members in formal participation roles • Staff & community participation has demonstrable influence on planning processes and decisions • 60-80% staff & community express satisfaction with participation process and outcomes	Document audit Organisational analysis Staff and community interviews Case studies – Survey?? Tools on participation that measure perceptions of usefulness & perceived level of participation

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1.3 Regional plans (and sub-plans e.g. Aboriginal Health, workforce development) are population- based and include realistic resource allocation for implementation and evaluation	• $$ amounts specified in regional plans realistically match requirements for implementation and evaluation	• Evidence of implementation as per regional plan	• Evaluation of plans against indicators	Document audit KPIs in planning document
1.4 Ensure regional plans and structures allow for local responsiveness and accountability to local communities while retaining evidence-based planning (not just loudest voice)	• Local knowledge has demonstrable influence on services and/or activities at individual sites • Individual community health centres retain local identity within regional community health service • 20% of local budget quarantined and available to address identified local community needs and measure effectiveness	• Local knowledge has demonstrable influence on services and/or activities at individual sites • Individual community health centres retain local identity within regional community health service • 20% of local budget quarantined and available to address identified local community needs and measure effectiveness • Structures developed to ensure local accountability to the community	• Local knowledge has demonstrable influence on services and/or activities at individual sites • 20% of local budget quarantined and available to address identified local community needs and measure effectiveness • community health service data available at local level on services and need	Case studies Staff and community interviews Site presentation and promotion (eg local noticeboards, publicity through local networks) Monitor data re geographic areas - disaggregated local data from region in terms of local need
1.5 Provide strong leadership which understands, drives, supports and advocates for comprehensive and equitable primary health care	• ?% Board members and EDs/managers can articulate/demonstrate understanding and support for CPHC and equity • baseline% staff and community perceive Board members and Regional leadership to be committed to primary health care • Regional leadership actively	• Orientation for new Board members and EDs/managers requires professional development in primary health care/health promotion • Board shares cohesive vision regarding comprehensive primary health care • Regional leadership actively advocates for primary health care in public forums	• PHC perceived to be of equal status ?? (achieve parity) with other health sectors • Increased % staff and community perceive Board members and Regional leadership to be committed to primary health care • Regional leadership actively advocates for primary health care in public forums	Board interviews (including re briefings on primary health care to minister) Staff and community interviews Media monitoring Assessment of

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	advocates for primary health care in public forums			- orientation process for new Board members and EDs/managers (include site visits) Professional development in region 360° evaluation of senior positions Document audit eg Board minute Monitor Regional and Minister's press releases
1.6 Establish transparent and effective communication channels between 'front-line' staff and regional centre see also 1.2	• Communication strategy established • Whole of staff meetings across CH 2x a year, linked to planning process (June and December)	• Transparent and clear communication structure(s) understood by staff • Range of communication mechanisms developed to meet needs of different users • Whole of staff meetings across community health 2x a year, linked to planning process (June and December)	• Transparent and clear communication structure(s) understood by staff • Range of communication mechanisms developed to meet needs of different users • Whole of staff meetings across community health 2x a year, linked to planning process (June and December)	Staff interviews Assess accuracy, timeliness and appropriateness Document audit Randomly selected sample of staff – telephone interviews Site visits (e.g. Vision statement visible)

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1.7 Establish policies, structures and processes to facilitate vertical and horizontal integration and reduce duplication of service and activities within and across sectors so that SDOH are being comprehensively addressed	• Cross agency collaboration described by baseline % primary health care staff as an important part of their work • Cross agency collaboration identified as a core organisational activity in regional policy and planning documents • Areas of existing collaboration and areas for development are defined and documented (not everything needs to be collaborative)	• Cross agency collaboration described by 50% primary health care staff as an important part of their work • Number of regional structures eg Roundtables in place to support partnerships with key agencies in priority areas e.g. Aboriginal Health	• Cross agency collaboration described by 80% primary health care staff as an important part of their work • Matrix of partnerships and networks provides points of contact at -practitioner -team leader and -managerial level • Evidence that at key points of leverage there is collaboration with departments and agencies in determinants sector (e.g CYWHS, Housing, Transport, CYFS, NGOs) • Number of regional structures eg Roundtables in place to support partnerships with key agencies in priority areas e.g. Aboriginal Health	Organisational analysis Document audit Staff interviews Establish site register of partnerships and networks
1.8 Improve IT and data management to increase utility for primary health care research practice and policy	• Resources committed to data system development • Staff consultation re data collection to ensure it reflects primary health care activity	• Data system established • training and investment in data system and collection • Aggregated data on clinical and prevention outcomes for 5% of all chronic condition patients	• % Staff report data collection reflects CH activity • Evidence of data being used to inform practice and policy • Aggregated data on clinical and prevention outcomes for 15% of all chronic condition patients	Staff interviews Document audit Extent to which data is used for planning

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1.9 Develop research and evaluation capacity	• Regional budget for R & E baseline %$ • Baseline % staff undertaken professional development on research & evaluation • MoU with Flinders University concerning R&E support including coordination of students on placement to assist with R&E needs of CHS and engage in ongoing projects	• Standard evaluation reporting template adopted • Staff have access to primary health care evidence (through regional subscription to appropriate databases??) • Increase % staff undertaken professional development on research & evaluation • % staff report evaluation is a routine and core activity	• Increased evidence base on outcomes of primary health care demonstrated by no of reports, peer reviewed publications, • Increase % staff undertaken professional development re evaluation • increased % staff report evaluation is a routine and core activity • Comprehensive continuous improvement (evaluation) framework for primary health care/acute services (Quantify outcomes in economic terms – what are we doing?; how much does it cost?; what are the outcomes?) • Meta analysis of program evaluations across sites (as previously undertaken for Effectiveness study?)	Document audit Staff Survey Results of comprehensive continual improvement - reports on evaluation of services

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2. Increased provision and reach of comprehensive primary health care services and activities, with emphasis on equity of access and upstream thinking on health promotion and disease prevention

Strategy	Indicator 1-2 year	Indicator 3-5 years	Indicator 5-10 years	Measurement tools
2.1 Resource and implement healthy settings initiatives, identify and prioritise what 'healthy settings' to address eg schools	• At least 2 priority settings with maximum health gain have been identified which build on policy or program initiatives and government priorities • partnerships are established • individual health outcome indicators are established where feasible for 1 yr, 5 yr, and 10 yr milestones	• At least 3 Healthy settings initiatives resourced and implemented • impact evaluation is established and reporting on health outcomes is undertaken • planning for next 5 years underway • additional resources are identified to continue the strategy	• At least 3 Healthy settings initiatives continue to be resourced and implemented • policies and practices support achievement of health outcomes • a demonstrated increase in community capacity within the setting • impact evaluation is established and reporting on health outcomes is undertaken • planning for next 10 years underway • additional resources are identified to continue the strategy • at 10 years – successful programs are generalised across the community	Audit strategic plan, service agreement, performance reports and budget
2.2 Ensure that health promotion & disease prevention are integral elements of all work undertaken in SAHS region regardless of the health care environment (core business for day to day activities) (links to 2.4)	• workforce development strategies have been implemented (2.4) • Health promotion is evident in business plans (region & health unit) • policy development (in HP?)	• 50% services, programs and activities include health promotion and illness prevention as core business	• All services, programs & activities include health promotion & illness prevention as core business • all staff trained & understand the practice of health promotion & disease prevention • extent to which environment and systems support staff to do health promotion well	Audit strategic plan, service agreement, performance reports and budget Survey staff Case note audits

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2.3 Strategic Plan developed, implemented and monitored to improve service to population groups with special needs with specific targets quantified	• Public statements on equity of access by ED/Board. • Equity discussed in newsletter, Board minutes. • Strategic plan developed to provide services to geographical communities currently under-served, with specific targets	• Public statements on equity of access by ED/Board. • Equity discussed in newsletter, Board minutes. • Strategic plan implemented to provide services to geographical communities currently under-served, with specific targets • Community engaged involved and understanding the decisions making in strategic panning & resource re-allocation in equity framework • political support and engagement in the planning process for CPHC • Increased or redesigned services provide equitable access to all areas in region and to population groups with special needs (especially ATSI and low SES)	• Public statements on equity of access by ED/Board. • Equity discussed in newsletter, Board minutes. • Equity of access Strategic Plan evaluated against targets established • evidence of increased access by priority groups • community and political support evident for CPHC	Media and communication monitoring Media and communication monitoring Audit strategic plan, service agreement, performance reports and budget Population survey with questions measuring access to services
2.4 Provide workforce development for all staff on PHC approach and social determinants of health	• 25% staff have attended professional development on PHC & SDOH. • Disciplinary and inter-disciplinary networks to support PHC practice identified in workforce development plans and ?% established • all new staff attend introduction to PHC & SDOH as part of orientation	• all managers undergo professional development in PHC & SDOH • All new job descriptions from 1st July 06 to include 'understanding of PHC & SDOH' as essential criterion • Professional development is monitored through performance appraisal process • 60% staff have attended professional development on PHC & SDOH. • short accessible PHC	• All staff attend comprehensive professional development including organisational values, SDOH & community engagement • All job descriptions to include 'understanding of PHC & SDOH' as essential criterion • update and further development is required every year or on new appointment. • disciplinary and inter-disciplinary networks established as in workforce development plan • %?network members believe	Audit workforce development records

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		orientation/professional development package has been developed	networks provide good support to PHC practice • Professional development is monitored through performance appraisal process	
2.5 Increase accessible and comprehensive PHC services and activities linked to regional strategic plan, PHC policy and SA Strategic Plan	• Building started for Marion PHC centre • outreaches planned at Hallet Cove and Castle Plaza • Aldinga CHS established • equitable distribution of services • out of hours services while maintaining appropriate level of service elsewhere in region	• Marion PHC centre running with recurrent funding established • outreaches at Hallet Cove and Castle Plaza under development • Aldinga CHS providing locally appropriate services	• Marion PHC centre running with recurrent funding established • outreaches at Hallet Cove and Castle Plaza running with recurrent funding established • Aldinga CHS providing locally appropriate services	Audit strategic plan, service agreement, performance reports and budget
2.6 Increase resources (budget and workforce) from SA Government/ Department of Health/ Regional HS to comprehensive PHC aligned to regional strategic plan, PHC policy and SA Strategic Plan and assessed for each activity.	• At least 10% inflation adjusted increase yearly on budget allocated to PHC. • 10% of total health budget devoted to PHC • 10% per year increase in FTEs dedicated to PHC. • 80% of PHC positions funded recurrently. (*check current) • reduction in short term project based funding (Adair – approx 30% workforce is on 1 year project money.	• At least 10% inflation adjusted increase yearly on budget allocated to PHC. • 15% of total health budget devoted to PHC • 10% per year increase in FTEs dedicated to PHC. • 85% of PHC positions funded recurrently. (*check current) • reduction in short term project based funding	• At least 10% inflation adjusted increase yearly on budget allocated to PHC. • 35% of total health budget devoted to PHC • 10% per year increase in FTEs dedicated to PHC. • 90% PHC positions funded recurrently.	Audit service agreement, performance reports and budget. Audit service agreement, performance reports and budget. Audit HR records Audit HR records

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2.7 Increase coordination between acute and PHC/community based services (list in appendix, private care providers, outpatients, allied health need to be included) by coordinated chronic disease management and transfer of care in both directions	• Shared care plan for 5% of patients with chronic conditions defined by regional priorities • Patients and their care team are connected and have easy access to the plan of care • 10% discharge planning includes referral (where appropriate) to PHC/ community based services • IT connectivity between GPs and NGOs • Care providers know what is available from other providers • ED staff identify and document trends • 50% care plans include prevention • disciplines are linked across region	• Shared care plan for 50% of patients with chronic conditions defined by regional priorities • 30% discharge planning includes referral (where appropriate) to PHC/ community based services • 75% care plans include prevention	• Shared care plan for 75% of patients with chronic conditions • Patients and their care team are connected and have easy access to the plan of care • 50% discharge planning includes referral (where appropriate) to PHC/ community based services • Health Connect used for all appropriate patients • Smart Card patient focused system in place • 100% care plans include prevention • reduction in avoidable hospital admissions	Audit share care plans Audit share care plans Survey patients and care team Audit discharge planning

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3. Adoption of a shared vision by the community and workers of the importance of the social and economic determinants of health and community engagement

Strategy	Indicator 1-2 years	Indicator 3-5 years	Indicator 5-10 years	Measurement tools
3.1 Develop and disseminate consensus vision statement on SDOH	• Explicit statement of organisational values/ vision in policy and planning documents • Vision statement is used to underpin partnerships with other organisations/sectors • Community members & staff engaged in developing the vision • Key staff and community members are able to articulate/ communicate the vision • Individual & team development planning is linked to vision	• Identify key areas where social determinants are having an impact • Processes are in place to ensure that vision is understood and supported by key players, staff and community members	• Processes are in place to ensure that vision is understood and supported by key players, staff and community members • Evidence that SDOH are being addressed	Document analysis Survey/interview key players for awareness of and implementation of shared vision Audit job descriptions Survey staff and community Media coverage of phc issues
3.2 Structures and processes established and resourced for community engagement	• Number of opportunities for community participation • Number of community people participating in health service • Levels of training, support, resources	• Number of opportunities for community participation • Number of community people participating in health service • Levels of training, support, resources	• Recognised consumer/ community advisory group, panel, alliance, coalition in existence for the south	Survey: satisfaction, engagement & empowerment Document analysis annual reports/ board meetings for evidence of consumer involvement

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3.3 Build social determinants of health and PHC approach into undergraduate and graduate training of all health professionals and other identified professional groups including student placements and field visits to PHC settings	• 25% of all graduates have understanding of (exposure to?) PHC/SDOH • PHC approach integrated into some PBL case studies	• 50% of all graduates have understanding (exposure to) of PHC/SDOH • Establish partnerships with tertiary bodies and other relevant training bodies • Increased number of placements/field visits to PHC settings	• 75% of all graduates have understanding (exposure to) of PHC/SDOH • Increased number of placements/field visits to PHC settings	Audit tertiary health curricula Compare with baseline data on current practice in training of health professionals Survey graduates
3.4 Link regional strategic plan to PHC policy and First Steps Forward and ensure planning at all levels is underpinned by SDOH	• CH/PHC staff are valued for their experience and expertise • CPHC (rather than primary care) approach underpinning change • Plans developed that have a population health approach including regional strategic plan, annual business plan and program/team plans • Strategies in plans have a SDOH focus	• evidence of implementation of plans and policies	• Evaluation of plans shows that strategies have been effective and partnerships are sustained. • Evidence of increased PHC programs??	Document analysis, board minutes/annual reports Community awareness survey Monitoring processes

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