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transformational change in health systems: a road strewn with obstacles

Gwyn Jolley, Fran Baum, Angela Lawless, Catherine Hurley



SACHRU . . .

South Australian Community Health Research Unit

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Abbreviations

SAHS Southern Adelaide Health Service

CNAHS Central Northern Adelaide Health Service

CYWHS Child, Youth and Women's Health Service

PHC Primary Health Care

SA South Australia



Transformational change in health systems: a road strewn with obstacles

The South Australian Community Health Research Unit (SACHRU) strives to enhance health and wellbeing in South Australian communities. It does this by undertaking research and evaluation and by assisting community health and primary health care organisations to undertake and use the findings from research and evaluation to make services more effective in maintaining and improving the health of their communities.

SACHRU is partly funded by the South Australian Department of Health and administered by Flinders University to provide a primary health care research and evaluation service for community health services and related agencies and groups that are funded by the SA Health in metropolitan and country South Australia.

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Contents

Key Lessons.....	2
Executive summary.....	3
Context.....	3
Aim	3
Methods	3
Findings.....	3
Limitations and issues with the research	5
Conclusions.....	5
1. Introduction	6
Context.....	6
Aim	6
2 . Health policy and evaluation of health system reform: brief review	7
Health policy	7
Evaluation of health reform.....	8
Implications for this study.....	9
Summary.....	9
3. Methods	10
Interviews	10
Service data.....	10
Policy documentation	10
Analysis and reporting.....	10
Limitations and issues with the research	11
4. Findings.....	12
Timeline of changes.....	12
Policy documents	12
Interview data	19
5. Discussion	31
Achieving transformational change.....	31
A critical framework for reviewing health policy	32
6. Conclusion.....	34
7. References.....	35
Appendices.....	36
APPENDIX 1: Research management.....	36
APPENDIX 2: Primary Health Care goals and indicators framework.....	37



Key Lessons

This research presents a case study of a change process that aimed to reform the South Australian health system. The case study is examined through a transformational change lens. Health policy is situated in a complex field with many stakeholders and competing interests. The reviewed literature indicates that a number of key criteria are needed to achieve deep structural change or reform in health policy and this case study research examines the extent to which these criteria have been met.

The literature suggests that effective health reform requires:

- consultation and trusting relationships
- a long time frame to implement
- rigorous systems for monitoring and evaluation before another change in policy is introduced.

In SA, reform and regional health service governance structures have led to some changes in placing PHC in a more central position within the health sector. All participating stakeholders acknowledge, at least to some extent, the importance of PHC and its role in prevention of disease, early intervention and maximising opportunities for health and wellbeing. However, it seems that the South Australian health care sector has some way to go in placing PHC at the centre of the system.

The research findings suggest that health services structure and governance reform should be based on the following key factors:

- clear goals and vision that are accepted and understood by key players
- multiple opportunities for local communities to have input to how services are planned, organised, delivered and evaluated
- accountability mechanisms which report to all stakeholders (including local communities)
- strong leadership
- policies that are informed by evidence
- minimising the influence of power brokers and political ideologies
- resources available to enable monitoring and evaluation of system structure and governance.

Further, the 'churning' identified within the health system undermines pre-conditions for structural change by continually introducing new goals and policies, new influential players and interested stakeholders, changing accountabilities and leaders and interrupting evaluation efforts.



Executive summary

This research study assesses the impact on primary health care of the reform changes in the South Australian health system from 2005 to 2007. The research follows a pilot study conducted in one of the newly created health regions in 2005/06 and reported in *Governance change in the southern metropolitan Adelaide health region: implications for Primary Health Care* (Baum et al. 2006). Both studies were intended as scoping exercises to contribute towards the development of an evaluation framework for primary health care.

Context

In 2002, the then new State government commissioned a 'Generational Health Review' (Government of South Australia 2003a) as one of its first actions. The review 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 confirmed the health care reforms in the metropolitan area 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) were created. Individual health unit boards of management were disbanded and regional boards established.

This research provided the opportunity to assess the impact of these changes on the State government funded primary health care (PHC) services which were planned to become a far more central plank of the reformed health system. The research makes use of lessons described in the academic literature about the need for clear goals, feasible strategies, consultation and trust, and sufficient time in order to bring about significant change.

Aim

The aim of the study was to begin an assessment of the impact of the new regional health structures in metropolitan Adelaide on commitment to, and implementation of, PHC. Since the pilot study was confined to the Southern Adelaide Health Service, this research looks at the other two health regions. The Central Northern Adelaide Health Service (CNAHS) was created by bringing together all the public hospitals and community health services in the central and northern areas of Adelaide. The Children's Youth and Women's Health Service (CYWHS) was created from an amalgamation of the Women's and Children's Hospital, a women's community health service and Child and Youth Health Services. As part of the State Government reforms announced in response to the Generational Health Review, these services have become part of new regional health structures. One of the intentions of the reform is to strengthen the focus on primary health care. This study is an evaluation of the early impact of regionalisation and new governance structures on primary health care.

Methods

The main method of data collection was through in-depth interviews with eight respondents who were involved in health reform and regionalisation: these comprised one member each of the CNAHS/CYWHS Boards, and six executive managers. Other methods included a review of PHC service budgets and activities, and a review of State and health system policy documents.

Findings

As is a common challenge in public sector re-organisation research, numerous political, policy and structural changes occurred before, during and after the period of data collection.

Key policy documents and regional health service plans reviewed for this research have shifted in language from primary health care and health promotion to 'out-of-hospital care' and a focus on chronic disease, lifestyle and risk factors.

An attempt to compare data for PHC activities and services over the time period of the research proved impossible within the resources and scope of the study. Issues that made this the case included:

- data not able to be made available to the project eg. PHC budgets and expenditure, minutes of Board meetings, level of unmet need
- 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 Prison Health and BreastScreen SA are now administered by CNAHS but were previously separate service providers.
- different ways of recording data between services and regions.



In response to the first question on hoped-for outcomes for PHC, responses expressed overlap between strategies and outcomes. Service outcomes were described first, health outcomes usually needed prompting. This could be linked to respondents' thinking in terms of time frames: initial short term thinking focuses on service development, then medium term is action on risk factors, leading to long term improvements in health status. Another explanation is that respondents were thinking in terms of outcomes for regional health services (as providers of primary health care) rather than outcomes for PHC as an approach to service delivery. This confirms the lack of common understanding and confusion about primary health care and its place in the overall human services sector.

Hoped-for service related outcomes included more integration and partnership, better access to services and hospital avoidance for chronic disease. Health outcomes included keeping people healthy, better management of chronic disease and a reduction in risk factors, and improved antenatal care and child development. Equity between Indigenous and non-Indigenous health outcomes and a reduction in the social gradient for health was rated as the most important outcome although this did not figure highly in the initial responses to outcomes for PHC.

Suggested barriers to achieving PHC outcomes were limited monetary resources (or the need to restructure current resource patterns), workforce issues (professional silos and workforce attraction and retention), and lack of cross-sector action, leadership and organisation change processes.

Discussion about strategies for achieving PHC outcomes revealed that a number of planning documents had been produced and this has highlighted the need for better quality planning data. The other major strategy described is to develop partnerships and networks in line with the related service outcomes described above. There was also some discussion about re-orientating community health services, from a broad social view of health, to an approach focussed on chronic disease management. On the other hand, examples were given of moves to re-orient services by influencing clinical planning agendas or by using resources to get leverage on the design of general practice. Tension between the acute and community health sectors was noted: hospital avoidance programs and a focus on chronic disease management were seen as a way to get the acute care sector on board in the reform process.

The main drivers of reform were seen to be the Boards and the Executive Directors. This obviously raises questions for the future when Boards are no longer in existence¹ and senior personnel change. Government policy was also a driver of reform, however the PHC policy was not widely believed to be used to underpin service delivery and indeed was seldom mentioned by respondents. Instead, new strategies – the establishment of GP Plus Health Care Centres and GP Plus Networks – are driving service development. As their name suggests, these health care delivery models are centred on clinical services provided by general practice and allied health in an attempt to improve chronic disease management, rather than the broader social view of health envisaged in the PHC policy.

In terms of evaluation and accountability, most of the interview discussion centred on quality and process measures. Individual key performance indicators for senior staff were also mentioned. The need for increased capacity and use of research and evaluation was recognised.

Perceived barriers to the sustainability of reform included: political will and 4-year election cycles, and the constancy of change and reform leading to 'change fatigue'.

At the end of the interview, respondents were taken through the draft Primary Health Care Evaluation Framework² and asked to comment. Suggested changes have been used to refine the framework (see Appendix 2).

¹ The Minister for Health announced the planned dissolution of the regional Boards in October 2006.

² The draft Evaluation Framework for PHC was an outcome of the pilot study in SAHS region



Limitations and issues with the research

This study was limited in scope (to one geographical health service region in metropolitan Adelaide and one population based state-wide health service) and time (an 18 month time frame). It built on a pilot study conducted in the southern metropolitan region in 2005/06.

The research is based mostly on the perspective of key stakeholders in the two regional health services at a specific point in time when there was ongoing change in policy and structures.

The continual 'churning' of policy and personnel presented particular challenges to data collection and analysis. A timeline was produced to show the major changes occurring during the time of this research and to illustrate the context in which interviews and analysis were conducted.

Access to respondents proved difficult and contributed to delays in completing planned interviews. Time and resource constraints meant that further efforts to arrange interviews could not be pursued and, despite considerable effort from the research team, only eight interviews were completed from a planned total of twenty-one.

Service activity and budget data also proved difficult to obtain and this part of the research had to be abandoned. One problem appears to be due to the different data definitions and systems used within health sector services. Activity and budget data was not available to the researchers in a format that adequately separated PHC services. Another problem was in finding the appropriate person to provide the data even it was collected in a suitable form. While Executive Directors were aware and supportive of the research, it proved extremely difficult, within the constraints of the research resources, to obtain data from the data managers.

Conclusions

In South Australia the definition and understanding of primary health care has undergone a change since the launch of the PHC Policy in 2003. Changes in leadership appear to have driven a narrowing of primary health care to services provided by general practice (with clinical allied health services as supporting partners) and in particular services aimed at chronic disease management.

Under the regional structures, what were previously known as community health centres are now labelled as primary health care services. The emphasis is shifting from a combination of universal health promotion, community development and services to individuals to a strong focus on clinical care for people with chronic disease or those who are disadvantaged. Two new services have been established and more are planned. These new centres are termed GP Plus Health Care Centres, further shifting the balance to medical and clinical interventions. This is particularly disappointing as, according to respondents in this research, the new regional structures, and the Boards in particular, were making good progress in a number of areas relating to a broader recognition of primary health care and its potential for improving population health outcomes.

Chronic disease management has become the focus of publicly funded primary health care services and appears to be aimed at reducing avoidable hospital admissions and providing outpatient services in community settings. While this is commendable in itself, it implies a very narrow understanding of primary health care and of the potential for individual, clinical based care to have an impact on population health.

Our respondents articulated multiple definitions of primary health care and what might be appropriate and realistic goals. Recent developments suggest that these notions are continuing to change, for example, the Department of Health has recently introduced new terminology referring to 'in hospital care' and 'out of hospital care', clearly articulating that hospitals and acute services continue to dominate policy thinking.

This lack of agreement and consistency means that it is very difficult to measure the strength of primary health care and how this changes in response to new policy. Our study found it impossible within the resources available to accurately assess and compare over time the investment in primary health care. There also appears to be little effort within the health system to monitor and evaluate the outcomes of health reform. Certainly there are no publicly available documents which show evidence of such activity that can be scrutinised. This absence of evidence will have an impact on our knowledge of whether genuine change for the better has been achieved.



1. Introduction

This research study assesses the impact on primary health care of the reform changes in the South Australian health system since 2004. The research follows on from a pilot study conducted in one of the newly created health regions in 2005/06 and reported in *Governance change in the southern metropolitan Adelaide health region: implications for Primary Health Care* (Baum et al 2006). Both studies were conducted with limited resources and were intended as scoping exercises to contribute towards the development of an evaluation framework for primary health care.

Context

In 2002, the new State government commissioned a 'Generational Health Review' (Government of South Australia 2003a) as one of its first actions. The review 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 confirmed health care reforms in the metropolitan area 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 (CNAHS) and Southern Adelaide Health Service (SAHS) and one population based region Child, Youth and Women's Health Service (CYWHS) were created. Individual health unit boards of management were disbanded and new regional boards established.

This research provided an opportunity to assess the impact of these changes on the State government funded primary health care (PHC) services which were planned to become a far more central plank of the reformed health system. It also aims to 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.

Aim

The aim of the study was to begin an assessment of the impact of the new regional health structures in metropolitan Adelaide on commitment to, and implementation of PHC, including allocation of resources. The Central Northern Adelaide Health Service was created by bringing together all the public hospitals and community health services in the central and northern areas of Adelaide. The Child Youth and Women's Health Service was created from an amalgamation of the Women's and Children's Hospital, a women's community health service and Child and Youth Health Services. As part of the State Government reforms announced in response to the Generational Health Review, these services have become part of new regional health structures. One of the intentions of the reform is to strengthen the focus on primary health care. This study is an evaluation of the early 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?



2 . Health policy and evaluation of health system reform: brief review

Health policy

Health policy is “a complex network of continuing interaction between actors who use structures and argumentation to articulate their ideas about health.” (Lewis 2005). Lewis describes three factors that distinguish health policy from other types of public policy. Firstly, professional groups (particularly medical) exert a powerful influence in shaping health policy due to their expert knowledge, access to the political process and their role as providers of health care. Secondly, modern health systems are underpinned by expert, professional knowledge while consumers, politicians and bureaucrats usually lack the technical expertise to challenge this. Thirdly, health care is characterised by high community expectations and high-stake (i.e. life and death decisions) leading to sensationalised media coverage and the need for political expediency.

This mix of complexity, professional knowledge and multiple players leads to jostling for power over ideas about health and is likely to make real change difficult to achieve and sustain. Despite the rise of consumer advocacy groups and bureaucratic attempts to take more control over health policy-making, medical power and influence is still apparent (Lewis 2005).

Structure, agency and ideation are key elements of health policy (Lewis 2005). Structures (institutions and health systems) represent the formal, structural arrangements for national health system, and governance; that is ways of governing interactions between the state and society. Agency (power and influence) identifies those individuals and groups that are considered most influential in determining policy; and professions – the professional groups and associations working in the health system – and their role in influencing policy decision-making and implementation. Defining policy objectives is not enough to bring about reform – changes are also needed in existing institutions, organisational structures and management systems (Figueras et al. 2005).

Structure and agency meet in ideation. Structure affects which ideas are conceivable and relevant and ideas contribute to structures. Actors use ideas to argue their case and ideas shape how actors think. According to Lewis, underlying ideas act to constrain policy change to that which is compatible to the existing ideation paradigm. Transformation is needed in order to achieve ‘deep structure’ change and a major impact on the policy equilibrium. For example, while there has been a rapidly increasing volume of research on the impact of the social determinants of health, Lewis argues that the focus of health policy has been on individual curative care delivered by medical professionals. This deep structure ideation of health has prevented social health policies from being seriously considered. On a brighter note, Lewis (2005) suggests that in the United Kingdom since 2000 there has been some movement towards acceptance of new ideas about health, with a shift to policy developments on health improvement and inequality.

Transformational policy change therefore requires a deep structural shift in ideation about health; for example a shift to primary health care and a focus on equity. This is what the SA Generational Health Review recommended and is therefore the focus of the current round of health reform, to which this research is addressed.

Requirements to achieve transformational change have been identified by Kotter (1995; 1996) 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.

This framework was drawn upon in the current research, both in designing the interview questions and in the analysis of data, in order to assess the extent of transformational change brought about by the health reform process.

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, 2005; 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).

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). 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).

Evaluation of health reform

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) and there is little evidence on the actual effectiveness of some reform policies (Figueras et al. 2005). 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). Figueras et al. (2005) suggest that this lack of evaluation effort may be linked to the idea that institutional reform is seen not as the means to achieve specific policy goals but as an end in itself. Governments are then reluctant to support systematic evaluations which may undermine political objectives. Indeed, reform may be driven by ideology and rhetoric more than by evidence that substantiates expected benefits.

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).

Figueras et al. (2005) identify five process elements that should define health sector reform: structural rather than incremental change; change in policy objectives followed by institutional change; purposive rather than haphazard change; sustained and long term rather than one-off change; political process led by government.

Comparing health system reform in New South Wales and Victoria in the 1990s, Stoelwinder and Viney (2000) suggest that significant changes, such as the introduction of casemix funding, budget cuts and restructuring, was possible in Victoria because of the perceived political strength of the state government at that time. In New South Wales, with a more marginal state government, change was similar but more incremental in its implementation. Interestingly, in both states plans to rationalise services by moving a major hospital from the inner city to an outer suburb were abandoned due to stakeholder pressure.

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 study used Kotter's framework (Kotter 1995; Kotter 1996) 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).



Implications for this study

This study attempts to describe and analyse structure, agency and ideation in health policy as it relates to reforms to strengthen primary health care. Structural elements influencing primary health care policy include the Australian federal and state division of responsibility for health, Medicare funding of private fee-for-service general practice (the major provider of primary care), the SA Department of Health and regional health service structure and governance. Groups acting as major agents in primary health care policy at state level are the political and bureaucratic decision makers, professional associations (including the Australian Medical Association as the most influential) and to a lesser extent researchers, service providers and community representatives. The national and state focus on medical and clinical care provision sets the scene for the ideation of health as individual, curative care with medical professionals as the experts. Sensationalised media coverage of 'heroic' interventions and length of hospital waiting lists for elective surgery add to the concept of health as medical treatment. Primary prevention, health promotion and social determinants of health struggle for recognition and funding in this environment. Implementation of the recommendations of the SA Generational Health Review and Primary Health Care policy therefore require transformational change within a somewhat hostile policy environment.

With very little previous evaluation of attempts to reform health, this study is an important step in addressing that gap. We investigated the extent to which the criteria outlined above have been applied and the extent to which transformational change with the SA health system has been achieved.

Summary

Health policy is situated in a complex field with many stakeholders and competing interests. A number of key criteria are needed to achieve deep structural change or reform in health policy and this study examines the extent which these criteria have been met. There are many barriers to evaluation of health reform and consequently there are few systematic examples. The literature suggests that health reform requires consultation and trusting relationships and a long time frame to implement and evaluate before another change in policy is introduced.



3. Methods

The main method of data collection was interviews with key informants in the two regional health services. Other methods included a review of service budgets and activities, and a review of State and health system policy documents.

Interviews

Semi-structured face-to-face interviews were conducted with 8 key informants (Executives and Board members) from the CNAHS and CYWHS regional health services. Questions were based on Kotter's framework (designed to assess processes of transformation change) to gain information on perceptions of the reform changes/re-orientation to PHC in the region. Respondents were asked to comment on the PHC Goal Framework produced in the pilot project in 2005. Interviews were audio-taped and transcribed for analysis.

Service data

The study gathered data on PHC services provided by the regional health services over two years post-regionalisation. These quantitative data 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 proceeded.

Policy documentation

Documentation from the SA Government and Department of Health 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 policy as it is implemented. Relevant documents include:

- Generational Health Review report
- PHC policy
- First Steps Forward
- SA State Strategic Plan and subsequent revision
- Regional plans as they became available
- SA Health Department Strategic Plan

Analysis and reporting

Interview data were transferred to NVIVO for collation and analysis under each question. Thematic analysis was used to identify common and conflicting themes. Responses to questions about the goals and potential indicators for PHC in the draft framework were also analysed. A draft report was reviewed by members of the research team and findings and implication discussed. The revised report and goal framework were then presented to the advisory group for feedback before finalising and dissemination.



Limitations and issues with the research

This study was limited in scope (to one geographical health service region in metropolitan Adelaide and one population based state-wide health service) and time (an 18 month time frame). It built on a pilot study conducted in the southern metropolitan region in 2005/06.

The research is based mostly on the perspective of key stakeholders in the two regional health services at a specific point in time when there was ongoing change in policy and structures.

The continual 'churning' of policy and personnel presented particular challenges to data collection and analysis. A timeline was produced (see Table 1) to show the major changes occurring during the time of this research and to illustrate the context in which interviews and analysis were conducted.

Access to respondents proved difficult and contributed to delays in completing planned interviews. Introductory letters and information about the study were first sent by post with numerous follow up by email and telephone. The Minister announced plans to dissolve the regional Boards and transfer governance to the central office of the Department of Health just as the interviews were about to begin. This may have contributed to the difficulties encountered in obtaining interviews. One Board chair was interviewed but was unwilling to pass on information about the research and the interview invitations to other Board members. The fact that the Board were undertaking their own review process was suggested as the reason for the reluctance. The other Board Chair was unavailable during the period of data collection, mostly through commitments overseas. There was an initial refusal to allow interviews with other Board members, with the Chair maintaining that they could 'speak for the Board'. After further discussion it was agreed that selected Board members would be forwarded information about the study but interviews did not eventuate. One Board member contacted the researcher directly and so was interviewed. Time and resource constraints meant that further efforts to arrange interviews could not be pursued and therefore only eight interviews were completed from a planned total of twenty-one.

Service activity and budget data also proved difficult to obtain and this part of the research had to be abandoned. One problem appears to be due to the different data definitions and systems used within health sector services. Activity and budget data was not available to the researchers in a format that adequately separated PHC services. For example, under the regionalisation process prisoner health and BreastScreen services have been brought together within the PHC portfolio whereas formerly only services provided by community health centres would have been counted. This difference in inclusion or definitions makes comparison over time impossible.

Another problem was in finding the appropriate person to provide the data even it was collected in a suitable form. While Executive Directors were aware and supportive of the research, it proved impossible, within the constraints of the research resources, to obtain data from the data managers. Difficulties included identifying the appropriate person with authority and access to the data, this person subsequently changing position, and different sources of data containing different statistics.



4. Findings

Timeline of changes

As is a common challenge in public sector research, numerous political, policy and structural changes occurred before, during and after the period of data collection. Some of these changes are illustrated in Table 1

Table 1: Timeline of changes during the research period

	Structures & Policy	Operational & Activity
2003	<ul style="list-style-type: none"> • GHR report • PHC Policy Statement • First Steps Forward 	
2004	<ul style="list-style-type: none"> • Proof of concept for PHCN approved by SA Govt • SA Strategic Plan (March) • Regional health services (SAHS, CNAHS, CYWHS) established (July) • DH Strategic Directions (Aug) 	<ul style="list-style-type: none"> • PHCN focus is broad – chronic disease management, early intervention, risk factor management and social determinants of health • SAHS PHCN – focus on hospital avoidance and Community Chronic Disease Strategy • CNAHS – 2 PHCN established
2005	<ul style="list-style-type: none"> • DH proposes chronic disease management as focus for PHCN 	<ul style="list-style-type: none"> • CNAHS PHCN key focus is diabetes • PHCN incorporated into CNAHS Strategic Plan • CNAHS Building the Capacity developed • CNAHS 3 sub-regions developed & 3rd PHCN added • Hon John Hill appointed as Minister for Health (Nov)
2006	<ul style="list-style-type: none"> • Country Health SA established (July) • Health Reform Report Cards (Aug) • Minister announces dissolving of Boards and new Health Care Act to be drafted (Oct) • Clinical networks announced (Nov) 	<ul style="list-style-type: none"> • SAHS – focus on GP modules, practice nurses, allied health strategy • DH Chief Executive appointed (Aug) • CYWHS Chief Executive resigned (Sept)
2007	<ul style="list-style-type: none"> • Revised SA Strategic Plan • SA Health Strategic Plan (April) • Draft Health Care Act released for comment (June) • GP Plus Health Care strategy (Aug) 	<ul style="list-style-type: none"> • SAHS Chief Executive resigns (Jan) • CNAHS Chief Executive resigns (Jan) • SAHS ‘Population and PHC’ and ‘Consumer and Community Participation’ become Foundation Policies (Feb) • CNAHS ‘Building the Capacity’ report (Feb) • CNAHS Chief Executive appointed (March) • SAHS Chief Executive appointed (May) • SAHS Executive Director Population and PHC resigns (July)



Policy documents

First Steps Forward 2003

First Steps Forward, the SA Government response to the GHR, is a 12 page booklet with a forward by the Premier and the (then) Minister for Health. The document summarises the 'case for change' as described by the GHR and lists seven statements of intent on health reform. The first of these is:

- 'provide services closer to home; and increase prevention, early intervention and health promotion

Some of the strategies are being implemented, for example, new governance structures, PHC practitioner networks, community participation policies, however little evidence of action is apparent on workforce development, increased health promotion, new models of funding and improved health services for vulnerable populations.

The document concludes with seven 'first actions'. All but one of these ('Establish Aboriginal Health Advisory Committees in the metropolitan area') have been developed further but several have been overtaken by more recent events. The 'office of health reform' is no longer active and legislation to remove the recently established metropolitan and country boards has been drafted.

PHC Policy 2003

The PHC Policy 2003 is a 6 panel fold out pamphlet with a one page insert. It includes a forward by the (then) Minister for Health and a 'vision for change' describing a strong PHC foundation building on the GHR, in particular better health and a reduction in health inequalities and building investment in PHC. PHC is defined as both an approach and a first level of service. Six principles are listed:

- Participation
- Comprehensiveness
- Equity
- Cultural accountability
- Sustainability
- Effectiveness and accountability

There are ten key directions for strengthening PHC and an Action List for 2003-2005 including responsibilities by the DH to:

'Develop a sustainable funding base for PHC by ensuring it is a greater priority within Department funding models'

And to ensure the regions:

'have PHC action plans that are consistent with the Department's PHC policy, and involve communities, General Practice, other agencies and departments and other PHC providers'

'have sufficient PHC leadership and delegated authority to enable them to develop 'local solutions to local problems''

'establish regional planning mechanisms that link with the Aboriginal Health Advisory Councils.'

The PHC Policy includes a 'vision for change' describing a strong PHC foundation building on the GHR, in particular better health and a reduction in health inequalities and building investment in PHC.

Regional action plans have been developed (see below)

Four PHC networks (now GP Plus Networks) had been established at the time of this project, three within the CNAHS region and one in the SAHS region. They include Divisions of General Practice and other partners. The CNAHS networks at this stage are focussed on Type 2 Diabetes and aim to provide coordinated and integrated care access for people with this chronic disease.

The PHC policy also promised an annual report card on PHC by the Minister for Health. At the time of this report, one set of Health Reform Report Cards had been released with two pages devoted to PHC (see below).



SA Strategic Plan 2004

SA Strategic Plan 2004, contains goals, targets, measuring tools and priority actions for the whole of the state. While not specifically mentioning primary health care, the section on health and wellbeing lists a number of relevant targets. The Plan was re-issued in 2007 with some revised targets. This Plan has become a key policy document with government departments developing their responsibilities and funding linked to strategies in the Plan. This approach, however, is unlikely to facilitate a cross-sector or whole of government response as envisaged.

CNAHS Annual Report 05/06

Developing Primary Health Care is the first of four strategic priorities for CNAHS. There are four strategic objectives, with one, 'Client Focussed Care' of particularly relevance to PHC:

- Increased community awareness and participation in determining required health services of CNAHS including Aboriginal & Torres Strait Islanders, people from culturally linguistic and diverse backgrounds and people with mental illness
- Re-design services within CNAHS to meet the current and future health needs and priorities of the local population
- Ensure accessibility and equity of health care services in a timely and effective manner
- Increase flexibility of services to support new and changing models of care
- Create an environment to support self management, early intervention/prevention and chronic disease management within CNAHS population.

Primary Health Care Directorate key achievements for 2005-2006 are described including:

Primary Health Care Networks (All Sub-Regions):

- A Planning Framework to enable population health planning to occur across the sub-regions was developed in consultation with the Primary Health Care and Service Development Directorates.
- MOUs were established and signed by key stakeholders.
- The Networks developed a sub-regional action plan for Diabetes Type 2.

BreastScreen SA formally transferred to CNAHS from 1 July 2005.

Primary Health Care – Building the Capacity Program (from Building the Capacity Program Final Report 2006):

- Project aimed at building the capacity within the primary health care sector, to improve the management of chronic conditions across the Central Northern Adelaide Health Service (CNAHS) region.
- Seven strategies have been implemented from October 2005 (listed below); these have had a focus on Type 2 diabetes. The work has continued through 2006/07 by transitioning successful strategies into mainstream services for ongoing coordination and management.
 - Practice Nurse as change agents (practice level)
 - Allied Health (private) in general practice
 - Data management in general practice
 - Addressing the risk factors of physical inactivity and poor nutrition (client and practice level)
 - Development of integrated systems and processes for Type 2 diabetes across Central Northern Adelaide Health Service (system level)
 - Chronic disease self management (client and practice level)
 - Building sustainable partnerships in the sub-regions (system level)



SAHS, 'A Healthier Community' 2006

In 2006 SAHS released a four page fold out document entitled 'A Healthier Community'. Three regional strategic intentions are described:

- Safety first – commitment to safety and quality of services
- Health and wellbeing of our population – addressing health differentials
- Appropriate care in the most appropriate setting – providing the right services in the right setting and within an appropriate timeframe.

A planning framework illustrates the links between National and State policy and SAHS plans and priorities.

A double sided insert lists the Strategic priorities for 2006-08. The second of these is 'Primary Health Care Reform' and describes:

- the establishment of two GP Plus Health Care Centres as effective models of PHC by June 2008
- expanded hospital avoidance packages by 970 packages
- increase to 400 the number of people on a structured care plan to manage chronic disease and expand the Chronic Disease Community Program from 200 to 285 packages.

SAHS Annual report 2005-06

The report card in the SAHS annual report highlights the following achievements under the Population Health and Primary Health Care directorate.

- Community and Consumer Participation Framework launched and being implemented.
- Instituted a Memorandum of understanding with the Southern Division of General Practice.
- Signed 18 general practices (approximately 100 General Practitioners to participate in Primary Health Care Networks. This network aims to bring together SAHS's primary health care services and local general practitioners to ensure a more coordinated service for people with a chronic illness.
- Provided 84 Chronic Disease Community Program packages.
- Provided 1,750 Metro Home Link hospital avoidance packages and 1,767 discharge packages.
- Expanded the Hospital @ Home services to include the Noarlunga Hospital.
- Enhanced the allied health and support services for people living in Supported Residential Facilities in the Marion area.

The document highlights that 'The Generational Health Review identified primary health care as a critical part of the delivery of health care services in the future. This has required us to adopt a more sophisticated business management approach to primary health care services, and information collection and accountability are a much higher priority than they have been in the past. The activity of the services is now more aligned to the regions strategic directions, and population data has been used more extensively in the planning of services'.

Southern Adelaide Health Service addressed diabetes, chronic obstructive pulmonary disease, and heart failure as initial priorities for the region. The report includes feedback on the Chronic Disease Community program which aims to identify people with chronic disease who need frequent admissions to hospital. The program helps patients to work with their general practitioner to maintain their health and reduce admissions to hospital. The report states that early indication shows that these patients have stayed healthier and have had a significant reduction in admissions to hospital. More than 180 patients were enrolled in the program in 2005-2006 with more than 50 patients being discharged.

Construction on the Aldinga GP Plus Health Care Centre, the first in the state commenced. In November 2006 the first GP Plus health care centre was opened at Aldinga and in May 2007 the second GP Plus health care centre was opened at Woodville. These centres provide a range of coordinated services including access to doctors after hours, antenatal care, child health and development, podiatry, nutrition, counselling and family support services.

Another major initiative of the Population and Primary Health Care Directorate has been the development of the Southern Primary Health Care Network. This network has aimed to bring together the Southern Adelaide Health Service's primary health care services and local general practitioners to ensure a more coordinated service for people who live with a chronic illness. Throughout 2005-06 SAHS report working closely with the Southern Division of General Practice. A pool of practice nurses was established to support general practitioners to identify patients with chronic illness and to implement new processes that will streamline referrals between general practice and allied health services.



Children, Youth and Women's Health Service annual report 05/06

In December 2006 CYWHS released their annual report 2005/06. Strategic goals listed are:

- Contribute to the Population's Health and Wellbeing
- Improve opportunities to prevent illness and promote health
- Improve the health of Aboriginal Children, Young People and Women
- Address health inequalities
- Support specialist services for the state
- Ensuring quality and integrated health care services

A summary of how PHC is being implemented and strengthened during 2005/06 under the strategic goals that have particular relevance to PHC:

1) Contribute to the Population's Health and Wellbeing

Regional Population Health Action Plan was developed. It identifies priorities for children, youth and women. Ongoing programs have included:

- Home Visiting – During 2006, CYWHS continued their Family Home Visiting program with more than 1500 families participating. The number of Aboriginal families participating in the program was reported to have risen.
- Universal Neonatal Hearing Screening – a program that identifies and assists newborns with significant hearing impairment – continued to be rolled out across the State with full implementation completed across the State. This program has been fully operational at the Women's and Children's Hospital with all babies born having their hearing screened before they go home.

Health and wellbeing

- State-wide leadership has been shown by the development of the South Australian Women's Health Action Plan which was developed in consultation with key stakeholders across the State. This plan is a key mechanism to translate the South Australian Women's Health Policy into action.
- Service Plan also developed for Vulnerable Infants.

2) Improve Opportunities to Prevent Illness and Promote Health

CYWHS aims to expand services for children, young people and women that focus on prevention, health promotion and early intervention. Some examples of progress towards achieving this goal during 2005-2006 include: Hearing Services – providing hearing assessments at the individual, family and community level, Youth Health Services such as The Second Story Youth Health Service provided primary health care services to young people aged 12 to 25, Child and Adolescent Mental Health Services launched two new services to assist young people between the ages of 12 and 18 with complex and severe mental health problems.

Other activity areas are:

- Illness Prevention
- Women's Health
- Child Health
- Health Information
- Promote Health



3) Improve the Health of Aboriginal Children, Young people and Women

The Aboriginal Health Strategy 2005-2010 was launched. Examples of progress include:

- Strengthening partnerships with agencies that support Aboriginal people. These include the Wiltja Aboriginal Hostel, Aboriginal Health Division, Pika Wiya Health Service, Muna Paiendi Community Health Service, selected schools in Adelaide to address behavioural risk factors for Aboriginal students who are disengaging from learning.

The Aboriginal Health Strategy identifies workforce development strategies to support the Service in achieving improved access and better health services for Aboriginal people. The Strategy commits to increase participation of Aboriginal people within the CYWHS workforce. During 2005-2006 more Aboriginal staff were recruited across the organisation. This represents a doubling of the number of staff who identified as being Aboriginal.

Work commenced on the development of an Aboriginal Workforce Development Plan. This Plan outlines a range of strategies to strengthen cultural awareness and respect throughout the organisation. A new leadership position of Director of Aboriginal Health was created for Aboriginal health services and professional support for Aboriginal health workers.

4) Address Health Inequalities

CYWHS aims to take account of the growing disparities in health experience and health outcomes between different groups in the community as services are developed. CYWHS will distribute resources, taking into account the health needs of different groups:

Vulnerable Children
Homelessness
Isolated families
Disability Support
Cultural Needs
Education and Childcare Assistance

SA Department of Health Strategic Directions 2004-2006

This 8 page fold out brochure is a first response to the SASP targets and aims to provide a framework for planning and prioritising actions across the State health system. To this end it is mainly concerned with operational aspects such as quality improvement, key performance areas and values underpinning the Department's business. The strategic directions are:

- Increase community inclusion and participation
- Collaborate and work in partnerships
- Direct resources to ensure access and equity
- Strengthen and reorient resources for prevention, early intervention and primary health care
- Improve the quality and safety of services

Health Reform Report Cards (2006)

Claims described under the PHC section of the report include: hospital avoidance initiatives, PHC Networks, developing systems to provide coordinated care between GPs, hospitals and PHC services for chronic disease, and commitment to the development of GP Plus Centres providing services such as GPs, nursing, mental health, health education, allied health and health promotion.

While these are no doubt worthy activities they fall well short of the vision in the PHC Policy of working to reduce health inequalities, encouraging a physical and social environment that promotes good health and a whole of government approach to advance health status. The focus is on delivering care to individuals and ignores population health strategies and 'upstream' health promotion initiatives.

There is also a two page report on 'better governance' which describes the formation of the three metropolitan regions and announces the establishment of one county health region (replacing the existing seven). County Health SA Inc will support a 'primary health care and population health focus.' The metropolitan regions are required to establish community participation structures processes and to report on these. A Clinical Senate has been established with aim of maximising continuity of care, improving access through improved service planning and workforce and operational management.



Health Strategic Plan in 2007

The SA Health Department issued its own Health Strategic Plan in 2007. This document lists the targets from the SASP above as those for which the Department is the responsible lead agency. 'Strengthening primary health care' is listed as the first strategic direction to achieve the Department's mission 'SA Health will lead and delivered a comprehensive and sustainable health system that aims to ensure healthier longer and better lives for all South Australians'. The mission also promises a commitment to 'positive health outcomes by focussing on health promotion, illness prevention and early intervention'; and to 'work with other government agencies and the community to address the environmental, socio-economic, biological and behavioural determinants of health and to achieve equitable health outcomes for all South Australians'. However the key objectives, strategies and performance measures listed under 'Strengthen primary health care' are focussed on individual, clinical care and make no mention of socio-economic determinants of health or issues of equity.

South Australia's Health Care Plan 2007 – 16

The foreword by the Premier and Minister for Health claims that:

'The Generational Health Review (GHR) was our first step towards reforming the health system. Recommendations from that have been implemented across the system over the past four years, including an increased focus on primary health care – keeping South Australians healthy and out-of-hospital.'

It goes on to emphasise healthy choices and lifestyles as the key:

'While we can change the way our hospitals provide services and remodel our system to improve it, so much of this plan is based on our community making its own healthy choices. Healthier lifestyles can reduce chronic diseases and the need for health services – prevention is always better than cure.'

The main focus of the plan is a new hospital:

'The government will build the 800-bed Marjorie Jackson-Nelson Hospital, a state-of-the-art facility in Adelaide's city centre that will become Australia's most advanced hospital.'

GP Plus Health Care Centres

The plan acknowledges the need for all sectors and community groups to work together:

'Improving the health and well-being of the South Australian community will require us all to take responsibility to develop a combined approach from individuals, community groups, government and non-government sectors, and will involve working closely with GP and other private health care providers.'

There is a strong emphasis on providing information about healthy lifestyles:

'All South Australians are entitled to enjoy good health and a long life. We will provide greater access to information on how to maintain a healthy lifestyle, and more importantly, we will ensure there is greater support to assist you.'

The support to be offered is described as follows:

'A new role will be developed to assist people with chronic disease risk factors to make changes to improve their health. Lifestyle coaches/care coordinators will help you manage your own health and well-being, and prevent you from becoming ill.'

- Ongoing investment in public health campaigns that will help lead lifestyle change, including smoking cessation, healthy weight, nutrition and physical activity campaigns.
- Healthy weight, nutrition and physical activity programmes in schools and childcare centres aimed at reducing the levels of obesity in the community, in particular through the Eat Well Be Active Healthy Weight Strategy.
- Falls prevention programmes and active ageing programmes to keep older people active and prevent injury through falls.
- The implementation of the National Health Call Centre.

Health promotion appears to have been dropped from the list of services to be provided by GP Plus Health Care Centres. However, there is a strong emphasis on providing information about healthy lifestyles. The list of supports, while likely to have some positive impact at an individual level, again falls well short of a comprehensive PHC and health promotion approach that includes structural and environmental changes to support health and wellbeing.

It is interesting to note that the cover of this document features white-coated and scrubbed medical professionals with health consumers relegated to the background. Earlier policy document covers featured diverse groups of people from the general community.



Interview data

In response to the first question on hoped-for outcomes for PHC, responses expressed overlap between strategies and outcomes. Service outcomes were described first, health outcomes usually needed prompting. This could be linked to respondents' thinking in terms of time frames: initial short term thinking focuses on service development, then medium term is action on risk factors, leading to long term improvements in health status. Another explanation is that respondents were thinking in terms of outcomes for regional health services (as providers of primary health care) rather than outcomes for PHC as an approach to service delivery. This confirms the lack of common understanding and confusion about primary health care and its place in the overall human services sector.

Hoped-for service related outcomes included more integration and partnership, better access to services and hospital avoidance for chronic disease. Health outcomes included keeping people healthy, better management of chronic disease and a reduction in risk factors, and improved antenatal care and child development. When asked to consider the most important outcomes for PHC, equity between Indigenous and non-Indigenous health outcomes and a reduction in the social gradient for health were rated as the most important outcomes.

Suggested barriers to achieving PHC outcomes were limited monetary resources (or the need to restructure current resource patterns), workforce issues (professional silos and workforce attraction and retention), and lack of cross-sector action, leadership and organisation change processes.

Discussion about strategies for achieving PHC outcomes revealed that a number of planning documents had been produced and this has highlighted the need for better quality planning data. The other major strategy described is to develop partnerships and networks in line with the related service outcomes described above. There was also some discussion about re-orientating traditional community health services, from a broad social view of health, to an approach focussed on chronic disease management. On the other hand, examples were given of moves to re-orient services by influencing clinical planning agendas or by using resources to get leverage on the design of general practice. Tension between the acute and community health sectors was noted: hospital avoidance programs and a focus on chronic disease management were seen as a way to get the acute care sector on board in the reform process.

The main drivers of reform were seen to be the Boards and the Executive Directors. This obviously raises questions for the future when Boards are no longer in existence¹ and senior personnel change. Government policy was also a driver of reform, however the PHC policy was not widely believed to be used to underpin service delivery and indeed was seldom mentioned by respondents. Instead, new strategies – the establishment of GP Plus Health Care Centres and GP Plus Networks – are driving service development. As their name suggests, these health care delivery models are centred on clinical services provided by general practice and allied health in an attempt to improve chronic disease management, rather than the broader social view of health envisaged in the PHC policy.

In terms of evaluation and accountability, most of the interview discussion centred on quality and process measures. Individual key performance indicators for senior staff were also mentioned. The need for increased capacity and use of research and evaluation was recognised.

Perceived barriers to the sustainability of reform included: political will and 4-year election cycles, and the constancy of change and reform leading to 'change fatigue'.

Interviews were conducted with 8 respondents who were involved in health reform and regionalisation; two members of the CNAHS/CYWHS Board, and six executive managers.

a) PHC outcomes

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

Most respondents talked first about outcomes for services and only discussed health outcomes after prompting. Also it seemed difficult for respondents to focus on outcomes and many in fact described strategies eg the use of lifestyle coordinators in chronic disease prevention and management; expanding the home visiting scheme for newborns.

In terms of service outcomes, most frequently mentioned were about integration, partnerships and working more with general practice.

¹ The Minister for Health announced the planned dissolution of the regional Boards in October 2006



And I guess the other outcome I'd like to see is the development and implementation of workforce strategy which thinks outside traditional roles of various professions. ID 02

I think another area, which I would class as an outcome would appear about getting a better understanding out there in the system around what we mean by this Primary Health Care approach and particularly within, around the tension between, I have perceived it, between Community Health and General Practice... I think we had a fairly polarised perspective about the sort of preventative social determinants of health agenda happening over here and that somehow GPs weren't in that place, they were here to provide clinical services. ID 01

This was closely followed by increased access to services by providing care closer to, or in, the client's home. Two respondents talked about equity of access to services for disadvantaged people and one talked about increasing equity of health outcomes. Another outcome raised by three respondents was an increase in hospital avoidance for chronic disease related admissions. Two mentioned an increased focus on prevention and early intervention.

Diverse issues were raised in relation to health outcomes. These included: keeping people healthy and well; better diabetes and other chronic disease management; and a decrease in obesity rates. Other specific topics for improved outcomes mentioned were domestic violence, mental health and Aboriginal and Torres Strait Islander health. Two respondents linked mental health and drug use to justice issues and prisoner health. Respondents from CYWHS naturally focussed more on maternal and child health issues eg immunisation, ante-natal and peri-natal care (including ATSI and disadvantaged population groups) child development and parenting.

One respondent stated:

We don't have a clear understanding of what we're trying to achieve in primary health care, the approach to that delivery, outcome, structure... ID 3

What outcome is most important to you?

Of the six respondents who indicated their most important outcome, three referred specifically to ATSI health: equity of health status between Aboriginal and non-Aboriginal people, maternal health and early intervention with at risk children (including ATSI and other disadvantaged groups). Another respondent talked about the importance of equity in terms of flattening out the social health gradient. One respondent believed mental health was the most pressing issue.

What is a reasonable time frame for achieving these outcomes?

The table below shows outcomes allocated to the suggested time frames as nominated by respondents.

Table 2: Outcomes by suggested timeframes

1-2 Years	3-5 years	6-10 years	11-20 years
<ul style="list-style-type: none"> • outcomes from home visiting program • increased access to services • increased partnership across sectors • better needs data 	<ul style="list-style-type: none"> • increased participation in BreastScreen • reduction in recidivism linked to mental health and drugs • increased rates of breastfeeding • decreased smoking in pregnancy • increased community participation • increased immunisation • new GP+ centres • decreased obesity rates • better HIV prevention • better maternal health 	<ul style="list-style-type: none"> • impact on social gradient • better children's health • better mental health 	<ul style="list-style-type: none"> • health outcomes from lifestyle changes • community level health outcomes



What barriers to achieving these outcomes can you identify?

All respondents listed a number of barriers to the reform process and strengthening of PHC. Four of the eight respondents included insufficient monetary resources as a barrier. However another person believed the barrier was more about a lack of willingness to work in different ways with the same resource allocation.

Funding, demand, in that whilst you're doing this new way of business, having to meet existing expectations, both from a client base perspective but from a political perspective and especially if we're able to gauge our services and working more heavily with the different population groups, ID 11

I think that the first is there's that mind-set around new things equal new money, that we're not very good at re-visiting the way which we currently do things in order to see whether we can do them better. ID 01

Four people talked about the fragmented nature of PHC and the lack of common understanding about PHC acting as a barrier to an increased focus for this approach.

Primary health care, the sector overall, is not sophisticated in its governance and lobbying because it doesn't work as an integrated whole and everybody's fighting for their own bit of territory. ID 02

If you look at the reform agenda as a major concern for change management, then we do not have the investment in the cultural and organisation development that we need because I think still people do not have a good enough understanding of a primary health care approach. ID 01

Workforce issues were also mentioned as barriers. Closed thinking about professional roles limited the capacity for change in the system and some professionals were thought to be resistant to losing their powerful status in the current system. Attraction and retention of a workforce with a good understanding of PHC was also problematic.

Workforce – very hard given the sorts of money we have to pay under, because we're advised to use awards and AWAs in our current workforce market trying to attract and keep our professional people. And so it's both attracting and keeping... ID 02

High level policy barriers suggested included difficulties in gaining cross-sector action for health, a lack of leadership in reform, lack of investment in cultural change and organisational development, and bureaucratic regulations.

It was a bit like domestic violence ... Put into the department to determine who should be a lead and quite frankly nothing will happen. So again it's the cross government department. ID 04

The obvious one's money. I think bureaucracy is also somewhat of a barrier. The way the health service is managed and organised is crucial to how it functions of course. Dealings with the Health Department are not always easy, not always smooth and not always efficient. ... I think if the generational health review is taken seriously and is implemented I think we've got a lot of scope for good outcomes. If bureaucracy and politics slow that down then I think it's the health of South Australia that will suffer. ID 18

Two respondents believed the current emphasis on ageing and chronic disease in policy decisions and in the media was unhelpful.

... the capacity of acute services to demand and get the attention of the media and potential of political expedient resource decision. And good on them I say if they can do that, but it does make our life a bit difficult. In a sense it develops a slight adversarial approach to resource acquisition whereas primary health care, as a very diverse fragmented system, has to fight for resources with other elements of the health system that have got a much better history of concerted lobbying and effort. ID 2

The size and complexity of the regional health services was also seen as a barrier to reform.

b) Strategies for change

Is there a region-wide change strategy for achieving the outcomes you have outlined?

The most common response to this question was to discuss an array of strategic plans that were either finalised or under development. Four respondents described plans or frameworks in population health, ATSI health, workforce development, primary health care, chronic disease management, and oral health.

Other change strategies, mentioned by two respondents each, were developing partnerships (mainly with general practice) and the establishment of the PHC Networks (now GP Plus Networks).

We have to create leverage in the system, and one way of doing that is through partnerships, so partnerships with general practice, which is very important and we spend a lot of time on our relationship to the fact of the point where we now have very good conversations with GPs, Divisions, the college etc. and quite a number of congruent programs, so I think that's a really important change process. ID 02

So the primary health care networks which we talked about earlier, we put together a planning framework to enable the population health planning to occur across the regions and interlinking with the different government and non government activities. ID 04.



Increased emphasis on data and measurement were mentioned by two respondents:

Well, first of all, you've got to have facts and data. So what we put together was we started with the University of Adelaide, in our social health atlas which provided a focus and data to work with to really identify the potential areas in chronic disease management. ID 4

And the other, it's not really a changed strategy, but it's an important element that I'm trying to build up, is our capacity to measure what we do, so that the data, both qualitative and quantitative describes what we do, is getting better, because without that we can't argue for what we do. ID 02

Other strategies related to developing new services or new approaches to service delivery:

I think what's going to be an interesting dynamic over the next period of time is the extent to which the individual type spectrum, because a lot of our community health staff have been in a mode which has been group activities and working in that sort of community development model, ... but it's going to be much more focused on individuals and individual behaviour change. ID 1

Well we are developing practice based sort of primary health care teams within our regions. And we've developed a chronic disease management framework obviously, that's the strategy. and of course the primary health care centres is a key platform for what we want to do, and in Aboriginal and Torres Strait Islander activity besides covering those items like chronic disease management we're putting a lot of activity on step down facilities for Aboriginal and Torres Strait Islander people. ID 04

...to change the culture of previous community health centres to one focusing on chronic disease management and population health, and the sort of strategies there are where we have vacant positions, for whatever reason, we are trying to fill vacant positions with clinical people, so if I have a community development worker that leaves and that job is done, and I've still got the funding, I'll fill that position with a speech pathologist or a physiotherapist or podiatrist or whatever I can find. So over a period of time, without wholesale changes, which I don't think is the right way to go, we are slow reorientating the services towards chronic disease management, because that's what we've been asked to do... and moving away from the more social activities. I'm not saying moving away from them completely because they have their role. It's a change of emphasis. ID 02

Only one respondent raised resource allocation issues and only one person workforce development/capacity building.

Our State Government has an aspiration for us to focus on the Population Health approach, therefore the first call on dollars should be those who with the most disadvantaged and so while we're thinking about \$2 million extra to the \$46, that has to go on Aboriginal Torres Strait Islanders; the challenge is how do you make sure the first \$2 million of the \$46 are spent on that, acknowledge that something else will drop off but we have a debate that whether that drops of. ID 18

One of the things that I think that we've really done well in the last two years, two and a half years is to decentralise and push decision making down and give people the responsibility and accountability to run their business and that you know gets people involved and motivated and they really get enthused about it. And that sort of an approach I think going forward is going to disappear. ID 4

Two respondents talked about efforts to reorient services towards a primary health care focus; one through guiding a work plan process for a clinical reference group and the other by using funding as a lever to change practice:

... the Neo-natal and Maternal Health Clinical Reference Group for the state, which in the past has been extremely tertiary focused ... We've just done a planning process with them and we have managed to get primary health care strategies and community involvement and a commitment to Aboriginal Health Maternal Care on this year's work plan. ID 14

The third element of change is where we can influence third parties, so this is about general practice in particular, which I've been given the job of driving that process, um so we're happy to put our resources on the table to put practice nurses into general practice and the quid pro quo is that that lever gets us into practice and we can slowly change internal business processes, so around best practice guidelines around the internal protocols etc, so we can actually drive change in an industry through that sort of leverage. ID 02

Are the change strategies widely understood and accepted? Most respondents believed that workers understood the need for change although at grassroots level there was still some filtering down to change actual day-to-day practice. Some people talked about the need to bring staff along with the changes. In the tertiary sector there was still some tension about the new directions but by focussing on hospital avoidance and chronic disease management acute services could see the value of buy in to the changes. PHC staff were also concerned about being swallowed up by the larger acute sector. For one respondent lack of clarity about level of autonomy between the regional service and the Dept of Health led to tensions. Another respondent voiced concern that the broader community did not understand the reform changes.



Who/what is the main driver at present?

Most respondents believed the Board and executive managers were the main drivers of change. Government was a driver by virtue of its priorities and policies although the PHC policy was only mentioned specifically by two people. One of these stated that the policy was a strong influence when it was first released but seemed to hold less influence now. The other respondent thought that the lack of specificity in the policy limited its usefulness.

c) Evaluation and sustainability

How are you assessing and evaluating progress in achieving the outcomes for PHC?

Monitoring and evaluation included target setting, accountability and performance management. It was also about demonstrating 'you're actually making a difference'. Most respondents mentioned that key performance indicators were either developed or were being developed.

Well at the moment, we've got a range of indicators, some other state-wide strategic plan indicators, indicators we have anyway that we developed over time. I think what's lacking is an integrated set of indicators across all the sectors which reflect what the strategic plan is going to be, so that's been agreed to at a Ministerial level. ID 15

However, most of these seemed to be linked to quality and process measures rather than impacts or health outcomes. Data on one health outcome linked to the BreastScreen service, breast cancer survival rates, is collected nationally.

Data collection and IT resources were mentioned by many respondents in terms of the need for better clinical and population data, and more consistent activity data, as prerequisites for evaluation.

Two people discussed plans to build capacity in research and evaluation: by linking staff to academia and by setting up an internal research and evaluation unit.

I think if we have an internal unit with the expertise to collect data, analyse it, we will be able to write better briefs for what we want our evaluations to do. We may still do some internal evaluations as a result of that, so the sort of things we're looking at as an example, is working with one of the Divisions of General Practice to develop a data extraction basis which matches data extraction from General Practices with data we've got down to almost street level, but certainly postcode level, so that we can actually monitor things like high blood pressure levels, then we can get real clinical data of population level, and when we develop that to the point where it's robust enough that we've got faith and the trends actually mean something, rather than just reflect how we are collecting the data, we will then be able to monitor real population health outcomes, I think that's where we want to be in 5 years time. ID 02

One respondent thought there was a need to develop logic models for services and one believed that evaluations currently carried out could be put to better use. Only one person stated that evaluation was poorly done. However, activity reports to the Board and individual performance appraisal appeared to be the main systematic evaluation activity. One respondent commented on challenges to evaluating primary health care

Well the problem is you can't do the scientific RCT Intervention Study in primary health care, change processes like this because you can't hold it in a hospital. By the time you've done your intervention study, the world's moved on so your results are not useful anyway so I think action research and social science's methodology is a much more critical than the RCT type studies ID2

What will be required to sustain reform changes?

Critical issues for ensuring sustainability of reform changes were: political commitment; monitoring and evaluation; appropriate workforce; and resources.

Political commitment was discussed in terms of the need for consistency and the difficulty with this under 4-year election cycles. This leads to the need to continually 're-educate' people in power about the PHC approach. The difficulty of recruiting and keeping an appropriately skilled workforce was mentioned as an issue for sustainability of reform. Offering professional development and leadership opportunities were suggested as ways to retain a skilled workforce.

We obviously need to continue to attract good skilled people, and keep them, which means we need to give them good support you know, professional development and leadership opportunities and all those sorts of things because I think we've even found this year, we've been working on reform on quite a few fronts, anybody with good writing skills, evaluation and research skills, program development skills and Primary Health Care knowledge, they need stability. ID 14

Several respondents talked about specific barriers to sustainability. These barriers all related to the pace and constancy of change. For example, the impending loss of the Board structure was seen as a major impediment to accountability and also as a threat to the ongoing reorientation to PHC that Boards were strongly supporting. There was a concern that without these PHC champions, reform would be stalled. New leaders might have a similar impact if they did not share a commitment to the values of the reform agenda as recommended in the GHR.



I've seen target setting work quite well over the last two years and so I think we need to keep that, we need to keep saying you know what about, here's our vision, if we want to improve access for these groups, what're we going to do this year, set a target, be clear about who's responsible for that action and then keep that, keep the tension going. It's worked, it has definitely worked in terms of shifting resources and shifting people with effort, so I think we need to do that. in terms of sustainability, that a board that's very very strong on a particular style of Primary Health Care and Population Health and when they go, and the reform agenda is set more centrally, which may well become adult focussed, may well become more about avoidance strategies for aged care reform and stuff like that, it will be interesting to see whether we can sustain that effort in the areas we need to ID 14

I think the constant changes are a major threat to its sustainability. I think a system as big as it is, is still part of a context, and when the bigger system that it's part of, which is, you know, the whole health system and the political system that encompasses that, when that is being mucked around with or is changing, whether it be because of election or because of the whim of a Minister or because of the departure of a CEO or whatever, all of which we're dealing with, those things destabilise a system and just as the system's getting its momentum going, which I think this system has been. ID 18



Comments on PHC Evaluation Framework

Interview respondents were asked to comment on the draft PHC Evaluation Framework (see Appendix 2) that had been developed following the pilot project in the southern Adelaide health region. The overarching goals, strategy and indicators are shown below.

Overarching goal: Improvement and greater equity in population health status

Overarching strategy: Strengthen PHC in SA health system through sub-goals and related strategies as stated below

Indicators 5 years	Indicators 10 years	Measurement tools
<ul style="list-style-type: none"> • 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 	<ul style="list-style-type: none"> • Life expectancy across population groups by ATSI status and SES. • Prevalence of chronic disease 	<ul style="list-style-type: none"> • Health Omnibus survey • Health Monitor survey • Mortality Statistics • State Strategic Plan

The goal of improved population health status and greater equity was questioned: is this realistic as a ten year goal or should it be a vision? Greater recognition of the role of non-health sectors and non-government organisations was suggested. It was also questioned whether addressing the social determinants of health was the responsibility of the health sector or whether the role is more of advocacy for recognition of these determinants. Many of the comments related to language and demonstrated the lack of a shared understanding of many terms and the need for a glossary to promote a common understanding for lay people and health professionals.

Some of the strategies were considered to be 'good management' or 'good practice' and therefore could be assumed rather than spelled out in the Evaluation Framework. Some additional indicators were suggested but in general respondents were uncomfortable with putting hard numbers on indicators.

Comments on overarching goal, strategy and indicators

Two people commented on the timeframe in the document. One stated that it was important to have a long time frame, extending beyond election cycles. The other believed that improving population health and increasing equity was not realistic in the 5-10 year time frame given. Another thought the goal was simply unachievable.

I had trouble with the goals, ... Is it achievable, based on say improvement and greater equity in population health, I just don't think it's achievable in the time frame. ID 3

Three people commented on the language used. For one, the language of the goals and strategies clearly reflected the southern region from where they had originated, while another respondent believed their region would use different words but would agree on the overall intent. Another respondent found the language too complex:

The social determinants of health and so forth, equity of access and underpinning by an understanding of the social, economic and other determinants of health, increased provision and reach for a comprehensive primary health care service, equity of access. I wasn't too sure what that really means you know, to a health person it probably means something but to me I struggle with that sort of stuff. ID 4

One respondent believed the definition of PHC used in the research was too focussed on the social determinants of health and that the state-funded community health sector needed to work with the more powerful parts of the health system. By defining primary health care as community health and social health there was a risk of disengaging major parts of the health system:

I was still concerned that this is focused on that broader definition of primary health care and social determinants of health etc, rather than on creating a primary health care focussed organisation, delivering the whole range of services ... For me the task is how do we get the whole system governed in a way which is with that mind-set of Primary Health Care; because if I don't do that, I will lose the engagement of some of the people who at the moment, through history of the whole are the ones who have a great deal of power, control, a great deal of resources etc etc. ID 01



Sub-goal 1.

Good regional governance and infrastructure established as prerequisite to PHC: including community engagement, leadership and agreed vision

Several respondents talked about the need to include partners such as other government sectors and NGO partners:

I don't think that we can under-estimate the investment from other government or non-government organisations into primary health care ID 3

One respondent believed very strongly that governance should be at state level:

I think there's an arbitrary things about regions, I don't think it necessarily works for women and children because you get caught up underneath this mountain of ageing, sick people and focus on hospitals, so while it might be called good regional governance I think it actually fragments, so for me I'd still like to stay with the state-wide focus rather than fragmenting to we're going to do this in Northern, and that in Southern. I think everywhere that's happened, children and women go down to the bottom of the heap. ID 15

Sub-goal 2.

Increased provision and reach of comprehensive primary health care services and activities, with emphasis on equity of access and underpinned by an understanding of social, economic and other determinants of health

Not everyone agreed that tackling the SDOH was the role of the health sector, rather the health sector could advocate for this broader agenda:

And I think we've got a huge job as a health service to advocate for that broader health agenda and enable other government departments and private sector and NGO sector to play their part, but we can't do it for them. And it's inappropriate to use health service money, I think, to take on those responsibilities when we know we've got a burden of disease that we've got to deal with as well. ID 01

Different understandings of equity were demonstrated: for one respondent this was about closing the gap in health status between different socio-economic groups and for another population health was about moving everyone up. The SDOH approach was mentioned as particularly important for ASTI populations.

In discussing the indicators, four respondents wanted to add rates of overweight/obesity or other risk factors to the five year indicators. Three people expressed support for chronic disease prevalence (i.e. diabetes) as a ten year indicator. Several people queried the notion that chronic disease rates in children would be quicker to respond. Two people expressed doubts about an indicator of avoidable hospital admissions as this was difficult to measure and, according to one respondent, increasing. Infant mortality was considered by one respondent as too crude a measure and birth weight was suggested as an alternative. One respondent wanted to add a mental health indicator.

Comment on Strategies

Next respondents were asked to select their five most important strategies and discuss why this strategy was important, whether the indicators were realistic and measurable and how the strategy and indicators could be improved. Although the framework was sent out in advance, few respondents had been able to consider it in depth and they found selecting the five most important was a difficult task. For one person the timing was critical.

*I went through and I thought 'oh we've done this, we've done this, we've done this'; so they **were** my most important, but they're not my most important **now**. ID 14*

One person commented that there seemed to be two types of strategies: some about activities and some about how things are done. There were also system strategies (considered to be generic and fuzzy) and more concrete strategies. Another respondent suggested strategies related either to planning or were levers to make the plan work.

For me the planning process is that you do the plan and then you have levers that you need to engage to actually make it work, such as communication, community involvement, workforce plans, so it's the structure. ID 11

A summary of comments to each strategy is given below along with the number of votes received by each.

Strategy 1.1 Clarify roles, management and accountability structures within region and with DH

For some respondents this strategy is considered a management task that can be assumed and in fact has already been achieved in both regions.

These are all a bit "me too", who hasn't got these already? The organisation charts, understanding roles and responsibilities you know, it's pretty much what you need if you're going to run an effective organisation. ID 15



It was noted that accountable is missing in the indicators, eg KPIs should be actively reported against responsibility at 1-2 years and to the community at 3-4 years.

On the other hand, some respondents recognised the constant change in the system had led to some disillusionment and that it was important to focus on how responsibilities related to the regional vision.

I mean it's vital that there's a view of organisational change, descriptions of responsibility, you know delegations and stuff. Similarly all managers have got to have a clear understanding of their roles and responsibilities. Staff - then that follows, especially the bit about how their role relates to the regional vision because as I said they are much more immediately focused on that. But that's something that grows. Whether you get to 100% in three to four years I don't know. ID 18

Strategy 1.2 Develop and disseminate consensus vision statement on CPHC (including population health)

Two respondents believed that separate regional visions were unnecessary. For one they were confusing and there should be an integrated state-wide vision that individual regions could then negotiate their role in delivering. For the other respondent a state-wide vision was suggested as more relevant with the State Strategic Plan partly fulfilling this role.

One respondent thought that the strategy and the 1-2 year indicators were appropriate, however was uncertain about how to ensure understanding and support by key players. Another believed a consensus vision statement was not relevant for clients and would do nothing to improve real health outcomes, while another thought that a statement of purpose might be more useful.

Strategy 1.3 Ensure regional plans (and sub-plans e.g. Aboriginal Health, workforce development) are population-based and include realistic resource allocation for implementation and evaluation

Four respondents were generally supportive of this strategy.

I think you've got to translate that vision into specific plans and monitor them and implement them etc. And I want dollar amounts specifically in regional plans, I mean it might just be shifting resources, it might not be new money, it might be taking the money from somewhere else. ID 14

It was suggested that an indicator could be added at years 1-2 that plans exist, and that the evaluation of plans should be brought forward to years 3-4. One respondent preferred to think in terms of implementation plans rather than regional plans.

Strategy 1.4 Link regional strategic plan to PHC policy and First Steps Forward and ensure planning at all levels is underpinned by an understanding of SDOH

There was moderate support for this strategy, one respondent linking this to an environmental scan. Another thought that health system was not good at writing policy.

... Look I actually think that we're very bad in health at writing policy, full stop. Getting it out there and you know like saying what does this mean? So I think it's more likely to be that than anything else and I think they're trying to resurrect a policy framework at the moment. I don't think that's just unique to Primary Health Care. ID 15

Strategy 1.5 Ensure regional plans and structures allow for local responsiveness and accountability to local communities while retaining evidence-based planning (not just loudest voice)

There was general support for this strategy. Two respondents saw it as part of a good planning process to include consultation with the community. Other comments were about the difficulty for a large organisation in balancing regional services with local responsiveness, and a belief that this was a policy principle rather than a strategy.

Strategy 1.6 Structures and processes established and resourced for community engagement

This strategy was generally supported. A suggestion for this strategy was to include volunteers. For one respondent community engagement was seen as a strength of the Board structure, while another mentioned the regional Community Participation Framework established an expectation that the organisation would engage with communities.

Strategy 1.7 Provide strong leadership which understands, drives, supports and advocates for comprehensive and equitable PHC

There was general support for this strategy. One comment was about the need for an indicator on how key decisions are made and whether this supports a commitment to primary health care. Another indicator - achieving parity with the acute sector - was considered unrealistic. It was noted that this strategy will need to be reword when Boards are removed.



Strategy 1.8 Establish transparent and effective communication channels between ‘front-line’ staff and regional centre

There was little support for this as a specific strategy, most respondents thought this was just part of good planning and management. A view was expressed that communication across large organisation should become easier as technology develops and becomes more accessible.

Strategy 1.9 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

Two respondents commented about reducing duplication: one believed that this is important while the other stated that this does not necessarily follow from integration.

Strategy 1.10 Improve IT and data management to increase utility for primary health care research practice and policy

There was moderate support for this strategy.

I've had to say IT and Data Management. I think Primary Health Care stats are a nightmare and it comes in decreasing accountability, it's becoming increasingly difficult to provide Boards, politicians, the Department with good quality data that stands up to rigorous test, and that weakens the case significantly, so I think that's really critical. ID 14

I think health is antiquated in its use of systems and systems will actually drive, good integrative systems, and by that I do mean IT, will drive complete reform in the way in which you deliver on a lot of stuff in the Primary Health Care area as well. I think people really under-estimate the importance of systems, in terms of driving change and integration across sectors and across silos ID 15

Respondents talked about the importance of good data systems and the lack of investment in IT for PHC. An additional indicator was suggested on the recognition of the value of good data and getting feedback on its use

I think people on the ground are very much more aware of the need for proper data collection and that's where its got to start. People on the ground have got to be aware of the value of it rather than it just being a bind and that's not an indicator that's here in particular, the recognition of the value of it by the staff who collect it because without that the whole, all the information becomes meaningless unless it's properly entered in the first place. ID18

Strategy 1.11 Develop research and evaluation capacity

Two respondents stated that research and evaluation was necessary in order to argue for PHC.

It was also recognised that flexibility and an action-oriented approach to research and evaluation was needed in order to inform service delivery and practice.

Strategy 2.1 Resource and implement healthy settings initiatives, identify and prioritise what ‘healthy settings’ to address eg schools

There was support for a broad range of settings, schools, workplaces but a recognition that changes in health outcomes would take a long time to be seen.

However the measurement's longer term, the measurements need to e longer term because you would expect that there's some ability to influence other like disease, like the connectiveness of communities, you would think the measurement tools over a longer period of time, the burden of disease you would think would decrease, assuming, depending on what those programs are, so not in the 10 years you wont' see an outcome, I would think measurements need to be longer term ID 11

Strategy 2.2 Ensure that health promotion & disease prevention are integral elements of all work undertaken in region regardless of the health care setting (core business for day to day activities) links to 2.7

There was limited support for this strategy. It was mentioned that smoking has been tackled in this way and that obesity might also be an issue that would be taken up broadly. For one respondent this strategy was an element of quality medical care:

I think of course you want all health care professionals to be good health care professionals, which means being person centred, time and space, you know, understanding the person's context, understanding what's happening before they came to see what's going to happen and after they go and see you, whether that health promotion and disease prevention or whether if you talked to medical people, whether they just say that's good comprehensive medical care, it's quality medical care, you know. ID 14



Strategy 2.3 Strategic Plan developed, implemented and monitored to improve service to population groups with special needs with specific targets quantified

There was limited support for this strategy. For one respondent it was already under development. There was a plea for young people to be prioritised as a population group

Strategy 2.4 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

There was moderate support for this strategy, particularly in terms of re-distribution of resources.

I mean there are obvious things like increasing resources. That's got to happen. And resources, it is not only money and workforce, that it says here, but its also social capital. ID 2

I think it's a lot about actually changing our systems, looking at what we don't need to do, re-orienting where we put our money and having some commitment to some of these longer-term outcomes by putting some money at the front end as opposed to applying it all at the end where it's all crumbling to bits, and doing less of some of the things that have been done at that end and also improving your efficiency and effectiveness, reducing duplication, all those sort of things, so you can invest in another end because I think it's more about how do you shift resources, than necessarily get more resources when health's going to bankrupt up the whole of the state anyway going the way we are. ID 15

A common view was that it was problematic to determine what counts as PHC eg federal funding, PBS, domiciliary care, RDNS could be all be included and this makes it difficult to keep track of changes to PHC budget over time.

Strategy 2.5 Increase accessible, appropriate and comprehensive PHC services and activities linked to regional strategic plan, PHC policy and SA Strategic Plan

The view was that the current indicators are very southern focussed and now out of date with the development of the GP Plus strategy.

Strategy 2.6 Increase coordination between acute and PHC/community based services by coordinated chronic disease management and transfer of care in both directions

This strategy was well supported. However there was a view that the indicators needed to go further to assess the impact of increased coordination on hospital admission and length of stay.

You're assuming that increasing of discharge planning in reality are connectedness and the key shared care plan that you've had an effect on chronic disease, but you're not measuring whether you have and whether there's less admissions to hospital, whether there's decreased length of stay in admissions to hospital. ID 11

Another comment was about the need to consider the role of health insurers in coordinated care.

Strategy 2.7 Provide workforce development for all staff on PHC approach and social determinants of health

For one respondent this was a given:

I think this is critically important, to me it's a philosophy which we should just do. To me it's a bit like saying to surgeons, we're going to have a strategy to make sure you're understand the importance of sharpening your scalpel, you know it's a given to me but I understand it's probably not a given to some people. ID 2

Another suggested that a PHC approach should become mandated within organisations like OHS - on every staff meeting agenda and the responsibility of the chief executive

Strategy 2.8 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

It was pointed out that consultation would need to occur with universities on this strategy. There was a concern that universities are not the appropriate place for training on the social determinants of health:

You can teach people a lot of things at an under-graduate level in a setting or a classroom I think has very little relevance unless sometimes it's seated in ... their understanding of what we're trying to deliver. ... Sometimes you've got to develop people who actually understand how they need to learn and how when they get into the right setting, they can actually find that knowledge and access and want to learn and be able to use knowledge and skills. I don't think universities in this state are necessarily involved enough in developing the capacity of the workforce, it's sort of left up to individual institutions. ID 15



e) Vision for primary health care

Finally respondents were asked to describe their vision for primary health care in the region in as simple and succinct terms as possible

The most common theme was related to service access, particularly providing services close to where people live rather than in a hospital:

It's about all people being able to get the right service in the right place in the right time. ID 2

It's something around being able to look at providing a level of service close to where people live. ID 11

This theme also incorporated ideas of equity, universal access and culturally appropriate services:

There's an equity element in there as well, so that if you're an unemployed homeless Aboriginal person, you've got just as much chance of getting the care you need as a pin-striped senior executive, but at the moment I suspect that's not the case. In fact I'm bloody sure it's not the case! ID 2

I would like to see universal primary health care, I'd like to see every person whether they're rich or poor be able to go to a good quality GP that has a holistic approach, you can go to get allied health services in the Community Health Centres, you can go to Early Childhood Services, you know that everybody has universal access to primary health care through a series of more accessible and more well resourced Primary Health Care centres and services. ID 14

Other vision elements included a common acceptance that prevention and early intervention are important and effective, increased status for PHC, an integrated health system, and a client-centred system:

My vision is that primary health care is recognised as important, if not more important, to population health status than hospitals and technological measures. That's the example I often cite, is a real one, is that if I spend 30 minutes counselling a suicidal teenager and hopefully save their life for only 35 bucks, whereas an orthopaedic surgeon gets \$2,000 for taking a cartilage out of a footballer's knee. ID 02

Clients are fully engaged with the decisions about their health care and the client's ownership of the health care and I would test that by saying is it is a decision that you want to do for yourself, or have the doctor tell you - because how many times do you hear 'the doctor's put me on these pills and I don't understand why I'm taking them' ID 3



5. Discussion

This section revisits the analytical frameworks described in Section 2 and positions the findings of the research within these frameworks.

Achieving transformational change

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

Although overall support and commitment to reform was expressed, the research identified significant policy tension between different understandings of PHC. This is similar to the findings of the pilot study in the southern region of Adelaide. The specific changes needed and ways to achieve these are open to debate. 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 PHC policy did not rate highly amongst our respondents and issues of social health and upstream health promotion appear to have lapsed in significance. The current focus on chronic disease management and the positioning of general practice at the centre of primary health care suggests a return to an 'illness' model of care. 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) and it represents a way for the health care sector to respond to current calls for a greater focus on the social determinants of health (CSDH, 2008). This model enables a focus on many health issues, including a range of chronic diseases but does so in a way that is not just focussed on management of health issues but also on primary prevention and positive health promotion. This 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 it would seem to us that the health reform process needs to be careful not to throw this particular baby out with the bathwater.

A powerful coalition of leaders to drive the change

Some powerful leaders driving change were identified in the executive staff and the Boards of Management. There was concern that the impending loss of the Board structure will have a negative impact on plans to strengthen primary health care. Board members were seen as external to the professional silos that plague attempts at radical reform and to have the ability to take a wider view of the reform process. They are also one way in which community involvement can be made real in a way that invests power with community members. With regional autonomy weakened and control vested centrally in the Department of Health, fears were expressed that the reform process would be stalled.

A simple statement of goals and vision for change that is easily and widely communicated

As Figueras et al. (2005: 334-5) suggest 'often reform programs are put in motion without a clear set of objectives.' A simple statement of goals and vision for change seems unrealistic given the many different stakeholders and interests within a regional health service. A few respondents dismissed the idea of a vision as irrelevant to health care users. Different philosophical and value bases and different uses of language are obstacles to the establishment of a simple goal and vision statement but, according to Kotter, there does need to be a vision that provides a philosophical framework and inspiration to guide the challenging process of changing a complex system. Making the vision and values of the health sector more clear and explicit in a way that goes beyond rhetoric is an essential part of the reform process but will need diplomacy and leadership.

'Small wins' along the way toward the final goal

Some of the planning documents produced by the regional health services reflect a strengthened focus on primary health care and its principles of working in partnership and engaging with the community. How effectively these plans will be implemented remains to be seen.

The willingness to confront and overcome barriers to change

While level of resources, monetary and workforce, for primary health care were rated as a barrier to reform, respondents were pessimistic about change. Expecting a shift in resources from acute to community health care was seen as unrealistic, as was much increase in overall health funding. The best that could be hoped for was some shifting of services to priority populations, with the implicit reduction of services to others. There was some effort to influence powerful groups outside the traditional state-funded primary health care sector, for example much of the resource support going to general practice was justified in terms of getting leverage to change how this sector works with the public health system.

Consolidating the improvements by ensuring that progress is not linked to the presence of key people

This research reflects the importance of ensuring that progress is not linked to the presence of a few key people as movement of personnel is common. A number of changes in key personnel took place towards the end of this research. Both regional Chief Executives have left their positions and there is a new Chief Executive in the Department of Health. The Health Minister



responsible for renewing the primary health care policy lost the portfolio in November 2005. Inevitably, as positions are filled the new occupants bring their own views of reform to the table. This emphasises the importance of reform as an organisational change process with a shared vision and strong leadership, otherwise it is easy to be deflected from the goals of health reform.

Institutionalising new approaches through checking that the changes have permeated the organisation's culture

Executive staff appear to be working hard at spreading the reform message throughout their regions. Both regions are considerably larger than the pilot site and individual health units within them have less history of working together. As described above, there is still tension between acute and community based services and considerably more time and effort is needed to create integrated organisations with a common culture. In addition to this complexity, other partners in primary health care, such as fee for service general practice, local government and NGOs, are not formally part of the regional health structure and bring their own priorities and ways of working to the mix.

A critical framework for reviewing health policy

Another approach to health policy review is described by Lewis (2005). This framework uses the interlinked elements of institutions and health systems, governance, power and influence, professions, and ideas

Institutions and health systems

Relevant issues in Australia include the national/state divide of responsibilities for funding and delivery of health services; the mix of Medicare and private funding (eg fee-for-service general practice) and the lack of national PHC policy. Historically in South Australia there are several large hospitals with high level local or consumer support and often working in competition rather than cooperatively. These factors all contribute challenges to the implementation of reform.

Respondents identified outcomes related to services rather than health outcomes suggesting strong attachment to service systems. Also identified from the data was the need for political commitment to ensure reform changes do not get derailed or watered down.

Governance

Across Australia there is a mix of governance systems for health services but most states have established regions or areas. The common feature seems to be constant re-structuring. In SA the Generation Health Review recommended a shift from individually incorporated health services to regional structures. The central health department provides funding to regional health services under a service agreement and each region has an executive director reporting to a board of management. This structure is about to change again with boards to be disbanded and regional chief executive directors to report to the Department of Health Chief Executive.

Respondents discussed barriers to reform in terms the need for consistent leadership at department level, the size and complexity of the bureaucracy, the lack of data and evaluation, and the pace of change. Much importance was placed on regional strategic plans and the boards and executive directors were identified as key drivers of reform. It is unclear at this stage how this further re-structuring will have an impact on health reform nor do there appear to be any plans to monitor this.

Power and influence

The medical profession, both as individuals and in professional associations, has traditionally yielded power and influence over health systems and policy. The combination of 'expert' knowledge and provision of services puts medical practitioners in an influential position. The media tend to focus on high drama stories such as bed shortages and waiting lists rather than prevention and health promotion initiatives. There has however been a rise in consumer and community advocacy which has led to some shift in power.

Respondents identified a need for more resources to go to PHC. The current focus on chronic disease management was seen as both a way to get the acute sector on side and as a result of the powerful influence of the medical model.

Professions

The medical professions, historically white middle class males, have dominated health systems thinking and ensured that the medical model is the paradigm underpinning health service policy and delivery. Community-based health service professions are more likely to be female and have less power within the system.

Respondents identified the fragmentation and lack of partnership approach as a key challenge to reform. Other issues were a lack of shared understanding of PHC and workforce attraction and retention.



Ideas

Despite some surface change to health policy ideation towards prevention and early intervention, the underlying structure is still focussed on providing individual services by medical or clinical professionals to people with an acute or chronic disease, or with high level risk factors.

Media and community outrage at hospital waiting lists and overcrowded emergency departments continue and any attempt to consolidate high cost specialist services is met with resistance. There has been little shifting of budgets from traditional 'illness care' to cross sector health promotion activities. Proposed governance changes may give the Minister and the DH more control over health service policy implementation but it will also lessen local opportunities for input and accountability. While consumer and community advocacy has increased, the medical professions still dominate the thinking and power relationships within the health system.



6. Conclusion

In attempting to monitor and evaluate the impact of health reform on PHC, this research has travelled a road strewn with obstacles. The questions raised at the beginning of the study

- 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?

have proved difficult to answer.

Reform and regional health service governance structures have led to some changes in placing PHC in a more central position within the health sector. All stakeholders acknowledge, at least to some extent, the importance of PHC and its role in prevention of disease, early intervention and maximising opportunities for health and wellbeing. The Boards were able to drive a focus on a broader approach to health rather than one centred on acute hospital care. Community participation on Boards and in other structures has been established. However, slippage of language and ideas have resulted in the comprehensive PHC agenda being reduced to chronic disease management and clinical interventions for individuals. While this is an important component of PHC, we know that these interventions on their own will have little impact on broader issues of population health and equity.

The research has demonstrated a lack of clear accountability mechanisms for the public reporting of PHC budgets and activities. With a fluid definition of PHC, that changes to suit political, institutional and professional perspectives (ideologies?), it is difficult to track the positioning and status of PHC within the health sector. Our research revealed that stakeholders found it impossible to agree on specific indicators for measuring PHC delivery and achievements. Figueras et al. (2005: 344) concluded that

Policy makers should make reform goals and objectives explicit, ensuring that they reflect societal values and that relative priorities and the unavoidable trade-offs between objectives are taken into account. These policy goals will need to be translated into a series of operational objectives to measure the impact of reforms.

It seems that South Australia has some way to go before there is agreement on the goals, objectives and measures associated with the current round of health reform.

However health services are structured and governed, some key factors in reform should be recognised:

- clear goals and vision that are accepted and understood by key players
- opportunities for local communities to have input to how services are organised and run
- accountability mechanisms which report to all stakeholders (including local communities)
- strong leadership and policies that are informed by evidence
- minimising the influence of power brokers and political ideologies.
- available resources to enable monitoring and evaluation of system structure and governance.



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Appendices

APPENDIX 1:

Research management

Project 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 as follows:

Mary Freer, Principal Project Officer, Strategic Coordination & Information, SA Department of Health

Helen van Eyk, Research Policy & Ethics, SA Department of Health

Chris McGowan, SAHS

Rob Pegram, CNAHS

Kae Martin, CNAHS

Gail Mondy, Executive Director, Primary and Population Health, CYWHS

Sheryle Pike, Regional Manager, Metro South Region, Child and Youth Health, CYWHS

Juli Ferguson, SAHS community member

Lyn English, CNAHS community member

Carolyn Donaghey-Harris, CYWHS community member

Project funding

This project was funded by the University Industry Collaborative Research Grants Scheme, Flinders University with a grant of \$25,000. These collaborative grants require matched funding from an industry partner, in this case the SA Department of Health provided \$25,000 and the two participating regional health services offered in-kind support.

Ethics approval

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



APPENDIX 2:

**Primary Health Care
goals and indicators framework**

Vision: Improvement and greater equity in population health status

Goal 1.

Good regional governance and infrastructure established as prerequisite to PHC including: community engagement, partnerships (including government and NGOs), leadership and agreed vision.

Goal 2.

Increased provision and reach of comprehensive primary health care services and activities, with emphasis on equity of access and underpinned by an understanding and advocacy of social, economic and other determinants of health

Vision: Improvement and greater equity in population health status

Overarching strategy: Strengthen PHC in SA health system through sub-goals and related strategies as stated below

Indicator 1-2 years	Indicators 3-4 years	Indicator 5-10 years	Measurement tools
<ul style="list-style-type: none"> • Reduction in risk factors eg overweight/obesity 	<ul style="list-style-type: none"> • Infant Mortality rates by population groups such as ATSI and SES • Low birth weight • Chronic disease rates • Injury rates across population groups such as ATSI and SES • Avoidable hospital admissions • Mental health indicator 	<ul style="list-style-type: none"> • Life expectancy across population groups by ATSI status and SES. • Prevalence of chronic disease 	<ul style="list-style-type: none"> • Health Omnibus survey • Health Monitor survey • Mortality Statistics • SA Strategic Plan



Sub-goal 1:

Establish good regional governance and infrastructure as prerequisite to primary health care including community engagement, leadership and agreed vision

Strategy 1.1 Clarify roles, management and accountability structures within region and with SA Health

Indicator 1-2 years	Indicators 3-4 years	Indicator 5-10 years	Measurement tools
<ul style="list-style-type: none"> • 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 • KPIs reported internally 	<ul style="list-style-type: none"> • 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 • KPIs reported to community 	<ul style="list-style-type: none"> • Key stakeholders (e.g. SDGP, RDNS, metro dom care etc) have an overview of the organisation and understand relationships 	<ul style="list-style-type: none"> • Document audit • Staff interviews • Survey • Monitor changes to organisational structures



Strategy 1.2 Develop and disseminate consensus vision statement on CPHC (including population health)

Indicator 1-2 years	Indicators 3-4 years	Indicator 5-10 years	Measurement tools
<ul style="list-style-type: none"> • 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 	<ul style="list-style-type: none"> • 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 	<ul style="list-style-type: none"> • Processes are in place to ensure that vision is understood and supported by key players, staff and community members • Evidence that programs and services are underpinned by an understanding of the SDOH 	<ul style="list-style-type: none"> • 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

Strategy 1.3 Ensure regional plans (and sub-plans e.g. Aboriginal Health, workforce development) are population-based and include realistic resource allocation for implementation and evaluation

Indicator 1-2 years	Indicators 3-4 years	Indicator 5-10 years	Measurement tools
<ul style="list-style-type: none"> • \$\$ amounts specified in regional plans realistically match requirements for implementation and evaluation • Plans exist 	<ul style="list-style-type: none"> • Evidence of implementation as per regional plan • Evaluation of plans against indicators 	<ul style="list-style-type: none"> • Evaluation of plans against indicators 	<ul style="list-style-type: none"> • Document audit • KPIs in planning document

Strategy 1.4 Link regional strategic plan to PHC policy and First Steps Forward and ensure planning at all levels is underpinned by an understanding of SDOH

Indicator 1-2 years	Indicators 3-4 years	Indicator 5-10 years	Measurement tools
<ul style="list-style-type: none"> • 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 	<ul style="list-style-type: none"> • evidence of implementation of plans and policies 	<ul style="list-style-type: none"> • Evaluation of plans shows that strategies have been effective and partnerships are sustained. • Evidence of increased PHC programs?? 	<ul style="list-style-type: none"> • Document analysis, board minutes/annual reports • Community awareness survey • Monitoring processes

Strategy 1.5 Ensure regional plans and structures allow for local responsiveness and accountability to local communities while retaining evidence-based planning (not just loudest voice)

Indicator 1-2 years	Indicators 3-4 years	Indicator 5-10 years	Measurement tools
<ul style="list-style-type: none"> • 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 	<ul style="list-style-type: none"> • 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 	<ul style="list-style-type: none"> • 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 	<ul style="list-style-type: none"> • 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



Strategy 1.6 Structures and processes established and resourced for community engagement

Indicator 1-2 years	Indicators 3-4 years	Indicator 5-10 years	Measurement tools
<ul style="list-style-type: none"> • Clear documentation of community participation frameworks • On-going structures to support & foster community participation / volunteers • Number of opportunities for community participation /volunteers • Number of community people participating in health service • Levels of training, support, resources 	<ul style="list-style-type: none"> • Number of opportunities for community participation • Number of community people participating in health service • Levels of training, support, resources • On-going structures to support & foster community & staff participation in planning • Number and diversity of community members in formal participation roles 	<ul style="list-style-type: none"> • Recognised consumer/ community advisory group, panel, alliance, coalition in existence for the region • Number & diversity of community members in formal participation roles • Community participation has demonstrable influence on planning processes and decisions 	<ul style="list-style-type: none"> • Survey: satisfaction, engagement & empowerment • Document analysis annual reports/ board meetings for evidence of consumer involvement • Case studies • Tools on participation that measure perceptions of usefulness & perceived level of participation

Strategy 1.7 Provide strong leadership which understands, drives, supports and advocates for comprehensive and equitable PHC

Indicator 1-2 years	Indicators 3-4 years	Indicator 5-10 years	Measurement tools
<ul style="list-style-type: none"> • % Board members and Eds/managers who 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 advocates for primary health care in public forums • Key decisions enforce commitment to PHC 	<ul style="list-style-type: none"> • 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 • Key decisions enforce commitment to PHC 	<ul style="list-style-type: none"> • 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 	<ul style="list-style-type: none"> • Board interviews • (including re briefings on primary health care to minister) • Staff and community interviews • Media monitoring • Assessment of 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



Strategy 1.8 Establish transparent and effective communication channels between ‘front-line’ staff and regional centre (see also 1.5)

Indicator 1-2 years	Indicators 3-4 years	Indicator 5-10 years	Measurement tools
<ul style="list-style-type: none"> • Communication strategy established • Whole of staff meetings across community health twice per year, linked to planning process (June and December) 	<ul style="list-style-type: none"> • 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 twice per year, linked to planning process (June and December) 	<ul style="list-style-type: none"> • 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 twice per year, linked to planning process (June and December) 	<ul style="list-style-type: none"> • Staff interviews • Assess accuracy, timeliness and appropriateness • Document audit • Randomly selected sample of staff – telephone interviews • Site visits (e.g. Vision statement visible)

Strategy 1.9 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

Indicator 1-2 years	Indicators 3-4 years	Indicator 5-10 years	Measurement tools
<ul style="list-style-type: none"> • 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) 	<ul style="list-style-type: none"> • 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 	<ul style="list-style-type: none"> • 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 <ul style="list-style-type: none"> - 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 	<ul style="list-style-type: none"> • Organisational analysis • Document audit • Staff interviews • Establish site register of partnerships and networks



Strategy 1.10 Improve IT and data management to increase utility for primary health care research practice and policy

Indicator 1-2 years	Indicators 3-4 years	Indicator 5-10 years	Measurement tools
<ul style="list-style-type: none"> Resources committed to data system development Staff consultation re data collection to ensure it reflects primary health care activity Recognition of value of data and feedback on its use 	<ul style="list-style-type: none"> 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 	<ul style="list-style-type: none"> % Staff report data collection reflects community health 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 	<ul style="list-style-type: none"> Staff interviews Document audit Extent to which data is used for planning

Strategy 1.11 Develop research and evaluation capacity

Indicator 1-2 years	Indicators 3-4 years	Indicator 5-10 years	Measurement tools
<ul style="list-style-type: none"> Regional budget for R & E baseline %\$ Baseline % staff undertaken professional development on research & evaluation MoU with university concerning R&E support including coordination of students on placement to assist with R&E needs of community health and engage in ongoing projects 	<ul style="list-style-type: none"> Standard evaluation reporting template adopted Staff have access to primary health care evidence (eg through regional subscription to appropriate databases) Increase % staff undertaken professional development on research & evaluation % staff report evaluation is a routine and core activity 	<ul style="list-style-type: none"> Increased evidence base on outcomes of PHC 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 PHC/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 	<ul style="list-style-type: none"> Document audit Staff Survey Results of comprehensive continual improvement - reports on evaluation of services



Sub-goal 2:

Increased provision and reach of comprehensive primary health care services and activities, with emphasis on equity of access and underpinned by an understanding of social, economic and other determinants of health

Strategy 2.1 Resource and implement healthy settings initiatives, identify and prioritise what ‘healthy settings’ to address eg schools

Indicator 1-2 years	Indicators 3-4 years	Indicator 5-10 years	Measurement tools
<ul style="list-style-type: none"> • 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 	<ul style="list-style-type: none"> • 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 	<ul style="list-style-type: none"> • 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 	<ul style="list-style-type: none"> • Audit strategic plan, service agreement, performance reports and budget



Strategy 2.2 Ensure that health promotion & disease prevention are integral elements of all work undertaken in region regardless of the health care setting (core business for day to day activities) links to 2.7

Indicator 1-2 years	Indicators 3-4 years	Indicator 5-10 years	Measurement tools
<ul style="list-style-type: none"> workforce development strategies have been implemented (see 2.4) Health promotion is evident in business plans (region & health unit) policy development 	<ul style="list-style-type: none"> 50% services, programs and activities include health promotion and illness prevention as core business 	<ul style="list-style-type: none"> 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 	<ul style="list-style-type: none"> Audit strategic plan, service agreement, performance reports and budget Survey staff Case note audits

Strategy 2.3 Strategic Plan developed, implemented and monitored to improve service to population groups with special needs with specific targets quantified

Indicator 1-2 years	Indicators 3-4 years	Indicator 5-10 years	Measurement tools
<ul style="list-style-type: none"> 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 Include youth as special group 	<ul style="list-style-type: none"> 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) 	<ul style="list-style-type: none"> 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. 	<ul style="list-style-type: none"> Media and communication monitoring Audit strategic plan, service agreement, performance reports and budget Population survey with questions measuring access to services

Strategy 2.4 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.

Indicator 1-2 years	Indicators 3-4 years	Indicator 5-10 years	Measurement tools
<ul style="list-style-type: none"> • 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. 	<ul style="list-style-type: none"> • 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 	<ul style="list-style-type: none"> • 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. 	<ul style="list-style-type: none"> • Audit service agreement, performance reports and budget. • Audit HR records

Strategy 2.5 Increase accessible, appropriate and comprehensive PHC services and activities linked to regional strategic plan, PHC policy and SA Strategic Plan

Indicator 1-2 years	Indicators 3-4 years	Indicator 5-10 years	Measurement tools
<ul style="list-style-type: none"> • 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 	<ul style="list-style-type: none"> • Marion PHC centre running with recurrent funding established • outreaches at Hallet Cove and Castle Plaza under development • Aldinga CHS providing locally appropriate services • increase in appropriate and timely PHC services 	<ul style="list-style-type: none"> • 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 • increase in appropriate and timely PHC services 	<ul style="list-style-type: none"> • Audit strategic plan, service agreement, performance reports and budget



Strategy 2.6 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

Indicator 1-2 years	Indicators 3-4 years	Indicator 5-10 years	Measurement tools
<ul style="list-style-type: none"> • 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 	<ul style="list-style-type: none"> • 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 	<ul style="list-style-type: none"> • 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 and length of stay 	<ul style="list-style-type: none"> • Audit share care plans • Survey patients and care team • Audit discharge planning



Strategy 2.7 Provide workforce development for all staff on PHC approach and social determinants of health

Indicator 1-2 years	Indicators 3-4 years	Indicator 5-10 years	Measurement tools
<ul style="list-style-type: none"> • 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 	<ul style="list-style-type: none"> • 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 orientation/professional development package has been developed 	<ul style="list-style-type: none"> • 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 networks provide good support to PHC practice • Professional development is monitored through performance appraisal process 	<ul style="list-style-type: none"> • Audit workforce development records

Strategy 2.8 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

Indicator 1-2 years	Indicators 3-4 years	Indicator 5-10 years	Measurement tools
<ul style="list-style-type: none"> • 25% of all graduates have understanding of (exposure to) PHC/SDOH • PHC approach integrated into some PBL case studies 	<ul style="list-style-type: none"> • 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 	<ul style="list-style-type: none"> • 75% of all graduates have understanding (exposure to) of PHC/SDOH • Increased number of placements/field visits to PHC settings 	<ul style="list-style-type: none"> • Audit tertiary health curricula • Compare with baseline data on current practice in training of health professionals • Survey graduates

