Emerging Findings

KEY POINTS FROM THE INTERVIEWS AND WORKSHOPS TO-DATE

- Based on 62 interviews
  - SA Health funders
  - Regional Health Service Executives
  - Managers
  - Practitioners
  - Admin staff

- At least 2 workshops with each site
- Audit of disciplines, funding, networks ...
- Discussion with CRG, Investigators, staff meetings
Variation

- PHC in Australia is fragmented (GP adjunct study)
- 2 NGOs
- 2 Aboriginal sites
- Size: at first audit 11 FTEs up to 170 FTE
- Different focus areas = different disciplines, programs of work
- 1 GP Plus, 1 becoming a GP Plus, 1 becoming part of superclinic
- Different approaches to Primary Health Care, different perspectives
- Fine line not to over-aggregate

Importance of Operating Environment

- Rapid change, health reform – AHS merge, GP Plus strategy, superclinics, Federal takeover, uncertainty

SA Sites:
- Chronic conditions focus

Govt services:
- Centrally imposed programs eg PEACH, DIFL
- Resource challenges eg childcare

NT:
- NT Emergency Response
- Language groups, transience/visitors

Sexual health:
- Taboo, negative media coverage, conservatism
Principles of CPHC: Current practice

Social view of health
Equitable access
Advocacy / Action on SDH
Community participation
Multi-disciplinary
Intersectoral collaboration
Prevention / health promotion
Community work
Chronic conditions / self management

Variability in emphasis

Social view of health
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Tensions (Government-managed services)

- Chronic conditions, more biomedical model/clinical/individual treatment focus

vs

- Central evidence-base, statewide programs

social view of health, comprehensive PHC

Community driven, local responsiveness

Equitable access

- Equity of access an unequivocal cornerstone, endorsed by practitioners up to government funders
- Non-Aboriginal services:
  - Priority populations (Aboriginal, newly arrived migrants, homeless, people with disabilities...)
    - Priority of access (but do they come through the door?) through to
      - Specific activities eg clinic days, outreach, community garden
- Location of service key strategy
- Barriers:
  - Transport, waiting lists, less partnerships
  - Govt non-Aboriginal services: reduction in community work and community participation
  - Awareness and promotion
**Multi-disciplinary care**

- Wide range of disciplines of staff
- Three of the sites have medical staff
- A site with no ‘direct care’ disciplines, but has a men’s health worker, women’s health worker etc.
- ‘Multi-disciplinary’ meant different things for different services
- Shared appointments, jointly run groups – esp. govt. sites, in particular early childhood teams
- Others: different professionals see “different” clients

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**Community participation**

- Were examples of community driven programs at all sites
- NGO/Community controlled, Aboriginal sites had structures, other govt services had less – reduction in community development roles
- Context: Govt services not having Boards of Management anymore

- Challenges of doing community participation
- Govt: How to balance with centrally-imposed programs. Being done at a higher level?
Advocacy / Action on Social Determinants of Health

Do health services have an obligation to take action on the conditions that affect the health of their local community?

Advocacy / Action on Social Determinants of Health

Continuum, from:
1. “Not part of my role” (clinical burden, not seeing it as part of role – clinical/project worker with specific responsibilities)

2. Client-level: e.g., writing letters of support, esp. around housing, Centrelink.

3. Through committees, networks, e.g., advocating for importance of addressing women’s health/migrant health for particular issue/context.

4. A broader, more active type of advocacy (typically NGOs)
Advocacy / Action on Social Determinants of Health

Barriers:

- 'role legitimacy', perceived ability/permission, flexibility in work role (esp. govt)

- sense of clinical burden, understaffed and overworked → low priority

Intersectoral collaboration

- Schools, DECS, kindergartens
- NGOs – Anglicare, Uniting Care Wesley
- Child care centres
- Universities – student clinics, programs/models eg PEACH
- Local government
- Prisons

- Prevent gaps in service provision, continuity of care for client
- 'Can't do it all', greater health outcomes for same resources

- Difficulties establishing partnerships – eg regionalisation, going to higher levels, understandings of social determinants
Aboriginal Health

- Context of “Close the Gap”, NT Emergency Response, also GP Plus, Superclinics
- 6 Sites, 6 different approaches to improving Aboriginal Health
- Diabetes and mental health important and relevant to Aboriginal Health
- Opportunity to examine outcomes, follow Aboriginal clients
- Intersection with community work, community participation, partnerships, accessibility and cultural respect