

Health promotion in Australian multi-disciplinary primary health care services: case studies from South Australia and the Northern Territory

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Summary

This paper reports on the health promotion and disease prevention conducted at Australian multi-disciplinary primary health care (PHC) services and considers the ways in which the organizational environment affects the extent and type of health promotion and disease prevention activity. The study involves five PHC services in Adelaide and one in Alice Springs. Four are managed by a state health department and two by boards of governance. The study is based on an audit of activities and on 68 interviews conducted with staff. All the sites undertake health promotion and recognize its importance but all report that this activity is under constant pressure resulting from the need to provide services to people who have health problems. We also found an increased focus on chronic disease management and prevention which prioritized individuals and behavioural change strategies rather than addressing social determinants affecting whole communities. There was little health promotion work that reflected a salutogenic approach to the creation of health. Most activity falls under three types: parenting and child development, chronic disease prevention and mental health. Only the non-government organizations reported advocacy on broader policy issues. Health reform and consequent reorganizations were seen to reduce the ability of some services to undertake health promotion. The paper concludes that PHC in Australia plays an important role in disease prevention, but that there is considerable scope to increase the amount of community-based health promotion which focuses on a salutogenic view of health and which engages in community partnerships.

Introduction

In the WHO Alma Ata Declaration (World Health Organization, 1978), the key emphasis of primary health care (PHC) was to prevent disease and promote health. Many countries, including Australia, are promoting PHC as a means of 'improving the quality, equity, efficiency, effectiveness and responsiveness of their health systems' (Glasgow *et al.*, 2005, p. 3). Countries with strong primary care infrastructures have been found to have lower costs and better performance on major aspects of health (Starfield and Shi, 2002). However, implementation of PHC has often been patchy and a more selective individualized

and disease-based approach has overtaken the original vision first promulgated in 1978 (Baum, 2008). Indeed, since its beginnings, the nature of PHC has been contested, with arguments that it should focus only on a few selective diseases rather than the broad Alma Ata mandate (Walsh and Warren, 1979) resulting in its disease prevention and health promotion aspects being the least developed (Baum and Sanders, 2011). The Ottawa Charter for Health Promotion (World Health Organization, 1986) drew international attention to these important aspects of PHC, arguing for a focus on healthy public policy to create environments supportive of health and, reiterating the Alma Ata ideals, strengthened community participation in, and a reorientation of health services towards, health promotion. The WHO recommitted to PHC in the 2008 World Health Report *Now More than Ever* (World Health Organization, 2008) and the Commission on the Social Determinants of Health (CSDH) (2008) has endorsed PHC as the corner stone of a health system and as a strategy for taking action on the social determinants of health at a local level. In Australia, recent reviews of the health system have also reinforced the importance of emphasis on PHC and health promotion in particular (Dwyer, 2004; National Health and Hospitals Reform Commission, 2009). Despite this, there is a paucity of research that reports on and assesses the health promotion activity of PHC services.

In Australia, PHC is largely divided between two parallel systems—a fee-for-service sector based on general medical practice and a state government funded and managed sector which differs from state to state in its forms and functions. This latter sector is frequently referred to as the community health sector and it established a tradition of undertaking innovative health promotion in the 1980 and 1990s (Baum *et al.*, 1992). Aboriginal health services are a third system that has maintained an amalgam of general medical practice and multi-disciplinary community health. Non-government organizations also provide PHC.

The origins of the Australian community health sector lie in the short lived Federal Community Health Program (National Hospital and Health Services Commission, 1973) and the development of an Aboriginal community controlled sector which pioneered the development of comprehensive PHC in Australia. Aboriginal community controlled health services developed within this context include Redfern in 1971 and Congress in 1973 (Foley, 1982; Anderson, 1994; Hunter, 1999).

Evidence on PHC's performance beyond the component of primary medical care is very limited. Most research reports on discrete program areas (such as nutrition or child health), issues or 'slices' of work (Labonte *et al.*, 2008; Hurley *et al.*, 2010). There has been little published research that has considered the ways in which PHC services as a whole approach disease prevention and health promotion. A previous study of primary medical care within PHC centres in Australia found that these doctors were more likely to report involvement in group health promotion activity and broader community development initiatives compared to their private practice counterparts who were limited by fee-for-service funding and reliance on a single discipline. The study concluded

that health promotion focused on the local community is best conducted within multi-disciplinary health centres (Baum *et al.*, 1998).

This study seeks to determine what health promotion is conducted in multi-disciplinary PHC centres and the extent to which health promotion is prioritized in these services. We recognize that health promotion operates on a continuum from medical interventions, behaviour and life style modification and interventions designed to change socio-environmental causes of disease (Labonte, 1992; Commission on Social Determinants of Health, 2008). We also conceptualize health promotion as including some activities which are primarily concerned with preventing disease and others that reflect salutogenic approaches concerned with the creation of health (Antonovsky, 1996). We note Kickbusch's (Kickbusch, 1996, p. 5) comment on Antonovsky's work that 'He is right that ... much of the literature and practice that carries health promotion in its title is just disease prevention in another guise'. In this paper, we consider the extent to which this is also true of the health promotion work in PHC services through reporting on research conducted at six PHC sites, five of which are in South Australia and one in the Northern Territory.

Methods

Overview of study

The data reported in this study were collected as the first stage of a 5-year study designed to evaluate the effectiveness of comprehensive PHC. The study is based on research partnerships with six service sites—an Aboriginal Community Controlled Organisation; an NGO sexual health service; and four services funded and managed by the South Australian government. These services were selected on the basis that they offer a range of service models and that the research teams had sufficiently good working relationships with the staff at the service to make an in-depth study of their activities extending over 5 years feasible. The entire research project is conducted as a research partnership with the study sites. Management staff from the services are involved as co-investigators in the study and involved in all major decisions about the study. Ethics approval was received from Flinders University's Social and Behavioural Research Ethics Committee and the Aboriginal Health Research Ethics Committee (South Australia).

Study sites

The services in this study differ in terms of their size, governance, population served, the services offered and the focus of their work. Table 1 provides an overview of the characteristics of the services. Four services are funded and managed by the South Australian Department of Health (SA Health) and are referred to as A, B, C, and D. The remaining two are governed by boards—Central Australian Aboriginal Congress, an Aboriginal community controlled service, and SHine SA, a sexual health service with a statewide role in promoting sexual health, who both requested to be identified in publications.

Site reports

Services collaborated with the research team to produce six monthly reports on a negotiated set of 19 questions which included staffing, discipline mix, funding, policies and programs and services. This paper draws on health promotion activity reported for the periods June–December 2009 and Jan–June 2010.

Interviews

At each site, 7 – 15 semi-structured interviews were conducted with managers, practitioners and administrative staff. In addition, regional health executive staff and representatives from the state health department were interviewed. With one exception, where two staff were interviewed together, interviews were conducted individually and privately. Interviews were conducted by seven members of the research team from the South Australian Community Health Research Unit experienced in conducting qualitative interviews between November 2009 and March 2011. The Unit is well known to PHC services in South Australia, having conducted research in collaboration with services, including many of the participating services, for over 20 years, and has a strong relationship with each of the participating sites. Except for the shorter (15 – 20 min) administration staff interviews, interviews were between 40 and 90 min in length.

A total of 68 interviews were conducted, and respondent characteristics are summarized in Table 1. Interviewees' length of experience in PHC ranged from a few months to over 30 years. Interview schedules were developed by the authors with additional expert input from other study investigators, based on the central tenets of PHC identified through literature and the team's extensive experience in PHC. Example questions include 'What advocacy work have you done in the last year?' and 'Overall, how well do you think the service contributes to improving population health?' The schedules were piloted with three practitioners and one manager, and changes made to clarify wording and reduce length. This paper uses information from these interviews to supplement and elaborate on the health promotion activity conducted at the sites.

Table 1: Positions of the participants interviewed
(*N* = 68)

Position	<i>n</i>
Health department representative	2
Regional health service executive	6
Manager	13
Practitioner	40
Aboriginal health worker/cultural worker	9
Lifestyle advisor	4
Nurse	6
Medical officer	5
Psychologist/social worker/counsellor	5
Occupational therapist	2
Speech pathologist	2
Dietitian/nutritionist	2
Project officer	3
Primary health care worker	1
Podiatrist	1
Administration staff	7

Data analysis

Thematic analysis was conducted by the authors. Codes were developed, discussed and revised during regular team meetings ensuring rigour through constant monitoring of analysis and interpretation (Morse *et al.*, 2002). Preliminary analysis revealed both emerging common themes covering underlying principles, activities, operating environment and desired outcomes as well as some divergent views, constituting a 'meaningful range' (Mason, 2002). The first author then finalized the codes concerning health promotion, and lead the development of the categories and analysis presented here. Emerging findings were presented to participants at staff meetings and to investigators and stakeholders at project meetings, and interpretations discussed with them to check their validity. All service managers were offered the opportunity to be a co-author and two (J.B., K.V.) took up this option. All service managers are sent the final drafts of all papers emanating from the study and invited to comment and agree to the submission of the paper.

Findings

Overview of disease prevention and health promotion activity Table 2 draws on the data collected for the audit and provides an overview of the disease prevention and health promotion activities reported in each service. The audit information was cross-checked and supplemented with the information from the interviews and the final listing confirmed with the services. Table 2 shows that each PHC service performed a wide range of disease prevention and health promotion roles that can be classified by who the services are designed for, the health issue they are targeting and the strategies used. Many activities cut across these classifications and address multiple groups, more than one health issue and use multiple strategies. It is this mix that makes the work of these services comprehensive, in contrast to a model which concentrates on the provision of primary medical care to individuals. We found that (with the exception of SHine SA) the services offered fell primarily into three categories: programs for children and parents, preventing chronic disease and promoting mental health; and we use these categories below to examine the activities in more detail. An overview of the activities suggests that disease prevention work was far more prevalent than salutogenic work focusing on creating health and well-being. The division between the two activities is rarely neat and may include elements of both disease prevention and salutogenic approaches. Thus supporting a play-group for African newly arrived migrants at Service C would serve to prevent disease by promoting immunization and also work to create a sense of well-being and control among the parents. While most of the activities we documented fall into disease prevention, each centre did at least some salutogenic work. Thus Service A's Community Foodies promoted healthy eating; Service C ran a Yoga group; Service B held exercise groups; Service D supported reconciliation week and promoted awareness of Aboriginal culture; Congress contributed to Alice Springs's Transformation Plan (a social and urban redevelopment plan for the town) and SHine SA was engaged in a wide range of

activities promoting healthy sexuality. The strategies used by the services clustered under:

1. primary prevention or early intervention with individuals or groups to prevent disease,
2. community education concerning health issues,
3. community development to strengthen the capacity of communities to be healthy,
4. advocacy to improve the living circumstances of individuals, and
5. advocacy for healthy public policy.

Two strategies stand out as being a feature of comprehensive PHC in the way envisaged in the Ottawa Charter and by the CSDH: working in partnership (community education and development) and advocacy for healthy public policy.

A striking feature about the health promotion partnership work undertaken by each of the sites was the breadth and range of partners with which it engaged: local government, Divisions of General Practice, a range of NGOs, other state government departments (especially education), schools, playgroups, childcare centres and neighbourhood houses. Services A, B and C reported less autonomy to engage in partnerships than in the past but were still involved in a significant number and range. SHine SA had very strong links with schools and the education department. Congress had links with local government, a planning transition team, churches, other health services and an alcohol coalition.

Table 2: Health Promotion Activity in Six Multi-disciplinary Primary Health Care Sites (2010)

Focus area	Focus on individuals	Group	Community development	Advocacy
Service A				
Children and families	Early childhood interventions, e.g. speech pathology, dietetics	Assistance with preparing food for children and on a budget Program for parents of children who were overweight	Visits, support for childcare centres, <i>Learning Together @ Home</i> (support for parents of 0–4 year olds), Aboriginal playgroup	—
Chronic conditions	Program of chronic conditions self-management Lifestyle program for people at risk of developing chronic disease	Exercise groups – walking groups, physical activity in older women Aboriginal health promotion group Healthy eating and lifestyle program	<i>Community Foodies, Community Kitchens</i> (nutrition, increase food security) Community development work with newly arrived migrant populations (particularly on nutrition, food security) Health promotion talks, e.g. <i>Keeping Well in Difficult Times</i> (chronic conditions self-management)	
Mental health	—	—	—	—
Other	Advocacy for individual clients on housing and other issues	—	Contribution to local networks, eg community safety forum, cultural diversity network	
Service B				
Children and families	Early childhood interventions, e.g. speech pathology	Program for parents of children who were overweight Group for children with speech delays	Outreach to children’s centres Aboriginal breastfeeding program, inc. peer support workers for younger Aboriginal women as lactation consultants Early intervention with Aboriginal children, inc. health promotion days	—
Chronic conditions	Lifestyle program for people at risk of developing chronic disease Program of chronic conditions self-management Nutrition clinic	Diabetes cooking and gardening Healthy eating and lifestyle program Assistance with preparing food on a budget Exercise groups—walking, physical activity groups	<i>Community Foodies</i> (volunteer group on cooking/nutrition)	
Mental health	—	—	—	—
Other	Medical health promotion, e.g. immunizations, health checks Advocacy for individual clients on housing and other issues	—	Contribution to local networks, e.g. healthy weight action plan group, nutrition and <i>Community Foodies</i> networks	

Continued

Table 2: Continued

Focus area	Focus on individuals	Group	Community development	Advocacy
Service C				
Children and families	Early childhood interventions, e.g. speech pathology, psychology	Program for parents of children who were overweight Assistance with preparing food for children Support groups for new dads, young parents Early childhood groups e.g. supported playground, African playgroup, speech, swimming, and sensory groups	Healthy eating for children Supporting schools to have healthy canteens	—
Chronic conditions	Lifestyle program for people at risk of chronic disease Program of chronic conditions self-management	Physical activity in older women group Diabetes group, inc. diabetes supermarket tour	<i>Community Foodies</i> (volunteer group on cooking/nutrition) Healthy weight peer leadership	
Mental health	<i>Community Visitors Scheme</i> (volunteer visitors to people in aged care facilities)	Domestic violence support group Meditation, yoga	Community garden for people with mental illness	
Other	Advocacy for individual clients on housing and other issues	—	Contribution to local networks e.g. local government community forum	
Service D (all programs for Aboriginal people in catchment area)				
Children and families	Maternal and infant care	Mums and bubs group Playgroup Aboriginal youth group	—	Support of national reconciliation week events Cultural awareness raising in other health services
Chronic conditions	Lifestyle program for people at risk of chronic disease Nutrition advice	—	—	
Mental health	—	—	—	—
Other	Mediation Advocacy for individual clients on housing and other issues, Family Violence etc Bowel cancer screening program	Men’s group, including camps Women’s group, including camps	Nunga lunches: regular drop-in lunches for community Support of national reconciliation week events, lead reconciliation events in region Cultural awareness raising in other health services Lead NAIDOC events in the region	

Congress (all programs designed for Aboriginal people in catchment area)				
Children and families	Child daycare Preschool program <i>Headspace</i> mental health program for young people Youth outreach, drop in Home visiting programs Antenatal care and birthing <i>Well baby</i> clinic (immunizations, development checks) <i>Targeted Family Support Service</i> (early intervention for at risk families)		<i>Community Health Education Program</i> (sexual health focused education—inc. community groups, young people, schools)	Stop the violence advocacy Advocacy on Primary Health Care, community control, alcohol, housing, Transformation Plan Community well-being program advocacy
Chronic conditions	Adult health checks (inc. screening) Chronic Disease Program (supports clients with diabetes/renal/cardiovascular conditions) <i>Frail Aged and Disabled Program</i> (outreach service supporting FAD clients)	<i>Healthy Lifestyle Program</i> (health promotion groups) Exercise groups, e.g. Pilates	Male health—health education Women's health—community health education for young women, inc. train the trainer	
Mental health	<i>Community Well-Being Program</i> (therapeutic interventions, social support and advocacy)	Program around alcohol/drug issues, inc. regular bush trips, linking clients in to training and education programs. Work with at risk youth, inc. drop in centre	Male health—health education, drop in centre, providing showers, Men's shed, cultural program Women's health—cultural program	
Other	Advocacy for individual clients on housing and other issues Medical health promotion, e.g. immunizations, health checks		Contribution to, leadership in local networks Education and training for health professionals, building capacity of local workforce	
SHine SA	Sexual Health Line Resource library lending service Health promotion interventions in counselling and medical sessions including Women's Prison Services Leaflets, fact sheets Internet resources	Health promotion with communities of interest, e.g. Refugee women's Pap Smear Awareness, programs for young people under Guardianship of the Minister, Parent and school staff sexual health	Health promotion, education talks Developing capacity of workforce to respond to sexual health—training doctors, nurses, AHWs, youth workers, disability workers, CALD workers, Pregnancy Choices training, supporting teachers to deliver Respectful relationships and sexual health education in schools Aboriginal sexual health education and promotion Youth action teams	Advocacy on sexual and reproductive health, e.g. forum on issues for international students National Sexual and Reproductive Health Strategy, State Sexual Health Strategy Sexual Health Awareness Week Sex and gender diversity advocacy, 'sex positive' advocacy Aboriginal sexual and reproductive health and well-being

The importance of partnerships indicated that much of the health promotion work is not siloed but rather conducted through a mix of informal and formal regional networks, drawing upon multiple partnerships; an approach often considered essential to effective health promotion practice (Jones and Barry, 2011).

The other activities that signified a more comprehensive approach concerned the advocacy work that the PHC services undertook. In the main, the advocacy reported by the four state government-managed services related only to issues faced by individual clients. They reported that advocacy on policies affecting groups or communities now happens at the regional level, and that they were very aware of the institutional limits on their ability to speak out:

There's doesn't seem very much scope for that because I think being part of a government agency we have to be careful about what sort of political things that we do, and if we were advocating for community against something that the government had decided, well then that wouldn't go down too well.—Service B health professional.

Table 2 shows that the two non-government services were more involved in community-level advocacy and the interviews suggested that they were freer to assume an advocacy role. These services provided an exemplar of

the ways in which PHC services can be advocates for health. One of the clinical staff at Congress commented '*I truly believe that Congress is probably one of the most powerful health advocates ... in Australia*'. Congress reported leading an advocacy campaign to reduce the harm caused by alcohol in the town in which it was situated. This campaign was run with a coalition of local agencies and groups for which Congress provided leadership. The campaign had been successful in attracting much media attention and in raising the unit price of cheap alcohol with an 18% reduction in alcohol consumption and a corresponding reduction in alcohol related harm (Senior *et al.*, 2009).

So on alcohol we've had the People's Alcohol Action Coalition since 1995 and we are mainly then working with legal practitioners, health professional groups, the churches, on a regular basis. We meet every month.—Congress health professional

Congress also reported beginning the process of advocating for improved literacy for Aboriginal people and for appropriate and safe housing. They noted that this was not their 'core business' but found through their work that both were fundamental to good health so felt that they should make time for this advocacy. This work represents a strong salutogenic view of the factors that create health. Congress staff noted that they could not devote as many resources as they would like to this work given the other pressures on their service. Congress was also very prominent in national debates about health policy (Bartlett and Boffa, 2005) as this manager explained:

So we advocate through writing submissions to enquiries. We advocate by attending federal senate enquiries into particular matters that we think are relevant to the goals. And we participate in our peak health body organisation and our national body around advocacy. But we do it individually at the level of organisations and through ministerial visits.—Congress manager.

SHine SA (the other NGO in our study) runs a high profile campaign to develop and support teachers to deliver a well-researched sexual health education program in schools particularly those in low socio-economic areas. Opposition from some politicians and religious figures has meant that the program has often been in the news and staff from the centre have been vocal defenders of the program and its benefits to young people. They have also campaigned to ensure that international students arriving in Adelaide had access to sexual health information and services, a campaign that resulted from the service's knowledge of the outcomes for these students when they did not have this access.

Further details of the types of health promotion conducted are given below in terms of the three main areas of activity: programs for children and parents, preventing chronic disease and promoting mental health.

Programs for children and parents

Many of the programs for children and parents aimed to promote health and were run at all the centres except SHine SA. This work was often done in groups which utilized the skills of a number of professionals. For example at Service C, an occupational therapist and dietician were involved with a group for children with eating issues and another which encouraged parents to play or read with their children. Service C also ran a playgroup for parents who for a range of reasons (being young, not speaking English as a first language, had a mental illness) did not use a mainstream playgroup. This group on occasion involved community health nurses and speech pathologists. A similar service was offered by Service D. Support was also given to young mothers by the Service D through Aboriginal maternal infant care workers who look after women through ante-natal care and when their babies are born. Service A offered a number of courses to encourage communication between parents and their children and language development. Service B offered services to support parents including a breastfeeding promotion group and a wellness intervention for Aboriginal children. Congress runs a nurse family partnership program providing home visitors to all mothers from early in pregnancy until the child is two. Unlike this latter program which was universal, most of the early intervention work was targeted at children for whom some developmental problem had been identified and so is perhaps better categorized as primary prevention rather than promotion of healthy childhoods. All services reported this work as having a significant element of prevention, as this regional manager highlights:

I'll go back to like the children with language delays, let's actually respond early so that there isn't the impact over the life course of those children by not being able to fully participate in society.

The four state-managed services all reported that staff conducted 'one-off' talks to school teachers about aspects of health at play groups, child care centres or workplaces. Congress also does preventive work in schools:

I think at the moment, just trying to keep our kids healthy, particularly now, because when I was growing up, we never heard anything about diabetes or anything, so getting out there to the schools I think, and the kids early, teaching about scabies, diabetes, all these things now, showing them the right things to eat and drink, so we have less and less people with diabetes.—
Congress health worker.

The ability for the services to offer a more comprehensive range of health promotion and disease prevention in relation to parents and children was shown by a salaried medical officer at Service B, who reported involvement in promoting breast feeding and infant health with Aboriginal people. This involved training young Aboriginal women as lactation consultants, actively promoting immunization, participating in health days at the local Aboriginal college and reconciliation day activities.

Chronic disease prevention

All of the sites except SHine SA reported health promotion activity which aimed to reduce the level of chronic disease in a population. At the time of our research, the four government-managed services were increasingly being asked to provide programs that had been developed by a university or central health department. These included an intervention for parents of overweight children, a program of chronic disease management where people with chronic disease set individual self-management goals and receive support to achieve these, and *'Do It for Life'*, a program for people who were at risk of chronic disease. This required services to appoint lifestyle advisors whose task it was to recruit people who were at risk for a chronic disease but as yet did not have one. The advisor worked with clients over a period of months to change their risk profile, linking with an exercise physiologist or nutritionist as necessary. The staff we spoke with expressed some concern about how well the program suited their clients:

We'll talk about something else in their life and that's what it's all about - is talking about something else and not the smoking. It could be something else that they might be worried about, not having a job, not having enough money to feed the family. So they'll go and do something else, they'll stress a lot, not eating the right food and that could lead to other issues and probably like smoking.— Service D Aboriginal Health Worker.

A number of managers and health professionals expressed concern that they were expected to deliver programs without adaptations they felt could have improved their effectiveness and acceptability for clients experiencing complex problems.

I guess some of the problems with that is it's a 12 week program done fortnightly and that just does not work with our population group. Those long length programs aren't particularly easy. It's also, a lot of the programs are PowerPoint and they don't necessarily work. What we need with our community, because of low literacy levels and low health literacy is interactive programs. . . . more experientially I guess rather than sitting and just listening to slides.— Manager

Congress, however, was able to take into account people's circumstances and the conditions of their everyday lives when developing and delivering programs and services. One of the Aboriginal health workers at Congress was very clear that his work involved him assisting people to make changes while recognizing the constraints in people's life circumstances:

It's really how you talk to people about things I suppose. Yeah, about their conditions and even about home life and helping people really. You can't just say 'you got to do this, this and this'. And people want help to do this, this and this. They want to do it, but it's finding that right road. How to get from A to B.

There are a number of factors that likely contribute to Congress's ability to respond more to local circumstances: they are a non-government organization, they have a community board, they are larger than the other participating services and they have had greater continuity in leadership, including regarding health promotion, compared to the government-managed sites.

Community development was also used to support programs designed to prevent chronic disease. A good example was the 'community foodies' program which several state-managed services participated in and which involved a partnership between local government, an adult education centre and many community volunteers:

they are volunteers that are trained in nutrition that then can go out and train other community members, so I'm a Community Foodies worker so I train the foodies and they train others One of my roles as a Community Foodies worker is to advocate for the Community Foodies, so if they need something, or if they need training, or if they'd like to do an activity, or they need some funding then it's my job to put my hand up and try to find them those things.—
Service A health professional

This program has benefits in terms of increasing knowledge about healthy diets but also aims to increase self-efficacy, social connectedness and to build community capacity. Community development techniques were reported by both Aboriginal services and were used as a means to engage people in conversation about health issues in an acceptable, non-threatening way. This approach was seen at the camps run by Service D:

At camps it's wonderful, there's a lot given out at camps because you've got them, they can't go anywhere, 'You're stuck with us for four days.' We have certain sessions every day, there are maybe three different sessions. You've got your little fun time, it's not a prison so you can go fishing now and when we come back we'll wash up, . . . then at three o'clock we're meeting in the boardroom at the camp we're at and we've got someone talking about kidney and alcohol and drugs and everything.— Service D Aboriginal Health Worker.

Mental health

All sites offered services aimed at preventing mental illness usually concerned with coping with depression and anxiety. For example, Service C offers meditation and yoga groups and Service D often tackled mental health issues through camps and community development activities. The four state-managed services reported that they did less work relevant to mental health (such as violence prevention) because there was pressure on them to respond to chronic disease. Congress has a social and emotional well-being program which focuses on mental health including a community development suicide prevention program, and support and educational programs for persons with mental illness primarily delivered through group work. Congress also runs the *headspace* program aimed at early intervention in mental illness with young

people. SHine SA was very aware that their work in promoting sexual health is also important to good mental health—as one of their workers put it *‘your control of your sexuality and your fertility impacts on mental health’*. So they played a key role in de-stigmatizing sexual choices and increasing sexual health literacy which was seen as good for both mental health and general well-being.

Service C provided an example of a long-standing program which supported people with mental illness who were living in supported residential facilities. This included a community garden of which a worker said:

We’ve got a little garden at the back here and people from supported residential facilities are brought across three times a week, to do healthy activity, gardening, and eating the veggies and doing healthy solutions . . . So people from supported residential facilities who would have never known that we are here, now have an appointment to see social workers, and to see lifestyle advisers, and to see the exercise physiologist...

Clearly this community garden was seen by staff as having a significant preventive role in helping people with mental illness stay well.

Size of the service

The services in this study ranged widely in size, from 12 to over 300 staff (Table 3). There were some indications staff felt the size of their service influenced their capacity for health promotion activity. One Congress practitioner felt ‘we’re so large we are often in a position to do something about a lot of [social determinants]’. The smaller services tended to feel like their work only ‘scrapes the surface’ (Practitioner, Service A) because of the small number of staff. As one regional health executive reflected: ‘when you look at what resources we’ve got, it’s minimal. It’s a drop in the ocean’.

Organizational support for disease prevention and health promotion

A theme running through the interviews was the pressures that mitigated against the workers undertaking disease prevention and health promotion. Our study is being conducted at a time in which the nature of PHC is undergoing change in Australia. The Federal Labor government embarked on a series of health care reforms in 2009 which intend to bring PHC more under the control of the Federal government. In anticipation of these reforms, the South Australian government has instituted a series of reorganizations of its PHC services. In addition, the Federal government supported by State and Territory governments has committed to the ‘Close the Gap’ campaign which aims to close the gap in life expectancy (Australian Institute of Health and Welfare, 2008) between Aboriginal and non-Aboriginal Australians. Congress, SHine SA and Service D have received significant funds from this initiative. All sites managed by SA Health have been significantly affected by health care reform.

Table 3: Characteristics of the six case study sites

Site	Budget (p.a.)	Main source of funding and management	Location	Approximate number of staff (FTE)	Disciplines employed
Service A	\$1.2m	SA Health funded and managed	Outer Metro	16 (13.5)	Social worker, nurse, speech pathologist, occupational therapist, dietitian, cultural worker, lifestyle advisor
Service B	\$1.1m	SA Health funded and managed	Inner Metro	26 (20)	Medical officer, lifestyle advisor, PHC worker, podiatrist, nurse, speech pathologist
Service C	\$1.7 m	SA Health funded and managed	Inner Metro	36 (22)	Nurse, dietitian, speech pathologist, psychologist, occupational therapist, cultural worker, social worker
Service D	\$0.5m	SA Health	Outer Metro	12 (10.8)	Aboriginal health worker, PHC worker
SHine SA	\$6.1m	SA Health + Commonwealth Dept. of Health & Ageing, Non-government organization with Board of Management	Inner Metro	100 (55)	Medical officer, nurse, counsellor, workforce educator, community health worker, disability worker, Aboriginal educator, multicultural worker
Congress	\$20m	Commonwealth Dept. of Health, Community controlled board of management	Regional City	320 (188)	Medical officer, psychologist, social worker, youth worker, midwife, nurse, Aboriginal health worker, pharmacist

Services A, B and C were formed when there was a strong policy emphasis on PHC, then termed ‘community health’. Centres operated as incorporated units with boards of management and the ability to set locally driven priorities. Governance changes over the last decade have resulted in a progressive withdrawal of local autonomy from the services. At the time the research commenced the services were integrated within regional health organizations. During the course of the research, the regions themselves were merged into a single metropolitan entity.

All service staff spoke of reform fatigue and loss of autonomy resulting from organizational restructuring and changed priorities. A typical comment made by a regional manager was:

Broader community participation, it doesn’t really fit with the command and control culture, which it’s hard to overstate how much the culture has changed ... the whole culture has really quite significantly changed, and it’s to a large extent around budget and around defining what is health’s business and what isn’t health’s business, and cutting off things that we can save money on.

Interviewees reported less local autonomy than in the past and new priorities that focused much more directly on specific proximal risk factors for chronic disease and on providing services to individuals rather than on integrating community development and advocacy into such approaches. The accounts in Services A, B and C suggested that the climate of uncertainty and organizational change compromised longer term plans for health promotion which require a degree of stability and organizational certainty. All services reported some frustration with funding models that essentially underpin a more selective

approach to PHC by targeting particular diseases and requiring specific programs to be developed in response to these diseases. This has led to the development of parallel disease programs that are variously funded by the Federal and/or State governments and which are seen to have detracted from the capacity of the services to work locally to define needs and priorities.

Despite these organizational issues which created a less than ideal environment for health promotion, it was evident from all the interviewees' accounts that they put a strong emphasis on the importance of disease prevention and health promotion. The pressures to respond to chronic disease, however, were overwhelming efforts to undertake health promotion, especially that of a more salutogenic variety. This was particularly acute in terms of the Aboriginal services. Congress staff were well aware that they were servicing people whose health status was among the worst in Australia as a board member noted *'We're dealing with very sick, vulnerable, disempowered, sad, depressed, sick population'* and noted that the history of colonization and dispossession created *'a lot of confusion and conflict . . . Stress and distress in the community is enormous. People are constantly worrying, worrying, worrying. Worrying for country'*.

These pressures to provide treatment services as a first priority led one Congress board member comment Well I don't think that there's a strong enough focus on primary prevention, so health promotion activities etc. The focus is on treating disease rather than preventing it.

One of the staff in Service C made a similar comment reflecting the pressures of responding to demand: *'a lot of workers do feel the incredible demand on services . . . I mean I've got months long, months and months waiting lists'*.

Conclusions and lessons for health promotion and phc practice

Our study has shown that each of the PHC sites undertakes significant amounts of disease prevention work and a more limited range of health promotion activity. We found that their staff are well aware of the importance of both activities. Interviewees at all sites made it clear that they would like to do more disease prevention and health promotion work but that the pressures of dealing with the immediate demand for curative services often means that health promotion takes a back seat. The health promotion movement has long recognized the constant tension between targeting high-risk individuals compared with strategies addressing a whole population (Labonte, 1989; Dahlgren and Whitehead, 2006; Baum, 2008; Frohlich and Potvin, 2008) and we found in our study that most effort is given to intervention with high-risk individuals. We also found that responding to growing levels of chronic disease was the focus of the four state-managed services. In the 1980 and 1990s, the South Australian community health centres were recognized for the very innovative work that they did in developing health promotion programs that responded to local need in the context of a social understanding of health (Baum, 1995). At that time, these centres were governed by their own boards

of management, a situation which contrasts with their current governance under a regional health service. The more centrally directed government agenda of responding to chronic disease appears to have come to dominate the work of the South Australian government-managed services. The two services with their own governance structures appear more readily responsive to hearing community needs and to be doing more from a salutogenic model to address the underlying determinants of health. All sites reported being part of a complex network of services that were involved in health promotion including local government, NGOs and other government departments. Staff from the state-managed PHC services reported that they were less able to engage in health promotion partnership work than in the past. Most likely, this is because recent health reforms have meant that they have less local autonomy and so have less ability to take initiative, two important criteria identified as key to successful partnership (Kalucy, 2009). The two NGOs with their own boards of management were more able to develop partnerships and use these for advocacy. This study was conducted at a time of significant health reform in Australia. A climate of uncertainty is not one in which health promotion flourishes. Health promotion requires careful strategic planning and this is difficult in an environment of almost continual reorganization (Van Eyk *et al.*, 2001; Braithwaite *et al.*, 2005). The demand for curative services means that this work is able to continue more easily than health promotion activity much of which relies on a significant degree of strategic planning which appears to be a casualty of organizational change. The strategic directions reported by the services from their regional health services and the health department were placing most emphasis on models of chronic disease self-management and lifestyle advice programs. A similar trend has been noted in Canada and elsewhere (Raphael *et al.*, 2008; Sanders *et al.*, 2008) where a broader social ideological reliance on individualism and neo-liberalism has led to de-socialized and de-politicized approaches to health, and a retreat to more medicalized and behavioural models of health promotion. The emphasis on chronic disease management and prevention is reinforced by funding streams which are disease specific. This form of funding was perceived to have led to a more selective form of PHC which detracts from the ability of services to define needs and priorities in collaboration with local communities. The health promotion activities, with the notable exception of Congress, appear to be largely dominated by service or practitioner led programs, with community participation in the planning, scope and focus of health promotion activity quite limited. These trends pose an important question for health promotion practiced within PHC about the degree to which they are able to move beyond a focus on people with existing risk factors and health problems to taking a broader salutogenic view of health within their local community (Antonovsky, 1996; Kickbusch, 1996). How able will they be to embody the re-orientation of health services towards a focus on community empowerment and healthy public policy envisaged in the Ottawa Charter?

Most research on health promotion in PHC services reports on one particular activity. This paper has provided an overview of the complete range of disease prevention and health promotion services offered in six PHC services. Despite the limitations noted above, our study suggests that each of these services offers a more comprehensive health promotion response than models of PHC based on primary medical care. This study has highlighted the diversity of Australian PHC service models which reflect the variety of organizational governance arrangement and the diversity of funding streams.

Population health promotion in Australia would be well served by strengthening the role of PHC in health promotion but this needs to be done in a way that ensures PHC services remain primarily responsive to their local communities and their needs and which includes action, particularly advocacy, on the underlying social determinants of health. Our study to date indicates that multidisciplinary PHC services provide a significant range of disease prevention activities and with additional resources and good planning would be well-placed to undertake comprehensive health promotion with their communities based on a salutogenic view of health which starts, in Kickbusch's (1996, p. 5) conception with health creation 'where people live, love, work and play'.

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