Best Practice in Primary Health Care

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Contents

1. Summary and Recommendations

This study was conceived as a contribution to strengthening the primary health care sector in Australia.

We have viewed primary health care in the terms of the primary health care policy model which delineates a sector of service delivery (the primary health care sector); articulates a set of principles to guide practice in the sector; and projects a set of outcomes that will follow if those norms of practice are realised in the sector.[1]

The primary health care sector in Australia is well resourced in aggregate terms but the principles of the primary health care model are not so widely realised in practice. This is particularly so with regard to the networking functions, the involvement of consumers and communities, the adoption of a social health approach and in integrating the micro and macro levels of analysis in practice (addressing people's immediate needs in ways which also contribute to redressing the underlying conditions which reproduce those patterns of need).

The purpose of this project was to collect a number of cases where these functions were being confidently and effectively addressed and to look for commonalities. We hoped to throw light on how some agencies were able to realise the ideals of primary health care in their practice and derive from that generalisations which might inform policy making and better practice. We also hoped to capture vignettes of good practice which would serve as benchmarks for agencies and practitioners striving to achieve world's best practice.

This study was also conceived as a search for strategies through which primary health care might adapt more effectively to contemporary changes in the wider policy environment. These changes affect the health needs and the environment within which programs and services are funded.

On the needs side there are two trends of particular significance: first, the widening inequalities in wealth and income, nationally and globally, and the implications this widening gap carries for widening health inequalities; second, the continuing degradation of human environments and the implications of this trend for health. The primary health care narrative recognises issues of equity in health and the interrelations of health and ecology. However, giving effect to these principles is increasingly difficult in a policy environment which is dominated by the slogan of international competitiveness and the strategies of neo-liberal economics (which may in fact be exacerbating economic inequality and environmental degradation).

These contradictions underline the importance of 'thinking globally while acting locally' in primary health care. However, this is easier to say than do and we felt that there was a need to look more closely at what it might mean in practice.

One of the most signal manifestations of neo-liberalism in health funding and health program administration has been the widespread introduction of market-oriented policies in the

[1] National Centre for Epidemiology and Population Health (1992), Improving Australia's health: the role of primary health care, the final report of the review of the role of primary health care in health promotion in Australia. DG Legge, DN McDonald, C Benger, Canberra: NCEPH, ANY

administration of public sector programs. With this movement has come an increasing focus on the measurement of health care and public health outcomes and the construction of program funding in terms of the prospective purchase of specified outputs or outcomes.

Primary health care has traditionally had a strong focus on organisational arrangements (such as community involvement) and on the principles of practice. However, the outcomes of primary health care have not been so clearly delineated. If advocates of primary health care are to engage with the discourse of outcomes and the sale and purchase of health care we felt the need for a clearer focus on the outcomes of primary health care.

In searching for resources which might be useful in adapting the primary health care model to new circumstances we have borrowed widely including from new thinking in corporate management. Two resources which we have drawn from this latter source are, first, the strategies of best practice in the pursuit of excellence and, second, the concept of organisational learning as a frame for thinking about managing change. This research is an exploration of the proposition that the primary health care tradition can learn about the pursuit of excellence from the best practice movement and about managing change from corporate thinking about organisational learning.

These background issues are developed in more detail in Chapter Two.

Objectives

The formal objectives of the study were to:

(i) survey recent descriptive accounts of primary health care in Australia with a focus on the networking, social health and developmental functions and to provide wider access to these reports by publishing abstracts and bibliographic details;
(ii) delineate more clearly the kinds of outcomes which are presently being achieved in primary health care in Australia;
(iii) delineate more clearly the patterns of practice which, in contemporary Australian conditions, lead to excellent outcomes and to delineate the pre-conditions for such patterns of practice;
(iv) identify possible themes and directions for professional development activities which would support primary health care practitioners in their striving for best practice;
(v) identify possible directions with respect to policy and program development which would help to create more favourable conditions for good practice in primary health care; and
(vi) identify and publish benchmarks of best practice in primary health care with a focus on the networking, social health and developmental functions.

Methods

This report presents a survey of 185 published accounts of primary health care practice; reviewer evaluations of 99 cases and an interview-based analysis of 25 highly rated cases. Our evaluation and analysis of these cases was organised around the structure => process =>outcomes model. (We conclude that this model is useful but too simple; see Chapter Nine.)

Collection and dissemination

The purpose of this first phase of the study was to identify as large a sample as possible (within the limits of our resources) of recent, well documented accounts of episodes of primary health care practice in Australia, focussing on the networking aspects of primary health care.

Our purpose in collecting these case studies was threefold:

- to create a bibliographic resource for the wider field;
- to create a data base for the Reviewer Evaluation and the Interview Studies; and
- to describe the distribution of published case studies in terms of topic, state of origin and institutional source.

We collected 185 published (or public domain) reports in accordance with four selection criteria:

- passages of practice undertaken within the primary health care sector in Australia;
- well documented with respect to process and outcomes;
- recent (1990 - 1994); and
- cases to include networking, social health or developmental aspects of primary health care practice (as distinct from purely clinical or single discipline professional work).

Abstracts and bibliographic details of these 185 cases have been published[2] and placed upon the HEAPS database[3]. These 185 stories include reports of projects, descriptions of episodes of organisational development and evaluations of models of program delivery. A descriptive analysis of the collection is presented in Chapter Three of this report.

Reviewer evaluation study

The objectives of the next phase of the study were, first, to explore the relationships between project outcomes and selected aspects of practice, as reflected in the judgements of peer reviewers and, second, to select, through a peer review process, a subset of 25 cases of excellent and contemporary practice in primary health care in Australia for more intensive study.

Five criteria were established for including cases in this phase of the study. These criteria corresponded to our interest in the networking, social health and developmental aspects of primary health care practice. These criteria were cast as aspects of practice and comprised:

- consumer and community involvement;
- collaborative local networking;
- vertical networking;

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[2] Butler P, Legge DG, Wilson G and Wright M (1995), Towards best practice in primary health care. Melbourne: Centre for Development and Innovation in Health.

[3] HEAPS (health Education and Promotion System) is a database of health promotion programs and resources, designed for personal computers and produced and maintained for the Commonwealth Department of Health and Family Services by Prometheus Information, PO Box 2319, Canberra, 2601; phone: (06) 257 7356; fax (06) 251 5284

- macro/micro balance (integrating a concern for the micro or immediate issues with the longer term or macro issues); and
- change consciousness.

For inclusion in the sample for this study at least three of these study criteria had to be judged to be present in significant degree in the case study.

These criteria corresponded broadly to the norms of primary health care practice but were focussed particularly on the four areas where Australian practice had been shown to be weak[4]. The fifth study criterion, change consciousness, was added as a consequence of our interest in best practice and organisational learning.

Ninety-nine case studies were selected from the larger data base and were despatched, each to a panel of three reviewers.

Reviewers were asked to provide a single global outcomes rating (in relation to the case as a single entity) and to comment on the relevance, to the outcomes achieved, of each of the five aspects of practice.

In commenting on the relevance of each aspect of practice, reviewers were asked to choose between four closed categorisations of relevance:

(i) that presence was positive;
(ii) that absence was deleterious;
(iii) the aspect of practice was irrelevant; or
(iv) can't judge.

The methods and results of this analysis are presented in detail in Chapter Four.

Interview study

We identified 25 cases which had been rated highly in the reviewer evaluation study and we interviewed at least two people who had been associated with each case, seeking to clarify:

- the outcomes which had been achieved;
- the patterns of practice which had contributed to the achievement of those outcomes; and
- the structural pre-conditions for producing those patterns of practice.

An abstract of each of these 25 cases is included in Appendix One of this report.

We then reviewed all of the documentation we had on all 25 cases with a view to drawing together a coherent account of the outcomes achieved, the patterns of practice which contributed to those outcomes and the pre-conditions for those patterns of practice. A coding frame was developed out

[4] NCEPH (1992), op cit.

of the case material so generated, structured around the broad headings of pre-conditions, strategies of practice and outcomes, and each case was indexed in relation to relevant codes.

Our analysis of this material is reported in Chapters Six, Seven and Eight, dealing with pre-conditions, strategies and outcomes respectively. A detailed account of the methods used in the interview study is provided in Chapter Five.

Findings

Collection

An analysis of the 185 case studies collected is presented in Chapter Three. The highlights are as follows:

- the total number of cases found, across the field of search, was disappointing;
- primary health care which takes a social health view and/or builds upon networks of collaboration and/or confronts the challenges of change is either not being undertaken or where it is being undertaken it is not being documented or where it is being documented it is not being published (in the media included in this search);
- certain topic areas, in particular occupational health, were strikingly sparse in the field of our search; and
- certain states, such as NSW and metropolitan Queensland, were dramatically under represented in the collection.

Reviewer evaluation

As described, 99 case studies were despatched to reviewers for their assessment of outcomes and the five aspects of process and general comment. (The reviewer reports for one of the case studies were unusable. Thus 98 cases were analysed.)

The findings of the reviewer evaluation study:

- confirm that, in the reviewers' judgement, most of the 98 cases analysed had achieved very good to excellent outcomes;
- demonstrate a strong association, in the reviewers' judgements, between good outcomes and 'present and positive' ratings for consumer and community involvement, macro/micro balance and change consciousness; and
- suggest that in the reviewers' judgement, vertical networking and collaborative local networking might not be as closely tied to the achievement of good outcomes as community involvement, macro/micro balance and change consciousness.

Interview study

The 25 most highly rated cases were selected for a more detailed data collection through interviews with protagonists.

The analysis of the interview data was structured around:

- the outcomes of primary health care practice;
- strategies of primary health care, with a focus on how these strategies contribute to valued outcomes; and
- an analysis of the pre-conditions for best practice in primary health care, with a focus on how these pre-conditions enable good practice to be achieved.

Outcomes

We categorised the outcomes data (see Chapter Eight) in terms of the time at which particular outcomes are or will be valued. This created three levels of outcome:

- the outcomes we value for today (immediate health gains);
- the outcomes we value for tomorrow (including improvements in the social conditions for health and the strengthening of identified health care programs and services); and
- the outcomes we value for 'the day after tomorrow' (community, institutional and professional capability-building).

We also explored a second categorisation based on the economic distinction between consumption goods and investment goods. This would classify outcomes into immediate health gain outcomes (analogous to consumption expenditure) and the creation of health capital (analogous to investment).

The key finding is that as well as immediate health gains, the outcomes of primary health care practice include the strengthening of services and programs, the creation of the conditions for healthier communities and building a capacity for better decisions tomorrow. This has particular significance in view of the increasing use of health care funding mechanisms such as output-based funding. Most of the investment type outcomes are difficult to measure and difficult also to specify in any detail in advance.

Strategies of practice

We have structured the description of primary health care practice which emerges from the study around eight elements of practice or strategies of primary health care. These strategies are:

- consumer and community involvement;
- collaborative local networking;
- strong vertical partnerships;
- intersectoral collaboration;
- integration of the macro and micro;
- organisational learning;
- policy participation; and
- good management.

These are broad categories within which we have grouped the elements of primary health care practice which emerged in the study. The finer codes which constitute each of these broad

elements are described in detail in Chapter Seven, with a focus on how they contribute to valued outcomes.

Pre-conditions

We have ordered our data about the pre-conditions for best practice in primary health care in terms of the following broad categories:

- clarity of need;
- strong and well resourced communities;
- supportive policy and program environment;
- supportive organisational environment;
- well prepared and committed workforce; and
- inspirational leadership.

The finer codes which constitute each of these broad elements are described in detail in Chapter Six, with a focus on how they enable good practice.

The outcomes/pre-conditions cycle

Limitations of the structure => process => outcomes model emerged clearly in the course of our analysis of the interview data.

It became increasingly obvious that the distinctions between these categories depend on the framing of the stories being told (eg short or long time frames) and on the purpose of the teller. If our interest is in day by day practice we construct a story which speaks in these terms; if our interest is in policy and program development we recast the field in different terms. For example, 'strength of community' was identified as a pre-condition for good practice, 'community involvement' was identified as an element of good practice, and 'community strengthening' was identified as an outcome.

There are a number of thematic continuities like this which weave their way through the stories of pre-conditions, elements of practice and outcomes. Indeed a number of new categories (under the headings of pre-conditions, elements of practice and outcomes) were added to our model, because of the logic of these continuities.

Recommendations

Our recommendations are listed below. Chapter Nine of this report details our conclusions and provides the context for the recommendations listed below.

Human resource development

Our fourth objective was to identify possible themes and directions for human resource development which would support primary health care practitioners in their striving to achieve best practice.

Our findings point to a number of key areas where investment in people development is likely to contribute to improved outcomes:

- supporting consumer and community involvement in health;
- developing styles of practice which address people's immediate needs but do so in ways which also contribute to redressing the structural influences which reproduce those patterns of need;
- managing change; anticipating and managing the impact of changing circumstances on health service organisations and programs;
- participating actively in system wide learning and policy making with a view to shaping the directions of change in the wider health service environment;
- leadership development; and
- management development.

These provide clear themes for human resource development in the primary health care sector but they also highlight the lack of institutional infrastructure through which such educational and other programs might be offered. The introduction of divisions is addressing some priority needs within general practice. However, there are others in the primary health care sector who also need resourcing (for example: nurses, pharmacists, local government staff, consumer activists and community volunteers) and there is an important need for multi-disciplinary fora where listening and shared commitment among people from different backgrounds can be cultivated.

In order to give our recommendations a strong practical orientation we have drawn upon earlier recommendations for the establishment of primary health care reference centres as a strategy for mobilising support to the primary health care sector on a multi-disciplinary basis. It is clear that such a strategy would require a network of centres, each operating on a regional basis, however they were to be designated, auspiced and funded.

Recommendations

Developing an appropriate infrastructure to support continuing human resource development in primary health care would be a strategic investment in better health for Australians.

We recommend that, in the context of developing a National partnership for public health, the Commonwealth, states and territories commit themselves to working with educational institutions and appropriate professional and peak bodies with a view to establishing a national network of primary health care reference centres, on a regional basis and with a multi-disciplinary orientation.

Among the key functions of these reference centres would be:

- supporting professional development opportunities for agency and program managers;
- nurturing a culture of organisational learning within the primary health care sector;
- supporting system-wide learning (research, evaluation, critical reflection, teaching, policy work, etc) with regard to consumer and community involvement, macro/micro balance, policy participation, organisational learning and improved collaboration (locally, vertically and intersectorally); and

- encouraging the search for best practice by supporting the documentation of contemporary primary health care practice and access to and dissemination of such documents.

We envisage that the proposed PHCRCs would have a direct staff capacity for education, evaluation, research and policy but would also carry out a brokerage function in linking primary health care practitioners to academic researchers and other resource people; and directing local fellowships, exchange visits and scholarships that would develop local leadership capabilities.

Policy and program development

Our fifth objective was to identify possible directions with respect to policy and program development which would help to create more favourable conditions for good practice in primary health care.

One such direction would be to provide infrastructure support for the kinds of professional development work we have outlined above.

However, there are also policy initiatives which could be taken which would contribute directly to a more supportive policy and program environment and a more supportive organisational environment with primary health care agencies.

Our findings in relation to outcomes are also relevant to policy making. Our data constitute a strong case for widening prevailing definitions of outcomes to include capability building, the building of 'health capital'. These are outcomes that cannot be so easily measured nor specified in advance and this has implications for reconstructing health service funding as the prospective purchase of outcomes.

Recommendations

Australia needs an overarching policy framework which would guide the development of primary health care programs, services and culture.

We recommend that the Commonwealth and States and Territories develop a National Primary Health Care Policy and Action Plan (within or independent of the proposed National Public Health Partnership).

We recommend that the proposed Primary Health Care Policy incorporate a set of goals and targets for the strengthening of the primary health care sector which would correspond to the pre-conditions for good practice identified in this report.

We recommend that policy objectives formalised in the proposed Primary Health Care Policy would recognise the 'investment-type' outcomes of primary health care practice (the building of health capital) as well as the immediate health outcomes, notwithstanding the difficulties in measuring such outcomes and in specifying them precisely in advance.

We recommend that the proposed Primary Health Care Policy would be directed in particular towards:

- strengthening consumer and community involvement;
- cultivating organisational learning across the health sector (integrating previously disparate activities such as research, education, planning, evaluation etc around a shared vision); and
- strengthening local, vertical and intersectoral collaboration.

We recommend that the proposed Policy include provision for funding support for innovative program development and evaluation in primary health care.

We recommend that the proposed Policy be developed as a vehicle for an inclusive conversation which involves all of the main stakeholders in primary health care. We envisage the discussions around the development of this Policy as contributing to the emergence of a shared understanding across the sector which would contribute to greater coordination and complementarity of people's practice. The participation of practitioners and consumer and community activists in the policy conversation would need to be actively supported.

We endorse the strategies suggested by the National Health Strategy[5] for strengthening consumer and community participation in health issues. We recommend that these strategies be incorporated in a National Primary Health Care Policy.

We affirm the importance of funding support (such as is currently provided at the National level through the Community Organisations Support Program) in strengthening the institutional fabric of consumer and community involvement at the State/territory and National levels. Funding is needed to support publications, conferences, education and training and consumer-perspective research as well as administration.

Benchmarks of best practice in primary health care

Our final objective was to identify and publish benchmark cases illustrating various facets of best practice in primary health care. This we have done in some detail in Chapters Six, Seven and Eight. The case material which we refer to in these chapters is rich.

One of our strongest conclusions from this project is the usefulness of the best practice approach to quality improvement in primary health care. The emphasis on looking for benchmarks in real life practice ensures a sensitivity to changing environments. The precept of looking for benchmarks from wide afield encourages innovation. The practice of visiting other organisations encourages a holistic approach to benchmarking which does not create unhelpful divisions between outcomes, processes and structure or between research and practice. The involvement of labour and management in the processes of assessment and planning makes win-win change more likely. The emphasis on customer satisfaction captures the concerns of the primary health care model for

[5] National Health Strategy (1993), Healthy participation: achieving greater public participation and accountability in the Australian health care system. NHS Background Paper No. 12, Melbourne: NHS

consumer and community involvement more broadly than do those models which reduce the role of the customer to their choice of vendor and to buy or exit in the health care market.

Recommendations

We recommend that the Commonwealth's Best Practice in the Health Care Sector program be continued with a brief to include a stronger focus on primary health care.

We recommend that the proposed Primary Health Care Policy ensure that support is provided for continuing documentation of passages of practice in primary health care.

We recommend that the Commonwealth, State and Territory health authorities agree to ensure that reports of all funded projects (Commonwealth, State and non-Government) should be at least indexed in a recognised bibliographic database, such as HEAPS, and that original reports be deposited in an accessible place.

Further research

The research we have reported in this study points to a range of further topics and strategies for public health research.

Recommendations

We recommend that the research funding agencies elicit and fund appropriate research proposals in the following areas:

- action research, directed at understanding the dynamics of the outcomes => pre-conditions cycle identified in this project;
- studies of the pre-conditions for best practice in primary health care and the degree to which the outcomes of good practice put in place the pre-conditions for better practice;
- exploration of models of accountability for the 'investment-type' outcomes in primary health care;
- explorations of the role of consumer and community involvement in creating the conditions for better health (including the three mechanisms identified in this study: determining priorities, exercising power and acquiring ownership of professional knowledges, methods and skills);
- documentation and assessment of the Victorian and South Australian experience in population-based consumer and community involvement as effected through the Victorian District Health Councils and the South Australian Health and Social Welfare Councils;
- study of barriers to and strategies for integrating micro and macro levels of analysis in primary health care practice including action research with practitioners and case study research;

- the impact of different arrangements for the funding of primary health care on the pre-conditions, patterns of practice and outcomes achieved in primary health care.

We recommend that research funding agencies continue to explore innovative research strategies including practitioner-based research, consumer-perspective research and policy-oriented research.

2. Background and Objectives

Over the last two decades, members of CDIH[6] have been working in different settings and with a range of different strategies towards more effective health care. More effective health care includes services and programs which are technically effective and economically efficient. However, it also implies services and programs which address the health issues of communities as well as individuals and which reconcile the social and existential dimensions of health care with the technical and the biological.

We have worked in hospitals, community health centres, state and local governments and academia. We have worked with quality assurance and program evaluation, in consumer rights and community involvement, in community education, community development, women's health and primary health care. We have worked at different levels also, from the micro details of practice-in-the-field to the more macro canvass of policy development.

We have been particularly concerned about how to address health problems associated with social and economic inequalities (globally as well as within Australia) and the current and threatened health problems associated with environmental degradation. Health issues such as these call for models of health care which reconcile the sectoral practice of health care with the wider civic project of social development (working towards a more equitable and sustainable world)[7].

In one sense, the goal of this research project was to develop our own practice; to look afresh at what we have been trying to do; to relate it more clearly to the changing environments in which we have been working; to rethink some of our own assumptions and strategies. Obviously we are not alone in this project. There are many different people working in a variety of settings who are striving in all sorts of ways towards the same kinds of ends. We would like this project to be a contribution to their work also.

Primary health care

In recent years we have used the primary health care model as a way of organising much of our work. Primary health care aspires to integrate:

- the personal and population levels of analysis;
- the technical and biological with the social and existential aspects of health care; and
- the sectoral tasks of health care delivery with the wider civic project of social development.

[6] The Centre for Development and Innovation in Health Inc (CDIH) is a not-for-profit research, education and policy organisation. The centre is committed to a world which is equitable, sustainable and health and to a health system which contributes to achieving this end. Members of the wider CDIH group come from a wide range of settings including primary health care, hospitals, public health and health promotion.

[7] See, for example, WHO (1994), *Community action for health.* Background document for technical discussions at the 47th World Health Assembly, Geneva: WHO

Primary health care is a complex concept.[8] We have found it useful to think of it as a narrative or story.[9] It is a narrative about a sector of service delivery (the primary health care sector); about a set of principles of practice (the primary health care approach); and about a set of projected outcomes that would be achieved if the norms of primary health care were realised in the primary health care sector (the primary health care promise)[10].

The primary health care sector comprises practitioners (for example, general practitioners, community health nurses) and agencies (for example, health centres, local government) and consumers and community groups. The principles which define the primary health care approach have been cast in various different ways by different authors. According to the WHO they include:

- self reliance
- community participation;
- intersectoral collaboration; integration of health services;
- special attention to high risk and vulnerable groups; and
- the use of appropriate technology.[11]

Shortfalls in implementation

Australia has a substantial investment in the primary health care sector, with an annual turnover of around $12-13 billion each year![12] The chief policy issues regarding the implementation of primary health care in Australia are about realising the principles of primary health care in practice.

The 1992 NCEPH review of health promotion and primary health care in Australia found that there was general support for the principles of primary health care; they were widely seen as corresponding to long-standing norms of excellence. It was generally agreed that if these principles were more widely realised in practice the Australian health system could be delivering better health outcomes more efficiently, more effectively and more equitably. However, the review found that patterns of practice on the ground fell well short of these norms.[13]

The NCEPH review identified four particular shortfalls in practice relating to:

- consumer and community participation;
- local networking;

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[8] WHO an UNICEF (1978), *Alma-Ata 1978. Primary health care: report of international conference on primary health care at Alma-Alta.* Geneva: WHO

[9] We return to narrative policy analysis below. A useful introduction is Fischer F and Forester J (eds) (1993), *The argumentative turn in policy analysis and planning.* London: UCL Press.

[10] National Centre for Epidemiology and Population Health (1992), *Improving Australia's health: the role of primary health care, final report of the review of the role of primary health care in health promotion.* DG Legge, DN McDonald and C Benger, Canberra: NCEPH, ANU

[11] WHO Regional Office for Europe (1985), *Primary health care in industrialised countries: report of 1983 conference in Bordeaux on primary health care in industrialised countries, Euro reports and studies #95.* Copenhagen: WHO Europe.

[12] NCEPH (1992), op cit, page 38, estimated primary health care expenditure at around one third of the total health budget.

[13] NCEPH (1992), op cit, p 61.

- vertical networking; and
- the macro/micro balance.

It was apparent that the structures and the processes for supporting meaningful consumer and community participation were patchy. There were instances of strong participation in many different forms, settings and locations but these were the exceptions, not the general pattern.

There were significant barriers to more effective local networking in the primary health care sector. Perhaps the most obvious of these was the economic and professional competition among and between practitioners and agencies.

Strong mutually respectful partnerships between primary health care practitioners and managers and experts of the secondary and tertiary sectors were rare enough to be celebrated. The problems with hospital discharge summaries, especially the variable quality of such summaries and delays in their dispatch after discharge, epitomise this.

The macro/micro balance is not widely achieved. This refers to styles of practice which address people's micro and immediate health problems in ways which also contribute to redressing the underlying social circumstances which reproduce those kinds of health problems.

The reasons for these shortfalls in implementation are complex. They include a range of historical factors which have focussed the Australian health care system mainly on episode-centred care of individuals. The primary health care model, with its focus on the social context of health and its engagement with the social development dimensions of health promotion, would involve some significant reorientation of established patterns of health care in Australia. This gap is reflected in a certain level of uncertainty about the meaning of primary health care and confusion about its underlying principles.

Achievements, failures and roll-backs

The barriers to the wider realisation of the principles of primary health care need to be seen within the wider context of health service development. Over the last 10 to 20 years there have been some important steps towards a more holistic health care system but there have also been some signal failures and some spectacular roll-backs.

One of the clearest instances of achievement has been in the women's health area where there have been significant changes in patterns of health care and strategies of prevention. The women's health movement illustrates the principles of primary health care in action, including the social health and networking aspects.[14]

[14] Webster K and Wilson G (1993), *Mapping the models, the women's health services program in Victoria* Melbourne: Women's Health Resource Collective and Centre for Development and Innovation in Health.

Community health and consumer and community involvement in health have both recorded important achievements and spectacular roll-backs. Achievements of earlier times have been dismantled or weakened under the pressure of economic rationalism.[15]

Striking improvements have been achieved in population health indicators, particularly with respect to heart disease, smoking related diseases and road trauma. However, the gap between the health status of the rich and the poor remains wide and in some respects is widening.[16] The determinants of inequalities in health clearly extend beyond the immediate reach of health policy.

The continuing failure to reduce the excess mortality and morbidity of Aboriginal Australia is the single clearest indicator of the need for rethinking health policy and practice.[17]

The macro policy climate

These various shortfalls, failures and roll-backs are disappointing for people whose working lives have been directed towards achieving more holistic systems of health care; service systems which address people's immediate health needs but in ways which also contribute towards a more equitable, sustainable and convivial global village.

If we were to judge the effectiveness of our work over the last 10 to 20 years only on the basis of what has transpired we might be depressed as well as disappointed. However, while we are keen to re-examine our own practice and the assumptions upon which it has been based, we are also very aware of the massive changes which have also taken place during this time in the economy, in technology, and in society generally.

Simply the pace of change, economic change and organisational change in particular, makes the project of primary health care more difficult. Working with people to shape healthier and safer ways of living and healthier, safer and more supportive environments calls for some continuity, building of trust, working through complex ideas together. The primary health care model, whilst broad, does not offer guidance about how to cope with increasingly drastic change in health service organisation.

It is not just the pace of change which makes the implementation of primary health care more difficult. There have also been big changes in the wider policy environment which throw up new difficulties and perhaps some new strategies.

Globalisation is one of the most profound of these changes. The conditions in which we work and live are tied increasingly tightly to macro structures and dynamics, the logic of which is only

[15] For example: the defunding of the Victorian District Health Councils in 1992 and of the South Australian Health and Social Welfare Councils in 1995.
[16] Mathers C (1994), *Health differentials among adult Australians aged 25-64 years.* Canberra: Australian Institute for Health and Welfare.
[17] Bhatia K and P Anderson (1995) *An overview of Aboriginal and Torres Strait Islander health: present status and future trends.* Canberra: Australian Institute for Health and Welfare.

evident at the global scale.[18] These dynamics make the need for more effective health strategies more pressing and the realisation of the primary health care model more difficult.

Increasing globalisation of economic activity and the weakening role of the nation state have been associated in recent years with increasing social polarisation (nationally and globally)[19] and accelerating environmental degradation.[20] Both have obvious implications for health.

The policy environment in which health services and programs are shaped is a field of turbulent discourse; different problems, different analyses and different strategies sweeping across the policy field like storm clouds under time lapse photography. Primary health care is just one narrative, just one stream of discourse in this stormy field.[21]

Some of the identifiable policy discourses which determine and reflect contemporary government initiatives in health include the discourses of: marketisation, tighter rationing, small government and international competitiveness.

Marketisation

The discourse of marketisation speaks of reshaping the health care system as a market place where health care outcomes can be purchased for a known price from competing vendors (providers). The discourse of marketisation promises that this reshaping will lead to increased efficiency.

This story is critical of large bureaucratic institutions with natural monopolies and sweetheart arrangements between management and labour. Such institutions are attacked for their failure to sustain quality service, for their inefficiency and their stagnation.[22] The advent of marketisation, including the construction of health care as a market for outcomes, has challenged the complacency of such bureaucracies. To this extent, there is common ground between the stories of primary health care and marketisation.

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[18] See, for example, Smith DA and J Borocz (eds) (1995), *A new world order? Global transformations in the late twentieth century*. Westport CT and London: Praeger.

[19] See O'Leary J and R Sharp (for the Social Justice Collective) (eds) (1991), *Inequality in Australia: slicing the cake*. Melbourne: William Heinemann Australia. See Also United Nations Development Program (1995), *Human Development report, 1995*. New York: Oxford University Press.

[20] See, fore example, McMichael AJ (1993), *Planetary overload: global environmental change and the health of the human species.* New York and Melbourne: Cambridge University Press, and Suzuki D (1993), *Time to change* St Leonards: Allen and Unwin.

[21] In employing discourse theory to map the policy field we re drawing upon the work of Michel Foucault (see especially Foucault M (1972), *The archaeology of knowledge.* London and New York: Routledge). Lemke comments on the use of the term discourse: "When I speak about discourse in general, I will usually mean the social activity of making meanings with language and other symbolic systems in some particular kind of situation or setting. I will also have in mind the symbolic systems in some particular kind of situation or setting. I will also have in mind the participants in the discourse, whether they speak and write or only listen and read…". Lemke JL (1995), *Textual politics: discourse and social dynamics*, p 4, London: Taylor and Francis. See Fischer and Forester, op cit, for an introduction to the use of discourse and narrative in polity analysis.

[22] See for example Patterson J (1994), *Politics, programs and perceptions, the 'beatle syndrome' in Victorian public life.* 1993-94 Annual Report of Victorian Department of Health and Community Services, Melbourne: H&CS.

However, there are aspects of marketisation which run counter to the primary health care model, for example: the creation of new bureaucracies as surrogate purchasers; the reduction of the consumer and community interest to an individualised customer; the reconstitution of health care as anonymous technically defined commodity; the impact of competition as a further barrier to collaboration between agencies.[23]

The ascendancy of markets in public sector reorganisation has contributed to a receptive environment for the development of an influential discourse of health outcomes in policy and management. Whilst the logic of the outcomes discourse is not tied to marketisation policies, the implementation of such policies is dependent upon the specification of purchasable outcomes. We return to outcomes below.

Tighter rationing

The tighter rationing story tells of an aging population, increasingly expensive health technology and the need for financial restraint. The combination points to the need for more effective rationing of public sector expenditure in health.

There are two major discourses which flow out of the discourse of tighter rationing. Sometimes they come together; sometimes they clash. These are the discourses of universalism and of residualism.

The discourse of universalism is the story of Medicare. Universalism tells a story about achieving cost containment through increasing efficiency but without sacrificing the guarantee of universal access to basic sick care and basic public health protection.[24] The discourse of residualism, on the other hand, argues that the role of the public sector ought to be reduced to the provision of safety nets, for the poor and for very expensive illnesses.

Surprisingly, the discourse of marketisation occupies common ground between universalism and residualism. In the universalist story, reshaping health care as a market place with multiple competing vendors will increase efficiency and decrease costs. In the residualist story, reshaping health care as a market place with multiple competing (corporatised) vendors will facilitate the flexible downsizing of the public sector.

Small government

Stories about small government weave their way through the discourses of markets and of residualism. They bring together disillusionment with the failures of government planning and cynicism about self-serving claims made on behalf of government programs and industries which are largely supported through public funds raised by taxation.

These stories argue for greater reliance on market mechanisms to deliver (blindly) what governments have not been able to deliver deliberately through planning. (The call for small

[23] NCEPH (1992), op cit, p 133.
[24] Macklin J (1990), *The national health strategy: setting the agenda for change, background paper #1*. Melbourne: NHS

government also draws some support from an anarcho-communitarian tendency within some social movements and from the entrepreneurialism of many non-government organisations.)

The discourse of small government contributes to the pressure for the marketisation of health care; for governments to withdraw from direct involvement in service and program delivery and to focus on making the markets work ('steering not rowing').

International competitiveness

Most of the stories weaving their way through the health policy tapestry are informed by the same underpinning story about the pursuit of international competitiveness.

According to this story Australia must become more competitive in export markets and in attracting and retaining investment and this requires that we reduce the tax burden on business and this requires that we reduce, or at least contain, public sector spending on health care.

Both the universalists ('universality can be reconciled with public sector cost control through increasing efficiency') and the residualists ('reduce public spending on health by creating a dual system with a residual role only for the public sector') invoke the pressure on Australia to achieve international competitiveness as part of their logic.

The residualists attach prime importance to achieving tax competitiveness and are less driven by the increasing inequalities associated with deregulation and the restructuring of the labour force.

The universalists are more concerned about social cohesion and the maintenance of some universal programs to ameliorate the concurrent pressures towards greater inequality. Whether the universalists' aims are possible within their own terms is open to question. The risks of the universalist strategy include a neo-Taylorisation of the health care industry, alienation of health professionals and increasing depersonalisation of patient care.[25]

From a primary health care perspective there are other concerns with the discourse of international competitiveness. The new world order is characterised by a sharply widening gap between the wealthy and the poor, both between nations and within nations. The contradictions between the new global regime of free trade and the achievement of ecological sustainability were brought out most clearly at the 1995 Berlin conference on greenhouse gas emissions where Australia argued against setting targets for the reduction of global greenhouse gas emissions on the grounds that it would prejudice our international competitiveness.

International competitiveness is commonly presented as an inevitable and objective parameter within which other policies must be shaped. However, ameliorating increasing inequality by maintaining universal access to sick care is an inadequate response to widening economic polarities, particularly in view of the evidence linking inequality to preventable morbidity and

[25] FW Taylor applied his engineering training to reorganise the work process with a fine division of labour. Taylorism refers to the reduction of the workers' roles to discrete, tightly defined and controlled tasks, as per the classic production line. See Taylor FW (1911), *Scientific management.* New York: Harper and Row, reprinted 1947.

mortality.[26] There are major ecological hazards to health associated with the new world order (including the destabilising consequences of widening inequalities and deregulating the exploitation of the environment).[27]

Changing discourses of corporate management

Sluggish markets and increasing competition have created the conditions for new thinking in corporate management as well as in government. Some of the themes of this new thinking stand in sharp contrast to the public sector managerialism being sponsored by the rational economists.

The term post-Fordism is sometimes used to refer to new patterns of production which are characterised by: flexible specialisation and a new capacity for customer responsiveness; increased workgroup autonomy and a new common purpose between management and labour; total quality management and a continuing search for best practice instead of fixed standards.[28] With increasingly complex manufacturing the costs of stock control point to the benefits of just-in-time supply. With increasing consciousness of the transaction costs associated with procurement, business theorists have discovered the value of trust between business collaborators.

Whilst many of the principles of the new business thinking are familiar to primary health care practitioners there are also innovations and new ideas which are well worth learning from. In this project we have explored, in particular, strategies of best practice and the concept of organisational learning (see below).

Key issues for primary health care

These macro policy movements help to explain some of the shortfalls, failures and roll-backs in health policy in Australia but what are the implications for practice? Could we be doing better? Where to from here?

Some of the key issues from this overview which are particularly relevant to the continuing development of primary health care concern: outcomes and evidence-based practice, best practice and organisational learning and policy participation.

Outcomes

The discourse of outcomes exerts a powerful influence in health policy at this time.[29] The outcomes movement emphasises: planning for outcomes; accountability for outcomes; and justifying health strategies and service delivery models in terms of known relationships to outcomes.

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[26] Wilkinson RG (1990), *Income distribution and mortality: a 'natural' experiment.* Sociology of Health and Illness, 12(4), 391-412

[27] McMichael AJ (1993), op cit.

[28] See Mathews J (1989), *Tools of change: new technology and the democratisation of work*. Sydney: Pluto Press.

[29] "The seminar agreed that it was vital that the Australian health system should be more strongly focussed on health outcomes so as to achieve optimal personal and community health with the available resources." *AHMAC Sunshine Statement.* February 1993.

The discourse of outcomes has delivered a timely attack on the authority of tradition in health care and in public health.[30] The traditional way is sometimes the best way of doing things but the traditional ways also preserve traditional privileges. The slogans of the outcomes movement are to be welcomed if they can challenge the self-serving uses of tradition in health care.

However, there are aspects of the discourse of outcomes which do not sit so easily with the discourse of primary health care. The discourse of outcomes tends to discount the existential dimensions of health care and the quality of personal relationships because these are not measurable and cannot be reduced to a single objective indicator. It is easier to record the discharge of an acute myocardial infarction than to consider whether a person has been supported in coming to grips with their uncertainties and fears and the processes of remaking themselves.

The discourse of outcomes argues that each health care transaction (or each public health engagement) can be described unproblematically by one set of objectives to which it is directed. However, the experience of primary health care is of a negotiation between stakeholders. The creation of a common story from different perspectives may be one of the most important parts of the transaction.

There is a strong synergy between the project of the outcomes movement and the need of the marketisation movement for the reshaping of health care in the form of purchasable commodities. This is reflected in the output-based funding policies adopted in Victoria, although policy makers in Victoria have been careful to speak of outputs rather than outcomes.[31]

Most accounts of the primary health care model are cast mainly in terms of process and structure; principles of practice and organisational arrangements (eg to support consumer and community involvement). The outcomes promised by the primary health care model are cast in very general terms.

What are the outcomes of primary health care? In a policy environment preoccupied with outcomes is it possible to speak more precisely about the outcomes of primary health care without conceding to reductionism and commodification?

Evidence-based practice

The discourse of evidence-based practice runs closely with the discourse of outcomes. It acknowledges that it is not always practicable to measure outcomes but takes a strong fall-back position with respect to the need for research evidence linking interventions and models for service delivery to outcomes.[32]

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[30] See hall J and A Sheill (1993), *Health outcomes: a health economics perspective.* Sydney: Centre for Health Economics Research and Evaluation.

[31] Victorian Department of Health and Community Services (1995), *Community health program output based funding implementation plan*, Melbourne: H&CS

[32] Braithwaite J, J Westbrook and L Lazarus (1995), *What will be the outcomes of the outcomes movement?* Aust NZJ Med 25, 731-735

The main focus of calls for evidence-based practice is clinical medicine. Estimates vary widely about the proportion of medical practice (however enumerated) which is based on experimental evidence. There is a powerful logic for a program of clinical research which exposes all medical interventions to continuing research scrutiny.

The call for evidence-based practice is clearly relevant to primary health care. We have pointed out that many of the outcomes of primary health care are difficult to measure and do not lend themselves to precise specification. This points the policy focus towards the patterns of care and the models of service delivery that the primary health care model claims will lead to better outcomes. What is the evidence?

The challenge to validate the practices of primary health care raises significant methodological issues. It presumes a canon of authorised procedures supported by validated theories and facts which is equally appropriate across a wide range of settings. Primary health care is much more contingent, much more context dependent, than this notion of a universal canon would allow.

Conventional reductionist research involves the definition of an abstract model of the system being studied and the collection of data which measure the essence of the constructs postulated by the model while controlling out the extraneous details which are peculiar to each case. This is easier to do in the clinical or laboratory situation than when dealing with people and families in their social and cultural context.

The situations with which primary health care deals and the strategies upon which it calls are very heterogeneous at the case by case level. Controlling out the case-specific detail leaves only very high level abstractions which are not so useful to guide practice nor to provide a framework for policy and program development.

Such contingency may be unfamiliar to the clinical and laboratory empiricists and the model builders of econometrics but it is very familiar to theorists of corporate management and business practice whose research and teaching tend to keep the abstractions in close proximity to the case material.

These reflections do not constitute a case for rejecting the challenge to validate the principles of primary health care. Rather they emphasise that to derive useful generalisations from research into outcomes and the elements of practice which contribute to good outcomes we will need to keep the contingent details so that the abstractions can remain alive and useful.

Best practice

The conventional approach to quality improvement in health care has been standards-based, with an expectation that the standards are themselves validated through research.

This standards-based approach presumes a domain of knowledge, including known relationships between structure, process and outcomes, which is separated, courtesy of the research process, from the settings in which that practice takes place. In a field which is so context dependent this

expert based standards approach has limited applicability because the standards so produced are so abstract, in relation to the contingency of practice.

It is for this reason that we have been keen to explore the application of the best practice philosophy, as developed in the business world, to quality improvement in primary health care.

Best practice is a strategy for promoting excellence.[33] It acknowledges contingency and is not dependent on universal models of the processes in question. The focus of best practice is on creating organisational cultures which are directed to the pursuit of excellence.

Our group has been working with case studies of primary health care practice for some years; collecting and publishing and assisting practitioners to document their own work.[34] We have been encouraged by the advent of best practice because it provides a wider and perhaps more systematic framework within which we can pursue the case study approach, drawing upon best practice ideas such as the practice of benchmarking. Benchmarking refers to the search for better ways of doing things with a view to exploring the possibility of adapting them in one's own practice.[35]

Benchmarking accommodates innovation as well as contingency. In a best practice environment practitioners are continually looking for instances where other people are doing similar things but using different models of practice or in different organisational configurations.

Organisational learning

One of the most destabilising aspects of the current environment is the continuing (and apparently accelerating) rush of organisational change. The primary health care narrative does not address organisational change in any depth nor does it provide guidance for practitioners engaging with the forces of change and seeking to exercise some influence over the direction of such change.

Rapid environmental and organisational change present problems for business organisations also. One approach which has attracted a great deal of attention in business circles is known as organisational learning.[36] Organisational learning brings together some good ideas for coping with change and engaging with the forces of change. The advent of organisational learning offers us a new framework for rethinking some old problems.

Members of our group have committed much of our effort over many years to supporting evaluation and planning in primary health care. In our evaluation work we have been particularly frustrated by pressures from funding agencies to construct evaluation as being primarily for accountability purposes disregarding its role in how to do it better.

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[33] See Australian Health Review 17(3), 1994, a full issue on best practice in health care

[34] CDIH (1988), *The resources collection;* CDIH (1993), *Case studies of community development in health;* CDIH (1993) *Australian case studies of community development:* CDIH (1993) Mapping the models; CDIH (1994) *Innovation and excellence in community health*; all published through CDIH in Melbourne.

[35] Lansbury R (1994), *Best practice and workplace reform*. Australian Health Review, 17(3), 17-28.

[36] Argyris C and DA Schon (1978), *Organisational learning: a theory of action perspective.* Reading MA: Addison-Wesley; Kempin G (1994), *Promoting learning in your organisation, report of the learning environments action research project.*

In some of our consultancy work we have worked in more explicit action research projects; working with practitioners and consumers to explore a problem, to try different strategies and to see how they go. The frustration in this kind of work is that it is generally not recognised as proper research and it is increasingly hard to find resources to support it.

We have also devoted a considerable effort into supporting planning functions in primary health care: project planning, local area health planning, municipal health planning, agency development and the development of health service agreements. We have done good work in all these areas but we are not confident of its lasting value in the face of increasing organisational change. Perhaps part of the problem lies with constructions of planning which may have been appropriate for more stable times but are less so now. Conventional constructions of planning have tended to carry something of a stop-start approach to planning and change. The purpose of planning is to restore stability until the next period of destabilisation when we shall have to plan again. Planning is what planners do and is organisationally separate from routine operations. Planning involves coping and adjusting; reacting to incursions and depredations.

In recent years we have been increasingly drawn to the more direct focus on change per se which characterises current writing about organisational learning. It provides a framework within which the functions of evaluation, planning, education and research can be integrated within a broader project and it invites us to rethink our assumptions about planning and organisational change.[37]

The concept of organisational learning suggests a set of expectations and practices which encourage and support continuing reflection on what we are doing and the way we are doing it and a continuing awareness of the external environment. It suggests a capacity to shape new patterns of practice which include a more pro-active approach to the forces of change externally as well as new ways of conducting our core business.

Senge describes organisational learning in terms of five slogans ("disciplines"): systems thinking, personal mastery, mental models, team learning and building a shared vision. [38]

System thinking involves being able to situate our strategies and arrangements within the complex institutional, social, political and cultural systems in which we practise; being able to orient these larger systems around the contingencies of our own practice.

Personal mastery involves managing the contradictions between the pressures of our work and our own personal and professional aspirations; integrating our own personal and ethical development within the challenges and opportunities of our routine practice.

Mental models calls for a rich library of theoretical resources which we can draw upon in confronting the challenges of our work and the skills to integrate the different (and often incommensurable) insights from these theories in our own actual practice.

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[37] Legge D, A Rotem and J Walters (1996), *System-wide learning for public health.* Canberra: Public health Association of Australia (in press).

[38] Senge P (1992), *The fifth discipline: the art and practice of the learning organisation.* Sydney: Random House Australia.

Team learning involves developing the expectations and skills to name our problems more clearly and to analyse and research them more effectively; using evaluation for learning (rather than just accountability); researching the conditions of our work.

Building a shared vision with respect to the directions and outcomes of our work involves building a discourse which continually restates and reworks the purposes of our work and the ways in which we are working towards them (including the big issues such as socio- economic inequalities).

Organisational learning offers us a fresh way of viewing our work in evaluation, planning, education and action research. It invites us to reorient ourselves away from constructions of planning as reactive and restabilising towards thinking about creating organisations which deal pro-actively with change and which take part in determining its directions.

Participating in policy making

In the public sector, engaging with organisational change and with the forces driving that change must involve participating in public policy formation. However, most popular accounts of primary health care do not address the challenges which face practitioners seeking to participate in policy-making.

The primary health care story tends to be told in the voice of the policy experts. It assumes that policy makers will put in place the preconditions which will enable practitioners to realise the principles of primary health care. It assumes the policy environment and focuses on the principles and strategies which practitioners should adopt in working with their communities. This is a discourse cast in the voices of policy activists, not centred around the experiences and needs of the practitioners. It is a weakness of this presentation that it fails to speak of the practical challenges for practitioners of participating in policy making; in the creation of those policy preconditions.

In part this is an issue of how policy is conceived. Policy may be understood as a set of decision-rules governing the decisions of senior managers who determine the allocation of resources and the regulation of programs. This construction of policy focuses our attention on the corridors of power and on the power relations which mandate the adoption and implementation of each policy.

However, this draws upon a very limited understanding of power. Foucault has contrasted notions of power as 'sovereign power' (explicit, top down) with notions of power as diffused throughout our culture, realised in our everyday practices and relationships.[39] He (and ideology theorists before him) argue that constructions of power as sovereign power have only limited usefulness in describing how society works and suggesting how we might practise. Foucault draws our attention to the ways power relations shape and are shaped by the ways we speak and listen.

Narrative policy analysis provides a way of conceiving policy which accommodates the more distributed notion of power embedded in language. Narrative policy analysis represents policies as stories.[40] A policy is a story which makes sense of a confusion of problems; depicts a scenario in

[39] Foucault M (1977), *Discipline and punish: the birth of the prison*. London: Penguin Books.
[40] See Fischer and Forester (1993), op cit.

which these problems will be resolved; and guides practitioners in different settings towards complementary patterns of practice which will come together in creating the preferred future.

This construction highlights the role of policy in the creation of meaning; in making sense of our problems and practice. The success of policy in these terms depends upon the clarity with which it names our problems, the desirability of the scenarios it promises and the practicability and the ethics of the actions of which it speaks.

Policy can be imposed and implemented in top down ways under the pressure of explicit sanctions. However, it may be difficult to sustain if it depends upon continuing inducements or threats. Understanding policy as the creation of new stories points more clearly to the ways in which new ways of doing things are naturalised and how power may operate through making new ways of seeing things seem more natural. Understanding policy in terms of the stories through which we make sense of our problems and which guide us in the shaping of our practice also points more clearly to the agency of practitioners and of consumers in 'naturalising' such stories or keeping alive alternative understandings.

Policy as implemented through sovereign power suggests a limited role for practitioners, outside the corridors of power. Policy understood as competing stories constructs policy engagement in more active and more personal terms, essentially speaking and practising differently.

It is not necessary to work through these ideas in detail here. The two conclusions which we would wish to carry forward from this discussion are as follows. First, if primary health care practitioners are to take a more pro-active stance in relation to organisational change this should include a more considered engagement in the processes of policy-making. Second, if we think of policy in terms of stories which circulate, rather than decision rules which are imposed, we will recognise more clearly the policy significance of the stories that practitioners use to make sense of and guide their practice.

Objectives

In sum, the aim of this project was to take a fresh look at primary health care in Australia, in particular, at the social health, networking and developmental functions of primary health care. We aimed to look at the outcomes of primary health care and the strategies and pre-conditions which contribute to these outcomes.

In this introduction we have articulated the kinds of aspirations and disappointments which have animated this research and have convinced us that we need to re-think our analysis and strategies. We have related these to the changing macro policy environment and have identified and discussed a number of key issues confronting primary health care.

Our hopes and disappointments and the changing policy environment set the context within which we have conceived and carried out the research which we report in the following chapters.

In formal terms our objectives were to:

1. Survey recent descriptive accounts of primary health care practice in Australia, with a focus on the social health, networking and developmental functions of primary health care, and to provide wider access to these reports by publishing abstracts and bibliographic details.
2. Delineate more clearly the kinds of outcomes which are presently being achieved in primary health care.
3. Delineate more clearly the patterns of practice and the organisational settings which are associated with excellent outcomes in primary health care.
4. Identify possible themes and directions for human resource development activities which would support primary health care practitioners (and consumer and community activists) in their striving to achieve best practice.
5. Identify possible directions with respect to policy and program development which would help to create more favourable conditions for good practice in primary health care. and
6. Identify and publish benchmarks of best practice in primary health care, focussing on the networking, social health and developmental functions.

3. Documenting Primary Health Care in Australia

The aim of the Best Practice in Primary Health Care project was to collect and analyse published case studies of primary health care in action with a view to:

- delineating the links between good outcomes in primary health care practice and models and strategies of practice; and
- defining the pre-conditions for good practice in primary health care, in particular the organisational arrangements which allow good practice to emerge.

The first section of this chapter describes and reviews the process of collecting 185 cases. This involved the following stages:

- establishing survey criteria;
- identifying sources of case material;
- scanning the sources;
- creating abstracts for cases which met the criteria; and
- creating a computer data base of the 185 cases.

The second section of this chapter provides an overview of the 185 cases. In the first instance we have looked at variations between the states and between agency types as sources of cases. We have then reviewed information about the cases under the 21 major topics by which they were categorised.

The first step was to survey the published literature and establish a data base of up to 200 primary health care programs. It was hoped that these programs would include a wide range of agencies, projects and districts that have been described in various published sources as places where good practice in primary health care was occurring.

A range of sources of published material was surveyed and details of 185 cases were placed on a data base. The data base established was subsequently published by CDIH in a working paper entitled 'Towards best practice in primary health care'[41] and also on the HEAPS database.[42] That collection of case studies, all of which had been published or distributed previously, provides a snap shot of primary health care in action in Australia during the early nineties. The cases came from a wide breadth of agencies, private, public, non-government and community-based, and they involved an equally wide range of people and professions - consumers, nurses, doctors, social workers, allied health workers and so on. The topics and strategies are no less impressive in their breadth, covering health issues from asthma to homelessness and working with many different groups in the community.

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[41] Butler P, Legge D,. Wilson G & Wright M (1995), *Towards Best Practice in Primary Health Care*. Centre for Development and Innovation in Health, Melbourne.

[42] HEAPS (health Education and Promotion System) is a database of health promotion programs and resources, designed for personal computers and produced and maintained for the Commonwealth Department of Health and Family Services by Prometheus Information, PO Box 2319, Canberra, 2601; phone (06) 257 7356; fax: (06) 241 5284

Survey criteria

Criteria were established for the collection of cases. We were looking for programs which:

(i) were carried out by practitioners and agencies in the primary health care sector;
(ii) involved collaboration (networking) and/or involved a social health orientation;
(iii) had been reasonably well documented with respect to both process and outcomes; and
(iv) had been undertaken since 1990.

'Programs' included services and other activities that may have had a time limit (such as a specific health promotion effort) or that may have been ongoing (such as an antenatal service).

The following definition of primary health care, adapted from the 1992 NCEPH review of primary health care[43] was used:

> Primary health care refers to a particular policy model which proposes a key role for the primary health care sector in health care and health promotion. The primary health care sector in this model includes general medical practitioners, pharmacists, community health practitioners, primary care hospital services, local government, self-help and volunteers. The policy model assumes a particular approach to health care practice. An emphasis is placed on: continuity of care, collaborative networking amongst agencies, integration of prevention with sick care, a concern for population as well as individual health and consumer and community involvement.

Network focus and/or social health approach

The second criterion for inclusion in the collection was that the programs had involved a networking focus and/or a social health approach. Networking was judged to exist where there was collaboration among agencies and/or between service providers and community or consumer groups. A social health approach was judged to exist where the health problems of individuals were seen to be located within the broader social or cultural context.

Collaboration is weak within the primary health care field. The NCEPH review drew particular attention to the networking dimension of the primary health care model. It reported that whilst most professional providers and agencies seemed to be delivering high quality programs, in the terms of their own professional or institutional norms of excellence, there appeared to be significant weaknesses with respect to collaboration across networks of providers and between professional providers and the communities and consumers they were serving.

In a number of fields of primary health care (for example, medical and dental care and psychiatric illness), the published work is overwhelmingly clinical in nature. In fact we found very few articles

[43] National Centre for Epidemiology and Population Health (1992), *Improving Australia's Health: the role of primary health care.* Final Report of the Review of the Role of Primary Health care in Health Promotion in Australia by Legge D, McDonald, D and Benger C, ANU Canberra.

and case studies in these areas which did not focus on specific clinical practices and procedures. Programs where the focus was exclusively clinical (for example, treatment of children with fever in a general practice) were not included in our survey.

It was initially proposed that we focus on the national outcome priorities determined through the National Health Goals and Targets process as one of our criteria for including cases in our collection. However, it quickly became clear that the current four priority areas account for only a small part of the documented work and most of the programs surveyed were not disease or risk factor specific. Therefore this was not used as a criterion for searching for cases.

Identifying sources

In selecting the sources to scan, our aim was to gather a range of material that represented the field as defined above and that would include sufficient examples of best practice for us to make generalisations. It was never our aim to comprehensively or exhaustively survey all possible published material, or to gather material on programs which were commendable in their practice but which had not been documented or published. The cases included in this collection should not be regarded as the 185 best cases of primary health care since not all cases have been documented and we did not survey every source of documentation.

The sources we scanned included:

Journals

* Australian Journal of Public Health, 1990-94
* Health Promotion Journal of Australia, 1990-94
* Aboriginal and Islander Health Worker's Journal, 1990-94
* Australian Family Physician, 1990-94
* Community Quarterly, 1990-94
* Health Issues Journal, 1990-94.

Books

* Innovation and Excellence in Community Health, CDIH, 1994
* Good Practices in Women's Mental Health, Healthsharing Women, 1994
* Australian Case Studies in Community Development 1972-1992, CDIH, 1993
* Community Health: A Focus on People, ACHA, 1993
* Mapping the Models, Victorian Women's Health Services, CDIH, 1993
* Primary Health Care Review, NCEPH, 1992
* Case Studies of Community Development in Health, CDIH, 1993
* South Australian Primary Health Care Casebook, SACHA, 1993
* Cases for Change, ACHA, 1992.

Conference proceedings

* General Practice Evaluation Program, Work-in-Progress Conference reports, 1992, 94
* National Health Promotion Conference, PHA and AAHPP, 1994
* ACHA Conference Proceedings, ACHA, 1993
* VCHA Conference Proceedings, VCHA, 1993
* Health Cities Conference Proceedings, ACHA, 1992
* Victorian Rural Health Conference, Deakin University, 1991
* ACHA Conference Proceedings, ACHA, 1990.

Other sources

* HEAPS (Health Education and Promotion System) data base
* 1992 General Practice Demonstration Grants reports
* Victorian Healthy Localities evaluation reports.

These written sources were scanned starting with the most recent material (for example, material published in 1994) and working back towards 1990.

In addition to scanning these publications, programs were also sought through the project's National Advisory Committee members and the informal networks of CDIH[44]. This process realised a number of unpublished project reports which were also scanned. This latter process was used particularly to try and increase the number of cases from NSW, which appears to be significantly under represented in the published literature, and from general practice.

No collection of this kind can be comprehensive and it was inevitable that some sources would be overlooked. One valuable source which was identified too late to be included was the annual proceedings of the primary health care conferences organised through the Faculty of Health Sciences at the University of Sydney.

Scanning and abstracting the sources

The physical process carried out in scanning these documents involved reading the abstracts, summaries, descriptions or conclusions of the article or report and comparing the information with the above criteria. If the program appeared to meet the selection criteria listed above, then the whole report was read. If the program still appeared to meet the criteria then it was entered onto the data base. The fields included in each record are indicated in Figure 3.1 which reproduces the cover sheet for one program.

[44] Valuable assistance in this process was received from staff in many agencies, but particularly the General Practice Branch of the Department of Health and Family Services, the Victorian Health Promotion Foundation, the South Australian Health Commission Social Health Branch, the Central Sydney Area Health Service, the Community Health Accreditation and Standards Program national office, the Health Issues Centre and the Wentworth Centre for Health Promotion.

TITLE:	Redfern Aboriginal Medical Service: Twenty Years On
AUTHOR/S:	Foley, G.
AGENCY:	The Aboriginal Medical Service Co-operative Redfern
ADDRESS:	36 Turner St, Redfern, NSW, 2016
PHONE:	02 699 5823
FAX:	02 319 3345
DESCRIPTION:	The Redfern Aboriginal Medical Service was established in 1971 and has since served as a model for the development of other Aboriginal health services throughout Australia. In this article Foley describes the historical development of the service, including: its struggles through changes of Government; its consolidation as a provider of direct services to the Aboriginal people; shifts towards broader roles in Aboriginal public health during the 1980's; education programs for Aboriginal health workers; and participation in the development of Government policy. The article concludes with a summary of the key strengths of Aboriginal controlled community health services.
MEDIA:	Journal article (5p) in Aboriginal and Islander Health Worker Journal, Vol. 15, No. 4, July/August, 1991
POPULATION:	Aboriginal people
LOCATION:	Sydney
AGENCY TYPE:	Metropolitan community health centre
SUBJECTS:	Aboriginal health / Community health services

Figure 3.1: Example of cover sheet.

Each record on the data base includes bibliographic details about the program, the auspicing agency and author, as well as an abstract of the program and some details around topic, subject, etc. The record was designed to allow HEAPS[45] to download our data onto their system with a minimum of editing. A number of the categories (for example, topic, subject, agency type) were based on the HEAPS categories and we have used their headings and topic listings.

No record was kept of the much larger number of programs which were scanned but not included. The major reasons for programs being rejected were that they were carried out in isolation from other agencies, that programs were not sufficiently documented and that the reports described work done before 1990.

There were also numerous needs assessments and surveys that were rejected. Where a needs assessment was part of a larger program where interventions had actually been carried out, the

[45] This work was undertaken prior to the recent redevelopment of HEAPS as a Windows-based program and some alterations to the categories used by HEAPS.

program was included. This distinction was due to our interest in outcomes and the desire to relate outcomes to process and structure.

Cover sheets were then sent to the authors of the case study. The objectives of this project were outlined. Authors were invited to confirm the information on the cover sheet and to provide us with any further material such as more recent or more detailed reports on a program.

The case studies

The 185 cases were indexed under the 21 major categories shown in Table 3.1 (the number of cases in each group is indicated by the number in brackets). These categories were decided upon after the cases had been collected and reflect the major themes present in the cases rather than any predetermined system of categorisation.

* Aboriginal and Torres Strait Islander health (14)
* cancer (11)
* chronic illness (12)
* dental care (4)
* ethnic health (8)
* homelessness (4)
* mental health (16)
* occupational health and safety (4)
* rural health (13)
* women's health (17)
* other (7).
* alcohol and drugs (8)
* child health (12)
* community development (8)
* environmental health (5)
* general practice (10)
* injury prevention (6)
* nutrition (8)
* prenatal/postnatal care and childbirth (8)
* social isolation (4)
* youth health (7)

Table 3.1: Major topics of the 185 cases.

Cases were also cross indexed by two or three other subjects and by the population group they involved. For example, in addition to the seven cases categorised under youth health, a further eight cases categorised under other headings were also coded as involving young people. Similarly, while local government was not a major topic, ten cases were listed where local government was a secondary subject.

State variations

There was substantial variation between states in the number of cases identified. Table 3.2 shows the number of cases from each state and whether or not the cases were from metropolitan or non-metropolitan settings. (A small number of cases were not able to be classified.)

There were fewer than expected cases from a number of states, particularly the territories, Tasmania and NSW. Discussions with people involved in primary health care in those states

suggested that the major reason for these disparities was not lack of work, but lack of documentation of the work being carried on.

State/Territory	Metropolitan	Provincial/Rural	Total
New South Wales	15	16	31
ACT	1	0	1
South Australia	30	11	41
Queensland	5	15	20
Victoria	48	21	69
Northern Territory	0	2	2
Western Australia	7	8	15
Tasmania	1	0	1
Total	**107**	**73**	**180***

Table 3.2: Cases included by state of origin
(*five cases were not able to be categorised).

The predominance of Victorian cases is partly explained by previous CDIH work. CDIH has been using case studies to promote and resource community work in health settings for several years. *The CDIH Resources Collection (1988[46])* contained six case studies, including the very successful Northcote Hydrotherapy Self-help Massage Group. In 1993 CDIH published *Case Studies of Community Development in Health*[47] with 16 detailed case studies, along with *Australian Case Studies of Community Development*[48] (a bibliography of material published throughout Australia between 1972 and 1992).

In 1993 CDIH also published *Mapping the Models*[49] which included 13 case studies of programs conducted by Victoria's Women's Health Services. Most recently, in 1994, we published *Innovation and Excellence in Community Health*.[50] This comprised 13 case studies of award-winning programs from Victorian community health services.

In South Australia the Social Health Branch of the Health Commission and the South Australian Community Health Research Unit have also encouraged documentation of primary health care. In 1993, the South Australian Community Health Association published the *South Australian Primary*

[46] Community Development in Health (1988), *A Resources Collection.* Preston/Northcote District Health Council, Melbourne.
[47] Butler P & Cass S (1993), *Case Studies of Community Development in Health*. Centre for Development and Innovation in Health, Melbourne.
[48] Webster K (1993), *Australian Case Studies in Community Development 1972 – 1992: An Annotated Bibliography.* Centre for Development and Innovation in Health, Melbourne.
[49] Webster K & Wilson G (1993), *Mapping the Models, The Women's Health Services program in Victoria.* Women's Health Resource Collective and Centre for Development and Innovation in Health, Melbourne.
[50] Butler P (1994), *Innovation and Excellence in Community Health.* Centre for Development and Innovation in Health, Melbourne.,

Health Care Casebook.[51] This book included short case studies of a number of good examples of primary health care.

In our experience, documentation of primary health care practice is a useful tool for agencies and workers to critically reflect on their own practice. It also provides the basis for sector-wide research of the type being carried out in this project. Greater assistance to workers in documenting their practice for publication would certainly enhance the field.

Agency variation

There was a wide variation among the type of agency for the 185 cases surveyed. The type of agency is shown below (Table 3.3) along with the number of cases for each type.

The table shows that the largest group of cases had been carried out by community health centres or services (this category included Aboriginal health services). The second largest group of cases, from general practice, reflects the General Practice Reform Program in that many of these cases had been funded as demonstration projects in 1992.

Type of Agency	Number of Cases	Percentage of Cases
Community health centre/service	68	37
General practice	31	17
Community/consumer group	23	12
Women's health service	13	7
State health department	12	6
Hospital	12	6
Educational institution	11	6
Local government	4	2
Other	11	6

Table 3.3: Cases included by agency type.

Variations among topics

In the following section, we have aggregated information about the case studies under the 21 major topics listed in Table 3.1. For each topic we have provided information about:

* numbers of cases[52];
* sites of the cases;
* agency types;
* subjects apart from the major topic;

[51] Phillips-Rees S, Sanderson C, Herriot M & May A (1992), *The Changing Face of Health: A Primary Health Care Casebook.* South Australian Community Health Association and the South Australian Health Commission, South Australia.

[52] Cases were cross categorised and so one case may have been listed under two or three different topics. The numbers of cases included under each topic in this section therefore total to well over 185

* population groups;
* sources of the original case studies; and
* reviewer ratings.

Aboriginal and Torres Strait Islander health

Nineteen cases were coded as involving Aboriginal health. Fourteen of the cases were rural based and most of them had been carried out in New South Wales, Queensland or South Australia. There were no cases from Victoria, Tasmania or the ACT.

Seven of the cases involved community health services with the rest being spread across a range of agency types. The subjects that the cases involved, beyond Aboriginal and Torres Strait Islander health, were diverse including nutrition, diabetes, women's health, youth health, HIV/Aids, alcohol/drug issues and dental health, with no particularly strong themes or concentrations.

The sources of cases were also diverse with the single largest source of material being the Aboriginal and Islander Health Worker Journal. Other sources included other journals, General Practice Demonstration Grant reports and the South Australian primary health care casebook.

Of the 19 cases, twelve were selected for reviewer evaluation (see Chapter Four) and five were subsequently included in the interview study (see Chapter Five).

Alcohol and drugs

There were eleven cases involving the topic of alcohol and drugs. Seven were in rural or provincial areas and four were metropolitan programs. Cases were spread around Australia with three cases in each of Queensland and Western Australia.

The types of agency involved varied widely, though all three cases from Western Australia involved the National Centre for Research into the Prevention of Drug Abuse at Curtin University. In half the cases, the program involved working with the general population, while the other half involved young people, Aboriginal groups or intravenous drug users.

Seven of the cases involved strong community development or community participation strategies. The sources of the cases were diverse; six of them were project reports and the other five had been published in five different publications.

Four of the eleven cases were considered by our reviewers and two of those were subsequently included in the interview study.

Cancer

Fourteen cases were listed under the topic of cancer. Seven of the cases were metropolitan, six were rural or provincial and one was a statewide program. Half of the cases had been undertaken in Victoria, with the rest spread around the country, though no cases came from Tasmania or the territories.

Seven of the cases had been carried out in general practices and three in women's health services. The cases were dominated by cervical cancer and screening through Pap smears (10) and three cases were about encouraging breast examination. A number of the projects focussed on sub-groups including older women, women in blue-collar industry and women with disabilities.

Four cases came from Australian Family Physician and three were General Practice Demonstration Grant Program reports with the other seven mainly from case study collections. Five of the fourteen cases were included in the reviewer study and three were among the 25 cases in the interview study.

Child health

There were 26 cases listed in the data base under the topic of child health. The state distribution was nine from South Australia, eight from New South Wales, seven from Victoria and two from Western Australia.

Twelve of the cases had been carried out by community health services, four by tertiary institutions and the balance were spread among most other agency types. The cases covered a very wide range of other subjects including schools (10), nutrition (5), dental health (4), asthma (3), community development (6), injury prevention (3) and a number of others involving one or two cases.

Most of these programs were working with children generally, however in a small number of cases, the programs were working with sub-groups including boys, children from non- English speaking backgrounds and Aboriginal children.

There was no particularly strong source of cases for child health. Nine were drawn from project reports; the other seventeen being spread among various journals, conference papers and collections.

Thirteen of the child health cases were reviewed and three of these were part of the 25 cases in the interview study.

Chronic illness

Fourteen cases involved chronic illness. Seven cases were from South Australia, with the balance spread between Victoria, New South Wales and Western Australia. Nine cases were from metropolitan agencies and five from rural settings.

Six cases had been carried out by community health services, five by general practices and one each by a hospital, a community/consumer group and one by a statewide agency. The major subjects of the cases were asthma or diabetes, together accounting for all but two of the cases.

In most cases the population group were sufferers of the particular chronic illness, though three of the cases focussed on children. Sources of cases regarding chronic illness were widely spread with no particular concentrations.

Six of the cases were reviewed and one case was among the 25 cases in the interview study.

Community development

Forty-nine cases involved community development. The cases were primarily in Victoria (19), South Australia (13) and Queensland (7), with the balance spread around the country. Twenty-nine of the 49 cases were in metropolitan areas.

In respect of agency type, 21 cases were carried out by community health services, a further ten by community/consumer groups with most of the other types having carried out only a handful of projects. Only one project had been carried out by a general practice.

The cases were coded across 28 different minor topic categories. The only minor topic headings with more than four cases were rural health (8) and nutrition (6). The leading population group focus of the cases was the general population (19), with the only other major focus being women (10).

The leading source of community development cases was individual project reports (18). Eight of the cases had been published in the *1993 ACHA Conference Proceedings*[53], with four cases each from the *Primary Health Care Casebook, Case Studies of Community Development in Health, the journal Community Quarterly* and *Innovation and Excellence in Community Health.*

Of the 49 cases, 26 were reviewed and nine were in the interview study.

Dental care

Five cases related to dental care. The projects came from New South Wales (2), South Australia (2) and Victoria (1). Three projects were from metropolitan agencies.

The projects were carried out by hospitals (2), a community health service, a State health department and a tertiary institution. The only minor topic categories coded were consumer participation (1) and nutrition (1). The population groups were Aboriginals (2), and children and adults from non-English speaking backgrounds.

The sources for these five cases concerned with dental health were project reports (2), the *1993 ACHA Conference Proceedings, the Primary Health Care Casebook and Cases for Change*[54].

Three of the cases were sent out for review although none were included in interview study.

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[53] Clarke B & MacDougall C (1993), *The 1993 Community Health Conference: Volume 1, Papers and Workshops*. Australian Community Health Association, Sydney.
[54] Ryan P (1992), *Cases for Change: CHASP in Practice.* Australian Community Health Association, Sydney.

Environmental health

Seven cases involved environmental health. Four of these projects were in South Australia, two in New South Wales and one in Victoria. Four cases were metropolitan and three rural.

There was a spread of agency types: state health department (2), community/consumer groups (3), a community health service and women's health service. The subjects involved were lead poisoning, housing, occupational health and safety and pesticides. Notably, three of the population groups focussed on were government departments.

The cases were sourced from a variety of places: individual reports/books (3), 1993 ACHA Conference Proceedings, Case Studies of Community Development in Health, the Primary Health Care Casebook and Community Quarterly.

Four of the cases were reviewed and one was included in the interview study.

Ethnic health

There were 13 ethnic health cases of which seven were from Victoria, four from South Australia and one each from New South Wales and Queensland. All of the projects were metropolitan.

Six cases were carried out by community health services, three by women's health services, two by community/consumer groups, one by a general practice and one by a foundation/society. There was a very wide range of subjects covered by these cases with no subject showing up more than once.

Where the cases involved a specific ethnic group these were older Italians and Indo- chinese (3) and eight of the projects were focussed on women.

The sources were widespread: *1993 ACHA Conference Proceedings* (3), project reports (2), *Innovation and Excellence in Community Health* (2), *Mapping the Models* (2), *the Primary Health Care Casebook, Community Quarterly, Case Studies of Community Development in Health and Cases for Change.*

Eleven cases were reviewed and three were included in the interview study.

General practice

Forty-three projects involved general practice. There were ten each from New South Wales and Victoria, eight each from Western Australia and Queensland, six from South Australia and one from Northern Territory. Twenty five cases were rural.

Thirty cases had been carried out by general practices, six by community health centres, and the balance spread across other agency types in ones. There was a very wide range of subjects covered with some of the more numerous being cancer (6), diabetes (6), chronic illness (6), Pap smears (5) and asthma (4).

The leading population groups focussed upon were general practitioners themselves (10), the general population (9) and women (10). The major source was project reports (usually reports to the GP Demonstration Practice Grants Program) of which there were 27 and the journal Australian Family Physician (12).

Homelessness

There were nine cases involving homelessness. All nine of the cases were from Melbourne and seven of them were carried out by community health agencies. The subjects of the projects were housing (2), mental health (2), pre-natal care (1) and deinstitutionalisation.

Within the broad topic of homeless people, three projects focussed on young people and one on mentally ill people.

Four projects had been published as project reports and three in Innovation and Excellence in Community Health.

Eight cases were reviewed but none were part of the interview study.

Injury prevention

Eight cases involved injury prevention; the cases were spread around: New South Wales (3), Victoria (3), Queensland (1) and South Australia (1). Four were rural projects.

Four had been carried out by community health agencies, one by each of a community/consumer group, a tertiary institution, general practice and a health department.

The projects involved a range of subjects including safety (1), burns (1), alcohol and drugs (1) and local Government. The main population groups focussed upon were the general population (5) and children (3).

The sources of cases were varied with no particular source except project reports having two cases.

Five cases were reviewed and two were included in the interview study.

Mental health

Seventeen cases involved mental health and most of the cases were in Victoria (11) and South Australia (4) and fourteen of them were metropolitan projects.

The agency types that carried out the projects included community health agencies (5), community/consumer groups (3) and general practices (2). Subjects included sexual health, sexual abuse, homelessness (2), housing (2), chronic illness and suicide.

A range of population groups were focussed upon apart from those with a mental illness (4) such as women (6), youth (2) and survivors of sexual abuse.

Apart from project reports (4), the single major source was the report *Good Practices in Women's Mental Health*[55].

Eleven cases were reviewed and one was part of the interview study.

Nutrition

There were fifteen cases involving nutrition. The projects were spread around Australia: New South Wales (4), South Australia (4), Victoria (4), nationwide (1), Western Australia (1) and Northern Territory (1). Six cases were rural.

Seven projects had been carried out by community health agencies, with the balance spread across most other agency types. Within the broad topic of nutrition, subjects included dental care, exercise (2) and social isolation.

The main population groups focussed on were the general community (6) and school children (6). The major sources for the cases were project reports (5) and the *1993 ACHA Conference Proceedings.*

Six cases were reviewed and two were included in the interview study.

Occupational health and safety

Six cases involved occupational health and safety. They were spread around: New South Wales (2), Victoria (2), South Australia (1) and Queensland(1). Three were rural.

Five of the projects had been carried out by community health agencies and the other by a women's health service. Subjects included screening (3), pesticides, environmental health and cancer (2).

The population groups were farm workers (2), blue collar workers (2), women from non- English speaking backgrounds and the general population.

Three of the cases were published in *Cases for Change*, one was a project report, one was in the *1993 ACHA Conference Proceedings* and one in *Mapping the Models.*

Three occupational health and safety cases were reviewed but none were included in the interview study.

[55] Cox M (1994), *Good Practices in Women's Mental Health, Training and Resource Kit.* Healthsharing Women's Health Resource Service, Melbourne

Prenatal/postnatal care and childbirth

Ten cases involved prenatal/postnatal care and childbirth. The projects were from New South Wales (2), Victoria (5), South Australia (1), Western Australia (1) and Queensland (1). Three were rural.

Four had been carried out by general practices and four by community health agencies. Apart from the main topic, one case was about sexual health and one was about homelessness.

Most cases focussed on pregnant women and/or young mothers, but two had specific youth focuses and one involved Vietnamese women.

Sources were varied including project reports (3), *Australian Family Physician* (2) and *Innovation and Excellence in Community Health.*

Five cases were reviewed but none were part of the 25 cases in the interview study.

Rural health

Twenty-seven cases involved rural health. The projects were from Victoria (11), New South Wales (2), South Australia (5), Western Australia (5) and Queensland (4). They were all rural.

Four had been carried out by general practices, five by community health agencies, five by women's health services and four by community/consumer groups. There was a wide range of subjects including isolation (2), smoking (1), sexual health (1), disability (1), nutrition (1), diabetes (2), cancer (2) and immunisation.

Most cases focussed on the general population (11) or women (7). Three cases focussed on Aboriginal peoples. Sources were varied including ten project reports, three from the *Primary Health Care Casebook*, three from *Mapping the Models* and the others spread among a variety of sources.

Thirteen cases were reviewed and five were included in the interview study.

Social isolation

Five cases involved social isolation. The projects were from South Australia (2), Victoria, New South Wales and Queensland. One case was rural.

Three had been carried out by community health agencies, one by a local Government, one by a health department and one by a tertiary institution. Subjects apart from the main topic were local Government, ageing, nutrition and maternal health.

The cases focussed on the general population, women carers, older people (2) and new mothers. The sources were two project reports, two from the 1*993 ACHA Conference Proceedings* and one from the *Australian Journal of Public Health.*

One case was reviewed and it was included in the interview study.

Women's health

Forty-seven cases involved women's health. Twenty five cases were from Victoria, eight from New South Wales, five from South Australia, four from Queensland, three from Western Australia and one from Tasmania. Seventeen projects were rural.

Eleven projects had been carried out by women's health services, fourteen by community health agencies, nine by general practices and the balance spread among a variety of agency types.

The subjects were very widespread with leading ones including Pap smears (8), sexual health (5), cancer (9), maternal health (8) and mental health (5). Within the broad focus on women, the main specific groups involved were women from non-English speaking backgrounds (9) and pregnant women (5).

Sources were widespread with leading ones including *Mapping the Models* (7), project reports (12), *Innovation and Excellence in Community Health* (6) and the *1993 ACHA Conference Proceedings* (5).

Twenty-three cases were reviewed and eight were included in the interview study.

Youth health

Fourteen cases involved youth health. Eight cases were from Victoria, one from New South Wales, two from South Australia, one from Queensland, one from the Australian Capital Territory and one from Western Australia. All of the projects were metropolitan.

Six projects had been carried out by community health agencies two by society/foundations and the rest spread around among a range of agency types.

The subjects were widespread including homelessness (3), alcohol and drugs (2), suicide, mental health (2), nutrition and sexual health. Beyond youth as a population focus, the main specific groups involved were pregnant women (3) and Aboriginals (3).

The only multiple sources were the *1993 ACHA Conference Proceedings* (4), project reports (3) and *Innovation and Excellence in Community Health* (2).

Nine youth health cases were reviewed, but none were included in the interview study.

Conclusions

In this chapter we have described how we collected 185 recently documented cases of primary health care practice in Australia. The collection is restricted to those which involved collaboration

among agencies and/or between service providers and community or consumer groups and/or were seen to address individual problems in their social context.

Our first purpose in collecting these cases was to create a bibliographic resource which would enable wider access to these descriptions of primary health care in action. This we have done with the publication of "Towards best practice in primary health care" and the loading of these cases onto HEAPS. We hope that these descriptions will inspire other practitioners to both develop and to document their own practice. We hope that "Towards best practice" will also be of use to teachers and students in health science courses and will enrich policy oriented discussions about primary health care and other strategies for better health.

Our second purpose in collecting these cases was to create a sample of documented cases of primary health care in action upon which the Reviewer Evaluation (described in Chapter Four) and the Interview Study (introduced in Chapter Five) would be based.

We can draw some further conclusions from the data base as a reflection of current patterns with respect to the documentation of primary health care practice in Australia.

We think that the total number of cases yielded in the search as described is disappointing. There is marked variation in the representation of major topics and of different states. This may be because this kind of primary health care practice:

- is not being carried out in certain fields and in certain states and involving certain professional groups;
- is being carried out but not documented;
- is being documented but not published; or
- is being published but not in generalist health media.

We believe that all four reasons help to explain the disappointing yield, although in different proportions in different areas. All four reasons provide grounds for concern.

The style of primary health care practice around which this project is structured corresponds to precepts and recommendations from a very wide range of authorities. The fact that it is simply not being implemented in many areas and fields should be a major cause for policy concern.

This style of practice is difficult and controversial. There are few firm standards or sets of guidelines. It is difficult to isolate within a controlled experimental situation. Documenting what is happening is a necessary pre-condition for evaluation and learning how to do it better; for the individual practitioner, the agency, the program planner and the researcher.

The fact that such work is being done but not documented (or is being documented but not published) has implications for managers, professional leaders, academics and journal editors.

4. Reviewer Evaluation

In this chapter we describe the second phase of the project: reviewer evaluation of a subset of 99 cases, selected from the 185 cases which had been collected as described in Chapter Three.

Objectives

The objectives of the reviewer evaluation study were:

- to select, through a peer review process, a further subset of 25 cases, reflecting best practice in primary health care, for the interview study (described in Chapter Five); and

- to explore the relationships between project outcomes and selected aspects of practice, as reflected in the judgements of peer reviewers.

Ethics approval for this study, and for the interview study, was provided through the Australian National University Ethics Committee.

Methodology

The three main steps involved in the peer review assessment were: selection, review and analysis.

Selection of cases

Ninety-nine cases were selected for peer review from the collection of 185 cases of primary health care practice (descriptions of episodes, projects or models of practice) which had been identified as described in Chapter Three.

The 185 cases were scanned by one member of the project team and assessed for the presence or otherwise of each of the five aspects of primary health care practice which had been adopted as the focus of this project. (The rationale for structuring the project around these five aspects of practice is outlined in Chapter Two.) The five aspects of practice were:

- collaborative local networking;
- consumer and community involvement;
- vertical networking;
- the macro/micro balance; and
- change consciousness.

Collaborative local networking refers to the relations between service agencies, practitioners, community groups and consumer activists at the local or community level. Do they work together? Do they see themselves as part of a collective enterprise (enhancing the health of this community)?

Consumer and community involvement refers to processes which may enable individuals and groups in the community, who are not paid service providers, to participate in debate and decision-

making about health policies and programs. This could include involvement in planning, implementing or reviewing services and programs and advocacy.

Vertical networking refers to a complementary and mutually respectful partnership between practitioners at the primary health care level and those at the secondary and tertiary levels.

The macro/micro balance refers to styles of practice which address the immediate clinical or public health issues but do so in ways that also contribute to redressing the social conditions which reproduce those patterns of need.

Change consciousness refers to the practitioners' and the agency's awareness of changing environments and circumstances and readiness to engage actively with the forces of change. Does the project reflect such an awareness and readiness? Was the project sustainable? Did the project address the developmental needs of the agency/ies and the practitioners?

As a rule of thumb, each of these aspects of practice was judged to be present in a case study if that particular aspect was evident in the documentation in such a degree as would be useful as an illustration of this aspect in explaining primary health care to health practitioners who were not familiar with it. Cases were included in the subset for peer review if they were scored as having at least three aspects present in these terms.

The application of these criteria to the 185 cases led to the selection of 99 cases for peer review. In one case the reviewer evaluation was unusable, thus 98 cases were included in the analysis.

Reviewers

A panel of 98 reviewers was recruited.

The names of potential reviewers were sought in the first instance from the members of the project's National Advisory Committee (see Acknowledgments, p iii). The Committee members were asked to scan diverse lists from the networks with which they were affiliated (for example, professional directories, committee members, authors) and to identify people who were familiar with the primary health care approach and were from a range of different disciplines and settings in the primary health care field. They were asked to characterise the field of interest of the reviewers suggested. The list so prepared (143) was circulated to members of the committee for further consideration, additions and the possibility of deletions (one was deleted at this stage).

Potential reviewers (142) were approached by mail with a brief description of the project and the nature of the task that reviewers would be asked to undertake. People were asked to indicate their fields of interest if they were willing to assist as reviewers. Ninety people agreed to serve as reviewers. Many of the other 52 potential reviewers indicated support and interest in the project, but did not have the time we required.

A sub-committee of the project's National Advisory Committee was formed to allocate cases to reviewers. Each case study was allocated to three reviewers. The guidelines for reviewer allocation were:

- one from the same general discipline or field of interest but from a different state or territory
- one from the same state or territory but from a different discipline or field; and
- one consumer-perspective reviewer.

These guidelines were followed in most cases. Towards the end of the allocations there were a small number of cases where the particular conjunction of interests and geography made it more difficult to follow the guidelines to the letter. A further eight reviewers were recruited at this stage in order to fill gaps (especially with respect to practitioners of non-English speaking background and consumer activists).

Most reviewers were asked to review three cases. In the end 89 reviewers had cases despatched to them of whom seventy-six returned assessments of case studies. Referees were asked to categorise themselves by the type of agency they worked for and the role they played within the agency. Table 4.1 (page 54) shows the agencies and roles of the 76 referees who finally provided comments. By agency type, the leading groups were people working in community health agencies (25) and Government health departments (20). By role, the largest groups were managers, administrators or directors (34) and research or project officers (12).

Questionnaire

Reviewers received a full copy of the published material for each case they were to review and any additional material which had been furnished by the author (in response to our first letter in which we had notified them of their inclusion in this project and requested any updates or supplementary materials). In addition they received a questionnaire to complete for each case.

The questionnaire (see Appendix Three) was designed to generate a global rating in relation to project outcomes and to generate a measure of the contribution to project outcomes of each of the five study criteria outlined above. The questionnaire was developed through a piloting process involving members of the project team and a small group of potential reviewers.

Agency type	Consumer/ Community Activist	Community Health Worker	Other Health practitioner	Research/ Project officer	Manager Director/ Admin-istrator	Academic	Other	Total
Consumer/ Community Group	5	-	-	1	2	-	-	8
Community Health	-	5	4	1	14	-	1	25
General Practice	-	-	2	-	1	-	-	3
Tertiary Education Department	-	-	-	2	-	7	-	9
Health Department	-	1	-	5	13	1	-	20
Other	-	1	1	3	4	1	1	11
Total	5	7	7	12	34	9	2	76

Table 4.1: Role and agency type of responding referees.

The first question concerned project outcomes and asked for a single judgement of the outcomes recorded ('taking into account the usual levels of skill and resources available to projects of this sort') to be expressed as a rating on a seven point scale which ranged from disappointing outcomes to excellent outcomes. In addition there were five questions about the contribution to the project outcomes achieved, of each of the study criteria listed (and explained) above. Each of these questions took the form of a forced choice between four options:

1. This aspect made a positive contribution to the project
2. Lack of this aspect negatively affected the project
3. This aspect is irrelevant to the project
4. Can't judge.

All of the questions also included a 'further comments' section. In addition there was an 'other aspects?' question and some affiliation details about the reviewer were requested (see questionnaire proforma at Appendix Three).

The 'further comments' data are yet to be analysed across the full 99 cases sent out for review but the reviewers' comments were included in the analysis of the 25 cases selected for the interview study (described in Chapter Five).

Unfortunately there was a typographical error in one of the questions (Question Five on the 'macro/micro balance', see proforma at Appendix Three) which created some ambiguity for reviewers. Consequently we reviewed the 'further comments' provided under this question by reviewers to gain some indication of the numbers who may have been confused by the error. Of 166 reviewer reports sampled, there were 21 with no comments under this question and we are unable to know how they interpreted it. There were a further ten where there were comments but it is not possible to judge from these how the reviewer interpreted the question. Of the 135 where there were comments, and it is clear from those comments how the reviewer interpreted the question, six (4.4%) had misinterpreted the question because of the error and 129 had clearly understood it correctly. On this basis we have analysed the reviewers' responses to the question as if they had understood it correctly.

Analysis

Data were tabulated manually from the response sheets and entered into a computer database through the Epi Info program.

Two hundred and fifty-seven reports from 76 reviewers concerning 98 case studies were available for analysis. 70% of case studies were assessed by three reviewers. Each reviewer assessed between two and five cases (88% rated two or three). 254 of the 257 reviewer case evaluations had valid project outcome scores (between one and seven). The three without outcome scores were excluded from further analysis.

Findings

Outcome scores

The distribution of outcome scores was strongly skewed towards the excellent end (highest scores). 91% of the 254 useable reviewers' evaluation reports had project outcome scores of four or more. The mean score was 5.4. The median score was 6.0 (Table 4.2). It is relevant to note that this is a select group of cases, those that have been published, and the reviewers were asked to take into account 'the usual level of skill and resources available to projects of this sort' in making their judgements.

Due to skewness of the ratings the outcomes were dichotomised into high scores (6-7) and low scores (1-5) and logistic regression performed. The generalised linear mixed modelling (GLMM) procedure of GENSTAT was used in order to account for the possible correlations between scores on the same study and between scores from the same referee.

Overall rating	No. of Reports	%
1 (disappointing)	1	0
2	9	4
3	13	5
4	24	9
5	69	27
6	86	34
7 (excellent)	52	20
Unknown	(3)	-
Total	**257**	**100**

Table 4.2: Distribution of outcome ratings, ignoring clustering by referees and case studies

Of 254 ratings 54% (138) rated 6 or 7 (confidence interval 47% - 61%, adjusted for correlation structure). The variance component associated with the projects was significant (likelihood ratio test 3.3, p=0.07) indicating that projects tended to be rated similarly by different referees but there was no evidence to suggest that the variance component associated with the referees was statistically significantly different from zero, indicating no correlation between scores assigned to different cases by the same referee.

The five aspects of practice

The overall judgement of the reviewers was that most of the five aspects of primary health care practice studied had contributed positively to the outcomes achieved. Table 4.3 is a summary of reviewer ratings of the relevance of the five aspects of practice to the project outcomes achieved. The numbers in each rating category are expressed as a percentage of the total number of reviewer reports with valid outcome scores (n=254).

We have a measure of the excellence of outcomes achieved in each case and for each of the five aspects of practice we have categorised the relevance of that aspect to the outcome achieved.

The next question was whether a judgement by our reviewers, to the effect that an aspect of practice had contributed positively to the outcomes achieved, was associated with the achievement of higher outcome scores.

Aspect of practice	Positive %	Negative %	Irrel-levant %	Can't Judge %	Un-known %	Total %
Collaborative local networking	84	6	2	6	2	100
Vertical networking	39	9	29	21	3	100
Consumer and community involvement	76	9	4	8	3	100
Macro/micro balance	60	14	8	13	5	100
Change consciousness	59	7	10	19	4	100

Table 4.3: Relevance of each aspect of practice to the project outcomes achieved. The judgements of the reviewers about the relevance of each aspect of practice are expressed as percentages of case reports reviewed (n=254). Clustering by case study and referees is ignored.

The random effects logistic regression[56] described above was extended to include the process rating. This is equivalent to testing whether the proportion of high rating studies associated with each of the four relevance categories, 'positive', 'negative', 'irrelevant' and 'can't judge' (the 'unknowns' were excluded from the analysis) was significantly different from what might be expected through chance alone.

First, five separate logistic regressions were fitted testing each of the five aspects of practice separately (Table 4.4). Then a multi-variate model was fitted to test the distribution of high outcome scores across the rating categories for each aspect of practice.

The univariate models showed statistically significant associations between positive ratings for each of the five process aspects and overall outcome scores. In each of five models the largest proportions of high outcome scores were among those studies with positive ratings for that aspect of process and the smallest proportions of high scores among those studies with negative ratings.

In the multi-variate model (based on 220 evaluation reports) positive contribution ratings for consumer and community involvement (p=.02), macro micro balance (p=.03) and change consciousness (p=.02) were still significantly associated with high outcome scores, but not so for collaborative local networking (p=.6) and vertical networking (p=.14). The adjusted coefficients

[56] For further information on this statistical method refer to Di Prele TA, Forristal JD (1994), *Multilevel models: methods and substance.* Annual Review of Sociology, 20: 331-57

for consumer and community involvement, macro micro balance and change consciousness in the multi-variate model indicated patterns similar to those for the unadjusted models in Table 4.4 with positive ratings for consumer and community involvement associated with high outcome scores and positive or irrelevant ratings for macro micro balance and change consciousness associated with high outcome scores.

Percentage of evaluation reports with high outcome scores						
Aspect of practice	**No. of reports**	**Positive**	**Negative**	**Irrel-evant**	**Can't Judge**	**Signifi-cance**
Collaborative local networking	248	60 (52,67)	30 (12,56)	45 (13,83)	14 (4,40)	p=.004
Vertical networking	246	61 (51,71)	22 (9,43)	63 (51,74)	44 (31,58)	p=.003
Consumer and community involvement	246	62 (54,70)	18 (7,39)	42 (16,73)	31 (15,54)	p=.0004
Macro/micro balance	242	65 (57,73)	19 (9,35)	60 (38.79)	48 (31,65)	p=.0001
Change consciousness	244	64 (55,72)	5 (1,27)	61 (41,79)	45 (31,60)	P=.001

Table 4.4: The percentage of reviewer evaluations with high outcome scores (6 or 7) tabulated according to reviewers' evaluations of the relevance of each aspect of practice. Separate logistic regression models were fitted for each aspect of practice taking into account the clustering of scores around case studies and reviewers. The p values indicate the likelihood that the distribution of high outcome scores across the different rating categories would have been due to chance alone for each aspect of process.

Conclusions

Outcomes

The reviewers' assessments confirm that we are looking at a selection of good practice. The median project outcome score across the 98 cases analysed was 6 out of a possible 7. Fifty-four percent were rated at 6 or 7. The selection of the 25 cases for the interview study was based on the rankings derived from the outcomes question (see Chapter Five). We are comfortable that the method has produced a judgement which would conform broadly to that of most practitioners and consumers in the field.

It is worth reiterating that the cases which were subject to this evaluation process had been through a two stage selection procedure with a focus on the network functions of primary health care practice, the social health approach and on organisational change. Whilst there were no constraints on the reviewers' judgements of outcome, the kinds of outcome which were described in these cases were thus focussed around the network, social health and change functions.

Rich outcome descriptions which would allow judgements with respect to other dimensions of outcome (such as clinical excellence or cost-effectiveness) were less common in the case material.

Aspects of process

For four of the five aspects of process a majority of the reviewer evaluations indicated that the presence of each of these aspects was making a positive contribution to the outcomes achieved. The exception was vertical networking (Table 4.3). This general tendency clearly reflected the selection procedures described.

Eighty-four percent of the 254 reviewer evaluations judged that collaborative local networking (CLN) contributed positively to the outcomes achieved and in a further 6% the lack of such networking was deleterious. In 2% of cases they judged it to be irrelevant and in 8% of cases they did not make a judgement.

A similar pattern was evident with respect to consumer and community involvement (CCI) which was judged to be contributory in 76% of reviews and its absence deleterious in a further 9% of reviews. It was judged irrelevant in 4% of reviews and they did not make a judgement in 11% of reviews.

The presence of a macro/micro balance (MM) was judged contributory in 60% of reviews and its absence deleterious in a further 14%.

The reviewers' assessments of vertical networking (VN) is perplexing. The presence of VN was judged to be contributory in only 39% of reviews and its absence was judged to be a problem in only 9%; it was judged to be irrelevant in 29% and no judgement was made in 24% of reviews. The low frequency with which vertical networking was judged to be contributory may reflect a real lack of support provided to the primary health care field by tertiary providers. However, it may also reflect the focus of the writers of the case stories who have not considered their work in relation to the work of the tertiary sector. In at least one of the 25 cases chosen for the subsequent interview study, vertical networking had been rated as irrelevant by the reviewers whereas in our interviews with protagonists a strong and important vertical partnership had emerged.

Correlating outcomes and process

Across the 98 cases analysed there was a strong association between high outcome scores and a positive contribution rating for each of the process aspects studied when analysed on a univariate model. (This finding takes into consideration the upwardly skewed distribution of outcome scores which reflected the fact that the cases reviewed in this project had been selected for excellence, having all been documented and published). We are not suggesting that these data support a conclusion of causal relations, for example, that excellent practice with respect to local networking causes better outcomes. It may do so but such a relationship has not been demonstrated in this project.

The associations we have demonstrated here are associations between particular judgements made by reviewers of constructs which we are conceptualising in terms of process and outcome. It would

be unlikely that reviewers, in making a judgement about the outcomes described, would be unaffected by their assessment of the process described (see below). These results may tell us more about the internal consistency of our conceptual frameworks (for example the notion that good process leads to good outcome) than demonstrating that (something real called) collaborative local networking contributes to (something else real called) excellent outcomes.

The notions of process and outcome are very useful but are very much shaped by the stories in which we embed them. In Chapter Nine we explore the concept of an outcomes cycle whereby some of the outcomes of today's practice are identified as the pre- conditions for good practice tomorrow. This may be contrasted with the more common linear conception of structure leading to process leading to outcomes.

The fact that CLN and VN dropped out of significance in the multi-variate model suggests that whatever these ratings are 'measuring' is fully encompassed by the other three process aspects (CCI, MM and Change consciousness). This is very suggestive. It is unlikely to simply reflect a conceptual overlap between our constructions of, for example, CLN and CCI. These are conceptually quite different. On the contrary the fact that CLN and VN dropped out of significance suggests that whatever dynamic of factors creates excellence (as measured in this project) it is reasonably encompassed by CCI, MM and Change consciousness.

These conclusions cannot be automatically generalised to a more universal setting of primary health care practice since this group of 99 cases was selected for excellence, in that they were published, and was further selected through two stages on criteria which overlap with the aspects of process in question.

Methodology

Validity and reliability of the outcome score

The range of types of cases in this group was very wide, including: evaluative project reports, evaluations of models of service delivery and reports of the development of service organisations over a period of time. The reference points that reviewers would have drawn upon in judging the outcomes of a short term project to have been excellent are likely to be different from those drawn upon to evaluate the development of an agency over 20 years.

The reference points against which reviewers judged excellence would also have varied across different people depending on their training, institutional role, cultural perspectives, etc. Not only may there be different dimensions of excellence of outcome which people of different backgrounds value differently but they may apply different standards of expectation (and hence assign different numerical ratings).

As indicated above, there is also some arbitrariness in the definition of outcomes. It will become clear in Chapters Six, Seven and Eight that there was considerable continuity between pre-conditions, aspects of process and outcomes. In some respects the boundaries between these moments of practice were quite arbitrary because they were imposed for the purpose of capturing the work of that agency or project in the form of a story, with a beginning, a middle and an end.

So, did excellence (versus disappointing) as applied to outcomes refer to the same kind of thing in all of the 98 cases and 254 evaluations? When we ranked these cases on an interval scale were we comparing like with like?

Despite the uncertainties mentioned we have some grounds for assuming that the data generated by the global outcomes question reflected, in considerable degree, a widely held understanding about excellence and outcomes.

The method which we have used relied upon the intuitive adjustment, by the reviewers, of their norms of excellence to the different types of cases they were asked to evaluate and the standards of expectation they used. In assigning a rating they were asked to take into account the usual level of skill and resources available to projects of this sort. In encouraging reviewers to assume reasonably similar definitions of the boundaries between process and outcomes we have relied on the communication value of basic English through the use of the scale delimiters "disappointing outcomes" and "excellent outcomes".

We have some evidence with respect to the inter-rater reliability of the outcome scores through the analysis of the sources of variation in the GLMM model. The variation in the outcomes scores was significantly attributable to variation between the cases. There was no evidence in this model of a tendency for the scores provided by individual reviewers to cluster. However, since most reviewers reviewed only two to four cases each, the data upon which reviewer clustering might be evidenced are thin.

Some inter-rater variation was built into the method in that the panel of reviewers who evaluated each case was deliberately mixed. This was conceived as a way of integrating the different perspectives of the different disciplines and stakeholders in the primary health care sector. If every case had been evaluated by every reviewer we would have much stronger grounds for delineating inter-rater variation.

In conclusion, we are comfortable with the ranking of the 98 cases analysed through this tool. It is an approach which is broadly comparable to that used by research funding bodies for allocating substantial resources. While different views might be held on local variations in rankings we feel that this strategy has produced a procedural judgement which would conform broadly to the judgements of practitioners and consumers in the field.

Validity and reliability of the process ratings

Reviewers were asked to make judgements about the relevance to the outcomes achieved of five aspects of process and whether the presence (or absence) of these aspects had made a positive (or deleterious) contribution to the outcomes achieved (or had been irrelevant). We also asked the reviewers to provide free text comment in relation to their ratings.

Each of the process questions was preceded by a short definition of that aspect of process (see Appendix Three). However, despite the singular form in which these questions were asked and the explanatory preamble, it should not be assumed that there is some essentially unitary phenomenon

at the core of each question. We are very conscious of the heterogeneity of the cases, the complexity of the aspects of process (see Chapter Seven particularly) and the different perspectives brought by our reviewers.

We do not make claims with respect to the inter-rater reliability of the process ratings. In assigning reviewers from different backgrounds to each case we were hoping to generate a broad rather than a narrow view on these issues.

The data we are reporting, the ratings and the unstructured comments, are judgements; each provided by a particular reviewer in response to a particular question in relation to a particular case. The correlations we are reporting are between sets of responses (outcome ratings and process ratings); we are not assuming that these responses and the correlations between them transparently reflect an underlying reality. (We do not find it useful to differentiate between an underlying reality and distortions incorporated in our data on account of our basing them on human judgement.) We are interested in the reviewers' judgements, and the correlations between different sets of judgements, because of what they tell us about how our reviewers make sense of their field and make sense of these cases.

Correlating outcomes achieved with aspects of process

Strong associations between the outcome ratings and the judgements of reviewers with respect to aspects of process were demonstrated despite the heterogeneity of the data (different types of cases and different backgrounds of reviewers) and strong selection bias in this project towards excellence (in that the cases had been documented and published).

We are confident that the associations reported are real although what they mean requires further exploration.

Our statistical analysis of the reviewers' ratings confirmed a strong association between good outcomes and each of consumer and community involvement, macro/micro balance and change consciousness. Collaborative local networking and vertical networking seem to be strongly associated with good outcomes on bi-variate analysis but the association disappeared in the multi-variate analysis. The associations documented in these data can be interpreted in terms of a causal relationship whereby these elements of process lead to good outcomes. Alternatively we may judge that the same phenomena are being interpreted by our reviewers through two different perspectives (outcomes and process) and this explains the statistical association.

Owing to the skew distribution of the outcome scores we chose not to use regression models which assume normality. We also explored but rejected the possibility of treating the process ratings as three points on an interval scale ('neg'=-1; 'irrel'=0; 'pos'=+1). In the GLMM analysis tabulated in Table 4.4 each of the process categories is treated as a separate group.

Next steps

This study has demonstrated the usefulness of documented accounts of episodes and projects in primary health care as a basis for analysis of outcomes and the patterns of practice which contribute to those outcomes.

This project has confirmed the willingness of reviewers to provide judgements with respect to these matters. This present project has also underlined some of the methodological pre- conditions for the generation of quantitative data from case documentation which is meaningful and can be handled statistically.

The analysis presented in Chapters Six, Seven and Eight foreshadows the possibility of finer and more discriminating questions, about outcome, process and structure. The insights arising from the interview study with respect to the mechanisms whereby aspects of process contribute to better outcomes suggests the possibility of more focussed questions to peer reviewers in future studies of this kind. The use of more homogeneous kinds of cases will also be explored in future studies.

There is a contradiction between the best practice perspective with its focus on excellence and the research interest which looks for a wider spread of quality to facilitate correlative analysis. This has implications for the use of published cases rather than a sampling approach and including the documentation of practice as part of the research.

5. Interview Study

The purpose of the interview study was to generate detailed qualitative information which would enrich our understanding of the outcomes of primary health care, the patterns of practice which produce good outcomes and the policy and program arrangements which predispose to good practice. The interviews would thus contribute to policy discussion, organisational and staff development as well as providing benchmarks of best practice for the field.

We interviewed at least two people associated with each of 25 selected cases (listed in Appendix One) asking about: the range of outcomes achieved, the processes used and the pre-conditions which enabled those good processes and outcomes to occur.

In this chapter we describe the methods which we used for: selecting cases for interview; developing the interview questions; carrying out the interviews; and analysing the data.

Selection of cases for interview

A subset of cases was selected for the interview study. We were aiming to focus on the cases which had been rated most highly with respect to project outcomes in the Reviewer Evaluation study (Chapter Four) and where the five aspects of process which were the focus of our interest had been rated by our reviewers as 'present and positive' (that is to say, present and judged to have contributed positively to the outcomes achieved).

Of the 98 cases that had been included in the reviewer assessment (described in Chapter Four), 23 had attracted average outcome scores of six or greater. These were selected for inclusion in the interview study.

These 23 cases were then reviewed with respect to the ratings given by their reviewers regarding the relevance of each of the five aspects of process. Each aspect of process was judged to have been 'present and positive' by all three reviewers with the following frequencies: collaborative local networking (11/23), consumer and community involvement (12/23), macro micro orientation (7/23), change consciousness (8/23) and vertical networking (1/23). Because of the low number of cases where vertical networking had been rated as 'present and positive', the remaining 75 were scanned for unanimous reviewer ratings of vertical networking as 'present and positive'. There were two further cases identified (which had average outcome scores of 5 and 4.3); these were added to the subset selected for the interview study.

Case study analysis

Each of the cases selected for interview were assigned to one of three members of the project team. These members undertook the case study analysis, interviews and case coding in consultation with the other members of the team.

The first step in preparing for the interviews was to review all of existing data held for each of the selected cases. The material for each case included: the published account through which it had been identified initially; any additional material provided by the authors (after our communicating

with them about the project, see Chapter Three); and the reviewers' comments on the questionnaires (see Appendix Three).

We developed a proforma for analysing each case study which was used for preparing for each interview and for analysing the results of the interviews. The proforma required the identification (for each case study) of salient elements of: outcomes achieved, aspects of process described and the apparent pre-conditions for good practice. The proforma required for each of these elements and aspects: a brief descriptive phrase, brief notes (especially about the links between preconditions, aspects of process and outcomes) and the formulation of questions to follow up.

Prior to the first interview for each case study the analysis and proposed questions were discussed with at least one other member of the project team. The case study proforma was revised after each interview and the questions to be followed up reworked as necessary.

Interview schedules

Interview schedules were prepared for each interview on the basis of a general proforma and the specific questions which emerged from the case analysis. A general proforma for preparing for interviews was developed and revised slightly on the basis of early experience. Following a basic introductory preamble, the interview schedules comprised:

1. Questions of fact that needed clarification;
2. Outcomes: a general question about outcomes achieved followed by probing with respect to elements of outcome claimed (and what was the evidence) and elements of outcome not mentioned;
3. Strengths: general questions about aspects of process and preconditions which appeared to have contributed to the outcomes achieved followed by more specific probing in relation to salient elements of process and preconditions identified in the case study analysis;
4. Limitations: general questions about limitations and constraints followed by more specific probing to follow up issues identified in the case study analysis.

Conduct of interviews

People who had been closely associated with the project were identified as potential interviewees. These included project workers, project steering committee members, consumers or community members, team leaders, committee of management members and managers of services.

In the first instance the person most involved with the initial writing of the case study was contacted. Often this person was already aware of this project as they would have been contacted in the course of our preparing the bibliography (see Chapter Three).

All of the people whom we proposed to interview were written to requesting their agreement to participate. They were provided with background material on our work and an indication of the kinds of topics to be discussed. In every instance the people contacted were keen to contribute to the project and gave generously of their time.

At the commencement of the interview details were requested about the interviewee's role, agency and current contact details. Each interviewee was asked for their permission to use information from the interview. They were assured that their names would be kept confidential. Most interviews were of 60 - 90 minutes duration. On completion of the first interview the interviewee was asked to nominate appropriate people for second or third interviews.

Interview data were recorded in the form of written notes.

Coding and analysis

After completion of the interviews the data available about each case comprised: the original published account, supplementary material provided by the original author following our first contact; reviewers' comments; notes of interviews and our own case study analysis proforma.

The unit of analysis was the case study; that is to say, the unit which was indexed in relation to the coding framework was the case study itself, not particular passages of text.

The coding framework was developed in a workshop involving project team members. Three cases were selected and the team member who had been exploring the case presented the story to, and was quizzed by, the other members of the team regarding the outcomes achieved, the salient elements of process and the important preconditions for the process and outcomes achieved. In the context of this presentation and critical discussion possible code terms were identified under the broad headings of outcomes, process and pre-conditions. This resulted in a preliminary set of codes which were then tested on another three cases and revised accordingly. The final set of codes used for indexing each case is listed at Appendix Four.

Codes were assigned to each of the case studies at two levels of importance: first, presence or absence, and second, outstanding and particularly contributory or not. The assignment of a code at the first level of importance was determined by the question, 'Was this aspect present or not present in this case?'. For assigning codes at the second level, 'outstanding and particularly contributory', two criteria were developed. Elements of outcome were coded at this level if they were judged (by our project team member) to be so outstanding that they could justify being given prominence in an annual report. Elements of process and pre-conditions were coded at this level if they were judged (by our project team member) to have so clearly contributed to the outcomes achieved that they would be worth publicising as benchmarks for study by the wider primary health care field.

We are conscious of the subjective nature of these assessments and they are not presented nor have they been used as if they are precise measurements. We have used them only to identify degrees of magnitude, the broad direction suggested by the case material.

Having tentatively assigned codes to each case study, members of the project team then prepared brief explanatory notes in relation to the codes which had been assigned as outstanding or particularly contributory. These one or two sentence memos indicated why this code was judged to be present in this case and why it was judged to be outstanding or particularly contributory. These

explanatory notes were then discussed within the project team to compare the kinds of criteria being used by different team members and to debate and revise the codings.

The memos were constituted as a data base (each record consisting of code number, case number and memo) from which three integrated documents were prepared (for each of outcomes, process and pre-conditions) providing an ordered account of all of the cases coded (represented by memos) listed under all of the codes.

These three documents were then reviewed by the project team in a workshop setting with a view to deriving a coherent narrative. The basic level codes were reordered and grouped into related groups of codes and the project team explored different scenarios describing how particular configurations of pre-condition appeared to contribute to particular patterns of process and how patterns of process appeared to contribute to particular kinds of outcome.

We were particularly interested to see how robust our original study criteria would prove to be as useful terms for describing primary health care practice meaningfully. The more complex data suggested some significant changes to the ways we had been conceiving process.

The term 'consumer and community involvement' was carried through, affirmed as important and relatively unchanged with respect to its meaning.

We formed the view that the term 'vertical networking' was not coherent because it did not distinguish between relationships within the health sector and intersectoral relationships; these are significantly different aspects of practice. In Chapter Seven we use 'collaborative local networking' and 'strong vertical partnerships' to refer to relationships within the health sector and we have included 'intersectoral collaboration' (local-local or local-central) which was not in the original list. (We discuss these new definitions in more detail in Chapter Seven.)

We are dissatisfied with 'change consciousness' and we believe that the introduction of 'organisational learning' and 'good management' enables us to delineate the key issues referred to by 'change consciousness' but in a more practical way.

The limitations of the linear model of "structure => process => outcomes" became quite evident as the analysis proceeded and the team elected to work with the 'circular' model illustrated in Figure 9.2. In this circular model the category 'outcomes' is taken to include capability building; the strengthening of process and creating the pre-conditions for the next round of practice (see below).

The following analytic headings have been adopted for the narrative presented in Chapters Six, Seven and Eight.

Pre-conditions:

* clarity of need;
* strength of community;
* supportive policy and program environment;

* supportive organisational environment; and
* inspirational leadership.

Process:

* consumer and community involvement;
* collaborative local networking;
* strong vertical partnerships;
* intersectoral collaboration;
* macro/micro orientation;
* organisational learning; and
* good management.

Outcomes:

(a) which are valued for their benefit today:
* immediate improvements in the health status of individuals,

(b) which are valued for their benefits tomorrow:
* improvements in the social conditions which shape the health of communities; and
* strengthening of health care programs and services.

(c) which are valued for their benefits the day after tomorrow:
* enhanced community capacity;
* enhanced institutional capacity; and
* enhanced professional capacity.

6. Pre-conditions

Five pre-conditions for good practice in primary health care emerged from the interview study.

These are:

* clarity of need
* strength of community
* supportive policy and program environment
* supportive organisational environment;
* inspirational leadership.

Two of these, clarity of need and strength of community, are in the nature of environmental pre-conditions which have been influenced by a range of social, political and economic circumstances. Lying more immediately within the determination of policy and management are supportive policy and program environment and supportive organisational environment. The fifth pre-condition, inspirational leadership, is not so easily prescribed, but the conditions for its emergence can be fostered.

In this chapter we discuss each of these five pre-conditions for best practice with three purposes in mind:

* to pull together what we have learned from our case studies and interviews the form of a coherent account of the ways in which these factors work together and contribute to better outcomes
* to identify vignettes of good practice (benchmarks) which illustrate these pre-conditions for best practice in primary health care to facilitate wider access and study; and
* to identify policy initiatives and professional development directions which could strengthen the conditions for continuing improvement in primary health care practice (discussed in Chapter Nine).

Clarity of need

Agencies and practitioners were confronting real needs in all of the interview cases but in around 40% of the 25 cases we judged that clarity of need had contributed significantly to framing the circumstances for best practice. Cases which illustrate manifest need include the ongoing crisis in Aboriginal health demonstrated in Gagudju (#95)[57] and among the Aboriginal refugees that flooded into Redfern in the post 1967 period (#60).

Further instances of clarity of need were evident in the gross river pollution at Onkaparinga (#56) and the anxiety among the women from non-English speaking backgrounds in Brisbane about cervical and breast cancer screening (#129). The needs related to the social isolation of people dependent on oxygen was well illustrated in the Home Oxygen project in Victoria (#34).

[57] Wherever we have used a case to illustrate a point, the case number has been given. Appendix One provides more details on each case and cases can be traced using the numbers provided I the text.

In some cases the crisis concerned the fate of a particular organisation such as the small country hospital in Babinda, Queensland, facing closure unless it changed its role and practices significantly (#21). In the case of the Patchwork project (#71) in Anglesea, Victoria, the needs related to the possibility of a repeat of the devastating Ash Wednesday bushfires.

How clarity of need contributes to good practice

We hypothesise that clarity of need contributes to good practice by short circuiting the sometimes lengthy processes of negotiation and consensus-building around needs. The crystallisation of a shared story about needs and priorities, due to the obvious nature of those needs, orients all the players to thinking about how they might contribute and to the emergence of a complementary program of initiatives.

Listening and catalysing

In some cases the revelation of need was catalysed by a key actor (practitioner or consumer). One person's initiative revealed to the wider system of players that here was need that was stark indeed. This may be illustrated by the Tea Trolley story (#128) where one practitioner's boldness in providing a tea trolley service to an oncology outpatient clinic, revealed the depth of need among the patients in that clinic for the chance of sharing their experiences and uncertainties.

The Coburg Carers story (#133) revealed a deep need (the isolation of carers) that might have been invisible to many but became clear through the success of the project. Likewise, the depth of concern among women from non-English speaking backgrounds in Brisbane about their choices with respect to breast and cervical cancer screening (#129) might not have been widely known prior to the setting up of this program but the success of the program was due, in part, to the urgency of those needs.

These cases underline the traditional precepts of primary health care about listening to the concerns of the people whose health is in consideration rather than relying entirely on the epidemiological indicators[58]. They underline the need for structures and forms of practice which allow community needs to be heard and recognised.

Interface with social movements

In some cases the energy revealed by particular cases was part of a wider social movement; reflecting and contributing to a wider discourse of concern, beyond the community setting of that particular case. Projects which reflected and contributed to wider social movements included:

* the Onkaparinga project (#56), which built, at least partly, on the strength of the environment movement;
* the determination within Aboriginal communities at Gagudju (#95) and Halls Creek (#161) to address alcohol-related problems; and
* Reclaiming the Womb (#16) and the women's movement.

[58] Wass A (1994), *Promoting health: the primary health care approach*. Harcourt Brace and Company, Australia

Strength of community

In around half of our 25 cases, we identified, as setting the scene for outstanding passages of practice, a complex of features which we are referring to as strength of community. This complex appears to include:

* a strong sense of shared identity;
* rich linkages within and across networks; and
* traditions of civic involvement and political activism.

Strength of community appears to contribute to better primary health care practice and better health outcomes in a number of ways including:

* communication links;
* shared identity;
* community accountability; and
* social action skills.

Recognising strength of community as a pre-condition for good practice underlines the importance of community development (facilitating the development of stronger communities) as an important outcome and therefore objective of practice.

Communication links

Richer and more complex communication links facilitate the development of a shared and more robust understanding of the problems and possible strategies. The cycles of talk are sustained through pre-existing networks rather than needing to be supported mainly by the project activists.

This pattern is illustrated in the richly networked community that supported the various arms of the Coburg Carers project (#133) and Healthy Localities Benalla (#132); and the Housing for Health project which started in one settlement in the Pitjantjatjara Lands (#186). Similarly, the networks associated with the Anglesea Neighbourhood House and the local meals-on-wheels volunteers supported the Patchwork project (#71).

Shared identity

In several cases it appeared that a greater willingness to share the problems of other individuals as our own contributed to good practice and good outcomes because the conditions existed for a stronger sense of shared identity. This was recognisable in different forms in the Brisbane Breast and Cervical Cancer project (#129) which was built up around the networks of bilingual community educators employed for the project; the Vietnamese Women's Domestic Violence Poster project (#10) where women, including Vietnamese women, came together to create an eye-catching poster advising women of their rights regarding domestic violence; the sense of shared identity among the patients in the oncology clinic where the Tea Trolley project was carried out (#128); and in several of the rural projects such as Halls Creek (#161) and Babinda (#21).

Community accountability

One mechanism through which strength of community contributes to better patterns of practice is where it sets the context for a stronger community voice in negotiating the terms of collaboration among local agencies and between local agencies and more centrally located expertise.

Competition (between practitioners, agencies and disciplines) can be a significant barrier to collaboration and local networking. It appears to us that a strongly articulated consumer or community voice can reduce the play of such rivalries; can encourage, even obligate practitioners to collaborate and perhaps increase the professional rewards of doing so. It may be that the Women's Health Rural Outreach project (#17) illustrates the role of a strong community constituency in creating the conditions for closer provider co-operation.

A similar dynamic may operate with vertical partnerships; collaboration between the primary and the secondary or tertiary sectors. A major barrier to harmonious and constructive vertical partnerships is the different priorities and world views which often characterise practitioners at these levels. To oversimplify somewhat, the technical experts of the tertiary sector are often less conscious of the family and social aspects of people's health care and the social conditions which constrain their health chances.

In situations where the tertiary sector is able to discount the concerns of primary health care practitioners, the conditions for a respectful negotiation of the different perspectives do not exist. (This is most notoriously illustrated in scrappy and long delayed hospital discharge summaries.) A clearer articulation of community concerns may help to encourage, even obligate, these different professionals to work through their different perspectives against some frame of reference of community need.

The Redfern story (#60) perhaps best illustrates how strength of community can help to shape the terms and conditions under which the experts of the tertiary sector participate in the vertical partnership.

Social action skills

Finally, strength of community may reflect a strong tradition of civic participation and/or more overt political activism. Such traditions may carry with them a rich resource of knowledge, skill and confidence in social action, community organisation and political advocacy.

Traditions of civic engagement are often more prominent in country towns and this may be relevant to Babinda (#21) and the Benalla Healthy Localities project (#132). The strong representation of Aboriginal health and women's health projects in this selection of 25 case studies may reflect the overlap between social movements (the women's health movement and the movement for Aboriginal self-determination) with primary health care practice.

Supportive policy and program environment

The importance of a supportive policy and program environment as a pre-condition for good practice would be hard to overstate. Some of the key features of such an environment are:

* a coherent and authoritative policy narrative;
* pre-existing models of program or service delivery;
* mandated structures to support community involvement in decision-making; and
* program infrastructure (being part of a wider program, availability of
* financial resources, existing networks for project collaboration).

Having a supportive policy and program environment contributes directly to all six areas of practice discussed in Chapter Seven. It contributes directly but it also contributes indirectly through helping to create a supportive organisational environment, discussed in the next section.

Policy narrative

In around 40% of the 25 cases included in the interview study, having a coherent and authoritative policy narrative within which to frame one's practice appeared to be a particularly important pre-condition for success. Such a policy narrative can be a source of guidance, of leverage and sometimes money in primary health care. Policy narratives serving these functions can be promulgated at the state, national or even international levels.

Policies which served this function for the cases in this project included the Queensland Primary Health Care Policy which provided a framework for the re-orientation of Babinda Hospital from an acute care service to a primary health care agency (#21) and the South Australian Primary Health Care Policy that provided guidance for the work of the Parks Community Health Service in both the Wilson Reserve project (#58) and the Parks Nutrition project (#27).

The NSW Mental Health Policy provided guidance for the Far West Mental Health Service (#157) and the National Mental Health Policy for both the Far West Mental Health Service and the Horizons project (#108). The National Women's Health Policy (NWHP) appeared to be a significant source of guidance, leverage and money for a number of projects:

* the Vietnamese Women's Domestic Violence Poster project (#10);
* Women-centred Resources (#15)
* Women in Industry and Community Health's (WICH) Factory Visits Program (#14
* Outreach to Rural Women (#17); and
* Reclaiming the Womb (#16).

The Ottawa Charter and the Alma-Ata Declaration were also cited by several informants as helping to frame their projects.

The NWHP and the National Mental Health policy were both backed up with some funding and this obviously assisted agencies in re-orienting their programs. However, the framework provided by the NWHP was also cited as providing useful guidance. The HealthSharing Women's Health

Resource Service consciously drew upon the NWHP emphasis on health system reform[59] and the development of new models in their Resource Development (#15) and Reclaiming the Womb projects (#16).

Models of program or service delivery

The availability of existing models of program or service delivery can also be a pre- condition for getting a new program off the ground. This appeared to be particularly important in three cases.

The reshaping of the Babinda Hospital (#21) drew self-consciously on models of service delivery common within the community health program elsewhere in Australia. The planning of the Brisbane Cervical and Breast Cancer project (#129) drew on a model of bi-lingual community educators previously used by the NSW Women's Advisory Council.

The setting up of the Victorian Home Oxygen Support Group (#34) benefited from the extensive experience of the Collective of Self-help Groups (a self-help group peak body) in Melbourne.

Structured community involvement

In around 40% of our interview cases institutional structures and policies (including legislation) which provided for or required community involvement in decision-making appeared to constitute important pre-conditions for good practice.

By far the commonest of these provisions was some sort of commitment to consumer and/or community representatives on committees of management of primary health care agencies.

Redfern Aboriginal Medical Service (#60) was managed by an Aboriginal controlled board. Major decisions were made with extensive community involvement, people coming to board meetings and having their say. This kept the agency politically oriented and working as an advocate for Aboriginal people.

Nganampa Health Council (#186) was an incorporated body constituted and managed by Aboriginal people. All project work was done under the supervision of Council and non-Aboriginal people needed permission to work on Pitjantjatjara lands.

Horizons Support and Living Skills Association (#108) was a community managed psychiatric disability support service. It was an incorporated body run by a committee of management with representatives from the local community and from consumers.

The Victorian Home Oxygen Support Group (#34) was an incorporated association. It was consumer managed and controlled; all members were consumers and only a limited number of non-consumers were invited to meetings.

[59] The dual strategy for health system reform refers to the need for women's health services to work towards changing the ways in which the mainstream health system addresses women's health issues whilst modelling ways of addressing such issues directly themselves.

Women in Industry and Community Health (#14) was a women managed and controlled service. The committee of management reflected a range of non-English speaking backgrounds and occupations. The service had a policy of employing women from a range of community cultural backgrounds which reflects those in the sector it is serving.

The Loddon-Campaspe Women's Health Service (#17) was an incorporated association run for women by women. The committee of management had reserved positions for six women from Bendigo (the regional centre for their service area) and six women from more rural locations.

The Parks Community Health Service (#27 and #58) was an incorporated association with a community/resident dominated committee of management.

In several of these cases, as well as having community-based committees of management, special project groups were established with strong community representation to run the projects.

The Parks Community Health Service had a long-standing practice of delegating significant decision-making to action groups consisting of community/consumer members and one or two staff.

Noarlunga Healthy Cities (#56) had provided for the involvement of community members on committees and the Onkaparinga project was directed by a sub-group, the Water Quality Group, led by community activists.

The Halls Creek project (#161) was required under the State Drug and Alcohol program to involve community members on project steering committees.

Program infrastructure

Being part of a wider program was apparent as a pre-condition for good practice in most of the 25 interview cases and was seen as particularly important in about one third of cases. Being part of a wider program includes a number of separate elements:

* a community of fellow practitioners with a shared interest in service models, professional development, critical reflection;
* existing networks for project collaboration; and
* the availability of financial resources.

Opportunities for peer support and critical reflection

The various women's health programs illustrated the value of being part of a wider program able to draw upon common resources and with opportunities for regular forums to explore shared problems. Both Women in Industry and Community Health (#14) and the Loddon-Campaspe Women's Health Service (#17) made extensive use of resources developed by other women's health agencies. There were regular opportunities for women's health services in Victoria to meet and discuss their work at statewide forums conducted by Women's Health in Victoria.

The Coburg Carers project (#133) and the Benalla project (#132) were both part of the Victorian Healthy Localities program which included provision to meet with other practitioners in the program and various professional development opportunities supported by central staff. Likewise the Billanook project (#187) was part of a wider project, the Health in Primary Schools project (HIPS).

Existing networks for project collaboration

The pre-existence of various networks through which some of these projects were organised has been identified as a pre-condition for good practice.

The West Australian Schools Health (WASH) project (#170) used local school networks to swap ideas/resources and to reflect together on projects. In addition there was a network of health promotion agencies which met on a regular basis to resource schools on topics as required.

The Vietnamese Women's Domestic Violence Poster project (#10) was based on a well established network of workers in a range of organisations who worked on domestic violence.

The Far West Mental Health Service (#157) was centred on Broken Hill, a regional town, and based on a well known service which had existed for a number of years. Staff time was specifically allocated for establishing contacts in other towns and isolated areas. Staff development programs assisted staff to make personal links with providers and specialists in capital cities.

The Horizons Support and Living Skills Association (#108) originated with a submission developed by staff from local, regional and state agencies and the service began with very strong connections. These were maintained through dedicated staff time and representation on the committee of management.

The Child Development Unit report (#106) came from Port Lincoln, a small self-contained provincial town. The community health centre (CHC) was part of the hospital structure and there were strong personal and institutional connections. The general practitioner involved practised next door to the CHC and had extensive informal contact. The doctor had previously trained as a paediatrician and therefore had close contact with specialists at Adelaide's Royal Children's Hospital as well as having a local network of contacts, through the Division of General Practice, with other participating general practitioners.

Availability of financial resources

The availability of financial resources is an obvious pre-condition for good practice; worth noting nonetheless. Some of the excellent projects included in our 25 interview cases were initiated or subsequently enabled by the availability of funding.

The Coburg (#133) and Benalla (#132) Healthy Localities projects were based on funding from the Victorian Health Promotion Program as was the HIPS project (Billanook, #87). The WASH project (#170) was also supported by the Western Australian equivalent, HealthWay, to enable

teachers to be taken out of the school environment to participate in training and planning activities. HealthWay also funded the research component of the Halls Creek project (#161).

Both the Gagudju (#95) and the Child Development Unit projects (#106) were supported through the Commonwealth's General Practice Reform Program.

Supportive organisational environment

The value of a supportive organisational environment in constituting the conditions for best practice leaps out of our 25 cases of best practice. From our analysis of these cases the features of a supportive organisational environment which appear to be most important include:

* organisational purpose clearly articulated, shared and alive;
* formal planning and review structures based on a strong policy framework;
* organisational policies which value critical reflection, evaluation and innovation;
* organisational policies which support staff development including participation in formal study and research;
* formal structures which support consumer and community participation in agency decision-making and project operations;
* structures which facilitate the recognition of macro as well as micro issues and the development of strategies and practices which encompass both; and
* a longer term perspective.

Organisational purpose articulated and alive

In around 80% of the interview cases there was a clearly articulated organisational purpose, actively shared among the members of the organisation and commonly referred to in orienting people's practice. In half of the cases the clear articulation of organisational purpose and its use in everyday practice was judged to be particularly contributory to the outcomes achieved.

In some of these cases the purpose of the agency or project was relatively narrow and had been specified clearly from its inception. The Home Oxygen Support group (#34) had a clear purpose related to the specific needs of its members. The WASH project (#170) was based on a clear vision of project purpose and direction and the principles upon which it was to operate.

The Horizons Support and Living Skills Association (#108) had a more general range of objectives but the main purposes were firmly specified in the rules of association, service philosophy and policies and protocols: to maximise consumer involvement in, and control over, the services they receive and the realisation of consumer rights. These were reinforced through regular review and evaluation by staff and consumers.

A range of women's health services or projects, all of which specialised in a particular program area, all rated highly on this measure. Through the NWHP the Women's Health Centre in Brisbane (#129) had received new money and appointed new staff and was energetic in its approach to a range of health issues for women. The Centre identified migrant and worker health and chose to focus in the first instance on cancer screening.

The Loddon-Campaspe Women's Health Service (#17) was established following high profile reviews of women's health at the state and national levels. There had also been extensive consultation locally. The objectives and priorities of the Service were shaped in relation to the national and state policies and through local consultation and accountability. The objectives and philosophy were reflected in the issues, projects and structures of the Service and in the staff training and employment practices. They were kept alive through vigorous internal debate and continuing interactions with the wider constituency.

Two projects from the Healthsharing Women's Health Resource Service were included in the interview study (Women-centred Resources, #15 and Reclaiming the Womb, #16). This service was established with a particular mandate as an information and resource service. Its organisational purpose is oriented to the NWHP and to feminism more generally. Its philosophy and principles are explicit and an understanding of and commitment to them are included in the selection criteria for employment. The service has a strong tradition of debate amongst staff and committee.

The story of Redfern (#60) was cast at a more general level and over a two decade period. Redfern's objectives about improving the health of Aboriginal people were clearly articulated and the underlying philosophy of the organisation was based on the principles of human rights, land rights and self-determination.

Two projects which were included in the 25 interview cases originated with the Parks CHC in Adelaide (Nutrition in the Parks, #27 and Wilson Reserve, #58). These also reflected the work of an organisation with a very broad mandate and a long history. The Parks CHC had a strategic plan based on the Ottawa Charter which was a key reference in project planning and review. The centre had a strong tradition of debate, study and critical reflection going back over two decades. There was a strong stream of discussion regarding the theory and practice of community development. The team structure and meeting arrangements were organised to facilitate project planning and evaluation and reflection. The centre's employment policies included consideration of the understanding of and commitment to the objectives of the centre.

Planning, evaluation and review

Most of the organisations in the interview study had formal planning, evaluation and review structures in which organisational purpose, priorities and principles figured strongly. We have described four examples of this below.

WASH (#170). A policy framework had been established at the commencement of the project based on primary health care, community development, the principles of the Ottawa Charter and previous work on school health promotion. The progress of the project was monitored against these principles and was refined each year.

Horizons (#108). The policy context for this organisation included the National Mental Health Policy, the National NESB Women's Health policy, moves to deinstitutionalise the provision of psychiatric care and the need for recreational programs for people with mentally illnesses. Formal

service planning and review structures were in place which included participants. Arrangements were also in place for participant groups to review existing programs and suggest new ones.

The Loddon-Campaspe Women's Health Service (#17) had an annual planning cycle which included the evaluation of all projects and the review of all programs. It was guided by the philosophy, aims and objectives of the Service which in turn were based on the NWHP and the state program. Knowledge of these policy references were reflected in priority setting, project planning and evaluation.

The Halls Creek project (#161) was provided with an evaluation infrastructure based on the expertise and previous experience of the researchers at the Western Australian Alcohol and Drug Authority.

A culture of critical reflection and innovation

Formal arrangements for evaluation and review are essential to best practice. In outstanding organisations such formal arrangements are reflections of a broader organisational culture which values evaluation, critical reflection and innovation.

Staff development practices are important indicators of this wider cultural commitment to critical reflection, including support for staff to participate in formal study and research, and where appropriate for them to structure their research and study around the organisation's experience and to feed relevant outcomes into the organisation's planning, evaluation and practice.

WASH (#170) was co-sponsored by the National Centre for Research into the Prevention of Drug Abuse so the whole process was researched and evaluated from the beginning. WASH provided resources for teachers to meet, receive training and to reflect on their practice during the project. These activities were central to building teachers' abilities to plan and deliver appropriate health education activities and to refining the whole project over time.

The Far West Mental Health Service (#157) placed a high priority on staff development, formal training, study leave and exchanges. Relationships with agencies in other states and capital cities had been established to facilitate staff exchanges and on-going peer support. The Service has a history of publication. Staff were encouraged to relate their work in the context of latest research and commentary and to write up and publish their results. There was a rigorous atmosphere of critical reflection at staff meetings; there was an expectation that colleagues ought to be able to justify their approach.

The Parks CHC (#58 and #27) also had a strong tradition of support for staff undertaking further study (the team leader of the Nutrition in the Parks project (#58) was studying herself at the time). The team structure of the organisation also facilitated critical discussion; team leaders challenged workers' approaches and program strategies. Projects were expected to be reviewed, evaluated and published. Staff time was protected for study; time was allowed to write up and funding support was provided for staff to attend and present at conferences. Workers were challenged to link and justify their work in relation to the organisation's strategic plan and the Ottawa Charter upon which it was based.

Consumer and community participation

Provision for community participation in decision-making and in project operations is an important element of the supportive organisational environment. It appeared to be particularly contributory to the outcomes achieved in around nine of the 25 cases. We have described this aspect of a number of cases under the heading structured community involvement earlier in this chapter.

Integrating the macro and the micro

In around one quarter of the 25 interview cases it was evident that the integration of macro and micro issues had been built into the organisational structure and arrangements and that this was contributing significantly to the outcomes being achieved.

Redfern (#60) had a range of workers in both service delivery and in policy advocacy and training positions. The organisation was involved in policy development nationally through its staff and board. Nganampa Health Council (#186) likewise was involved in providing a clinical service and public health programs. It also had links with the land council and legal service and a range of other organisations related to Aboriginal people's lives.

Kensington CHC (Vietnamese Women's Domestic Violence Poster, #10) was an agency providing clinical services and community level programs. Time was formally allocated for staff to work at the macro end of the scale. For example, staff working in the domestic violence field had time to provide training to police and to participate in policy development forums and to support initiatives such as the poster project reported here.

The Parks CHC (Wilson Reserve, #58; and Nutrition in the Parks, #27) was another centre with a structured integration of the macro and the micro. The Centre's statement of strategic directions and their program planning proforma were based on the Ottawa Charter. There were two staff teams: the community development team and the direct care team. Joint meetings were held to discuss how to identify community development issues and opportunities in the work of the direct care providers.

HealthSharing Women (Reclaiming the Womb, #16; and Women-centred Resources, #15) included in its aims and objectives a commitment to re-orienting mainstream health services. Work organisation included a blend of direct service (an information line), professional education and training and research.

Longer term perspective

It seems that one important factor in creating a supportive organisational environment for best practice in primary health care is time; time, tradition, experience and provision for organisational learning.

The long range perspective is also necessary in thinking about the substantive processes of community development for better health. Organisations do not simply produce best practice

overnight any more than communities overcome the burdens of disadvantage overnight. Small engagements lead to small steps forward and to new opportunities for other small engagements.

One of the most fragmenting influences on community development work in health is the need to seek fresh outside funding for each new engagement; specifying objectives (which may have not yet emerged) and being committed to performance indicators that may make more sense to the funders than to the people whom the project is supposed to assist.

Redfern and the Parks CHC both illustrate the importance of organisational history, the long distance running of community development and the importance of long term and stable funding for community development.

Questions about the dynamics of creating supportive organisational environments

We are interested in the dynamics which create and sustain supportive organisational environments as well as the basic features of such environments.

Our analysis points to the importance of the elements discussed above. It also raises questions about some of the coding categories which did not emerge as strikingly important, in particular:

* customer focus;
* recognition of need for change;
* critical mass; and
* union involvement.

Customer focus

Our approach to the analysis of the 25 interview cases has been discussed in Chapter Five. Each case was coded twice in relation to the coding categories; firstly to record that the feature referred to was present; second, to record whether that pre-condition appeared to have been particularly important in contributing to the patterns of practice and health outcomes produced.

Among the descriptive codes that we used for indexing the 25 cases were two which speak to the concern for customer focus which is part of the best practice movement. These were:

* an organisational culture which values commitment and team work; and
* staff characteristics include commitment, skills and team practice.

These two codes were recorded as present in almost all of the 25 cases but were recorded as being particularly contributory in only one or two. We speculate that whilst these sorts of values are essential for good practice, the direct cultivation of a heightened consciousness of their importance may not be the most strategic way of producing them. For example, structured provisions for consumer and community involvement and close attention to evaluation and critical reflection may be more strategic in this sense. Cultivating a prominent organisational discourse about customer focus without strong community involvement and rigorous evaluation might be less strategic.

Recognition of need for change

Another code which was recorded as being present in well over half of the cases but particularly contributory in only three was 'shared acceptance of necessity for change among staff'.

It is clearly important but is it created directly, through exhortation, or through building a strong analysis of the macro environment as well as the immediate health issues and supporting staff development so that the staff are confident of their ability to learn new skills as necessary?

Critical mass

The question of critical mass arose frequently in this analysis. The advantages of organisations such as Parks CHC and Redfern AMS of having a range of different disciplines and perspectives to bring to bear was particularly evident in our analysis of the processes of peer support and critical reflection. These functions need adequate numbers.

On the other hand the quality of some of the women's health work suggests that peer support and critical reflection can be created across a network of smaller organisations as well as within one larger one. Small organisations which are not part of a wider program infrastructure would be doubly disadvantaged it appears.

Union involvement

Union involvement was a code which was included as part of our interest in best practice. It was recorded as being present only three times and particularly contributory only once.
Taking the Message (#14) was a project of Women in Industry and Community Health (WICH), an organisation which originated as a partnership between women in unions, migrant organisations and the Family Planning Association. The union affiliation had lasted with a reserved position on the committee of management.

Inspirational leadership

Leadership is clearly important. Inspirational leadership is a special asset.

We coded around 80% of our 25 interview cases as involving people of extraordinary commitment, vision and leadership. In around half of the total cases we judged it to have been particularly significant in contributing to the outcomes achieved.

The outstanding leader in the Onkaparinga story (#56) was the community activist who led the action group, was central to planning, managing, involving people, advocating in public and lobbying and negotiating with health and environmental agencies.

The story of Babinda (#21) is also the story of a newly appointed director of nursing who inherited a hospital of insecure status, brought a new vision and new model of service delivery to the hospital and the town and led the changes that took place.

In the Brisbane NESB women's cancer screening project (#129), community educators operated as leaders among their networks recruiting, educating and supporting women and then advocating for them with specialists and services.

Redfern (#60) has produced a number of outstanding leaders over its two decades, not least the author of the case study used in this project.

The coordinator of the Far West Mental Health Service (#157) has built successfully upon a rich history of community based mental health care supported by the visiting psychiatrist.

The Parks CHC (#58 and #27) has had three exceptional co-ordinators over a decade. Other senior staff are also recognised nationally in their fields. They had strong commitment to quality health care and to building a more healthy society.

What is such leadership? It appears to include:

* skills in political analysis and an ability to chart a path in confusing territory;
* ability to take insights from different places and bring coherence to them in the context of a program of action;
* ability to listen to people and reflect back, with added value;
* clarity of vision and an ability to depict possibilities as achievable;
* confidence and readiness to act (even where full certainty is still not possible) and to inspire others to act even where (especially where) there is uncertainty about the outcomes; and
* readiness to critically examine what happens, to take feedback and to learn how to do it differently and better next time.

Clearly some people have more aptitude for such leadership than others. But equally clearly leadership skills are acquired through experience and can be cultivated through training, mentoring, encouraging study and research, staff training and support.

7. Process

In this chapter we present the findings of the interview study in relation to the aspects of process which constitute best practice in primary health care. We use seven broad categories, namely:

* consumer and community involvement;
* collaborative local networking;
* strong vertical partnerships;
* intersectoral collaboration;
* macro/micro balance;
* organisational learning; and
* good management

Three of these (local networking, vertical partnerships and intersectoral collaboration) are basically about different aspects of collaboration and we present a common framework for analysing collaboration before discussing the features which are specific to each of these.

In this chapter we discuss each of these aspects of process for best practice with three purposes in mind:

* to pull together what we have learned from our case studies and interviews in the form of a coherent account of the ways in which these factors work together and contribute to better outcomes;
* to identify vignettes of good practice (benchmarks) which illustrate these pre-conditions for good practice in primary health care to facilitate wider access and study; and
* to identify policy initiatives and professional development directions which could strengthen the conditions for continuing improvement in primary health care practice (discussed in Chapter Nine).

Consumer and community involvement

Both in the reviewer evaluation study (see Chapter Four) and in the interview study (see Chapter Five), meaningful consumer and community involvement was strongly associate with good outcomes. We have identified three dynamics which may be seen as mediating this influence:

* determining the priorities;
* exercising power; and
* acquiring ownership of professional knowledge, methods and skills.

Determining the priorities

The most obvious way in which consumer and community involvement contributes to better outcomes is in putting issues on the agenda and setting priorities. This is more than just moving items onto or up an agenda; it is also about the framing of issues, the terms of the story which says what matters and why.

The system from which such priorities emerge may be pictured (albeit oversimplified) as an interface between two different world views; the professional world view (often cast in terms of diseases, risk factors, diagnostic and therapeutic possibilities) and a community world view (often cast in terms of the living circumstances of identified people; environments, stresses and choices).

A holistic story about needs, causes and strategies will generally draw upon both of the sestories, the social and the technical. However, the construction of such shared stories must commonly negotiate comprehension difficulties and resistances associated with different world views. The power relations prevailing in the settings where such negotiations take place will determine to some extent the outcome of such negotiations.

The power relations which shape consumer and community involvement vary widely and these variation are associated with different patterns of involvement; ranging from overt community control, through good consultation, to the interpretive skills of agencies and practitioners who are particularly responsive to consumer and community priorities. In general the stronger patterns of involvement subsume the features of the less strong.

The differences between control, consultation and responsiveness are blurred and in some cases open to different judgements. However, in general, where consumer and community participation depends wholly on the good offices of practitioners (through consultation and responsiveness) it seems clear that some consumer and community concerns and understandings will be silenced. On the other hand good consultation and a high level of responsiveness can lead to more powerful forms of participation in the next round.

The two Aboriginal health services in this set of cases illustrate most clearly the workings of community control.

Redfern (#60) was controlled by a community board and employed Aboriginal staff where possible. This allowed the Service to remain outspoken and advocate on behalf of their community in a sometimes hostile bureaucratic and political environment. There had been a high level of community participation in decision-making and in advocacy and political action. This provided political support for the Service and strengthened the Service's position in relation to policy and individual issues taken up. Concerns raised by community members over the years have been responded to with the development of new services and advocacy, both for individuals and collectively. This commitment helped to maintain the confidence and trust of the community.

Nganampa Health Council (#186) was also controlled by the Aboriginal people it served, in this case the Pitjantjatjara people. The Housing for Health project was located in the Pipalyatjara community; the project was initiated and approved and staff were selected by the Council.

Less clear cut as community control was the Parks CHC (Wilson Reserve, #58 and Nutrition in the Parks, #27). The Centre was controlled by a committee of management consisting of local residents and others. Action groups, consisting of residents and some staff, undertook projects with delegated authority and budget control from the committee.

The Babinda story (#21) reflected the good community consultation pattern; there were no organisational arrangements for community control. A survey, undertaken at the start of the process, set directions for non-acute program development. Ongoing consultation and discussion raised other issues which were addressed.

The third level of consumer and community involvement turns upon the responsiveness of particular agencies and practitioners. In the case of the Far West Mental Health Service (#157), new directions in psychiatric service delivery were based on the community mental health model and a partnership relationship with clients. It was a model which valued the client's view and understanding of their illness and sought to construct the psychiatric help around the context of that person's life. Clients participated in case management.

Exercising power

A second dynamic, through which consumer and community participation contribute to best practice and good outcomes, we have labelled exercising power. This dynamic brings together a number of cases where the political power associated with consumer and community support for a particular movement appear to have determined administrative decisions or the mobilisation of resources. Such exercise of political power is not always deliberate nor overt. It is the particular skill of politicians and politically sensitive administrators to be aware of the sensibilities of particular constituencies.

The Onkaparinga project (#56) illustrates the influence of such understated political power. The project was part of the Noarlunga Healthy Cities project and was run by a community committee with the involvement of a range of health and environment groups. This allowed for wide involvement and ownership and advocacy across sectors. The project responded to widely held concerns about the pollution in the river and its environmental and health impact. The issue had legitimacy with community, institutions, developers and government. The project brought together individuals and groups who had been active in campaigning to clean up the river at different places and times. The coalition under the name of the Water Quality Group gave broader support and showed political strength.

The Babinda story (#21) also illustrates the political influence of community opinion; in this case the interest of the regional office of Queensland Health in effecting its rationalisation plans with the cooperation rather than the antagonism of the community affected.

Healthsharing Women's project on hysterectomy (Reclaiming the Womb, #16) involved a range of activities: information provided to individual women; production of resources summarising the latest research; liaison with professional organisations; professional education; and a research project on the experiences of women from a non-English speaking background. This group had not been "heard" in previous research. The project worker was an Italian woman.

Acquiring ownership of professional knowledge, methods and skills

The third dynamic through which consumer and community involvement contributes to best practice and excellent outcomes is through acquiring a sense of ownership, by consumers and community members, of knowledge, methods and skills previously restricted to the professionals and acquiring confidence in their use or disposition.

It is not simply a matter of acquiring the knowledge and skills (although this may be the case). More generally it is about ownership; being able to speak as the knowing subject within these professional discourses rather than appearing as the silent object about whom such knowledges speak, upon whom such skills are practised.

For some health care interventions the people who are the objects of the interventions play an essentially passive role (for example, administering anaesthetics, determining approval for a new vaccine). For other interventions (for example, rehabilitation after illness, adopting moderate levels of drinking, adopting clean air policies) the success of the interventions depend on the active participation (the agency) of the objects of the interventions. The interventions depend upon the people who are the objects of the intervention being able to draw upon the professional knowledge and methods in shaping the stories which they tell (as subjects) to make sense of their life projects.

Several of the interview cases where consumer and community involvement appears to have contributed have been categorised in this group.

Paps I Should (#1) was a project on cervical screening for and by women with a disability. One of the major transitions effected by this project was the acquisition of ownership by networks of women with disabilities of some of the knowledge and technologies underpinning cervical screening. In the process these women added value to this knowledge with innovative work on methods for taking Pap smears from, for example, wheelchair-bound women.

The Horizons project (#108) likewise involved consumers in confronting the knowledge and precepts of the professionals in the processes of putting in place a community mental health recreation program.

The Home Oxygen Support Group (#34) was a self-help group controlled and managed by its members. Membership was restricted to people requiring oxygen therapy. The work of the group involved an integration of technical information concerned with the delivery of oxygen, therapeutic information about the role of oxygen therapy and the indigenous knowledge and skills of the people who were using the equipment.

The Gagudju project (#95) built on previous plans by the Gagudju Association for Aboriginal health workers to work in the area of alcohol use. Government authorities had done little to develop health services for the Gagudju people. A new doctor employed by the Association applied for money through the General Practice Reform Program to enable the employment and training of an Aboriginal health worker. That alcohol use was widely recognised by black and white communities as a major problem gave the project legitimacy and focus. The net effect was a transfer to the Gagudju community of greater ownership over the knowledge (technical and about funding possibilities) and the technologies associated with alcohol programs.

The Brisbane Women's Cancer Screening program (#129) was a response to concerns among women from various cultural backgrounds about cancer information and access to services. It was based on bilingual workers from the different ethnic communities. The bilingual community educators were community members with their own networks both formal and informal. Women attended the project in huge numbers, justifying the project and leading to a massive funding increase and expansion of the program. It was not simply about accessing a service. It was also about acquiring a degree of ownership of the knowledge underpinning that service.

Collaboration

Three key aspects of process that emerged in the interview study concern different kinds of collaboration, different collaborative linkages:

* collaborative local networking;
* strong vertical partnerships; and
* intersectoral collaboration.

This is an essentially arbitrary division because these categories overlap irretrievably. However, for the purposes of a linear description of a complex and multi-dimensional reality we have elected to use the following definitions in this chapter.

Collaborative local networking refers to collaborative links between practitioners, health service agencies and community organisations at the local level. Collaboration with practitioners and organisations whose main identification is with other sectors of social practice is categorised as intersectoral collaboration.

Vertical partnerships refers to collaborations and cooperative arrangements between practitioners and organisations operating at the primary health care level and more specialised health practitioners or agencies at the secondary or tertiary levels, including public health agencies and practitioners. Collaborations which involve more specialised or more centralised resources in other sectors are discussed under the heading, intersectoral collaboration.

Intersectoral collaboration refers to linkages between practitioners and agencies which identify as operating within the health sector and practitioners and agencies which identify as operating in

other sectors of social practice, such as housing, environment, schooling. Intersectoral collaboration in our usage operates at a local level or with more centrally located resources.

We have identified four dynamics through which collaboration may contribute to better health outcomes, as a common framework for discussing our findings in relation to local, vertical and intersectoral collaboration. They are:

* building a broader story;
* a story that coordinates different players;
* mobilising additional resources; and
* capability-building.

Building a broader story

Collaboration involves sharing different perspectives about the nature of the problems that we are confronting; about causes and about strategies for their solution. Mobilising different understandings will help to produce a broader story; one that a broader range of players will find useful.

Coordinating different players

Sharing a common story about the problems, causes and strategies can help to orient the responses of a number of people with different skills and knowledge to act in complementary ways. Players who stand in a different relation to the problem may nonetheless respond in complementary and mutually reinforcing ways if they are orienting their action around a common story.

Mobilising additional resources

Involving a wider range of players generally also means mobilising additional resources of various kinds. In many cases this will help to ensure a more enduring or more definitive response to the problem/s.

Capability building

The experience of successful collaboration puts in place a greater readiness for similar collaborations in the future. Such experiences may contribute to reorienting individuals, organisations, even wider networks to the possibility of different ways of working.

Collaborative local networking

Networking at the local level was evident in almost all of the 25 cases included in the interview study and in just under half we judged it to have been particularly important in contributing to the outcomes achieved.

Telling a broader story

One way in which better local collaboration contributes to better outcomes is by mobilising different understandings to produce a broader story about the problems and strategies and directions for their solution.

The Far West Mental Health Service (#157) built on strong connections between the staff of mental health services, the hospital and other providers. The time cost of building community links (for example, visiting the pub, standing in the street) was recognised as important. Stories told and retold in these different settings gradually evolved into a shared story which accommodated the perspectives of all the main players.

The Babinda project (#21) included some very careful consultation, with other service agencies and meeting regularly with community groups to hear about their health issues. This consultation helped to set a new agenda for projects and services to be undertaken.

The Vietnamese Women's Domestic Violence Poster project (#10) built on a previously formed network of domestic violence workers from a range of agencies. Through this project this network of domestic violence workers came to work more closely with women's networks within the Vietnamese community. The conversations undertaken at the meshing of these networks helped to build a broader picture of the problem being addressed.

Creating a story that coordinates the contributions of different players

A shared story may provide a frame of reference within which different players may be better able to see how they can contribute to addressing a shared set of problems. A range of players with different skills and knowledge may be assisted to act in complementary ways which are also stronger in the aggregate.

The Horizons Service (#108) originated in discussions among a range of local services who were very supportive of the association. These discussions included community groups, people from the local psychiatric hospital, consumers and family members. The story underpinning the development of the service helped to weave a complementarity in the contributions of this wide range of other players in providing services to (and with) people with psychiatric illnesses.

The Child Development Unit report (#106) likewise tells of the creation of a forum within which local practitioners could share their understandings with family members and with more specialist practitioners and weave their contribution to the program of care around the stories which emerge.

Benalla Healthy Localities project (#132) involved members of the police force and local liquor licensees meeting together to build an understanding of and strategies for addressing youth alcohol abuse.

The Tea Trolley project (#128) describes the unique combination of chaplains, nurses, cancer sufferers and their supporters joining together to more adequately address the needs of patients in the oncology clinic.

Mobilising additional resources

Local collaboration can also help to mobilise additional resources.

The Patchwork story (#71) tells of the cooperation of the whole meals-on-wheels network to recruit local co-ordinators and to distribute fire safety information to the public.

In the Brisbane Women's Cancer Screening project (#129) the links with pre-existing ethnic community networks led to a much more effective information provision and recruitment to screening.

Capability building

The experience of successful collaboration may put in place the conditions for more effective practice in the next round; reorienting professionals, agencies, even whole networks of providers.

The Rural Outreach project (#17) included the establishment of advisory groups involving key people and organisations in local towns. A number of specific projects developed through partnerships with a range of local organisations, services and groups. Much of this work continued after the Loddon-Campaspe Women's Health Service reduced its resource commitment in these towns.

The Housing for Health project (#186) reflects the latest in a history of environmental health engagements of the Nganampa Health Council. The expertise, insights and skills of the Aboriginal participants and the non-Aboriginal collaborators have been developed through such engagements over many years.

Collaboration within organisations

Our initial focus in exploring collaborative local networking was on collaboration between local providers, operating as separate autonomous agents, since this had been identified in the 1992 Primary Health Care Review as being a particular weakness of the primary health care system.

However in analysing the 25 cases in the interview study, collaboration within larger institutions also emerged as an important issue. In around 20% of cases good practice with respect to intra-

organisational collaboration appeared to have made an important contribution to the achievement of good outcomes.

These are well illustrated by the Babinda story (#21) and the two schools projects Billanook (#187) and WASH (#170). In each of these cases, individuals from different parts of the same organisation came together in a team to collaborate around agreed goals and objectives. The contribution made by having different parts of the organisation represented appeared to contribute far more than could have been achieved by any part of the organisation acting alone.

Strong vertical partnerships

We are using the term vertical partnerships to refer to the relationships between agencies which identify as lying within the health sector. The next section deals with issues associated with intersectoral collaboration. As before we will discuss the contribution of strong vertical partnerships in terms of:

* building a broader story;
* creating a story that coordinates the contribution of different players;
* mobilising additional resources; and
* capability-building.

Building a broader story

Several of the vertical partnerships in our interview cases illustrate experts from the tertiary sector working with family members and local primary health care personnel to develop a shared story which weaves together knowledge and strategies at the family and community level with knowledge and strategies which focus more on disease process and treatment and prevention. By creating a story which all of the different players find useful, within which they can each locate their own agency, they set the conditions for complementary and mutually reinforcing action.

In the case of the Child Development Unit project (#106), family members, general practitioners and specialists from the Adelaide Children's Hospital came together to create a shared story about the needs of particular children.

Paps I Should (#1) tells of consumers - women with disabilities - working with health specialists, exchanging knowledge and skills about doing pap smears for women with disabilities.

The Far West Mental Health Service (#157) likewise had families, clients and local community mental health staff working with visiting psychiatrists, sharing different perspectives and knowledge, building a shared understanding of people's troubles and needs.

Creating a story that coordinates the contribution of different players

A shared story can contribute to more effective care and more successful project work by orienting consumers, community people, local practitioners and the experts/specialists to act in complementary ways. This aspect of collaboration, harnessing a richer and more complex workforce through the creation of a shared story about the problems in hand, is illustrated by the following cases.

Redfern (#60) included the building of close relationships between clinical and public health specialists over a number of years. These involved the weaving together of stories of the life world of Aboriginal people in Sydney with the technical insights of various trusted specialists.

Reclaiming the Womb (#16) likewise illustrates a collaboration between women's health activists and academic specialists, two royal colleges and a range of clinicians in various Melbourne hospitals who shared the concern of the project about inappropriate hysterectomy.

Mobilising additional resources

Building a strong vertical partnership mobilises additional expertise and human resources. In some cases it also contributes to mobilising additional financial resources.

In the case of Babinda (#21), building vertical partnerships led to new sources of money including Home and Community Care (HACC) program funding and new services. This was also associated with decisions taken at the regional health department level to delegate budgetary discretion to Babinda management, enabling them to use existing resources more flexibly.

The Nutrition in the Parks project (#27) included a relationship with Foundation SA which led to additional resources for the project. The Child Development Unit project (#106) was supported by a General Practice Demonstration grant. Halls Creek (#161) received $1million from ATSIC to provide additional family support services.

Capability building

It is inevitable that only some of the effort which goes into building new relationships and reorienting the thinking of consumers, local practitioners and specialists, feeds directly into the present project, into measurable and immediate outcomes. Of comparable importance are the processes of capability building, putting in place a readiness and a capacity to act more effectively at some stage in the future.

Projects such as the Horizons Living Skills Program (#108), Paps I Should (#1) and Rural Outreach (#17) were in large part directed at capability-building for future engagements which were impossible to specify at that stage.

The Gagudju story (#95) tells of the development of an innovative alcohol program which the local people had been wanting for some time but which had not been supported by the Territory authorities. A grant from the General Practice Demonstration Grants program provided the support necessary to demonstrate what could be achieved leading in due course to the Northern Territory Health and Community Services Department providing longer term funding support.

Intersectoral collaboration

Intersectoral collaboration was identified as being present in around 80% of the interview cases. It was judged to be particularly outstanding in around half of the 25 cases.

Two broad patterns were identified:

* intersectoral collaboration at the local level; and
* collaboration with agencies working in other sectors at a more centralised level.

Intersectoral collaboration at the local level

The following examples illustrate best practice with respect to intersectoral collaboration at the local level.

The Wilson Reserve project (#58) involved the Parks CHC people working together with local councillors and council staff to improve safety and usefulness of a local park and thereby improve the physical and social conditions for better health.

Housing for Health (#186) illustrated the Nganampa Health Council working collaboratively with the land council and parallel housing and infrastructure organisations.

The Onkaparinga project (#56) brought together residents groups, recreation groups and tourist interests with health people, local environmentalists and other individuals concerned about water quality in the estuary.

The Vietnamese Women's Domestic Violence Poster project (#10) built on collaborative networks previously established including a range of agencies: local council people, the community arts officer and community police.

Taking the Message (#14) was primarily a collaboration between WICH and the unions on one hand, and companies like Toyota on the other, in order to offer women factory workers access to the information provided by WICH.

The Nutrition in the Parks project (#27) involved local collaboration with shopping centre management, businesses and local schools.

Collaboration with more central agencies working in other sectors

Some of the cases that illustrated best practice by drawing upon more centralised expertise across intersectoral boundaries include the following.

In the WASH project (#170) collaboration between health promotion agencies and schools was the essence of the project, allowing schools to develop "whole school health promotion" beyond traditional class room teaching. The Onkaparinga project (#56) involved collaboration with environmental experts and authorities as well as with local partners.

Macro/micro balance

Integrating the macro and the micro is a key aspect of best practice in primary health care: addressing the immediate health issues in ways that also contribute to redressing the underlying conditions which reproduce those patterns of need. This was associated with good outcomes in the reviewer study (see Chapter Four) and was judged to be outstanding in around half of the cases in the interview study.

Redfern (#60) had always operated at a range of levels; addressing the immediate health needs of individual clients and families; addressing the public health needs of the local community and the wider community of Aboriginal people in Sydney and beyond. However, the historical, political, cultural and economic issues which constituted the circumstances of Aboriginal health were also an every day reality (in terms of discrimination in mainstream health services and the longer term circumstances of disadvantage). Awareness of these aspects and how these might be overcome were also present in shaping the health care and preventive strategies adopted by the Service.

The Vietnamese Women's Domestic Violence Poster (#10) was conceived in relation to a multi-layered analysis of the problems facing Vietnamese Australian women and their families. The range of resources drawn upon included understandings about the material circumstances of lives in Australia now, the circumstances of migration and insights derived from feminism about the relations between patriarchy and violence.

Taking the Message (#14) was likewise based on an analysis of the circumstances of women from non-English speaking backgrounds working in factories and the complex of problems including access to health information, particularly information about contraception and occupational safety. The strategies of the organisation drew upon conceptual insights from feminism, industrial relations and the cultural experience of migration.

The Nutrition in the Parks project (#27) identified the health consequences of poor nutrition in relation to a hierarchy of analyses ranging from individual choice to the institutional and political dynamics of the food industry. At the same time the health- focussed concerns of the nutritionists were integrated with the community concerns about shopping, cooking and family life.

Reclaiming the Womb (#16) built on an analysis which extended from the micro interactions of the clinic to the institutional factors which shape the patterns of medical practice. The medical discourses about the indications for hysterectomy were blended with discourses from health service researchers and from feminist researchers and commentators and were informed by the life experiences of the women who sought assistance from the various arms of the HealthSharing Women's Service. Strategies were developed which responded at the individual and system levels, contributing to professional training, dialogue with professional bodies, policy advocacy and new research.

Paps I Should (#1) began with a focus on access to cervical cancer screening for disabled women. However, the project was also informed by a related analysis about the rights of people with disabilities to participate fully in society. The project responded in an integrated fashion to issues identified at different levels.

Organisational learning

Organisations with a structured capacity for learning how to do their work better are more likely to produce better practice and improve outcomes than organisations without such a capacity. A deliberate approach to organisational learning was evident in around half of the 25 interview cases but it was judged to be outstanding in only six or seven cases.

We identified three main dynamics which supported organisational learning in these agencies. These were:

* evaluation and critical reflection upon practice;
* linking practice with theory and research; and
* investing in personnel training.

Evaluation and critical reflection on practice

The picture of evaluation which emerges from these cases is very different from that which dominates contemporary managerialist accounts of evaluation with their emphasis on summative or outcome evaluation. Many of the projects included in this study have collected data for accountability and reporting purposes but the evaluative strategies which appear to be contributing to excellent outcomes are as much about creating a culture of critical reflection as they are about measuring performance indicators.

The story of the Far West Mental Health Service (#157) tells of an organisation where staff were: encouraged to justify their strategies and practices at team meetings and other staff discussions; where programs were evaluated; papers were written; and conferences were attended (and papers presented).

The Horizons story (#108) likewise tells of formal processes for evaluating programs from both participant and worker perspectives. Evaluation included checking progress against targets, surveying participants and workers and modifying programs accordingly.

The WASH project (#170) was subject to an on-going external evaluation through the National Centre for Research into the Prevention of Drug Abuse. This enabled periodic modifications to be put in place to improve the program. The project also ensured that there was time and space for the teachers and school teams to reflect upon how they were going which led to improved local action. These discussions were also resourced in some respects by the outside evaluation.

The Rural Outreach Program (#17) was formally evaluated as part of its first phase; weaknesses were identified and the program remodelled accordingly with better results. Money was set aside for evaluation and to protect worker time for critical reflection on how things were proceeding.

Paps I Should (#1) was developed within a culture of critical reflection. It was initiated by a service which had: a separate program evaluation subcommittee; encouraged workers to use an evaluation framework for reflection on progress; and annual targets to provide a framework for monitoring goals and progress.

Linking practice with theory and research

It may be no coincidence that a significant number of the cases in this study have had an active interface with theory and research in their development. After all, this study was based upon documented reports of projects and episodes; such reports are more likely to be generated where practice is entwined with research and study. Nonetheless the picture which emerges of an active interplay between theory and practice in these cases is salutary.

The WASH project (#170) was conceived from the start as a model for piloting and if successful for wider emulation. This entailed a comprehensive review of the literature and relevant theoretical issues. The role of the National Centre for Research into the Prevention of Drug Abuse in the evaluation and related research was influential throughout the project.

The Far West Mental Health Service (#157) did not have a formal research mandate but the organisation supported its workers in undertaking further study (through study leave and a recognition of the importance of study and research). Staff were encouraged to submit papers for publication or conference presentation.

The Parks CHC (Wilson Reserve, #58 and Nutrition in the Parks, #27) had developed a culture in which staff were encouraged to undertake further study including research, programs were evaluated, papers written and conferences attended and papers presented. Billanook Primary School (#187) established a culture where teachers were reflecting on theory and practice and most of the teachers were pursuing further study.

Investing in personnel training

Most basic, by way of creating learning organisations, must be the investment in personnel training. This includes training opportunities for consumers and community activists as well as professional development opportunities for staff.

A major expenditure in the WASH project (#170) was on training for school team members (parents and teachers) in health promotion and project planning. This broadened their skills beyond curriculum knowledge and class room skills.

The success of the Gagudju alcohol project (#95) depended in part on the training for the Aboriginal health worker (who was the mainspring of the project) which was provided in Alice Springs through an Aboriginal run training program for alcohol workers and at the local TAFE. He gained access to knowledge, skills and experience in other indigenous settings in tackling alcohol issues which contributed to the success of the program that he developed at Jabiru.

Redfern (#60) developed and ran a training program for Aboriginal health workers from early in its existence as mainstream training opportunities were not appropriate.

In the Brisbane Women's Cancer Screening Program (#129) training was provided to bilingual community educators at the start of the project in how to run information sessions.

As indicated above, the Far West Mental Health Service (#157) had a strong staff development program as part of its strategy for retaining skilled staff in an isolated provincial town. This included opportunities for distance education, adequate supervision, on the job training with visiting staff, staff exchanges and conference and study leave.

Good management

Good management was not one of the initial foci of attention in this study but clearly emerged as important in the interview studies.

There is a wide overlap between the notion of good management and the other aspects of good practice which have been already discussed in this chapter. Managers play a key role in:

* promoting consumer and community involvement;
* supporting better collaboration, both within and beyond this agency;
* integrating the micro and the macro aspects; and
* cultivating a learning organisation.

In this degree the contribution of good management to best practice has been adequately discussed already and readers interested in the special contribution of management should regard all of the preceding sections of this chapter as being directly relevant. However, there are four aspects of good management which are not adequately covered by the preceding headings and which warrant brief mention. These are:

* flexibility and risk taking;
* effective personnel selection;
* using available information resources; and
* mobilising financial resources.

There are of course other aspects of good management, such as financial control and support to committees, that have not figured prominently in this study.

Flexibility and risk taking

A willingness and ability to take unforeseen opportunities, and risks in some cases, was present in most of the cases in this study and was judged to have been particularly important in contributing to the outcomes achieved in about a quarter of cases.

The Brisbane Women's Cancer Screening program (#129) was refused funding by Queensland Health initially and the Women's Health Centre committed a significant proportion of its own resources to the project including money for training and employing the bilingual community educators. The project demonstrated its effectiveness and subsequently Queensland Health provided additional financial backing.

Housing for Health (#186) was about innovation; new strategies for community communications as well as new approaches to project design and new ways of building houses were developed.

The Rural Outreach project (#17) was based from the start on the requests and interests of women from small towns in the region. It was not tightly planned and was able to identify opportunities and needs as the project unfolded in the different towns.

The focus of the Coburg Carers Project (#133) as a Healthy Locality Project was changed in response to community consultation.

Effective personnel selection

We identified effective personnel selection as a feature of around half of the 25 cases but it was scored as particularly contributory in only two or three cases.

Redfern Aboriginal Medical Service (#60) had in place an explicit policy and carefully developed processes for selecting non-Aboriginal staff who would be able to work in a fully accountable way in a Koori service.

WICH (Taking the Message, #14) likewise developed a careful approach to staff selection to ensure that language and cultural background needs were addressed and the range of skills were maintained for the needs of the factory visits program.

Using available information resources

A sensitivity to appropriate information resources was evident in many of our interviews (if not emphasised in the written documentation).

Healthsharing Women's Health Resource Service (Women-centred Resources, #15; and Reclaiming the Womb, #16) had a systematic approach to the use of published literature and a range of other information sources. Further access to information was facilitated by a network of links to specialist staff, women with specific experiences related to particular health issues, other health professionals and other women's health services.

Mobilising financial resources

The mobilisation of financial resources is a key contribution to excellent outcomes. It was recorded as a key feature in more than half of our 25 cases and as an important contribution to the outcomes achieved in around one quarter of cases.

In the case of Gagudju (#95) the procurement of demonstration money from the Commonwealth's General Practice Reform Program for a service that the Territory Department had not been able to fund was a key achievement. It lead in due course to the Department supporting Aboriginal Health Workers' positions at Jabiru.

The mobilisation of more than $1 million from local, state and Commonwealth governments to build the Onkaparinga wetlands (#56) was a major achievement of this project. In the case of Babinda (#21), the ability to identify and draw upon new sources of money, such as HACC, in order to provide new services was a key contribution.

In the Nutrition in the Parks project (#27) the procurement of project funding from Foundation SA was also an important benefit.

8. Outcomes

The outcomes of the cases that we have studied are of different kinds. They range from immediate improvements in the health of individuals through to improved community, institutional and professional capability to work towards better health in the future.

The principle behind our classification of outcomes is time; the time between the events described in the case study and the outcomes of value. The three time periods that we have used are: today, tomorrow and the day after tomorrow.

The outcomes we value for today are:

* immediate improvements in the health status of individuals.

The outcomes we value for tomorrow are:

* improvements in the social conditions which shape the health of communities (and will be manifest in health status improvements tomorrow); and
* the strengthening of health care programs and services (which will therefore deliver better sick care services and better public health programs tomorrow).

The outcomes we value for what they will yield the day after tomorrow are the capability building and institutional strengthening that will enable health practitioners and community activists to work more effectively for continuing improvements in the social conditions for health and for improvements in programs and services. These outcomes include:

* enhanced community capacity;
* enhanced institutional capacity; and
* enhanced professional capacity.

We are not proposing our classification as reflecting any universal truth. It is a classification with a purpose which is to focus attention on best practice in primary health care. What we are referring to as outcomes in this project are generally operationalised, in settings of practice, as objectives. Practitioners shape their thinking around what they are doing and what they are trying to achieve. We think that it may be helpful, in relation to settings of practice, to think about the objectives and strategies of practice as directed at these three temporal frames of planning: today, tomorrow and the day after tomorrow.

This categorisation of outcomes corresponds to some extent to the economists' distinction between consumption expenditure and investment. The effort which is reflected in the 25 cases we have studied has been expended partly for the purchase of better health today. Some of these efforts have been invested in the expectation of better health tomorrow: improvements in the social conditions which shape the health of communities and the strengthening of health programs and services. Some of the effort is invested in longer term outcomes: building an enhanced capacity (community, institutional and professional) to work towards better health, including improving the

social conditions which shape the health of communities and working towards improved programs and services.

In this chapter we discuss these outcomes of best practice with three purposes in mind:

* to pull together what we have learned from our case studies and interviews in a coherent account of the nature of these outcomes;
* to identify vignettes of good practice (benchmarks) which illustrate these outcomes of best practice in primary health care to facilitate wider access and study; and
* to identify policy initiatives and professional development directions which could strengthen the conditions for continuing improvement in the outcomes of primary health care (discussed in Chapter Nine).

Immediate improvements in the health status of individuals

In four of our 25 cases there were substantiated improvements in people's health status documented in the original report or in our subsequent interviews.

There was a decrease in eye and skin infections in children at Pipalyatjara during the Housing for Health project (#186).

The Far West Mental Health Service (#157) reported reduced readmission rates to acute psychiatric units over the period that the service introduced a more community based outreach and negotiated treatment approach.

The Home Oxygen Support Group (#34) reported that for most members the frequency of hospital admissions was significantly less after joining the Group than before.

At Halls Creek (#161) there were fewer admissions to the hospital casualty of people who had been violently assaulted.

There were strong grounds for assuming improvements in people's health status in around ten further cases.

Three of the projects reported increased use of women's cancer screening services. The Brisbane Pap Smears and Breast Self Examination project (#129) reported substantially increased use of breast and cervical cancer screening services by women from non-English speaking backgrounds. The Rural Outreach project (#17) reported that rural women achieved increased access to screening programs especially cervical screening as a consequence of the project. Paps I Should (#1) contributed to women with disabilities gaining easier access to cervical cancer screening programs.

Healthsharing Women believed that the Reclaiming the Womb project (#16) was likely to have contributed to a reduction in the frequency of unnecessary (or unnecessarily extensive) surgery, particularly among women from non-English speaking backgrounds.

The Redfern story (#60) documents increased access to a wide range of health services both directly at the Service and indirectly through referral to trusted specialists and hospitals.

The Horizons project (#108) reported declining readmission rates to acute psychiatric units on account of the consumers gaining assistance with medication, social support, and referral to services through this agency.

The project worker who coordinated the Nutrition in the Parks project (#27) reported that the supply and sale of good quality whole grain food increased as a consequence of the project and that the availability of information on nutrition led to some people eating healthier diets.

The Child Development Unit project (#106) is likely to have led to more effective programs of support for the children and families participating.

At Benalla (#132), long term and fundamental change appears to have been made in many teenagers lives due to the commitment to youth health over the three years of the Healthy Localities project. Two youth clubs and a pre-driver education program, developed by teenagers, were established. Local police reported that there were fewer teenagers drinking in and around the town's hotels.

Improvements in the social conditions which shape the health chances of communities

In this section we report upon improvements in the social conditions which shape the health chances of individuals and communities. These are the project outcomes of today which will be manifest in health status improvements tomorrow.

We have identified three kinds of project outcomes which contribute to improvements in people's health chances:

* intersectoral progress towards the conditions for better health;
* strengthening social support; and
* increased consumer and community knowledge.

Intersectoral progress towards the conditions for better health

In just under half of the interview cases the outcomes achieved included significant steps on the intersectoral front towards creating the social conditions for better health. The importance of this lies in the contribution which sectors other than health can make to bringing about such conditions. That health status reflects conditions outside the health sector (for example, income, education and housing) is well documented and intersectoral progress is a centre-piece of the Ottawa Charter for Health Promotion.

Both the WASH project (#170) and Billanook (#181) contributed to the development of health promoting schools with better health knowledge and skills among the students and teachers and healthier school environments including improved nutrition in school canteens.

The outcomes of the Onkaparinga project (#56) included having a cleaner river providing healthier recreational opportunities and with fewer health hazards for river users.

The Coburg Carers project (#133) resulted in a greater awareness by many service providers (for example, community health, local Government, neighbourhood houses) of the issues faced by carers and subsequently to increased service provision.

The Housing for Health project (#186) led to improved communication between agencies responsible for housing, sewerage, water and roads to facilitate a team approach to solving maintenance problems for Aboriginal housing, thus improving the material conditions for better health.

The work of WICH (Taking the Message, #14) had been based on a co-operative and productive partnership with unions and management which had resulted in a number of changes in working conditions which directly affect the occupational health and safety of the women.

The Wilson Reserve project (#58) led to co-operation between the local council responsible for public parks, residents and the staff of the health centre resulting in safety improvements (for example, the removal of syringes) and increased use of a healthy community resource.

At Benalla (#132), the youth health, transport, health in primary schools, and the occupational health and safety on farms activities all required the involvement of various providers in the community such as police, community health agencies, schools, hotels, local Government and adult education providers.

The Nutrition in the Parks project (#27) led to a partnership between shopping centre management, residents and health centre staff. The results included wider access to food and nutrition information and increased purchases of nutritious foods.

The Patchwork project (#71) contributed to the wider implementation of fire prevention and fire damage minimisation principles among the local community.

Personnel associated with Redfern (#60) have been centrally involved in lobbying for improved policies for Aboriginal health at the state and national levels.

Strengthening social networks and social support

Stronger community networks were evident as outcomes in around 80% of the interview cases. Such outcomes were judged to be particularly outstanding in around seven cases.

The Brisbane Pap Smears and Breast Self Examination project (#129) involved bilingual community educators from a number of different ethnic community networks providing support to women in negotiating health services and reinforcing those networks at the same time.

Women in a domestic violence self-help group (#10) have supported each other through difficult times and have reached out into their community to support and resource other Vietnamese women who are at risk of violence.

Through the Horizons project (#108) participants have assisted each other and new consumers to manage their illness through, amongst other means, sharing of stories and after hours support contacts.

The Home Oxygen Support Group (#34) has mobilised a significant level of support to members who were previously isolated and house bound. This support includes speakers, outings, health care information, a newsletter and phone tree, new friends and extended social networks.

The residents living around Wilson Reserve (#58) got to know other people in their area as well as Parks CHC staff. For some, increased involvement in the project and then in the Parks CHC itself, led to new friendships and responsibilities.

Coburg Carers (#133) provided opportunities for sharing in a wide range of ways by utilising innovative craft activities and exhibitions of the crafts provided.

The Tea Trolley project (#128) facilitated a sharing among oncology outpatients of common experiences and worries. What had seemed unique and sometimes frightening was for many people reframed as a shared experience.

Increased consumer and community knowledge about health and skills in self-care

Increased access by consumers and communities to knowledge about health and the development of skills which will contribute to better health were common outcomes of the projects studied. Some examples:

Through the WASH project (#170) teachers, other school staff, parents and students all received training in health promotion and local projects further promoted health literacy among students and parents (for example, nutrition, exercise).

Participants in the Home Oxygen Support Group (#34) gained specific information regarding the use and regulation of oxygen therapy leading to increased comfort and well-being for members of the group, especially those who have only recently commenced home oxygen.

WICH (Taking the Message, #14) provided information in community languages for women who previously had no access to such information and informed them about the availability of various services.

Through the Brisbane Women's Cancer Screening program (#129), women in a range of ethnic communities became more informed about their own health generally and with respect to breast and cervical cancer.

Through the Vietnamese Women's Domestic Violence Poster project (#10), the participating women were assisted in reframing the problem of domestic violence, locating it in a social and political context and no longer blaming themselves. They acquired new knowledge about the availability of services and increased access to these. Two key women in the group became more widely known through existing community networks as resource people in relation to services associated with domestic violence.

As a consequence of the Housing for Health project (#186), Aboriginal people were employed in the project, received training and gained further employment following its completion. Community/household members learnt basic housing maintenance (for example, how to repair water tank pipes) which continued after the project had finished.

The Horizons recreation program (#108) enabled participants to develop new skills, through their participation in formal program review and planning processes and by joining the Association's committee of management.

Patchwork (#71) increased the knowledge of community members about bushfire prevention and about how to better protect their lives and their properties in the case of fire. The community members who became involved in the Patchwork project as area co-ordinators were likely to have become very knowledgeable about these issues and about how to create safer environments around people's homes.

The strengthening of health care programs and services

We have identified three pathways whereby the projects included in the interview study have achieved outcomes which will lead to better sick care services and better public health programs in the future. These are:

* improved access to existing services;
* improved quality of service; and
* programs and services established or developed to meet community needs.

Improved access to existing services

Project outcomes which included increased community access to services were common among the 25 cases and in at least a third appeared to be highly significant.

Several of the women's health projects led to increased access by women to (more appropriate) cancer screening services (Brisbane Women's Cancer Screening project, #129; Rural Outreach project, #17; and Paps I Should, #1). Two projects concerned support for people with psychiatric illness and led to more appropriate and more easily accessed services (Far West Mental Health Service, #157; Horizons, #108).

Through the Vietnamese Women's Domestic Violence Poster project (#10), women in the Vietnamese community shared information about the nature of domestic violence and available services (for example, health services, refuges and social security). The project participants acted as community links to particular service providers thus increasing Vietnamese women's access to these services.

The Coburg Carers project (#133) involved women who were otherwise quite isolated in community activities and made those women far more aware of a range of services available to them. By supporting activities in other settings (for example, neighbourhood houses), the project also made those services more accessible to the carers.

Improved quality of service

In a number of cases it is evident that the quality of service provided had improved as a consequence of the programs described.

All of the women's cancer screening projects directed some of their efforts to improving the quality of cancer screening services (Brisbane Women's Cancer Screening program, #129; Rural Outreach project, #17; and Paps I Should, #1).

The Far West Mental Health Service (#157) developed the partnership/negotiated care model for services to people with mental illness. As a consequence, recommended drug treatments are followed more effectively and consumers' confidence to access the service when required increased. Reports from the project emphasised the role of staff development and staff exchanges in increasing staff skills and quality of service.

The Tea Trolley in Oncology (#128) project ensured that the service provided to patients better met their needs by the provision of more information in an accessible fashion and by treating the patients and their supporters in a more holistic fashion.

Reports from the Child Development Unit project (#106) likewise emphasised improved quality of care which flowed when all the partners in the child's care, education and health provision had a shared understanding about what was required.

Programs and services established or developed to meet community needs

New or redeveloped services and programs to better meet community needs were

important outcomes in around ten of the 25 interview cases. Examples included:

* funding attracted for the provision of a family support program at Halls Creek (#161);
* a wide range of services for Koori people of Sydney such as mobile dental care and a hostel for older frail aboriginal people (Redfern #60);
* an Aboriginal health program established with the employment of two Aboriginal health workers (Gagudju, #95);
* new services and programs including Home and Community Care programs, health promotion programs and a road safety campaign were established in response to needs identified through community consultation in Babinda (#21);
* a mental health outreach program was developed for isolated and remote residents of NSW/SA (Far West Mental Health Service, #157);
* a recreational and living skills program was established in Melbourne (Horizons, #108);
* a youth worker and a community development position were created in the local Government as part of the Benalla Healthy Localities project (#132);
* new services were established in rural locations including well women's clinics and other preventive health services (Rural Outreach, #17).

Enhanced community capacity to work towards better health

An important set of outcomes achieved through these projects has been an increased community capacity to respond to future health issues. These represent an investment in a capacity to work more effectively tomorrow for the social conditions for better health and for improved programs and services.

Redfern (#60) has for 20 years been a rallying point for the Koori community and an institution they have used to act on their behalf in negotiations with services and Governments. The service has contributed to increased health knowledge and skills at the personal, family and community level which are manifest in more effective use of services, moves to healthier and safer ways of living and programs towards healthier, safer and more supportive environments.

The Halls Creek (#161) Alcohol Action Advisory Committee, known as 'Triple AC', petitioned the Director of Liquor Licensing in Western Australia to restrict hotel trading hours after two failed attempts to negotiate this with hotel licensees.

Women who participated in the advisory groups of the Rural Outreach project (#17) learnt new information about women's health and new skills in campaigning. After the project these groups organised their own actions on behalf of their communities (for example, a safe playgrounds for kids project).

The Wilson Reserve project (#58) was an introduction to community action for many of

the participants. Some of them subsequently joined the Parks CHC and became active in other action groups and on the centre's committee of management.

The pathways through which community capacity has been enhanced in the various projects studied in this series included:

* consumer/community activists developing new skills and understandings;
* leaders emerging in particular communities;
* community networks becoming stronger; and
* new opportunities being established for consumer and community participation in health care organisations.

Consumer and community activists developing new skills

Project outcomes of this kind were common and in most cases were judged to be outstanding.

In the WASH project (#170) teachers, other school staff, parents and students received training in health issues (for example, nutrition, exercise) and in planning and implementing health promotion projects.

People associated with the Onkaparinga project (#56) acquired greater understanding about environmental issues and new skills in campaigning, lobbying and project management.

In the Brisbane Women's Cancer Screening program (#129), bilingual community educators acquired technical knowledge about women's health issues; they also acquired skills in running information sessions and advocacy and liaison in dealing with mainstream health Services.

Participants in the Horizons program (#108) developed new skills through participating in program review and development discussions and in some cases participating on the committee of management.

Young people at Benalla (#132) learnt new skills through assisting in designing their own pre-driver training program for teenagers.

The production of Women-centred Resources (#15) was a partnership between the Healthsharing Women's Resource Service and a number of women's groups. As a result a diverse network of women gained new skills in writing, drawing, designing, layout and production.

Members of the Home Oxygen Support Group (#34) learned how to conduct meetings and produce newsletters as well as gaining particular knowledge about the management of their illness.

Through the Rural Outreach project (#17), women in rural towns who participated on

advisory committees developed new skills in group processes, staff management, newsletter production and campaign strategies (as well as a wide grounding in women's health information).

Residents who participated in the Wilson Reserve project (#58) learnt about the structures and funding of local government and acquired skills in campaigning, public speaking, meeting preparation and lobbying as well as knowledge about the health issues associated with community safety.

Residents participating in the Nutrition in the Parks project (#27) learnt skills related to training, workshop presentation, lobbying, campaigning, production of information resources as well as nutritional information matters. Two were subsequently employed, one by the local shopping complex and one by the health centre.

An important outcome of Paps I Should (#1) was a significant increase in the skills (for example, in meeting procedure) and confidence (for example, as speakers and peer educators) of a number of women with disabilities through a long period of participating in the work of the Women's Health Service for the West, as project activists and in some cases as members of the service's committee of management.

Wider appreciation of the social (structural) dimensions of health issues

Among the diverse new insights and knowledge that project participants may have acquired, a wider appreciation of the social (or structural) dimensions of health is particularly worth commenting upon (see discussion of the integration of the macro with the micro in Chapters Six and Seven).

Examples of such a wider appreciation included:

* the links between the pollution of an estuary and commercial and bureaucratic organisations involved in producing and controlling that pollution (Onkaparinga, #56);
* the links between patterns of care provided to women from non-English speaking backgrounds and the wider structures of female and ethnic participation in society (Reclaiming the Womb, #16); and
* the links between implementing successful programs for children with developmental difficulties and the wider determinants of family functioning and school environments (Child Development Unit, #106).

Leaders emerge in particular communities

Leadership is an important dimension of community capacity. Many of the projects studied in this series have contributed to the emergence of indigenous leadership, sometimes in the form of organisational leadership, often as role models in particular

communities. Leadership of this nature emerged as part of Paps I Should (#1), Onkaparinga (#56), Brisbane Women's Cancer Screening (#129), Redfern (#60), Patchwork (#71), Halls Creek (#161) and Gagudju (#95).

Strengthening community networks

A strengthening of community networks is a critical outcome of current projects if they are to contribute to capacity building for the issues to be faced tomorrow. (See discussion of strength of community in Chapter Six.) Strengthening of community networks was commented upon in around 80% of cases. It was seen as particularly significant outcome in about one third of these.

The Brisbane Women's Cancer Screening project (#129) built upon existing networks within ethnic communities and also contributed to strengthening those networks by employing bilingual community educators.

The Home Oxygen Support Group (#34) created new friendships and extended networks through speakers outings, the newsletter and phone tree to members who were previously isolated and house bound.

Residents participating in the Wilson Reserve project (#58) got to know other people in their area leading to new friendships and new involvements.

Carers at Coburg (#133) who participated in the craft activities established new social networks and friendships among themselves and with other people participating in activities at various community facilities.

New opportunities established for consumer and community participation in health care organisations

Explicit arrangements for consumer and community participation in the management and other operations of primary health care organisations is an important resource in terms of building community capacity. Progress in this respect was noted in around half of the cases studied but was judged to have been particularly important in only a few.

Two examples of this were the new opportunities for participating in the running of Redfern (#60) and through Redfern for participating in policy making at the state and national levels and the new structures in Victoria for rural women to participate in health issues as a consequence of the Rural Outreach project (#17).

Enhanced institutional capacity to work towards better health

Institutional strengthening is a key strategy for ensuring that working towards better health

will be more effective tomorrow than it was today. We have identified three main patterns whereby institutional strengthening has emerged as an outcome of the projects studied in this series:

* opportunities strengthened for consumer and community participation;
* intersectoral links developed; and
* program models established for others to implement and develop further.

This list clearly does not exhaust the range of strategies for institutional strengthening.

Opportunities established for consumer and community participation

This pattern was described in the previous section of this chapter.

Intersectoral links developed

In almost all of the 25 cases, project outcomes were achieved which had the effect of strengthening intersectoral links: within the health system (between primary, secondary and tertiary sectors) and between the health sector and other sectors of social practice.

Two examples of stronger links within the health sector:

> As a consequence of the Reclaiming the Womb project (#16) Healthsharing Women established new connections with the local medical schools and colleges, resulting, among other outcomes, in improved training to medical students and vocational trainees in relation to women's health issues.
>
> Paps I Should (#1) also involved a partnership between various health profession trainers and women with disabilities resulting in the project video being used in medical and nurse education.

Examples of stronger intersectoral links beyond health:

> Child Development Unit (#106): links established between primary care and tertiary care experts and at the local level with education services, disability and allied health professionals.
>
> Babinda Hospital (#21): links established with Aboriginal groups, women's groups, Alcoholics Anonymous, police, tourism authorities and local industry.
>
> WASH (#170): links established between schools and health promotion agencies which will outlive the project and form a basis for further co-operation.
>
> Links established between sports clubs and the Billanook Primary School (#187) provided greater opportunities for sporting activities for young people out of school

hours in the local area.

Taking the Message (#14): links established with unions and management in a range of factories (including Ford and Toyota). These partnerships between WICH and industry resulted in changes in the working conditions of women which directly affected their exposure to occupational hazard.

Wilson Reserve project (#58): links developed between the Parks CHC, residents, council staff and councillors. From this a series of campaigns evolved which had the effect of strengthening the role of local government in health prevention. Co-operation between council, residents and the Centre resulted in safety improvements with the clean-up and removal of syringes and increased use of a healthy community resource.

Onkaparinga (#56): cooperative links established between health agencies, resident groups and environmental organisations leading to a cleaner river, healthier recreational opportunities and fewer health hazards for river users.

Housing for Health (#186): improved communication between agencies responsible for housing, sewerage, water and roads to facilitate a team approach to solving maintenance problems, thus improving the material conditions for better health.

Nutrition in the Parks (#27): partnership between shopping centre management, residents and Centre staff resulted in a new shop retailing nutritional food and nutritional food demonstrations.

Coburg Carers (#133): links between community health, local Government and neighbourhood houses ensured that there was a commitment to tackling the issues for carers beyond the life of the Healthy Localities project.

Program models established for others to implement and develop further

Several of the cases in this project have contributed to the wider field by implementing and documenting models of practice which other agencies are able to take up and develop or at least learn from.

The WASH project (#170) was developed in consultation with colleagues from overseas (through a World Health Organisation network) and has been thoroughly evaluated with the results disseminated through published articles and reports. The project provides the basis for the further development of health promoting schools nationally and internationally.

The Brisbane Women's Cancer Screening project (#129) proved to be a highly successful model for working with ethnic communities and improving screening rates. The use of bilingual community educators in working with ethnic communities has been picked up in

other projects (for example, child injury prevention at the Royal Children's Hospital in Melbourne).

Redfern (#60) was the first Aboriginal Medical Service in Australia and became the role model for the development of services throughout Australia: as a model of a service; as an advocate for Koori health; as a training organisation; as a participant in policy development and political action. Activists from Redfern have helped and supported other communities who wanted similar services.

Housing for Health (#186) undertook ground breaking work in the area of health hardware, its maintenance and its relationship to health status. A comprehensive report has been published and widely disseminated.

The Far West Mental Health Service (#157) has been reported in conference papers and journal articles. The success of the service in maintaining skilled staff in isolated areas has been made available to and influenced other services.

The success of the Home Oxygen Support Group (#34) for domiciliary oxygen users has been documented and disseminated. The group has extended to cover three other areas in Victoria.

The success of the Rural Outreach program (#17) has been documented and the model used elsewhere.

A private oncology practice in Melbourne has introduced a 'Tea Trolley' style service following the good results at Western Hospital (#128).

Halls Creek (#161) is now used as a successful model of a sobering-up centre in Western Australia.

The bushfire safety campaign run by Patchwork (#71) has been adopted by the Victorian Country Fire Authority who employed a team of project officers to establish similar community based campaigns in other fire prone areas of Victoria.

Paps I Should (#1) has already been replicated and funding for developing appropriate breast screening for women with disabilities has been received. A key aspect of the model is the importance of the information resources being created in collaboration with the key consumer group. The video has been widely used by and incorporated into curricula in nurse and doctor education.

Enhanced professional capacity to work towards better health

Capability building is about strengthening our capacity (resources, strategies, relationships and knowledge) to work effectively for better health tomorrow. Strengthening the capabilities of the professional workforce is a key aspect of this. In around one quarter of

the cases included in this project the outcomes achieved included important contributions to capability building with respect to the primary health care workforce. The women's health cases and the Aboriginal health cases are outstanding in this respect.

The Brisbane Women's Cancer Screening project (#129) led to changes in practice among health workers running screening services; leading to better access and quality of service for women from non-English speaking backgrounds.

The work of Healthsharing Women (Women-centred Resources, #15; Reclaiming the Womb, #16) involving both research, collaboration and resource development has contributed in many respects to undergraduate training of health professions (nursing and medicine in particular) and in professional conferences and workshops for a range of health professions.

The Rural Outreach project (#17) has contributed to clinical staff in hospitals learning new skills relevant to conducting well women's clinics and more primary care services including health promotion.

The video produced by the Paps I Should project (#1) has been utilised in health education programs and led to changed practice of some clinicians.

Redfern (#60) pioneered Aboriginal health worker training early in its history; a major contribution to Aboriginal health.

The success of the Gagudju project (#95) likewise turned upon the availability in Alice Springs of specialist health worker training for alcohol work.

The Housing for Health project (#186) produced a comprehensive report documenting the project's aims, and strategies and strengths and weaknesses and including implications for policy. It is an excellent resource for professional education on public health, conditions for health and Aboriginal health.

The Billanook School Health Program (#187) was published as part of a comprehensive review of the statewide Healthy Schools program. This widely distributed book now provides a valuable resource for professionals interested in promoting health in school settings.

9. Conclusions

In this final chapter we briefly review the background to this project, our objectives and our methods, and what our conclusions have been in relation to our original five objectives. We make a series of recommendations which, if implemented, will strengthen the primary health care sector and the achievement of health outcomes in Australia.

This project started with the assumption that the primary health care model can be useful as a resource in health care policy making and practice. Not that it is the only story that can or should be told; simply that it is a useful story which policy makers may draw upon in their thinking and which practitioners may use to guide their practice.

The 1992 NCEPH Primary Health Care Review confirmed that a wide range of commentators and practitioners agreed with the propositions that constitute the primary health care model; if these norms were realised across the primary health care sector, then certain valued outcomes would follow, specifically, more efficient, effective and equitable health care and prevention[60]. However, the NCEPH Review also identified a number of shortfalls between the ideals of primary health care and the reality of practice in Australia.

These shortfalls were mainly to do with the networking and the social health functions envisaged by the primary health care model. Networking here includes local networking, vertical partnerships (between local and more centralised health agencies), intersectoral collaboration and consumer and community involvement. The main shortfall in terms of the social health perspective was described in terms of the macro/micro balance, patterns of practice which address the immediate health needs of families and communities but in ways which also contribute to redressing the structural factors which reproduce those patterns of need.

The present project was originally conceived as a contribution to the wider realisation of the primary health care model, in particular, in relation to those aspects of practice which had been identified as shortfalls. During the development of the project we added a concern for the management of change as a further focus of study. We conceived the project as a contribution to on-going conversations about policy and about practice. The specific contribution that we would make would be to collect, disseminate and analyse case studies of good practice.

In developing the objectives of the project we were conscious of contemporary movement in the wider policy environment within which primary health care operates, in particular, the influence of market-oriented policies and an increasing focus on outcomes. We were also interested in new thinking in corporate management, in particular, the implications for primary health care of concepts such as best practice and organisational learning. (These issues are explored in more detail in Chapter Two.)

[60] National Centre for Epidemiology and Population Health (1992), *Improving Australia's health: the role of primary health care. Final report of the review of the role of primary health care in health promotion in Australia.* DG Legge, DN McDonald and C Benger, Canberra: NCEPH, ANU

In formal terms our objectives were to:

1 Survey recent descriptive accounts of primary health care in Australia with a focus on the networking, social health and developmental functions and to provide wider access to these reports by publishing abstracts and bibliographic details.

2 Delineate more clearly the kinds of outcomes which are presently being achieved in primary health care in Australia.

3 Delineate more clearly the patterns of practice which, in contemporary Australian conditions, lead to excellent outcomes and to delineate the pre-conditions for such patterns of practice.

4 Identify possible themes and directions for professional development activities which would support primary health care practitioners in their striving for best practice.

5 Identify possible directions with respect to policy and program development which would help to create more favourable conditions for good practice in primary health care.

6 Identify and publish benchmarks of best practice in primary health care with a focus on the networking, social health and developmental functions.

The process of this research has been essentially inductive: deriving generalisations from the detailed raw material through processes of selecting, sorting, ranking, correlating, coding, retrieving and synthesising. The product of these strategies of induction is the story which is told in Chapters Six, Seven and Eight. It is a story about pre-conditions, processes and outcomes; about elements, mechanisms and modes of contribution.

The story which emerges from the analysis, animated by the vignettes from the 25 individual cases, gives flesh, detail and movement to the primary health care narrative (which is often presented in a more abstract style). This rich text enables us to speak more clearly about:

- the outcomes of primary health care and the ways in which primary health care can contribute to better health today, tomorrow and the day after (see Chapter Eight);
- the patterns of practice and the diverse mechanisms whereby they contribute to valued outcomes (see Chapter Seven); and
- the kinds of pre-conditions (environmental and policy-dependent) which facilitate such patterns of practice (see Chapter Six).

Recapitulation: what we have done

We have collected and published a book of abstracts of 185 accounts of primary health care in action[61]. These 185 stories included reports of projects, descriptions of episodes of organisational development and evaluations of models of program delivery. There are many good ideas in the accounts and it will be useful to practitioners and teachers to have these stories more easily accessible. The stories will also provide useful raw material for research of the kind described in this report.

We selected a subset of 99 cases (where at least three of our study criteria were present) and sought the assistance of 78 reviewers in assessing outcomes and evaluating the role of particular aspects of process in achieving the outcomes recorded.

We selected for further study the 25 cases which attracted the highest ratings by the reviewers in response to a global question about outcomes. We investigated and analysed these 25 cases in detail. On the basis of this analysis we prepared a systematic account of the pre-conditions, processes and outcomes of best practice in primary health care, illustrated throughout with vignettes from the 25 cases. These vignettes are offered as possible benchmarks of best practice in relation to a range of different aspects of primary health care. As benchmarks of best practice they will be useful to many practitioners, managers and teachers.

A 120 page report of our preliminary findings[62] was prepared on the basis of the analysis of the interview study reported in Chapter Five. The report presented the project's background and methodology and the conclusions drawn by the project team. This preliminary report was circulated to over 300 people around Australia who had some contact with the project as referees, case study authors, members of the National Advisory Committee and others nominated by Committee members or who had previously indicated a particular interest in the project.

Those people who received the report were invited to make comment on any aspect of the preliminary report. Comments, which were received from a range of people and organisations, were predominantly positive. All of the comments received were taken into consideration in revising the preliminary report for publication in this form.

The documentation of primary health care practice

Our first objective was to survey recent descriptive accounts of primary health care practice in Australia. We identified 185 adequately documented accounts of recent (1990-1994) episodes of primary health care practice in Australia which correspond in some degree to the social health, networking or developmental functions of primary health

[61] Butler P, DG Legge, G Wilson and M Wright (1995), *Towards best practice in primary health care.* Melbourne: CDIH

[62] Legge D, G Wilson, P Butler and M Wright (1995), *Preliminary report of best practice in primary health care project.* Melbourne: CDIB

care which were our interest. This collection of cases has been published in hard copy[63] and through HEAPS[64] with an abstract and bibliographic details for each case.

Outcomes in primary health care

Our second objective was to delineate the kinds of outcomes which are being achieved in primary health care.

Good outcomes are being achieved. Our reviewers rated as very good to excellent (6 or 7 on a scale of 7) the outcomes achieved in around half of the 99 cases reviewed.

In a small number of the 25 cases in the interview study, the outcomes achieved included measurable health gains at the individual or community level. In the cases we have reviewed, attributable health gains are rarely documented. The difficulties and costs involved in documenting such gains are well known.

In many of the cases we reviewed the outcomes which have been recognised as excellent by our reviewers are better defined in terms of the social conditions for better health and/or the development of better health services and programs, rather than in terms of the biomedical dimensions of health gain. At a more distant level are the outcomes which are recognisable in terms of capability-building; developing our capacity for the next round of practice.

Figure 9.1 illustrates diagrammatically the pre-conditions, strategies and outcomes that emerged in the interview study. The continuities between pre-conditions, strategies and outcomes may be read horizontally across the columns of Figure 9.1. The outcomes column has three sub-headings indicating the outcomes we value for today, those we value for tomorrow and those we value for the day after tomorrow.

Project outcomes which we value for today are the immediate improvements in the health status of individuals. Project outcomes that we value for tomorrow are: first, improvements in the social conditions which shape the health of communities (and will be manifest in health status improvements tomorrow); and, second, the strengthening of health care programs and services (which will therefore deliver better sick care services and better public health programs tomorrow). The project outcomes we value for what they will yield 'the day after tomorrow' are the capability-building and institutional-strengthening outcomes that will enable health practitioners and community activists to work more effectively for continuing improvements in the social conditions for health and for improvements in programs and services (and which in due course will lead to individual health gain).

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[63] Butler P et al (1995), op cit.

[64] HEAPS (Health Education and Promotion System) is a (Windows based) data base focussing on resources and models in health promotion, designed for personal computers and produced and maintained for the Commonwealth Department of Health and Family Services by Prometheus Information P/L, PO Box 2319, Canberra, 2601; phone (06) 257 7356; fax (06) 241 5284

Pre-Conditions		Strategies of Practice	Outcomes		
Earlier pre-conditions	***Immediate pre-conditions***	***Including clinical and preventive services***	***Valued for today***	***Valued for tomorrow***	***Valued for the day after tomorrow***
Strong well resourced communities	Clarity of need	Consumer and community involvement			
		Collaborative local networking	Immediate health gains		
Supportive policy and program environment	Pre-existing community networks	Vertical partnerships		Service and program development	
		Intersectional collaboration			
Supportive organisational culture	[Established institutional resources and arrangements]	Macro/micro balance. Good management		Social conditions for better health [Policy development}	
[Well prepared and committed workforce]	Inspirational leadership	Organisational learning [Policy participation}			Capability-building - professionals - institutions - communities

Figure 9.1 Pre-conditions, strategies of practice and outcomes. (Elements shown in square brackets are elements which have been added to the diagram as interpolations dictated by the 'logic of circularity' depicted in Figure 9.2)

Immediate health gain

In around half of the interview cases there was firm or suggestive evidence of immediate health gains. Indicators included decreased morbidity, more effective programs of care, reductions in avoidable admissions and unnecessary procedures, greater use of screening services, greater access to specialist services, healthier diets and reduced adolescent drink driving.

In only a few of these cases were definitive quantitative data available to document these health gains and to justify the claim that this project was responsible for those outcomes.

Our respondents have emphasised the costs and difficulties associated with collecting such

data. In many cases the costs of data to document health gains and justify attribution would have exceeded the costs of the project or added greatly to it.

Improvements in the social conditions which shape the health chances of communities

We identified three kinds of project outcomes which we categorised as contributing to improvements in the social conditions for health (improving people's health chances) and which will be manifest in health status improvements tomorrow. These were:

- intersectoral progress towards the conditions for better health;
- strengthening social networks and social support; and
- increased consumer and community knowledge about health and skills in self-care.

These kinds of project outcomes correspond to well established conditions for better health. They are being achieved (see the cases which are discussed in Chapter Eight) but they are hard to measure and difficult to specify in advance.

The strengthening of health care programs and services

We identified three categories of outcome which were classified as strengthening health care services and public health programs. These were:

- improved access to existing services;
- improved quality of service; and
- programs and services established or developed to meet community needs.

Illustrative cases are cited in Chapter Eight.

Enhanced community capacity to work towards better health

An important set of outcomes identified in this project was the strengthening of community capacity to respond to future health issues. This represents investment in the community's capacity to work more effectively tomorrow for the conditions for better health and improved programs and services.

Outcome categories which were classified as community strengthening included:

- consumer and community activists developing new skills and understandings;
- leaders emerging in particular communities;
- community networks becoming stronger; and
- new opportunities being established for consumer and community participation in health care organisations.

These kinds of outcomes (illustrative cases are cited in Chapter Eight) correspond to well established principles of community development. However, as project outcomes they are difficult to measure and are difficult to specify in advance (as in the context of output-based funding).

Enhanced institutional capacity to work towards better health

A range of project outcomes was categorised within the broad group of institutional strengthening outcomes; ensuring that working for better health tomorrow will be more effective than it was today. Three main kinds of outcomes were categorised as institutional strengthening:

- opportunities strengthened for consumer and community participation;
- intersectoral links developed; and
- program models established for others to implement and develop further.

Whilst this list does not exhaust the range of strategies for institutional strengthening the outcomes identified clearly correspond to well established strategies for capability building. (See Chapter Eight for illustrative examples.)

Enhanced professional capacity to work towards better health

Capability building is about strengthening our capacity (resources, strategies, relationships and knowledge) to work effectively for better health tomorrow. Strengthening the capabilities of the professional workforce is a key aspect of this.

In around one quarter of the cases included in the interview study outcomes were recorded which were coded as outstanding enhancements of professional capacity. (See Chapter Eight.)

Capability-building as an outcome of current practice

In economic terms many of the outcomes which have been lauded by our reviewers represent the production of investment goods rather than consumption goods. The immediate health gains, documented or inferred in around half of the cases in the interview study, would be represented as consumption goods while the outcomes which involve practitioners putting in place the conditions for better health, better health care and more effective prevention in the future would be represented as investment goods. Such outcomes might be represented as the creation of 'health capital'.[65]

There are two key features about outcomes which involve the creation of health capital:

[65] See Cox E (1995), *The Boyer Lectures.* 1995, ABC.

- they are difficult to measure and value (and very difficult to amortise to a present value, in either dollars or future health gain equivalents);
- they are difficult to specify precisely in the context of planning investment expenditure.

In many of our cases the investment outcomes which we have described were not planned for, at least not at the level of detail which emerged in the case studies. Complexity theory suggests that there may be absolute limits to planning for and delivering long range outcomes in complex systems. Investing in capability-building, creating the conditions for tomorrows' decisions to be better decisions, may be a wiser strategy than trying to determine programmatic outcomes (in terms of individual health gains) too far into the future.

The recognition of capability building as an outcome of current practice also points to the limits of the linear 'structure => process => outcomes' model, suggesting instead a more circular relationship (captured diagrammatically in Figure 9.2) where some of the outcomes of today's practice constitute the pre-conditions for tomorrow's practice.

This developmental analysis has implications for how we think about best practice as well as outcomes. It fits in well with the concept of the macro/micro balance, styles of work which address the micro and immediate health needs of today in ways which also contribute to redressing the underlying circumstances which reproduce those patterns of need. It also corresponds to new thinking in corporate management about building organisational learning into the routines and cultures of corporate enterprise. (These issues are discussed in more detail in Chapter Seven.)

Figure 9.2 illustrates the way in which some of the outcomes of today's practice constitute the pre-conditions for good practice tomorrow. This framework corresponds also to our analysis of pre-conditions in Chapter Six, where we demonstrate that many of the pre-conditions for best practice are in some degree developable. Thus we have cited social conditions for better health as one of the outcomes of today's practice and we have cited strong well-resourced communities and pre-existing community networks as pre-conditions for good practice.

The correspondence between such outcomes and pre-conditions is a restatement of one of the basic assumptions of community development in health. It invites continuing research to delineate this link more clearly.

It should be no great surprise that supportive policy and program environment emerged as a critical pre-condition for good practice. However, we were surprised that policy participation did not emerge from our data as a key element of process nor did policy development emerge as a salient outcome. Both of these have been added to Figure 9.1 on the grounds of the logic of circularity depicted in Figure 9.2. We infer that participation in policy making does not figure strongly in primary health care practice but perhaps it should.

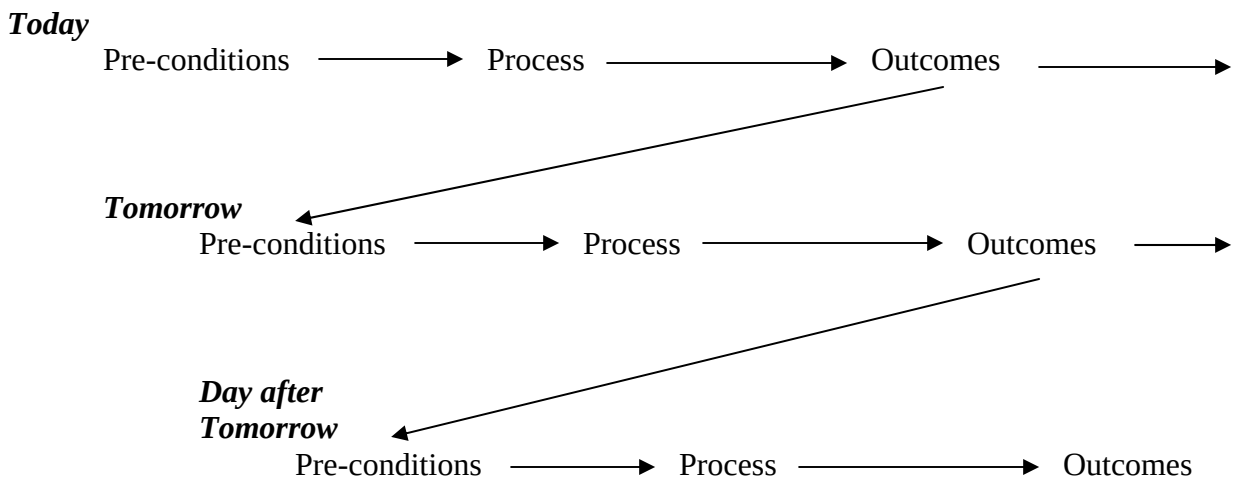

Figure 9.2: The outcomes cycle; the outcomes of today are the pre-conditions of tomorrow (primary health care outcomes as investment goods as well as consumption goods).

This developmental framework does not sit so well with more reductionist notions of outcome, where the only outcomes which are valued are those which involve immediate health gains. This reductionism may have been encouraged by the wider implementation of market oriented funding mechanisms. The notion of purchasing outcomes (or outputs) leads to an emphasis on those outcomes which are measurable and specifiable in advance. Many of the capability-building outcomes documented in Chapter Eight are neither measurable nor specifiable in advance. If health care administration is reduced simply to the purchase of immediate health gains from the cheapest provider there is clearly a risk that working towards the social conditions for better health and investment in capability-building will be discounted.

Strategies of practice

Our third objective was to delineate more clearly the strategies of practice which in contemporary Australian conditions lead to excellent outcomes and the pre-conditions for such patterns of practice. A clearer understanding of the elements of good practice should contribute to more strategic professional development programs (our fourth objective, see below); a clearer understanding of the pre-conditions for good practice should point towards new directions in policy and program development (our fifth objective, see below).

In Chapter Four we reported that we found positive correlations between our original five aspects of practice and the outcome scores given by the reviewers for the 98 cases they

considered. The associations between local and vertical networking and better outcomes were no longer statistically significant in the multi-variate model but community and consumer involvement, macro/microbalance and change consciousness still showed significant positive correlations with high outcome scores.

We found it useful to categorise the elements of practice manifest in the 25 interview cases (and described in Chapter Seven) in terms of:

- consumer and community involvement;
- collaborative local networking;
- strong vertical partnerships;
- intersectoral collaboration;
- macro/micro balance;
- organisational learning; and
- good management.

Our thinking about elements of practice changed between the review of the 98 cases, where we used the original five aspects, and our analysis of the 25 cases, where we re-framed these into the seven aspects listed here. The first change was that we re-categorised what we had originally described as vertical collaboration in terms of two aspects: vertical partnerships within the health system, and collaboration with organisations outside the health sector.

We also altered our original notion of change consciousness in light of the results of the interview study. What we had been calling change consciousness seemed more usefully conceived as two separate aspects: organisational learning and good management.

In the course of writing up this report we have added a number of elements to our framework, indicated by square brackets in Figure 9.1. These have been added on the grounds of the developmental logic illustrated in Figure 9.2.

On these grounds **policy participation** was added to our list of elements of practice. This reflected the salience of supportive policy and program environment as a pre-condition for good practice in the interview study. Since we are arguing that the outcomes of today include the pre-conditions for tomorrow and that institutional strengthening is an important category of outcomes we conclude that policy development should be listed as an outcome which we value for tomorrow and that policy participation should be listed as an element of practice.

The insights in relation to practice which emerged from the interview study will be of particular interest to practitioners. Some of the highlights follow. (These are discussed in more detail in Chapter Seven.)

Consumer and community involvement

Meaningful consumer and community involvement was strongly associated with good outcomes in both the reviewer study (we found significant positive correlations using both univariate and multi-variate statistical models) and the interview study. We identified three mechanisms in the interview study which appeared to mediate this involvement. These were:

- determining priorities;
- acquiring ownership of professional knowledges, methods and skills.

The case studies cited in Chapter Seven illustrate how these elements of process contribute to the outcomes described.

Collaboration

Local and vertical collaboration were found to be positively correlated with high outcome scores in the univariate model. However, in the multi-variate model the associations of local networking and vertical collaboration with high outcomes did not achieve significance. We infer that the positive effects of such collaboration are encompassed in some way by the other three aspects of practice which did retain their significance in the multi-variate model. Whatever dynamics contributed to the excellent outcomes achieved in the programs reviewed, it appears that it was encompassed by consumer and community involvement, the macro/micro balance and change consciousness.

In the interview study of the 25 cases, we identified collaboration as an important unifying theme, applying in relation to local collaboration, strong vertical partnerships, and intersectoral collaboration (at the local as well as the policy and program levels).

We identified four mechanisms through which collaboration appears to contribute to better health outcomes. These were:

- building a more broadly based story;
- producing a story that coordinates different players;
- mobilising additional resources; and
- capability-building.

The case studies cited in Chapter Seven illustrate these dynamics.

Macro/micro balance

The notion of the macro/micro balance is a key concept in primary health care. In the reviewer study high outcome scores correlated positively (and significantly) with reviewers' judgements that the passages of practice described reflected the macro/micro

balance. The macro/micro balance emerged as an important aspect of process in the interview study also.

Achieving this macro/micro balance is difficult, conceptually as well as practically. How shall we conceive the continuities between the micro and immediate problems and the underlying social conditions which contribute to reproducing those patterns of need?

We often find ourselves using different theoretical frameworks for speaking about the micro and the macro but with no articulation between the two. For example, we might recognise the impact of colonialism and dispossession on Aboriginal health at the macro level but be unable to find strategies in our own practice to work to redress those influences at the micro levels. This is not so surprising. There are not so many reference points in common between the historical and political disciplines which we draw upon in understanding the macro and the behavioural and biomedical disciplines we draw upon in addressing the micro and immediate problems.

It may be that the ways in which separate academic disciplines all model the same world using different specialist languages is part of the problem, particularly where those more macro models do not include any reference to 'me', the 'on-the-ground' practitioner, trying to engage with the dynamics of which they speak.

Policy participation

The policy discussion in Chapter Two extends the principle of the macro/micro balance to include participation in policy making. However, it is easy to feel confused and disempowered by the fast moving and treacherous currents of the policy environment. It is sometimes hard to see what is happening until it is all too obvious. It is hard to find levers to which the practitioner might have access which could influence these processes.

We have used discourse theory as a way of describing this policy environment, giving names to particular discourses and speaking of them as stories which are being told about different problems, variously clashing and flowing together. Speaking of stories also helps to render audible the voices in which these stories are told, the world view within which each story is constructed.

Discourse theory also emphasises the ways in which discourses are shaped by and shape the practices and structures within which they are spoken. The corollary is that by speaking and practising differently we can redirect the flow of discourses, not as individuals alone but as participants in social movements whose coordinated action is oriented around shared stories. This also emphasises the importance of our being aware of how our own practices and ways of speaking are positioned in these different discourses (even while stepping out of them to name them).

Organisational learning

Organisational learning emerged strongly from our data as an important element of process, strongly associated with good outcomes. The variable 'change consciousness', which we used in the reviewer study, was subsumed by the more useful concept of organisational learning after the interview study. Organisational learning includes three codes which emerged as important in managing change: evaluation and critical reflection on practice, linking practice with theory and research and investing in personnel training.

We have commented in Chapter Three that traditional narratives of primary health care are not strong in speaking about the elements of practice which practitioners may deploy in responding to environmental change and in shaping organisational change. We think that the concept of organisational learning is a useful way of formulating what it is that good practitioners do in these respects.

Management

The management of change is, of course, part of management generally. Management was not a focus in the initial planning of this project but it emerged as very important, particularly in the interview study, and warrants further study. Everything we have learned in this project has relevance to the practices of management. Much of what we might have said about management we have said in relation to all of the other headings we have used in this report.

Four further elements of good management which emerged in the interview study and which we have not discussed under other headings (see Chapter Seven) were:

1. flexibility and risk taking;
2. effective personnel selection;
3. using available information resources; and
4. mobilising (and economising with) financial resources.

Pre-conditions for good practice

We identified five broad categories of pre-conditions for good practice through the interview study. These were:

- clarity of need;
- strength of community;
- supportive policy and program environment;
- supportive organisational environment; and
- inspirational leadership.

These pre-conditions are all, to a greater or lesser degree, developable, through earlier cycles of practice.

Clarity of need

Starkness of need is sometimes a consequence of injustices or catastrophes which no one would wish to develop. However, in some cases, earlier patterns of work have helped to create a consensus about needs which has facilitated more coordinated strategies.

Strength of community

Strength of community, as a broad category of pre-conditions, included the following descriptive codes: a strong sense of shared identity, rich linkages within and across networks, and traditions of civic involvement and activism.

Such resources are in part the legacy of history, patterns of settlement, the development of cultural bonds, access to resources, etc. However, strength of community can in some degree be developed as the outcome of earlier passages of practice. Two elements of practice which appear to be particularly relevant to the achievement of such outcomes are community and consumer involvement and the macro/micro balance.

Supportive organisational environment

Supportive organisational environment emerged from our interview study as an important category of pre-conditions. The pre-conditions codes which were included in this group were:

- organisational purpose clearly articulated, shared and alive;
- formal planning and review structures based on a strong policy framework;
- organisational policies which value critical reflection, evaluation and innovation;
- organisational policies which support staff development including participation in formal study and research;
- formal structures which support consumer and community participation in agency decision-making and project operations;
- structures which facilitate the recognition of the macro as well as the micro issues; and
- a longer term perspective.

These pre-conditions for good practice are self-evident when listed in this way; they correspond to established and familiar precepts of management. Nonetheless they were not so commonly present in the case studies. These pre-conditions are largely developable given time and good management and correspond clearly to the notion of institutional strengthening as an outcome of good practice. They point clearly to professional development and policy and program initiatives which could contribute to building these pre-conditions.

Supportive policy and program environment

The presence of a supportive policy and program environment emerged strongly in our interview data. This category included the following codes:

- a coherent and authoritative policy narrative;
- pre-existing models of service delivery;
- mandated structures to support community involvement in decision-making; and
- program infrastructure (being part of a wider program with access to financial resources and to existing networks for project collaborations).

These are all conditions which can be cultivated by policy makers and we comment further on these later in this chapter.

Inspirational leadership

Inspirational leadership emerged as a pre-condition for good practice. This category included the following codes:

- skills in political analysis and ability to chart a path in confusing territory;
- ability to take insights from different places and bring coherence to them in the context of a program of action;
- ability to listen to people and reflect back, with added value;
- clarity of vision and an ability to depict possibilities as achievable;
- confidence and readiness to act (even where full certainty is still not possible) and to inspire others to act even where (especially where) there is uncertainty about the outcomes; and
- readiness to critically examine what happens, to take feedback and to learn how to do it differently and better next time.

The importance of leadership as a pre-condition points to the importance of professional development as an element of process and capability building as an outcome. Professional development is an important part of organisational learning.

Research also has a key strategic role to play in developing the infrastructure of the primary health care field and creating the conditions for leadership to emerge. Research policies which support practitioner-based research and consumer-perspective research would contribute significantly to the emergence of such leadership.

We added two more broad categories of pre-conditions during the analysis and writing up stage on the basis of the logic of the continuities between pre-conditions, practice and outcomes (see Figure 9.1). These additional pre-conditions were:

- established institutional resources and arrangements; and
- well prepared and committed workforce.

Both of these are self-evident. The reason they did not emerge in the interview study may have been because they were taken for granted and in a group of best practice cases they were not highlighted through comparison.

Human resource development

The fourth objective of this project was to identify possible themes and directions for human resource development activities which would support primary health care practitioners in their striving to achieve best practice.

Consumer and community involvement emerged as an important aspect of process in both the reviewer evaluation study and the interview study. Clearly there is a continuing need for resources and opportunities directed towards increasing the skills of practitioners in these areas and for resources and programs to support consumer and community activists in their participation.

The macro/micro balance (addressing people's immediate health needs in ways which also contribute to redressing the structural influences which continue to reproduce those patterns of need) emerged as a key process factor in both the reviewer study and the interview study. It is particularly relevant to organisational learning, policy participation and creating the social conditions for better health. We have cited a number of benchmark cases which illustrate best practice in this respect. However, there was a relatively high number of cases in the reviewer study where the absence of this element of practice was judged to be deleterious to the outcomes achieved. This is clearly a difficult area of practice and we are proposing further study of this element of practice.

Change consciousness was strongly associated with good outcomes in the reviewer study. The results of the interview study led us to reframe this in terms of organisational learning which included: evaluation and critical reflection on practice, linking practice with theory and research and investing in personnel training. These codes point clearly to the kinds of initiatives which might weld activities which we have previously considered separately (evaluation, research, study and professional development) into a culture of organisational learning.

Participation in policy making was one of those elements of practice codes which did not emerge clearly from our data but which we added as a consequence of the logic of the pre-conditions, practice, outcomes cycle. Clearly it overlaps with organisational learning and with the macro/micro balance.

The primary health care sector would be strengthened by mobilising practical leadership from, and participation by, primary health care practitioners in policy-making. Wider support for practitioner-based research, scholarships and fellowships and appropriate support to conferences and journals will contribute greatly to the emergence and nurturing of effective leadership in policy development. We plan to explore the issue further.

Management is another area of practice which emerges as a key focus for continuing professional development.

Identifying the importance of these areas of practice provides clear themes for human resource development in the primary health care sector but they also highlight the lack of institutional infrastructure through which such programs might be offered. The introduction of divisions is addressing some priority needs within general practice. However, there are others in the primary health care sector who also need resourcing (for example: nurses, pharmacists, local government staff, consumer activists and community volunteers) and there is an important need for multi-disciplinary fora where listening and shared commitment among people from different backgrounds can be cultivated.

In order to give our recommendations a strong practical orientation we have drawn upon earlier recommendations for the establishment of primary health care reference centres as a strategy for mobilising support to the primary health care sector on a multi-disciplinary basis. It is clear that such a strategy would require a network of centres, each operating on a regional basis, however they were to be designated, auspiced and funded.

Recommendations

Developing an appropriate infrastructure to support continuing human resource development in primary health care would be a strategic investment in better health for Australians.

We recommend that, in the context of developing a National partnership for public health, the Commonwealth, states and territories commit themselves to working with educational institutions and appropriate professional and peak bodies with a view to establishing a national network of primary health care reference centres, on a regional basis and with a multi-disciplinary orientation.

Among the key functions of these reference centres would be:

- supporting professional development opportunities for agency and program managers;
- nurturing a culture of organisational learning within the primary health care sector;
- supporting system-wide learning (research, evaluation, critical reflection, teaching, policy work, etc) with regard to consumer and community involvement, macro/micro balance, policy participation, organisational learning and improved collaboration (locally, vertically and intersectorally);
- encouraging the search for best practice by supporting the documentation of contemporary primary health care practice and access to and dissemination of such documents.

We envisage that the proposed PHCRCs would have a direct staff capacity for education, evaluation, research and policy but would also carry out a brokerage function in linking primary health care practitioners to academic researchers and other resource people; and directing local fellowships, exchange visits and scholarships that would develop local leadership capabilities.

Policy and program development

Our fourth objective was to identify possible directions with respect to policy and program development which would help to create more favourable conditions for good practice in primary health care.

One such direction would be to provide infrastructure support for the kinds of professional development work we have outlined above.

However, there are also policy initiatives which could be taken which would contribute directly to a more supportive policy and program environment:

- developing a coherent and authoritative policy narrative;
- researching and disseminating models of program and service delivery;
- mandating structures to support community involvement in decision-making, at the regional, agency, program and locality levels; and
- infrastructure support to develop collaboration in program delivery.

A supportive organisational environment also emerged as a pre-condition for good practice. The elements of this pre-condition (reviewed above) point to ways in which funding programs could contribute to this kind of institutional strengthening. In particular funding programs should aim to encourage:

- formal planning and review structures based on a strong policy framework;
- organisational policies which value critical reflection, evaluation and innovation;
- organisational policies which support staff development including participation in formal study and research;
- formal structures which support consumer and community participation in agency decision-making and project operations.

Our findings in relation to outcomes are also relevant to policy making. Our data constitute a strong case for widening prevailing definitions of outcomes to include the medium term and longer term outcomes (listed in Figure 9.1); to include the building of health capital. These are not outcomes that can be so easily measured or specified in advance and this has implications for constructing health service funding as the prospective purchase of outcomes.

Recommendations

Australia would benefit from an overarching policy framework which could guide the development of primary health care programs, services and culture.

We recommend that the Commonwealth, States and Territories develop a National Primary Health Care Policy and Action Plan (within or independent of the proposed National Partnership for Public Health).

We recommend that the proposed Primary Health Care Policy incorporate a set of goals and targets for the strengthening of the primary health care sector which would correspond to the pre-conditions for good practice identified in this report.

We recommend that policy objectives formalised in the proposed Primary Health Care Policy would recognise the 'investment-type' outcomes of primary health care practice (the building of health capital) as well as the immediate health outcomes, notwithstanding the difficulties in measuring such outcomes and in specifying them precisely in advance.

We recommend that the proposed Primary Health Care Policy be directed in particular towards:

- strengthening consumer and community involvement;
- cultivating organisational learning across the health sector (integrating previously disparate activities such as research, education, planning, evaluation etc around a shared vision); and
- strengthening local, vertical and intersectoral collaboration.

We recommend that the proposed Policy include provision for funding support for innovative program development and evaluation in primary health care.

We recommend that the proposed Policy be developed as a vehicle for an inclusive conversation which involves all of the main stakeholders in primary health care. We envisage the discussions around the development of this policy as contributing to the emergence of a shared understanding across the sector which would contribute to greater coordination and complementarity of people's practice. The participation of practitioners and consumer and community activists in the policy conversation would need to be actively supported.

We endorse the strategies suggested by the National Health Strategy[66] for strengthening consumer and community participation in health issues. We recommend that these strategies be incorporated in a National Primary Health Care Policy.

We affirm the importance of funding support (such as is presently provided at the National level through the Community Organisations Support Program) in strengthening the institutional fabric of consumer and community involvement at the State/Territory and National levels. Funding is needed to support publications, conferences, education and training and consumer-perspective research as well as administration.

[66] National Health Strategy (1993), *Healthy participation: achieving greater public participation and accountability in the Australian health care system.* NHS Background Paper No. 12, Melbourne NHS

Benchmarks of best practice in primary health care

Our final objective was to identify and publish benchmark cases illustrating various facets of best practice in primary health care. This we have done in some detail in Chapters Six, Seven and Eight and Appendix One.

One of our strongest conclusions from this project is the usefulness of the best practice approach to quality improvement in primary health care. The emphasis on looking for benchmarks in real life practice ensures a sensitivity to changing environments. The precept of looking for benchmarks from wide afield encourages innovation. The practice of visiting other organisations encourages a holistic approach to benchmarking which does not create unhelpful divisions between outcomes, processes and structure or between research and practice. The involvement of labour and management in the processes of assessment and planning makes win-win change more likely. The emphasis on customer satisfaction captures the concerns of the primary health care model for consumer and community involvement more broadly than do those models which reduce the role of the customer to their choice of vendor and to buy or exit in the health care market.

Chapters Six, Seven and Eight of this report provide a living account of primary health care, as it operates on the ground in Australia now. We hope that by publishing this account of best practice in primary health care we may be making more accessible to a wider range of users a narrative which we believe they could find useful as a story to be woven in through the various other stories they are telling about the problems and possibilities in their work.

There are numerous barriers to more effective practice: in the structural arrangements of health care; in the cultural practices of the workforce; and in the policy environment, as discussed above. Some practitioners in some localities and programs are overcoming some of these barriers. By making more widely accessible vignettes of best practice which may be useful as benchmarks we hope that we may contribute to improvements in primary health care practice in diverse respects; from the breadth of topics covered in the 185 cases, to the depth of analysis of the 25 cases. By holding up a mirror to their practice we hope that we may be able to assist practitioners to reflect more clearly on their own practice and their practice environment and to manage their own practice more effectively.

These are times of sweeping change in the health industry, occasionally exhilarating, often stressful, sometimes distressing and destabilising. Many of the social health problems which confront practitioners are getting worse; increasing inequalities, violence and alienation, continuing environmental degradation. Primary health care practitioners are looking for new strategies for negotiating the changing practice environment. We hope that the analysis of practice which has emerged from this project will contribute to the development of new strategies and new resources for confronting the health development task.

Some of the major health-policy issues presently confronting us are not addressed within

the dominant discourses of health policy, in particular, widening inequalities and continuing environmental degradation.

Widening economic inequalities (in Australia and globally) are associated with widening inequalities with respect to health status and in some cases absolute deteriorations in population health status. Unsustainable environmental exploitation and the threat of ecological destabilisation are structured into the global competitiveness of the New World Order.

These trends are treated as inevitable in the dominant policy discourses, all of which (with the exception of primary health care) take the need for Australia to achieve international competitiveness within the New World Order as a basic assumption.

These are not simple issues and simply adopting a primary health care policy would not of itself reduce inequalities and achieve ecological sustainability. But the stories which are told in the health sector are not unrelated to the ways in which society as a whole constructs its problems and frames its possible directions.

These are not simply issues of policy, understood as a set of rules for decision makers. The ways in which we speak about health and society reflect but also reshape how we conceive what it is to be human. There are reasons to be cautious about the dominance of policy discourses which construct health care simply as a commodity for bulk purchase. It is of no small consequence if the meaning of health care is being reshaped to exclude the interpersonal relationships which ameliorate the existential or spiritual fears which are so much part of the human experience of sickness, the fear of death, loneliness, meaninglessness and freedom.

There is rich material in this report which speaks to a concern for social justice and for ecological sustainability as integral to health and health care. These concerns are deeply embedded in the primary health care tradition.

Recommendations

We recommend that the Commonwealth's Best Practice in the Health Care Sector program be continued with a brief to include a stronger focus on primary health care.

We recommend that the proposed Primary Health Care Policy ensure that support is provided for continuing documentation of passages of practice in primary health care.

We recommend that the Commonwealth, State and Territory health authorities agree to ensure that reports of all funded projects (Commonwealth, State/Territory and non-Government) should be at least indexed in a recognised bibliographic database, such as HEAPS, and that original reports be deposited in an accessible place.

Further research

In outlining the background to this research we have sketched a program of continuing explorations within which this project has made some small progress.

Our priorities for further work include:

- strategies of practice which integrate more effectively the micro and the macro frames of analysis; and
- strategies for developing a culture of organisational learning in primary health care, including practitioner engagement in policy formation.

We look forward to developing the methods we have used in this project and applying them to other selections of case material. In particular, we hope to apply this method to a narrower selection of cases (ie with greater homogeneity of setting and purpose) but with a broader range of approaches and styles represented.

We are looking forward to applying action research strategies in order to develop a clearer account of the dynamics of the pre-conditions, process, outcomes cycle (and the mechanisms of contribution); looking in detail at practice on the run and in the process of change.

Recommendations

The research we have reported in this study points to a range of further topics and strategies for public health research. We recommend that the research funding agencies elicit and fund appropriate research proposals in the following areas:

- action research directed at understanding the dynamics of the pre-conditions, practice and outcomes cycle identified in this project;
- the pre-conditions for best practice in primary health care and the degree to which the outcomes of good practice put in place the pre-conditions for better practice;
- models of accountability for 'investment-type' outcomes in primary health care;
- the role of consumer and community involvement in creating the conditions for better health (including the three mechanisms identified in this study: determining priorities, exercising power and acquiring ownership of professional knowledges, methods and skills);
- documentation and assessment of the Victorian and South Australian experience in population-based consumer and community involvement as effected through the Victorian District Health Councils and the South Australian Health and Social Welfare Councils;
- barriers to and strategies for integrating micro and macro levels of analysis in primary health care practice including action research with practitioners and case study research; and
- the impact of different arrangements for the funding of primary health care on the pre-conditions, patterns of practice and outcomes achieved in primary health care.

We recommend that research funding agencies continue to explore innovative research strategies including practitioner-based research, consumer-perspective research and policy-oriented research.

Appendix One: Twenty-Five Cases of Best Practice in Primary Health Care

This appendix contains an entry for each of the 25 cases of best practice that were selected on the basis of referee's reviews; these are listed in the table below. The process of selection of these cases is detailed in Chapter Four. For each case we have included the relevant reference from our data base as published in 'Towards Best Practice in Primary Health Care'. (This publication includes similar entries for all 185 cases surveyed). In addition we have described in brief the significant pre-conditions, processes and outcomes that we identified in each case.

Case Number	Case Title
1	Paps I Should
10	Vietnamese Women's Domestic Violence Poster Project
14	Taking the Health Message to Women
15	Developing Women-centred Resources
16	Reclaiming the Womb
17	Reaching Out to Women in Rural Victoria
21	Babinda Hospital
27	Nutritional Health in the Parks
34	Victorian Home Oxygen Support Group
56	The Onkaparinga Estuary
58	Wilson Reserve Project
60	Redfern Aboriginal Medical Service
71	"Patchwork" - Bushfire Safety Education
95	Innovative Alcohol Intervention
106	General Practitioner Involvement in Child Development Unit
108	Horizons Women's Program
128	A Tea Trolley Support Service in Oncology
129	Pap Smears and Breast Self Examination for NESB Women
132	Healthy Localities Benalla
133	Coburg Carers Project
157	Far West Mental Health Service
161	The Care of Public Drunks in Halls Creek
170	WASH, Making Schools Healthy
186	Housing for Health
187	Billanook Primary School

#1

Paps I Should

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J:>Jiqne:.03 96&9 9&$··· fllX:0 3 9689 38JiJ•··

Rates of cervical screening are particularly low amongst women with disabilities. Farnan and Gray[1] outline how the Women's Health Service for the West (referring to Melbourne's western suburbs) successfully worked with women with disabilities to help them improve their access to Pap smear tests. The project was a partnership between the Service, the women and other health agencies. A range of strategies were used including professional education, advocacy, peer education and improving local services. By utilising peer education strategies the project was able to be extended to women with disabilities who were also from non-English speaking backgrounds.

The significant outcomes of the project appeared to include a probable improvement in the health status of women with disabilities; personal development of many of the women involved in the project; role models provided to other women with disabilities; improved practice among professionals providing Pap smears; a major contribution to the field in regard to screening and primary health care services for women with disabilities; and intersectoral progress towards the conditions for better health for women with disabilities.

The processes adopted in this project that seemed particularly important were the high level of control exercised by the women involved; working in ways that recognised both the need to improve current practice and work on longer term strategies; intersectoral collaboration, mobilising more centrally located expertise, and regular critical reflection and evaluation of practice during the project.

The pre-conditions that appeared to be significant included an authoritative national policy which provided a framework; organisational structures and practices which ensured the participation of women with disabilities in the management of the Service and the project; a clearly articulated vision at the Service level; service structures which provided for work at the micro and macro levels; a service culture of critical reflection; staff with a strong commitment to women and community participation.

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1 Farnan S, Gray J (1994), *Paps I Should.* In Butler P (ed), Innovation and Excellence in Community Health, CDIH, Melbourne.

#10

Vietnamese Women's Domestic Violence Poster Project

Inner West Community Network Against Violence Towards Women and Children
c/– 12 Gower St, Kensington, Vic, 3031
Phone: 03 9376 0523 Fax 03 9372 1588

Domestic violence support groups for women from non-English speaking backgrounds are rare despite the fact that such violence crosses the barriers of class, culture and race. Kennedy, Clarke and Yong[2] tell the story of a Vietnamese women's domestic violence support group (based in the inner western suburbs of Melbourne), their decision making processes and strategies and the gradual development of trust and sharing of personal experiences. The authors discuss how the Vietnamese women, working with a community artist, designed an eye-catching poster which provided important information about domestic violence in Vietnamese. They also outline other group activities which included offering advice and support to women who were experiencing or who had left violent domestic situations.

The project's significant outcomes included increased access by Vietnamese women to health and welfare services; strengthened community and social networks; and improved skills and knowledge for those involved in the project.

The significant processes that appeared to contribute to these good outcomes were collaboration among a number of organisations from different sectors, including local Government, health, welfare, arts and recreation; networking at the local level; working in ways that recognised the balance between the macro and the micro; a collaborative approach to the project's planning and execution among the organisations involved; and the project's responsiveness to the needs of Vietnamese women.

Significant pre-conditions appeared to include organisational structures that reflected the balance between working at the micro and macro levels; a shared and alive vision of the project; the existence of a network of local domestic violence workers funded by the State Women's Health Program; a national policy that identified domestic violence as a major issue for women and justified the project; and a shared sense of identity among the Vietnamese women involved.

2 Kennedy L, Clarke H, Yong H (1994), *Vietnamese Women's Domestic Violence Poster Project.* In Butler P (ed), Innovation and Excellence in Community Health, CDIH, Melbourne.

#14

Taking the Health Message to Women

Women in Industry and Community Health
83 Johnston St, Fitzroy, Vic, 3065
Phone: 03 9416 3999 Fax: 03 9416 3749

Conventional models for delivering health information often assume competence in English, a shared cultural understanding of health, and an ability to access health services for more than the most pressing of health concerns. It is difficult to contemplate how the health needs of women from non-English speaking backgrounds, working in factories, could be met using these models. This program illustrates how one women's health service, Women in Industry and Community Health (WICH), developed innovative ways of reaching these women.

The Service developed a successful 'Factory Visits Program' which took health information to women in the workplace via a team of bilingual and bi-cultural workers who, between them, spoke over 100 languages. Webster and Wilson' outline the team's health promotion strategies which included discussing health issues identified by the women workers over lunch, as well as the use of a range of written and audio-visual material.

The significant outcomes from the program included increased knowledge and health literacy among the women in the factories; intersectoral links developed; increased access by women from non-English speaking backgrounds to health services; and intersectoral progress made in relation to the conditions for better health.

The processes that appeared to contribute significantly to these good outcomes included responsiveness to the health information needs of women; intersectoral collaboration; working in ways that recognise the balance between micro and macro levels; and effective selection processes in recruiting staff for the program.

The important pre-conditions appeared to include a coherent and authoritative policy narrative at the national level; organisational policies that provided for community participation in decision making; WICH being part of a statewide program; and union involvement.

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3 Webster K, Wilson G (1993), *Taking the Health Message to Women.* In Webster K, Wilson G, Mapping the Models, CDIH, Melbourne.

#15

Developing Women-centred Resources

Healthsharing Women's Health Resource Service
3rd floor, 373 Lt Bourke St, Melbourne, Vic, 3000
Phone: 03 9670 0855 Fax: 03 9670 0683

It is widely agreed that health promotion and illness prevention strategies have a major role to play in improving the health status of the community. Health providers and women in the community have repeatedly pointed to the absence of accessible, relevant and appropriate information about a broad range of women's health issues, a key element in health promotion strategies. The case study' on this project documents how Healthsharing Women's Health Resource Service (formally the Women's Health Resource Collective and HealthSharing Women), Victoria's statewide women's health service, generated its resources. Key strategies discussed in the case study include: beginning with women's needs; valuing women's experience; generating material in a range of media, styles, and languages; and working for change by developing strategic partnerships.

The significant outcomes of the program appeared to be Healthsharing's contribution to the development of professional education; the skilling and improved practice of professional practitioners; the skilling and personal development of women generally; and the probable improvement in the health status of women.

The processes that appeared to contribute to these important outcomes included active and visionary leadership of the organisation; the utilisation of available information resources; the mobilising of more centrally located expertise; intersectoral collaboration; working at both the micro and macro levels; taking a collaborative approach to the development of resources; and the active participation by women in the program.

The pre-conditions that appeared significant in this program were a shared acceptance of necessity for change amongst staff; organisational structures which supported working at both micro and macro levels; a clearly articulated and shared organisational purpose; the agency being part of a statewide network of women's health services; the National Women's Health Policy providing guidance and leverage; and a tradition of political activism in the women's movement.

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4 Webster K, Wilson G (1993), *Developing Women-centred Resources.* In Webster K, Wilson G, Mapping the Models, CDIH, Melbourne.

#16

Reclaiming the Womb

Healthsharing Women's Health Resource Service
3rd floor, 373 Lt Bourke St, Melbourne, Vic, 3000
Phone: 03 9670 0855 Fax: 03 9670 0683

Whether to have a hysterectomy is a significant decision in the lives of many women. It concerns not only their physical well being, but their emotional health, sexuality and self-image. Australian research has shown that almost 17% of women between the ages of eighteen and sixty-nine have had a hysterectomy.

The project case study[5] outlines the range of ways that Healthsharing Women's Health Resource Service sought to improve the situation of women facing this difficult and complex decision and how this contributed to reducing sometimes unnecessary surgery. They included: face-to-face and over the telephone support to individual women; the development of the Hysterectomy Support Group; production of resources summarising the latest research information and issues; a research project on the experiences of non-English speaking women; professional education; regular forums and conference papers.

The important outcomes of the project appeared to include probable improvements in the health status of women; a wider appreciation of the social and structural dimensions surrounding hysterectomy; the skilling and changed practice of professional practitioners and a major contribution to the development of their education including changes to tertiary medical curricula; a contribution to the development of the field and sector in the form of research on the specific needs of women from non-English speaking backgrounds; and improved links between various medical colleges and Healthsharing's professional education and research teams.

The processes that appeared to contribute to these good outcomes included active and visionary leadership; responding to women's immediate needs as well as addressing professional education issues; intersectoral collaboration; networking with medical educators and colleges; linking practice with theory and research; and involving women from diverse backgrounds.

The pre-conditions for this good work appeared to include organisational structures at Healthsharing which promote a balance between working with individual women via a telephone information line and with organisations to achieve change; a clearly articulated and shared organisational purpose; the agency being part of the statewide women's health program; the guidance and leverage provided by the National Women's Health Policy; and the tradition of political activism within the women's movement.

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5 Webster K, Wilson G (1993), *Reclaiming the Womb.* In Webster K, Wilson G, Mapping the Models, CDIH, Melbourne.

#17

Reaching Out to Women in Rural Victoria

Loddon Campaspe Women's Health Service
31 Mackenzie St, Bendigo, Vic, 3550
Phone: 054 430 233 Fax: 054 414 0741

One of the most significant challenges facing rural services is how they can have a meaningful impact on the lives of women in rural and remote communities without spreading their resources so thinly that they become ineffectual. Webster and Wilson[6] outline how the Loddon Campaspe Women's Health Service responded to this challenge by developing an Outreach Service. To ensure that the Service would be resource-effective they decided to employ staff who lived in or near their targeted towns. Thus these women brought existing and extensive networks to the Outreach Service.

These staff and networks formed the basis for part-time services in three locations which addressed local women's health issues, collaborated with other health agencies and practitioners, provided opportunities for skill sharing and exchange and advocated for women's needs within the community. After two years, as planned, the Outreach Service was relocated to other small towns in the region, leaving behind established links..

The outcomes appeared to have included probable improvements in the health of women in the three locations; increased skills and enhanced personal development of the women involved in the Service's activities; increased capacity in the three communities to respond to issues more generally; the establishment, development and extension of programs and services to meet the needs of rural women; the skilling and changed practice of rural health professionals; and contributions to the development of the sector more widely.

The processes that appeared to have contributed to these good outcomes included community control of the Women's Health Service; a collaborative approach to service development and management of the Service and at the local sights; staff and advisory groups working in ways that support initiatives for individual women; changes in hospital processes and local Council funding programs; mobilising more centrally located expertise; critically reflecting on and evaluating practice; and flexibility, opportunism and risk-taking.

The pre-conditions for this good work seemed to include the guidance provided by the Natbnal Women's Health Policy; Loddon-Campaspe being part of the statewide network of women's health services; organisational structures and policies that promoted women's participation in decision making; a clearly articulated and shared organisational purpose; planning and review structures at the Service that were based on an understood policy framework; and a shared acceptance of the necessity for change among staff.

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6 Webster K, Wilson G (1993), *Reaching Out to Women* in *Rural Victoria.* In Webster K, Wilson G, Mapping the Models, CDIH, Melbourne.

#21

Babinda Hospital

Peninsula and Torres Strait Regional Health Authority
88 Abbott St, Cairns, Qld, 4870
Phone: 070 503 400 Fax: 070 315 710

Barker and May' describe how the principles of community development and participation in health, intersectoral co-operation, healthy public policy and primary health care became the blueprint for change at Babinda Hospital, a small rural service in North Queensland. They discuss how the hospital staff grasped the opportunities provided by the regionalisation of Queensland's health administration to re-orient their services to be more responsive to local needs.

Adopting the philosophy of the Ottawa Charter and using community development strategies, the hospital moved away from the traditional medical model and towards a service that was community driven and health promoting. Barker and May conclude that Babinda created a functional, well organised and collaborative health care network. Further, they argue that the benefits of this change extend beyond the health system and were manifested in an improved community spirit.

The significant outcomes at Babinda appeared to include increased access by residents to a range of primary health care services; the development of new services such as continuing care, public health and health promotion; the strengthening and maintenance of the agency itself; and the development of intersectoral links with groups including the police, tourism operators, local industry, women's groups and Aboriginal organisations.

The important processes which seemed to contribute to these outcomes included consultation with the community by the hospital prior to developing their change strategy; being responsive to community suggestions and needs as they arose; networking with local organisations, as noted above; collaborating with organisations outside the health sector (for example, police, industry); mobilising new financial resources (for example, HACC funding); and active and visionary leadership by the agency's management.

The pre-conditions for these processes and outcomes appeared to include the relatively small, close-knit community within which the hospital sat; the economic crisis posed by the potential loss of the hospital to the town; the introduction of regionalisation and devolution of management functions by Queensland Health to a local level; the guidance provided by Queensland's Primary Health Care policy and the Ottawa Charter; existing models of program organisation; staff with commitment, vision and leadership; and a shared acceptance of necessity for change among staff of the hospital.

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7 Barker R, May H (1993), ***Babinda: The place where people count.*** In Clarke B, MacDougall C (eds), The 1993 Community Health Conference, Vol. 1, Papers and Workshops, ACHA, NSW.

#27

Nutritional Health in the Parks

Parks Community Health Service
Trafford St, Angle Park, SA, 5010
Phone: 08 243 5611 Fax: 08 347 4221

Parks Community Health Centre is located in a lower socio-economic suburb of Adelaide. Spurr, Ward and Payton' describe how they undertook initiatives related to nutrition which saw them move away from a traditional health education approach with individuals, to more innovative ideas involving local people in addressing structural barriers to better health.

A health promotion grant to promote breads and cereals was used to support a community working party which: undertook nutrition promotions in shopping centres; encouraged the supply of nutritional foods through local shops; helped research and tackle poor nutrition amongst school children; campaigned over 'cholesterol free' labelling; and planned to improve the supply of fresh fruit and vegetables. These achievements, the authors argue, were only possible as a result of a partnership between local people, health professionals, food retailers, and local schools.

The important outcomes of this project appeared to be increased intersectoral links which in turn improved the conditions for better health; a contribution to the development of the field more widely; a contribution to the development of professional education; programs and services established and enhanced to meet community needs; skilling and personal development of community members; and probable improvements in people's health status.

The processes that appeared important in achieving these outcomes included active and visionary leadership; linking practice with theory and research; accessing additional funding for health promotion; networking with CSIRO nutritional health researchers to develop more appropriate information materials; the development of productive links with the manager of a large local shopping centre and other retailers and local schools; working to improve the nutrition of individuals as well as the availability of healthy food in the local area; and community control of the project.

The pre-conditions for this best practice included the involvement of staff with high levels of commitment, vision and leadership; policies at the Service that valued evaluation, critical reflection and experimentation; structures at the Service that supported community development work as well as direct clinical work; a clearly articulated and shared organisational purpose; policies and structures at the Service and State Government levels which provided for community participation in decision making; and guidance and leverage provided by the Sth Aust Primary Health Care Policy and the Ottawa Charter.

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8 Spurr C, Ward J, Payton J (1993), *Nutritional Health in the Parks: From worker control to community ownership/participation.* In Clarke B, MacDougall C (eds), The 1993 Community Health Conference, Vol. 1, Papers and Workshops, ACHA, NSW.

#34

Victorian Home Oxygen Support Group

West Heidelberg Community Health Centre
20 Morobe St, West Heidelberg, Vic, 3081
Phone: 03 9459 8833 Fax: 03 9459 5808

Chronic illness usually represents a decisive turning point in the life situation of individual sufferers, affecting not only themselves but people in their immediate environment. Frequently their attention is no longer primarily focused on their medical condition but rather on the long term effects of that condition. In this context, Stefanovski[9] asserts that self-help groups can provide individuals with complimentary and additional support.

Stefanovski discusses the origin of the Victorian Home Oxygen Support Group and its role in assisting those people who were affected by chronic lung illness and who receive domiciliary oxygen therapy in association with hospitals and community health centres.

The good outcomes of the Group appeared to include substantiated improvements in the health status of members; an increase in the members' confidence to manage their illness; skilling and personal development of group members; increased community and consumer knowledge related to oxygen therapy; strengthening of the groups social and community networks; and the development of similar groups in other municipalities based on the same model.

The processes that appeared to contribute to these good outcomes were the community health centre's responsiveness to the needs of people with chronic lung illness; the control over the group exercised by the consumers; the group's accessing of specific exyertise related to oxygen therapy; and active and visionary leadership provided by group members.

The pre-conditions for this best practice appeared to be the clarity of need expressed by the consumers involved; existing models of program organisation; existing networks between services; institutional structures and policies that provided for consumer participation in decision making at the Community Health Centre and in the statewide Collective of Self Help Groups; and a shared and articulated commitment to self-help groups by the Centre's staff and management.

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9 Stefanovski M (1993), *Victorian Home Oxygen Support Group.* In Clarke B, MacDougall C (eds), The 1993 Community Health Conference, Vol. 1, Papers and Workshops, ACHA, NSW.

#56

The Onkaparinga Estuary

Onkaparinga Water Quality Group
14 Seaspray Crt, Seaford Rise, SA, 5169
Phone: 08 327 2012

The degradation of a river estuary in metropolitan Adelaide due to pollution grew to the extent that it became an increasing concern to the local community. People using it for recreational purposes were at risk of skin irritation, gastro-intestine upsets, and ear, nose and throat infections. Native vegetation and wildlife had all **but** disappeared. Although community concern had been brewing for almost twenty years, a Healthy Cities Project, and a nearby health service, in partnership with local people, galvanised action in 1990.

Lewin[10] briefly documents their collaboration and their outstanding success. The organisations involved proposed strategies to address stormwater pollution, the development of the area into wetlands, and the return of native wildlife. Further, the group was successful in their lobbying of local, state and federal governments to commit the $900,000 required to implement the report's recommendations.

The significant outcomes from the project appeared to include the skilling and personal development of the community members involved in the campaign; the role model provided to other communities in respect of environmental management; and the intersectoral progress (between health and the environment) made towards the conditions for better health.

The important processes that appeared to contribute to these good outcomes included the project's responsiveness to community needs; the very active community participation in and control of the project; the local networking between many groups with a stake in having a cleaner river; the collaboration across sectors and the mobilisation of central expertise (for example, environmental scientists); the effective mobilisation of financial resources, particularly the money to build the wetlands; and the active and visionary leadership by the community activists involved.

The pre-conditions for this example of best practice appeared to include a local tradition of political activism; the existence of real needs and a precipitating crisis - in this case a seriously polluted river; the availability of financial resources; structures and policies within Healthy Cities and Noarlunga Health Services that provided for community participation in decision making; and people of extraordinary commitment, vision and leadership within these organisations.

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10 Lewin V (1992), *The Onkaparinga Estuary: Community action on water pollution.* In Phillips-Rees S et al, The Changing Face of Health, South Australian Community Health Association and the South Australian Health Commission, South Australia. (See also Cooke R (1995), Two Healthy Cities in South Australia, in Baum F (ed), Health for All, the South Australian Experience. Wakefield Press, Adelaide.)

#58

Wilson Reserve Project

Parks Community Health Service
Trafford St, Angle Park, SA, 5010
Phone: 08 243 5611 Fax: 08 347 4221

The Wilson Street reserve was constructed in 1987 as a Community Employment Project. Initial ambitious plans for the reserve (drawn up without community consultation) were never realised with the result that the partially completed park was inappropriate to the needs of local residents and represented a threat to health and safety.

Tesoriero" reports a small successful campaign by local residents, with the assistance of the Parks Community Health Service, to have the council effect necessary repairs and alterations to the reserve. Tesoriero reflects on the role of the community development worker in the intervention and the capacity of community health centres to address health concerns, such as those at Wilson Street, relatively cost effectively.

The good outcomes from the Wilson Reserve project appeared to include progress made in developing closer links between the Council, residents and the Service; improvements in the conditions for better health - a safer recreational facility; increased capacity among the local residents to respond to future issues; strengthened community and social networks among the residents involved in the campaign; opportunities established for community participation in the Service; and skilling and personal development of residents and workers involved in the campaign.

The processes that appeared to contribute to these good outcomes were active and visionary leadership by some residents and workers; linking practice with theory (in this case theories of community development); critically reflecting on and evaluating the project as it developed; intersectoral collaboration between health and local Government; working at both the macro and micro levels; and control of the campaign by the local residents.

The pre-conditions for this best practice appeared to be people of extraordinary commitment, vision and leadership; policies at the Service that valued evaluation, critical reflection and experimentation; policies at the Service that supported staff development, participation in study and research and linking this to critical reflection in planning and practice; team structures in the Service that reflected the balance between working at the micro and macro levels; a longer time span for the development of projects and programs; and the existence of a coherent policy narrative to provide leverage.

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11 Tesoriero F (1990), *Wilson Reserve Project. Health promotion and community development.* Unpublished report, Parks Community Health Service, Adelaide.

#60

Redfern Aboriginal Medical Service

The Aboriginal Medical Service Co-operative Redfern
36 Turner St, Redfern, NSW, 2016
Phone: 02 699 5823 Fax: 02 319 3345

The Redfern Aboriginal Medical Service (AMS) was established in 1971 and has since served as a model for the development of other Aboriginal health services throughout Australia. The AMS is controlled by the Aboriginal community and provides a comprehensive range of primary health care services to the local community in central Sydney and in some cases to Koori people throughout NSW. AMS has played a strong role in advocacy on Aboriginal health and in national health policy development.

Foley[12] describes the historical development of the AMS, including its struggles through changes of Government; its consolidation as a provider of direct services to the Aboriginal people; shifts towards broader roles in Aboriginal public health during the 1980s; education programs for Aboriginal health workers; and participation in the development of Government policy. Foley concludes with a summary of the key strengths of Aboriginal controlled community health services.

Significant outcomes at Redfern appeared to include probable improvement in people's health status; role models of service provided to other Aboriginal and non-Aboriginal communities; improved opportunities for participation by Aboriginal peoples; increased community capacity to respond to issues; the development and extension of a range of programs and services to meet the needs of Aboriginal peoples; a strong contribution to the development of professional education in primary health care and a strong contribution to the development of the primary health care sector generally.

Significant processes that appeared to contribute to Redfern's success included their responsiveness to community needs; active community participation; very strong community control of the organisation; a style of working at both the micro and macro levels; a commitment to investing in personal training and development; and effective personal selection procedures.

Significant preconditions for best practice at Redfern appeared to include a tradition of political activism among Aboriginal peoples; the ongoing crises in the health of Aboriginal peoples; organisational structures at the AMS that promoted community participation; a shared vision and purpose within the organisation; structures for working which supported the need to operate at both micro and macro levels; and the involvement in Redfern of people of extraordinary vision and leadership.

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12 Foley G (1991), *Redfern Aboriginal Medical Service: Twenty years on.* Aboriginal and Islander Health Worker Journal, Vol. 15, No. 4, July/August. (See also Campbell D, Ellis R (1995), The Redfern Aboriginal Medical Service. Aboriginal and Islander Health Worker Journal, Vol. 19, No. 4.)

#71

"Patchwork" - Bushfire Safety Education

Anglesea Community House
9 Mawson Ave, Anglesea, Vic, 3230
Phone: 052 632 116

Having lived through the Ash Wednesday devastation, Millicer" recounts her initiative to prevent a repetition of the disaster by establishing a Bushfire Safety Education Campaign. The project was named "Patchwork" to signify its aim of encouraging maximum ccmmunity awareness and involvement.

In co-operation with the local Country Fire Authority (CFA), and using the resources of the Anglesea Community House in rural Victoria, the project allocated volunteers to different sections of the town, in which each was responsible for distributing information, reporting fire hazards and preparing emergency evacuation procedures. The project involved a large number of local volunteers and was commended by the CFA as a worthy model for other towns to follow.

The significant outcomes appeared to be no major bushfires in the area since Ash Wednesday; the development of skills and knowledge among the community members involved in the project, in relation to both fire prevention and organising; the role model provided by Patchwork to other country towns; an increased capacity among the local community to respond to issues more generally; and a contribution to the development of similar work elsewhere .

The important processes that appeared to contribute to these good outcomes were the project's responsiveness to an important community need; the high level of community control exercised by the community activists and volunteers involved; the use of local networks to involve people and spread the safety message; the effective utilisation of information resources provided by the CFA; and the active and visionary leadership of the project co-ordinator.

The pre-conditions that appeared to contribute to the Patchwork project included a real need and a shared sense of identity based on community and the experience of the Ash Wednesday bushfire. The World War II British idea of neighbourhood wardens provided the model for the community activist who orchestrated the project with vision and leadership. The involvement of existing networks, particularly the volunteers from meals-on-wheels, ensured the success of the project.

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13 Millicer *K* (1993), *"Patchwork" - Bushfire safety education.* In Butler P, Cass S (eds), Case Studies of Community Development in Health, CDIH, Melbourne.

#95

Innovative Alcohol Intervention

This project focused on alcohol abuse within the Jabiru community in rural Northern Territory. The project was only for six months and was conducted under the auspice of the Gagudju Association which represents the interests of the Aboriginal community in the area. The project was funded by a Demonstration Practice Grant from the General Practice Funding Section of the Commonwealth Department of Human Services and Health.

In their report, John Furler and Kevin Bulliwana[14], the Association's general practitioner and a local Aboriginal man, address the politics of Aboriginal health, describe their community, its location in Kakadu National Park and the health needs of local people. The project's key strategy was to train Kevin as an alcohol counsellor and for him to undertake research into how to tackle the problems of alcohol abuse. The training program was Aboriginal controlled and implemented. The authors detail the training and the changes Bulliwana achieved within his community.

Significant outcomes appeared to include the role model provided by Bulliwana to other men in the community; improved access to local community health services for the Gagudju people; the establishment of Aboriginal health services to better meet local needs and changed practice of other health professionals.

Processes that appeared to contribute to the project's success included the way it responded to a significant community need; control of the project by the Gagudju Association; the opportunistic attraction of Commonwealth project funds by the Association's general practitioner and the investment in training and supervision for the counsellor position.

Important preconditions that appeared to contribute to the project's success included the very real health problems of the Gagudju people caused by alcohol abuse; the availability of financial resources initially from the Commonwealth and subsequently from the Territory Government and the active leadership shown by John and Kevin.

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14 Furler), Bulliwana K (1993), *Innovative Alcohol Intervention.* Demonstration Practice Grants Program Report No. 488.

#106

General Practitioner Involvement in a Child Development Unit

Dr M Taylor
PO Box 1642, Port Lincoln, SA, 5606
Phone: 086 830 788 Fax: 086 822 040

Port Lincoln, a provincial town in rural South Australia, had a population of 25,000 people and was served by twelve town based general practitioners and five located in outlying regions. The town was visited three times a year by the multi-disciplinary Child Development Unit, an Outreach Clinic of the Children's Hospital in Adelaide. Taylor[15] describes an initiative which enabled general practitioners to attend the Clinic's Review meetings and thereby participate in case management and review discussions related to their young patients. Taylor argues that attending these meetings resulted in major improvements for the patients, increased co-ordination between agencies and services and improved referral networks.

The good outcomes of this initiative appeared to be probable improvements in the health of the children attending the Clinic; a wider appreciation of the social and structural dimensions of the health issues surrounding children with disabilities; improved quality of service; and intersectoral links developed or extended.

The processes that appeared to contribute to these good outcomes were collaboration between local schools, disability services, the community health service and general practitioners; the involvement of a visiting paediatrician; accessing project funding; and active and visionary leadership provided by Dr Taylor.

The pre-conditions that appeared to support this example of best practice were the availability of financial resources (from the General Practice Demonstration Grant Program); previous experience in establishing such a Clinic; strong local connections due to the nature of the small provincial town; and staff characteristics which included commitment, skills and teamwork practices.

15 Taylor M (1993), *General Practitioner Involvement iwa Child Development Unit.* Demonstration Practice Grants Program Report No. 86.

#108

Horizons Women's Program

Horizons Support and Living Skills Association
2 Erica Ave, St Albans, Vic, 3021
Phone: 03 9364 1455

Traditionally women and people from non-English speaking backgrounds have been under represented in their use of psychosocial rehabilitation services. In this case study by Cox[16], workers and consumers from the Horizons Support and Living Skills Association discuss the highly successful strategies they used to encourage the involvement of women from non-English speaking backgrounds in their service.

Horizons was a community managed psychiatric disability support service located in an outer western suburb of Melbourne. The service provided social and recreational activities, skills development, individual support and outreach programs for people with psychiatric disabilities. Cox describes the establishment and implementation of the women's program which involved "women's only" time one morning per week followed by lunch and female focussed, culturally relevant activities in the afternoon. The case study also includes discussion of specific access issues, the use of interpreters, participation strategies and the outcomes of the service.

The important outcomes of the Horizon's Women's Program appeared to include the extension of services to meet the particular needs of women from non-English speaking backgrounds who had psychiatric disabilities and an increased rate of these women attending programs; increased access for these women to a range of related support services; strengthened community and social networks; skilling and personal development of consumers; and probable improvements in the health of consumers.

The processes that appeared to contribute to these good outcomes included flexibility, opportunism and risk taking by the staff of the service; critical reflection, evaluation and modification of practice; accessing other mental health expertise; networking amongst a range of mental health services at the local level; a collaborative approach to service development and management; and community participation in and control of the service.

The pre-conditions that appeared to underpin this best practice were commitment to the customer and the community among the staff; planning and review structures at the agency based on an articulated and understood service policy; a discussed and shared organisational purpose; structures and policies that ensured community participation in decision making at the management and project level; existing mental health consumer and provider networks at the local and regional levels; and a coherent and authoritative policy framework at the National level.

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16 Cox M (1994), *Horizons Women's Program.* In Cox M, Good Practices in Women's Mental Health, Healthsharing Women's Health Resource Service, Melbourne.

#128

A Tea Trolley Support Service in Oncology

Western General Hospital
Gordon St, Footscray, Vic, 3011
Phone: 03 9319 6666

Menon[17] describes the formation of a support group for cancer patients that grew out of a community development initiative within a suburban Melbourne hospital. A hospital survey had revealed that patients identified other patients as the most preferred source of support and information exchange. The author initiated a tea trolley service to provide a focus for building links among patients and their families.

Operated by a woman who herself had had cancer, the tea trolley service acted as a catalyst for communication. Whereas previously the weekly oncology clinic waiting room had been silent and full of fear and despair, it had now become a warm supportive environment. Other self-help initiatives, such as a telephone support network, emanated from the Service.

The important outcomes associated with this Service include the skilling and personal development of the volunteers involved ; increased knowledge and health literacy among the patients and their families; strengthened social networks between patients; increased access by patients to services; and improved quality of service in the oncology clinic.

The processes that appeared to support these good outcomes were the service's responsiveness to the patients' needs; the collaborative approach to the projects development and management; intersectoral collaboration of hospital staff; flexibility, opportunism and risk taking by the project's visionary worker; and linking practice with theory and research.

The pre-conditions that appeared to underpin this best practice were strong personal links among the patients; the very real needs experienced by the patients and the crisis situation at a personal level brought on by the diagnosis of cancer; people of extraordinary commitment, vision and leadership; and union involvement.

17 Menon M (1993), *A Tea Trolley Support Service in Oncology.* In Butler P, Cass 5 (eds), Case Studies of Community Development in Health, CDIH, Melbourne.

#129

Pap Smears and Breast Self Examination for non-English Speaking Background Women

Women's Health Centre
PO Box 665, Spring Hill, Qld, 4004
Phone: 07 839 9962 Fax: 07 831 7214

Prasad and Shinwari" profile an awareness raising project, undertaken by the Women's Health Centre in Brisbane, which aimed to communicate the importance of pap smear tests and breast self-examination to women from twelve different ethnic communities. The authors describe how they attempted to increase these women's participation in such tests by removing the barriers identified by the women in consultations. The case study records the selection and training processes for a team of bilingual community educators, describes their key activities, documents participation rates, discusses the project's achievements and reflects on how strategies could be modified to improve the project.

The significant outcomes from this program appeared to include probable improvement in the health status of women from non-English speaking backgrounds; the skilling and personal development of the women recruited as bi-lingual educators; the role models these women provided to other women and other communities; strengthened social and community networks; increased access for ethnic women to screening services; increased advocacy by the educators and the Centre on behalf of these women; improved quality of service from the agencies providing the screening services; improved practices among the professionals providing the screening services; and a wider contribution to the field by way of example.

The important processes that appeared to support these outcomes included responding to community needs; involving women from non-English speaking backgrounds in the process of the program; networking through ethnic organisations to recruit women into the program; flexibility, opportunism and risk taking in regard to the organisation of the program and the information sessions; and investing in training for the educators.

The pre-conditions which supported this example of best practice included a sense of identity among the women involved; the very real needs that existed in the community; existing models of program organisation (le other examples of using bi-lingual community educators); existing networks within and among ethnic organisations in Brisbane; a articulated and shared organisational purpose within the Women's Health Centre; and women of extraordinary commitment, vision and leadership among the educators.

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18 Prasad R, Shinwari W (1993), *Pap Smears and Breast Self Examination for non-English Speaking Background Women.* In Butler P, Cass S (eds), Case Studies of Community Development in Health, CDIH, Melbourne.

#132

Health Localities Benalla

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The Healthy Localities Benalla Project'[9] was one of the six Healthy Localities projects funded for three years through the Victorian Health Promotion Foundation. This project was a community development project which linked changes in rural communities, particularly negative changes such as service reductions and lower incomes, to health.

The project aimed to provide the community with a greater chance of control over it's future and to use an intersectoral approach to tackling identified health issues. The major areas of work for the project included youth issues, drug and alcohol issues, farm occupational health and safety and transport. A major effect of the project was that the issue of alcohol and youth was recognised as a whole community issue and not the sole problem of young people.

The significant outcomes of the project appeared to be the skilling and personal development of the community members involved in the project's activities; the increased capacity of the local community to respond to issues in the future; establishment of youth and community development positions at local Council thereby meeting identified community needs; the strengthening of services and agencies involved in the project; and the project's contribution to the wider field through extensive evaluation and documentation.

The important processes that appeared to lead to these good outcomes included the project's responsiveness to community needs; the very active community participation; working at both the micro and macro levels; the extensive networking at the local level; active and visionary leadership by project worker, who was then appointed as the community development officer at the completion of the three year project.

The pre-conditions for this best practice appeared to involve a strongly linked community; real needs in the community; the project being part of a statewide program and the availability of relatively generous financial resources through that program; and people of extraordinary commitment, leadership and vision.

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19 Healthy Localities Project Benalla (1993), *Yes, Community Action Does Work: Final report of the Bena/la Healthy Localities Project.* City of Benalla, Benalla.

#133

Coburg Carers Project

Moreland City Council
Locked Bag 10, Moreland, 3058
Phone: 03 9350 0290 Fax: 03 9350 0158

Healthy Localities Coburg, was one of the six projects funded under the Victorian Healthy Localities Program which aimed to assist local councils to plan and implement health promotion and disease prevention activities. It encouraged an approach to health promotion which emphasised a social view of health, locally identified and relevant health needs and participation and collaboration with community, business and health Services at a range of levels.

Hurle and Harris's report[20] documents the Coburg Project in metropolitan Melbourne that began as a result of an extensive community consultation, which identified the needs of women caring for children, aged, ill or disabled relatives or friends. The report details the project's aims, strategies, processes and impacts and provides information about the effectiveness of the project in relation to their three key target groups; carers, services and the general community. The report also features some of the innovative, creative and beautiful projects undertaken by the diverse women who participated over the three year period.

The significant outcomes of Coburg Carers appeared to be the strengthening of local community organisations; increased access by women who were carers to community and health services; an increased community capacity to respond to future issues; the establishment of innovative opportunities for community participation; and the skilling and personal development of the women involved in the project's activities.

The important processes which led to these outcomes appeared to include flexibility, opportunism and risk-taking by the project team; networking through a series of local community organisations to involve women; celebrating successes as the project progressed; involving carers in all activities of the project; and being responsive to the needs of women carers.

The pre-conditions which appeared to support this best practice were strong personal links in the Coburg community; the very real needs of the women carers; the project being part of the statewide Healthy Localities Program and the availability of relatively generous funding through that program; and project staff who were skilled, committed and worked as a team.

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20 Hurle W, Harris S (1993), *Coburg Carers Project Final Report.* Coburg City Council.

#157

Far West Mental Health Service

Far West Mental Health Service
PO Box 457, Broken Hill, NSW, 2880
Phone: 080 878 800 Fax: 080 882 926

Hemming[21] provides a detailed description of the Far West Mental Health Service, an agency which has developed a range of effective strategies for servicing mentally ill people living in the isolated rural communities of far west NSW. He describes the demographics and characteristics of the area, the organisational structure, management approach, staff profile and service provision of his agency.

In particular he details their outreach strategies, approach to assertive care management, and their visiting psychiatrists program. The Service has had success in reducing hospital admissions for mentally ill people and increasing the access of Aboriginal mentally ill people to mental health care.

The significant outcomes associated with the service appeared to be substantiated improvements in the health of people with mental illness; increased access to mental health services for Aboriginal people; the establishment of outreach services to meet isolated rural communities needs; an improvement in the quality of care being provided; the skilling and changed practice of mental health care professionals; and a contribution to the development of the mental health field via the publication of journal articles.

The important processes that lead to these good outcomes appeared to include the involvement of consumers; networking at the local level including visiting the pub; accessing external psychiatric services; critical reflection on and evaluation of practice by most staff; staff linking practice with their study and research; and generous allocations for study leave, conference attendance and support for documenting work.

The pre-conditions that appeared to underpin this example of best practice were the existence of the National Mental Health Policy which justified and supported the Service's approach; existing networks at the local and state levels; the Service having an organisational purpose which was clearly articulated and shared; Service policies that supported staff development, participation in study and research and linked this critical reflection to planning and practice; Service policies and a culture which valued critical reflection, experimentation and risk taking; and people of extraordinary commitment, vision and leadership.

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21 Hemming M (1993), *Development of an Integrated Mental Health Service in the Far West of NSW.* Mental Health in Australia, December.

#161

The Care of Public Drunks in Halls Creek

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Midford, Daly and Holmes[22] provide a description of the community development processes used to establish a locally managed sobering up centre and the intervention model on which these were based. The project was undertaken in Halls Creek, a small town in northern Western Australia with a population of 3,029, of which 80% were Aboriginal. The community advisory group established for this purpose also responded to alcohol problems in a more comprehensive manner and became the Halls Creek Alcohol Action Advisory Committee[23].

The Committee, with public support, were successful in restricting the trading hours for liquor licensees and also successfully sought funding from ATSIC for family support. The authors argue that their processes encouraged the people of Halls Creek to own the alcohol problem and to take control of interventions as far as possible. They claim that the community's motivation and commitment to do something beyond the sobering up centre was based on a greater understanding of the alcohol problem as a consequence of their involvement.

Important outcomes from the project appeared to include substantiated improvements in health status; skilling and personal development of community members; improved opportunities for community participation; increased community capacity to respond to issues and intersectoral progress made in relation to conditions for better health in Halls Creek.

Processes that appeared to contribute significantly to these outcomes included responding to a major community need; a collaborative approach to planning and managing the project and services; networking at the local level; mobilising financial resources and investing in personnel training and development.

Significant preconditions for good practice and outcomes appear to include a strongly linked local community; real needs in the community; organisational policy changes at the regional, state or national level in relation to drunkenness and deaths in custody; availability of financial resources; institutional structures and organisational policies which require community participation in decision-making and people of extraordinary commitment, vision and leadership.

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22 Midford R, Daly A, Holmes M (1994), *The Care of Public Drunks in Halls Creek.* Health Promotion Journal of Australia, Vol. 4, No. 1.

23 Douglas M (1995), *Halls Creek Turns Around.* Aboriginal and Islander Health Worker Journal, Vol. 19, No. 2.

#170

WASH, Making Schools Healthy

National Centre for Research into the Prevention of Drug Abuse
GPO U1987, Perth, WA, 6001
Phone: 09 368 2055 Fax: 09 367 8141

The World Health Organisation, "Healthy People 2000" in the United States and Australia's "Pathways to Better Health", all identify schools as institutions that can play an important role in providing opportunities to improve the current and future health status of school-aged children. McBride et al[24] describe the Western Australian Schools Health Project which aimed to promote health within the school setting using a comprehensive school health promotion approach.

This involved focusing beyond the school curriculum to the whole school environment, its policies and structures and all aspects of school life. A range of pre, primary and secondary schools participated with disadvantaged schools being identified as a special focus of the project. A series of reports have been published over the life of the project providing significant detail on the project's methodology, processes, partners, outcomes and also recommendations for future work.

The significant outcomes from WASH appeared to include skilling, personal development and increased health literacy of teachers, health workers, parents and students; a contribution to the wider field of school health promotion through evaluation and documentation of the WASH project; and intersectoral links developed and progress made towards the conditions for better health.

The important processes that appeared to contribute to these good outcomes included intersectoral collaboration between health and education; the mobilisation of centrally located health promotion expertise; critical reflection and evaluation as the project progressed; linking practice with theory and research in school health promotion; and investing in training for project participants.

The pre-conditions for this example of best practice appeared to include the availability of financial resources through WA's Health Promotion Foundation; existing networks both among schools on a regional basis and among health promotion agencies on a statewide basis; a clearly articulated and shared purpose among the staff and Committee for the project; a planning and review system based on a commitment to research, evaluation and critical reflection; and people of extraordinary commitment, vision and leadership.

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24 McBride N, Midford R, James R, Cameron I (1994), *Making Schools Healthy II.* National Centre for Research into the Prevention of Drug Abuse, Western Australia. (See also three articles by McBride et al in Health Promotion Journal of Australia 1995; 5(1).)

#186

Housing for Health

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Phone: 029 731 316

There is substantial evidence that improvements in essential health hardware (for example, clean water and waste removal systems, appropriate housing) in remote Aboriginal communities will lead to specific improvements in Aboriginal health status, particularly for children. The study and project comprehensively documented by Pholeros, Rainow and Torzillo" refutes the idea that Aboriginal peoples will not use health hardware facilities. The authors demonstrate that Aboriginal peoples enthusiastically use these facilities when the facilities are maintained and functioning.

Pholeros et al argue that effective functioning and maintenance of facilities are dependent upon the implementation of certain strategies which they outline in some detail. (For example, well maintained underground waste removal systems). They emphasise that these strategies will only succeed if the specific requirements for their implementation and maintenance are acknowledge and adhered to. The authors conclude that it is the attention to detail in maintaining health hardware which is necessary if the final health benefits are to be successfully delivered.

The significant outcomes in this project appeared to be substantiated improvements in the health status of the community especially children's morbidity related to eye and skin infection rates; skilling and personal development of community members including some Aboriginal people being employed to implement the project at other sites; development of a wider appreciation of the structural dimensions of health issues in Aboriginal communities; changes to practice and improved skills of health practitioners; a contribution to the development of the Aboriginal and environmental health fields and intersectoral progress made towards improved conditions for better health.

Processes that contributed to the project's success in a significant way appeared to include strong community control; a balance between working at the micro and macro levels; local networking; collaboration between a range of utilities such as water and housing; critical reflection and evaluation of practice by Healthabitat and the Aboriginal community members involved; flexibility, risk taking and visionary leadership by the Nganampa Health Council and Healthabitat.

Preconditions that appeared significant included a strongly linked local community with existing local and national networks; structures and policies that supported community participation and control, such as land rights and ownership and community control of Nganampa Health Council; organisational structures which reflected a balance between working at the macro and micro levels; and the involvement of people with extraordinary commitment, vision and leadership.

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25 Pholeros P, Rainow S, Torzillo P (1993), *Housing for Health*, Healthabitat. (See also Torzillo et al (1995), Nganampa Health Council, in Baum F (ed), Health for All, the South Australian Experience. Wakefield Press, Adelaide.)

#187

Billanook Primary School

facµl/ji of Epµ(a.ti61i/1\1ohaslt Univetsity
Wellii:t$tpn Rd .91ayton/Vir13168
Phone: 03 9905 2819

Billanook Primary School was one of fourteen schools located in rural Victoria and metropolitan Melbourne which participated in the collaboratively designed Health in Primary Schools Program (HIPS). Fensham26 recorded the progress made at this rural school in terms of enhanced fitness and nutritional programs. Utilising a structural approach the school generated a Health Policy, a Canteen Policy and a comprehensive Health Curriculum to provide guidelines for healthier behaviours. The author also specifies the range of activities and events relating to drugs, sexuality, body knowledge and personal development which were implemented in an attempt to establish good health within and outside the school.

The significant outcomes that appeared to flow from this project included providing a role model to other school communities; strengthened social and community networks; the development of new policies and programs to meet the needs of the school community; skilling and changed practice of teachers; and a contribution to the development of professional education.

The important processes that led to these good outcomes seemed to be a collaborative approach to program development and management; working at both the micro and macro levels; mobilising more centrally located expertise from the tertiary education sector; accessing additional financial resources; and active and visionary leadership of the project team.

The pre-conditions that appeared to underpin this best practice at Billanook were a tradition of political activism by staff at the school; an external precipitating crisis; the project being part of a statewide program; the availability of financial resources through HIPs; and organisational policies that supported staff development, participation in further study and research and linking these to critical reflection in planning and practice.

26 Fensham P (1991), *Bil/anook Primary Sc/zool,* in Went S (ed), A Healthy Start: Holistic approaches to health promotion in school communities, Monash University, Melbourne.

Appendix Two: 185 Cases of Primary Health Care

This appendix lists each of the 185 cases of primary health care in the project data base. The cases have been listed under 21 major topics shown below. For each case, we have listed the project title, the authorl of the article or report, the agency which auspiced the project and the source of the article or report. Full bibliographic details and an abstract for each case may be found in 'Towards Best Practice in Primary Health Care', published by the Centre for Development and Innovation in Health in 1995 and available from CDIH.

Topics

1 Authors fall into two groups. In many cases authors were the people involved in working on the program, however in a significant number of cases authors were reporting the work of other people.

Aboriginal and Torres Strait Islander health

Aboriginal Primary Health Care Project
Beaton, N.
Dr N Beaton, Cairns, Qld
Report.

Aboriginal and Torres Strait Islander Health Program
Beaton, N.
Wuchopperen Medical Service, Cairns, Qld
Demonstration Practice Grants Program Report No. 741.

Doing It Differently and Doing It Well. Torres Strait Islander health care
Campbell, D., Ellis, R.
Torres Strait Health Council, Qld
Journal article (Sp) in Aboriginal and Islander Health Worker Journal, Vol. 17, No. 4, July/August, 1993.

The Illawarra Aboriginal Health Advancement Project
Campbell, D., Ellis, R.
Illawarra Area Health Service, Port Kembla, NSW
Journal article (3p) in Aboriginal and Islander Health Worker Journal, Vol. 17, No. 5, September/October, 1993.

Redfern Aboriginal Medical Service: Twenty years on
Foley, G.
The Aboriginal Medical Service Co-operative Redfern, NSW
Journal article (Sp) in Aboriginal and Islander Health Worker Journal, Vol. 15, No. 4, July/August, 1991.

Nanima Aboriginal Outreach
Haack, R.
Wellington District Hospital and Health Services, Wellington, NSW
Report.

Young Aboriginal Women Project
Hamilton, S.
Hilton Community Health Centre, Hilton, WA
Conference paper (3p) in Clarke, B., MacDougall, C. (eds), The 1993 Community Health Conference, Vol. 1, Papers and Workshops, Australian Community Health Association, NSW, 1993.

Aboriginal and Torres Strait Islander health (cont)

Hep B Immunisation in Winton
Heatherington, R.
Dr R Heatherington, Winton, Qld
Demonstration Practice Grants Program Report No. 205.
Aboriginal and Torres Strait Islander health (cont)

Streetwize Aboriginal HIV/AIDS Poster Project
Heiss, A.
Streetwize Comics, Leichardt, NSW
Journal article (2p) in Aboriginal and Islander Health Worker Journal, Vol. 17, No. 5, September/October, 1993.

Food and Nutrition Policy Issues in Remote Aboriginal Communities: Lessons from Arnhem Land
McMillan,S.
Arnhemland Progress Association
Journal article (Sp) in Australian Journal of Public Health, Vol. 15, No. 4, December, 1991.

Mookai-Rosie-Bi-Bayan
Moggs, R.
Mookai-Rosie-Bi-Bayan, Earlville, Qld
Report.

Listening, Learning and Responding - A community program for Aboriginal women
Phillips-Rees, S., Sanderson, C., Herriot, M., May, A.
Riverland Community Health Service, Berri, SA
Case study (lp) in Phillips-Rees, S. et al, The Changing Face of Health, South Australian Health Commission and the South Australian Community Health Association, Adelaide, 1992.

Housing for Health
Pholeros, P., Rainow, S., Torzillo, P.
Healthabitat, Newport Beach, NSW
Book.

Aboriginal and Torres Strait Islander health (cont)

Aboriginal Control Over Diabetes
Ryan, P.
Aboriginal Community Recreation and Health Services Centre, Adelaide, SA
Case study (2p) in Ryan, P., Cases for Change, Australian Community Health Association, NSW, 1992.

Alcohol and drugs

Minor Tranquilliser Project
Kasearu, E.
Marion-Brighton-Glenelg Health and Social Welfare Council, Warradale, SA
Report.

Empathic Approaches to Alcohol Education
Australian Drug Foundation
Australian Drug Foundation, South Melbourne, Vic
Report.

Southern Downs Community Care Project
Walters, J., Leech, D.
Warwick Medical Centre, Warwick, Qld
Report.

COMPARI Year 1 and 2 Project Reports
Laughlin, D., Harrison, D., James, R., Midford, R., Boots, K.
National Centre for Research Into the Prevention of Drug Abuse, Perth, WA
Report.

Innovative Alcohol Intervention
Furler, J., Bulliwana, K.
Gagudju Association Inc, Winnellie, NT
Demonstration Practice Grants Program Report No. 488.

Alcohol and drugs (cont)

Locals, Not Yokels, Community Action on Alcohol and Marijuana
James, R., Marsdon, G., Harrison D., Laughlin, D.
National Centre for Research into the Prevention of Drug Abuse, Perth, WA
Journal article (8p) in Community Quarterly, No. 24, September, 1992.

The Care of Public Drunks in Halls Creek
Midford, R., Daly, A., Holmes, M.
National Centre for Research into the Prevention of Drug Abuse, Perth, WA
Journal article (4p) in Health Promotion Journal of Australia, Vol. 4, No. 1, 1994.

Operation Drink Safe
Ryan, P.
West Moreton Regional Drug and Alcohol Advisory Service, Ipswich, Qld
Case study (2p) in Ryan, P., Cases for Change, Australian Community Health Association, NSW, 1992.

Cancer

General Practice Screening for Prostate Cancer
Brett, T.
Dr T Brett, Mosman Park, WA
Journal article (4p) in Australian Family Physician, Vol. 23, No. 4, April, 1994.

Cancer Support Program
Siemienowicz, J.
Langpark Medical Centre, Langwarrin, Vic
Demonstration Practice Grants Program Report No. 121.

Quality Assurance and Pap Smear Taking in General Practice
Beattie, A.
Dr A Beattie, Coffs Harbour, NSW
Journal article (6p) in Australian Family Physician, Vol. 21, No. 3, March, 1992.

Cancer (cont)

General Practitioners in Preventive Health Screenings
Penna, J., Rosenthal, D.
Dr J Penna, Berri Medical Clinic, Berri, SA
Journal article (3p) in Australian Family Physician, Vol. 20, No. 1, January, 1991.

Preventative Women's Health Program
Birks, K.
Moe Medical Centre, Moe, Vic
Demonstration Practice Grants Program Report No. 522.

Pap Test Victoria - Increasing cervical screening in unscreened and underscreened women
Hirst, S., Torcello, N.
Anti-Cancer Council of Victoria, South Carlton, Vic
Conference paper (3p) in Clarke, B., MacDougall, C. (eds), The 1993 Community Health Conference, Vol. 1, Papers and Workshops, Australian Community Health Association, NSW, 1993.

Paps I Should
Farnan, S., Gray, J.
Women's Health Service for the West, Footscray, Vic
Case study (6p) in Butler, P. (ed), Innovation and Excellence in Community Health, Centre for Development and Innovation in Health, Melbourne, 1994.

Pap Test Program in Rural Victoria
Webster, K., Wilson, G.
Gippsland Women's Health Service, Sale, Vic
Case study {2p) in Webster, K., Wilson, G. Mapping the Models, Centre for Development and Innovation in Health, Melbourne, 1993.
Cancer (cont)

Opportunistic Cervical Screening in General Practice
Brett, T.
Dr T Brett, Mosman Park, WA
Journal article (6p) in Australian Family Physician, Vol. 21, No. 12, December, 1992.

Cancer (cont)

Sunscreen with Farmers
Miller, **R.**
Kiewa and Ovens Valley Community Health Service, Mt Beauty, Vic
Report, Miller, **R.,** The Skin Cancer Awareness Pilot Program, Kiewa and Ovens Valley Community Health Service, Victoria, 1991 and Ryan, P., Cases for Change, Australian Community Health Association, NSW, 1992.

A Tea Trolley Support Service in Oncology
Menon,M.
Western General Hospital, Footscray, Vic
Case study (7p) in Butler, P., Cass, S. (eds), Case Studies of Community Development in Health, Centre for Development and Innovation in Health, Melbourne, 1993.

Child health

Boys and Relationships: A School based program for pre-adolescent boys
Koszegi, B., Hunt, **G.**
Tea Tree Gully Community Health Service, Madbury, SA
Conference paper (3p) in Clarke, B., MacDougall, C. (eds), The 1993 Community Health Conference, Vol. 1, Papers and Workshops, Australian Community Health Association, NSW, 1993.

Making Schools Healthy, WASH
McBride, N., Midford, **R.,** James, R., Cameron, I.
National Centre for Research into the Prevention of Drug Abuse, Perth, WA
McBride, N. et al, Making Schools Healthy II, National Centre for Research into the Prevention of Drug Abuse, Western Australia,1994.

Beechworth Primary School
Went, S.
Faculty of Education, Monash University, Clayton, Vic
Evaluation report in Went, S. (ed), *A* Healthy Start, Monash University, Melbourne, 1991.

Child health (cont)

A Healthy Start: Holistic approaches to health promotion in school communities
Went, S.
Faculty of Education, Monash University, Clayton, Vic
Published evaluation report (309p), 1991.
Child health (cont)

Story A Day
Ryan, P.
Noarlunga Health Services, Noarlunga Centre, SA
Case study (3p) in Ryan, P., Cases for Change, Australian Community Health Association, NSW, 1993.

Bilanook Primary School
Went,S.
Faculty of Education, Monash University, Clayton, Vic
Evaluation report in Went, S. (ed), A Healthy Start, Monash University, Melbourne, 1991.

Twenty Years of Immunisation in a Public Hospital
Forsyth, H.
Adelaide Children's Hospital, North Adelaide, SA
Conference paper (3p) in Hall, R., Richters, J. (eds), Immunisation: The Old and the New, Proceedings of the Second National Immunisation Conference, Public Health Association, Canberra, 1992.

The Personal Health Record
Jeffs, D., Harris, M.
Illawarra Public Health Unit, Keiraville, NSW
Journal article (6p) in Australian Family Physician,Vol. 22, No. 8, August, 1993.

General Practitioner Involvement in a Child Development Unit
Taylor, M.
Dr M Taylor, Port Lincoln, SA,
Demonstration Practice Grants Program Report No. 86.

Child health (cont)

Organisation, Management and Delivery of Immunisation in a Community Setting
Pringle, J.
Northam Community Health Centre, Northam, WA
Conference paper (4p) in Hall, R., Richters, J. (eds), Immunisation: The Old and the New, Proceedings of the Second National Immunisation Conference, Public Health Association, Canberra, 1992.

Kids Have Good Ideas
Renney, L., Pike, L.
Parks Community Health Service, Angle Park, SA
Conference paper (3p) in Clarke, B., MacDougall, C. (eds), The 1993 Community Health Conference, Vol. 1, Papers and Workshops, Australian Community Health Association, NSW, 1993.

A Comprehensive Approach to School Health Promotion
Bola-Browne, V., Muller, P.
Kwinana Community Health Centre, Kwinana, WA
Conference paper (3p) in Clarke, B., MacDougall, C. (eds), The 1993 Community Health Conference, Vol. 1, Papers and Workshops, Australian Community Health Association, NSW, 1993.

Chronic illness

Chronic Disease Management
Beilby, J.
Crafter Medical Centre, Hawthorn, SA
Demonstration Practice Grants Program Report No. 99.

A Diabetic Day in the Outback
Jackson, S.
Dr S Jackson, Roxby Downs, SA
Journal article (3p) in Australian Family Physician, Vol. 23, No. 3, March, 1994.

Asthma Council
South West Centre for Public Health
South West Centre for Public Health, Albury, NSW
Report.

Chronic illness (cont)

Asthma and Diabetes Clinics in General Practice
Rasool,M.
Dr M Rasool, Jurien, W A
Demonstration Practice Grants Program Report No. 202.

Diabetes Control Through Community Education: Teaching hospital and community together
Nosworthy, A.
Queen Elizabeth Hospital, Woodville South, SA
Conference paper (llp) in Rees, A. (ed), Healthy Cities: Reshaping the Urban Environment, Australian Community Health Association, NSW, 1992.

St Agnes Diabetic Clinic, One Year On
Hart,M.
Dr M Hart, Modbury, SA
Demonstration Practice Grants Program Report.
Chronic illness (cont)

Open Airways - A joint health project
Birrell, C.
Inner South Community Health Service, South Melbourne, Vic
Conference paper (2p) in Clarke, B., MacDougalt C. (edst The 1993 Community Health Conference, Vol. 1, Papers and Workshops, Australian Community Health Association, NSW, 1993.

Breath of Relief
Shah, S.
Auburn Community Health Centre, Auburn, NSW
Journal article (7p) in Community Quarterly, No. 24, September, 1992.

Victorian Home Oxygen Support Group
Stefanovski, M.
West Heidelberg Community Health Centre, West Heidelberg, Vic
Conference paper (4p) in Clarke, B., MacDougall, C. (eds), The 1993 Community Health Conference, Vol. 1, Papers and Workshops, Australian Community Health Association, NSW, 1993.

Chronic illness (cont)

The Asthma Project
Marion-Brighton-Glenelg Health and Social Welfare Council and the Cove Community Health Centre
Marion-Brighton-Glenelg Health and Social Welfare Council, Warradale, SA
Report.

Arthritis Phone Link
Reilly, J.
Arthritis Foundation of Victoria, Kew, Vic
Case study (4p) in Butler, P. (ed), Innovation and Excellence in Community Health, Centre for Development and Innovation in Health, Melbourne, 1994.

"The Asthma Story", by the Wheezers
Munzel, A., Graves, K., Henery, M., Maher, J.
Echuca, Bendigo, Northern District and Central Victorian Community Health Services, Echuca, Vic
Case study (3p) in Butler, P. (ed), Innovation and Excellence in Community Health, Centre for Development and Innovation in Health, Melbourne, 1994.

Community development

New Community Living Program
Woodbridge, S.
Near North Housing Service, Burpengary, Qld
Report.

The "Vote for Health" Campaign
Phillips-Rees, S., Sanderson, C., Herriot, M., May, A.
Parks Community Health Service, Angle Park, SA
Case study (2p) in Phillips-Rees, S. et al, The Changing Face of Health, South Australian Community Health Association and South Australian Health Commission, South Australia, 1992.

Community development (cont)

Wilson Reserve Project. Health promotion and community development
Tesoriero, F.
Parks Community Health Service, Angle Park, SA
Report.

The Ivanhoe Place Health Development Project
Ansems,H.
Ryde Health Promotion Unit, Eastwood, NSW
Case study (12p) in Butler, P., Cass, S. (eds), Case Studies of Community Development in Health, Centre for Development and Innovation in Health, Melbourne, 1993.

Christie Downs Gala Fun Day
Marvis, C.
Noarlunga Health Services, Noarlunga Centre, SA
Report.
Consumer's Health Advocacy Network Project
Consumer's Health Advocacy Network Project Reference Group
Consumer's Health Advocacy Queensland, Toowong, Qld,
Report.

Consumer's Health Advocacy Network
Consumer's Health Advocacy Network Project Reference Group
Consumer's Health Advocacy Queensland, Toowong, Qld,
Report.

Brukunga: A healthier place to live
Phillips-Rees, S., Sanderson, C., Herriot, M., May, A.
Brukunga Community Action Group, Brukunga, SA
Case study (lp) in Phillips-Rees, S. et al, The Changing Face of Health, South Australian Community Health Association and South Australian Health Commission, SA, 1992.

Crime and Social Health- The Noarlunga "Together Against Crime" project
Prior, G.
Woodcroft Community Health Centre, Woodcraft, SA
Conference paper (2p) in Clarke, B., MacDougall, C. (eds), The 1993 Community Health Conference, Vol. 1, Papers and Workshops, Australian Community Health Association, NSW, 1993.

Dental care

Teeth for Keeps - A school oral health promotion project
Short, L.
University of New England and Regional Dental Service, Moree Plains Shire, Armidale, NSW
Conference paper, International Conference on Community Health Nursing Research, Edmonton, Canada, September, 1993.

It's Easier Than Pulling Teeth - Changing a dental service
Phillips-Rees, S., Sanderson, C., Herriot, M., May, A.
South Australian Dental Service, Adelaide, SA
Case study (lp) in Phillips-Rees, S. et al, The Changing Face of Health, South Australian Community Health Association and South Australian Health Commission, SA, 1992.

Healthy Smiles
Ryan, P.
Parks Community Health Service, Angle Park, SA
Case study (2p) in Ryan, P., Cases for Change, Australian Community Health Association, NSW, 1993.

Dental Health Promotion Project
Wilkins, J.
Royal Dental Hospital of Melbourne, Melbourne, Vic
Report.

Environmental health

Hunter Lead Study
Galvin, J., Stephenson, J., Walter, G., Loughran, B., Clarke, R., Wlordarczyk, J.
Public Health Unit, Hunter Area Health Service, Newcastle, NSW
Report.

CORE - Coalition of Residents for the Environment
Knothe, C.
Dandenong/Springvale District Health Council, Melbourne, Vic
Case study (9p) in Butler, P., Cass, S. (eds), Case Studies of Community Development in Health, Centre for Development and Innovation in Health, Melbourne, 1993.

Environmental health (cont)

The Onkaparinga Estuary: Community action on water pollution
Phillips-Rees, S., Sanderson, C., Herriot, M., May, A.
Onkaparinga Water Quality Group, Old Noarlunga, SA
Case study (lp) in Phillips-Rees, S. et al, The Changing Face of Health South Australian Community Health Association and the South Australian Health Commission, South Australia, 1992.

Passion in Parks!
Verity, F., Goodes, L.
Parks Community Health Service, Angle Park, SA
Journal article (6p) in Community Quarterly, No. 20, 1991.

Environmental Protection and Health: The case of air quality on the Le Fevre Peninsula
Shuttleworth, C., Tassie, J.
Dale Street Women's Health Centre, Port Adelaide, SA
Conference paper (3p) in Clarke, B. MacDougall, C. (eds), The 1993 Community Health Conference, Vol. 1, Papers and Workshops, Australian Community Health Association, NSW, 1993

Ethnic health

Mensa - A recreational program with an older Italian community
Phillips-Rees, S., Sanderson, C., Herriot, M., May, A.
Eastern Community Health Service, Paradise, SA
Case study (lp) in Phillips-Rees, S. et al, The Changing Face of Health, South Australian Community Health Association and the South Australian Health Commission, South Australia, 1992.

A One Year Reflection on Primary Health Care with Women from non-English Speaking Backgrounds
Pugh, L.
Fairfield Multicultural Family Planning Association, Fairfield, NSW
Conference paper (4p) in Clarke, B., MacDougall, C. (eds), The 1993 Community Health Conference, Vol. 1, Papers and Workshops, Australian Community Health Association, NSW, 1993.

Ethnic health (cont)

Vietnamese Rubella Education Program
Deafness Foundation, Victoria
Deafness Foundation, Highett, Vic
Report.

Hablamos por Nuestras Propias Voces ... In Our Own Voices, Spanish Speaking Women Speak Out About Interpreter Services
Murray, C., Chiappe, M.
North West Suburbs Health and Social Welfare Council, Alberton, SA
Conference paper (3p) in Clarke, B., MacDougall, C. (eds), The 1993 Community Health Conference, Vol. 1, Papers and Workshops, Australian Community Health Association, NSW, 1993.

Inda-Chinese Communities and Primary Health Care: Increase access and participation
Lieu, T., Tuyet, N., Lanh, N., Tran, L.
Parks Community Health Service, Angle Park, SA
Conference paper (3p) in Clarke, B., MacDougall, C. (eds), The 1993 Community Health Conference, Vol. 1, Papers and Workshops, Australian Community Health Association, NSW, 1993.

Vietnamese Women's Domestic Violence Poster Project
Kennedy, L., Clarke, H., Yong, H.
Inner West Community Network Against Violence Towards Women and Children, Kensington, Vic
Case study (3p) in Butler, P. (ed), Innovation and Excellence in Community Health, Centre for Development and Innovation in Health, Melbourne, 1994.

A Passport to Health and Participation
Ziguras, S.
Yarra Community Health Service, Carlton, Vic
Journal article (Sp) in Community Quarterly, No. 24, September, 1992.

Ethnic health (cont)

Pap Smears and Breast Self Examination for NESB Women
Prasad, R., Shinwari, W.
Women's Health Centre, Spring Hill, Qld
Case study (7p) in Butler, P., Cass, S. (eds), Case Studies of Community Development in Health, Centre for Development and Innovation in Health, Melbourne, 1993.

General practice

Patient Education Classes in General Practice
Schattner, P.
Dr P Schattner, Murrumbeena, Vic
Journal article (4p) in Australian Family Physician, Vol. 22, No. 7, July, 1993.

Blacktown Area Community Services
O'Connor, J., Gupta, S.
Dr J O'Connor, Lalor Park, NSW
Demonstration Practice Grants Program Report No. 324.

Small Practice Patient Recall System
Mears, T.
Dr T Mears, Drummoyne, NSW
Demonstration Practice Grants Program Report No. 301.

Fairfield General Practice Liaison Unit
Ryan, P.
Fairfield Hospital, Fairfield, NSW
Case study (2p) in Ryan, P., Cases for Change, Australian Community Health Association, NSW, 1992.

Osborne Park Health Service, General Practitioner Unit
Surveyor, M.
Osborne Division of General Practice, Stirling, WA
Demonstration Practice Grants Program Report.

General practice (cont)

Community Based Primary Care of People with Disabilities
Davis, R.
Knox Division of General Practice, Boronia, Vic
Report.

Involving General Practitioners in Public Health Initiatives
Jeffs, D., Gray, T., Wenzel, W.
Illawarra Area Health Service, Keiraville, NSW
Journal article (4p) in Australian Family Physician, Vol. 20, No. 1, January, 1991.

Learning More About Your Practice Through Preventive Medicine Projects
Hays, R., Stanley-Davies, P., Odlum, T.
Dr R Hays, Sydney
Journal article (3p) in Australian Family Physician, Vol. 20, No. 11, November, 1991.

The General Practitioner and Community Health Centre Liaison Project
Birrell, C.
Inner South Community Health Service, South Melbourne, Vic
Conference paper (3p) in Clarke, B., MacDougall, C. (eds), The 1993 Community Health Conference, Vol. 1, Papers and Workshops, Australian Community Health Association, NSW, 1993.

South Kingsville Health Service
Whitfield, K.
South Kingsville Health Services Co-op, South Kingsville, Vic
Demonstration Practice Grants Program Report No. 386.

Homelessness

Hospital/Community Care of Homeless People
Royal District Nursing Service Homeless Persons Program
Royal District Nursing Service Homeless Persons Program, Collingwood, Vic
Report.

Opening the Doors
Romios, P., MacWilliams, J., Crawford, S.
Melbourne District Health Council, c/- Victorian Consumer Health Voice, Yarra House, Fairfield Hospital, Melbourne, Vic
Report.

Needs Assessment of Former Residents of Great Southern
Spurling, S.
Royal District Nursing Service Homeless Persons Program, Collingwood, Vic
Case study (3p) in Butler, P. (ed), Innovation and Excellence in Community Health, Centre for Development and Innovation in Health, Melbourne, 1994.

It Can Be Done: Health care for people who are homeless
Royal District Nursing Service
Royal District Nursing Service, Melbourne, Vic
Report, A Model of Primary Health Care, Royal District Nursing Service, Melbourne, 1992.

Injury prevention

"Patchwork" - Bushfire safety education
Millicer, K.
Anglesea Community House, Anglesea, Vic
Case study (7p) in Butler, P., Cass, S. (eds), Case Studies of Community Development in Health, Centre for Development and Innovation in Health, Melbourne, 1993.

Penrith Panthers Buckle Up Campaign
Wentworth Area Health Service
Wentworth Centre for Health Promotion, East Blaxland, NSW
Report.

Injury prevention (cont)

Safe Living Program
Hennessy, M., Arnold, R., Harvey, P.
Accident Research Centre, Monash University, Clayton, Vic
Report, Hennessy, M. et al Safe Living: The First Three Years, Shire of Bulla, Vic, 1994.

Local Injury Information, Community Participation and Injury Reduction
Jeffs, D., Booth, D., Calvert, D.
Illawarra Public Health Unit, Keiraville, NSW
Journal article (8p), in Australian Journal of Public Health, Vol. 17, No. 4, 1993.

How Dangerous is that Visit to the Beach?
Grenfell, R., Ross, K.
Dr R Grenfell, Geelong West, Vic
Journal article (4p) in Australian Family Physician, Vol. 21, No. 8, August, 1992.

Linking Community Health with Statewide Campaigns
Lawrence, A., Elkington, J., Fowler, D., Brown, J.
Australian Community Health Association, Bondi Junction, NSW
Conference paper (3p) in Clarke, B., MacDougall, C. (eds), The 1993 Community Health Conference, Vol. 1, Papers and Workshops, Australian Community Health Association, NSW, 1993.

Mental health

Women's Advisory Group
Cox,M.
North Eastern Metropolitan Psychiatric Services, Bundoora, Vic
Case study (4p) in Cox, M., Good Practices in Women's Mental Health, Healthsharing Women's Health Resource Service, Melbourne, 1994.

Primary Mental Health Care, Caboolture Shire
Easton, D.
Dr D Easton and Associates and Sunshine Coast Regional Health Authority, Caboolture, Qld
Report.

Mental health (cont)

The Survivors Group
Bosworth, D., Bowles, A., Coward, J.
Berwickwide Community Health Centre, Doveton, Vic
Case study (4p) in Butler, P. (ed), Innovation and Excellence in Community Health, Centre for Development and Innovation in Health, Melbourne, 1994.

Approachable Mental Health Care
Ryan,P.
Hillcrest Northern Outreach Service, Elizabeth Vale, SA
Case study (lp) in Ryan, P., Cases for Change, Australian Community Health Association, NSW, 1992.

The Boomerang Club Women's Program
Cox,M.
City of Essendon, Moonee Ponds, Vic
Case study (Sp) in Cox, M., Good Practices in Women's Mental Health, Healthsharing Women's Health Resource Service, Melbourne, 1994.

Making the Net Work - From mental institutions to community life
Dixon, C.
Yarra Community Health Service, Fitzroy, Vic
Conference paper (3p) in Clarke, B., MacDougall, C. (eds), The 1993 Community Health Conference, Vol. 1, Papers and Workshops, Australian Community Health Association, NSW, 1993.

Inner South Housing Support Program
Sullivan, K.
Inner South Community Health Service, St Kilda, Vic
Case study (3p) in Butler, P. (ed), Innovation and Excellence in Community Health, Centre for Development and Innovation in Health, Melbourne, 1994.

Young Women's Outreach Pilot Project
Cox,M.
Richmond Fellowship of Victoria, West Brunswick, Vic
Case study (4p) in Cox, M., Good Practices in Women's Mental Health, Healthsharing Women's Health Resource Service, Melbourne, 1994.

Mental health (cont)

Horizons Women's Program
Cox, M.
Horizons Support and Living Skills Association, St Albans, Vic
Case study (Sp) in Cox, M., Good Practices in Women's Mental Health, Healthsharing Women's Health Resource Service, Melbourne, 1994.

The Role of SelfHelp Groups in Assisting General Practitioners in the Management of Mental Illness: Partnerships in practice
Health Issues Centre
Health Issues Centre, Melbourne, Vic
Report.

The Mental Illness Project: A consumer driven plan for the development of services for people with mental illness in the southent area of Adelaide
Mott, K., Palmer, H., Lofthouse, B.
Marion-Brighton-Glenelg Health and Social Welfare Council, Warradale, SA
Conference paper (2p) in Clarke, B., MacDougall, C. (eds), The 1993 Community Health Conference, Vol. 1, Papers and Workshops, Australian Community Health Association, NSW, 1993.

Safe Place for Women
Cox, M.
Safe Place for Women, Northcote, Vic
Case study (3p) in Cox, M., Good Practices in Women's Mental Health, Healthsharing Women's Health Resource Service, Melbourne, 1994.

Development of an Integrated Mental Health Service in the Far West of NSW
Hemming, M.
Far West Mental Health Service, Broken Hill, NSW
Journal article in Mental Health in Australia, December, 1993.

Mid March SelfHelp Groups Project
Wallace, J.
Dr J Wallace, Clare, SA
Demonstration Practice Grants Program Report.

Mental health (cont)

SelfHelp Education and Support Program
Schizophrenia Fellowship Victoria
Schizophrenia Fellowship Victoria, Nth Fitzroy, Vic
Report.

Uncovering Women's Needs
Webster, K., Wilson, G.
North East Women's Health Service, Reservoir, Vic
Case study (2p) in Webster, K., Wilson, G., Mapping the Models, Centre for Development and Innovation in Health, Melbourne, 1993.

Nutrition

Maffra "Get About Nutrition" Project
Young, J.
Shire of Maffra, Maffra, Vic
Report.

Cringila Nutrition and Dental Project
Langridge, D., Russell, C.
Illawarra Area Health Service, Wollongong, NSW
Demonstration Practice Grants Program Report No. 608.

Beyond Glossy Resources - Working with schools in a low income area to improve nutrition
Central Sydney Health Promotion Unit
Central Sydney Health Promotion Unit, Camperdown, NSW
Report.

Local Food and Nutrition Policy
Grossman, J., Webb, K.
Journal article (6p) in Australian Journal of Public Health, Vol. 15, No. 4, Dec, 1991.

Nutrition (cont)

The Family Food Program - A primary health care approach to nutrition education in low income families
Booth, S.
South Australian Health Development Foundation, Women and Children's Hospital, North Adelaide, SA
Conference paper (3p) in Clarke, B., MacDougall, C. (eds), The 1993 Community Health Conference, Vol. 1, Papers and Workshops, Australian Community Health Association, NSW, 1993.

Nutritional Health in the Parks: From worker control to community ownership/participation
Spurr, C., Ward, J., Payton, J.
Parks Community Health Service, Angle Park, SA
Conference paper (3p) in Clarke, B., MacDougall, C. (eds), The 1993 Community Health Conference, Vol. 1, Papers and Workshops, Australian Community Health Association, NSW, 1993.

Improving Nutrition in a Low Income Community: The food in Redfern project
Finlay, P., Hodge, W.
Central Sydney Health Promotion Unit, Camperdown, NSW
Report.

Healthy Food Choices Program
Bordas, E., Tinney, M., Williams, S.
Port Adelaide Community Health Service, Port Adelaide, SA
Conference paper (2p) in Clarke, B., MacDougall, C. (eds), The 1993 Community Health Conference, Vol. 1, Papers and Workshops, Australian Community Health Association, NSW, 1993.

Occupational health and safety

The Health Surveillance Program for Vineyard Workers
Galvin, J., Christine, D., Brown, T., James, J., Ball, J.
Public Health Unit, Hunter Area Health Service, Newcastle, NSW
Report, Galvin, J. et al, Health Surveillance Program for Vineyard Workers Report, Hunter Area Health Service, Newcastle, NSW, 1994.

A Collaborative Approach to High Blood Pressure in the Workplace
Ryan, P.
Salisbury Community Health Centre, Salisbury, SA
Case study (lp) in Ryan, P., Cases for Change, Australian Community Health Association, NSW, 1992.

Worksite Health Promotion in Wagga Wagga
Lemerle, K.
Wagga Wagga Community Health Centre, Wagga Wagga, NSW
Conference paper (7p) in Rees, A. (ed), Healthy Cities: Reshaping the Urban Environment, Australian Community Health Association, NSW, 1992.

"Is it Work Related?" Screening for occupational injury and disease
Ryan, P.
Inala Community Health Centre, Inala, Qld
Case study (2p) in Ryan, P., Cases for Change, Australian Community Health Association, NSW, 1992.

Prenatal/postnatal care and childbirth

Antenatal Care in General Practice
Azoury, J.
Dr J Azoury, Queanbeyan, NSW
Demonstration Practice Grants Program Report No. 686.

A Comparison of Two Methods of Breastfeeding Management
Rowe, L., Cumming, F., King, R., Mackey, C.
Dr L Rowe, Bannockburn, Vic
Journal article (6p) in Australian Family Physician, Vol. 21, No. 3, March, 1992.

Prenatal/postnatal care and childbirth (cont)

Vietnamese Antenatal/Postnatal Project
Tran, H.
North Richmond Community Health Centre, North Richmond, Vic
Case study (6p) in Butler, P. (ed), Innovation and Excellence in Community Health, Centre for Development and Innovation in Health, Melbourne, 1994.

The Little Clinic
Morrison, J., McRae, S.
Ballarat Community Health Centre, Ballarat, Vic
Conference paper (13p), 1993 National Midwives Conference, Adelaide, September, 1993.

Obstetrics in a Small Maternity Hospital
Elliott, C.
Dr C Elliott, Northgate, Qld
Journal article (5p) in Australian Family Physician, Vol. 21, No. 5.

Deconstructing Antenatal Care - The birthwise project
Shame, L., Kazan, Z., Littlejohn, A., Gunn, J., Henderson, M.
Dale Street Women's Health Centre, Port Adelaide, SA
Conference paper (3p) in Clarke, B., MacDougall, C. (eds), The 1993 Community Health Conference, Vol. 1, Papers and Workshops, Australian Community Health Association, NSW, 1993.

Providing Antenatal Care for Teenagers
Ryan,P.
The Warehouse Youth Health Centre, Penrith, NSW
Case study (3p) in Ryan, P. Cases for Change, Australian Community Health Association, NSW, 1993.

Lindisfarne Postnatal Support Project
Creagh, A.
Lindisfarne Medical Group, Mt Lawley, WA
Demonstration Practice Grants Program Report.

Rural health

The Challenge of Change: A country hospital's experience
Phillips-Rees, S., Sanderson, C., Herriot, M., May, A.
Laura Hospital, Laura, SA
Case study (lp) in Phillips-Rees, S. et al, The Changing Face of Health, South Australian Community Health Association and the South Australian Health Commission, South Australia, 1992.

Community Development in Maryborough - The Good Health Expo
Kassulke, D.
Epidemiology and Prevention Unit, Queensland Health, Brisbane, Qld
Video.

Rural Women Sharing Change
South Gippsland Farmer's Support Group
South Gippsland Farmer's Support Group
Report to Victorian Health Promotion Foundation.

Hopetoun Health Centre
Haggett, T.
Ravensthorpe and Hopetoun General Practice, Ravensthorpe, WA
Demonstration Practice Grants Program Report No. 116.

Taking Health Care to a Small Community: The town of Hawkesdale
Thomas,M.
Faculty of Nursing, Deakin University, Warmambool, Vic
Conference paper (7p), 1991 Rural Health Conference, School of Nursing, Deakin University, Warrnambool, 1991.

Dalwallinu Multi-purpose Health Service
Lee, J., Steed, D.
Dalwallinu District Hospital, Dalwallinu, WA
Report.

Passive Smoking and Children
Davey, C., Storti, C.
Traralgon Community Health Centre, Traralgon, Vic
Article.

Rural health (cont)

The Dalwallinu Project
Steed, D.
Dalwallinu District Hospital, Dalwallinu, WA
Report.

Disability Health Promotion Project
Goss, A.
Baimsdale Community Health Centre, Bairnsdale, Vic
Report.

Health Localities Benalla
Healthy Localities Project Benalla
City of Benalla, Benalla, Vic
Report.

Reaching Out to Women in Rural Victoria
Webster, K., Wilson, G.
Loddon Campaspe Women's Health Service, Bendigo, Vic
Case study (3p) in Webster, K., Wilson, G., Mapping the Models, Centre for Development and Innovation in Health, Melbourne, 1993.

Babinda: The place where people count
Barker, R., May, H.
Peninsula and Torres Strait Regional Health Authority, Cairns, Qld
Conference paper (3p) in Clarke, B., MacDougall, C. (eds), The 1993 Community Health Conference, Vol. 1, Papers and Workshops, Australian Community Health Association, NSW, 1993.

Tin Can Bay Community Health Project
Martin, P.
Cooloola Medical and Professional Centre, Tin Can Bay, Qld
Demonstration Practice Grants Program Report No. 17.

Social isolation

Coburg Carers Project
Hurle, W., Harris, S.
Coburg City Council, Coburg, Vic
Report.

Redlands "Link a Friend"
Allard, S.
Program Development Branch, Queensland Health, Brisbane, Qld
Report.

Woodcroft Co-operative Gardening- Building green community networks
Ranson, 0.
Woodcraft Community Health Centre, Woodcraft, SA
Conference paper (2p) in Clarke, B., MacDougall, C. (eds), The 1993 Community Health Conference, Vol. 1, Papers and Workshops, Australian Community Health Association NSW, 1993.

Social Isolation and the Elderly
Molyneux, M.
Parks Community Health Service, Angle Park, SA
Conference paper (3p) in Clarke, B., MacDougall, C. (eds), The 1993 Community Health Conference, Vol. 1, Papers and Workshops, Australian Community Health Association, NSW, 1993.

Women's health

Taking the Health Message to Women
Webster, K., Wilson, G.
Women in Industry and Community Health, Fitzroy, Vic
Case study (2p) in Webster, K., Wilson, G., Mapping the Models, Centre for Development and Innovation in Health, Melbourne, 1993.

Women's Cancer Screening at BHP
Ryan, P.
Illawarra Area Health Service, Wollongong, NSW
Case study (2p) in Ryan, P., Cases for Change, Australian Community Health Association, NSW, 1992.
$286.00

Women's health (cont)

Recreating the Village: The development of groups to improve social relationships among mothers of newborn infants in Australia
Lawson, J., Callaghan, A.
School of Health Services Management, University of NSW, Kensington, NSW
Journal article (3p) in Australian Journal of Public Health, Vol. 15, No. 1, March, 1991.

Massage and Older Women's Health
Byrnes, M., Turner, M.
East Preston Community Health Centre, East Reservoir, Vic
Case study (Sp) in Butler, P. (ed), Innovation and Excellence in Community Health, Centre for Development and Innovation in Health, Melbourne, 1994.

Riverland Women's Health Project
Henn, E., Roberts, D.
Riverland Health and Social Welfare Council, Berri, SA
Report.

Reclaiming the Womb
Webster, K., Wilson, G.
Healthsharing Women's Health Resource Service, Melbourne, Vic
Case study (4p) in Webster, K., Wilson, G., Mapping the Models, Centre for Development and Innovation in Health, Melbourne, 1993.

Preventive Health for Female Patients
Lee, J.
Francisco Medical Centre, Rivervale, WA
Demonstration Practice Grants Program Report No. 83.

Health For Women in Waverley
Health for Women in Waverley Committee
Waverley Community Health Centre, Glen Waverley, Vic
Report.

Women's health (cont)

Risdon Vale Women's Health Program
Ryan, P.
Risdon Vale Community Health Centre, Risdon Vale, Tas
Case study (2p) in Ryan, P., Cases for Change, Australian Community Health Association, NSW, 1992.

Women's Health Matters
Cosier, G.
Orana Community Health Centre, Dubbo, NSW
Report.

Rockhampton Sexual Assault Program
Collins, F.
Rockhampton Women's Health Centre, Rockhampton, Qld
Report.

Women's Health Ethnic Liaison Project
Jobst, J.
South Central Region Migrant Resource Centre, St Kilda, Vic
Report.

Developing Women-centred Resources
Webster, K., Wilson, G.
Healthsharing Women's Health Resource Service, Melbourne, Vic
Case study (4p) in Webster, K., Wilson, G., Mapping the Models, Centre for Development and Innovation in Health, Melbourne, 1993.

Frankston Young Women's Support Program
Heffernan, K.
Frankston Community Health Centre, Frankston, Vic
Case study (Sp) in Butler, P. (ed), Innovation and Excellence in Community Health, Centre for Development and Innovation in Health, Melbourne, 1994.

Sharing the Load of Caring
Webster, K., Wilson, G.
Wellcoming Women's Health Service, Horsham, Vic
Case study (2p) in Webster, K., Wilson, G., Mapping the Models, Centre for Development and Innovation in Health, Melbourne, 1993.

Women's health (cont)

Women's Health Infonnation in "Plain English"
Kerrigan, S., Oberin, J.
Loddon Campaspe Women's Health Service, Bendigo, Vic
Case study (8p) in Butler, P. (ed), Innovation and Excellence in Community Health, Centre for Development and Innovation in Health, Melbourne, 1994.

Feeling at E.A.S.E.
Morano, P., Buck, H.
Craigiebum Family Services, Craigiebum, Vic
Journal article (3p) in Community Quarterly, No. 27, June, 1993.

Youth health

The Red Cross Youth Health Service
Wright, K., Bagozzi, R.
ACT Red Cross, Mawson, ACT
Conference paper (2p) in Clarke, B., MacDougall, C. (eds), The 1993 Community Health Conference, Vol. 1, Papers and Workshops, Australian Community Health Association, NSW, 1993.

Life on Easy Street
Crockett, S.
Yarra Community Health Service, Collingwood, Vic
Journal article (6p) in Community Quarterly, No. 17, and Australian Family Physician, Vol. 20, No. 9.

Young Mothers on the Move, Pregnancy Support Project
Norallinger, J., Lynch, T.
Youth Emergency Accommodation Project, Reservoir, Vic
Report.

Lots of Love John and Betty: An evaluation
Glanville, L., Webster, K.
Sunbury Community Health Centre, Sunbury, Vic
Report.

Youth health (cont)

Healthy Cities Caboolture: Youth needs taskforce
Scriven, S.
Healthy Cities Caboolture, Caboolture, Qld
Conference paper (6p) in Rees, A. (ed), Healthy Cities: Reshaping the Urban Environment, Australian Community Health Association, NSW, 1992.

Teenagers and Suicide
Martin, G.
South Australian Child and Adolescent Mental Health Service, Bedford Park, SA
Case study (3p) in Ryan, P., Cases for Change, Australian Community Health Association, NSW, 1993.

Homeless Young Persons Health Access Program
Hannon, C., McDonough, V., Philip, L.
Inner South Community Health Service, St Kilda, Vic
Case study (8p) in Butler, P. (ed), Innovation and Excellence in Community Health, Centre for Development and Innovation in Health, Melbourne, 1994.

Other

One Stop Body Shop
Hill, H.
Sunbury Community Health Centre, Sunbury, Vic
Case study (4p) in Butler, P. (ed), Innovation and Excellence in Community Health, Centre for Development and Innovation in Health, Melbourne, 1994.

Community Support Network NSW Incorporated - "Prepared to Care"
Stokes, M.
Community Support Network NSW Inc, Darlinghurst, NSW
Conference paper (3p) in Clarke, B., MacDougall, C. (eds), The 1993 Community Health Conference, Vol. 1, Papers and Workshops, Australian Community Health Association, NSW, 1993.

Other (cont)

Discharge Planning at Cabrini Hospital
Kiehne, R.
Caulfield Community Care Centre, South Caulfield, Vic
Report.

Addressing Inequalities in Health - An action learning program for health workers
Ryan, P., Roach, J.
Community Health Accreditation and Standards Program, Bondi Junction, NSW
Report.

Gold Coast AIDS Association and Injectors' Newsline
Patterson, E., Barker, C.
Gold Coast AIDS Association and Injectors' Newsline
Conference paper (Sp) in Clarke, B., MacDougall, C. (eds), The 1993 Community Health Conference, Vol. 1, Papers and Workshops, Australian Community Health Association, NSW, 1993.

Medicine Information Project
Pedler, K.
Combined Pensioner's and Superannuants Association of NSW, Sydney,NSW
Journal article (2p) in Health Issues, No. 24, September, 1990.

The 60 and Better Project: Creating a healthier community for older people
Cartwright, C.
Acacia Ridge Community Support, Acacia Ridge, Qld
Conference paper (7p) in Rees, A. (ed), Healthy Cities: Reshaping the Urban Environment, Australian Community Health Association, NSW, 1992.

Appendix Three: Reviewer's Questionnaire

BEST PRACTICE IN PRIMARY HEALTH CARE

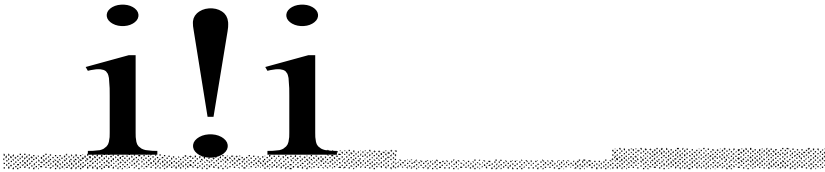
REFEREE QUESTIONNAIRE

Case Study No: Case Study Title:

Referee Name: Referee No:

Please read the case study and then answer the questions below as best you can. Each question encourages you to comment and we urge you to do so.

Question 1. Outcomes



1 2 3 4 5 6 7

Disappointing Outcomes — Excellent Outcomes

Please Comment

Page 1

The National Primary Health Care Review (1992) identified five aspects of primary health care practice which contribute to positive outcomes. The following five questions ask you to evaluate the contribution of these aspects to any positive outcomes the project achieved, regardless of the overall rating you gave the project in question 1. A sixth question allows you to suggest any other aspect of practice which you think contributed to the outcomes of this project.

Question 2. Collaborative Local Networking

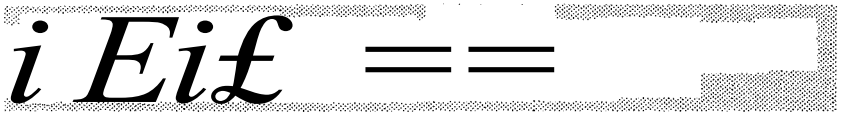
Regardless of how you rated this project, please evaluate whether collaborative local networking made a contribution to any positive outcomes achieved.

	Tick one box
This aspect made a positive contribution to the project	D
Lack of this aspect negatively affected the project	D
This aspect is irrelevant to the project	D
Can't judge	D

Please Comment

Page2

Question 3. 'Vertical' Networking



Regardless of how you rated this project, please evaluate whether 'vertical' networking made a contribution to any positive outcomes achieved.

	Tick one box
This aspect made a positive contribution to the project	D
Lack of this aspect negatively affected the project	D
This aspect is irrelevant to the project	D
Can't judge	D

Please Comment

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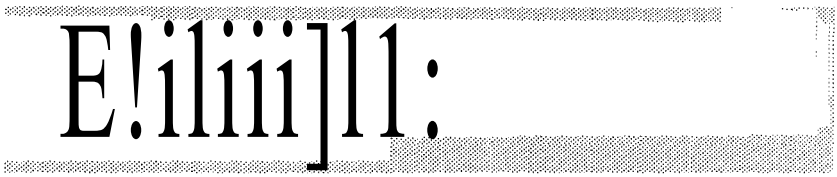
Question 4. Consumer and Community Involvement



Regardless of how you rated this project, please evaluate whether consumer and community involvement made a contribution to any positive outcomes achieved.

	Tick one box
This aspect made & positive contribution to the project	D
Lack of this aspect negatively affected the project	D
This aspect is irrelevant to the project	D
Can't judge	D

Please Comment

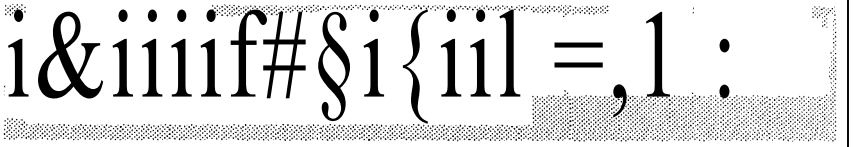
Question 5. Balancing Micro and Macro Level Needs

Regardless of how you rated this project, please evaluate whether consumer and community involvement made a contribution to any positive outcomes achieved.

	Tick one box
This aspect made a positive contribution to the project	D
Lack of this aspect negatively affected the project	D
This aspect is irrelevant to the project	D
Can't judge	D

Please Comment

Question 6. Change Consciousness



Regardless of how you rated this project, please evaluate whether change consciousness made a contribution to any positive outcomes achieved.

	Tick one box
This aspect made a positive contribution to the project	D
Lack of this aspect negatively affected the project	D
This aspect is irrelevant to the project	D
Can't judge	D

Please Comment

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Question 7. Other Aspects

Please comment on any other aspects of primary health care practice which made a contribution to any positive outcomes in this case.

Referee Details

Please tick the box that most accurately represents the type of agency you work for and your role within it.

Agency Type

Consumer/Community Group	D	General Practice	D
Community health agency	D	Community health centre	D
Community welfare agency	D	Education system	D
Government department	D	Tertiary education department	D
Hospital	D	Health department	D
Local government	D	Inter-sectoral group	D
Society/foundation	D	Self help/lobby group	D
Other (please specify)	D		

Role

Consumer community activist	D	General practitioner	D
Community health worker	D	Manager/Director/Administrator	D
Health practitioner	D	Academic	D
Research office/project officer	D	Other (please specify)	D

Thank you for taking the time to complete the questionnaire.

Please return to: **Best Practice in Primary Health Care,**
C.D.I.H.
P.O. Box 57, Northcote 3070

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Appendix Four: Analysis Codes

Pre-conditions codes

1 Sense of shared identity based on community
2 Strongly linked community (strong personal links)
3 Locality, proximity
4 Tradition of political activism (locality or in social movement)
5 Real needs
6 External precipitating crisis
7 Organisational policy change at the regional, state or national levels
8 Organisational management change (devolution or delegation) at the regional, state or national levels
9 Coherent and authoritative policy narrative at state or national level providing guidance and leverage
10 Agency part of a wider program (regional, state or national)
11 Availability of financial resources
12 Longer term scope
13 Existing models of program organisation
14 Existing networks at local, regional, state or national levels
15 Limited number of service agencies
16 Institutional structures, organisational policies and/or legislative provisions which provide for community participation in decision making
17 Organisational purpose (direction, vision) which is clearly articulated, shared, discussed and alive
18 Organisational planning and review structures based on an articulated and understood policy framework
19 Organisational structures which reflect the balance between working at the macro and micro levels
20 Organisational policies which support staff development, participation in study and research and link it to critical reflection in planning and practice
21 Organisational policies which value evaluation, critical reflection and experimentation
22 People of extraordinary commitment, vision and leadership
23 Critical mass at an organisational level
24 Commitment to the customer and community amongst staff and other personnel

25 Staff characteristics include commitment, skills, and team practice
26 Shared acceptance of necessity for change amongst staff

Process codes

1 Consulting the community (by agency and/or community activist group)
2 Responsive to community needs
3 Active community participation
4 Community control
5 Collaborative approach to project, service development and management.
6 Involving consumers
7 Building constituencies
8 Celebrating successes
9 Working in a way which recognises the balance between macro and micro levels
10 Networking at the local level
11 Intersectoral collaboration
12 Mobilising more centrally located expertise
13 Mobilising financial resources
14 Utilising available information resources
15 Critically reflecting and evaluating practice
16 Flexibility, opportunism and risk taking
17 Linking practice with theory and research
18 Investing in personnel training and/or development
19 Effective personnel selection processes
20 Active and visionary leadership

Outcome codes

1 Probable improvements in people's health status
2 Substantiated improvements in people's health status
3 Skilling and/or personal development of consumers/community
4 Increased community and consumer knowledge/health literacy
5 Wider appreciation of social/structural dimensions of health issues
6 Role models provided to particular communities
7 Opportunities established for consumer/community participation

8 Strengthening community networks/social support
9 Increased community capacity to respond to issues (confidence, awareness, networks, readiness to act)
10 Increased access by community to services
11 Programs and services (including advocacy and activism) established, developed or extended to meet community needs
12 Service agencies or institutions strengthened
13 Service agencies or institutions culture of evaluation and critical reflection strengthened
14 Improved quality of service
15 Skilling and changed practice of professional practitioners
16 Contribution to the development of professional education
17 Contribution to the development of the field or sector more widely
18 Intersectoral links developed or extended
19 Intersectoral progress made in relation to the conditions for better health
20 Progress towards healthy public policy
21 Organisational policies which value evaluation, critical reflection and experimentation
22 People of extraordinary commitment, vision and leadership
23 Critical mass at an organisational level
24 Commitment to the customer and community among staff and other personnel
25 Staff characteristics include commitment, skills and team practice
26 Shared acceptance of necessity for change amongst staff
27 Union presence