SYSTEM BUILDING BLOCKS FOR HEALTH

PROMOTION POLICY AND PRACTICE IN

A REGIONAL HEALTH SYSTEM

IN SOUTH AUSTRALIA

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of the requirements of the degree of
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Summary

This thesis examines health promotion (HP) policy and practice in a regional multisectoral health system in South Australia (SA). Evidence suggests that HP policy and practice must address action on the determinants of health to reduce health inequities through reorienting health services towards HP, developing partnerships and intersectoral collaboration, and ensuring community participation. Through these actions a balance of strategies are recommended that integrate developing personal skills, creating supportive environments and building healthy public policies. Despite this, HP policies and practices often remain targeted to supporting individual behaviour change or coping skills.

There is considerable research about challenges to HP and these include issues of power, politics and ideology, and the lack of strong leadership and governance and information regarding acceptable evidence of HP effectiveness. There are few studies that have investigated HP challenges using systems thinking lenses that incorporate health system building blocks (leadership and governance, financing, workforce, service delivery and information) and consider feedback mechanisms as leverage points to strengthen HP.

This thesis asks: from a systems thinking perspective, what are the key factors that influence HP policy and practice in a regional multisectoral health system in SA? Three sub-questions were developed:

1) Over a ten year period (2003-2013) to what extent does the policy context support HP and health system building blocks for HP?

2) What are the perspectives of key stakeholders within a regional multisectoral health system regarding the extent to which HP is addressed and health system building blocks are in place for HP?

3) What feedback mechanisms appear to influence HP policy and practice in the regional health system?

This thesis was a single instrumental case study that used qualitative methods: document review of 20 government policies, interviews with 53 stakeholders, and the creation of a causal loop diagram identifying feedback mechanisms among key findings.

The policy context in 2013 did not support HP and health system building blocks to any great extent and a striking finding was cuts to and the lack of financing for HP services or practice and human resources. There was a near abdication of reorienting health services toward HP and key factors that influenced this included the lack of policy alignment between federal-state governments and the perceived lack of information regarding evidence of HP effectiveness.

Stakeholders indicated that leadership changes at the state level in times of budgetary constraints and the dominance of the biomedical model were integral to the diminished HP policy and practice environment. The policy context was stronger for developing partnerships and intersectoral collaboration because of the *Public Health Act* (2011) and the focus on whole-of-government approaches. However, challenges were reported by stakeholders that included fears of cost-shifting from the state to local governments for HP and fragmented system elements. Additionally, there was a lack of support for community participation in HP policy and practice.

This study found that 'leadership and governance' was a central theme and a superordinate health system building block for HP policy and practice primarily because of the clear reciprocal relationships with HP goals and actions, federal, state and local government policy directions, and all other building blocks. The implications of this research include the need to address the challenges in leadership and governance to ensure community participation in HP as well as 'health governance' for reorienting health services toward HP. There are clear opportunities to strengthen leadership and 'governance for health' through developing partnerships and intersectoral collaboration. However, these implications all demand skilful navigation of the stormy waters of power, politics and ideology that influence HP policy and practice.

Declaration

I certify that this thesis does not incorporate without acknowledgment any material previously submitted for a degree or diploma in any university; and that to the best of my knowledge and belief it does not contain any material previously published or written by another person except where due reference is made in the text.

Acknowledgements

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Chapter 1: Introduction

This thesis examines key factors that influence health promotion (HP) policy and practice in a regional multisectoral health system in South Australia (SA) from a systems thinking perspective. The impetus for this study is my 30 years of experience working, studying and teaching HP in Canada and the voluminous literature on policy and practice that all point to how difficult it is to implement HP based upon the most promising evidence.

An interviewee in a study by Kingdon (1995) stated that

> As I see it, people who are trying to advocate change are like surfers waiting for the big wave. You get out there, you have to be ready to go, you have to be ready to paddle. If you're not ready to paddle when the big wave comes along, you're not going to ride it in (p. 165).

As a Canadian studying HP policy and practice in SA I was taken by this quote about comparing advocating for policy change with surfing. I tried surfing in Australia and it is indeed a difficult thing to do and I have also tried to advocate for change in HP policy and practice in Canada and it too is very difficult. For me the key to this quote is the optimism that it may be possible that if you are out there and ready to paddle, and not only catch the wave, but ride it in, then change may be possible in HP policy and practice.

I find that after working with many organisations (regional health authorities, schools, nongovernment organisations, universities, local government) and in numerous positions (director, manager, researcher/evaluator, consultant) to advance HP policy and practice, I have only once been close to riding a big wave in. I was a Public Health Director in a regional health authority with a leadership role and responsibilities for HP and was able to plan, implement and evaluate policy and practice that evidence suggested was the most effective. Why is it so difficult? Instead of studying this question in Alberta or another province in Canada, I set the goal of studying in another country to get a new perspective and I was particularly set on studying an exemplary case to find answers as to how difficulties could be overcome. I found what I thought was a safe harbour in SA where HP policy, practice and research were considered world class, however, the seas turned unexpectedly stormy for HP right from the start of my journey. In my first year, I wrote a research proposal

to study key factors that influenced the implementation of an exemplary HP policy document which provided direction for practice in state and regional health systems. Following this, the state government undertook a review of health services and this resulted in cuts to HP financing and the withdrawal of the policy document. Thus, this thesis is the result of several revisions of my proposal and although I was not able to study an exemplary case, I was perhaps better positioned to study why it is so difficult to implement HP policy and practice because the challenges were so evident.

In this introductory chapter I first highlight the context of my research and the importance of studying HP policy and practice. I then give a brief synopsis of the relevant literature and indicate a gap in knowledge regarding how a systems thinking perspective could help explain key factors that influence HP policy and practice in one regional multisectoral health system. In the third section I outline my research questions and overall research design. The final section provides an overview of the structure of my thesis.

1.1   Context for my research and importance of my topic

My research is based upon my desire to be better prepared for my work in HP by answering the question: why is it so difficult for health systems to adopt and sustain HP that is based upon health equity focused policy and practice which evidence suggests may be most effective? The World Health Organization's definition of HP is widely accepted and it is "the process of enabling people to increase control over, and to improve their health. It moves beyond a focus on individual behaviour towards a wide range of social and environmental interventions" (World Health Organization, 1986). An important and key goal of HP is to reduce health inequities through action upon the unfair or avoidable distribution of social determinants of health (CSDH, 2008).

Health systems can be considered as not only clinical health care services, but to also include the broad social systems that influence health and well-being (Martin & Sturmberg, 2009) or "all organizations, people and actions whose primary intent is to promote, restore, or maintain health" (World Health Organization, 2007, p. 2). A system is a "comparatively bounded structure" (McLaren & Hawe, 2005, p. 13) which consists of interdependent elements that

form a whole and this definition sets the stage for systems thinking which has been called a "huge untapped potential" (de Savigny & Adam, 2009, p. 19) for understanding health systems. Systems thinking demands "a deeper understanding of the linkages, relationships, interactions and behaviours among elements that characterize the entire system" (de Savigny & Adam, 2009, p. 33). Thus, conceptualising health systems as more than health care services (Baum, 2016) and thinking of them in terms of the sum of interactions among system elements are important foundations for my research (Sturmberg & Martin, 2013).

There is increasing acceptance that the social, economic, and environmental determinants of health need to be at the heart of HP policy and practice because evidence indicates that they are the structural drivers in society that influence differences in health or rather health inequalities (Baum, 2016; CSDH, 2008; Raphael, 2004; World Health Organization, 2010). Health inequalities have been shown to be highly correlated with socio-economic status where the burden of ill health falls upon the most vulnerable in society and furthermore, there is a social gradient in health outcomes where the lower on the social ladder the worse one's health is (Marmot, et al., 1991; Wilkinson, 1996). While the term 'health inequalities' relates to the measurement of differences in health status or the distribution of determinants of health between population groups, the term 'health inequities' takes this further to respond "to a subset of inequalities that are deemed unfair" and avoidable (Evans, Whitehead, Diderichsen, Bhuiya, & Wirth, 2001, p. 4). Thus, reducing health inequities can be seen to be a moral or social justice issue that forces those in HP to consider power imbalances and thus political determinants of health (CSDH, 2008; Kickbusch, 2005; Marmot & Allen, 2014).

There is a rich history of international documents that call for HP policy and practice to reduce health inequities. Actions and strategies include: reorienting health services towards HP and not just the treatment of illness or injury; ensuring community participation in identifying priority determinants of health and actions to address them; and developing partnerships and intersectoral collaboration among different levels of government, departments within government, and organisations and institutions to improve population health (Jackson, et al., 2007; World Health Organization, 1978, 1986, 2014). Although there is evidence to suggest that actions such as those identified above would be most effective (CSDH, 2008; Jackson, et al., 2007; Solar & Irwin, 2010; Ziglio, Simpson, & Tsouros, 2011) there is a lack of population health intervention research to clearly demonstrate improved

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population health. The reasons for this are reported to be due to intervention design and methodological challenges (Hawe & Potvin, 2009) or the lack of practice-based evidence because the conditions are unfavourable for the multiple strategies at multiple levels that are called for (Green, 2006).

Furthermore, despite calls for population health oriented HP, scholars have long argued that most HP policy and practice in reality continues to mostly target individual behaviour change (Alvaro, et al., 2011; Baum, 2011; Labonte, Polanyi, Muhajarine, McIntosh, & Williams, 2005; Raphael, 2004; Shiell & Hawe, 1996; Syme, 2007). Behavioural risk factors such as diet and physical activity appear to be weak predictors of health outcomes (Raphael, 2004), but are often targeted in HP policy and practice. Baum and Fisher (2014) suggest that reasons for the focus on behavioural risk factors include: ideological factors such as the power of neoliberal individualism, practical factors such as the logic of appealing to individuals to change risk behaviours, and political factors such as "not talking about health in a structural way, because to do so presents a critical, de-normalising perspective on the socio-economic status quo" (Baum & Fisher, 2014, p. 219). However, there is a gap in research as to how these factors play out in a regional health system responsible for HP policy and practice.

To counter the HP challenges outlined above, some scholars call for strengthening leadership and governance for HP (Best, 2011; Kickbusch & Gleicher, 2012; Plsek & Wilson, 2001). Health systems require strong leadership in both 'health governance' (stewardship within the health sector) and 'governance for health' (government stewardship in multisectoral health systems) to ameliorate challenges to HP (Kickbusch & Gleicher, 2012). The concept of 'health governance' fits well with the HP action of reorienting health services. 'Governance for health' relates well to the HP action of developing partnerships and intersectoral collaboration. An important component of both is governance through ensuring community participation (Kickbusch & Gleicher, 2012). Thus, examining leadership, governance, and community participation was considered important in my study of HP policy and practice.

1.2 The gap in the literature

Despite the considerable amount of research about HP policy and practice (Alvaro, et al., 2011; Baum, Lawless, & Williams, 2013; de Leeuw & Breton, 2013; Friel, et al., 2012) and key challenges (Bambra, Smith, Garthwaite, Joyce, & Hunter, 2011; Hawe, 2015; Kickbusch, 2014; Labonté, 2011; Raphael, 2014), there are few studies that have investigated in detail how HP is shaped in a regional multisectoral health system that have also taken an explicit systems thinking perspective. This is particularly the case with respect to the application of analytic tools from systems thinking, such as feedback mechanisms (Finegood, 2011; Malhi, et al., 2009; Riley, et al., 2015), as system leverage points (Carey & Crammond, 2015; Johnston, Matteson, & Finegood, 2014). This is important because these techniques allow us to move beyond a listing of general factors affecting HP policy and practice, to a greater understanding of health systems and the mechanisms that underlie these general factors. Systems thinking may indicate ways to mitigate or address some of the threats to HP policy and practice, and allow it to better flourish, and hence improve the health of populations and reduce health inequities.

A search of the literature revealed a burgeoning interest in strengthening health systems and in particular, a framework of essential health system building blocks to guide investigation (de Savigny & Adam, 2009; World Health Organization, 2007). There have been some studies investigating health system building blocks (leadership and governance, financing, workforce, service delivery, information, and medicines and technology) in terms of the extent to which they are present in a health care system (Mutale, Bond, et al., 2013; Mutale, Godfrey-Fausset, Mwanamwenge, Kasese, & Chintu, 2013). However, I found no studies that applied this framework of building blocks to research a) HP policy and practice, b) a regional multisectoral health system that includes broad social systems that influence health and well-being, and c) systems thinking tools to explore feedback mechanisms as system leverage points. To my knowledge, this study of factors that influence HP policy and practice in a regional multisectoral health system using the framework of building blocks and systems thinking is a first.

1.3   Research questions and overview of research design

My research takes the form of a qualitative case study of the key factors that influence HP policy and practice in an anonymous health system in one region of SA. A case study approach was a good fit because the health system was an explicitly set and purposive bounded system (Stake, 2000). The aim was to examine in-depth the HP policy and practice environment by employing qualitative modes of inquiry through document review and stakeholder interviews combined with systems thinking.

The study sought to answer the following overarching research question: from a systems thinking perspective, what are the key factors that influence HP policy and practice in a regional multisectoral health system in SA? Three sub-questions were developed:

1. Over a ten year period (2003-2013) to what extent does the South Australian policy context support health promotion and health system building blocks for health promotion? I define HP in terms of its goal of reducing health inequities and three key actions it uses to accomplish this: reorienting health services toward HP; developing partnerships and intersectoral collaboration; and ensuring community participation. HP strategies include: developing personal skills, creating supportive environments and building healthy public policy. The health system building blocks are: leadership and governance, financing, workforce, information and services/practice.

2. What are the perspectives of key stakeholders within a regional multisectoral health system regarding the extent to which health promotion is addressed and health system building blocks are in place for health promotion?

3. What feedback mechanisms appeared to influence health promotion policy and practice in the regional multisectoral health system?

Overall, the aims of my study are to first, describe the historical HP policy context in SA; second, describe the perspectives of stakeholders in HP leadership positions on key factors that influence HP policy and practice; third, explore feedback mechanisms among key findings and identify system leverage points to positively influence HP; and finally, offer recommendations and conclusions for HP policy and practice in SA, Australia, and overseas.

1.4   The structure of this thesis

My thesis is structured in eight chapters including this introductory chapter. Chapter Two begins by reviewing the literature to explain what is already known about HP policy and practice. The main topics in this chapter are: conceptualisations of health; social determinants of health; health promotion goals, actions and challenges; and systems thinking, in particular feedback mechanisms to strengthen health systems for HP.

The third chapter is concerned with the design of my research and includes details of the conduct of the research. I begin this chapter with a discussion of philosophical foundations and the theoretical framework (social constructionism and a critical approach) and this is followed by a description of my qualitative methodology which includes a single, instrumental case study approach. I then describe the three research methods I employed: conducting a document review of pertinent government documents, interviewing stakeholders in the regional health system, and identifying feedback mechanism from key findings. Chapter 4 presents a brief but detailed description of the case and I provide background information as to the structure of the Australian and South Australian health care systems.

The fifth and sixth chapters are devoted to providing a descriptive analysis of my key findings. Chapter 5 describes the SA HP policy context in terms of the extent to which 20 SA government documents supported HP and health system building blocks for HP. In Chapter 6 I report on the perspectives of 53 stakeholders regarding the HP policy and practice environment and the extent to which health system building blocks were in place for HP. I begin this chapter with an overview of stakeholder perspectives and this is followed with how HP and health system building blocks were discussed in terms of key factors that influenced HP policies and practice.

The seventh chapter is devoted to first discussing my key findings through the identification of feedback mechanisms and their implications for leveraging system change. This includes a visual model in the form of a causal loop diagram. Secondly, I discuss key findings and feedback mechanisms in relation to the literature and answer my overarching research question as to the key factors that influence HP policy and practice in a regional multisectoral health system in SA. In this section I focus on leadership and governance as critical factors that influenced HP policy and practice in my research.

The final chapter draws upon the entire thesis to tie together a review of my topic, what I did, what I found, my main contributions to the literature and the implications for future research.

Chapter 2: Literature Review

This thesis examines key factors that influenced health promotion (HP) policy and practice in a regional multisectoral health system in South Australia (SA) employing a systems thinking perspective. A review of the relevant literature was undertaken and this chapter begins with a description of my literature review strategy. My starting point was an exploration of the differing conceptualisations of health which act to shape policy and practice. While HP remains a contested term, my thesis was concerned with HP based on a social view of health. Therefore in the following section I review the literature with respect to the social determinants of health (SDH). Proceeding from this, I distilled the vast literature specific to HP policy and practice. I reported on successive international documents and peer reviewed literature that have advanced HP, built upon the SDH literature, and set reducing health inequity as a key goal. In the final section I report on the literature that calls for systems thinking to further understanding of complex health systems, complex interventions, and the use of feedback mechanisms to help explain influences on HP policies and practices.

2.1   Literature review strategy

At the beginning of my doctoral studies I broadly searched and reviewed literature on HP from the Flinders University Library collection (books), from Medline, CINAHL, PsycINFO, PubMed and Web of Science databases (peer reviewed articles), and from the World Health Organization and Australian federal and state governments (grey literature). My initial search strategies focused on the terms 'health', 'determinants of health', 'public health', 'health promotion', 'HP policy and practice', and 'systems science' and this strategy provided me with a solid foundation for writing my proposal. Textbook resources included those from HP and systems science and they are indicated in Table 2.1.

Table 2.1   Health promotion and systems science textbooks used in my literature search

Public Health/Health Promotion
Baum, F. (2008, 2016). *The new public health*. Melbourne: Oxford University Press.
Bracht, N. (1990). *Health promotion at the community level*. Newbury Park, SAGE
Evans, T., Whitehead, M., Diderishsenm F., Bhuiya, A. & Wirth, M.(Eds.) (2001). *Challenging inequities in health.* New York: Oxford University Press.
Green, L., & Kreuter, M. (1991). *Health promotion planning: an educational and environmental approach* . Mountain View, CA: Mayfield Publishing Company.
Green J. and Tones, K. (2010). *Health promotion: planning and strategies*. London, Sage.
Hall, P. & Lamont, M. (2013). *Social resilience in the neoliberal era.* New York: Cambridge University Press.
IUHPE. (1999). *The evidence of health promotion effectiveness: shaping public health in a new Europe.* A report for the European Commission by the International Union for Health Promotion and Education IUHPE: Part Two Evidence Book.
Labonte, R. and Laverack, G. (2008). *Health promotion in action: From local to global empowerment.* London: Palgrave Macmillan
Laverack, G. (2004). *Health promotion practice: power and empowerment.* New Delhi, SAGE.
Marmot, M. (2004). *The status syndrome: How social standing affects our health and longevity.* London: Times Books
Raphael, D. (2004). *Social determinants of health: Canadian perspectives*. Toronto: Canadian Scholar Press.
Rootman, Dupere, Pederson, and O'Neill. Eds. (2012). *Health promotion in Canada.* Toronto: Canadian Scholatr Press.
Tesh, S. (1988). *Hidden arguments: Political ideology and disease prevention policy.* New Brunswick, NJ: Rutgers,
Tulchinsky, T., & Varavikova, E. (2014). *The new public health: An Introduction for the 21st Century* London: Academic Press.
Wilkinson, R. (1996). *Unhealthy societies: the afflictions of inequality*. London4, Routledge.
Systems thinking/Systems science
Capra, F. (1996). *The web of life.* New York: Doubleday
Capra, F. and P. Luigi Luis (2014). *The systems view of life: A unifying vision*. New York: Cambridge University Press
Meadows, D. (2008). *Thinking in Systems: A Primer*. White River Junction, VT: Chelsea Green Publishing Co.
Midgley, G. (Ed.). (2003). *Systems Thinking: An introduction and overview* (Vol. Volume I: General Systems Theory, Cybernetics and Complexity). London: SAGE
Jackson, M. (2003). *Systems thinking: Creative holism for managers*. West Sussex, John Wiley.
Lima, M. (2011). *Visual complexity: Mapping patterns of information*. New York: Princeton Architectural Press
Quinn Patton, M. (2011). *Developmental evaluation*. New York: Guilford Press
Quinn Patton, M. (1990). *Qualitative evaluation and research methods*. Newbury Park: Sage Publications
Richardson, G. (1999). *Feedback thought in social science and systems theory*. Waltham: Pegasus Communications Inc.
Senge, P. (2006). *The fifth discipline: The art and practice of learning organizations*. London: Random House

Once my research questions were crystallised, I set up systematic processes to continually receive updates of journal articles pertinent to my research. Flinders University library staff advised that the Scopus database would be the most useful because of its comprehensiveness (i.e. it includes most other relevant databases), therefore I set up alerts that provided me with new articles on a regular basis. The search terms are indicated in Table 2.2 below and the cross referencing of the terms 'health promotion' and 'public health' with a host of terms from policy through to systems science worked well to keep up to date with the literature.

Table 2.2   Search terms used for Scopus Alerts

Search terms used for Scopus alerts	
Health promotion	policy, practice, services, leadership, evidence, public policy, government
Public health	policy, health policy, politics, political will, power, ideology, economics, economic policy, political economy, neoliberalism, health system, intersectoral, multisectoral, healthy settings, systems thinking, systems science, systems theory, complexity, complexity theory, complex adaptive systems, complex systems science, critical systems theory, critical theory, systems dynamics, feedback mechanisms

I did not rely solely on these alerts because I was eager to discover older articles that I might have missed in my initial search strategy. Therefore, after reviewing articles obtained through the alerts I scanned the reference section of each article for further potential literature to inform my research. This proved to be an effective process as some articles were not identified through the initial search strategy and also because it identified important grey literature (e.g. World Health Organization documents). All references were saved to an Endnote library and categorised into groups.

2.2   Conceptualisations of health

I begin with a discussion of the contested nature of the term 'health' because this defined the focus of my research and exerted a cascade-like effect on all other topics and themes. Conceptualisations of health shape the ways in which health is acted upon. For example, if health is deemed to be mostly an individual matter then this positions actions to improve health in a more biomedical or clinical model. If health is conceptualised more in terms of a collective understanding then this positions action toward a social model.

Different conceptualisations of health are apparent throughout history. From ancient Greece to 5th and 6th century B.C., health was identified as one of the highest goods and considered to be present when conditions were in perfect balance (Sigerist, 1996). The preservation of health was a consistent theme in early writings as was the acknowledgement that class (i.e. those who had slaves and those who were slaves) had much to do with living a life that would produce health (i.e. being able to choose and being economically independent) (Sigerist, 1996).

There are numerous and varied present-day understandings of health. Blaxter (2010) wrote about "how deeply embedded ideas about health are, and how many perspectives may be brought to bear" (p2) and Baum (2016) devoted a chapter in her textbook to discuss the many ways in which health is understood by academics, professionals, as well as lay people. Table 2.3 summarises key perspectives regarding conceptualisations of health.

Table 2.3   Key perspectives regarding conceptualisations of health [Adapted from Baum (2016) and Blaxter (2010)]

Perspective on health	Description
1. Health is the absence of disease or illness.	The biomedical perspective focuses on the human body as a machine and its functioning parts and most attention is paid to diagnosing disease and treating illness and little attention to the context of human life. If there is no disease or illness then health is implied.
2. Health is based upon individual behaviour.	This perspective relates to individual lifestyle choices and related risk factors that may influence health and disease and concepts of self-control and willpower are associated with this perspective.
3. Health is based upon functionality, energy or a reserve, and sense of wellbeing.	Being able to recover from illness, doing the things one wants to do, and feeling well are key elements of this perspective.
4. Health is a sense of belonging and/or contributing to community.	Having good relationships with others and being a part of community are fundamental to this perspective.
5. Health is a function of social and economic factors.	This perspective is based upon the distribution of health in populations and the structural factors that influence health and uncovers health inequities.
6. Health is located in settings and is linked to social, economic and physical factors in one's environment.	This perspective focuses on place as a determinant of health, where cities, schools and workplaces are examples of settings that influence health. Further to this, ecohealth is a term that explicitly links human health to the health of the world's ecosystem.

These six perspectives illustrate how health can span from a narrow biomedical interpretation, that is, the absence of disease and illness in individuals, through to one that embraces health as a function of human interaction with social, economic and physical environmental factors embedded in various settings.

It is important to discuss Aboriginal people's perspectives of health in order to further illustrate that there are many ways to conceptualise health. The National Aboriginal and Torres Strait Islander Health Council of Australia (2003) stated that health is not only comprised of the physical well-being of an individual, but also includes the social, emotional and cultural well-being of the whole community where each individual is able to achieve their full potential. This whole-of-life view of health can be equated with at least the fourth perspective in Table 2.3. The Australian Aboriginal conceptualisation of health is further described in terms of "a strong commitment to a more holistic, extended identity involving

nature, society, knowledge, values and spirituality as inseparable aspects of one world, and identity as a oneness of being" (Morgan, Slade, & Morgan, 1997, p. 600).

Bopp and Bopp (2001) described the medicine wheel as an archetype thought to be common among many Indigenous peoples around the world. Their conceptual model is illustrated in Figure 2.1 where the circle is demonstrative of the whole, signifying that everything is connected to everything. This is congruent with a fundamental concept in systems thinking that is "concerned with the interrelationships between parts and their relationships to a functioning whole, often understood within the context of an even greater whole. It is ancient in origin and familiar to us all, but it is also something very modern" (Trochim, Cabrera, Milstein, Gallagher, & Leischow, 2006, p. 539).

Figure 2.1   Medicine wheel conceptualization of health (Bopp and Bopp, 2001)
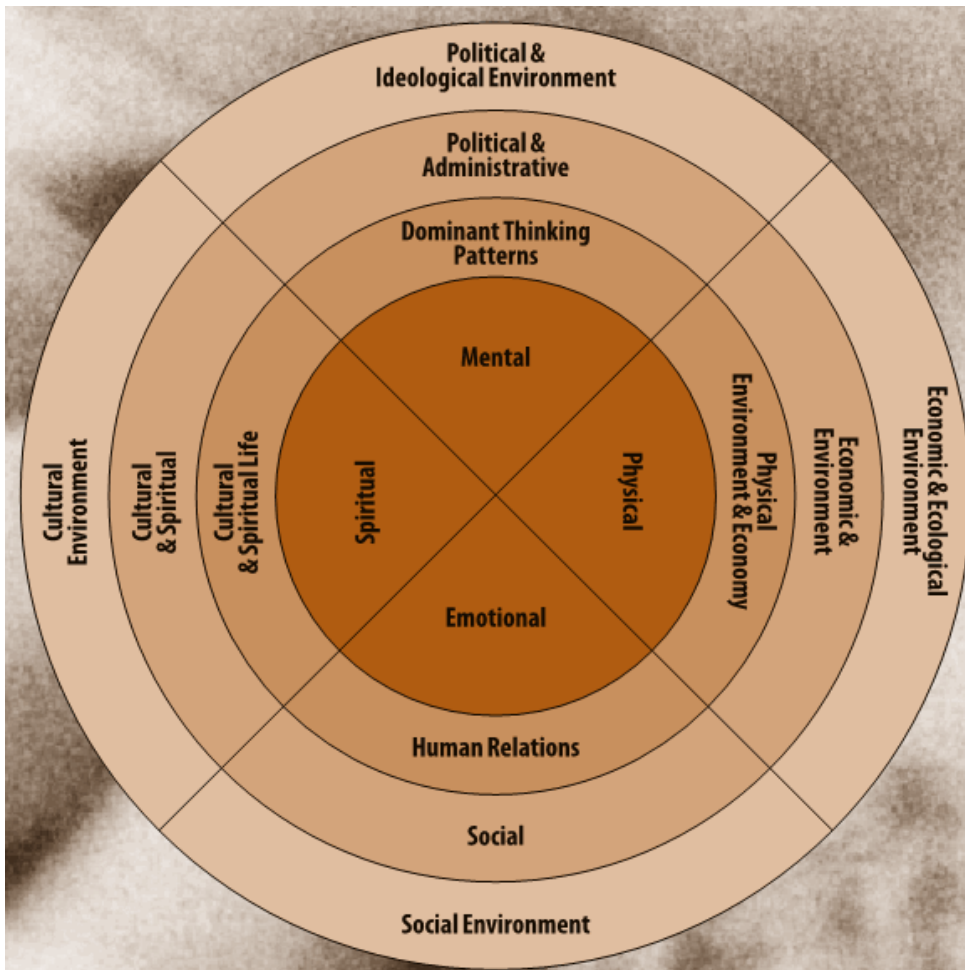
The World Health Organization's (WHO) oft cited definition of health is "complete physical, mental and social well-being not just the absence of disease" (World Health Organization, 1948, p. 1) and can be seen as a positive and aspirational view of health. However, it is contested as critics have pointed out that this definition shapes thinking about health and action on health in particular ways. For example, Huber and colleagues (2011) described the WHO definition as counterproductive because it entrenched the medical model of health, that is, the need to eliminate all disease and illness thus leading to dependency on such aspects of the medical system like technology and pharmaceuticals. They also pointed out that non-communicable diseases and living with chronic disease were pressing issues in health care (as opposed to the more dominant focus on acute care and communicable diseases when the WHO definition was created) and suggested that for this reason complete physical, mental and social well-being is neither attainable, practical, operational, nor measurable.

The meaning of the term 'social wellbeing' in the WHO definition has also been critiqued as there appears to be no consensus regarding the definition and furthermore, it can be a vague concept (Larson, 1999). At the centre of the social domain of health and wellbeing are the interactions and relationships associated with human networks (Labonte & Laverack, 2008) and although social wellbeing may be complicated, there is a rich literature which supports its inclusion into any definition of health (as discussed below).

The aspirational quality of the WHO definition of health is embedded in the *Ottawa Charter for Health Promotion* definition and it conveys movement toward not only enhancing personal but also social resources and capacities to change and cope to meet needs. Health is

> … the extent to which an individual or group is able to realize aspirations and satisfy needs, and to change or cope with the environment. Health is a resource for everyday life, not the objective of living. Health is a positive concept emphasizing social and personal resources, as well as physical capacities (World Health Organization, 1986).

This conceptualisation of health links personal and social resources in that "social-biologic interrelations" are central and where social environments (e.g. social resources) directly impact individual biologic functioning (e.g. personal resources) (Diez Roux, 2007, p. 571). Examining the way health is defined is important because it triggers how health issues are framed and shapes responses to issues. Each perspective drives different decisions or actions and this is fundamental to my research. For example, Tesh (1988) used the example of how

cancer is framed. On one hand, cancer can be seen as being caused by cigarette smoking (narrow focus on individual behaviour), or on the other hand, caused by tobacco (broader focus that includes corporate factors that influence the social, economic and physical environments).

Conceptualisations that favour health as a function of social and economic factors would support public policies, such as those that identify how the political economy shapes health, and point to political and economic structures that need to be modified in order to improve population health (Raphael, 2011b). Thus, the framing of health issues can influence policies and practices in quite different directions. In my research I adopted a multidimensional and explicitly social view of health and examined how conceptualisations of health appear to influence HP policy and practice. I discuss further the rationale for selecting this approach in the following section.

However, before moving on it is important to highlight the contributions of people such as Hancock (1993) in examining the interrelationships between health, economy, environment and community. In Figure 2.2 below health is dependent upon

> … a system of economic activity that enhances human development while being environmentally and socially sustainable; the term 'social sustainability' is included to make the point that economic activity must not only preserve the environment, it must also preserve and indeed enhance the social systems and strengthen the social resources of a community" (Hancock, 1993, p.43).

Figure 2.2   A model of health and the community eco-system (Hancock, 1993)

This conceptualisation of health is consistent with that in Figure 2.1 and is based upon a systems view, but more clearly illustrates qualities that are desirable for health such as:

- convivial, liveable and equitable communities,
- liveable, viable and sustainable physical environments; and
- equitable, adequately prosperous and sustainable economies.

2.3   Social determinants of health

A social view of health is the foundation for my research and is supported by a large literature regarding social, economic, political and environmental factors that influence health (Baum, 2016; Tulchinsky & Varavikova, 2014). In this section I discuss selected literature and historical developments since the 19th century that have defined and advanced social conceptualisations of health.

I start with Rudolf Virchow, a physician in 19th century Prussia, who made famous the statement "Medicine is a social science and politics is nothing else but medicine on a large scale" (Virchow in Ashton, 2006). Virchow's study of typhus epidemics led him to determine that inequalities in incidence were associated with hunger, famine, lack of education, poverty, and political oppression and he called for political reforms and legislation to address the social and economic causes of disease in a report to the Upper Silesian government (Mackenbach, 2009; Reilly & McKee, 2012). Following on Virchow's contribution, Emile Durkheim was another important 19th century pioneer because of his study of suicide, not in terms of the individual act but in terms of the lack of social integration that formed patterns of suicide in populations (Berkman, Glass, Brissette, & Seeman, 2000; Wilkinson, 1996). Both Virchow and Durkheim illuminated important social, economic and political influences on health.

Raphael (2004) recounted the work of another pioneer, Freiderich Engels (1820-1895). Engels correlated death rates with living and working conditions of workers in Manchester, England and was instrumental in linking deleterious conditions of housing, streets, clothing,

diet, stress, the nature of work to illness, injury and health threatening behaviours (e.g., high alcohol consumption as a coping mechanism). Engels' descriptions were distinctly focused on the political economy: "the industrial greatness of England can be maintained only through the barbarous treatment of the operatives, the destruction of their health, the social, the physical and mental decay of whole generations" (Engels in Tesh, 1988, p.73). The studies discussed above provide critical insights into how population health is integrally linked to social, economic, environmental and political factors.

More recent literature includes Fuch's (1974) study of the decline of infant mortality in New York in the early 1900s where he reported that medical care played "almost no role in this decline" (p.32) and that enhanced living standards such as increased education levels were found to be of greater influence. Illich (1926-2002) and McKeown (1912-1988) were also influential in challenging a predominant focus on medical care as the means to improve population health. Illich (1976) is noted for his forceful statements on the negative effects of the medicalisation of society. McKeown's (1976) enduring thesis is that improved living standards, particularly nutrition, not medical practices, were largely responsible for the decline of mortality prior to the mid-20th century (Colgrove, 2002; Scott-Samuel, 2003). Szreter (1988, 1995) agreed with McKeown's basic thesis, however, he argued further that improvements to health were largely due to actions taken by government health authorities, local governments and public health movements not simply the invisible hand of economic growth and prosperity. These more recent studies built upon earlier work and provided clear support for a social view of health.

However, it was Rose's (1985) studies of population health that consolidated understanding that population health is different from the sum of individuals' health. His main thesis was that a "large number of people at a small risk may give rise to more cases of disease than the small number who are at high risk" (Rose, 1985, p. 37), therefore implying that whole population approaches are needed as opposed to a singular focus on high risk individuals in order to improve health outcomes. His approach would shift the health of the entire population regardless of the risk distribution and is widely cited in public health research in terms of the critical population-level factors that influence health (Schwartz & Diez-Roux, 2001).

While Rose's work was an important contribution, Frohlich and Potvin (2008) critiqued the whole population approach because it had the potential to increase health inequalities due to variation in risk distribution. This was particularly the case with respect to vulnerable populations. They differentiated 'vulnerable populations' from 'populations at risk' because they are a subgroup who are more likely to be at risk due to shared social characteristics. In other words, vulnerable populations have higher risk exposure (i.e. higher concentration of risk and higher number of risk factors) because of shared social characteristics (e.g. Aboriginal descent, low socioeconomic position) and importantly these are experienced throughout their life course. A life course approach takes into account the synthesis of knowledge that demonstrates not only the powerful cumulative effect that poor social circumstances during gestation, childhood, adolescence, and young adulthood have on adult health, but also demonstrates critical biological and social pathways (Kuh, Ben-Shlomo, Lynch, Hallqvist, & Power, 2003). Frohlich and Potvin's (2008) contribution is important to the study of the SDH because of their thesis that efforts to reduce health inequalities need to be directed at vulnerable groups in concert with population approaches.

A review of the social determinants of health (SDH) literature would not be adequate without discussion of the work of Marmot et al (1991). They are renowned for investigating the inverse social gradient in morbidity and mortality. Their Whitehall studies of British civil servants found that male civil servants from each rung down the occupational hierarchy had higher rates of death. Further studies explained the gradient in terms of imbalances between control and demands in work and home life, varying participation in social networks, and the extent of social capital present at the community level (Marmot, 2006). These findings drive home the point that there are population effects with respect to the SDH that go far beyond the effects of individual agency. Marmot was also the Chair of the Commission on Social Determinants of Health (CSDH, 2008) and this work advanced understanding of SDH and particularly the notion of health equity, that is, the "unequal distribution of health-damaging experiences is not in any sense a natural phenomenon but is the result of a toxic combination of poor social policies and programmes, unfair economic arrangements, and bad politics" (p.1). Thus, a key point from the CSDH (2008) was that SDH are "structural determinants and conditions of daily life" (p.1) and their unfair distribution is responsible for health inequities. The work of the CSDH (2008) is discussed further below.

I have selected some key literature that is particularly salient to demonstrate the long history of ideas and findings that current SDH and health inequities studies build upon. So far in this section I have discussed social, economic and environmental factors that have been found to influence health and health inequality, including living and work conditions, education levels, social integration, social capital, and social structure and position. I have noted that examining health at a population level highlights inequalities and inequities and establishes the importance of social conceptualisations of health and how they may shape responses. A biomedical understanding of health is likely to lead to policies and practices that focus on individuals and a social view of health directs attention to the 'causes of the causes' or the structural determinants of health (CSDH, 2008).

There are a multitude of frameworks that have been created all over the world to aid in understanding and taking action on the SDH. The Canadian Council on the Social Determinants of Health (2015) undertook a review of frameworks and found 36 unique approaches to "raising awareness of the determinants of health, improving our understanding of complex problems, and supporting innovative planning and policy development to advance action on the determinants" (p.27). It is beyond the scope of this thesis to discuss all of these models, but it is instructive to highlight two of the most influential in order to continue to expand the discussion of the SDH. Among the frameworks highlighted were Dahlgreen and Whitehead's (1991) model shown in Figure 2.3. This "widely known and widely used" (Canadian Council on the Social Determinants of Health, 2015, p.17) model is useful because of its attention to explaining specific influences from micro through to macro levels.

Figure 2.3   Wider Determinants of Health Model (Dahlgreen & Whitehead, 1991)
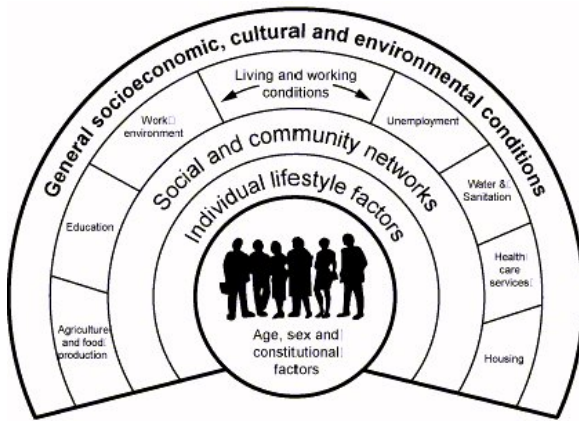
However, the Dahlgreen and Whitehead (1991) model, like many others, does not explicitly draw attention to strengthening health equity and the political determinants of health as in the Commission on Social Determinants of Health (CSDH) (2008) framework in Figure 2.4.

Figure 2.4   Conceptual framework of the CSDH (2008)
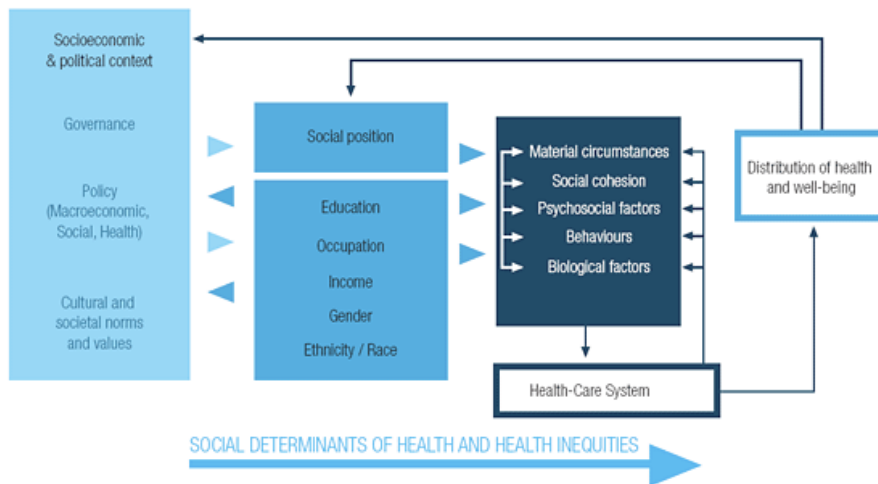
Source: Amended from Solar & Irwin, 2007

The CSDH was established by the World Health Organization "to collect, collate, and synthesize global evidence on the social determinants of health and their impact on health inequity, and to make recommendations for action to address that inequity" (CSDH, 2008, p.i). This framework directs attention to the socioeconomic and political context (governance, policy and cultural and societal norms and values) and their effect on the distribution of health and wellbeing. The framework also points to areas that are amenable to change: "from structural conditions of society to the daily living conditions in which people grow, live and work from global to local, across government and inclusive of all stakeholders from civil society and the private sector" (CSDH, 2008, p.43). Kickbusch (2012) argued for the need to strengthen conceptualisations of social health to include the political determinants of health, or rather the inequitable distribution of power, money and resources as reported by the CSDH (2008). This is a good example of examining systems because of the deliberate attention to the many influential levels (global to local) and sectors (government, civil society and private sector) and their impact on health.

The political context was a key factor in the SDH literature and therefore my research attended to the political context or how economic and social resources were organised and distributed in society. This has been described as a political economy perspective (Raphael, 2004) and this perspective asserts that power dynamics are central, or in other words, "resources are allocated not on the basis of relative merit or efficiency but on the basis on power" (Minkler, 2005, p. 7). Further to this, class, race and gender are critical issues in any analysis of power (Raphael, 2004). In their research on fundamental causes of disease, Link and Phelan (1995) related that variables such as race and gender were linked to access to resources which included power, money, prestige and knowledge, and therefore health inequalities are rooted not only in social and economic forces, but also political forces. Thus, power dynamics are rooted in systemic structures of society that create differences in health in population groups where:

> [g]ender differences that arise from patriarchal norms or discrimination, class
> differences that arise from inequalities in wealth, power, and ownership/control of
> capital; and geographic differences that arise from higher exposures to risk or less
> access to remediable care or preventive resources" (Labonte & Laverack , 2008, p.8).

So far in this section I have reviewed key literature regarding the SDH and highlighted the importance of political context as a key factor that influences health and I discuss politics further in terms of a HP challenge below. I now turn to discuss key conclusions from the vast literature on the SDH. These are important for my research in terms of examining the extent to which HP policy and practice address these conclusions.

Firstly, SDH are thought to contribute upwards of fifty percent to population health status in comparison to twenty-five percent for health care, fifteen percent for biology and genetics, and ten percent attributed to physical environment (Marmot & Allen, 2014; The Standing Senate Committee on Social Affairs Science and Technology, 2007). Although there are different configurations, estimations in the literature all point to the overwhelming consensus that social, economic and physical environments have significant effects on population health and therefore should be prominent in HP policy and practice.

Secondly, the widening gap in health inequalities is a trend within and among countries around the world. There is abundant evidence of this (Baum, 2016; Commonwealth of Australia, 2011; CSDH, 2008; Frohlich, Ross, & Richmond, 2006; Marmot & Allen, 2014; World Health Organisation, 2010) and perhaps the most striking example is with respect to the health of Indigenous peoples. For example, "it has long been clear that the health of Aboriginal and Torres Strait Islander Australians, on average, is worse than that of other Australians" (Australian Institute of Health and Welfare, 2014b, p. vii). Life expectancy at birth is approximately 10 years lower for Aboriginal and Torres Strait Islander peoples than for other Australians and Aboriginal and Torres Strait Islander peoples have higher rates of major health conditions such as diabetes, heart disease and kidney disease. The gap in health inequality has been linked to Aboriginal and Torres Strait Islander Australians being more likely to be unemployed, have lower levels of household income and wealth, be lone parents and, on average, live in neighbourhoods which are more disadvantaged (Australian Institute of Health and Welfare, 2014b). Furthermore, Aboriginal and Torres Islander peoples report experiences of racism and discrimination that negatively affect their health (Paradies & Cunningham, 2009; Ziersch, Gallaher, Baum, & Bentley, 2011). There is some evidence to suggest that reductions in smoking rates and improvements in maternal and childhood health may be contributing to decreased death rates in the Australian states of Queensland and the Northern Territory, however, this does not appear to be the case in South Australia, New

South Wales or Victoria (Holland, 2014).

Finally, the distribution of the SDH produces health inequities, that is, those that are avoidable and unfair and therefore reducing health inequities can be thought of as a moral responsibility (Marmot & Allen, 2014). The CSDH (2008) provides a compelling synthesis regarding health inequity where

> … the poor health of the poor, the social gradient in health within countries, and the marked health inequities between countries are caused by the unequal distribution of power, income, goods and services, globally and nationally, the consequent unfairness in the immediate, visible circumstances of people's lives (p.1).

Additionally, Oxfam International (2014) reported that "extreme economic inequality has exploded across the world in the last 30 years, making it one of the biggest economic, social and political challenges of our time" (p.6) and this is a driver of health inequities at the global, national and subnational levels. Addressing the 'causes of the causes' or the structures of society such as extreme economic inequalities is fundamental to reducing health inequity. The CSDH conceptual framework (Figure 2.3 above) is helpful to illustrate health inequity in terms of the structural drivers (i.e. socioeconomic and political context, governance, policy, and cultural and societal norms and values) that are mediated through intermediary determinants (i.e. social position and education, occupation, income, gender and ethnicity/race). These intermediary determinants can lead to inequity via differential exposure (e.g. to influences linked to social stratification), differential vulnerability (i.e. to health-compromising conditions and therefore poor health), and differential consequences (e.g. having a health condition and little access to health services) (Jackson, Birn, Fawcett, Poland, & Schultz, 2013).

These three conclusions (SDH contribute approximately fifty percent to health status; there is a widening gap in health inequalities; and the unfair distribution of SDH produces health inequities) sum up the importance of taking a social view of health and they lead to three "ways of conceiving of and describing health inequalities: targeting disadvantaged groups, closing gaps, or addressing the gradient" (Mantoura & Morrison, 2016). Each way of considering health inequalities leads to different policy and practice implications:

It is possible, for example, to adopt policies aimed at improving the daily living conditions of children from economically disadvantaged backgrounds by, for example, instituting school-based breakfast programs, while at the same time having broader, structural policies which influence the social determinants of health inequalities in such a way that inequality increases in a society. An example of the latter would be social welfare policies which tend to worsen or entrench poverty. (Mantoura & Morrison, 2016, p4).

2.4   Health promotion

In the section above, I discussed a selected literature on the SDH in order to set my research in the context of a social view of health. The SDH literature reviewed supported the discourse of a 'new public health' that focuses on "what produces health in modern societies" (Rootman & O'Neill, 2012, p. 23). Despite the rise of the new public health, the strategies to promote health remain a contested field. For example, Baum (2016) reported that

[t]he past 30 years have seen a continuous tension between approaches to health promotion and public health that emphasise the agency of individuals and try to change their behaviours directly, and those … which pay more attention to the need to create supportive environments and make healthy choices the easy choices. In the 1970s and early 1980s behaviour paradigms reigned supreme but the lack of success, especially in producing equitable outcomes, meant the new public health evolved (p.479).

In this section I examine key international documents that have emerged alongside and built upon the new public health and SDH literature and have advanced thinking about HP. The World Health Organization (1998) defined HP in terms of social and political processes and that it is not only

… directed at strengthening the skills and capabilities of individuals, but also action directed towards changing social, environmental and economic conditions so as to alleviate their impact on public and individual health. Health promotion is the process of enabling people to increase control over the determinants of health and thereby improve their health. Participation is essential to sustain health promotion action. (no page)

Threaded throughout the international documents is the overarching goal of reducing health inequity and three cross cutting actions (reorienting health services toward HP, ensuring community participation in HP, and developing partnerships and intersectoral collaboration for HP) and I discuss these along with three HP strategies (developing personal skills, creating supportive environments, and building healthy public policy) in the following section. Together these form one way of conceptualising HP that is based upon the *Ottawa Charter for Health Promotion* (World Health Organization, 1986).

Following this, I discuss 'healthy settings' approaches as they are not only advocated for in international documents and HP literature but are salient to my research. My research is set in a regional context that is geographically and organisationally defined and includes multiple sectors with a stake in HP. The promotion of health "requires the action of many other social and economic sectors in addition to the health sector" (World Health Organization, 1978) because many sectors contribute to the distribution of the determinants of health. The final section deals with key challenges found in the HP literature and they are power, politics and ideology; leadership and governance; and evidence of HP effectiveness.

2.4.1 International conceptualisations of health promotion

There are three international documents that provide a strong foundation for HP and I discuss these in detail because of their particular historical significance. The first, *A new perspective on the health of Canadians* (Lalonde, 1974) (also called the Lalonde Report), was one of the first documents in the world that introduced the 'health field concept', that is, health as a product of not only human biology, lifestyle, and health care, but also of environments. The Lalonde Report called for policy makers to explicitly consider a greater social responsibility for health. The document spoke to not only multiple dimensions of health but also to how various systems such as schools, environmental protection, and recreation affect health. However, the report has been criticised for not strongly linking personal with social responsibility because personal responsibility continued to be at the forefront of HP through the emphasis on the role of individuals in 'moderating self-imposed risk'. Hancock (1986) stated that this emphasis led to potential victim blaming approaches, and furthermore, Frohlich and Potvin (2008) indicated that these approaches did nothing to support initiatives

to eliminate the cycle of new populations that emerge with the same risk. Although the focus on individual risk has had limiting, stigmatising and judgmental tendencies that have endured in HP (Petersen & Lupton, 1996), the Lalonde Report provided "a signpost pointing the way at the start of a journey" (Hancock, 1986, p.100) toward a social view of health.

Following the Lalonde Report, the *Declaration of Alma Ata* (World Health Organization, 1978) was another important document for HP in that it built upon the call for greater social responsibility for health by asserting the values of social justice and health as a human right. Protecting and promoting health were seen to be integral to primary health care where addressing health inequalities, coordinating intersectoral action, and ensuring that "people have the right and duty to participate individually and collectively in the planning and implementation of their health care" were emphasised. From the *Declaration of Alma Ata* the concept of comprehensive primary health care was established in which HP was seen as an integral service alongside curative and rehabilitative services in meeting health needs.

The *Ottawa Charter for Health Promotion* (World Health Organization, 1986) built upon the *Declaration of Alma Ata* and continues to be an important touchstone particularly with respect to its widely held definition of HP: "the process of enabling people to increase control over, and to improve, their health". The charter advocates for a comprehensive definition of health (including political, economic, social, cultural, environmental, behavioural and biological factors) with action directed to enabling health equity and mediating intersectoral and community efforts. The themes of intersectoral action and community participation to reduce health inequity addressed the shortcomings of the Lalonde Report described above. The five actions or strategies contained in the charter continue to guide HP and they are: 1) build health public policy, 2) create supportive environments, 3) strengthen community action, 4) develop personal skills, and 5) reorient health services. The Ottawa Charter endures because of its clear ecological approach that calls for multiple actions and strategies to address reducing health inequities through action on the determinants of health at different levels (Green & Kreuter, 1991; Green, Richard, & Potvin, 1996; McLeroy, Bibeau, Steckler, & Glanz, 1988; Minkler, 1999; Richards, Potvin, & Mansi, 1998; Wallerstein, Mendes, Minkler, & Akerman, 2011). Furthermore, the ecological approach as advanced in the charter has direct theoretical links with systems thinking (McLaren & Hawe, 2005).

The three documents discussed above provide critical and foundational directions for HP, however, there are numerous subsequent World Health Organization documents that continued to set out parameters for HP and these are summarised in Table 2.4. The documents offer expanded discussion of goals, actions and strategies for HP and these are discussed in the next section.

Table 2.4   Summary of post-*Ottawa Charter for Health Promotion* World Health Organization documents

Document	Summary
Adelaide Recommendations on Healthy Public Policy (1988)	Focuses on one Ottawa Charter strategy – building healthy public policy – and is seen as critical to establishing environments that make the other four strategies possible. The call for linking social, economic and health policies (from local to international) to reduce health inequities and thus increase intersectoral action is particularly notable.
Sundsvall Statement on Supportive Environments for Health (1991)	Creating supportive environments formed the focal point and core recommendations were founded upon the belief that social, political, and economic dimensions of health need be mediated through building alliances and coordinated through strengthening community action.
Jakarta Declaration on Leading Health Promotion into the 21st Century (1997)	Greater social responsibility for health through policies and practices such as protecting the environment, restricting trade in harmful products, and undertaking health equity impact assessments. It states that comprehensive approaches, i.e. the implementation of multiple strategies and multiple levels were more effective than "single track approaches" and also recommends settings approaches (e.g. city, municipality, school, workplaces). Recommendations included increased investment and strengthened infrastructure for health promotion.
Mexico Ministerial Statement for the Promotion of Health (2000)	Issued a rallying cry for bridging the equity gap though increasing responsibility for health at all levels of society, specifically with respect to such areas as planning at local, regional, national and international levels that incorporate HP.
Belfast Declaration for Healthy Cities: The power of local action (2003)	Key actions were: reduce inequalities and address poverty through local assessment and regular reporting; plan health development at the city level which includes sustaining strategic partnerships for health; ensure good governance and create inclusion for citizen participation; safe and supportive cities through healthy urban planning practices; and utilising health impact assessment in all sectors to support health and well-being.
The Bangkok Charter for Health Promotion in a Globalized World (2005)	Although the Ottawa Charter strategies were affirmed, the focus shifted to the role of globalisation (specifically with respect to the widening inequalities within and between countries, patterns of consumption, and changes in the global environment and urbanisation) and commitments to such areas as government responsibility and good corporate practices.
Closing the gap in a generation (CSDH, 2008)	Actions to reduce health inequity were recommended: improve the conditions of daily life; tackle the inequitable distribution of power, money and resources; and measure the problem, evaluate action, expand the knowledge base, develop the workforce, and raise public awareness about the SDH.
Adelaide Statement on Health in all Policies(World Health Organization & Government of South Australia, 2010)	Concentrated on the need to engage multisectoral policy makers in setting health as an overarching objective. Multisectoral action was seen as necessary because the causes or determinants of health are most often outside the purview of the health system.
Rio Political Declaration on Social Determinants of Health (2011)	Focus on political will to achieve social and health equity through action on the SDH via comprehensive intersectoral approach. Five key action areas include: adopt better governance for health and development; participation in policymaking and implementation; further reorient health services; strengthen global governance; and monitor progress and accountability.
The Helsinki statement on Health in all Policies (2013)	Recognition that governments have a responsibility for health and that equity is a form of social justice. Policies in all sectors can have a profound effect on population health. Health in all policies is an approach that takes into account the impact on health in public policies and seeks to avoid harmful health impacts at all levels of policy making. It is a practical response to powerful economic interests that resist regulation.

2.4.2 Key goals, actions and strategies of health promotion

The rich HP history described above through the successive World Health Organization documents offers an increasingly "more complex picture of health and health promotion" (Norman, 2009, p. 870) and provides critical insights into goals, actions and strategies that form the basis for desired HP policies and practice. Table 2.5 provides a framework for studying HP that includes: the goal of reducing health inequities; three actions; and three strategies discussed in the literature.

Table 2.5   Framework for studying health promotion (goal, actions and strategies)

HP goal (why)
Reduce health inequities through action on the broad social, structural, economic, political, environmental and behavioral determinants of health

HP Actions (how)	HP strategies (what)
Reorient health services toward HP	Develop personal skills
Develop partnerships and intersectoral collaboration for HP	Create supportive environments
	Build healthy public policy
Ensure community participation in HP	

Threaded throughout the SDH literature and international documents identified above is the clear goal of reducing health inequity through action on the broad social, structural, economic, political, environmental and behavioural determinants of health. The *Ottawa Charter* called for HP to be focused "on achieving equity in health … reducing differences in current health status and ensuring equal opportunities and resources to enable all people to achieve their fullest health potential" (World Health Organization, 1986) and the *Jakarta Declaration* (World Health Organization, 1997) emphasised that HP is "a practical approach to achieving greater equity in

health". Reducing health inequities was the focus of the CSDH (2008) report and therefore this can be considered to be an overarching goal in a framework for studying HP policy and practice (Table 2.5).

Three HP actions were also threaded throughout the international documents reviewed above. Reorienting health services toward HP, developing partnerships and intersectoral collaboration, and ensuring community participation can be regarded as the fundamental processes through which HP strategies need to be planned, implemented and evaluated. For me, these actions address the question as to 'how' to take action on reducing health inequities. Ja
ckson et al (2007) used a similar framework based upon key international documents to sort HP actions and strategies and the three actions are defined and described in Table 2.6.

Table 2.6   Definitions and descriptions of three health promotion actions (reorienting health services; developing partnerships and intersectoral collaboration; and ensuring community participation)

HP Actions	Definitions and descriptions from key international documents
Reorient health services toward HP	*Declaration of Alma Ata* (World Health organization, 1978): Primary health care must include promotive and preventive services alongside curative services.
	Ottawa Charter (World Health Organization, 1986): "The role of the health sector must move increasingly in a health promotion direction, beyond its responsibility for providing clinical and curative services … and open channels between the health sector and broader social, political, economic and physical environmental components" (no page).
	Health Promotion Glossary (World Health Organization, 1998): "Health services re-orientation is characterized by a more explicit concern for the achievement of population health outcomes in the ways in which the health system is organized and funded" (p.18).
Develop partnerships and intersectoral collaboration	*Ottawa Charter* (World Health Organization, 1986): "Health promotion demands coordinated action by all concerned: by governments, by health and other social and economic sectors, by nongovernmental and voluntary organization, by local authorities, by industry and by the media" (no page).
	Sundsvall Statement (World Health Organization, 1991): "This call for action is directed towards policy-makers and decision-makers in all relevant sectors and at all levels. Advocates and activists for health, environment and social justice are

	urged to form a broad alliance towards the common goal of Health for All" (no page).
	Health Promotion Glossary (World Health Organization, 1998): "A partnership for health promotion is a voluntary agreement between two or more partners to work cooperatively towards a set of shared health outcomes. Such partnerships may form a part of intersectoral collaboration for health, or be based on alliances for health promotion. Such partnerships may be limited by the pursuit of a clearly defined goal – such as the successful development and introduction of legislation; or may be on-going, covering a broad range of issues and initiatives" (p.17).
	Health Promotion Glossary (World Health Organization, 1998): "A major goal in intersectoral action is to achieve greater awareness of the health consequences of policy decisions and organizational practice in different sectors, and through this, movement in the direction of healthy public policy and practice" (p. 15).
	Rio political declaration (World Health Organization, 2011) "health equity is a shared responsibility and requires the engagement of all sectors of government, of all segments of society, and of all members of the international community" (p.1).
Ensure community participation in HP	*Ottawa Charter* (World Health Organization, 1986): "Health promotion works through concrete and effective community action in setting priorities, making decisions, planning strategies and implementing them to achieve better health. At the heart of this process is the empowerment of communities – their ownership and control of their own endeavours and destinies" (no page).
	Sundsvall Statement (World Health Organization, 1991): "A call for the creation of supportive environments is a practical proposal for public health action at the local level, with a focus on settings for health that allow for broad community involvement and control" (no page).
	Health Promotion Glossary (World Health Organization, 1998): "A distinction is made between individual and community empowerment. Individual empowerment refers primarily to the individuals' ability to make decisions and have control over their personal life. Community empowerment involves individuals acting collectively to gain greater influence and control over the determinants of health and the quality of life in their community, and is an important goal in community action for health" (p.6).
	Belfast Declaration (World Health Organization, 2003): "Good governance and creating inclusion for citizen participation is critical" (p.1).
	Adelaide Statement on Health in All Policies (World Health Organization & Government of South Australia, 2010): Community action is central to the fostering of healthy public policy.

In terms of reorienting health services toward HP, I discuss this in detail later in this chapter in relation to the HP challenge of leadership and governance. I focus on the 'health governance' challenges of HP, that is, the challenge of governance for HP within the health sector. Similarly, developing partnerships and intersectoral collaboration for HP is also described in the section below regarding the HP challenge of leadership and governance, but this time with respect to 'governance for health'.

Ensuring community participation in HP is tied to evidence showing that "successful engagement of target communities in decisions about how to address social determinants of health will increase the likelihood of policies and actions being appropriate, acceptable and effective" (Blas, et al., 2008, p. 1686). There are a number of complexities that need to be discussed with respect to community participation and one has to do with levels or typologies of participation. A widely cited conceptualisation of participation is Arnstein's (1969) ladder that identifies increasing levels of control and power at each step up the ladder (Figure 2.5).

Figure 2.5   Arnstein's (1969) ladder of citizen participation
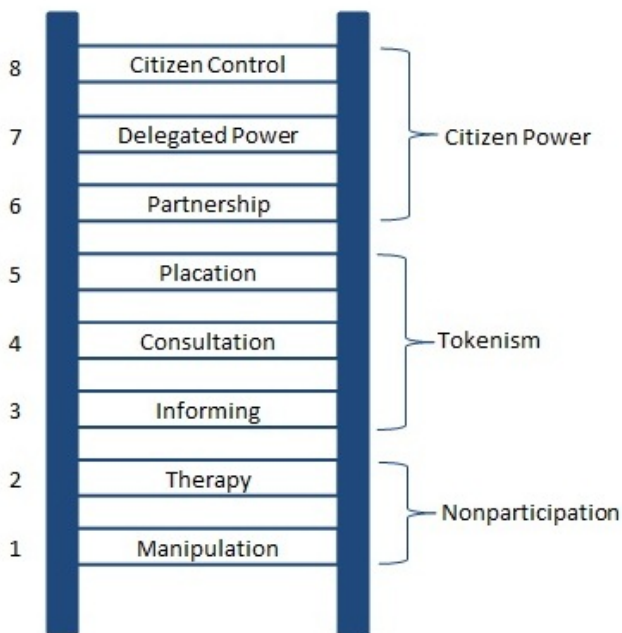
Arnstein's ladder in Figure 2.5 indicates manipulation and therapy as the first two steps and these are considered nonparticipation. The next three steps up the ladder are: informing, consulting and placating, and these are judged to be degrees of tokenism. The top three steps are described in terms of degrees of citizen power and included partnerships, delegated power, and citizen control. Labonte (1992) described a similar continuum, including personal empowerment at one end, followed by small group development, community organisation, coalition advocacy, through to political action at the other.

There are more examples of such continuums in the literature, however, Cornwall (2008) suggested that regardless of the model there are three questions that need to be asked. First: who participates? This question points to the need to define the community and this can include geographical associations, people who share common interests, or perhaps people at risk of ill health (Rifkin, 1986). The second question is: participation in what? For Cornwall (2008) this question attended to the need to identify what decisions are needed and at what level of participation. However, this is a narrow interpretation of participation and does not seem to address building community capacity. Smith, Baugh Littlejohns and Thompson (2001) linked building community capacity to the Ottawa Charter of strengthening community action, discussing this as not only a means to an end (as in an intervention or program), but an end or outcome unto itself (as in community empowerment). In other words, " the social relations created by building capacity, such as trusting and caring relationships, sense of purpose, sense of control over individual and community life, are health enhancing in their own right" (Smith, et al., 2001, p. 37). Thus, the question regarding 'participation in what' is much more complex and requires broad consideration in terms of an end and/or a means.

The third and final question is: to what extent does power lay with the community? A good example was offered by Labonte (2005) who noted that in 'community-based' programs the power to define the health problem and develop strategies commonly lies with health professionals (e.g. physical activity and heart health promotion), whereas in 'community-developed' programs the power to identify priority determinants of the community's health and to plan and implement strategies lay with community members (e.g. healthy communities). Thus,

decisions about empowerment and participation are inextricably linked to HP. Overall, the logic of ensuring community participation in HP as an "intermediary step to create the conditions for a healthy society" (South & Phillips, 2014, p. 692) has been widely reported in international documents and HP literature. However, there are continued calls for more participatory research in order to clarify definitions and theoretical frameworks, establish links to health outcomes, examine balance of power, and further report on facilitators and challenges to the social process of community participation (George, Mehra, Scott, & Sriram, 2015).

Further to Table 2.5, three HP strategies (develop personal skills, create supportive environments, and build healthy public policy) form the remaining components of a framework to study HP and for me, these clarify key ways to follow through on reducing health inequities. These are clearly Ottawa Charter strategies, however, threads of discussion about these run through many international documents and Table 2.7 provides definitions and descriptions of these three strategies.

Table 2.7   Definitions and descriptions of three health promotion strategies (developing personal skills, creating supportive environments, and building healthy public policy).

HP strategies	Definitions and descriptions of HP strategies from World Health Organization documents
Develop personal skills	*Ottawa Charter* (1986): "Health promotion supports personal and social development through providing information, education for health, and enhancing life skills. By so doing, it increases the options available to people to exercise more control over their own health and over their environments, and to make choices conducive to health". *Health Promotion Glossary* (1998): "Individual lifestyles, characterized by identifiable patterns of behaviour, can have a profound effect on an individual's health and on the health of others. If health is to be improved by enabling individuals to change their lifestyles, action must be directed not only at the individual but also at the social and living conditions which interact to produce and maintain these patterns of behavior".

Create supportive environments	*Ottawa Charter* (1986): "The inextricable links between people and their environment constitutes the basis for a socioecological approach to health. The overall guiding principle for the world, nations, regions and communities alike, is the need to encourage reciprocal maintenance – to take care of each other, our communities and our natural environment".
	Sundsvall Statement (1991): "In a health context the term supportive environments refers to both the physical and the social aspects of our surroundings. It encompasses where people live, their local community, their home, where they work and play. It also embraces the framework which determines access to resources for living, and opportunities for empowerment. Thus action to create supportive environments has many dimensions: physical, social, spiritual, economic and political".
Building healthy public policy	*Ottawa Charter* (1986): "Health promotion goes beyond health care. It puts health on the agenda of policy makers in all sectors and at all levels, directing them to be aware of the health consequences of their decisions and to accept their responsibilities for health".
	Adelaide Recommendations on building healthy public policy (1988): "Healthy public policy is characterized by an explicit concern for health and equity in all areas of policy and by an accountability for health impact. The main aim of health public policy is to create a supportive environment to enable people to lead healthy lives".
	*Helsinki Statement (*2013): "Health in All Policies is an approach to public policies across sectors that systematically takes into account the health implications of decisions, seeks synergies, and avoids harmful health impacts in order to improve population health and health equity".

From Tables 2.6 and 2.7, the common threads that emanate from the *Ottawa Charter* appear to have withstood the passage of time as their relevance has not diminished in subsequent documents. One reason reported for this is the "compelling logic" of the *Ottawa Charter* (Nutbeam, 2008, p. 440). Catford (2011) called the charter "the fulcrum or tipping point" (p. 166) for HP, and although de Leeuw (2011) stated that the charter still provides "profound inspiration",

> [t]here needs to be continuing vigilant commitment to empowerment, community engagement and political action; the need remains to strengthen and validate the role of advocacy, mediation and enabling; and the health promotion community needs to train and maintain a key eye for windows of opportunity for these strategic parameters (p.158).

In the next section I discuss how the HP goal, actions and strategies identified above are embedded in HP literature with respect to healthy setting approaches.

2.4.3 Healthy settings approaches to health promotion

Healthy settings approaches to HP can be described as influencing action on "the places or social contexts in which people engage in daily activities, in which environmental, organizational, and personal factors interact to affect health and well-being" (Nutbeam & Kickbusch, 1998, p. 19). Settings approaches are clearly articulated in the 'Healthy Places – Healthy People' chapter of the CSDH (2008) report and the sweeping array of topics covered attests to the importance of these approaches to reducing health inequities. Topics covered included urbanisation, governance, shelter/housing, air quality and environmental degradation, urban planning, diet and physical activity, violence and crime, land rights, rural livelihoods, infrastructure and service, migration, and natural environments.

This approach to HP is relevant because the setting for my research is a regional setting in SA that is geographically and organisationally defined and the bounded health system includes multiple sectors and levels of government (discussed in detail in Chapter 3: Research Design and Chapter 4: Description of the case). Local governments are significant components in the regional health system and there is a rich literature regarding the Healthy Cities approach to improving population health.

The Healthy Cities movement can be traced to the 19th century where people like Edwin Chadwick in England lead a Health of Towns Association to address the role of local government in ensuring the health of populations (Hancock, 1993). The idea of Healthy Cities grew and evolved as a settings approach to HP with a clear connection to the *Ottawa Charter* (World Health Organization, 1986). Healthy cities approaches address actions including developing partnerships and intersectoral collaboration as well as ensuing community participation in decision-making (Baum, 2008b; Baum & Cooke, 1992; Hancock, 1993). Health outcomes have improved through healthy cities approaches where intersectoral collaboration

(e.g. through the development of communities of practice among multisectoral stakeholders) and community participation (e.g. ensuring vulnerable populations are engaged) are employed (Rydin, et al., 2012). In addition to a rich history rooted in HP, healthy cities approaches are linked to systems thinking. Glouberman et al (2003) theorised this in the following terms: a) cities are complex systems and therefore studying their complexity characteristics are called for, and b) the complexity of population health calls for the study of interactions among the many determinants of health and at numerous levels. Healthy settings approaches (e.g. healthy cities/communities, healthy schools) are characterised not only in terms of ecological models where health is conceived as a function of interactions and interdependencies of various levels (e.g. from local to global), but also linked with systems thinking (discussed below) and to whole systems where there is top down commitment (i.e. intersectoral collaboration) and bottom up engagement (i.e., community participation) for HP (Dooris, 2006).

Furthermore, Rydin (2012) suggested that a Healthy Cities approach would benefit from "a complexity analysis to understand the many overlapping relations affecting urban health outcomes" (p. 3), or in other words, this type of analysis would address a lack of research that gives explicit consideration to different levels and the interconnections across levels. Dooris (2006) drew attention to the need to further develop qualitative methods to map the synergistic patterns of relationships in HP policy and practice and this recommendation accords with those of Rydin et al (2012). These recommendations were useful for my research as I addressed this gap in the literature and explored patterns of interdependencies and reciprocal relationships across levels and elements that influenced HP policy and practice in one regional health system that included cities. The healthy settings literature informed my research through the importance placed on the context for HP, community participation, levels of government and sectors for partnership development and intersectoral collaboration, and systems thinking through thick descriptions of key interactions.

Another important literature regarding healthy settings approaches is about joined-up government and/or whole-of-government and/or Health in All Policies approaches and these approaches are based upon "social structural policy change in settings" (Jackson, et al., 2013, p.

468). The roots of Health in All Policies were firmly planted in the international documents discussed above. For example, the *Alma Ata Declaration* (1978) calls for intersectoral action, the *Ottawa Charter* (1986) includes the strategy of building healthy public policies, and notably the *Adelaide Recommendations on Healthy Public Policy* (1988), *Adelaide Statement on Health in all Policies* (2010) and the *Helsinki Statement on Health in All Policies* (2013) develop this approach further. The links between developing partnerships and intersectoral collaboration (HP action in Tables 2.6 and 2.7) and building healthy public policy (HP strategy in Tables 2.6 and 2.8) are clear. Further, the development of these approaches can also be linked to systems thinking where:

> [h]ealth is an exemplar of the interconnected policy-making required in the 21st century, not only because of the need to address the health determinants but also because it is clearly a so-called 'wicked problem'. This term is applied to problems that are difficult or impossible to solve because of incomplete, contradictory and changing requirements. Moreover, because of complex interdependencies, the effort to solve one aspect of a wicked problem may reveal or create other problems (Government of South Australia, 2010b).

The significant role of the Government of South Australia in furthering the Health in All Policies approach worldwide was important to my research because this was likely to be a key factor that influenced the direction of HP in my study. The approach is described as follows:

> Health in All Policies (HiAP) … is about promoting healthy public policy. It is a way of working across government to encourage all sectors to consider the health impacts of their policies and practices, and at the same time it examines the contribution that a healthier population can make towards achieving the goals of other sectors. The SA HiAP approach can contribute to the achievement of cross sector goals through applying a 'health lens' to broader policy and strategy considerations (Government of South Australia, 2011e, p. 4).

Government of South Australia (2010b, 2011e) documents highlight that Health in All Policies is a process that facilitates the shared goal of reducing health inequity by addressing priority determinants of health across government. It is through the systematic integration of assessing health impacts in the policy development process which is thought to bring to light the benefits of improved population health to other government sectors. Lawless et al (2012) evaluated the early South Australian experience with Health in All Policies and concluded that the process

increased understanding in policy makers of the impact of their work on health equity, changed policy direction, increased policy-relevant research, and produced stronger partnerships between health and other government departments.

2.4.4   Key challenges to health promotion

In this section, I describe key challenges for HP identified in the literature in order to articulate what is known regarding factors that influence HP policy and practice. The challenges I discuss are politics, power and ideology; leadership and governance; and the lack of evidence of HP effectiveness.

2.4.4.1   Politics, power and ideology

Health inequity can be defined as "the unequal distribution of power, income, goods, and services, globally and nationally, the consequent unfairness in the immediate, visible circumstances of people's lives" (CSDH, 2008, p.1) and importantly, inequity is not considered a natural occurrence, but the result of bad politics, policies, practices and unfair economic structures. However, as Hawe (2009) stated, this view has been criticised by some policy makers as "ideology with evidence attached" and this is an obvious challenge to HP. In order to unpack this challenge and set my research on sturdy ground, I first review the literature regarding the relationship between political ideology and health outcomes and then discuss how this influences HP.

Navarro and Shi (2001) built upon the work of people such as Durkheim (1858-1917) who contributed greatly to study of the relationship between social dynamics and health (Berkman, et al., 2000) and more contemporary research conducted by Wilkinson (1996) who contributed to the study of the inverse relationship between social and income inequalities and health outcomes. They specifically studied political parties in power in capitalist countries from 1945 to 1980 and found that parties had different track records in terms of redistributive policies. These policies

were linked in terms of their impact on income, social inequalities and health indicators such as infant mortality. Countries with dominant Social Democratic parties (and labour movements) were found to have better records in terms of redistributive policies and health outcomes than countries with Liberal traditions.

Further to this, Coburn (2004) reported that the causes of income inequalities (not just the consequences) and the link to health inequalities could be traced to the socio-political-economic trends of neoliberalism. He summarised neoliberal ideology as the philosophy and policies that focus on individualism, personal responsibility, and market-driven solutions as opposed to government-driven interventions. Countries that had dominant neoliberal policies were found to have increased income and social inequalities and poverty than countries with more social democratic policies (Coburn, 2004). With respect to post-war Australian political history and health inequity, the federal political parties in power have been mostly Liberal Democratic in orientation, however, there has been a convergence in Australian politics where political parties (Labor and Liberal-Nationals) share similar economic and social policies (Baum, 2008b). Progressive reforms by each federal political party in Australia in areas such as economic rationalism, managerialism, trade unions (weakening), privatisation and deregulation have increased health inequality and inequity even though overall health status has improved (Baum, 2016). Thus, while neoliberal political ideology and policies appear to be incongruent with a social view of health and health equity goals they dominate many Anglo-Saxon cultures including Australia (Navarro, 2007).

Baum et al (2009) pointed out that "the dominant contemporary political discourse of market individualism, with its culture of opportunity over entitlement and its disavowal of the distributive role of the state" (p. 1969) makes it unsurprising that the health care and other sectors do not support HP approaches that address the SDH in Australia. Studies have shown that HP policy and practice often reflect the current political ideology of neoliberalism and perhaps reinforce it (Schrecker, 2013a). For example, Ayo (2012) claimed that reinforcing individualism or a personal responsibility for health is one way to shift burden away from government responsibility to individual accountability, increase the commodification and corporatisation of

health where citizens are consumers. Therefore societal issues such as unemployment and poor housing become a matter of moral failure. Thus, HP policy and practice is very challenging politically because neoliberal ideology strongly favours an individual approach as opposed to a social justice approach (Labonte, 1998).

In Australia, Baum et al (2013) reported on former Health Ministers' perspectives on HP and found confirming evidence that ideology matters and the "age of neoliberalism" did not support social responsibility with respect to redistributive policies, but did support individual responsibility and lifestyle-behavioural approaches to HP. Thus, political ideology and the power inherent in political contexts shape HP profoundly (Baum, 2016; Labonte, 1994; Tesh, 1988) and there are calls for initiatives to expose the incongruence between neoliberal ideology and the goal of reducing health inequities (Schrecker, 2013b).

To sum up this section, Raphael (2014) described politics as 'power' in terms of "the process through which desired outcomes are achieved in the production, distribution and use of resources in all areas of social life" (p. 6). On the other hand, he describes politics as 'government' largely in terms of the differences in "the amount of public and social spending expenditures on citizens across the life span" (p. 7). He related that politics, both as power and as government, intersect with HP where people working in HP must go further than improving the distribution of SDH "through individual interactions, community work, and developing public policy recommendations that may be ignored" to "building social and political movements that can shift the distribution of influence and power" (p. 12).

2.4.4.2   Leadership and governance

From the above discussion of politics, power and ideology, it is not surprising that there is a growing call for strengthened leadership and governance for HP. Leadership and governance for HP can be seen as a two sided coin: the need for 'health governance' on one side and 'governance for health' on the other. Although the terms have been used interchangeably there

appears to be greater clarity in recent literature (Kickbusch & Gleicher, 2014). Carey, Crammond and Keast (2014) provide a helpful distinction in that they depict 'health policy' as being concerned with the health sector and public health policy (leadership and health governance) and 'healthy public policy' as being concerned with whole-of-government approaches (leadership and governance for health). Both call for vertical (i.e., federal, state, and local governments) and horizontal (i.e., across the broadly defined health system and within government) governance structures.

As discussed above the *Ottawa Charter* (1986) identified reorienting health services as a key HP action and this is a useful linkage to understanding 'health governance' for HP. Wise and Nutbeam (2007a) stated that "there is little evidence to suggest systemic integration of health promotion strategies and principles in the health sector" (p. 24) and Ziglio, Simpson, and Tsouros (2011) affirmed the importance of this action and suggested that there is a lack of leadership to actively advocate for greater integration of population health into the health sector.

One reason for this is the focus on the provision of health care services and not on the social, economic and environmental factors that influence health and this effectively crowds out HP and prevention efforts (Bambra, Fox, & Scott-Samuel, 2005; Baum, 2008a; Bishai, Paina, Li, Peters, & Hyder, 2014; Marmot & Allen, 2014). Power dynamics were particularly noted by Green and Raeburn (1990) and by Baum et al (2013) in that the acute care sector (primarily the medical profession) wields enormous power in decision-making and voices in other areas of the health sector have far less power. Powerful health care interests are firmly entrenched in health sectors in countries like Australia and resource allocation follows these interests (Baum, 2008b; Duckett & Willcox, 2011). Therefore, there is often little room within health sectors to provide leadership in reducing health inequities through action on the SDH.

Further to this, it has been reported that HP often succumbs to 'lifestyle drift' (Popay, Whitehead, & Hunter, 2010), where health sector policies may include statements indicating the importance of action on the SDH, however, they do not translate into practice. HP practice falls back to individual lifestyle or behavioural approaches (Baum, 2011; Baum & Fisher, 2014;

Bryant, Raphael, Schrecker, & Labonte, 2011; Popay, et al., 2010) and the HP strategy of developing personal skills (as in Table 2.8). HP practice remains focused on reducing risk factors such as smoking cessation, healthy eating and physical activity and where individual responsibility for making healthy choices rules (Baum & Fisher, 2014). This is not necessarily the fault of HP professionals as they are often forbidden to lead advocacy and must work on politically acceptable lifestyle programs even though policies speak to health inequities and SDH (Hawe, 2009).

Additionally, the lack of health sector reorientation and the persistent focus on health care can hinder partnership development and intersectoral action which is foundational to addressing health inequity through building healthy public policy (Marmot & Allen, 2014). There is ample literature that suggests that the health sector must lead efforts to reduce health inequity by first, ensuring equitable access to health services, second, providing services that reduce health inequity caused by the SDH, and third, increasing intersectoral action to address SDH (Public Health Agency of Canada & World Health Organization, 2007; World Health Organization & Government of South Australia, 2010). These are clear roles for leadership and health governance.

In terms of the 'health governance' role of steering other sectors toward HP, Kickbusch and Gleicher (2014) summed up the challenge in terms of working "in partnership with other sectors to advance governance for health, which means jointly exploring policy innovation, novel mechanisms and instruments, and better regulatory frameworks" (p. 155) to reduce health inequities. Key capacities for health governance for HP were described in terms of leadership that is outward-oriented, cultivates champions, and provides the workforce with the bureaucratic structure, mandate, knowledge, skill, and resources to take a systems approach (Kickbusch & Gleicher, 2014).

While the health sector needs to play a leadership or at the least, a stewardship role in HP, it is acknowledged that most actions on the SDH must come from other sectors (CSDH, 2008). Thus, 'governance for health' through partnership development and intersectoral collaboration has

been identified as a challenge. A health system can be defined as consisting of "all organizations, people and actions whose primary intent is to promote, restore or maintain health. This includes efforts to influence determinants of health as well as more direct health-improving activities" (World Health Organization, 2007, p. 2). From this definition, a health system is much more than the delivery of clinical and/or curative services and 'governance for health' is concerned with shared leadership to improve health.

Kickbusch and Gleicher (2012) defined 'governance for health' as "the joint actions of health and non-health sectors, of public and private sectors and of citizens for a common interest" (p. ix) and further reported that this requires alignment of policies coupled with effective collaborative structures and mechanisms. It then becomes clear that the health sector and governments must play a strong leadership role in governance for health (Kickbusch & Gleicher, 2014).

The positioning of the promotion of health and partnership development between governments, government departments (e.g., finance, agriculture, education, trade, and social services), the private sector, and civil society to develop and sustain policies, structures and mechanisms for collaboration is therefore vital. Strengthened 'governance for health' is called for in many international documents described above and the aim is for whole-of-government and whole-of-society approaches to health and wellbeing. The leadership and governance challenge for HP includes leading and governing through developing partnerships and intersectoral collaboration among many sectors, through ensuring community participation, and through the establishment of adaptive policies, resilient structures and foresight (Kickbusch & Gleicher, 2014).

2.4.4.3   *Evidence of health promotion effectiveness*

The third and final challenge that I discuss in this section is the perceived lack of evidence of effectiveness with respect to HP interventions. The pursuit of evidence-based HP policy and practice relies upon access to good quality information derived from population health research

and evaluation (Rychetnik & Wise, 2004). Nutbeam (2008) stated that a HP challenge was to continue "to build credible evidence that demonstrates effect" (p. 440). The evidence base for effective population health promotion strategies has been described as lacking (CSDH, 2008; Davies & Macdowall, 2006), "patchy" (Hawe & Potvin, 2009), "weak" (Bambra, et al., 2010; Shiell, 2011) and "very limited" (Lorenc, Petticrew, Welch, & Tugwell, 2013). Some key challenges to gaining acceptable evidence of effectiveness in HP interventions are described in Table 2.8.

Table 2.8   Some key challenges to gaining evidence of effectiveness in HP interventions

Challenge	Description
Challenges in HP interventions	Poor implementation of interventions (Hawe & Potvin, 2009) and/or interventions that do not aim to reduce risk exposure in populations (Potvin, 2012). While some interventions may improve population health they may also increase health inequalities, for example, those with lower risk may benefit more than those who with higher risk (Lorenc, et al., 2013).
Challenges to measuring outcomes	Limited quality data and benefits of population health interventions are delayed (Shiell, 2011; Willis, et al., 2014). The gold standard of evidence is randomised controlled trials and these are inappropriate for most population health interventions (CSDH, 2008; Susser, 1995). Poor research design and/or weak program theory, for example, there is limited quality data because studies are often too small (Hawe & Potvin, 2009; Shiell, 2011; Susser, 1995). There is a lack of evidence regarding effective policy and practice change processes (Best & Holmes, 2010) and specifically, the pathways of policy implementation that have impacts upon health inequality (Bambra, et al., 2010).
Challenges to using evidence	Contexts and/or settings of interventions are variable therefore transferability of findings is limited (Jolley, 2014). Evidence is mostly based upon descriptive and epidemiological studies therefore it is difficult to identify effective interventions (Bambra, et al., 2010).

Further to the challenges listed in Table 2.8, a main challenge to increasing evidence of HP effectiveness lay with the nature of the interventions themselves, for example, much of the HP research reports on individual behavioural approaches as opposed to socio-ecological approaches to reducing health inequity (Bambra, et al., 2010; Willis, Riley, Herbert, & Best, 2013). Jackson et al (2007) reported that

> [m]any reviews of health promotion effectiveness showed that developing personal skills (including the actions of health education, health communications and training and skills development) was an ineffective strategy if implemented in isolation from other strategies particularly with disadvantaged groups and community of low socio-economic status. (p. 78)

Even though some HP interventions indicate that ecological approaches are foundational there have been few examples in practice and research (Baum & Sanders, 2011; Bryant, et al., 2011; McLeroy, et al., 1988; Richard, Potvin, Kishchuk, Prlic, & Green, 1996). Mackenbach (2009) described the priority given to the individual level of analysis: "many epidemiologists prefer to study specific environmental exposures, health behaviours, biomedical characteristics and other 'proximal' causes of disease … because of the greater scientific certainty about the roles they play in disease aetiology" (p. 183). Thus, there is less certainty in explaining pathways to poor health as one moves upstream to study the 'causes of the causes' of poor health.

Contributing to this is the political nature of HP (as discussed above) that prevent ecological population health interventions from acquiring necessary resources and therefore this is a fundamental limitation to research opportunities (Willis, et al., 2014). Discussion of the political nature of HP links back to the need to be clear about the prevailing conceptualisations of health and HP and therefore of dominant ideology, values and principles. Raphael (2000) stated that "ideology, values and principles strongly influence what is accepted as valid evidence" (p. 361) of HP effectiveness and described ideological principles as "how things should be" and functional principles as "how best to bring about a moral end" (p. 363). The key point here is that if fundamental values and principles such as social justice, enabling participation and empowerment are critical outcomes, then these are arguably instrumental to determining evidence in HP. HP values and principles need to be more explicit in terms of identifying criteria of acceptable evidence (Rychetnik & Wise, 2004).

In sum, Li et al (2015) reported that the disagreements about the type of evidence to be used in HP go beyond concerns about political and social contexts to include "the need to reflect intervention complexity, employ a range of evaluation methods … incorporate lay knowledge, and evaluate implementation processes as well as outcomes" (p. 193). Compounding these concerns is the often fragmented nature of health systems for HP and this limits the ability to scale up, sustain, and/or institutionalise effective interventions (Shiell, 2011).

2.5   Systems thinking

In this section I turn to the growing literature that calls for systems thinking in HP. I first provide an overview of systems thinking and this is followed by a review of the literature regarding complex health systems and strengthening health systems. In the next section I focus on system thinking and HP and finally I discuss the use of feedback mechanisms as a gap in the literature regarding systems thinking and HP policy and practice.

2.5.1   Overview of systems thinking

Reflecting upon the prior sections of this chapter it is not hard to see that planning, implementing and evaluating HP policy and practice is riddled with "wicked" (Rittel & Webber, 1979) or complex problems that seem to be intractable and for which cause-effect problem-solving approaches do not point to adequate solutions (Best, 2011; Homer & Hirsch, 2006; Luke & Stamatakis, 2012; Marcus, Leischow, Mabry, & Clark, 2010; Norman, 2009). Cause-effect approaches are described as focused on components or reductionism and typified by "Newton's clockwork universe" where problems are broken down into smaller ones, analysed, and where solutions emerge from rational deduction (Plsek & Greenhalgh, 2001). Instead of this type of approach, there are calls for the use of systems thinking to explore dynamic interrelationships to strengthen HP interventions and health systems (Aslanyan, et al., 2010; Atun, 2012; Best, et al., 2003; Commonwealth of Australia, 2007; Green, 2006; Hawe, Shiell, & Riley, 2009; Kickbusch & Gleicher, 2012; Leischow & Milstein, 2006; Luke & Stamatakis, 2012; Sterman, 2006;

Trenholm & Ferlie, 2013). Although systems thinking has been applied to complex issues such as tobacco control (Borland, Young, Coghill, & Zhang, 2010; Marcus, et al., 2010), obesity (Finegood, 2011; Frood, Johnston, Matteson, & Finegood, 2013; Mabry & Bures, 2014; Vandenbroeck, Goossens, & Clemens, 2007) and strengthening health systems (Adam & de Savigny, 2012; de Savigny & Adam, 2009; Sturmberg, Martin, & Katerndahl, 2014), it is still considered to be early in its development.

Systems thinking (or sometimes called systems or complexity science) has been applied across many disciplines (Midgley, 2003) and there is little consensus in the literature as to correct terminology for the broad array of concepts (Axelrod & Cohen, 2000; Best, et al., 2003). Systems science has been called a "jungle of terminology" (Peters, 2014), however it can be traced to general systems theory as advanced by von Bertalanffy (1969). He advocated for the convergence in thinking about systems from fields as diverse as biology, mathematics and management and suggested that "there exist models, principles, and laws that apply to generalised systems or their subclasses, irrespective of their particular kind, the nature of their component elements, and the relations of forces between them" (von Bertalanffy, 2003, p. 37). Thus, general systems theory emerged in terms of explicating principles that would be generalisable to universal systems.

I studied systems thinking literature in several disciplines, but mostly looked to the public health, primary health and HP literature in order to present a more coherent understanding of the state of the field relevant to my research. I included literature from other disciplines when I felt that concepts were not presented clearly for my research. Within the public health and HP literature, systems, complexity and chaos theory are sometimes grouped under the rubric of systems science (Mabry & Kaplan, 2013; Mabry, Olster, Morgan, & Abrams, 2008) and in other cases the term 'systems thinking' was used. For my research, I use 'systems thinking' to describe the use of these concepts.

2.5.2 Systems thinking and complex health systems

There are common threads that run through the literature as to the characteristics that delineate a complex from a simple, complicated, or chaotic system (Snowden & Stanbridge, 2004; Van Beurden, Kia, Zask, Dietrich, & Rose, 2011). Health systems, defined as not only health care services but also the broad social systems that influence human health and wellbeing (Martin & Sturmberg, 2009), are widely considered complex because of certain characteristics (Atun, 2012; Begun, Zimmerman, & Dooley, 2003; Greenhalgh, Plsek, Wilson, Fraser, & Holt, 2010; Plsek & Greenhalgh, 2001; Plsek & Wilson, 2001; Pourbohloul & Lieny, 2011). In Table 2.9 I identify and describe three characteristics of complex health systems that appear consistently in the literature.

Table 2.9   Three characteristics of complex health systems

Characteristic	Description
Interactions	Heterogeneity: Complex health systems are comprised of a large number of nested and heterogeneous system elements.
	Interdependency: Complex health systems have numerous interdependent connections and reciprocal interactions among multiple levels and system elements and among proximal and distal variables that influence policy and practice.
Feedback	Complex health systems self-organise or adapt to their environment and this is influenced by the boundaries of the system, positive and negative feedback mechanisms and time delays.
Emergent order	Interactions and feedback mechanisms produce emergent properties of the whole health system.

Figure 2.6 below illustrates the relationship of these characteristics to each other and in the following sections I describe these in more detail.

Figure 2.6   Illustration of the relationship between three characteristics of complex systems (Maverick and Boutique, n.d.)
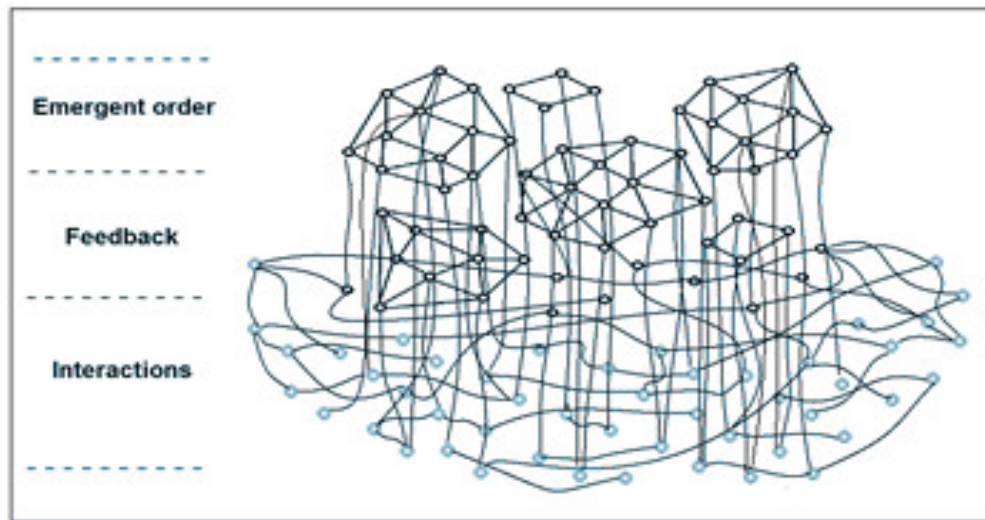
2.5.2.1   *Interactions*

Complex systems have a large number of nested and heterogeneous system elements that exhibit considerable variation and each element can be considered a system in their own right (Finegood, 2011; Hawe, et al., 2009; Keshavarz, Nutbeam, Rowling, & Khavarpour, 2010). Health systems are complex because they are comprised of numerous organisations, agencies and sectors at local, regional, state, national and international levels that vary in terms of their structure, function, and interests, where each organisation, agency and sector has a unique relationship to and influence on the whole health system (Leischow & Milstein, 2006).

Key to understanding complex health systems are the interactions and interdependence between system elements (organisations, agencies and sectors at multiple levels) and their relationships to and influence on the whole health of the system (Atun, 2012; Finegood, 2011; Shiell, Hawe, & Gold, 2008a). Systems thinking directs attention to not only the interdependencies but also the reciprocal interactions between system elements and the relationships that influence the behaviour of whole systems (Luke & Stamatakis, 2012; Trenholm & Ferlie, 2013; Trochim, et

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al., 2006). Nonlinear interactions are also characteristic of complex systems, that is, system behaviour is not guided by proportionality nor predictability (Best, 2011; Plsek & Greenhalgh, 2001). Shiell, Hawe and Gold (2008b) defined this, stating that the "change in outcome is not proportional to change in input" (p. 1281). For example, a change in health policy such as a large (small) allocation of resources toward health care reform or financial rewards can have little (large) effect in changing system behaviour.

In sum, health systems can be described in terms of the synergy of the numerous, interdependent, nonlinear interactions among multiple levels and system elements and the large number of proximal and distal variables which can influence policy and practice. Taken together these relationships can produce a picture of dense causal networks and it is the whole health system that is of interest in systems thinking.

2.5.2.2   Feedback

Complex systems are dynamic because of their continuous ability to change, adapt and reorganise to respond to their environment (Trochim, et al., 2006). Self-organisation is a term used to describe the adaptation of systems to their environment and adaption can result in stability or increased complexity and this broad concept is seen to have potential application in the study of how health systems organise, change and/or innovate (Best, 2011; Meadows, 2008; Rickles, Hawe, & Shiell, 2007). Factors that could influence self-organisation are:

- heterogeneity and interdependencies (e.g. the number, formality, and intensity of interactions between parts or elements in the health system),
- micro-level adaptation in one system element (e.g. local government) could give rise to meso- and macro-level change in the whole health system, and
- the ability to balance the maintenance of valued functions (e.g. water and air quality monitoring in public health) with innovation (e.g. whole-of-society approach to reducing health inequities) to harness transformational change in the whole health system (Trenholm & Ferlie, 2013; Trochim, et al., 2006).

There are three integral concepts concerning self-organisation: boundaries, feedback loops and time delays. Boundaries are the borders between complex health systems and their environments and these can often be indistinguishable or "fuzzy" (Plsek & Greenhalgh, 2001) and the key is to assess the extent to which a variable or element is endogenous or exogenous to the system. For example, drawing boundaries of a health system (i.e., delineation of system elements, stakeholders and variables) is necessary because this shapes or defines how one might study the self-organisation of the system (Finegood, 2011).

Feedback loops are the interconnections that can illustrate self-organisation in complex systems (Best, 2011; Luke & Stamatakis, 2012). Richardson (1999) stated that a feedback loop is

> … a circle of interactions, a closed loop of action and information. The patterns of behaviour of any two variables in such a closed loop are linked, each influencing, and in turn responding to, the behaviour of the other. Thus, the concept of the feedback loop is intimately linked with the concepts of interdependence and mutual or circular causality" (p.1).

The behaviour of complex systems are in large part the accumulative effect of positive (reinforcing or self-enhancing) and negative (balancing or goal seeking) feedback mechanisms based upon the flow of information (Homer & Hirsch, 2006; Meadows, 2008). Jackson (2003) stated that the branch of applied systems thinking called system dynamics "sees the key to system behaviour as lying in the inter-relationships between positive and negative feedback loops within which important system elements are bound" (p. 25). Time delays are characteristic of feedback loops and Senge (2006) related that "virtually all feedback processes have some form of delay … when the effect of one variable on another takes time" (p. 89). An example of feedback mechanism at work in public health is as follows:

> [I]f left unchecked the flu creates reinforcing feedback loops – the more people who catch the flu, the more they infect others. Balancing this feedback loop then would be the administration of flu shots. How effective this is depends on the strength of the balancing effort compared to the force it is trying to correct. If only a small number of individuals get flu shots, or if the shot itself has only a limited impact on whether individuals catch the flu, the power of its balancing effect will be too small in comparison to the force it is countering and the flu will continue to spread (Carey, et al., 2015, p. 8).

2.5.2.3   Emergent order

A final concept I discuss here is emergence and this is where interactions and feedback mechanisms produce emergent properties of the whole system (Checkland & Scholes, 1990). Emergent properties therefore cannot be inferred by the study of components and their interactions but through a study of relationships in the whole system (Rickles, et al., 2007). Factors that influence emergence include history and context, nonlinear interactions, and feedback loops (Sturmberg & Martin, 2013; Sturmberg, O'Halloran, & Martin, 2012). Popular examples of emergence are the fluctuations in the stock market, creation of termite mounds, and the flocking of birds. In health systems, one example of emergent order are the "patterns of communication between patients and providers and levels of trust among medical specialists" (McDaniel, Lanham, & Anderson, 2009, p. 194).

2.5.3   Systems thinking and health promotion

Systems thinking has been broadly described to be a good fit to study population health and socio-ecological approaches to HP (Best, 2011; CSDH, 2008; Kreiger, 2001; Mabry, et al., 2008; Ureda & Yates, 2005; World Health Organization, 1986). Systems thinking concepts are seen to help to conceptualise population health status as an emergent property of complex societal systems and can offer directions for policy and practice (Hertzman & Siddiqi, 2013; Jayasinghe, 2011). For example, Jayasinghe (2011) offered broad theoretical directions for HP that included the need for a) increased awareness of the different levels and scales of causal association among factors that influence population health status, b) multi-level, -sector and -strategy interventions, and c) networked (vs hierarchical) organisations that closely heed feedback loops through effective communication and decentralised decision making. These directions provide an example of applying systems thinking to population health promotion.

Systems thinking has been called for in the HP literature for many years (Green, 2006; Mabry & Bures, 2014; Mabry & Kaplan, 2013; National Cancer Institute, 2007; Nicholas & Gobble, 1991)

and recent literature appears to particularly focus on increasing understanding of how interventions take place in various settings, contexts and/or complex health systems (Mabry, Milstein, Abraido-Lanza, Livingood, & Allegrante, 2013). Hawe and colleagues (2009) drew attention to interventions as events in systems. They argued that the complexity of HP lies in large part in the complex systems within which interventions take place and furthermore, interventions can change the system because of the interactions unleashed between system elements. Increased awareness of settings, contexts and systems are important because of the increasingly complex system configurations in HP. For example, a consistent call in the literature is to implement multisectoral approaches to HP and therefore the increased number of system elements (e.g., government ministries, nongovernment organisations) and the horizontal (e.g., between various levels of government) and vertical (e.g., between various levels of government) governance environments characterise the complexity of HP (Aslanyan, et al., 2013).

2.5.4 Systems thinking and health system building blocks

The WHO produced several reports (de Savigny & Adam, 2009; World Health Organisation, 2007) focused on strengthening health systems and where health systems are described as consisting "of all organizations, people and actions whose primary intent is to promote, restore or maintain health" (World Health Organization , 2007, p.2). An integrated set of building blocks that identify key capacities needed for effective functioning were identified and these include: governance, information, service delivery, workforce, financing, and medicines and health products (de Savigny & Adam, 2009). Table 2.10 describes the first five building blocks and omits the sixth -- medicines and health products -- because this building block is not particularly relevant to the type of HP policy and practice based upon a social model that I described above. Even though service delivery is included I discuss this building block more in terms of HP practice based upon advocating for health equity, enabling supportive environments, and mediating among different interests in society. Thus, it is much more than delivering a service to individuals. It is noteworthy that two building blocks are related to two HP challenges I

discussed earlier: leadership and governance, and information (i.e., evidence of HP effectiveness in terms of health system performance).

Table 2.10   Five building blocks of health system structure (based upon de Savigny & Adam, 2009)

Building block	Description
Service delivery	Effective interventions that are provided to those in need, where and when needed with a minimal waste of resources.
Human Resources	Sufficient, efficient, responsive and fair workforce given available resources.
Information	Production, analysis and dissemination of reliable and timely information on health determinants, health status and health system performance.
Financing	Adequate funding for health in ways that ensure people can use needed services.
Governance	Leadership in effective oversight, system design, coalition building, and accountability through effective strategic policy frameworks, regulations and incentives.

The key to strengthening health systems using the framework of building blocks is systems thinking in that a) the relationships and interdependencies between the building blocks are what makes it a health system, and b) the synergies created between interacting building blocks are instrumental to achieving system goals (de Savigny & Adam, 2009). This approach is affirmed by other authors who call for systems thinking to study all the building blocks of a health system as opposed to focusing on one building block, such as studying changes to service delivery (Aslanyan, et al., 2013; Best, 2011; Mutale, Bond, et al., 2013; Swanson, et al., 2012; Willis, et al., 2014; Ziglio, et al., 2011).

2.5.5 Gaps in the literature regarding health promotion and system thinking

Through my review of the literature regarding systems thinking and HP I found a lack of research examining HP policy and practice in regional multisectoral health systems through the

lenses of the WHO building blocks and feedback mechanisms. To my knowledge there are no empirical studies to date using the WHO building blocks to study HP policy and practice, however, Mutale et al (2013) reported on using this framework in a qualitative study of a health care system in Zambia and found it useful for uncovering the interdependencies among building blocks. Therefore, this framework appeared to be useful for my research in order to study a regional multisectoral health system in terms of the interactions of building blocks and their relationship to HP policy and practice.

Furthermore, there were few studies that used feedback mechanisms to study HP policy and practice. For example, Tenbensel (2013) identified feedback loops as potentially helpful to highlight certain features that may receive less attention in other approaches and may help to build rich and nuanced stories of health policy. I found five examples of studies that applied feedback mechanisms to advance the study of systems thinking in health systems. Two focused on the health *care* system (Agyepong, et al., 2014; Paina, Bennett, Ssengooba, & Peters, 2014) and a third focused on the determinants of immunisation coverage (Varghese, Kutty, Paina, & Adam, 2014). Another study applied feedback mechanisms to a community-based social marketing innovation and found that this approach was useful to "explore insights such as identifying the components of a system; describing how the components are related through feedback mechanisms; and postulating where one could intervene" (Biroscak, et al., 2014, p. 261). Alvaro et al (2011) studied the "lopsided" emphasis of Canadian HP policies on individual lifestyle and behavioural approaches to HP and found that there were positive (or reinforcing) feedback loops that maintained a focus on individuals. They suggested that while this study was helpful to increase understanding of the complex policy environment it failed "to deliver in terms of how we might actually and substantially move government policies" (Alvaro et al, 2011, p. 97).

To address the gap in what Alvaro et al (2011) found above with respect to ways to move government policies toward HP based upon the goal, actions and strategies discussed above, studying feedback mechanisms as 'system leverage points' offered potential. Meadows (1999) is widely credited for bringing clarity to systems change processes through the identification of

twelve leverage points that included paradigms and goals (the greatest leverage but hardest to change), changing feedback (medium leverage), and changing system parameters such as guidelines and standards (the least effective but perhaps easiest to change). Malhi et al (2009) developed an intervention level framework based upon Meadows' (1999) work that included paradigms, goals, structure, feedback and delays, and structural elements and this is shown in Figure 2.7. They used this framework to sort qualitative data regarding actions to improve food systems and found that feedback and delays were addressed to the least extent.

Figure 2.7   Intervention level framework (Mahli et al, 2009)

Intervention Level Framework

- Paradigm
  - deepest held beliefs driving the system
- Goals
  - what the system is trying to achieve
- Structure
  - As a whole, eg enhancing connections across most of the system
- Feedback and delays
  - Self-regulation, self-reinforcement, adaptation
- Structural Elements
  - Subsystems, actors, and the physical structure of the system

(vertical axis labels: Effectiveness, Difficulty)
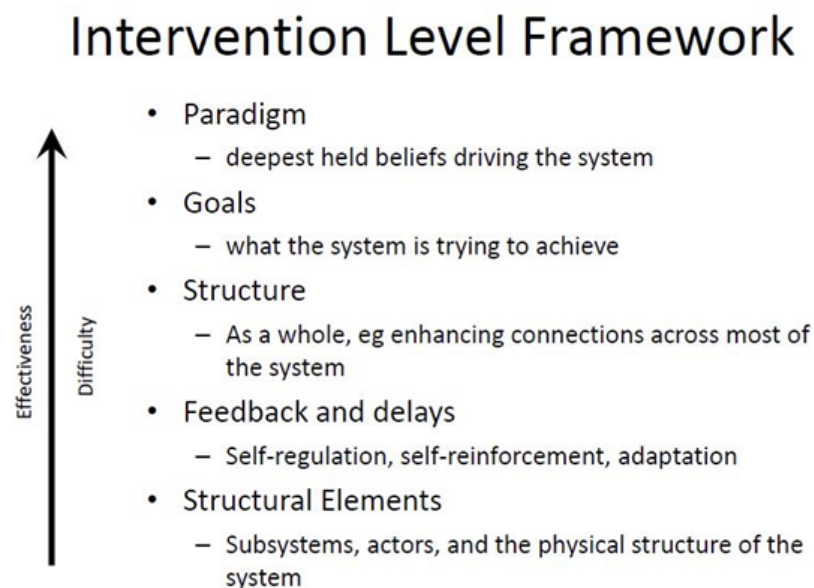
Johnston et al (2014) also used the framework in Figure 2.5 and they studied the extent to which recommendations in 12 policy documents addressed obesity in complex systems in terms of the various leverage points. They found that most documents addressed structural elements and to a lesser extent goals and system structure, and very little attention was paid to paradigms or feedback mechanisms. The framework was thought to be useful to examine "the paradigms and goals driving decision making, while also pushing one to think about which feedback mechanisms and connections across the system's structural elements might support

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[intervention] success" (Johnston et al, 2014, p. 1276). Interestingly, Carey and Crammond (2015) undertook a similar study, but this time in terms of recommendations contained in international documents. They found that

> [r]ecommendations that addressed feedback loops were common … Taking an example from the Marmot Review, the recommendation to provide support and advice to young people regarding training and employment opportunities will only create pathways into good employment if there are a) sufficient number of training placements and jobs are available and b) other structural barrier are minimised. Otherwise, the corrective force of this intervention will be too weak to counter the broader issues which mean young people do not take up training opportunities" (p. 8).

In sum, studying feedback mechanisms in health systems for HP are beginning to be reported in the HP literature and there appears to be potential in exploring the value of this in terms studying factors that influence HP policy and practice in a regional multisectoral health system.

2.6   Summary

In this chapter I have discussed salient literature with respect to a social conceptualisation of health and have provided a historical review of how the SDH have been discussed in the literature. These sections formed the foundation for my research which takes an explicit social view of health. I then discussed international conceptualisations of HP and these lead to identifying the goal of reducing health inequities, three HP actions (reorienting health services toward HP, developing partnerships and intersectoral collaboration, and ensuring community participation) and three HP strategies (developing personal skills, creating supportive environments, and building healthy public policy) that formed a framework to study HP. Here I demonstrated that the goal, actions and strategies had clear threads throughout international documents and key literature. I then described HP challenges of power, politics and ideology, leadership and governance, and evidence of HP effectiveness and made links to the HP goal, actions and strategies. In the final section I reviewed key literature with respect to system thinking, complex health systems, and HP and described the potential with respect to exploring and demonstrating how systems thinking, and particularly feedback mechanisms, may aid in

enhancing understanding of factors that influence HP policy and practice. In the following chapter I describe my research design which builds upon the literature reviewed in this chapter.

Chapter 3: Research Design

In the previous chapter I explored the literature from a number of fields to examine the state of the health promotion (HP) field in order to set my research in context. This included conceptualisations of health, social determinants of health, historical developments in HP, and concluded with increasing calls to use systems thinking to study HP policy, practice and research. My study seeks to contribute to the HP literature by examining key factors that influence HP policy and practice in a regional multisectoral health system in South Australia (SA) from a systems thinking perspective. The empirical aims are to first analyse relevant government documents to describe the historical policy context and second, to determine the perspectives of stakeholders in leadership roles in a regional health system regarding factors that influence HP policy and practice. The third aim is to explore feedback mechanisms that influenced HP policy and practice. The final aim is to offer conclusions and recommendations for HP policy and practice in SA, Australia and overseas. In this chapter I describe my research design to meet these aims and include discussion of philosophical foundations, methodology and methods.

Crotty (1998) identified four elements that need to be explicated in research design and these are epistemology, theoretical perspectives, methodology and methods. Epistemological and theoretical perspectives can be seen as overarching philosophical foundations for research (Creswell, 2003) and these are discussed in the next section. Methodology and methods, however, are treated as discrete aspects of research design and are discussed in the third and final sections of this chapter.

3.1   Philosophical foundations

Epistemology can be defined as "a way of understanding and explaining how we know what we know" (Crotty, 1998, p.3) or as Labonte and Robertson (1996) stated, it is the "assumptions about what we can know about reality" (p. 433). My research was guided by social

constructionism, that is, an epistemological stance where there is not one truth or one reality that can be arrived at objectively and this ontological view is shared by researchers who reject a dominant positivist assumption (Creswell, 2003; Crotty, 1998). My outlook was based upon people's meaning as determined by their encounters with the realities of their world and this leads to people having different meanings. This worldview grounded me in a social constructionist paradigm where "we do not construct our interpretations in isolation but against a backdrop of shared understandings, practices, language, and so forth" (Schwandt, 2000, p. 196). In Berger and Luckman's (1966) seminal work on the social construction of reality they argued that while people create personal meaning, it is the collective meaning created through social processes that sustains or institutionalises meaning. In my research, this translated into a lens for viewing socially constructed meanings of health, HP and the factors that shape HP policy and practice.

Lincoln, Lynham and Guba (2011) presented useful 'positions' to help describe the social constructionist approach. For example, they stated that the aim of inquiry is 'understanding' and that the foundation of knowledge is "the constructed meanings of actors" (p. 107). Creswell (2007) also stated that in terms of a social constructionist approach, participant views are the focus of inquiry. Thus, social constructionism forms a base for my research design where I seek to understand and describe patterns in how HP policy and practice is constructed or interpreted first in key government policies and second through stakeholder perspectives.

Alvesson and Skoldberg (2009) suggested that on the surface "most of us are social constructionists" (p. 34) because it is hard to argue against the fundamentals of societal influence on meaning. However, they further elaborated and questioned this by asking "How do we know, for example, that the individual is not secondary and that overarching structures are the primary constructors – or rather creators – of individuals in the first place?" (p. 36). This question was pivotal for me in clarifying my desire to not only understand and describe meaning but to have another lens to view and possibly explain the role of overarching structures that shape constructions of HP policy and practice. Crotty (1998) discussed this in terms of being

"suspicious of the constructed meanings that culture bequeaths us" (p. 59). Thus, I included a critical approach in my theoretical framework.

Patton (2002) offered a helpful way to conceptually bridge social constructionism and a critical approach, in that, "views of reality are socially constructed and culturally embedded, those views dominant at any time and place will serve the interests and perspectives of those who exercise the most power in a particular culture" (p. 100). In Chapter 2 I discussed power, politics and ideology as challenges to HP and incorporating a critical lens was therefore a good fit for my research. On one hand, social constructionism leant a frame for understanding and describing patterns of how HP is constructed or interpreted in policy and stakeholder perspectives. On the other hand, a critical approach offers a lens to possibly explain the role of powerful overarching structures, hierarchies, institutions, processes and practices that shape HP policy and practice.

3.2   Qualitative methodology

I adopted a qualitative methodology for this research and Denzin and Lincoln (2003) stated that "qualitative implies an emphasis on the qualities of entities and on processes and meanings that are not experimentally examined or measured" (p.13). They also asserted that qualitative research stresses "the socially constructed nature of reality, the intimate relationship between the researcher and what is studied, and the situational constraints that shape inquiry" (p. 13). This methodology linked well to the aims and philosophical foundations of my research that called for descriptions and explanations of *how* and *why* (Crotty, 1998). *What* questions can also be linked to a qualitative study (Hess-Biber & Leavy, 2011). My research focused on *what* factors and also on *how* and *why* these factors influence HP policy and practice. What, how and why questions lend themselves well to thick descriptions that are a hallmark of qualitative research (Patton, 2002).

3.2.1   Case study

I employed a case study approach for similar reasons as for a qualitative methodology because it was particularly appropriate for *how* and *why* research questions (Yin, 2003). Luck et al (2006) described a case study as "a detailed, intensive study of a particular contextual and bounded phenomena that is undertaken in real life situations" (p. 104). For my research a case study approach supported my research aims to study the phenomena of HP policy and practice and the case was a bounded regional health system, explicitly set and purposive (Stake, 2000).

To further delineate the methodology, my research followed an instrumental case study approach where

> [a] particular case is examined mainly to provide insight into an issue or to redraw a generalization. The case is of secondary interest, it plays a supportive role, and it facilitates our understanding of something else (Stake, 2005, p. 445).

Stake (2005) describes an instrumental case study in terms of it being an in-depth examination to increase understanding of an external interest. This type of case aligned with my desire to focus on an area of concern (HP policy and practice) via the case (Luck, et al., 2006).

My case study is an in-depth analysis of factors that influence HP policy and practice in a multisectoral health system in one region of SA and was therefore a single-case design. Yin (2003) discussed five rationales for designing a single case study: where the case describes 1) a critical case in terms of a testing a well-developed theory; 2) an extreme or unique case of a particular phenomenon; 3) a representative or typical case of a common circumstance; 4) a revelatory case that investigates a unique opportunity; and 5) a longitudinal case which investigates the same case over time. I located my single case study as a 'representative' case because all regions in SA are governed by the same state-wide HP policies, therefore, the state policy environment would be the same for all. It would be naïve to think that there would not be variation between regional health systems, particularly given the importance of settings approaches to HP that I discussed in Chapter 2. However, a single, representative, instrumental

case study was deemed to be the best fit because my focus of interest was on factors that influenced HP policy and practice and a regional multisectoral health system would facilitate understanding of this.

Flyvbjerg (2006) discussed limitations regarding the generalisability of single case studies and stated that "formal generalization is overvalued as a source of scientific development, whereas 'the force of example' is underestimated" (p. 228). The 'force of example' is in the high conceptual validity, the deep understanding gained from a context dependent and proximate view of reality provided by a single case study. Yin (2003) summarised the discussion by stating that case studies "are generalizable to theoretical propositions and not to populations or universes" (p. 10). In my research, an in-depth , representative, and instrumental case study of one case demonstrated high conceptual validity in order to build greater understanding about key factors that influence HP policy and practice.

3.2.1.1 Selection of the case

Selection of the case in my research involved the integration of a systems thinking concept, that of boundary judgment. According to Ulrich (2002, 2003) how one draws boundaries of a system, that is, what elements are considered legitimate in the system under study, builds in selectivity and partiality. Boundaries must be set because one cannot study everything and Richardson (1999) was helpful in explaining that setting boundaries signals an endogenous point of view where the emphasis is on the internal relationships or structures that create dynamic system behaviour. In essence, boundary judgments are value laden and need to be transparent and examined for how they may affect findings.

I selected a regional health system in SA for my case study because it exhibited characteristics that would best provide rich data to answer my research questions. Firstly, I adopted a definition of a health system that includes numerous sectors and organisations that contribute to health (as described in Chapter 2) therefore the presence of diverse, multi-sector subsystems (i.e., state

managed primary health care services, state health department, other state government departments, federally-funded and regionally managed primary health care entities, local governments, non-governmental organisations) was fundamental to my selection. These subsystems were representative of the federal, state and local governance structures that guided all health systems in SA and had co-terminus geographical boundaries with one regional health system. Secondly, as described in Chapter 2 a key action of HP is intersectoral collaboration and the study of cross-jurisdictional interactions was vital to taking a systems perspective. In selecting the case I sought out a regional health system that had a history of partnerships, networking and intersectoral collaboration. Thirdly, I selected a regional health system where the health sector had a long history in community health and HP initiatives that demonstrated commitment to the type of HP described in Chapter 2.

The regional health system I selected for the case study also included stakeholders in leadership positions with a history of positive research relationships with the Southgate Institute for Health, Society and Equity at Flinders University and therefore it was anticipated that my research would perhaps gain greater acceptability than in other health systems. This was important because of the turbulence in SA with respect to HP policy and practice at the time of my research (as described in Chapter 1). I selected the regional health system with the support of my supervisors and together we felt it supported a good case study. A description of the case in terms of the federal, state and local levels of governance landscape is provided in Chapter 4 to set the context for my research and I return to discuss the criteria of a good case study and how my study is appropriate later in this chapter.

3.3   Research methods

In this section I describe the data collection and analysis methods I used in my research. I begin by identifying my research questions and then discuss in detail two methods – document review and interviews – followed by a discussion of how I used a critical approach and systems thinking to analyse key findings. I end this chapter with a discussion of how I ensured that my research was credible and of high quality.

3.3.1   Research questions

My overarching research question is: from a systems thinking perspective, what are the key factors that influence HP policy and practice in a regional multisectoral health system in SA? Three sub-questions were developed to help answer this question and they were:

1. Over a ten year period (2003-2013) to what extent does the policy context support HP and health system building blocks for HP? I define HP in terms of its goal of reducing health inequities and three key actions it uses to accomplish this: reorienting health services toward HP; developing partnerships and intersectoral collaboration; and ensuring community participation. The health system building blocks are: leadership and governance, financing, workforce, information and services (practice). HP strategies include developing personal skills, creating supportive environments and building healthy public policy.

2. What are the perspectives of key stakeholders within a regional multisectoral health system regarding the extent to which HP is addressed and health system building blocks are in place for HP?

3. What feedback mechanisms appear to influence HP policy and practice in the regional health system?

In order to address my research question, two types of information were needed: 1) a historical overview of the HP policy context in SA, and 2) the perspectives of key stakeholders in leadership positions with respect to HP. This information supported describing, interrogating and understanding patterns in how HP policy and practice was constructed or interpreted. Therefore, the two research methods used were document review and interviews.

3.3.2 Document review

Document review is regarded to be particularly well suited to case studies because written materials offer a record of historical import (Stake, 2005; Yin, 2009). Hodder (2000) suggested that "mute evidence" (p. 703) provides qualitative research challenges that are quite different from information obtained through dialogue because there is limited opportunity to discuss findings. He described the interpretation process as relying instead upon the "simultaneous hermeneutical procedures of context definition, the construction of patterned similarities and differences, and the use of relevant social and material culture theory" (Hodder, 2000, p. 714).

The written documents of interest for my research were primarily health policy documents produced by the state government health department. Health policy can be defined as "courses of action (and inaction) that affect the set of institutions, organizations, services and funding arrangements of the health system" (Buse, Mays, & Walt, 2008, p. 6) and this guided my inclusion criteria. The fundamental criterion for inclusion for document review was that the policy or document offered direction for HP and/or public health in the regional health system. While most documents selected and reviewed were health department policy documents, a small number were from other state government departments, for example, the government of South Australia's strategic plan was included because it provided direction for taking action on targeted SDH. Federal government documents that were referenced in state policies and documents were reviewed and reported in Chapter 4 to give a broad perspective of the governance structures for health systems at the national level. Policy documents from other sectors such as local government were not included due to time and resources constraints and furthermore, policy and legislation at the state and federal level were considered to be primarily responsible for setting direction for HP.

The other key criteria were that the policies and documents were dated between 2003 and 2013 and that they were publically available on the internet. It was necessary to select a time frame for the analysis and ten years was set because a major health reform review was released in 2003 (Government of South Australia, 2003a) by the state government that offered reflection on prior

history and set direction for HP into the future. Furthermore, during this time frame there were many relevant health policy documents published which aided in obtaining a comprehensive and up-to-date picture of the policy context. Thus, this ten year period was considered to be an appropriate time frame to gain an understanding of HP policy directions.

Gathering policies for document review was undertaken in a four part process. First, a review of the state health department website was completed and documents were skimmed for evidence of the criteria mentioned above. Second, as documents were selected for inclusion, a review of each reference section was undertaken to identify any documents that might be of particular pertinence. Third, the list of potential policies and documents were reviewed with my supervisors to identify those that might have been missed. And last, the list was reviewed with a 'critical friend' with a long history working in senior positions in HP policy and practice in SA to ensure comprehensiveness and relevance. A critical friend is defined as "a trusted person who asks provocative questions, provides data to be examined through another lens, and offers critiques of a person's work as a friend" (Costa & Kallick, 1993, p. 50).

3.3.2.1 Data analysis: document review

I used content analysis to analyse data for document review. There are many forms of content analysis and there appears to be no single widely agreed upon approach. However, what is common is the identification of patterns in textual material and the use of this knowledge to draw assumptions about how messages and meanings are represented in and communicated through texts (Lupton, 1999). Hsiu-Fang and Shannon (2005) defined qualitative content analysis as "a research strategy for the subjective interpretation of the content of text data through the systematic classification of coding and identifying themes or patterns" (p. 1278). Furthermore, I followed a 'directed content analysis' approach where the goal is to "validate or extend conceptually a theoretical framework or theory" (Hsiu-Fang & Shannon, 2005, p. 1279). The key reason I used directed content analysis was that the literature was well developed in terms of conceptualising HP and health system building blocks (Chapter 2).

The document review was conducted in the early phase of my research in order to gain a greater understanding of the policy environment before interviewing took place. Mikecz (2012) discussed this in terms of the central importance of pre-interview preparation, that is, to consolidate my knowledge of the topic and background thus setting the conditions for good rapport and trust.

All documents were downloaded as PDF files, imported into QSR NVivo 10, and coded and analysed from November 2012 to May 2013. The coding nodes I used in NVivo are listed in Appendix A. Constant comparison was an important aspect of my data analysis and Patton (2015) explains this in terms of the iterative process of ensuring consistency and accuracy of coding as well as actively looking for difference and variations. I held the following questions close as I coded in order to ensure that I followed a systematic analysis of data to validate findings: "What things go together in the data? What things are different? What explains these similarities and differences? What are the implications for your overall inquiry, purpose and conclusions?" (Patton, 2015, p. 658). Patterned evidence (Hodder, 2000) in my research was reflected in the articulation of themes that illustrated similarities and differences in terms of how HP and health system building blocks were evident in the reviewed documents. Once I finished coding documents I completed a narrative summary of each document in terms of the themes regarding HP and system building blocks.

Following this, I rated each document in terms of the extent to which they identified and supported the HP goal (reducing health inequities) and actions (reorienting health services toward HP, developing partnerships and intersectoral collaboration, and ensuring community participation in HP) and health system building blocks (leadership and governance, financing, workforce, services (practice), and information) described in Chapter 2. Ratings for each document were based upon the following color-coded scheme:

Green = identified and supported HP goal/action or health system building blocks *to a great extent* (i.e., the document not only discussed but offered specific strategies or recommendations).

Amber = identified and supported HP goal/action or health system building blocks *to some extent* (i.e., the document discussed but did not offer specific strategies or recommendations).

Red = identified and supported HP goal/action or health system building blocks *to no or very little extent* (i.e., the document did not discuss nor offer specific strategies or recommendations).

All aspects of HP and health system building blocks were rated in this manner except for *leadership and governance*. In Chapter 2 I identified reorienting health services toward HP and developing partnerships and intersectoral collaboration as key HP actions and these actions paralleled the two dimensions of leadership and governance: health governance and governance for health respectively. Table 3.1 indicates how I linked the two dimensions of leadership and governance with two HP actions.

Table 3.1   Linking dimensions of leadership and governance with HP actions

Dimensions of leadership and governance	HP actions
Health governance	Reorienting health services toward HP
Governance for health	Developing partnerships and intersectoral collaboration

This conceptualisation of leadership and governance is consistent with Kickbusch and Gleicher's (2014) definitions:

> Two challenges go hand in hand: (1) governance of the health system and strengthening health systems, which we refer to as health governance; and (2) the joint actions of health and non-health sectors, of public and private sectors and of citizens for a common interest, which is what we call governance for health (p. xi).

In order to rate leadership and governance as one discrete building block I compared the ratings for the two HP actions and arrived at one rating in the following manner:

- If both HP actions (leadership and governance dimensions) were assigned a green rating then the document was assigned a green rating for leadership and governance.
- If one HP action (leadership and governance dimension) was rated red and the other amber then the document was assigned an amber rating for leadership and governance.
- If both HP actions (leadership and governance dimensions) were rated amber then the document was assigned an amber rating for leadership and governance.
- If both HP actions (leadership and governance dimensions) were rated red then the document was assigned a red rating for leadership and governance. However, all documents discussed at least one HP action (leadership and governance dimension) to some extent therefore no documents were assigned a red rating for leadership and governance.

Using this method to rate documents painted broad brush strokes of the policy landscape where the value lay mainly with revealing patterns in the data which were then interrogated to more fully describe the policy context.

3.3.3. Interviews

The goal of interviewing is to gain information and understanding on the perspectives, understandings, and meaning constructed by people regarding events and experiences (Aberbach & Rockman, 2002; Patton 2002). The purpose of conducting interviews in my research was to gather in-depth knowledge and diverse perspectives from people in leadership positions working in the case study health system. Although document review of relevant SA government policies provided a rich description of the HP policy context, it did not tell me very much about *how* and *why* questions. For example, how and why the HP policy and practice environment changed in the regional health system.

From a social constructionist stance, Koro-Ljungberg (2008) stated that "constructionist interviews are dialogical performances, social meaning-making acts and cofacilitated knowledge exchanges" (p. 430). For my research, interviews were socially negotiated dialogues that connected meaning-making of participants with meaning-making of me as a researcher. Holstein and Gubrium (2003) reported that interviews from this stance are interactional where interviewees co-construct various realities with the researcher and my case study therefore represented a method for me to share and understand diverse perspectives as to the HP policy and practice context.

In the following sections I describe the study population, study sample, interview guide, ethics approvals, recruitment and participation rates, and the interview process. I end this section with a discussion of the steps I undertook to analyse interview data.

3.3.3.1   Study population

The scope of the study population included people working within organisations that had a role and responsibility in HP and who also had leadership positions in the regional health system. The sectors and organisations and the rationale for this study population were as follows:

- The health care sector had leadership roles and responsibilities in HP policy and practice. Leaders within the central state health department (SA Health) and the state (Local Health Network) and federal (Medicare Local) primary health care sectors were considered vital to include in my study in order to seek information as to past, current and future directions.
- Another key sector in the regional health system was local government. People in leadership positions with roles and responsibilities for public health planning and implementation in four cities within the geographical area were included in the study population.

- Other state government departments that had close connections to HP policy and practice were included in order to determine wider state government stakeholder perceptions. Four departments were identified for inclusion in the study in consultation with my supervisors and critical friend (as described above). I do not name these departments because of the anonymity concerns of stakeholders.
- Non-government organisations (NGOs) were known to be engaged in HP and the types of NGOs included in my study ranged from professional associations providing training, accreditation and advocacy, to intersectoral networks, through to those whose mandate included health service delivery.

3.3.3.2 Study sample

Purposeful sampling was required for my case study and this can be defined as selecting "information-rich cases strategically and purposefully" (Patton, 2002, p. 243). The selection of the study sample was characteristic of a maximum variation sampling strategy. Patton (2002) described the goal of this strategy as documenting diverse perspectives in order to "identify important common patterns that cut across variations" (p. 243). For me this translated into identifying numerous positions within each sector for potential interviews in order to gain different perspectives both within and across sectors.

The strategy I employed was to first identify the key positions in the health sector and local governments. The positions included chief executive officers, directors, managers, coordinators, team leaders and mayors. Through internet searches, phone calls and my critical friend and supervisors, I was able to identify names of people in those positions. From this strategy I identified 19 people who worked within the state funded health system and the federally funded primary health care organisation (Table 3.2). Of the 19, two had recently left their positions and were included to obtain their historical perspectives. I identified 21 people working in four local governments.

I then turned to NGOs and identified 14 different organisations: five professional organisations, three service delivery organisations and six intersectoral networks. These were identified through discussions with my supervisors and internet searches. A total of 21 people in leadership positions were identified within the nongovernmental sector. Finally, four people working in management positions in four state government departments (other than health) were identified by my critical friend and they were included in the study sample. The total sample was 65 people (see Table 3.2) and this was large enough to capture the desired breadth and scope of perspectives necessary to credibly report on my research aims (Patton, 2002). I have not described these sectors and positions in any further detail because of my commitment to maintaining maximum anonymity among interviewees.

Table 3.2   Summary of the study sample

Sector	Study sample
Health sector	19
Local government	21
Nongovernment organisations	21
Other state departments	4
Total	**65**

3.3.3.3   *Interview guide*

Semi-structured interview guides were prepared and pretested. I prepared a predetermined guide with questions that directly related to my research aims and followed much of the advice contained in literature about interviewing elites. Definitions of elites commonly contained descriptions such as: people in positions of power with decision-making capacity and privileged information who can best answer the interview questions (Harvey, 2011; Morris, 2009; Neal & McLaughlin, 2009; Rice, 2010). This definition fit well with my study sample.

A semi-structured approach was beneficial in that I was able to modify the order of questions, change question wording and offer explanations depending on my perception of appropriateness with interviewees (Robson, 2002). I took heed of Aberbach and Rockman's (2002) advice regarding being flexible in interviewing elites and this required increased concentration on the part of the interviewer "since such an interview has a more conversational quality to it than the typical highly structured interview" (p. 674). This conversational style enhanced the depth of information I obtained from the interviews. Furthermore, open-ended questions were suggested to allow elites more room to formulate responses according to their own interpretation (Aberbach & Rockman, 2002). A final piece of advice I incorporated was to use a funnel approach where the interview started with easier questions and moved consistently toward more difficult or abstract questions in order to build confidence, trust and rapport (Harvey, 2011; McEvoy, 2006).

The development of the interview guide began with an exploratory interview (December 2012) with my critical friend who was knowledgeable about the HP policy and practice environment. As noted in Chapter 1, the context changed considerably in the first year of my research (i.e., the implementation of the policy I was planning to study was withdrawn) therefore many of these preliminary questions were not appropriate for the revised research plan. However, through this exploratory interview I increased my understanding of the HP policy and practice context and was able to pilot test a preliminary series of interview questions.

Once my final research proposal was approved (May 2013) I prepared and pretested new interview guides for the various sectors in my study sample. I piloted two guides – one for the health sector and the other for local governments – in June 2013 with two health care managers and one manager in a local government outside of the case (regional health system). These face-to-face interviews were recorded and reviewed to identify any difficulties with the questions and to assess the richness of the information I obtained. As a result of pretesting, I found that separate interview guides were unnecessary because there was no discernable difference in terms of the need to explain questions in interviews in the pilot. Therefore, one interview guide was prepared and this is included in Appendix B.

3.3.3.4   Ethics

As noted above and in Chapter 1, revisions to my research proposal made it necessary to submit and seek multiple approvals from the research ethics committees of Flinders University (Social and Behavioural Ethics Committee) and SA Health (Human Research Ethics Committee). Ethics applications were first approved in October 2012 by the two committees and final applications were approved in July 2013.

Included in both ethical review processes were approvals for recruitment, my letter of introduction (Appendix C), my research information sheet (Appendix D), and a consent form (Appendix E). The consent form addressed issues of the right to privacy and protection from harm (Fontana & Frey, 2000).

A third research governance procedure was required by SA Health called 'Site Specific Assessments' and these were necessary to obtain approval from specific site and department managers to ensure that they had approved the research being conducted. Two separate approvals were received; one in July 2013 pertaining to the Local Health Network and the other in September 2013 for SA Health, Public Health Branch.

3.3.3.5   Recruitment and participation rates

Potential participants were sent a letter of introduction (Appendix C) from my principal supervisor with a research information sheet (Appendix D) via email with a short message stating that she was requesting their assistance in my PhD research and that I was a Canadian student with over 25 years HP experience and a recipient of an International Postgraduate Research Scholarship. This was done to support my credibility and possibly enhance access to potential interviewees. I then followed up with an email requesting participation. If I had not heard from the potential participant within one week, I followed up with a telephone call. The

maximum number of times I called was two. If the person agreed to an interview I then sent a schedule of available dates and times and asked them to select two that would work for them. Once a date was confirmed I sent out the consent form (Appendix E) and the interview guide (Appendix B).

Fifty five of the 65 stakeholders that were identified and invited to participate in an interview agreed and ten declined to participate (Table 3.3). Of the ten who declined, five were from local government and lack of time was the most frequently mentioned reason for declining. Although 55 people agreed to participate, two from the Health sector were not able to make scheduled interviews resulting in a final total of 53 study participants, thus giving an 81.5% participation rate.

Table 3.3   Study sample by sector, system element and participation rate

Sector, system element, and number of participants	Total study sample	Declined participation	Accepted participation	Final participation
Local government Local Council A (4) Local Council B (5) Local Council C (3) Local Council D (3) Local Government Association (1)	21	5	16	16
Health sector Medicare Local (5) Local Health Network (6) SA Health (5)	19	1	18	16
Nongovernment organisations Intersectoral Networks (6) Professional Associations (8) Health Services (4)	21	3	18	18
Other state government departments (4)	4	1	3	3
Total	65 (100%)	10 (15%)	55 (85%)	53 (81.5%)

Most participants agreed to a face-to-face one hour interview, however, eight participants requested group interviews; four each from the Local Health Network and from SA Health. Interviews were conducted between July and November 2013 and as reported above, the HP policy and practice environment during this time was in the midst of change, therefore, I considered the participation rate to be good given these circumstances.

The positions and the number of years in positions of participants are reported in Table 3.4. Most participants held senior positions including CEOs, mayors, directors and managers and the range was from one to 16 years in terms of years in their current position. Thus, participants represented people in leadership positions and many had knowledge of the history of the HP policy context.

Table 3.4   Positions and years in positions of participants

System element	Position titles	Years in current position (range)	Years in public health or HP (range)
Local government	CEO, mayor, director, manager, community development, strategic planner, project manager	1-16	1-32
Health sector	CEO, director, acting director, officer, manager, coordinator	1-12	6-35
Nongovernment organisations	CEO, president, past president, chair, manager, coordinator	1-10	10-30
Other state government departments	director, manager	2-4	6-28

3.3.3.6   *Interview process*

Individual face-to-face interviewing was the desired method because "respondents tend to provide less detailed responses in a telephone interview than a face-to-face interview" (Harvey, 2011, p. 435). Furthermore, face-to-face interviews lend themselves to the establishment of good rapport with interviewees through visual communication, particularly having the ability to pick up on body language. Face-to-face interviews were also appropriate because I was able to travel to the interviewee's place of choice for interviews. However, I remained open to telephone interviews if the respondent expressed a preference or could only consider a telephone interview. All participants agreed to a face-to-face interview except for two who requested telephone interviews and these were successfully conducted. In sum, I completed 45 individual interviews and conducted two group interviews. One person joined in the Local Health Network group interview by telephone. The individual interviews were conducted by me alone. For the group interviews, Senior Research Associates from the Southgate Institute for Health, Society and Equity (Flinders University) attended as note takers in order for me to concentrate on facilitating the interview.

The interviews were conducted in two rounds. The first round was conducted in July and August 2013 and targeted those in the study sample working within the health sector, local government and non–government service delivery organisations. I did this in order to start with participants who were likely to be most knowledgeable about HP in the regional health system. I began coding interviews immediately. The second round was conducted from September to November 2013 and targeted those working in non-government professional organisations and intersectoral networks, and other state government departments. However, in order to accommodate participants, the rounds of interviewing overlapped, most particularly with respect to the group interviews (Local Health Network and SA Health) being conducted at the end of the data collection period.

All interviewees completed a consent form (Appendix E) before the interview commenced and all interviews were digitally recorded. Digital recordings were downloaded onto a secure server at Flinders University, which only my supervisors and administrative staff had access to. Recordings were then sent to a professional transcription company that researchers at Flinders University used. Once transcripts were completed and returned they were again saved to a secure server on the Flinders University system. The transcripts were first reviewed by listening to the recorded interviews for accuracy, transcripts were then saved as PDF file and imported into QSR NVivo 10 software for coding and analysis.

3.3.3.7 Data analysis: interviews

As in my data analysis methods for document review, I used Hsiu-Fang and Shannon's (2005) directed content analysis approach for the interview data. The reason was the same: the conceptual foci were well developed for HP and health system building blocks. The coding scheme was the same as the one I used for document review (Appendix A) and this allowed for comparison with the analysis of the policy context. However, additional codes were added to gather information about interviewee roles and years of experience.

The process I followed began with reading each interview transcript and making notes with preliminary insights. This stage is what some describe as immersion (Green, et al., 2007). I then coded each transcription and following this, I used NVivo to generate a report that provided me with a detailed list of all data coded to each node by subsystem (e.g., a report contained all the data coded to each node from all interviews from Local Government A). From these reports, I analysed the coded data in terms of convergence, that is, I began by

> … looking for 'recurring regularities' in the data. These regularities represent patterns that can be sorted into categories. Categories should be judged by two criteria: internal homogeneity and external heterogeneity. The first criterion concerns the extent to which the data that belong in a certain category hold together or 'dovetail' in a meaningful way. The second criterion concerns the extent to which differences among categories are bold and clear (Patton, 1990, p. 403).

Following this process I prepared summaries for each subsystem and reported on similarities and differences in themes or categories. Summaries included a description of the sample (range of individual roles, years in role, and years of experience) and themes with respect to HP and system building blocks that clustered around key factors that influenced policy and practice.

From the summaries I followed the process that Patton (1990) labelled as divergence: this entailed "processes of extension (building on items of information already known), bridging (making connection among different items), and surfacing (proposing new information that ought to fit and then verifying its existence)" (p. 404). This process was instrumental for building upon the data from document review (extension), making connections among document review and stakeholder perspectives regarding HP and health system building blocks (bridging), and identifying new patterns and relationships in the data (surfacing).

3.3.4   A critical perspective in the analysis of key findings

In Chapter 2, power, politics and ideology were identified as HP challenges and earlier in this chapter I described how incorporating a critical lens would be important to examine the role of powerful overarching structures, hierarchies, institutions, processes and practices in shaping HP policy and practice. Duncan and Reuter (2006) suggested that

> a critical policy analysis exposes the ideologies and values underlying policy issues and their proposed solutions … this includes an analysis of how issues are understood and framed by the various policy communities – those groups of actors from government, private sector, pressure groups, advocacy groups, media or academia who seek to influence the course of public policy (p. 244).

They further related that the identification of power relations and the flow of policy agendas from decision makers are instrumental areas to include in critical analysis. In my research I established key findings from document review and interview data and report in Chapters 5 and 6 how power, politics and ideology emerged as themes regarding factors that influence HP policy and practice. In Chapter 6 and 7 I highlight the significance of these factors in my research.

3.3.5   A systems thinking perspective in the analysis of key findings

As discussed in Chapter 2, health systems are widely considered to have characteristics of complex systems (Mabry, Marcus, Clark, Leischow, & Mendez, 2010; Plsek & Greenhalgh, 2001; Sturmberg & Martin, 2013) and therefore methods and tools congruent with systems thinking are needed to study and identify patterns in system behaviour (Luke & Stamatakis, 2012). This means that methods or tools to examine interactions and illustrate self-organisation or adaptation of systems to their environment are needed (Best, 2011; Meadows, 2008; Rickles, et al., 2007). One way to study the behaviour of complex health systems is through examining positive (reinforcing or self-enhancing) and negative (balancing or goal seeking) feedback mechanisms (Homer & Hirsch, 2006). Complex systems can produce new patterns based upon feedback mechanisms (Meadows, 2008) and one aim of my research was to explore feedback mechanisms as analytic tools to study factors that influenced HP policy and practice in the case health system. Although I highlight systems thinking concepts in Chapters 5 and 6, Chapter 7 is devoted to studying feedback mechanisms with respect to key findings and discussing their significance.

3.3.5.1   Health system building blocks

Before I describe the methods I used to study feedback mechanisms it is important to draw attention to how I used the framework of health system building blocks (de Savigny & Adam, 2009) described in Chapter 2. Figure 3.1 illustrates the health system building blocks and the minor adaptations I made for my research. As noted in Chapter 2 the study of medicines and technology was not congruent with my conceptualisation of HP and was therefore not salient to my research. The adaptations I made to the framework were as follows:

- I added 'leadership' to the governance building block because of my discussion of leadership and governance as a HP challenge in Chapter 2.

- I added 'practice' to the label of service delivery to better reflect the nature of HP actions and strategies in a regional health system.

- I adapted the information building block to include a) monitoring and reporting of population health status and b) gaining evidence of HP effectiveness through research and evaluation.

Figure 3.1   Adapted model of the dynamic architecture and interconnectedness of the health system building blocks (de Savigny & Adam, 2009)

I applied the framework as a novel way to study HP policy and practice (that embedded two HP challenges of leadership and governance and information) and I used the building blocks as coding nodes (Appendix A). The emphasis in using this framework was on the "the multiple relationships and interactions among the blocks – how one affects and influences the others and is in turn affected by them – that convert these blocks into a system" (de Savigny & Adam, 2009, p. 31). Therefore, I first analysed the data and identified key findings with respect to each building block and then turned to identify the patterns in the interactions among the blocks.

3.3.5.2   Feedback mechanisms and causal loop diagrams

I followed Kim and Andersen's (2012) process to link qualitative data with systems thinking and specifically feedback mechanisms. I first established key findings from document review (Chapter 5) and stakeholder interviews (Chapter 6) and then identified causal links among key findings (Chapter 7). This was an intensely iterative process that ended only when I believed that I could verify and clearly substantiate each causal link and the overall patterns in the data. I then transformed the causal links into words-and-arrows diagrams (feedback loops) and this was followed by reassembling data to find relationships among key findings and merge these into one map or causal loop diagram. I used Vensim PLE software to create word-and-arrow diagrams and the final causal loop diagram.

Richardson (2013) explains that a causal loop diagram of feedback loops is a visual model of a snap shot in time that illustrates complex interactions or patterns of behaviour in a system. Although facilitating a group model building process (Vennix, 1999) for completing a causal loop diagram (i.e., with interviewees) would have been preferable for my research, time and resource constraints prevented this. In the next section I provide a detailed description of how I constructed the word-and- arrow diagrams (feedback loops) and the causal loop diagram included in Chapter 7.

Figure 3.2 illustrates a visual model of three connected entities or variables: human health and well-being, state of the earth system, and state of the urban complex. The numbered arrows simply label the number of connections. This model is useful as a starting point to depict connections among entities or variables in a system, however, it does not tell us about causal links or how feedback flows through the system.

Figure 3.2   Diagram of connected entities: human health and well-being, state of the earth system, and state of the urban complex [Proust et al. (2012)

Establishing polarity of causal links is a first step in studying how feedback flows through the system. Figure 3.3 is a widely used example that illustrates the concept of polarity:

- The arrows from *Births per year* to *Population* and from *Population* to *Births per year* signal that *Births per year* influence *Population* and *Population* influence *Births per year*.
- The (+) sign by the two arrow tips signify that as *Births per year* increase/decrease so does *Population* increase/decrease; and conversely, as the *Population* increases/decreases so does *Births per year*.
- The (+) signs establish the polarity of the causal links.
- The (+) sign associated with arrows (causal links) indicates that both variables move in the same direction, thus the direction is reinforced.

99

Figure 3.3   Causal loop diagram to illustrate positive (+) and negative (-) feedback loops using birth and death rate and population.
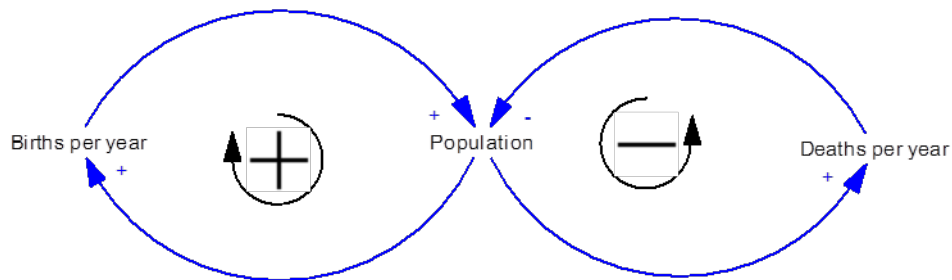
The two arrows connecting *Births per year* and *Population* form a positive (or reinforcing) loop because of the polarity of the causal links (two + causal links) and I labelled this with the symbol ⊕ .This symbol indicates not only the polarity but the direction to read the positive loop, that is, to read in a clockwise direction.

Population and *Deaths per year* form another causal loop:

- I indicate a (-) sign by the arrow tip from *Deaths per year* to *Population* because as *Deaths per year* increase (or decrease) then *Population* decreases (or increases).
- Unlike the (+) sign, the (-) sign indicates that the variables move in <u>different</u> directions.
- The causal link from *Population* to *Deaths per year* is indicated with a (+) sign by the arrow tip because these two variables move in the same direction, that is, as *Population* increases so do *Deaths per year*.

The two signs by the arrow tips in this causal loop are different (one is + and the other is -) therefore this is a negative loop and I labelled this with the symbol ⊖. This is often called a balancing loop that "characteristically tends to diminish or counter act a change in any one of its elements" (Richardson, 1999, p.5).

In feedback loops, the polarity of each causal link is indicated and it is important to remember that the polarity of each is dependent upon whether the direction of influence is going in the same or different direction [(+) same direction or (-) opposite direction]. Furthermore, the polarity of each feedback loop is dependent upon the direction of the cumulative causal links: two (+) or two (-) create a positive loop and one (+) and one (-) create a negative loop.

In sum, feedback loops illustrate how patterns of interactions in complex systems cause system behaviour (Meadows, 2008). Senge (2006) discussed another important dimension in the study of feedback and that is the concept of delays. In every system there are always delays or rather "when the effect of one variable on another takes time" (p. 89). Although the concept of delays is important to feedback mechanisms, this concept is not addressed to any great extent in my research because the feedback loops represent a snap shot in time.

In the interest of providing a more reader friendly causal loop diagram in Chapter 7 I did not label the polarity of each feedback loop, however, they can be easily determined because the polarity of each causal link (arrow) is labelled. Instead of labelling each feedback loop in terms of positive or negative polarity I took the next step in analysis and ascertained if the causal influence of each feedback loop was going in the right direction for desired HP policy and practice. Thus, I simplified labelling in terms of each feedback loop's facilitating 🙂 or inhibiting 🙁 influence on HP policy and practice.

3.3.6   Ensuring quality and credibility of my research

In the final section of this chapter I discuss how I ensured quality and credibility of my research. I first describe the criteria for judging a good case study and then more generally to the criteria for judging quality and credibility in qualitative research.

3.3.6.1   *Criteria for judging a good case study*

Yin (2003) identified five characteristics of exemplary case studies. First, a good case study needs to be significant. As described in Chapter 2, there is a growing literature on the use of systems thinking in HP, however it is still considered to be early in its development. My case study makes a meaningful and original contribution to the literature by enhancing understanding and explanation of influences on HP policy and practice from a systems perspective.

Second, a good case study needs to be complete. I addressed this characteristic in terms of explicitly defining boundaries of the case, both in terms of the institutional and geographical contexts as well as in conceptual foci (i.e., HP and systems thinking).

Third, a good case study needs to consider alternative perspectives. My case study addressed this through data source and methods triangulation (Patton, 1990), that is, I used two data sources (analysis of data from numerous government policies and a large number of stakeholders from a wide range of sectors). This echoes an attribute of good qualitative research. This diversity in data and methods also satisfied the completeness criteria in terms of ensuring that "exhaustive effort" (Yin, 2003, p. 163) had been expended in collecting critical data. Furthermore, my supervisors were important critical listeners (Yin, 2003) to help identify competing perspectives regarding the data. My critical friend reviewed Chapter 5 and provided positive feedback.

Fourth, a good case study is one that "presents the most relevant evidence, so that the reader can reach an independent judgment regarding the merits of the analysis" (Yin, 2003, p. 164). To address this, I described my data collection and analysis methods in enough detail to present a data or audit trail that culminated in reporting of sufficient evidence. Finally, composition and writing style are considered key to a good case study. Yin (2003) described this as effectively communicating enthusiasm for the case and the results and this was a clear goal for me.

3.3.6.2   *Criteria for judging quality and credibility in qualitative research*

Generating findings based upon rigorous analytic processes is a key to any research and according to Reynolds et al (2011) and Patton (2015) there are no set criteria agreed upon to judge qualitative research and there are many different terms and frameworks. Lincoln and Guba (2011) suggested that in social constructionist inquiry, credibility is analogous to internal validity, transferability to external validity, dependability to reliability, and confirmability to objectivity. Furthermore, they stated that trustworthiness was analogous to rigor. For my research I used Patton's (2015) criteria that takes into account my philosophical foundations, methodology and methods to arrive at descriptions of how I judged my research design. Table 3.5 includes the criteria for social constructionist inquiry and the descriptions of my research processes to ensure quality and credibility.

Table 3.5   Criteria for judging the quality and credibility of qualitative inquiry: social constructionism (Adapted from Patton, 2015)

Criteria	Description of my research processes
Subjectivity acknowledged, enhanced and deepened understanding, and contribution to dialogue	Based upon my experiences and background and my literature review, I formulated the aims of my research to more deeply understand key factors that influence HP policy and practice in one case study in order to further knowledge development.
Trustworthiness	I described in detail the "systematic processes that I systematically" followed for data collection and analysis (Patton, 2002, p. 553). The essence of demonstrating trustworthiness is the articulation of my research design in enough detail to allow an assessment of such issues as clarity of research questions, my role and actions, analytic constructs, data collection techniques and effects, and data analysis processes (i.e. leaving a data trail of how the data were analysed and meanings derived).

Triangulation	I designed my research to gather data from two sources, that is, reviewing 20 documents and interviewing 53 stakeholders from diverse sectors and organisations to capture different perspectives in order to validate and corroborate findings and to establish convergence of themes (Yin, 2003).
	Triangulation was also important to find differences: "either consistency in overall patterns of data from difference sources or reasonable explanations for differences in data from divergent sources can contribute significantly to the overall credibility of findings" (Patton, 2015, p662). My supervisors and critical friend provided triangulation in terms of incorporating multiple observers of my research and this provided a check on potential bias in data collection and analysis (Patton, 2015).
Reflexivity	Through data collection I identified early on several notable insights that formed preliminary interpretation. Focusing on these insights propelled me to ask what factors might be behind the interpretations that I formed quite quickly and to challenge those first impressions.
	The analysis and interpretation phase of my research was guided by various frames of reference (i.e., health promotion and systems thinking), but I allowed "the empirical material to inspire, develop and reshape theoretical ideas" (Alvesson & Skoldberg, 2009, p273). The question that I kept front of mind was: to what extent did my frames of reference shape the "winners and losers as a result of a particular interpretation"? (Alvesson & Skoldberg, 2009, p 277). For example, what themes did I move forward and what themes did I reject?
	Finally, self-reflection with respect to my writing and language amounted to questioning whether I got stuck in one line of thinking without adequately allowing for other positions to emerge. The insights I gleaned from answering these probing questions are contained in Chapters 5-8.
Extrapolation and transferability; particularity (doing justice to the integrity of unique cases)	I made every effort to ensure that I provided the reader "with sufficient information on the case studies such that readers could establish the degree of similarity between the case studies and the case to which findings might be transferred" (Patton, 2015, p 685).
Credible to and deemed accurate by those who have shared their stories and perspectives	All participants in my research were invited to attend my final presentation (March 2016).

Patton (2015) also offered a set of criteria to judge the quality and credibility of qualitative inquiry that employs a systems thinking perspective. I found this to be a useful framework to

guide my research as I sought an alternative way to gain insight and explanation of my findings through systems thinking and all criteria were consistent with my approach. To be credible to systems thinkers, the qualitative inquiry must:

- capture, describe, map, and analyse systems of interests,
- attend to interrelationships,
- capture diverse perspectives,
- attend to emergence,
- be sensitive to and explicit about boundary implications,
- must document nonlinearities,
- adapt the inquiry in the face of uncertainties, and
- describe system changes and their implications (Patton, 2015, p694).

In the next chapter (Chapter 4) I describe the case study and focus on the institutional (federal-state-local level health system) and geographical boundaries of the region health system, the various system elements, and why it is a meaningful and appropriate case in relation to my research questions.

Chapter 4: Description of the Case

In Chapter 3 I described why a single, representative, instrumental case study was an appropriate methodology for studying the phenomena of health promotion (HP) policy and practice in a regional health system. The significance of my case study is with respect to enhanced understanding and new ways of explaining key factors that influence HP policy and practice through a systems thinking lens. I articulated criteria for selecting the case and the key reasons were that a) it was a bounded health system in terms of institutional governance structures and geography; b) there were diverse and numerous sectors and subsystems with a role in HP; c) there was a rich history of partnerships and intersectoral collaboration; and d) there was history of the state and local government and health sector commitment (and leadership) to HP. With respect to the latter, I discuss key state government policy documents in Chapter 5 that set the context for HP and I discuss the rich history throughout my thesis. However, in order to further acknowledge the SA context for my case study I provide the following list of key initiatives that arguably have contributed to national and international leadership in HP.

1970-80s	Strong community health movement (Baum, 1995)
1988	Adelaide recommendations on healthy public policy (World Health Organization & Australian Department of Community Services and Health, 1988)
1990s	Early adoption of healthy cities movement (Baum & Cooke, 1992)
2005-2008	Professor Fran Baum from Flinders University of South Australia was Australia's only Commissioner on the Commission on Social Determinants of Health (CSDH, 2008)
2007	Ilona Kickbusch was Adelaide Thinker in Residence on Healthy Societies, whole of government approaches and Health in All Policies (Kickbusch, 2008)
2010	Adelaide statement on Health in All Policies: Moving toward a shared governance for health and well-being (World Health Organization & Government of South Australia

Yin (2009) stated that examining the context and the conditions related to the case is integral to case study and in this chapter I focus on providing enough background information to set my research in context. In this chapter I describe the case, that is, the regional health system and the system elements or organisations and institutions that had roles and responsibilities for HP policy and practice in 2013. I do not name the regional health system because of stakeholder requests for anonymity due to the heightened sensitivity regarding the significant changes that were occurring in the HP policy and practice environment at the time of my research.

In general terms, the case (regional health system) had a co-terminus geographic boundary with the Local Health Network (state-managed regional health authority) and this boundary also incorporated the geographical area of four cities (local councils). The following information is taken from a government of South Australia website. The case region contained both urban and rural areas with the majority of the population (over 300,000 residents) living in urban settings while others lived in small communities, farms and towns. Regarding the age of the population, about 20% were between 0 and 17 years and 20% were aged 60 years and over. The land mass of the region was over 600 square kilometres. Approximately three quarters of the population were Australian born and about 1% were identified as Aboriginal or Torres Strait Islander. Employment or labour force participation in the region was high where approximately 95% of persons aged 15+ years were employed in 2011. In terms of education, almost 50% of people over the age 15 years had completed Year 12 as of 2011. The top three sectors of employment were health care and social assistance, retail trade, and manufacturing. With respect to household income the population was fairly evenly distributed among quartiles in 2011.

Turning to institutional structures, Table 4.1 outlines the sectors, system elements and levels (federal, state, regional and local) in the case (regional health system) at the time of my research (2013). Four sectors were included in the case: the health sector, other state government departments, local government, and non-governmental organisations. In total there were 28 system elements that operated at federal, state, regional and local levels.

Table 4.1   Description of the sectors, system elements and levels in the case (regional health system) as at 2013

Sector	System elements	Level and description
Health sector	The Department of Health of the Australian Government played an important role in the policy environment with respect to the case (regional health system) (1).	*Federal level:* Department of Health portfolios include population health, pharmaceutical services, medical and dental services, acute care, primary health care, private health, infrastructure, regulation, safety, quality, workforce capacity, biosecurity, and sport and recreation (Australian Government, 2015)
	One Medicare Local was part of the case (regional health system) (1). Medicare Locals were established through the Department of Health, Australian Government (changed to Primary Health Networks in July 2015) and had a large geographical area that included boundaries of the Local Health Network.	*Regional level:* the Medicare Local was a federally-funded regional institution with the aim to coordinate primary health care services, address local health care priorities, support health professionals, and improve access to primary care (Primary Health Care Research & Information Centre, 2016)
Health sector	SA Health (state government health department), Government of South Australia played an important role in the policy environment with respect to the case (regional health system) (1).	*State and regional level:* SA Health supported public hospitals (with a joint agreement with the Australian Government), health service delivery, public health (environmental health, epidemiology, communicable disease control, health promotion), pathology services, drug and alcohol services, dental services, GP Plus health centres, emergency and ambulance, and organ donation (Government of South Australia, 2016c).
	One Local Health Network (state-managed regional primary health care services) was part of the case (regional health system) and provided the geographical boundaries of the case (1).	*State and regional level:* under the direction of SA Health, Local Health Networks are the regional health authorities that manage the acute, sub-acute and mental health services delivered in public hospitals and GP Plus Centres (Government of South Australia, 2016b).
Other state government departments	Four state government departments were included in case (regional health system) (4).	*State and regional levels:* Other state government departments delivered services in areas such as education, family support, sport, recreation, and transportation.
Local government	Four local councils were included in the case (regional health system) because taken together they had co-terminus boundaries with the Local Health Network (4).	*Local level:* local councils are the public health authority for their geographical area with responsibilities to preserve, protect and promote health, ensure adequate sanitation measures are in place, identify public health risks, respond to impacts upon public health, prepare public health plans, and provide immunisation services (Government of South Australia, 2011f).
Non-governmental organisations (NGOs)	Three types of NGOs were included in the case (regional health system): five professional associations, three health service delivery organisations, and six intersectoral networks (16).	*State level:* professionals associations *State and Regional level*: health service delivery organisations (e.g. sexual health). *Regional and local level:* intersectoral networks of regional and community service delivery organisations.

In the following sections I describe the federal-level governance structures, key health reform initiatives, Medicare Locals, health care financing and expenditures. I then discuss the state-level governance structures including SA Health, Local Health Networks, and other state departments. Following this, I describe the role of local government and non-governmental organisations at the local level in terms of HP.

4.1   Federal level: Australia's health care system

The federal system of health governance is critically important to understanding the web of relationships in the case and how HP fit within those structures. From a very broad perspective, Weller and Fleming (2003) reported that the Australian Constitution of 1901 was based upon the British parliamentary system of government and furthermore, the federal government's role in health has been rooted more in control over taxation than in specific constitutional powers (Duckett & Willcox, 2011). The federal government's role has gradually expanded over time even though the states and territories have the dominant role in the delivery of most public services including health (Moon & Sharman, 2003). Philippon and Braithwaite (2008) characterised relationships between levels of government in the Australian health system as "increased centralization of decision-making at the state level, with increasing degrees of intervention by the Commonwealth government" (p.181). Overall, the federal government is responsible for Medicare and this includes financing for hospitals (via the state and territory governments through National Health Care Agreements), general practice, medical practitioners, and some other health professionals (through the Medicare Benefits Schedule) (Duckett & Willcox, 2011).

4.1.1 Federal governance structures, health reform and health promotion

The interdependent relationship between the federal and state levels of government has given rise to governance structures such as the Australian Health Ministers Conference. However, more recently the Council of Australian Governments (COAG includes federal, state, and

territorial heads of governments and the President of the Australian Local Government Association) has negotiated health care reform agreements (Duckett and Wilcox, 2011).

Federal health care reform initiatives have influenced HP policy in Australia. Federal reform initiatives to strengthen HP in Australia can be traced back to at least the *Better Health Commission* (1985) and more recently the *National Partnership Agreement on Preventive Health* (2008), *National Health and Hospital Reform Commission* (2009), *National Health Reform Agreements* (2011) and the formation of the *National Preventive Health Agency* (2011) (Duckett & Willcox, 2011; Palmer & Short, 2010).

With respect to the *National Partnership Agreement on Preventive Health* (Australian Government, 2008) the Rudd Labor government "committed $872 million over six years … retaining $229 million for its own expenditure on prevention … states receiving $335.5 million, with a further $307.5 million to states as a 'reward' if they meet specified performance targets" (Duckett and Wilcox, 2011, p. 138). The desired outcomes were to:

> a) increase the proportion of children and adults at healthy body weight;
> b) increase the proportion of children and adults meeting national guidelines for healthy eating and physical activity;
> c) reduce the proportion of Australian adults smoking daily;
> d) reduce the harmful and hazardous consumption of alcohol; and
> e) help assure Australian children of a healthy start to life (Australian Government, 2008).

The role of the federal government was to support a national workplace wellness program, establish a national preventive health agency, and support social marketing, surveillance, research and workforce development. The states and territories had the responsibility for delivering a range of programs to encourage healthy lifestyles (including social marketing activities to support national level activities and services to complement national level tobacco campaigns) and supporting monitoring and surveillance activities (Australian Government, 2008). At the time of conducting my research (2013) the agreement and financing for the

delivery of HP services described above was ongoing in SA and two healthy eating and active living projects with different target populations were operating in the regional health system.

Following the *National Partnership Agreement on Preventive Health* (2008), the split responsibility for health between the federal and state levels of government was identified as a key challenge and targeted for action in the final report of the *National Health and Hospital Reform Commission* (Australian Government, 2009b). This report called for a new accord based upon 'one health system' with defined roles and responsibilities and importantly called for the federal government to have *full* policy and funding responsibility for primary health care (including HP and other areas such as basic dental care and aged care, and services for Aboriginal and Torres Islander people).

Subsequent to the above two documents (*National Partnership Agreement on Preventive Health* and the *National Health and Hospital Reform Commission*), a preventive health strategy was prepared by the *National Preventative Health Taskforce* (Australian Government, 2009a) which resulted in the establishment of the *Australian National Preventive Health Agency* in 2011. A number of strategies to address obesity, tobacco use and alcohol were targeted and roles and functions included such areas as: building evidence, developing and sustaining social marketing campaigns for obesity, tobacco and alcohol, providing a clearinghouse for policies and programs for preventive health, publishing reports, advising COAG and AHMC, and delivering national programs. However, in 2014 (after my research took place) the agency was abolished by the Abbott Liberal National Coalition government as it was deemed to be a duplication of the roles and functions of the federal Department of Health (Parliament of Australia, 2014).

The context for HP at the federal level changed once again with the establishment of the *Australian Prevention Partnership Centre:*

> The Prevention Centre has $22.6 million in resources over five years that has been provided by the National Health and Medical Research Council (NHMRC), the Australian Government Department of Health, the NSW Ministry of Health, ACT Health and the HCF Research Foundation. It is one of two NHMRC Partnership Centres launched in 2013 to improve the availability and quality of research evidence for policy makers (Sax Institute, 2016).

4.1.2 Medicare Locals

One important federal health care reform initiative that was of importance to the case (regional health system) was the formation of Medical Locals in 2011 to replace Divisions of General Practice. Medicare Locals were established under the Rudd Labor government following a series of consultations and reports: the *National Health and Hospital Reform Commission* (Australian Government, 2009b), the *National Primary Health Care Strategy* (Commonwealth of Australia, 2009), and an initial *National Health Reform Agreement* (Council of Australian Governments, 2011). The latter laid out federal responsibility for the funding and management of primary health care services (Duckett and Willcox, 2011). The Agreement stated that

> The Commonwealth will take lead responsibility for the system management, funding and policy development of GP [General Practice] and primary health care with the objective of delivering a GP and primary health care system that meets the health care needs of Australians, keeps people healthy, prevents disease and reduces demand for hospital services (Council of Australian Governments, 2011, p52).

However, changes were made to the initial *National Health Reform Agreement* (2011) resulting in responsibility for primary health care services to revert back to state and territorial governments (Duckett and Willcox, 2011). The change impacted federal-state roles, governance structures and policy directions for HP.

At the time of my research, Medicare Locals were charged with improving coordination and integration of primary health care services at the local and regional levels, addressing service gaps, and making it easier for patients to access health services. There was the expectation that Medicare Locals would develop partnerships with Local Health Networks as well as other key players, including communities. However, Javanparast et al (2015) reported on a study of Medicare Locals and Local Health Network partnerships in South Australia and found "no specific examples of collaboration between MLs and LHNs that were directed towards social determinants of health" and that Medicare Local participants "believed that they had neither the capacity nor the funding" (p. 219.e3) to undertake HP. Funding was originally set for a 5 year

period (2011/12 to 2015/16) and 61 Medicare Locals were established across Australia with five located in SA. One Medicare Local was included within the boundaries of my case.

As described in Chapter 3 I collected my data in 2013 but to further describe the changing health care policy and governance structures in Australia it is notable that in 2014 the recently elected Abbott Coalition government (in 2013) commissioned a review of Medicare Locals to assess its structure, operation and functions and make recommendations for future directions. Professor John Horvath (2014), a consultant to the Australian Department of Health and Aging, conducted the review and found that there was support for a new "entity to be tasked with working to improve service integration and reduce fragmentation to deliver improved health outcomes and ensure the health system is more productive" (p4) and a new name to better reflect function.

In 2015 the federal Minister of Health stated that Primary Health Networks would "replace Labor's flawed Medicare Local system of 61 fragmented regions" (Ley, 2015) and 31 new entities would be created (two in SA). Thus, on the heels of my research, Medicare Locals transitioned into new entities called Primary Health Networks.

4.1.3   Health financing and expenditures in Australia

Federal health financing is a significant health system building block because it shapes HP policy and practice at the state-level and in regional health systems. Figure 4.1 below maps the funders and areas of expenditures in the Australian health system. Community and public health initiatives (including HP) are part of Primary Health Care in this configuration and are shown to be delivered by all levels of government. However, state and territorial governments are shown to have a larger funding share than the federal government for community and public health initiatives. I could find no publically accessible data on funding for HP.

Figure 4.1   Health services funding and responsibility in Australia
(Australian Institute of Health and Welfare, 2014a)
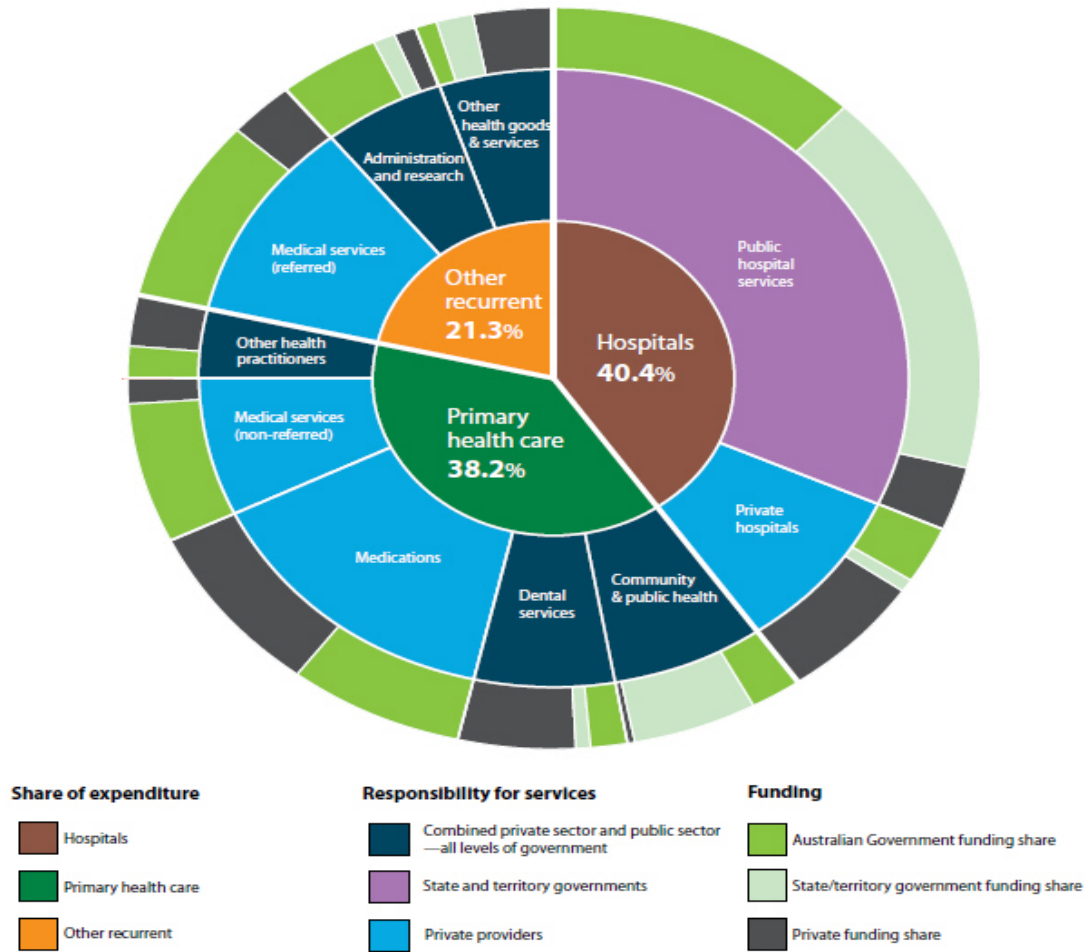
Another aspect of health financing is the trend in Australia's health care expenditures as one of consistent growth. Figure 4.2 indicates that total health spending was approximately 10% of GDP in 2013 and this was higher than the 8.9% average of other Organization for Economic Co-operation and Development countries (OECD, 2015). Both federal and state and territorial governments expenditures have generally grown over time and this is attributed to "increasing burden of chronic disease, the ageing population, rising incomes and changing consumer expectations, as well as the effects of new medical technologies" (Australian Government, 2015).

Figure 4.2   Australia's growing health care expenditures (Australian Government, 2015)
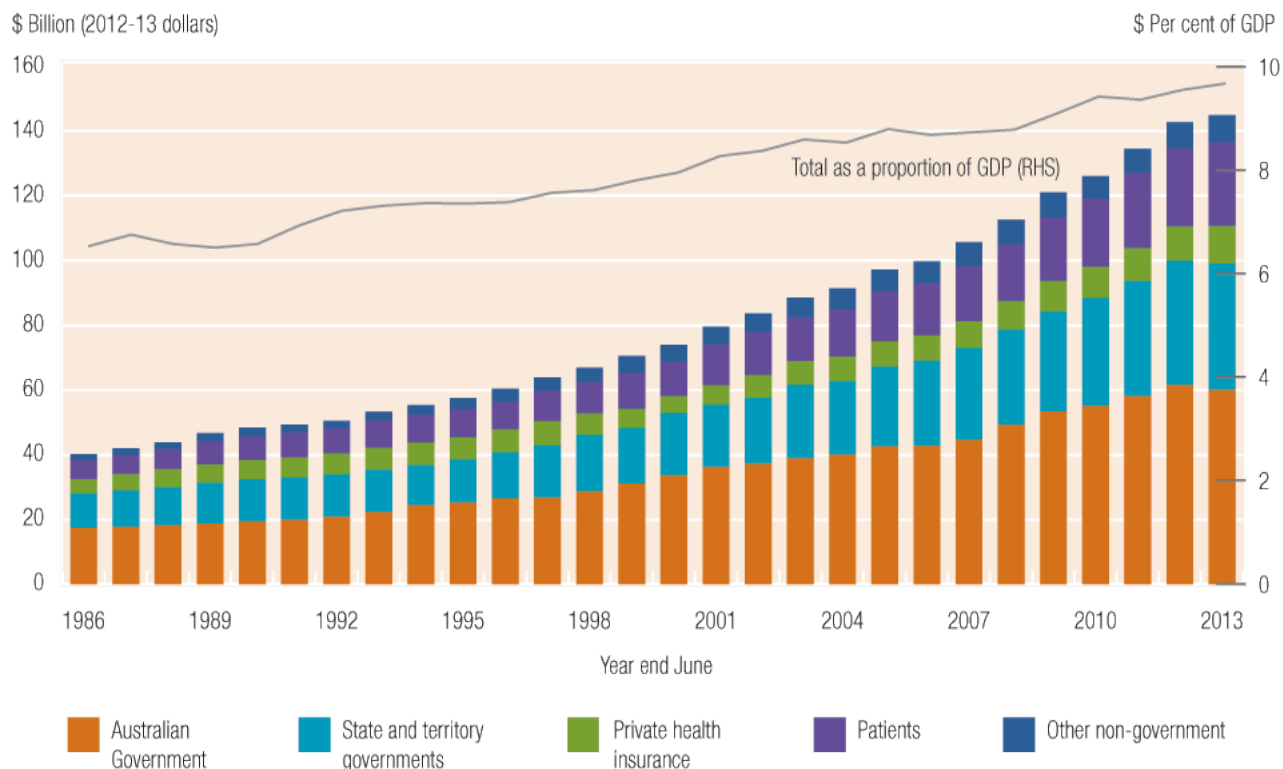
4.2   State level: South Australia's health care system

In the next chapter (Chapter 5) I discuss in detail the HP policy context in South Australia over a ten year period (2003-2013). In this section I confine my description to the general structure of the state health system and the system elements that are included in the boundaries of my case.

4.2.1   SA Health

SA Health is the brand name for all the services and programs that report to the Ministers of Health, Ageing and Mental Health and Substance Abuse under the SA Department of Health and Ageing. At the beginning of my research (in 2012) there was a Health Promotion Branch within

SA Health, however, this organisational structure changed during my research in 2013. The Health Promotion Branch was disbanded and the Public Health and Clinical Systems division was established with the role and responsibility to plan, implement and monitor policies and programs to improve public health and clinical care. In 2013, the Population Health Strategy and Partnerships Branch of the Department was in the early stages of supporting the implementation of the *South Australian Public Health Act* (Government of South Australia, 2011f) and the development of the state-level public health plan (Government of South Australia, 2013b). Thus, stakeholders from this branch were expected to be key players in leadership and governance for HP in the state.

4.2.2 Local Health Networks

As part of the *National Health Reform Agreement* (2011) discussed above, funding for Local Health Networks commenced in SA to improve the delivery and coordination of primary health care services and public hospitals and to take "a lead role in managing public health" (Council of Australian Governments, 2011, p 7). There were five regional Local Health Networks in SA at the time of my research (2012-2013) and one had a co-terminous geographical boundary of my case (regional health system).

Local Health Networks were the peak organisations for managing and delivering primary health services (outside of General Practice as it was funded through the Medicare Benefits Schedule and privately delivered) at the state level and included such services as physiotherapy, podiatry, social work, dental, drug and alcohol, mental health, children and youth, healthy lifestyle and health assessment counselling, and Aboriginal health services. The Local Health Network in my case had the responsibilities for leading HP and had a long history rooted in a community health movement. For example, Baum (1995) reported on a history of community health services in SA that exemplified the importance of reducing health inequity, ensuring community participation in HP, developing partnerships and intersectoral collaboration, and reorienting health services toward HP.

Services were provided in GP Plus Health Care Centres and two Centres were located within the boundary of my case. The mandate of GP Plus Health Care Centres (at the time of my research in 2013) was to work in partnership with General Practice, health care agencies, Aboriginal Community Controlled Services, local government and the non-government sector to meet the health needs of local communities. Six target areas were: 1) primary prevention; 2) avoiding unnecessary hospitalisation; 3) avoiding emergency department presentations; 4) reducing admissions from emergency departments; 5) reducing length of stay; and 6) reducing the use of hospitals for outpatient services. However, as I describe in Chapter 5 the primary prevention mandate was withdrawn at the beginning of my research.

SA Health in partnership with the federal Department of Health and Aging also established GP Plus Super Clinics. These Clinics were to increase coordination among health professionals (e.g., general practitioners, nurses, allied health professionals) to deliver better health care in geographical catchment communities and to contribute to chronic disease prevention with initiatives that promote healthy lifestyles, address risk factors and lifestyle modification and improve the early diagnosis of chronic health problems. One GP Plus Super Clinic was located within the boundary of my case and had an expanded list of services including sexual health, domestic violence, gambling counselling, chronic disease management, support for children with developmental delays, and specialist clinics (e.g., cardiac, sleep disorders, and respiratory).

The significance of the historical roots of the regional Local Health Network in supporting HP through critical health system building blocks (leadership and governance, financing, workforce, services (practice) and information) and of the vastly changing policy and practice landscape formed a central backdrop to my case study.

4.2.3   Other state government departments

Although SA Health had a lead role in managing the state health system, other state government departments had roles in HP and this was particularly notable in areas such as the merging of the

departments of education and child development, and the strong history of whole-of-government approaches or Health in All Policies in SA (discussed in Chapter 2 and 5-7). Several departments were identified for inclusion to the case because of known partnerships and intersectoral collaborations as reported by my supervisors and my critical friend (described in Chapter 3). Due to the need for anonymity among stakeholders the names of departments are not reported in this thesis.

4.3   Regional: non-government organisations

Beyond the regional geographical organization of Local Health Networks and Medicare Locals, there were numerous nongovernment organisations (NGOs) in SA that provided HP support and initiatives at the state, regional and local levels at the time of my research. Although it is beyond the scope of this thesis to describe this large and vital sector, I highlight areas that are particularly salient to HP and the case. Again, due to anonymity concerns of stakeholders the names of the NGOS are not reported in this thesis.

The NGO sector was rich with disease and/or disability specific organisations such as those that addressed heart disease, cancer, and brain injury. Some of these state level NGOs provided health services at the regional and local levels such as those for sexual health. There was a peak body that undertook research to enhance collaboration and capacity building within the community services sector and to advocate for vulnerable and disadvantaged people in public policy and legislative processes. Health was a key social justice issue of this peak body. Other NGOs at the state-level that contributed to the HP environment in my case were professional associations that included public health, health promotion, medicine, nursing and midwifery.

There were several NGOs working at the regional and local levels that convened intersectoral networks mostly geared to identifying service gaps and advocating for collaboration to address gaps. There was a strong history of these networks (i.e., youth, housing, children and families, domestic violence, healthy cities) coming together to strengthen collaborative efforts, build

capacity, influence policy and planning, and enhance community development. Many of these had strong history of support in terms of leadership and memberships roles from local council and Local Health Network staff.

4.4   Local level: local councils

Local government in SA has a long history in public health and the following is a brief historical perspective on the role:

> Since the 1900's, municipal authorities have been responsible for health measures such as the provision of sewers, the cleaning of streets, the regulation of slaughterhouses and the provision of clean water to their districts. Roles and responsibilities have developed over time and priorities have shifted as diseases caused by effluent, contaminated water or person to person contagion such as measles, polio and cholera have been controlled and contemporary conditions such as non-communicable disease (heart disease, diabetes and certain cancers) have become the leading cause of mortality and morbidity in our society (Local Government Association of South Australia, 2013).

Local councils played an important role in the state and regional health systems at the time of my research because of their central role as the Public Health Authority for their area as laid out in the *South Australian Public Health Act* (2011). It is inferred in the Act that HP would be addressed through the development of regional or local public health plans. Four local governments, more commonly known as local councils, were included because together their geographical boundaries were co-terminus with the case (regional health system).

The *South Australian Public Health Act* (2011) replaced the *Public and Environmental Health Act* (1987) and it better defined the role of local councils in public health. Local councils' roles include the following:

- collaborating with other authorities involved in the administration of the Act;
- providing adequate sanitation measures;
- identifying and responding to public health risks;
- determining and responding to the impacts upon public health

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- providing or supporting activities to preserve, protect or promote public health; and

- providing or supporting the provision of immunisation.

Local councils provided a wide array of health services such as food business inspections, school immunisation programs, human waste and waste water control, and health risk assessments. The provision of recreational facilities such as playgrounds, sporting facilities, and parks are also important to public health. Furthermore, community development departments in local government could play a large role in partnership development and intersectoral collaboration. It is notable that one local council in the case (regional health system) had a strong history in the healthy cities/communities approach to HP and this work clearly built upon the traditions of healthy settings approaches and the community health movement described earlier.

Chapter 5: South Australian Policy Context for Health Promotion

In this chapter I describe the health promotion (HP) policy context based upon a review of key South Australian (SA) government documents over a ten year period (2003-2013). Having a detailed perspective of historical trends shapes understanding and provides a foundation for the examination of factors that influence HP policy and practice. Thus, one of the aims of this research was to describe the extent to which a broad cross section of SA government documents identified and supported:

- the HP *goal* of reducing health inequity through action on the social determinants of health (SDH) and three HP *actions* of ensuring community participation, reorienting health services, and developing partnerships and intersectoral collaboration; and
- the health system building blocks of leadership and governance, financing, workforce, HP service delivery (practice), and information for HP.

This chapter is organised by first providing a chronological overview of the key developments in HP policy decisions of the state government over the ten year period. The next section focuses on the extent to which documents identified and supported the HP goal, three actions and key themes that emerged from the analysis. The third section provides an analysis of the extent to which health system building blocks are identified and supported in documents. The final section answers the sub-question: over a ten year period (2003-2013) to what extent does the policy context support HP and health system building blocks for HP?

The documents I reviewed are listed in Table 5.1 and brief descriptions of the aims of the documents are included. The selection criteria for documents were described in detail in Chapter 3 however to summarise: the main consideration was that selected documents represented key SA policy directions for HP over a ten year period.

Table 5.1   South Australian government documents reviewed (2003-2013)

Year	#	Title of document	Aims of document
2003	1	Better Choices Better Health: Final Report of the South Australian Generational Review	"… to deliver a plan to the Minister for Health that provides effective strategies for health system reform, which ensures that all South Australians enjoy the best possible health and have access to high standards of health care" (Government of South Australia, 2003a, p. vii).
	2	Primary Health Care Policy Statement	"Key directions for strengthening primary health care in SA" (Government of South Australia, 2003c, p. 1) .
	3	First Steps Forward: South Australia's Health Reform	"The First Steps Forward in our health reform strategy will focus on three main themes – building better governance, building better services and building better system support" (Government of South Australia, 2003b, p. 1).
2007	4	South Australia's Strategic Plan	"South Australia's Strategic Plan is a commitment to making this state the best it can be – prosperous, environmentally rich, culturally stimulating, offering its citizens every opportunity to live well and succeed" (Government of South Australia, 2007c, p. 1)
	5	South Australia's Health Care Plan	"Better coordinated hospital services. A responsive health workforce for the future. GP Plus Health Care Centres, with more primary health care services. More elective surgery. Less pressure on emergency departments. Improved management of chronic diseases. But to make these changes, we need South Australians to get involved – and to make their good health a focus and priority" (Government of South Australia, 2007c)
	6	GP Plus Health Care Strategy (2007-2016)	"… provides a clearer understanding of the role of GP Plus Health Care Centres and other primary health care initiatives as well as outlining how they will operate within South Australia's health system" (Government of South Australia, 2007a, p. 1).
2009	7	Health Service Framework for Older People (2009-2016)	"… maximise the period in which older people maintain good health and wellness; compress the period in which they transition to ill-health, become frail and increasingly dependent on care; deliver services and programs that keep older people out of hospitals and shift the balance of care toward care provided in the community" (Government of South Australia, 2009c, p. 2).
	8	Chronic Disease Action Plan (2009 -2018)	"… outlines SA Health's ten year plan to address chronic disease. It provides evidence and actions to support the prioritisation of secondary prevention, early intervention and disease management strategies to address the increasing burden of preventable chronic disease in South Australia" (Government of South Australia, 2009a, p. 1).
2010	9	Adelaide Statement on Health in All Policies	"… to engage leaders and policy-makers at all levels of government—local, regional, national and international. It emphasizes that government objectives are best achieved when all sectors include health and well-being as a key component of policy development" (World Health Organization & Government of South Australia, 2010, p. 1).
	10	South Australia's Oral Health Plan (2010-2017)	"… outlines a stepped approach to resources that are intended to promote oral health and treat oral diseases for the whole population" (Government of South Australia, 2010c, p. 3).
	11	Aboriginal Health Care Plan (2010-2016)	"Reduce Aboriginal ill-health; Develop a culturally-responsive health system; Promote Aboriginal community health and wellbeing" (Government of South Australia, 2010a, p. 3) .

2011	12	South Australia's Strategic Plan	"Since 2004, the Plan has driven our state's growing prosperity, assisted us to work towards attaining sustainability, and fostered our creativity and innovation; all the while the Plan has worked to share these successes with all South Australians through improved wellbeing, expanded opportunities and stronger communities" (Government of South Australia, 2011d, p. 14).
	13	A Framework for Comprehensive Primary Health Care Services for Aboriginal People	"… to set out the core elements that will comprise a comprehensive primary health care response by SA Health for Aboriginal people, irrespective of where they may live"(Government of South Australia, 2011b, p. 3).
	14	South Australian Tobacco Control Strategy (2011-2016)	"… will guide state tobacco control efforts to reduce the impact of tobacco smoking on the health and wellbeing of South Australians" (Government of South Australia, 2011g, p. 7).
	15	The Eat Well Be Active Strategy for South Australia (2011-2016)	"… outlines a way forward for government and non-government organisations to work together to promote healthy weight for children, adults and families. It includes preventive and management strategies and identifies priority actions at a variety of levels, including policy and program development, workforce planning, research and monitoring" (Government of South Australia, 2011a, p. 4).
	16	Statewide Cancer Control Plan (2011-2015)	"… is the second SA Cancer Control Plan developed to guide the provision of cancer control and care in SA" (Government of South Australia, 2011h, p. 3).
	17	Primary Prevention Plan (2011-2016)	"… sets out a framework for primary prevention effort across SA Health, through both the Department of Health (DH) and the regional health services. It recognises the importance of working with a broad range of government and non-government partners, as well as individuals and communities, to support South Australians to lead and maintain healthy lives" (Government of South Australia, 2011c, p. 3).
	18	South Australian Public Health Act	"… to promote and to provide for the protection of the health of the public of South Australia and to reduce the incidence of preventable illness, injury and disability; to make related amendments to certain Acts; to repeal the Public and Environmental Health Act 1987" (Government of South Australia, 2011f, p. 1).
2012	19	Review of Non-hospital Based Services	"1. Gain an understanding of the range of metropolitan non-hospital programs currently in place. 2. Identify the scope and cost of delivery for each specific service. 3. Establish an evaluation framework against which the non-hospital services can be assessed for effectiveness and efficiency, including an assessment of the productivity of each program. 4. Identify the services that have a direct impact on hospital services in accordance with the Independent Hospital Pricing Authority definition of non-admitted patient services. 5. Develop recommendations to assist in achieving sustainable, effective and efficient services into the future identifying any services that have reached the end of their effectiveness. 6. Identify those services that can no longer be justified given the financial situation of the State Budget. 7. Identify the risks and potential community response with ceasing any services" (Government of South Australia, 2012, p. 4).
2013	20	SA Health's Response to the Review of Non-hospital Based Services	"New recommendations following the Review were made for: Youth Primary Health Services, Women's Primary Health Services, Health Promotion Services, Children's Primary Health Services, Child Protection Services, and Aboriginal Workforce Initiative"(Government of South Australia, 2013a, p. 5).

As reported in Chapter 4, the multilevel governance structures for health care in Australia was important and although this chapter focuses on state level policy developments, health care reform agreements at the federal level figured prominently in the policy context for HP and these are discussed throughout this thesis.

In Table 5.2 below I present the rating results of each document using the method detailed in Chapter 3 (rating the extent to which each document supported HP (goal of reducing health inequity through action on the SDH and three HP actions of ensuring community participation, reorienting health services, and developing partnerships and intersectoral collaboration) and health system building blocks (leadership and governance, financing, workforce, HP services (practice), and information). This was useful to paint the broad brush strokes of the policy landscape in order to see patterns in the data and to then interrogate those patterns further to more fully describe the policy context.

Table 5.2　　　Ratings of the extent to which documents identified and supported HP and health system building blocks*

Year	Document	Health promotion (HP)				Health system building blocks for HP				
		HP Goal: reduce health inequity	HP Action: community participation	HP Action: partnerships and intersectoral collaboration	HP Action: reorient health services	Leadership and Governance	Financing	Workforce	Service delivery (practice)	Information
2003	Better Choices Better Health: Final Report of the SA Generational Review	Green	Green	Green	Green	Green	Green	Gold	Gold	Gold
	Primary Health Care Policy Statement	Green	Green	Green	Green	Green	Green	Green	Gold	Gold
	First Steps Forward: SA's Health Reform	Green	Green	Red	Green	Gold	Green	Red	Green	Gold
2007	SA's Strategic Plan	Gold	Green	Green	Green	Gold	Gold	Green	Green	Green
	SA's Health Care Plan	Gold	Red	Gold	Red	Gold	Red	Green	Gold	Red
	GP Plus Health Care Strategy	Gold	Gold	Gold	Gold	Gold	Gold	Green	Gold	Red
2009	Chronic Disease Action Plan	Gold	Gold	Gold	Gold	Gold	Red	Green	Gold	Green
	Health Service For Older People	Gold	Gold	Gold	Gold	Gold	Gold	Green	Gold	Red
2010	Aboriginal Health Care Plan	Green	Green	Green	Green	Green	Green	Green	Green	Green
	Oral Health Plan	Gold	Red	Gold	Gold	Gold	Gold	Red	Gold	Green
	Adelaide Statement on Health in All Policies	Green	Green	Green	Green	Green	Green	Gold	Green	Green
2011	SA's Strategic Plan	Gold	Green	Green	Red	Green	Gold	Gold	Gold	Green
	Framework for CPHC for Aboriginal People	Gold	Red	Gold	Gold	Gold	Gold	Gold	Gold	Red
	SA's Tobacco Control Strategy	Gold	Gold	Green	Gold	Gold	Green	Gold	Gold	Green
	Eat Well Be Active Strategy for SA	Gold	Gold	Gold	Gold	Gold	Green	Green	Green	Green
	Statewide Cancer Control Plan	Gold	Red	Gold	Red	Gold	Red	Gold	Green	Green
	Primary Prevention Plan	Green	Green	Green	Green	Green	Green	Green	Green	Green
	SA Public Health Act	Gold	Gold	Green	Gold	Gold	Red	Red	Gold	Gold
2012-13	Review/SA Health's Response	Red	Gold	Gold	Gold	Gold	Red	Red	Red	Red
	Totals	Green (6) Gold (12) Red (1)	Green (9) Gold (5) Red (5)	Green (10) Gold (7) Red (2)	Green (7) Gold (7) Red (5)	Green (6) Gold (13) Red (0)	Green (7) Gold (4) Red (8)	Green (4) Gold (6) Red (97)	Green (3) Gold (15) Red (1)	Green (9) Gold (5) Red (5)

*Green: To a great extent　　Amber: To some extent　　Red: To little or no extent

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5.1 From championing to near abandonment: a chronological overview of state government policy directions for health promotion

The review of selected state government documents over the ten year period (2003-2013) offered a rich picture of how the policy context in SA changed from advocating strongly for HP in 2003 to its near abandonment in 2013. From Table 5.2 above, the ratings for policy directions in 2012-2013 were notably lower than the ratings for 2003-2011 documents.

In 2003, three documents heralded the results and strategic directions of health reform deliberations in SA (*Generational Review, Primary Health Care Policy Statement, First Steps Forward*). These were particularly strong in supporting HP through statements that addressed health inequity and action on the SDH, and appealed for implementation of the *Ottawa Charter for Health Promotion* (1986) strategies and systems thinking. Reference to social justice and the *Alma Ata Declaration* (1978) grounded these health reform efforts in key international literature. The three HP actions – community participation, reorientation of health services, and development of partnerships and intersectoral collaboration – all featured in these documents and the foundational building blocks of leadership and governance, financing and workforce for HP were supported to a great extent.

Documents from 2007 (*SA's Strategic Plan, SA's Health Care Plan, GP Plus Health Care Strategy*) revealed a weakening of support as HP goals and actions and building blocks were addressed to a lesser extent than in the documents of 2003. The latter two documents were focused mainly on health care, but the inclusion of these in this study was instructive to reveal the extent to which the integration of HP was evident. By 2007 the focus had shifted to chronic disease management and reform of the acute care sector and primary health care services and the documents reported that HP was already being addressed in the health system as a result of the *Generational Review* (2003). The *SA Strategic Plan* (2007), a document produced by the Premier's office, set out a whole-of-government approach to enhancing economic, social and environmental goals and this appeared to provide a favourable framework for addressing the goal of reducing health inequities and HP actions. However, on the whole most of the 2007

documents reviewed focused on the provision of health care services and furthermore, there was little evidence of any explicit attention to the reorientation of health services toward HP.

The two 2009 documents *(Chronic Disease Action Plan, Health Services Framework for Older People)* that I reviewed were similar to the 2007 documents as they were not strong in their support of HP or health system building blocks for HP. However, both documents referenced the pending *Primary Prevention Plan* (2011) and set up the expectation that it would address HP more fully. HP was dealt with separately in these two 2009 documents therefore there was little indication of a comprehensive primary health care approach and this represented a missed opportunity from both a HP and systems perspective. Attention in these 2009 documents was focused on enhancing chronic disease management and the provision of health care for older people.

Two documents reviewed from 2010 – *Aboriginal Health Care Plan* and the *Adelaide Statement on Health in All Policies* – addressed reducing health inequity and three HP actions (reorienting health services, ensuring community participation, and developing partnerships and intersectoral collaboration) to a great extent. This was not surprising given that these documents addressed two policy directions where HP would be expected to be included. In contrast to the 2009 documents, HP was well embedded in the 2010 documents, for example, even though the *Aboriginal Health Care Plan* had a focus on health care, the very first sentence quoted the Australian Institute of Health and Welfare's (1989) *National Aboriginal Health Strategy* thus setting the stage for a more comprehensive and integrated approach:

> Health to Aboriginal people is a matter of determining all aspects of their life, including control over their physical environment, of dignity, of community self-esteem, and of justice. It is not merely a matter of the provision of doctors, hospitals, medicines or the absence of disease and incapacity (Government of South Australia, 2010a, p. 10).

The pending *Primary Prevention Plan* (2011) was mentioned again, as in prior documents, and this signalled a delay in its preparation thereby creating a gap in policy direction for HP particularly since the promising rhetoric in 2003. The *Adelaide Statement on Health in All Policies (*2010) was co-authored by the Government of South Australia and the World Health

Organization as a result of an event that followed upon the foundational work by Ilona Kickbusch as Thinker in Residence in SA on Health in All Policies (Kickbusch, 2008). It was not surprising to find that the *Adelaide Statement on Health in All Policies* (2010) was strong because improving population health through building healthy public policy through intersectoral action was its central aim.

2011 was a very productive year in that seven documents were produced that had relevance to HP (*SA Strategic Plan* (revised), *Framework for Comprehensive Primary Health Care for Aboriginal people, Tobacco Control Strategy, Eat Well Be Active Strategy, Cancer Control Plan, Primary Prevention Plan,* and the *Public Health Act*). All documents in 2011 identified the goal of reducing health inequity through action on the social determinants of health (SDH), however, the revised *SA Strategic Plan,* the *Eat Well Be Active Strategy* and the *Primary Prevention Plan* did so to a greater extent. The latter was a particularly strong document because it not only identified the HP goal and all three HP actions, but all health system building blocks. Furthermore, HP was integrated as a third pillar in SA health reform where:

> Strategies to support good health and prevent illness are complemented by the provision of effective primary health care services through the GP Plus strategy to prevent, treat and manage common conditions, and by access to tertiary hospital services for more specialised care (Government of South Australia, 2011c, p. 5).

Thus, the *Primary Prevention Plan* (2011) appeared to meet expectations that were built in prior documents. Also notable was the *Public Health Act* in 2011 which legislated formal partnership agreements for protecting and promoting population health between the state and local governments and other partnering authorities.

As at 2011, the policy context appeared to be strong for HP with numerous interlocking documents [i.e., *Aboriginal Health Care Plan* (2010), *Adelaide Statement on Health in All Policies* (2010), *SA Strategic Plan* (2011)*, Primary Prevention Plan* (2011), *Eat Well Be Active Strategy* (2011), *Tobacco Control Strategy* (2011), *SA Public Health Act* (2011)] that described multiple strategies at multiple levels to address reducing health inequities and offered explicit support for the three HP actions. Taken together these documents provided a supportive

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environment for the *SA Strategic Plan* (2011), which in turn was already providing support for Health in All Policies developments (Delany, et al., 2015). Furthermore, the policy environment was supported by federal policy developments such as establishment of the *Australian National Preventive Health Agency* described in Chapter 4.

Policy developments in 2012-2013 overturned this bright outlook. The *Review of Non-hospital Based Services* (hereafter referred to as the *Review*) was conducted by Warren McCann, an internal consultant in the Office of Public Employment, and a report was released in late 2012. This was followed by a brief public consultation period ending in early 2013 and the *SA Health Response* to the *Review* was released in March 2013. The *Review* reported that at the heart of the process was the need to:

- address the failing state economic environment and the rising (and argued to be unsustainable) cost of the health care system;
- delineate leadership and governance roles of the federal, state and local governments for non-hospital based services (including HP); and
- acknowledge the perceived lack evidence of effectiveness of non-hospital based services.

These will be discussed in detail later in this chapter specifically in relation to health system building blocks for HP.

SA Health's Response (2013) to the *Review* (2012) accepted most recommendations and these included cuts to HP financing, workforce and services (practice) delivered through Local Health Networks (regional state- managed primary health care services). Shortly thereafter the *Primary Prevention Plan* (2011) was withdrawn and although the *Public Health Act* (2011) remained a policy vehicle for HP at the state and local government levels, key policy directions for HP at the regional or local level and the necessary building blocks for HP (including leadership and governance, financing, workforce, HP services or practice) were weakened.

5.2   The extent to which the documents identified and supported health promotion over a ten year period (2003-2013)

Tracking the development of the policy context through key documents revealed that support for HP had waxed and waned. From 2003 to 2011 there was considerable support for HP but the policy context had notably diminished in the wake of the SA government's response to the *Review* (2012). Four themes emerged from my analysis of the HP environment, each with negative consequences for HP. These themes are mostly attributed to the decline in support for HP and are as follows:

- the wavering recognition of reducing health inequities as a HP or health system goal;
- the unlikelihood of the policy context supporting community participation as a HP action;
- the near abdication of reorienting health services as a HP action by the state; and
- unanswered questions about partnerships and intersectoral collaboration as a HP action.

5.2.1   The wavering recognition of reducing health inequities as a health promotion goal

It was instructive to study the extent to which the documents identified the HP goal of reducing health inequity as this further uncovered the progression from very strong support to near abandonment at the regional level over the ten years. Overall six (of 20) documents were rated highly in terms of addressing health inequity and from Table 5.2 above, this goal was addressed to some extent in all documents except for the *Review* (2012) and *SA Health's Response* (2013) thus signalling a significant shift.

Although the 2003 documents were rated highly, the social justice argument for reducing health inequity that was contained in these documents did not carry forward into subsequent documents. For example, the *Generational Review* (2003) presented health inequities as a social justice issue where "all people have a right to health" (Government of South Australia, 2003a, p. 148). Strategic actions were described in terms of advocacy for the right to health of various

population groups because of social, economic and environmental influences that have differential impacts upon people and the negative effects of the widening gap in socioeconomic circumstances. Social justice and the right to health were not explicitly reported in subsequent documents except for the *Primary Prevention Plan* (2011).

A common thread that I did follow from the 2003 documents through to 2011 was the concern for Aboriginal and Torres Islander people who were identified as experiencing the most profound health inequity. The *Primary Health Care Policy Statement* (2003) and *First Steps Forward* (2003) pledged to address health inequities through such strategies as building healthy public policy through a whole-of-government approach to address Aboriginal and Torres Islander People's health. These strategies followed through to many documents such as the *SA Strategic Plan* (2007, 2011), *Adelaide Statement for Health in All Policies* (2010), *Aboriginal Health Care Plan* (2010), and the *Primary Prevention Plan* (2011).

The *Review* (2012) and *SA Health's Response* (2013) coupled with the withdrawal of the *Primary Prevention Plan* (2011) were a clear blow to the HP policy context, particularly given that the *Primary Prevention Plan* (2011) presented an integrated framework for the state health care sector (SA Health and Local Health Networks) to address broad determinants of health and inequities. Both the gradient in health inequalities and the identification of disadvantaged population groups were elaborated upon as areas of concern for reducing health inequities in this policy document.

Two documents produced in 2010 – the *Aboriginal Health Care Plan* and the *Adelaide Statement on Health in All Policies* – were rated highly with respect to reducing health inequity. As noted above, the former prioritised closing the gap in health status between Aboriginal people and the rest of the South Australian population. Specific SDH and potential actions were identified in the *Aboriginal Health Care Plan* (2010) and they included addressing food security, housing, employment, healthy child development, and education. Achieving social, economic and environmental development was at the core of the *Adelaide Statement on Health in All Policies* (2010) and it emphasised that "reducing inequalities and the social gradient improves

health and wellbeing for everyone" (World Health Organization & Government of South Australia, 2010, p. 2). The central focus was joined-up, high level policy development "because the causes of health and wellbeing lie outside the health sector and are socially and economically formed" (World Health Organization & Government of South Australia, 2010, p. 1).

The strengths of the *Public Health Act* (2011) for reducing health inequities appear to lie in its legislated mandate, governance structures and mandatory parliamentary reporting. Although calls for action on the SDH were present in the Act, the direction for action was mostly limited to two broad principles:

- The equity principle stated that "decisions and actions should not, as far as is reasonably practicable, unduly or unfairly disadvantage individuals or communities" (Government of South Australia, 2011f, p. 10)
- Sustainability as a principle was described as "public health, social, economic and environmental factors should be considered in decision-making" (Government of South Australia, 2011f, p. 10).

These principles supported reducing health inequity to only 'some extent'; while they are important they appear to be weak and inadequate on their own to guide concerted and complex actions required to reduce health inequities.

Other documents that addressed reducing health inequities to only 'some extent' did not offer explicit strategic direction for action on the SDH. For example, *SA's Health Care Plan* (2007) referred to the *Generational Review* (2003) as a key direction setting document and HP was discussed only as a matter of individual behaviour change and not in terms of reducing health inequity or action on the SDH.

The *GP Plus Health Care Strategy* (2007) was mostly silent on the SDH and discussed health inequity to only a very limited extent. For example, it stated that the health care system needs to "consider issues of equity" (Government of South Australia, 2007a, p. 13) in addressing the

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needs of the most disadvantaged communities such as Aboriginal and Torres Strait Islanders but no further support of actions were included. These documents primarily addressed access to health care services and not reduction in health inequities.

The two state strategic plans (*SA Strategic Plan* 2007, 2011) were rated 'to some extent' because the whole-of-government approach to achieve targets on a host of SDH was evident. The 2007 plan identified and proposed targets based upon the knowledge that "[q]uality of life is determined by a number of things, including education and employment opportunities, a healthy environment, a rich cultural life, and good health" (Government of South Australia, 2007c, p. 21) and the 2011 plan prioritised protecting the most vulnerable South Australians and more specifically to reducing inequalities in Aboriginal health.

Other documents received a rating of 'to some extent' because they focused on secondary prevention, disease management, and/or health care services. For example, the *Chronic Disease Action Plan* (2009) pointed to the pending *Primary Prevention Plan* (2011) as the critical link to addressing health inequities, but stated that implementation of chronic disease management services would take into account environmental, economic and social causes of health inequities. This was also the case with the *Health Services Framework for Older People* (2009) (i.e. acknowledgement that older people considered to be of socioeconomic disadvantage were more likely to have higher incidence of disease and disability), *Oral Health Plan* (2010) (e.g., causes of poor oral health were attributed in part to SDH), *Tobacco Control Strategy* (2011) (e.g., highest smoking prevalence was indicated to be in the most disadvantaged quintile of the population), and *Cancer Control Plan* (2011) (e.g., explained health inequalities by way of people's differential exposure to risk factors and conditions).

In sum, the rhetoric of reducing health inequities through action on the SDH was evident in many documents. However, the policy context in 2013 could be characterised as having a high degree uncertainty as to how action would unfold. This uncertainty was due to four factors: the *Review* (2012) and *SA Health's Response* (2013); the early days in the implementation of the

Public Health Act (2011); the withdrawal of the *Primary Prevention Plan* (2011); and questions about the implementation of other policy directions.

5.2.2   The unlikely support for community participation as a health promotion action

As discussed in Chapter 2, community participation in HP is a fundamental element of an empowerment approach to HP. Although nine (of 20) documents identified and supported community participation in HP 'to a great extent' (Table 5.2), this distribution of ratings does not give a clear portrayal of this foundational tenet of HP because of the *Review* (2012), *SA Health's Response* (2013) and the withdrawal of the *Primary Prevention Plan* (2011). In 2013, together these policy directions resulted in the greatly diminished role of Local Health Networks at the regional and community level in HP.

The policy context for HP in 2013 was dominated by the *Public Health Act* (2011) and although it included a participation principle it was weak in comparison to the proclamation for strengthening community action put forward in the *Ottawa Charter for Health Promotion* (1986). For example, the *Public Health Act* (2011) states that "[i]ndividuals and communities should be encouraged to take responsibility for their own health and, to that end, to participate in decisions about how to protect and promote their own health and the health of their communities" (Government of South Australia, 2011f, p. 10) and this conceptualisation appears to place responsibility for participation on individuals and communities. On the other hand, the *Ottawa Charter* strategy states that community empowerment is at the core of HP and community development requires health system support (more than just encouragement) to ensure access to information, learning opportunities and funding support. This conceptualisation is linked to social justice ideals and thus incorporates a strong social responsibility for health, unlike the approach outlined in the Act.

The state of the HP policy context in 2013 was inadequate with respect to supporting community participation, particularly given that there were good examples of how some documents

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addressed community participation in terms of the *Ottawa Charter* conceptualisation. Statements from the *Generational Review* (2003) demonstrated this richness: "Local community participation and engagement processes will be critical to the development and design of networked primary care services and centres" (Government of South Australia, 2003a, p. 79). The *First steps forward* (2003) document was equally forceful in asserting the need to "increase community participation – providing greater opportunities for the community to have a say in the health system" (Government of South Australia, 2003b, p. not indicated). It went further to discuss the need to provide relevant information to community members in order that they would be better able to engage in decision-making. A key direction in the *Primary Health Care Policy Statement* (2003) was "recognizing the inherent strengths of communities (both geographic communities and specific populations) and supporting their capacity to create supportive, resilient and healthy environments" (Government of South Australia, 2003c, p. not indicated).

In terms of the *Strategic Plan* (2007) it was developed through a process that involved "the most comprehensive, whole-of-state community engagement programs ever conducted in South Australia" (Government of South Australia, 2007c, p. 5). The plan included an objective to build communities and through this action, community participation was supported. Although it did not speak to community participation in HP specifically it broadly covered this topic with respect to improving quality of life. For instance, one strategic direction stated that

> [a] healthy community relies on its social networks. These connections help to share burdens and build a sense of community trust. In turn, this creates a more efficient society. Strong communities encourage social inclusion, contribute to the state's overall quality of life, and create opportunities for development and growth for all South Australians (Government of South Australia, 2007c, p. 32).

The following section offers other examples of how community participation was identified and supported 'to a great extent' in documents. Facilitating the participation of Aboriginal communities was supported in the *Aboriginal Health Care P*lan (2010) where "empowering Aboriginal people, and building consistent and transparent mechanisms for the effective, meaningful and representative engagement of Aboriginal South Australians in planning, implementing and evaluating health services and programs" (Government of South Australia, 2010a, p. 4).

Although not a state government policy document *per se*, engaging civil society, conducting community consultations, and employing citizens' juries were recommended as ways to engage communities in the *Adelaide Statement on Health in All Policies* (2010). Community participation was a vital process in updating the *Strategic Plan* (2011), as in the 2007 plan, where a Community Engagement Board oversaw "the biggest community engagement process in the history of the Plan, involving people in all regions of South Australia" (Government of South Australia, 2011d, p. 17). It is reported that over 9,200 people participated and that this built upon SA's "exceptional history of leading the establishment of democratic systems and giving political and social power to its people" (Government of South Australia, 2011d, p. 18). This document was the only one reviewed that used such words as "political and social power" to describe outcomes of community participation.

The *Eat Well Be Active Strategy* (2011) was strong in advocating for the mobilisation of communities to take action to promote healthy eating and physical activity and to publicly recognise achievements. One example from the strategy was the Community Foodies program that used a peer education model to engage and train community members in basic nutrition and healthy eating so that they may transfer this knowledge and skillset to families and community groups. This is a good illustration of an approach to build the community's capacity to address a health issue defined by health professionals (community-based approach) and not necessarily by community members (community-developed approach).

There was substantive discussion of involving communities in developing strategies to improve health in the *Primary Prevention Plan* (2011). It stated that "improving health and wellbeing relies on active engagement with and participation by citizens" and addressed the need for "individual and community participation in their own health and in planning, implementing and evaluating policies, programs and services" (Government of South Australia, 2011c, p. 35). This is a different form of community participation that goes beyond the mobilisation of community members in health initiatives (as in the *Eat Well Be Active Strategy* discussed above) to engaging community members in defining the health issue.

The examples presented above describe the foundational ideas for community participation that are widely regarded to be critical to HP practice. The conceptualisation of community participation in the *Primary Prevention Plan* (2011) is most closely aligned with the community empowerment ideals in the *Ottawa Charter* (1986). In the remainder of policies studied, community participation was seen more as consultation or mobilisation of community members with the health sector maintaining control over the agenda and scope of participation. Examples of documents that addressed community participation 'to a limited extent' were found to mostly contain reference to involving community members in identifying needs or improving health services, thus positioning community as consumers of health care as opposed to being empowered partners in HP. The following are examples of this:

- The *GP Plus Health Care Strategy* (2007) indicated the importance of community participation to "determine the health needs of vulnerable populations" (Government of South Australia, 2007a, p. 7).
- The need to "develop partnerships with communities to identify and address local community needs related to chronic disease prevention and care" (Government of South Australia, 2009a, p. 36) was stated in the *Chronic Disease Action Plan* (2009).
- The *Health Services Framework for Older People* (2009) mentioned community participation with respect to meeting the needs of Aboriginal people: "SA Health will work in partnership with Aboriginal people (including elders) and key agencies to strengthen the health system's ability to ensure respectful and culturally safe care to older Aboriginal people" (Government of South Australia, 2009c, p. 24).
- An underpinning value in the *Tobacco Control Strategy* (2011) was to "meaningfully involve the community and stakeholders" (Government of South Australia, 2011g, p. 10), however, there is little mention of involving community members in planning, implementing and evaluating tobacco control strategies.

Despite the lack of consistent and strong attention to community participation, SA Health had a *Consumer and Community Participation Policy* (2009b) (which was not reviewed for my research) with the purpose to:

…ensure consumers and the community have the ability to participate in health care decisions. The policy relates to an individual's participation in decisions concerning their own health care, as well as consumer and community participation in decisions related to health service quality improvement, equity and management (Government of South Australia, 2009b, p. 1).

The focus appears to be on health care services in this policy, but it was somewhat surprising that there were no linkages made to this policy in the documents reviewed for this research.

Despite the numerous descriptions of the need for community participation in the policies studied, as at 2013 the context was weak in terms of an empowerment approach to HP and appeared unlikely to provide a strong platform for this to occur. This was particularly the case given the limited attention to this principle in the *Review* (2012), *SA Health's Response* (2013), and the *Public Health Act* (2011), and in the withdrawal of the *Primary Prevention Plan* (2011).

5.2.3 The abdication of reorienting health services by the state government

One of the most salient findings regarding the HP policy context was the abdication of reorienting health services towards HP by the state. *SA Health's Response* (2013) to the *Review* (2012) accepted the recommendations that a) funding to state managed HP services would cease at the end of the fiscal 2012–13 year; b) discussions would ensue with the federal and local governments about their future plans for HP; and c) HP activity would be "reoriented to chronic disease management services to reduce waiting times for existing services and/or to develop service responses where gaps currently exist" (Government of South Australia, 2013a, p. 12). It was not surprising then to find that the *Primary Prevention Plan* (2011) was withdrawn in 2013 as the purpose of the document was very much centred on reorienting health services towards HP.

There appeared to be much riding on the *Primary Prevention Plan* (2011), as many documents from 2009-2011 referenced the plan as the direction setting document for building capacity in the health sector for HP. Many documents in 2011 (Table 5.2) did not address this HP action at all

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and this seemed to reinforce the importance of the pending plan. The *Primary Prevention Plan* (2011) was designed to help drive health system reform and "provide support to regional health services to identify specific strategies to implement evidence-informed equity actions" (Government of South Australia, 2011c, p. 31). It stated that

> … there are barriers to reorienting practice towards prevention. Effective implementation will require communication to build support for the value of prevention within the health system; increase community understanding of the value of prevention and the types of strategies that are most effective (Government of South Australia, 2011c, p. 41).

Therefore, when the *Primary Prevention Plan* (2011) was withdrawn in 2013 there was little indication of the state health sector leading HP at the regional or local level, except through partnership with local government in public health planning. The *Primary Prevention Plan* (2011) laid out a clear model of an integrated health system where primary prevention was a third pillar of the health reform agenda (Figure 5.1).

Figure 5.1   Health care reform and the role of *Primary Prevention Plan* (2011) (Government of South Australia, 2011c)
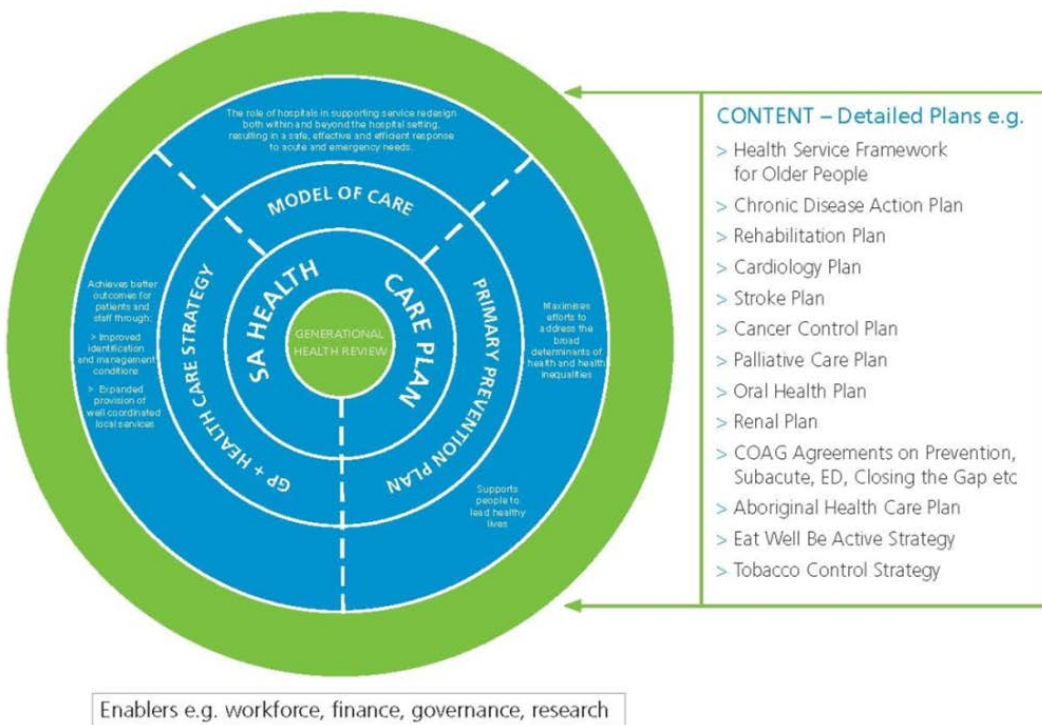
It is notable that 'primary prevention' was the term used not 'health promotion" and this appeared to signal a shift in thinking about or acceptance of HP. The integrative function of the *Primary Prevention Plan* (2011) for 'health governance' was eliminated and the health system was reoriented to clinical health care services.

Similar to my discussion about facilitating community participation, there were detailed descriptions about the importance of reorienting health services in early documents. In 2003, all three documents identified this HP action 'to a great extent' (Table 5.2). The *Generational Review* (2003) affirmed that the health system needed to change from an "illness focused system into a health focused system" (Government of South Australia, 2003a, p. 14) and acknowledged that a commitment to HP was going to be a "significant shift" (Government of South Australia, 2003a, p. 14). *First Steps Forward* (2003) also called for a reformed health system with increased focus on HP: "We need to strengthen primary health care services in communities. The focus needs to be on prevention, health promotion, early intervention and the management of people's health in their local community" (Government of South Australia, 2003b, p. not indicated). Building "the system's capacity for prevention, health promotion and early intervention" (Government of South Australia, 2003l, p. not indicated) was included as a goal in the *Primary Health Care Policy Statement* (Government of South Australia, 2003c, p. not indicated).

These types of descriptions supporting the reorientation of health services carried through other documents. For example, the *Strategic Plan* (2007) viewed "healthcare as not just treating the sick but as helping people to stay healthy" (Government of South Australia, 2007c, p. 18) and more explicitly, "SA Health will reorient services to improve access to primary health care services [including HP] for Aboriginal South Australians" (Government of South Australia, 2010a, p. 17) as portrayed in the *Aboriginal Health Care Plan*.

Documents that discussed reorienting health services 'to a limited extent' were generally focused on the provision of health care services, not HP. For example:

- The *GP Plus Health Care Strategy* (2007) focused on the need to strengthen primary health care and discussed the need to shift to more HP "rather than just providing more resources into the acute care sector" (Government of South Australia, 2007a, p. 2). However its strategies were narrowly targeted to addressing individual risk factors, lifestyle behaviours and self-management programs.

- The *Chronic Disease Action Plan* (2009), *Health Services Framework for Older People* (2009), and the *Eat Well Be Active Strategy* (2011) specifically stated that other documents such as the *Primary Prevention Plan* (2011) and the *Adelaide Statement on Health in All Policies* (2010) would provide key directions for reorienting the health system toward more HP.

- The *Public Health Act* (2011) offered broad support for this action through the role of the Minister of Health and particularly the role of the Chief Public Health Officer "to develop and implement strategies to protect or promote public health" (Government of South Australia, 2011f, p. 14).

In summary, there was little to no evidence in the policy context for the reorientation of health services to increase attention to the integration of HP in 2013. However, SA Health did have an oversight or facilitative role as proclaimed through the *Public Health Act* (2011) for public health planning at the state and regional or local levels, but it was unclear how this might translate into HP services (practice) in the regional health system.

5.2.4   Unanswered questions about developing partnerships and intersectoral collaboration

Almost all documents identified the need for developing partnerships and intersectoral collaboration for HP to some extent and this HP action garnered the most number of 'to a great extent' ratings (10 of 20 documents in Table 5.2). This finding points to the potential importance of this action in the HP policy context and furthermore, this HP action offers a clear link to

systems thinking in that its crux is strengthening connections or relationships between system elements to take joined-up action on SDH.

The *Review* (2012) and *SA Health's Response* (2013) clearly placed emphasis on the federal (through Medicare Locals) and local governments assuming leadership for HP at the regional and local levels and acknowledged that communication between levels of government would be important. Communication was the term used, as opposed to collaboration, and therefore there was not a particularly strong endorsement for this HP action and the need for strong relationships between system elements. However, the *Public Health Act* (2011) drew attention to the state's collaborative role through statements such as "The protection and promotion of public health requires collaboration and, in many cases, joint action across various sectors and levels of government and the community" and that "People acting in the administration of this Act should seek ways to develop and strengthen partnerships aimed at achieving identified public health goals consistent with the objects of this Act" (Government of South Australia, 2011f, p. 10). Public health goals were to be derived from planning processes at the state and regional or local government levels. Partnerships and intersectoral collaboration appeared to be a dominant strategic direction for public health planning and action, however, specific accountabilities or responsibilities for HP among system elements were not clearly articulated.

The following describes how partnerships and intersectoral collaboration were discussed 'to a great extent' in documents in order to portray the historical richness of this HP action. The *Generational Review* (2003) was comprehensive in advocating for local, state and federal governments to work together in a more coordinated fashion and the health sector working with local agencies and organisations in a more collaborative manner for HP. It identified systems thinking as a foundation for health reform and characterised the health system as having a "lack of a system culture and fragmentation and duplication of services" (Government of South Australia, 2003a, p. 23). Although this was not in direct reference to HP, it appeared to have overall relevance to the policy context. The discussion went further and incorporated key systems concepts in identifying that "intervening in one part of the system will affect the rest because of the intrinsic interconnectedness" (Government of South Australia, 2003a, p. 181).

The collaborative development of regional action plans to address population needs was highlighted in the *Primary Health Care Policy Statement* (2003) and this appeared to link well with the planning processes articulated in the *Public Health Act* (2011). The *Statement* elaborated and broadened the discussion to include developing cross-sectoral collaborative systems and this systems view was also evident in the *Generational Review* (2003).

The *Strategic Plan* (2007) described the need for strong partnerships to support the collaborative development of regional priorities and the alignment of state and regional plans. The 2011 revised *Strategic Plan* devoted an entire section to partnerships and working together for a healthier and more prosperous state. It specifically noted that partnerships with the federal and local governments would be required to achieve targets in areas that influence population health such as public transportation, urban development, employment and education.

The *Chronic Disease Action Plan* (2009) maintained that a shared responsibility for health would be critical to successful implementation. "Combining the efforts of government, non-government and community controlled sectors and working in partnership with communities to provide the best method in improving the broader determinants of health" (Government of South Australia, 2010a, p. 38) was the approach to partnerships outlined in the *Aboriginal Health Care Plan* (2010). The plan repeatedly called for enhanced engagement, collaboration, and integration in the health system.

The *Adelaide Statement on Health in All Policies* (2010) emphasised new governance structures and processes for partnerships in order to join up efforts to improve population health and the Statement stressed:

> Government can coordinate policy-making by developing Strategic Plans that set out common goals, integrated responses and increased accountability across government departments. This requires a partnership with civil society and the private sector (World Health Organization & Government of South Australia, 2010, p. 2).

A strong case was made for why intersectoral partnerships and collaboration in joined-up governmental approaches were necessary to improve health through building healthy social,

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economic and environmental policies. The intentions of the *Adelaide Statement on Health in All Policies* (2010) appeared to be embedded in the *Strategic Plan* (2011) and linked to principles in the *Public Health Act* (2011).

The *Eat Well Be Active Strategy* (2011) was particularly strong in its call for partnerships and intersectoral action and offered priorities for action that would result in "widespread, coordinated and sustained" (Government of South Australia, 2011a, p. 5) stakeholder collaborations and create synergy to support increased healthy eating and physical activity. Local government was singled out as having a crucial role and this approach appeared to link with the aims and governance structures articulated in the *Public Health Act* (2011). The *Tobacco Control Plan* (2011) discussed "engaging in collaborative relationships with key partners" (Government of South Australia, 2011g, p. 10), notably in terms of working with other states and the federal government in policy development regarding plain packaging and pricing and with Aboriginal organisations to implement tobacco reduction programs.

The final document that identified and supported developing partnerships and intersectoral collaboration to a great extent was the *Primary Prevention Plan* (2011). It identified intersectoral collaboration as a central action:

> Many of the determinants of health are outside the direct control of the health sector. By forming strong partnerships with different organisations, we can collectively create healthy policies and environments (Government of South Australia, 2011c, p. 1).

It further stated that action by SA Health to participate or lead "cross-agency efforts to tackle the causes of disadvantage is a legitimate response to preventing poor health" (Government of South Australia, 2011c, p. 30) and offered detailed roles and responsibilities that would be needed in the multisectoral health system. Thus, the call for linking system elements was strong.

Similar to other actions, documents that addressed this HP action to a more limited extent tended to focus on health care services and not HP. The *SA Health Care Plan* (2007) only touched upon intersectoral collaboration, but did state that "improving the health and well-being of the South Australian community will require us all to take responsibility to develop a combined approach

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from individuals, community groups, government and non-government sectors, and will involve working closely with GPs and other private health care providers" (Government of South Australia, 2007b, p. 11). The focus here and in other documents such as the *GP Plus Health Care Strategy* (2007), *Oral Health Plan* (2010), and *Cancer Control Plan* (2011) was collaboration for enhanced health care services. Documents such as the *Framework for Comprehensive Primary Health Care Services for Aboriginal People* (2011) were rated generously as they did not explicitly discuss partnerships for HP, however, in this case it emphasised that it was a companion document to the highly rated *Aboriginal Health Care Plan* (2010) where developing partnerships was a prominent recommended action.

Overall, developing partnerships and intersectoral collaboration was the strongest or most endorsed HP action in the policy context because of the number of documents that were rated 'to a great extent' and the clear direction offered in the *Public Health Act* (2011). The Act set out governance structures for partnerships and collaboration and was the main policy driver for HP in 2013. However, there remained unanswered questions regarding the following:

- the extent to which a shared responsibility for HP was valued;
- the extent to which the meaning of the terms partnerships and intersectoral collaboration were shared;
- the strength of relationships between the federal and state government and between the state and local governments;
- the capacity of local governments to assume leadership roles and responsibilities for intersectoral and collaborative public health planning;
- governance structures and relationships within the state government for whole-of-government approaches (or Health in All Policies); and
- processes for engaging the private sector and community members.

Even though it remained the most endorsed HP action, the policy landscape was diminished, having appeared so strong in 2011 with the *Public Health Act* and the *Primary Prevention Plan* (where together these documents portrayed a strong shared leadership and collaborative

approach between the state health sector and local government for HP). The 2013 policy context prompted questions about the potential impact of weakened connections between the state's Local Health Networks and local government for regional HP planning. The role of other system elements such as Medicare Locals and other state government departments was unclear. Nongovernment organisations were not discussed to a great extent in the documents and this made it difficult to assess their role in HP as well. The ambition to partner and collaborate on HP initiatives is evident in these state level documents, however questions remain as to how this would play out in practice.

5.3 The extent to which the documents identified and supported health system building blocks for health promotion

As described in Chapters 2 and 3, the World Health Organization framework for building blocks to strengthen health systems include leadership and governance, financing, human resources (or workforce), services (practice) and information (de Savigny & Adam, 2009). There were two documents that addressed all building blocks (as well as all components of HP) to a great extent and they were the *Aboriginal Health Care Plan* (2010) and the *Primary Prevention Plan* (2011) (Table 5.2). Thus, systems thinking, in terms of explicitly addressing all key building blocks for HP was evident in some but not many documents. In the following sections, I examine the extent to which each building block was evident in documents and how this appeared to shape the policy context in 2013.

5.3.1 Leadership and governance

As discussed in Chapter 3, I grouped two HP actions (reorienting health services, and developing partnerships and intersectoral collaboration) with two dimensions of leadership and governance (health governance and governance for health, respectively) in order to rate the overall extent to which leadership and governance for HP was evident in the documents. In Table 5.2 above, six (of 20) documents [(*Generational Review* (2003), *Primary Health Care Policy Statement* (2003),

Strategic Plan (2007), *Aboriginal Health Care Plan* (2010), *Adelaide Statement on Health in All Policies (*2010) and *Primary Prevention Plan* (2011)] identified and supported leadership and governance for HP to a great extent. These documents illustrated the importance of both dimensions of leadership and governance and gave clear support to not only critical HP actions but also a key health system building block for HP. However, neither the *Public Health Act* (2011) nor the *Review* (2012) and *SA Health's Response* (2013) addressed both dimensions of leadership and governance and this pointed to deficits in the policy context. Beyond rating the documents there were several themes with respect to leadership and governance for HP and these are discussed in the following sections.

5.3.1.1   *Delineation of leadership roles and governance structures for health promotion*

The governance structures and roles of the system elements for HP leadership as at 2013 are summarised in Table 5.3. The *Review* (2012) and *SA Health's Response* (2013) altered the governance structure significantly in that decisions about 'health governance' for HP (at regional and local levels) conceded leadership to the federal government through Medicare Locals and to local governments through their increased leadership role as envisioned in the *Public Health Act* (2011). These decisions appeared to negate the rich history of policy documents calling for the state government to strengthen the reorientation of health services to HP and lead collaboration among levels of government for HP at the regional and local levels.

Table 5.3   Governance structures for HP and their relationship to system elements (2013)

System element	Documents defining governance structure for HP	Leadership roles identified in documents
Federal government	The *Review* (2012) and *SA Health's Response* (2013)	Medicare Locals had a leadership role in health governance for primary health care and HP (regional and local levels) as described in the National Health Reform Agreement.
State government	*Public Health Act* (2011)	SA Health's leadership role was governance for health where partnership development with local government, other state government departments, NGOs and other sectors was the focus.
	The *Review* (2012) and *SA Health's Response* (2013)	Local Health Networks have no leadership role in HP.
Local government	*Public Health Act* (2011)	Local governments are the Public Health Authority for their city (or region) and therefore have leadership roles in HP.
NGOs	*Public Health Act* (2011)	No clear HP leadership role but NGOs are identified as potential partners.

SA Health's leadership role was focused on state-level leadership in implementing the *Public Health Act* (2011) where partnership development with local government and intergovernmental and intersectoral collaboration were central. The *Public Health Act* (2011) delineated leadership and governance roles and responsibilities, notably for the Minister of Health, the Chief Public Health Officer, South Australian Public Health Council, and local governments.

The *Review* (2012) and *SA Health's Response* (2013) occurred after the *Public Health Act* (2011) became legislation, therefore the extent to which local governments were prepared for the withdrawal of HP leadership support from the regional Local Health Networks is a question. This line of questioning also parallels potential issues about the extent to which system elements were prepared for the withdrawal of the *Primary Prevention Plan* (2011) as this document addressed state government leadership and governance to a great extent. For example, it stated that:

[t]he Department of Health has an important leadership role to play in setting directions in consultation with partners, building capacity for effective prevention practice by SA Health services and other partners through leadership, training programs and support for prevention champions advocating across government for public policies and programs that will contribute positively to addressing the social determinants of health (Government of South Australia, 2011c, p. 33).

Several documents such as the *Chronic Disease Action Plan* (2009) and the *Health Services Framework for Older People* (2009) referred to the pending *Primary Prevention Plan* (2011) as key to future leadership and health governance for HP and thus, the assertions in these documents were unsupported by the removal of the *Primary Prevention Plan* (2011).

5.3.1.2   *Whole-of-state government leadership for health promotion*

The 2003 documents discussed the importance of a whole-of-state government approach to HP, for example, the *Generational Review* (2003) stated that "the quality of life of Aboriginal people should be a first priority area for whole-of-government action" (Government of South Australia, 2003a, p. 160). This was clearly echoed in the *Aboriginal Health Care Plan* (2010) as it set out to guide "a whole of state coordinated system working across and with local regions, as well as supporting whole of state health promotion" (Government of South Australia, 2010a, p. 22). Following this thread, the *Strategic Plan* (2011) then stated that it was "the main instrument for determining strategic priorities within government agencies" and "for whole of government decision making" (Government of South Australia, 2011d, p. 18). It was, however, the *Adelaide Statement for Health in All Policies* (2010) that formally described state health department leadership in joined up, horizontal collaboration (with other state government departments) as a critical way forward to improve overall population health and the *Public Health Act* (2011) incorporated this as a key governance mechanism.

Other documents also included calls for whole-of-government approaches and examples are as follows:

- "Addressing legislative, policy and structural issues requires whole of government input and collaboration as many factors are beyond the jurisdiction of the health sector" was urged in the *Cancer Control Plan* (Government of South Australia, 2011h, p. 8).
- The *Eat Well Be Active Strategy* (2011) called for an ongoing, high level, interdepartmental leadership group to hold decision makers accountable for improved health outcomes.
- The *Primary Prevention Plan* (2011) recommended that an implementation committee be established with membership drawn from the state department of health, regional health services, other government departments, academia, general practice, local government, and nongovernmental organisations.

5.3.1.3 *Intergovernmental relations*

Another theme in the documents with respect to leadership and governance for HP was the call for strong intergovernmental relationships. The *Generational Review* (2003) emphasised the importance of enhancing leadership skills to address problems associated with multiple planning processes, governance, funding arrangements and regional boundaries between the federal and state government. The need for more effective leadership to improve federal-state relations in order to address duplication and administrative waste were recognised as roadblocks to effective reform in the *Primary Health Care Policy Statement* (2003) and the *First Steps Forward* (2003).

In the *Aboriginal Health Care Plan* (2010) enhanced leadership and 'health governance' was stated as necessary at all levels of government and the establishment of strong partnerships to implement culturally respectful, systemic and prioritised initiatives were urged. The *Adelaide Statement for Health in All Policies* (2010) was specific in stating that not only horizontal but vertical (between levels of government) joined-up leadership was necessary. The *Tobacco*

Control Plan (2011) acknowledged that continued coordination with the federal government as part of the *National Partnership Agreement on Preventive Health* (2008) was important, specifically in relation to tobacco control social marketing campaigns. As a final example, shared leadership with the federal government was considered essential in the *Oral Health Plan* (2010) to "ensure that low income earners are able to receive regular dental check-ups and timely treatment" (Government of South Australia, 2010c, p. 16). These are a handful of examples that illustrate the consistent calls for strengthened and shared leadership with particular focus on federal and state relations.

Attention was also paid to state-local government relations in documents. Both *Strategic Plans* (2007 and 2011) emphasised state and local government collaboration to greater extent than relationships with the federal government in terms of HP. For example, the *Strategic Plan* (2007) stated that "concerted effort not only from the State Government but also from local government" (Government of South Australia, 2007c, p. 8) was needed to improve quality of life. Although other documents mentioned the importance of shared leadership between the state and local government [e.g., *Eat Well Be Active* (2011), *Primary Prevention Plan* (2011)] it was the *Public Health Act* (2011) that provided the governance structure and appeared to be most germane in the 2013 policy context for HP as the Act was "to be a primary source of advice to the Government about health preservation, protection and promotion" (Government of South Australia, 2011f, p. 13).

The *Review* (2012) and *SA Health's Response* (2013) alluded to leadership and 'health governance' for HP being a contested area because every level of government was identified as having a role. For example, the *Review* (2012) stated that:

The State will continue to be responsible for both the funding and provision of a significant part of the primary care service spectrum for the foreseeable future (Government of South Australia, 2012, p. 7).

The role of the Medicare Local is to develop integrated and coordinated services; support clinicians and service providers to improve patient care; identify the health needs of local areas and facilitate the implementation of primary care initiatives and services (Government of South Australia, 2012, p. 7).

The provision of primary prevention services such as health promotion and illness prevention are identified by the Commonwealth as areas for Medicare Locals to address (Government of South Australia, 2012, p. 26).

These quotes demonstrate that the state government saw Medicare Locals as having a significant leadership and 'health governance' role in HP. Furthermore, there was an example in the *Review* (2012) that implied that not only Medicare Locals might be responsible for an existing state financed HP service, but also local councils:

Community members involved in the Community Foodies program may be concerned about future support for the education sessions they have been running and how they will continue to use these skills. Opportunities with the [Local] Council led OPAL services and Medicare Locals which have a primary prevention role, should be explored to support the transition. In the event that Local Councils and Medicare locals do not choose to deliver similar primary prevention services a transition out strategy will need to be developed for the relevant services (Government of South Australia, 2012, p. 27).

Therefore, it is not unexpected to see in the list of a recommendation in the *Review* (2012) that "there are discussions with Local Government and the Commonwealth Government about their future plans in this area" (Government of South Australia, 2012, p. 27).

5.3.1.4   Summary: leadership and governance

The relationships between system elements are critical components of the leadership and governance building block as the themes from the document review attests. Furthermore, leadership and governance appears to be foundational or the superordinate building block because without it progress towards the HP goal and actions do not seem possible nor allow

other building blocks into existence. The emphasis in the 2013 policy environment appeared to be on the delineation of roles and responsibility and 'governance for health' (shared responsibility) by the state government and these would require strong partnerships and intergovernmental and interdepartmental relations.

5.3.2 Financing

A second building block or component of system structure is financing for HP and it was found to be the least identified and supported building block as almost half the documents (8 of 20) did not discuss this at all (Table 5.2). The most significant finding was regarding *SA Health's Response* (2013) to the *Review* (2012) where it was reported that state funding for HP services (practice) would cease at the end of the fiscal 2012-2013 year. The need to address state finances was a key consideration and *SA Health's Response* (2013) to the *Review* (2012) explained that reducing health care expenditures was a clear priority:

> Health spending is at a record high … A significant reduction in taxation and GST revenues have placed greater pressure on the State's finances … While SA Health continues to deliver quality health outcomes for South Australians, its financial growth is unsustainable in this environment (Government of South Australia, 2013a, p. 3).

It was notable that the study of the cost effectiveness of non-hospital services appeared to be done in isolation from the cost effectiveness of hospital-based services and therefore this lacked the ability to identify and isolate key drivers of escalating health care costs. The *Public Health Act* (2011) was the only formal state policy for HP as implementation of other policies, strategies, and plans were questionable, given the policy context at the end of 2013 and it did not reference financing at all. Thus, the policy context from a state perspective appeared to be indeterminate for resourcing HP. The following section reports on how other documents called for financing for HP.

Seven policies discussed financing for HP explicitly and these called for adequate and stable funding for primary health care and/or HP, but did not indicate any allocations [*Generational*

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Review (2003), *Primary Health Care Policy* (2003), *First Steps Forward* (2003), *Aboriginal Health Care Plan* (2010), *Adelaide Statement on Health in All Policies* (2010), *Eat Well Be Active Strategy* (2011), *Primary Prevention Plan* (2011)]. Stabilising HP funding was equated with moving away from short term grants [*Generational Review* (2003)]. The *Adelaide Statement on Health in All Policies* (2010) took a systems view where budgetary commitments to HP were embedded as an integral component of health system structure. For example, HP financing was linked to the leadership and governance building block and the need for collaborative processes to arrive at solutions to problems that may alter the power dynamic, or rather who wins and loses, in budget allocations. The *Primary Prevention Plan* (2011) discussed the financial pressures facing the health system, however, it called for an ongoing commitment to invest in HP in order to implement effective strategies. The key aims of the plan were to provide a platform for integrating and coordinating efforts and to advocate for an "identified budget for primary prevention with a commitment to an annual increase" (Government of South Australia, 2011c, p. 40). It also called for a five year financing window in order to demonstrate effectiveness thus moving away from short term grants.

Beyond these general descriptions as to how the documents did or did not address financing for HP, there were two themes that emerged from document review: first, there was discussion about financial arrangements with the federal government, and second, financing for primary health care was addressed.

5.3.2.1   Financial arrangements with the federal government

Several documents highlighted strategic financial arrangements with the federal government. The *Aboriginal Health Care Plan* (2010) discussed several federal funding schemes that increased investment in HP such as the *Closing the Gap* initiative and the *Aboriginal Regional Birthing and Maternal and Infant Care* programs. The important financial role of the state government was also recognised to support the Aboriginal Community Controlled Health Services (largely funded by the federal government) by providing more extensive primary health

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care and funding priority programs. The loss of the Commonwealth Dental Health Program and the state's allocation to support increased access to dental services was noted in the *Oral Health Plan* (2010). Although the plan did not discuss HP funding, it addressed this building block through strong support for the implementation of other plans such as the *Aboriginal Health Care Plan* (2010). Financing for HP was discussed to a limited extent in the *Tobacco Control Strategy* (2011), but it too identified the importance of federal funding through the *National Partnership Agreement on Closing the Gap* that targeted Aboriginal specific initiatives as well as mass media campaigns.

As a final example, the *Eat Well Be Active Strategy* (2011) identified the Obesity Prevention and Lifestyle (OPAL) initiative as the largest financial commitment to prevent obesity in children with five local governments (local councils). Financing for OPAL was part of a joint $40 million federal–state funding arrangement (with local governments as key partners). The strategy also discussed *National Partnership Agreement on Preventive Health* (2008) funding of $10.57 million allocated to the Healthy Workers–Healthy Futures initiative (2011-2015) and the desire to fund a new initiative to promote walking. These examples depict the importance and changing nature of financial arrangements between the federal and state governments for HP, but they offered little in terms of securing future financing for HP.

5.3.2.2   Financing for primary health care

Population-based primary health care funding models were recommended in the 2003 documents to better meet the needs of vulnerable populations [e.g., *First Steps Forward* (2003)]. New funding models based upon population need would determine funding allocations based upon the degree of disadvantage in populations and this was thought to support the HP goal of addressing health inequity [e.g., *Generational Health Review* (2003)]. Population-based funding models were also linked to the need for adequately funded health services for Aboriginal and Torres Strait Islander people and to "creating a sustainable funding base for primary health care [including HP]" in the *Primary Health Care Policy statement* (Government of South Australia,

2003c, p. not indicated). However, calls for population-based funding models for financing primary health care did not appear in subsequent documents and furthermore, *SA Health's Response* (2013) to the *Review* (2012) appeared to negate aspects of this call by cutting funding for HP at the regional and local levels.

The *Strategic Plan* (2007) highlighted financing in terms of the ageing population and the increased prevalence of chronic disease and these were considered a "significant financial burden on the health care system" (Government of South Australia, 2007c, p. 19). It reported on increased investment in infrastructure and programs to support primary health care but did not provide further details. Similarly, the *GP Plus Health Care Strategy* (2007) reported that new Health Care Centres would be funded and that through the implementation of *First Steps Forward* (2003), health reform had progressed to where "investment in community-based health services" had been achieved (Government of South Australia, 2003b, p. not indicated). If one presumed that the conceptualisations of primary health care and community health services in the *Strategic Plan* (2007) and *GP Plus Health Care Strategy* (2007) paralleled those in the 2003 documents, that is, more in the tradition of comprehensive primary health care, then HP might have been addressed to some extent.

5.3.2.3   Summary: financing

State economic circumstances and rising health care expenditures as reported in the *Review* (2012) and *SA Health's Response* (2013) were identified as key factors that influenced cuts to HP services (practice) and the workforce. Financing for regional and local HP activities were left to the federal and local governments. In 2013, calls for adequate and sustained funding for HP appeared to be unheeded, population-based funding models to support HP were absent, further federal funding did not surface in documents, and funding for primary health care that included HP either in the federal or state health sectors was indeterminate at best.

5.3.3 Workforce

As with the discussion regarding leadership and governance and financing, the workforce (or human resources) as a system building block for HP was significantly diminished as a result of the *Review* (2012) and *SA Health's Response* (2013). The decision to cut HP funding (and reassign some staff to chronic disease management roles) represented cuts to the HP workforce in the state health care sector (Local Health Networks and the state health department) and furthered the assumption that Medicare Locals and local government would be responsible for providing the formal HP workforce at the regional and local levels. This was particularly the case given that the *Public Health Act* (2011) made no mention of this building block except for a broad goal: "to establish and maintain a network of health practitioners and agencies designed to foster collaboration and coordination to promote public health" (Government of South Australia, 2011f, p. 15).

Twelve (of 20) documents (Table 5.2) identified the workforce as a key enabler for HP and the following descriptions were helpful to identify attributes of a desired HP workforce:

- Flexible and innovative workforce developed through training, education and information about primary health care (including HP) [*Primary Health Care Policy Statement* (2003)].

- More people to work with communities and to facilitate action and change at the community level [*Eat Well Be Active Strategy* (2011), *Aboriginal Health Care Plan* (2010)].

- A culturally responsive health workforce developed by employing more Aboriginal people across all levels of the health workforce [*Aboriginal Health Care Plan* (2010)] and providing a supportive work environment to attract and retain Aboriginal people [*Framework for Comprehensive Primary Health Care for Aboriginal People* (2011)].

- A joined-up or collaborative workforce development at various stages in building healthy public policy [*Adelaide Statement on Health in All Policies* (2010)].

- A sufficient number of staff that represent multiple disciplines with high level knowledge and skill, capacity building of local government officials and other sectors, and support for workplace learning environments where continuous learning and quality improvement are encouraged in order to strengthen the workforce [(*Primary Prevention Plan* (2011)].

- All senior managers (clinical and primary care) would have "a high-level understanding of and commitment to evidence-informed HP practice, why it is important, how it is an integral plank of the operation of the regional health service and the implementation of the *SA Health Care Plan*" [*Primary Prevention Plan* (2011)].

Other documents discussed workforce issues but either provided broad descriptions of building the capacity of the entire health workforce or focused on the provisions of health care services and the need for collaboration. For example, the *Generational Review* (2003) highlighted the need for considerable workforce development because of "entrenched racism in the workforce" (Government of South Australia, 2003a, p. 190) against Aboriginal people. Furthermore, improvements to management/employee relations were targeted to enhance trust throughout the health system because "[a]t the operational level workers stated that they receive such inconsistent messages regarding policy and processes that they no longer understood the parameters within which they were to work" (Government of South Australia, 2003a, p. 159). This document also made reference to health professionals needing to work in a more integrated way.

Building workforce capacity was identified and elaborated upon to some extent as a key enabler in the *Chronic Disease Action Plan* (2009), however, the focus was on supporting health care professionals in chronic disease management strategies. This was also the case in the *Framework for Older People* (2009) but with a focus on "a workforce that delivers health services responsive to the needs of older people" (Government of South Australia, 2009c, p. 20). Out of 13

statements relating to recruiting and retaining a strong, capable health workforce in the *SA Health Care Plan* (2007) only one was pertinent to HP and that was the need to identify partnerships to best make use of existing knowledge and expertise. The *First Steps Forward* (2003) document emphasised health professionals working in teams and working in partnership with General Practitioners and the federal government to support the role of GPs in primary health care services but again with no mention of HP.

5.3.3.1   Summary: workforce

In 2013 there appeared to be almost no HP workforce in the state health care system to work at the regional and local levels as a result of policy decisions. From document review alone it was not possible to discern if other system elements had workforce capacity for HP.

5.3.4   Health promotion services (practice)

Although service delivery was a term used for a health system building block, I described this in Chapter 3 in terms of HP practice to better reflect the nature of HP actions and strategies. A framework which included three strategies from the *Ottawa Charter for Health Promotion* (1986) was discussed in Chapter 2, and these were: developing personal skills, creating supportive environments, and building healthy public policy. Table 5.4 provides examples of how these three HP strategies were identified and supported in the state government documents reviewed.

Table 5.4   Examples of how three health promotion strategies were identified and supported in SA documents (2003-2013)

Documents	HP strategies		
	Develop personal skills	**Create supportive environments**	**Build healthy public policy**
Better choices better health: Final Report of the SA Generational Review (2003)	Advocate for self-management for people with chronic disease.	Create healthy work environments to develop the health sector. Urban environments contribute to quality of life.	Advocate for a whole-of-government approach.
First steps forward: SA's health reform (2003)		The physical social and economic environments in which people live have impacts upon health and wellbeing.	Adopt a whole-of-government approach to particularly improve the health status of Aboriginal people.
Primary Health Care Policy Statement (2003)	Support individuals and families to achieve good health and manage their health needs.	Encourage physical and social environments that promote good health.	Adopt a whole-of-government approach. Develop public policies and programs that support healthy choices and strengthen preventive approaches.
SA's Strategic Plan (2007)	Establish strong preventive services targeting healthy lifestyles early in life by educating young people about smoking, excessive drinking and obesity.	Support industrial awards that allow workplace flexibility and enshrine occupational health and safety principles.	Ban junk food in schools, tighten penalties for unsafe driving, ban the sale of fruit-flavoured cigarettes, reduce the risks to children from adults smoking in cars, and ban smoking in all bars and hotels.
SA's Health Care Plan (2007)	Implement public lifestyle change health campaigns in areas such as smoking cessation, healthy weight, nutrition and physical activity.		
GP Plus Health Care Strategy (2007)	Implement lifestyle and risk factor programs to focus on behavourial SNAPS (smoking, nutrition, alcohol, and physical inactivity), particularly targeting people with chronic diseases, people at risk of developing a chronic disease, and people most in need of assistance to achieve good health		

Chronic Disease Action Plan (2009)	Use evidence based strategies to prevent chronic disease by reducing risks associated with biomedical (excess body weight, high blood pressure, high blood cholesterol, and impaired glucose tolerance), behavioural and lifestyle factors (smoking, poor nutrition, alcohol misuse, physical inactivity, stress and psychological factors). Detect disease and risk of disease early and intervene effectively, and manage existing disease effectively and proactively.	Acknowledgement that chronic disease can be modified through environmental changes.	Acknowledgement that chronic disease can be modified through policy changes and the Primary Prevention Plan and Health in All Policies framework would address this.
Health Service Framework for Older People (2009)	Build health literacy and reinforce the foundations of healthy lifestyles through eating and exercising well through disease prevention programs and services which aim to maintain and extend the healthy living well (e.g., Falls Prevention Programs).		
Aboriginal Health Care Plan (2010)	Build health literacy to support Aboriginal South Australians' understanding of how to be healthy, how to access health services, and to actively participate in the planning and implementation of health services. Create specific, culturally appropriate health information about the risks associated with hot fluids in the home, safety around campfires and appropriate first aid for burns into programs and services for families of young children.	Health promotion is not just the responsibility of the health sector, but goes beyond healthy lifestyles to wellbeing and supportive environments. Safe and healthy housing and broader environments including access to healthy food. Prevention of unintentional injury requires a strong public health approach to both changing environments and behaviour.	Health in All Policies emphasises horizontal and multi-level policy development to improve Aboriginal health.
Oral Health Plan (2010)	Support a nationally consistent set of oral health messages.	Work with rural Aboriginal communities to ensure that healthy foods, cold tap water with adequate fluoride levels where feasible and toothbrushes and toothpaste are available at an affordable price.	Acknowledgement that the causes of poor oral health are similar to the underlying cause of other health disorders thus the call for broad based policies that extend beyond health services to address the SDH.

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Adelaide Statement on Health in All Policies (2010)			The health sector needs to engage systematically across government and with other sectors to address the health and well-being dimensions of their activities. The health sector can support other arms of government by actively assisting their policy development and goal attainment.
SA's Strategic Plan (2011)	Educate young people about healthy living.		100 targets are identified as a "long term vision" (p17) for action in areas such as health, education, economy, safety.
A Framework for *Comprehensive Primary Health Care for Aboriginal People* (2011)	Provide advice and counselling about healthy eating, healthy weight. Ensure women are aware of the need for cervical screening, breast screening, counselling against smoking, and alcohol/drug screening and counselling.		
SA Tobacco Control Plan (2011)	Mass media campaigns and targeted public education messages to promote quitting among young smokers. Support the healthy workers program to assist workplaces to encourage workers to quit smoking. Quit SA to provide effective evidence-based services and tobacco cessation programs in community settings accessible to people with mental illness, socio-economically disadvantaged people, and prisoners. Enhance efforts by health services to encourage and support smokers to quit as part of routine care while providing more support to reach high prevalence smokers, pregnant women, and those with chronic health problems.	Create smoke-free places and limit access to tobacco products.	Tobacco taxes were raised by 25% in April 2010. Policy actions targeting children include minimising the promotion of tobacco products and reducing access to them by children. Smoke-free policies are called for across government, prisons, outdoors areas providing food and drink, playgrounds, sports stadiums, covered public transport and taxi areas, and workplaces.

Eat Well Be Active Strategy for SA (2011)	Provide a range of information, programs and services to assist people throughout life to be more active, eat a healthy diet and maintain a healthy weight with particular attention to those in need. Ensure availability of consistent information. Identification of people with behavioural and biomedical risk factors and referral pathways for advice, support and management of health problems.	Individuals have the responsibility to maintain a healthy lifestyle, but government and the wider society can ensure that the physical environment, the social and cultural norms, and the places where people live, work and play all help people be active and eat a healthy diet. Telling people how and why they need to adopt healthy behaviours is not enough. Behavior is influenced by a range of factors, including: the norms of society, and the ease in which a healthy choice is possible.	Use of levers such as policy, legislation and taxation to provide incentives for changes in organisational, individual and household behavior. Implement actions to support healthy eating, physical activity and healthy weight through Health In All Policies.
Statewide Cancer Control Plan (2011)	Reduce the risk of cancer through lifestyle changes. (tobacco smoking, sun protection, nutrition, physical activity and healthy weight, alcohol).	Minimise exposure to carcinogens. Reduce exposure to environmental carcinogens in the workplace.	Address legislative, policy and structural issues through whole of government input and collaboration, that is, through Health in All Policies.
Primary Prevention Plan (2011)	Health literacy includes making accessible timely, clear and accurate advice and information about health and its broader determinants: healthy behaviours; self and family care; health systems and services; and how and where to get help. Social marketing (based on an understanding of people's lives, current awareness of risk, what drives current behaviours, what might motivate behaviour or be a barrier, and who could influence behavior) can be a powerful tool for achieving a measurable impact on behaviour.	Local partnerships underpin the creation of healthy and sustainable settings and communities that includes: built environments (transport options, pathways, urban design, recreation facilities, location of supermarkets or fast food outlets, child- and youth-friendly spaces); social environments (communities that are welcoming to all members regardless of age, gender, sexual preference; social support activities; acknowledgment of connection to the land; arts and culture; safety); natural environments (climate change, maintenance of open space, air and water conservation); and economic environments (enhancing access to work, education and employment).	Implement policies, legislative changes, regulations and standards, or introduce economic instruments such as taxation or pricing measures to help protect against adverse social conditions and create safer, healthier environments, products and settings. Continue to implement Health in All Policies across government and start with South Australia's Strategic Plan. Government agencies work with SA Health to explore the interconnections between targets, identify joint areas of work and examine policy proposals using a population health perspective or a health lens.

SA Public Health Act (2011)	Encourage individuals and communities to take responsibility for their own health and to participate in decisions about how to protect and promote their own health and the health of their communities.	Encourage individuals and communities to plan for, create and maintain a healthy environment.	Support policies, strategies, programs and campaigns designed to improve the public health of communities and special or vulnerable groups (especially Aboriginal people and Torres Strait Islanders) within communities. Develop policies or codes of practice that are relevant, identify risks to public health, and/or to set standards in connection with any activity, material, substance or equipment relevant to public health.
The Review of non-hospital based service (2012) and *SA Health's Response* (2013)			Referred to the Public Health Act (2011) as the policy framework for building healthy public policy.

From Table 5.4, ten documents identified the three HP strategies (developing personal skills, creating supportive environments, and building healthy public policy) 'to some extent', however, most did not go beyond acknowledging the need for particular strategies through to incorporating specific or explicit recommendations. Three documents addressed all three strategies in detail and they were the *Aboriginal Health Care Plan* (2010), *Eat Well Be Active Strategy* (2010) and *Primary Prevention Plan* (2011). This analysis is indicated in Table 5.2 where these documents were the only ones rated as addressing HP practice 'to a great extent'.

The *Primary Prevention Plan* (2011) was perhaps the strongest document in terms of HP practice. It was touted as a key driver for health system reform specifically to support regional health services to identify and implement HP strategies. Many system elements including Local Health Networks, GPs, Medicare Locals, local governments, Aboriginal Community Controlled Health Services and non-government organisations were identified as the key entities for HP practice. Perhaps most notable in this document were the specific recommendations for multi-strategy and multi-level approaches and to optimise the mix, reach and effectiveness of strategies. Recommendations included that HP practice be culturally safe, community-based, sufficient in terms of intensity of effort, invested for at least 5 years, targeted services to meet the needs of disadvantaged groups, and a core set of universal good practice programs and services across the life course on priority health issues. Other system building blocks were included as instrumental to effective HP practice. They included having a workforce that is knowledgeable and skilled in community development to engage the hard to reach, and having good information or evaluation for accountability in terms of implementation and outcomes.

The cuts to HP funding and the workforce in Local Health Networks were a disruption in the HP practice environment as a result of the *Review* (2012), *SA Health's Response* (2013) and the subsequent withdrawal of the *Primary Prevention Plan* (2011). One criterion in the *Review* (2012) was to assess whether services overlapped or duplicated other activities in the health system (either the health or other government departments). It was reported that some obesity prevention services provided in partnership with local governments "have a close relationship with State programs and there may be opportunities for synergies in this area" and that "the State Public Health plan [Public Health Act] may provide a framework for better coordination and partnership across government and NGOs" (Government of South

Australia, 2012, p. 25). Furthermore, it found that Medicare Locals "offer the opportunity to explore with the Commonwealth [federal government] its plans and the extent of its proposed investment in the health promotion/illness prevention area" (p. 25). The *Review* also made a call for a significant commitment from the federal government for "programs that seek to change the behaviour of large segments of the population" (Government of South Australia, 2012, p. 25).

Table 5.4 also illustrates that three documents did not address developing personal skills, however, most described HP practice in some fashion at the individual level, with clear targets to reduce risk regarding lifestyle behaviour and emphasis on individual responsibility for health. This finding offers a caution that the HP practice context might succumb to behaviour-focused HP (Baum & Fisher, 2014) and not fully implement a balanced approach inclusive of addressing supportive environments for health.

Furthermore, a common theme among documents was the intention to improve health care and HP services for Aboriginal and Torres Strait Islander People with the *Aboriginal Health Care Plan* (2010) and the *Framework for Comprehensive Primary Health Care Services for Aboriginal People* (2011) leading in this regard. Other documents such as the *First Steps Forward* (2003), *Oral Health Plan* (2010), *Primary Prevention Plan* (2011), and the *Public Health Act* (2011) also directed attention to the need to address health inequities in Aboriginal health and called for targeted HP strategies to this population.

A final theme in the analysis of HP practice as a health system building block was the frequent reference to the Health in All Policies approach to building healthy public policy. This parallels the theme discussed above with respect to the leadership and governance building block and the need for state level, horizontal, whole-of-government leadership for HP. Table 5.4 indicates that 13 (of 20) documents addressed this explicitly [*Generational Review* (2003), *First steps forward* (2003), *Primary Health Care Policy Statement* (2003), *SA Strategic Plan* (2007 and 2011), *Chronic Disease Action Plan* (2009), *Aboriginal Health Care Plan* (2010), *Oral Health Plan* (2010), *Adelaide Statement on Health in All Policies* (2010), *Eat Well Be Active Strategy* (2011), *Cancer Control Plan* (2011), *Primary Prevention Plan* (2011), and the *Public Health Act* (2011)]. Of all the documents reviewed, the *Adelaide Statement on Health in All Policies* (2010) was most clearly directed toward building healthy

public policy through health sector leadership for cross government and intersectoral action. It is notable that the *Public Health Act* (2011) indicated the importance of joint action across various sectors and levels of government to promote and protect public health, however, the phrase 'Health in All Policies' was not used.

Although there were numerous examples, the *Eat Well Be Active Strategy (*2011) was particularly clear in discussing across-government commitments negotiated through the Health in All Policies process and offered the following explanation:

> Recognising the importance of policy change and the key role that government must play, the Executive Committee of Cabinet Chief Executives Group requested that the HiAP [Health in All Policies] initiative work with departments to identify policy actions they could implement to help achieve the SASP [SA Strategic Plan] healthy weight target. This dialogue has achieved a better understanding of the issues and opportunities to ensure complementary policy approaches and win-win outcomes (Government of South Australia, 2011a, p. 30).

5.3.4.1   Summary: Health promotion services (practice)

There were ample descriptions of HP practice in the traditions of Ottawa Charter strategies in the documents reviewed, however, there was uncertainty in the policy context in 2013. The *Public Health Act* (2011) and the planning processes associated with its implementation appeared to be the most important policy direction for HP practice at a regional health system level.

5.3.5 Information

The last health system building block discussed is information, and this is described in Chapter 3 in terms of the extent to which documents addressed a) monitoring and reporting of population health status, and b) gaining evidence of HP effectiveness through research and evaluation. Table 5.2 shows that nine documents addressed this building block 'to a great extent', five 'to some extent', and five 'to no or little extent'.

5.3.5.1   *Monitoring and reporting of population health status*

With respect to monitoring and reporting of population health status, documents such as the *Tobacco Control Strategy* (2011) suggested that monitoring the prevalence of smoking in Aboriginal populations and people with mental illness would be important. The *Primary Prevention Plan* (2011) called for enhanced monitoring of the determinants of health, most particularly regarding inequalities and adverse social environments, and also monitoring of the utilisation of HP services. However, two documents appeared to offer the most support: the *Strategic Plan* (2011) and the *Public Health Act* (2011).

The *Strategic Plan* (2011) identified six objectives (growing prosperity, improving wellbeing, attaining sustainability, fostering creativity and innovation, building communities and expanding opportunities) and each objective had numerous targets. Targets were considered instrumental to "tracking progress statewide", "acting as points of reference", and "providing a framework for the activities of the South Australian government, business and the entire South Australian community" (Government of South Australia, 2011d, p. 8). Numerous targets and indicators in the *Strategic Plan* (2011) were to be reported on every two years and it was acknowledged that economic indicators were easier to report on than social and environmental health. Therefore the establishment of a Well Being Index was recommended. However, despite this there was little explicit attention to health inequities.

The *Public Health Act* (2011) highlighted areas for monitoring and these appeared to focus on medical risk factors and on the incidence and prevalence of diseases that were to be used for research and/or public reporting. A significant aspect of the Act, however, was the requirement by the Chief Pubic Health Officer to produce and table in Parliament a Public Health report every two years that not only included trends but also a description of the implementation of the State Public Health Plan and regional public health plans.

5.3.5.2 Health promotion research and evaluation

Although many documents called for increased HP research and evaluation, the lack of acceptable evidence of HP effectiveness was addressed only in the *Review* (2012) and *SA Health's Response* (2013). Key criteria (among others) used in the *Review* (2012) regarding HP practice were:

- The extent to which services were consistent with current primary health care policy as set out in key documents including *South Australia's Health Care Plan* (2007) and the *GP Plus Health Care Strategy* (2007). This included a specific focus on whether HP services targeted reductions in hospitalisation, improvements in the management of chronic disease, and positive and measurable impacts on population health.
- Evaluation of the cost effectiveness of HP and primary health care services from measurable evidence of service performance or outcomes.

With respect to the first criterion, the *Review* (2012) stated that "the current service profile does not contribute significantly to the key policy objectives of chronic disease management, hospital avoidance and population health" (Government of South Australia, 2012, p. 25). Regarding the second, it was reported that there were no measurable outputs for HP services, that is, there was no activity data available. This was attributed to the nature of the initiatives (e.g., awareness campaigns, community activities and pamphlet development were initiatives where data could not be collected in terms of occasions of service). The *Review* (2012) acknowledged that there had been some regular process and client feedback evaluation that had indicated improvements in delivery for individual services, however, there had been no evaluations of overall service impact. The perceived lack of information about the quantity and effectiveness of HP services was instrumental in the policy decisions contained in the *Review* (2012).

I noted that a key finding in the *Review* (2012) was the lack of alignment of HP services with directions outlined in documents such as the *SA's Health Care Plan* (2007) and the *GP Plus Health Care Strategy* (2007). I reported earlier in this chapter that both of these documents

were rated low in terms of support for HP (Table 5.2), therefore I questioned why these documents would form the basis of assessment. In the same vein, it was unexpected to find that the *Review* (2012) identified reductions in hospitalisation and improvements in the management of chronic disease as key criteria for the assessment HP effectiveness because these are mostly areas of clinical accountability and not widely considered to be the purview of HP (e.g., the goal of reducing health inequities).

The *Review* (2012) further reported that "even in population health, where it could be argued that the case for continued funding is strongest, there was insufficient HP service evidence to demonstrate that these services were having a positive impact" (Government of South Australia, 2012, p. 25). It is notable that at the time of the *Review* (2012) the South Australian Community Health Research Unit was defunded by SA Health and this represented a loss in research and evaluation capacity. In this respect, the numerous recommendations for more HP research and evaluation in many of the documents reviewed appeared to have not been implemented. For example:

- The *Chronic Disease Action Plan* (2009) explicitly called for an "investment in research to further the evidence based for health promotion, prevention, early detection and evidence based chronic disease management; and the translation of research to practice" (Government of South Australia, 2009a, p. 37).

- Building more effective evaluation was identified in the *Aboriginal Health Care Plan* (2010).

- Good information as a key pathway for policy development and joint accountability for outcomes was reported in the *Adelaide Statement on Health in All Policies* (2010), particularly in terms of "providing feedback mechanisms so that progress is evaluated and monitored at the highest level" (World Health Organization & Government of South Australia, 2010, p. 3). Strong information and evaluation systems were thought to be needed to build knowledge and the evidence base of policy options and strategies through pooling intellectual resources, and integrating research and sharing wisdom from the field.

- In the *Eat Well Be Active Strategy* (2011) information was described as an essential building block in terms of monitoring, evaluation and research, and one example was the important work of the Physical Activity Nutrition Observatory: Research and Monitoring Alliance (PANORAMA) in reporting on *SA's Strategic Plan's* (2011) target of increasing the proportion of the population regarding healthy weights.

- One goal of the *Cancer Control Plan* (2011) was to provide and improve information for cancer control. Although the focus was mostly on patient care, it stated that research was needed to discover how best to address health inequalities.

- A key recommendation in the *Primary Prevention Plan* (2011) was to have good evaluation for accountability in terms of implementation and outcomes. It called for SA Health to continue to support university partnerships for research in areas such as evidence-based policy and practices, population health needs, health services for disadvantaged groups, and primary prevention strategies to reduce inequities.

5.3.5.3   Summary: information

Information as a health system building block for HP was widely addressed in the documents reviewed. There was considerable attention to monitoring and reporting population health in documents such as the *Strategic Plan* (2011) and the *Public Health Act* (2011). Although there were many calls for increased HP research and evaluation, the perceived lack of evidence of HP effectiveness (identified as a HP challenge in Chapter 2) figured prominently in the *Review* (2012) and *SA Health's Response* (2013) and factored into the cuts to HP in SA.

5.4 Over a ten year period (2003-2013) to what extent did the policy context support health promotion goals and actions and health system building blocks?

In reviewing documents over a ten year period (2003-2013) I found a pattern that commenced with documents that strongly supported HP in 2003, followed by a period of wavering support, and in 2011, several documents rekindled recommendations regarding HP and the need to strengthen health system building blocks for HP. However, the generally supportive HP policy context in 2011 was punctuated with the policy directives contained in the *Review* (2012) and *SA Health's Response* (2013) and the withdrawal of the much anticipated *Primary Prevention Plan* (2011). With the exception of the *Public Health Act* (2011) it appeared that the state government had retreated from HP. The key factors that appeared to influence the HP policy context in 2013 are illustrated in Figure 5.2 below.

Figure 5.2   Key factors that influenced the health promotion policy context (2013)

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Reducing health inequity was identified and supported to some extent in most documents, including the *Public Health Act* (2011), however, it was not a criterion used in the *Review* (2012) and *SA Health's Response* (2013). Although the policy context did not strongly support system goals targeting health equity, the public health reporting mandate by the state and local government inherent in the *Public Health Act* (2011) offered potential to address this goal through monitoring and reporting on population health status.

The *Public Health Act* (2011) provided support for leadership and 'governance for health' through developing partnerships and intersectoral collaboration for HP. Although this action was frequently supported in documents and formed a foundation of the *Public Health Act* (2011) there were many unanswered questions specifically about collaborative mechanisms between system elements. The *Public Health Act* (2011) was the strongest document in articulating vertical governance structures between state and local governments and partnerships with other Public Health partners. The Act also provided a framework for a horizontal or a whole-of-government approach to HP, both at the state and local government levels, and this was clearly called for in many of the documents reviewed. Thus, the Act supported the call for enhanced intergovernmental relations between state and local governments. However, it did not discuss the relationship between the federal and state governments in Public Health and HP. Calls for clear delineation of roles and responsibilities among system elements was a common theme in documents reviewed. Most striking was the lack of state government leadership and 'health governance' for reorienting health services to HP.

Financing was the least identified building block in documents although the importance of financial arrangements with the federal government and financing for comprehensive Primary Health Care were themes. Despite these themes, an outcome of the *Review* (2012) and *SA Health's Response* (2013) were cuts to HP by the state government and these were seen as solutions to poor state economic circumstances, rising health care costs, and unclear roles and responsibilities between the state and federal governments.

The HP workforce was cut in the state health care system as a result with the assumption that other system elements such as Medicare Locals and local councils would have the workforce capacity for HP. Furthermore, it was reported in the *Review* (2012) that there was a lack of

evidence of HP effectiveness and this figured prominently in the recommendation to cut HP services. Thus HP research and evaluation was a significant aspect of the information system building block that shaped policy directives. Support of monitoring and reporting on population health status was an important aspect of the information building block.

Finally, there appeared to be little policy support for community participation as a HP action. The *Review* (2012) and *SA Health's Response* (2013) coupled with the focus of the *Public Health Act* (2011) placed future effort regarding community participation in HP with Medicare Locals (replaced with Primary Health Networks in 2015), local councils and NGOs.

Overall, the policy context in 2013 did not appear to support HP goals and actions and health system building blocks to a great extent. Norman (2009) used the term "structural holes" (p. 870) in relation to the use of network theories in HP but here I use the phrase to describe gaps in systems for HP as a summation of the policy context in 2013 in SA. The structural holes were in the lack of leadership and governance for providing explicit system goals for reducing health inequities, reorienting health services toward HP, and ensuring community participation in HP. The policy context was strongest in terms of leadership and governance for developing partnerships and intersectoral collaboration, but this too had holes in terms of system structure and processes for HP at all levels.

Chapter 6: Stakeholders' perspectives of the health promotion policy and practice environment

In this chapter I report on findings from interviews with key stakeholders in the regional health system regarding their views on health promotion (HP) policy and practice. As described in Chapter 3, the aims for this chapter were to build upon findings from document review (extension), make new connections among document review and stakeholder perspectives regarding HP and health system building blocks (bridging), and identify new patterns and relationships in the data (surfacing).

The first section presents an overview of stakeholder perspectives that demonstrate two divergent views regarding HP policy and practice. The following section reports on leadership and governance as a dominant building block and factor that influenced HP policy and practice. This section is organised into ten sub-sections that demonstrate the centrality of leadership and governance. Following this I report on how stakeholders described current HP services (practice) and then how the regional health system for HP was portrayed. The chapter ends with answering the research question: what are the perspectives of key stakeholders within a multisectoral health system with respect to the extent to which HP goals and actions and health system building blocks are present for HP?

6.1   Is the glass more than half full or more than half empty? Two divergent perspectives regarding health promotion policy and practice

Participants were asked to describe the current HP policy and practice environment (as at November 2013) and two distinct narratives emerged. The vast majority of participants (48 of 53) described the HP policy and practice environment in very negative terms and their disillusionment painted a bleaker picture than that reported in the preceding chapter. These participants included those with HP roles and responsibilities in the Medicare Local (5), Local Health Network (6), SA Health (1), other state government departments (2), local councils (16), nongovernmental organisations that delivered health services (4), intersectoral networks (6) and professional associations (8).

In contrast, a small group of participants including SA Health group interviewees (4) and one other state government department manager (1) described the HP environment in positive terms because there were policies in place for future development.

The sense that HP had fallen from favour in SA was a common theme contributing to the negative narrative. Several participants said that HP was now a "dirty word" (#2/NGO Health Service, #34/NGO Professional Association, #7 Local Government Association) and another remarked that the SA government had "thrown out the baby with the bathwater" (#2/NGO Health Service). The view expressed by one participant seemed to sum it up: "We've seen a decimation of health promotion in South Australia which is a shame because we used to be quite good at it" (#24/NGO Intersectoral Network). To illustrate further, the following descriptors were used to describe the HP environment: absolutely appalling, big void, challenging times, chaotic, despicable, devalued, devastating, dire, disappointing, disconnected, disgraceful, dismal, expendable, fragmented, fucked, going nowhere, knee jerk, madness, mess, not highly valued, obliteration, oppressed, patchy, quite poor, reactive, sad, short-sighted, short-term, silly, toxic, and very fractured.

In contrast, the other narrative portrayed the HP environment positively. One state government department stakeholder stated that "I think it's really strong at the moment" (#32) and gave an example of policy directions in the education sector that identified improved health for children and young people as a desired outcome. The SA Health group interviewees suggested that the "the glass is more than half full" because of the potential of the relatively new *Public Health Act* (2011) to lead future HP policy and practice. This minority group, who were closely involved in the drafting and implementation of the *Public Health Act* (2011), saw it as providing the strategic policy framework that the majority so clearly saw as missing or broken. However, most participants agreed that it was the key policy driver for HP in 2013 and this corroborated my analysis of the policy context presented in Chapter 5.

Effective leadership and governance to ensure oversight of strategic policy frameworks constitutes one of the building blocks needed to underpin effective health systems (de Savigny & Adam, 2009). The negative perceptions and language used by most stakeholders

regarding the HP environment strongly suggested that this building block was inadequate and in the next section I discuss leadership and governance as a dominant factor that influenced HP policy and practice in my case study.

These divergent perspectives revealed a collective sense-making that was strikingly dependent upon whether a stakeholder worked within or outside the central state government (e.g., SA Health). One possible explanation for this, as discussed in Chapter 3, is that elites may not always be forthcoming in discussing sensitive issues (Tansey, 2007) and will often avoid political issues and conform to the perspectives of those in power (Harvey, 2011). Other divergent perspectives and 'silences' in the interview data are highlighted throughout this chapter.

Viewing these findings through a social constructionist lens illuminated the reality of HP policy and practice as a subjective construct. Making meaning of the HP environment appeared to be based in part upon the system element that stakeholders were most closely associated with. From a critical perspective, the 'glass is more than half full' narrative appeared to collectively conform to the perspectives of people in positions of power while the views expressed by the other narrative were quite the opposite. As I will demonstrate later in this chapter, SA Health group interviewees not only conformed to dominant views of people in politically powerful positions (i.e., Minister of Health), but they too had power in constructing the HP environment. For example, SA Health group interviewees played a role in shaping the *Public Health Act* (2011) and therefore had influence on how the HP environment would change. The majority of stakeholders had little to no say in how HP was being defined, implemented and cut. This metaphor of the 'glass being more than half full' or 'more than half empty' was significant and symbolic as it illuminated the socially constructed nature of the divergent perspectives among stakeholders, as well as highlighting the role of powerful overarching structures, institutions and processes in shaping HP policy and practice.

6.2 Health system building blocks for health promotion: the centrality of leadership and governance

In my review of the literature I discussed leadership and governance in terms of a HP challenge. The definition of leadership and governance used in my research was the presence of effective oversight of strategic policy frameworks which encompassed two dimensions: health governance, and governance for health. In Chapter 3 I discussed two HP actions: reorienting health services, and developing partnerships and intersectoral collaboration, in terms of health governance and governance for health respectively. This signals that leadership and governance played a pivotal role in effective HP policy and practice. My assessment of documents in Chapter 5 illustrates that the HP policy environment was deficient with respect to leadership and 'health governance' for reorienting health services toward HP, but was stronger for 'governance for health' through developing partnerships and intersectoral collaboration. In the following sub-sections I present key findings from stakeholder interviews that align and build upon this assessment of the HP environment.

6.2.1 "Whose job is it to lead health promotion?": the impact of federal and state leadership and governance and health promotion policy directions

In Chapter 5, I reported that key documents called for the delineation of HP leadership and governance structures as well as strong intergovernmental relationships and these findings threaded through stakeholder interviews. This section discusses stakeholder perspectives with respect to the impact of federal as well as state policy directions.

6.2.1.1 Federal health promotion policy directions

A common theme in interviews with stakeholders from all system elements was the influence of federal directions in HP policy. A key area discussed was the lack of implementation of the *National Health Care Reform Agreement* (2011) that I described in Chapter 4 and this was thought to be a key factor influencing the *Review* (2012) and *SA Health's Response* (2013). For example, SA Health group interviewees stated that the federal government had

"really messed up" health reform efforts particularly regarding the delineation of HP roles, responsibilities and health governance with the state government.

Medicare Local participants suggested that much of their work entailed sorting out roles and responsibilities between the federal and state governments, particularly who pays for what health care services, and there was no indication that sorting out roles and responsibilities for HP was on their agenda. HP was seen as a "casualty" (#21/Medicare Local) of the politics between the levels of government in that no one level had accepted a leadership role and responsibility:

> the top thing is politics and as a subheading of politics is a lack of clarity around roles and the fact that we have a three tiered government system … There is a gross lack of clarity around the roles between those different groups. (#21/Medicare Local)

The lack of coordination between these levels of government was described in terms of primary health care being fragmented to the point where people working in the health sector did not know who was doing what. This was described by one participant as a split:

> Despite the national reform work being about trying to create better connections between the state and the federal government, we still have the split between what happens at a federal level, what happens at a state level. And now we're going to add what happens at a local government level. (#9/Medicare Local)

The split discussed in the above quote and the lack of federal-state leadership in implementing a shared responsibility for HP was top of mind for Interviewee #2 (NGO/Health Service) who noted that "there are no incentives to do stuff at the state level" if health care reform called for the federal government to take responsibility for HP.

The impact of the confusion between federal and state government roles and responsibilities for HP in the regional health system was reported to have resulted in poor relations between the Medicare Local and SA Health. Anger was expressed: "I've been at several meetings where the head honchos [SA Health] are there and say 'it's not that we're walking away from HP and primary prevention, we're just doing it differently'… That is absolute bullshit" (#21/Medicare Local). This same interviewee stated that "Local councils are much easier to work with than state health" (#21/Medicare Local). Two participants from Local Council B

(#5 and #12) declared that collaboration was weak between the state health department, state managed local health services, and the federally funded Medicare Local.

Participants from three local councils echoed the perspective that the policy environment suffered from a lack of policy alignment between levels of government. For example:

> I think there could be a lot more alignment from local government to state and federal sort of outcomes and that's perhaps where I'd start. What are the outcomes that you want and how can we line up people with those sort of things? (#4/Local Council A)

Local Health Network group interviewees also traced the deterioration of the HP policy environment to the failure of federal-state health reform agreements. They understood that the federal government was to lead primary health care (including HP) and the state government would focus on other health care services as in the *GP Plus Health Care Strategy* (2007). This explanation is consistent with my analysis of this strategy in Chapter 5, in that it only discussed HP to a limited extent and focused on clinical services.

The confusion about leadership and governance does not seem to stem from the guiding policy documents alone. In Chapter 5 I reported that leadership and governance structures for HP and their relationship to system elements in 2013 were quite clearly laid out (see Table 5.3) and enhancing intergovernmental relations was a theme throughout the state government documents reviewed. Yet stakeholders almost universally reported a lack of federal government implementation of HP policy directions in a shared leadership arrangement with the state government and the lack of clear roles of responsibilities among levels of government and these were thought to be a significant factor influencing HP policy and practice in the health system.

Stakeholders clearly felt that a shared vision was absent in the regional health system and health care reform in Australia was thought to be a significant factor in shaping HP policy and practice. This is consistent with what Duckett and Willcox (2011) reported: "although the National Reform Agenda created a welcome new emphasis on funding prevention and early intervention in the health sector, it did not constitute a comprehensive vision or plan for health system reform" (p.123).

6.2.1.2   State health promotion policy directions

Moving from the federal to the state level, the combination of two state policies held promise by providing a comprehensive vision for HP; the *Primary Prevention Plan* (2011) and the *Public Health Act* (2011). As reported in Chapter 5, the *Primary Prevention Plan* (2011) was rated highly in all aspects of HP and system building blocks (Table 5.2), however, its potential was never realised as it was withdrawn shortly after the *Review* (2012) and *SA Health's Response* (2013).

SA Health group interviewees explained that the *Primary Prevention Plan* (2011) was not implemented because it was superseded by the *Public Health Act* (2011). That is, the Act would address the actions and recommendations contained in the plan and SA Health could relinquish their leadership role:

> It seemed clear that rather than having something separate, which was in some kind of way trying to coordinate the effort of others, why wouldn't we allow others to just get on with it and use the Chief Public Health Officer's Report as the organising framework (SA Health group interview).

Local Health Network group interviewees had high hopes for the *Primary Prevention Plan* (2011) and believed it would have provided state-level health governance for HP, but it was described as being "stillborn." The *Review* (2012) and *SA Health's Response* (2013) were thought to provide "an excuse to close it all down" and shift responsibility for HP to other levels of government.

Although other policies, documents and plans were identified as influential for HP, none were discussed to the same degree as the *Review* (2012*), SA Health's Response* (2013) and the *Public Health Act* (2011). Participants identified other documents reviewed for Chapter 5 as being influential and these included: *Generational Review* (2003), *GP Plus Health Care Strategy* (2007), *Aboriginal Health Care Plan* (2010), *Health in All Policies* (2010), *Eat Well Be Active Strategy* (2011), *SA Public Health Act* (2011) and the *SA Strategic Plan* (2011). However, overall there was an air of uncertainty as to the implementation of many of these policy directions in terms of HP, except perhaps with respect to the *Eat Well Be Active Strategy* and its links to the OPAL (obesity prevention initiatives funded by federal and state

governments in partnership with 5 local governments in SA) and Healthy Communities initiatives (physical activity and health eating initiatives funded through federal and state government short term grants to local government). These initiatives were not widely discussed except for coordinators and a few other participants from local councils who were generally enthusiastic about working with a variety of community groups to encourage healthy eating and active living. There was certainty, however, that these initiatives would be ending as a result of short term funding arrangements.

Other policies, documents and plans that were identified (and not included in my document review) appeared to directly relate to portfolio concerns and legal requirements for local governments and included the *Disability Discrimination Act, Environment Protection Act, Food Act, Housing Improvement Act, Local Government Act*, municipal bylaws, and land use planning guidelines. The *30 Year Plan for Greater Adelaide* was identified by several local council participants. As noted above, one participant from a state government department reported that the document which outlined new directions for education and child development [*Brighter Futures* (2013)] was the most influential for HP, however no other participant referred to this document. It was instructive to see that these policies, plans or strategies were thought to influence HP policy and practice, and these point to the potential of policy directions outside of SA Health.

Similarly, other types of planning and/or program specific policies and plans were mentioned as influential for HP and these included needs assessments, key priority indicators, strategic plans and program guidelines [e.g., Headspace (mental health services)]. Thus, the HP context was reported to be informed by a range of policies and plans from macro to micro levels and this finding appeared to support the aims of the defunct *Primary Prevention Plan* (2011), that is, to coordinate and enhance action across sectors and at different levels.

6.2.2 "What I don't see is a vision for the future": the need for a strategic policy framework as a key element of leadership and governance

Participants from all system elements reported the lack of a shared vision or strategic policy framework for HP, a key aspect of the leadership and governance definition. By focusing on the *Public Health Act* (2011) and Public Health planning, SA Health group interviewees

believed that they would address the lack of a strategic policy framework and the lack of coordination of the apparent "thousand flowers blooming" approach to HP. This phrase was a negative connation that implied that although there were a number of state-level policies, plans and strategies (as described in Chapter 5), they were not being implemented in an integrated fashion. No other participants talked about the need to "de-flower" HP (SA Health group interview). The *Public Health Act* (2011) requires state-level Public Health planning and a report from the Chief Public Health Officer, and these would encourage coordinated action on health issues or policy coherence both at the state and local government levels:

> … the vision for this report is that if you look at people working at a community level and whole of government … it's giving information about health issues in a way that when people come together to think about what the health issues are for their communities and that would include health and equity … and a range of determinants … so that they can understand what the problems are for their community and do something about it. Because that's what we want to do, we want to get coordinated action around these things. (SA Health group interview)

The views of SA Health group interviewees were also consistent with my findings in Chapter 5 where leadership and 'governance for health' for HP had become the clear focus. The development of partnerships and intersectoral collaboration in a legislative and centrally driven approach to HP appeared to characterise the HP environment in 2013. Other interviewees supported the need for a strong strategic policy framework, however, there were divergent ideas as to the potential of the *Public Health* Act (2011). The SA Health group interviewees had central roles in preparing and implementing the Act, therefore it is understandable that this is where their advocacy and attention would be focused.

The lack of a strategic policy framework was often reported in terms of the lack of a shared vision for HP or the big picture as to how various initiatives fit into the overall system. For example, "What I don't see is a vision for the future" (#35/NGO Professional Association) and "what we have got is an ad hoc, politically influenced, double-dipping, cherry picking State-Commonwealth split"(#2/NGO Health services). Other examples of this call for a strategic policy framework are as follows:

> [W]hat's needed is a mutually agreed and endorsed framework that holds all of the pieces together. So that whether it be an individual government agency that is drafting certain policy initiatives or whether it's a non-government organisation, or a local council, who can actually have a framework that links all of those pieces together, to get a coordinated outcome for communities. (#12/Local Council B)

> I think you need a vision, this is where we're going, this is the direction we're all moving to, to have people who are well. These are the systems that we're building so the population is a healthy population. I don't see that. (#35/ NGO Professional Association)

Although Interviewee #12 was hopeful that the Public Health plan being developed would provide coordination, this was not widely held among those I interviewed. Interviewee #35 (NGO/Professional Association) stated that there were no "policy drivers" to support HP as a result of the *Review* (2012) and *SA Health's Response* (2013) except through the *Public Health Act* (2011), and s/he did not support the SA Health assertions that the Act would be adequate to guide HP in the regional health system.

The need for a strategic policy framework was also framed in terms of the lack of roles and responsibilities as described above and this is consistent with findings in Chapter 5. Many local council participants attributed the lack of clear roles and responsibilities to a lack of leadership at the state level. Questions were left unanswered as to who takes the lead, on what, why, and who the potential partners are, and these mirror the questions I posed in Chapter 5. It was reported that local government leaders were challenged to "live and breathe" (#12/Local Council B) strong public health plans that do not "just sit on the shelf" and to ensure ongoing communication and learning about community issues. However, local council participants, such as Interviewee #4 (Local Council A), reported that without clear leadership roles or explicit attention to financing as a health system building block, there was a fear of getting "dudded" because of potential cost-shifting (discussed further in section 6.2.8).This is a good example of the relationship between leadership and governance and financing building blocks. Even among local council participants who were able to articulately discuss HP and action on the broad determinants of health (Local Councils B and C) stated that there was a lack of coherent understanding and direction as to roles and responsibilities.

A quote from Interviewee #2 (NGO/Health Service) summed up the confusion regarding responsibility for HP and action on the SDH: "[N]o one is doing anything about addressing them because that is really expensive, and whose job is it to lead HP? Local council, state, commonwealth, education, take your pick". The lack of clear roles and responsibilities was

linked with not only a lack of policy coherence, but also to the lack of shared vision for HP strategy: I don't think there's any core agreement about strategy. We haven't got agreement between levels of government about who's taking responsibility for what, let alone agreement about what it might be important to do. Where some of us thought that we'd fought the good fights 20-30 years ago around investing … in social issues and in health issues – while there is reference to it, there's not respect for it in the way that the system is behaving. (#50/NGO Intersectoral Network)

6.2.3 "He understood the role of health promotion": the impact of leadership changes at the state-level on health promotion policy and practice

Many participants linked changes in the HP environment with leadership changes in Premiers (2011) and Health Ministers (2012) at the state level as the timing of key HP policy developments in 2013 coincided with marked changes in the SA political environment. The longtime leader of the Labor Party and Premier, Mike Rann, stepped down in 2011. He was opposition leader for 9 years (1994-2002) and was South Australia's Premier for another 9 years (2003-2011). Jay Weatherill then became party leader and Premier. Within the first year of Weatherill's premiership (October 2011 to October 2012), the *Review* (2012) was announced. Shortly thereafter, the long serving (2005-2013) Minister of Health, John Hill, retired from politics. In light of the Health Minister's resignation, Premier Weatherill shifted cabinet membership, moving the former Treasurer, John Snelling, to the Health portfolio (January 2013) with the Premier assuming the Treasurer post (January 2013 to March 2014).

An interviewee from SA Health elaborated on leadership changes: "You know [cuts to HP] probably wouldn't have been able to happen if our previous health minister had been there, even with the pressures. He understood the role of health promotion" (#14). The former Health Minister was described as "great" because he was instrumental in securing "space and money" (#14/SA Health). Upon his retirement and with the former Treasurer moving into the Health portfolio, one participant (#4/ Local Council A) said this change "just signals heaps from my point of view, that it's all about numbers and it's all about cutting". Another participant echoed this: "we got the Treasurer for god's sake, how much more can that say that it's about money?" (#22/NGO Professional Association). Again, these findings show the

close inter-relationship between the leadership and governance, and the financing building blocks.

It was a common perception that these political changes and the decision to cut HP funding displayed a shift in attention to economic interests, rather than giving priority to population health. One participant stated that "it's about the money, honey" (#6/Local Council B). Changes in state-level leadership were discussed to a great extent by NGO Professional Association participants and several reiterated that past state leaders had a really good understanding of HP and were able to secure necessary funding (#22, #35) and the new Health Minister obviously did not have a commitment to HP (#2). Interviewee #35 (NGO/Professional Association) reported that it was common to hear that the new health minister "doesn't believe in health promotion, or so he says" (discussed further in 6.2.5). Although Local Health Network participants did not discuss leadership issues to a great extent (this seemed to reflect the sensitive nature of my research and the difficult role of public servants), they reported the recent change in Health Ministers as having a negative impact upon HP.

It was notable that SA Health group interviewees related that it would be unfair to link all the changes in the HP environment to the new Minister:

> I think it's also unfair to perhaps go away from this meeting thinking that changes were exactly consistent with a change of Minister, because I think you'll find there were conversations happening, maybe not in the public domain, but where our previous Minister who'd been extremely supportive I think of this area in the past, was starting to question us. (SA Health Group Interviewees)

These participants offered more nuanced perceptions of the political changes and this quote helped to explain the fact that the cover page of the *Review* (2012) indicated that the report was prepared for John Hill, the former Minister of Health, even though he had since retired.

Beyond the political level, it was reported by participants that leadership in the state government health department bureaucracy had also changed. For example, the long serving Director of Health Promotion (SA Health) retired in 2012. The individual interviewee from SA Health (#22) explained that the demise of HP would not likely have happened had there

not also been significant leadership changes within the state health department. This was because former leaders had left the department and "they would have been difficult I think to knock off" and the changes left "no leader leading at the state level." The resulting leadership for HP was described as "we're at the bottom … other people are controlling the space really." The reason for the changes at the bureaucracy level was attributed to leaders seeing the "writing on the wall" (#22/NGO Professional Association) regarding funding cuts and the lack of vision for HP. The following quote is a further example of this perspective:

> … they just realized there was no money [and they could not protect HP financing] and everything went out the window. The people, the good leaders got out while they saw the chance. (#22/NGO Professional Association)

6.2.4 "Putting our wagging fingers well and truly away": how state leaders influenced the discourse of health promotion

SA Health group interviewees reported that "we need to put our wagging fingers well and truly away" regarding HP practice. This appeared to be a factor in explaining the move away from leadership and health governance for reorienting health services toward HP. They stated that HP had become synonymous with social marketing campaigns (and focused on individual behavioural change). Although these campaigns were thought to suffer from a lack of strategic direction, they had fallen out of favour mostly because of the new state health minister's edict: "He made it very clear that he didn't like what he called the wagging finger … Health telling people how to live their lives" (SA Health group interview). This quote demonstrates the power of the Minister of Health in affecting the language and discourse used to describe HP and the resulting policy and practice environment.

Health promotion as a term was also linked with "*nanny state*" approaches and SA Health stakeholders emphasised that the term was not to be used anymore:

> We've now got a government that has declared its loathing of the nanny state and it sees prevention as nanny state and unless we change the way they see it – I mean the barriers go up straight away as soon you start talking about, in fact, you would barely dare use the word health promotion anymore. (SA Health group interview)

The conflict that surrounded terminology was also reported by other stakeholders. For example, even though HP principles were deemed to be integrated into policy and practice,

an interviewee in one state government department reported that "we're not allowed to call them health promotion for fear of being laughed out of town" (#31/State government department). S/he suggested that while HP had resonance, staff were instructed to not "use Ottawa Charter language because we lose half the game before we even get started."

The use of 'primary prevention' as opposed to 'health promotion' emerged in the policy context, for example, the *Primary Prevention Plan* (2011) was not titled the 'Health Promotion Plan' and this appears to have been due to the change in political support. Nevertheless, the *Primary Prevention Plan* (2011) was rated highly in the preceding chapter in terms of HP and all building blocks and aimed "to contribute to improving health and wellbeing and reducing inequities for South Australians" (Government of South Australia, 2011c, p. 3). This negative view of health promotion was corroborated by an individual SA Health interviewee:

> I've been in health promotion for a really long time. We go through ebbs and flows. It's just part of the cycle. This is probably the worst I've been in and I've been in really bad ebbs before. [HP is] so little understood and so negatively presented. (#14/SA Health)

It is notable that the Do It For Life (one-on-one lifestyle counselling) services were cut as a result of the *Review* (2012) and *SA Health's Response* (2013) and these services could potentially be grouped under a 'wagging finger' approach to HP. Cuts to these services were explained in terms of lack of evidence of effectiveness and this seems justified particularly if these services were stand-alone and not embedded in a multi-strategy approach. However, the nanny state and wagging finger interpretation of HP views held by the Minister of Health and SA Health stakeholders can be mostly linked to a HP challenge identified in Chapter 2. The challenge lies in the ideology that specifically values individualism where "individuals are responsible for their own health status, whatever their social and economic circumstances" (Baum, 2016, p. 518). The nanny state interpretation is consistent in terms of the wider context of a current political ideology of neoliberalism (Schrecker, 2013a). From a critical perspective, the findings I have discussed so far in this section appear to expose the significance of the power vested in leaders, the changing political agenda, and the antithetical ideology that shaped HP policy and practice in negative ways in my research.

6.2.5 "Becoming lazy and just throw large chunks of money at things": leadership, governance, and HP financing

As noted earlier, the leadership and governance and financing building blocks were found to be closely related in interview data as well as in document review. There was significant discussion in the SA Health group interview about the amount and way HP dollars were allocated to social marketing campaigns in the past and this was not discussed by any other interviewee. Repeated phrases such as "large sums of money", "huge amount", "massive amount", and "large chunks of money" were used by SA Health group interviewees to describe financing from the federal and state governments to the former HP Branch. HP was characterised derogatorily as "quite luscious strategy development with a three word slogan" and that this "poisoned the way the Government has done HP for an awful long time." It was further stated that "having lots of money is incredibly corrupting and you can become very lazy and just throw large chunks of money at things" and that in their current role in implementing the *Public Health Act* (2011), they would "have effective control of the authorizing environment", that is, this stakeholder group would now have control over strategic directions and finances for HP.

No other participant spoke of past financing of HP in this way, neither did the *Review* (2012) or *SA Health's Response* (2013). However, conflict was confirmed by Interviewee #14 (SA Health individual interviewee) in that s/he reported that there were different perspectives in the state health department as to how HP funding was allocated in the past and this had caused friction within the department.

6.2.6 "A real drive for Health in All Policies": leadership and governance and whole-of-state government approaches to health promotion

Divergent views among stakeholders were also detected with respect to the call for the Health in All Policies approach. The implementation of the *Public Health Act* (2011) was seen by SA Health group interviewees as a way to move HP more upstream in terms of action on the determinants of health and "into the territory of other policy sectors." It was clear that leadership and 'governance for health' through developing partnerships and intersectoral collaboration was the focus. They emphasised that this would be done "without any sort of

concept of health … I think that's the sort of stuff that we want to try and facilitate and encourage and not be seen to be doing it in the name of health". Despite this, they did not suggest what name this work would fall under if not health, but did clarify that improving health through the *Public Health Act* (2011) was "a real drive for Health in All Policies, not Health over All Policies". This was the only instance in which the term Health in All Policies (HiAP) was used in this interview, although working in partnership with other government departments was considered a key policy direction. Further to this, it was reported that:

> … an appetite is there if we can show how it's useful to government, how it fits in with their priorities. It's not new or additional work, it's normal, and it helps them with their agendas and we put our wagging fingers well and truly away. (SA Health group interview)

This view reinforced the desire to move away from "nanny state" and "wagging finger' approaches to HP and also signalled the need to move away from health imperialism and its negative connotation. Kemm (2001) discussed health imperialism as stemming from the Ottawa Charter's strategy of building health public policy and that some approaches may be "misinterpreted as an attempt to make all policy areas subordinate to health" and this "can disturb the balance of influence between branches of the policy-making organization" (p.83).

The perspective voiced by SA Health group interviewees is consistent with what I reported in Chapter 5 in that a whole-of-state government approach was strongly recommended. Government documents commonly used the term HiAP and it was noticeable that SA Health group interviewees did not, thereby flagging a potential downplaying of the term.

Conversely, very few other participants emphasised the potential of the *Public Health Act* (2011) to strengthen HiAP and when it was identified as important there was little discussion of what policies were being examined or what outcomes had been achieved at the state level. There appeared to be some knowledge and a certain pride that this approach was in play at the state level, but there appeared to be little to no involvement of the stakeholders in the regional health system.

Contrary to the perspectives of SA Health stakeholders, one participant understood that HiAP had been cut, much like other HP initiatives, as a result of the *Review* (2012) and *SA Health's*

Response (2013). S/he lamented that "there is no money, so all the policies, the Primary Prevention Plan, all of the fabulous things that we had, Health in All Policies, gone". S/he went on, stating with respect to HiAP: "I'm fairly sure if it's not gone in name not much is happening there. The people I knew who were in Health in All Policies have gone to other jobs. I thought that wouldn't go." (#22/NGO Professional Association)

This view was not accurate as SA Health group interviewees were clear that this work was ongoing and emphasised through the implementation of the *Public Health Act* (2011). However it is instructive to include here in order to demonstrate the negative perspectives that many interviewees had. In sum, there was clearly very little discussion of whole-of-government approaches and most particularly in local governments with respect to public health planning.

6.2.7   Health promotion is a "soft and easy target": the politics of cuts to financing and services in times of fiscal constraint and the power of the biomedical model

As reported above, the HP environment was described as very poor by the majority of participants and this was mostly attributed to the *Review* (2012) and *SA Health's Response* (2013). All participants discussed these policy developments except for SA Health group interviewees; they did not elaborate upon them at all. I asked broad, open-ended questions about the HP policy and practice environment and did not ask questions about specific policy directions, except to gain clarification. Therefore their avoidance or reticence may have been due to the political or controversial nature of the *Review* (2012).

This subsection provides the majority view regarding the *Review* (2012) and *SA Health's Response* (2013) and sheds light on how HP was seen to be a soft and easy target and a casualty of politics. HP was described in these terms because it did not address the biomedical or clinical issues facing the acute health care sector and the perceived lack of a significant backlash from funding cuts to an area receiving a relatively small proportion of the health budget.

There was an overall sense in the interviews that the *Review* (2012) and *SA Health's Response* (2013) came as a shock to the vast majority of stakeholders. Numerous participants

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highlighted the state's poor economic picture and a SA Health graph (Figure 6.1) that
projected health care spending to consume the entire state budget by the year 2030 as key
factors that influenced the *Review* (2012) and the cuts announced in *SA Health's Response*
(2013).

Figure 6.1   Total state budget compared to health sector expenditure
                  (Government of South Australia, 2011e, p. 9)
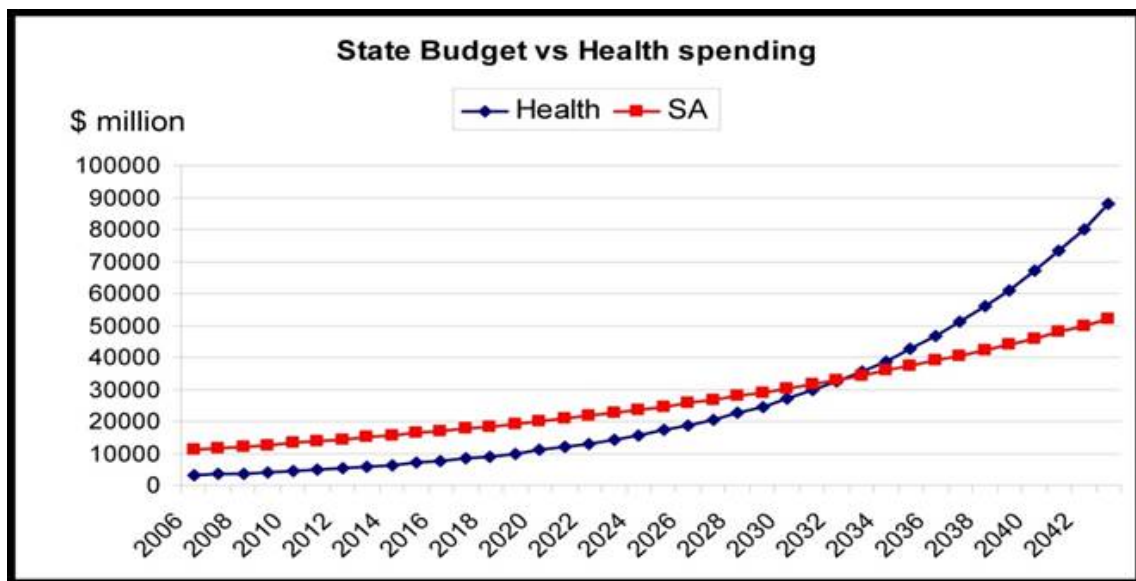
NGO/Professional Association participants described HP as: "going backwards" (#35), "the
worst that people had seen" (#40), "a bicycle without wheels" (#47), "very constrained"
(#34), "challenging" (#40), "quite difficult" (#46), "no overarching vision for HP" (#49), and
"a policy vacuum" (#47). The term 'soft target' was used by numerous stakeholders (e.g.,
#22, #25, #35, #49, #46, and #40). For example, Interviewee #35 (NGO Professional
Association) used the phrase several times to suggest that looking for efficiencies in the
health budget needed to occur in "clinical areas as well as, you know, the soft targets"
Speaking with respect to cuts to the HP workforce, s/he further stated: "so they're not a group
that's kind of homogenous in a union, working under one umbrella that can then gather
strength from each other and, you know, it becomes a very difficult situation when it's a soft
target". HP was described as a 'soft target' in matter-of-fact terms, many reporting that the
HP workforce had little power.

Many participants shared the view that that SA Health did not demonstrate "that prevention and HP is as important as frontline clinical health services in acute care settings" (#46/NGO Professional Association). The environment had shifted to an increased focus on a "biomedical" (#40/NGO Professional Association) view of health and that "you could regard the Minister as the Minister of Hospitals not the Minister for Health" (#49/ NGO Professional Association). This was echoed by Interviewee #31 (State government department): "there's nobody out there beating the drum for HP and how to integrate it into people's work" and this had resulted in "going back to the old days of SA Health being the Department of Ill Health rather than looking at preventive stuff" (#31/State government department). One participant summed up this perspective well:

> It has to be the vision of population health, not about hospital-based services. It's about what the principles of population health are about in terms of understanding the distribution of health in the population and having an equitable approach to the way that you do things (#40/ NGO Professional Association).

Participants from three of the four local councils were very knowledgeable about the *Review* (2012) and *SA Health's Response* (2013) and the following phrases were used to describe these policy developments: "proactive healthcare has been effectively given the boot" (#4/Local Council A); "massacred at the moment" (#6/ Local Council B); and "I see that health promotion is just fading away because no one's got the time or the money" (#27/Local Council C). Participants from the fourth Local Council (D) were the least knowledgeable about HP policy directions and two said that they were unable to respond to questions about the HP environment because they did not have enough information (#17 and #15/Local Council D).

Medicare Local participants were particularly vocal about the *Review* (2012) and *SA Health's Response* (2013) and HP being pushed "further into the background" (#21/ Medicare Local) when it was never really in the foreground. One participant suggested that "it's lucky [Medicare Local] doesn't have a policy in particular regarding HP or prevention because then we would be left holding the ball" (#19/Medicare Local). As reported in Chapter 5, the *Review* (2012) and *SA Health's Response* (2013) specified that Medicare Locals would assume responsibility for HP and this was clearly not the case.

Medicare Local participants were quick to state that they worked from a biomedical model. They suggested that there needs to be a demand for HP on the part of the public because unlike people's response to lack of access to hospital care in a timely manner, there was no outcry when HP services were not available. They also talked about health financing in terms of an increased focus on hospitals and this made HP a soft target. For example, "the whole palaver about building a new hospital in SA has really driven the agenda" (#9/Medicare Local). Another interviewee stated that "the new Royal Adelaide Hospital is my theory. I think that's where all the funding's gone" (#21/Medicare Local).

Further to this, Medicare Local interviewees stated that they had no dedicated funding for HP. However, they talked about the $1 million in discretionary funding allocated to the Medicare Local, but HP was not deemed to be a priority. For example, it was stated that "squeaky wheels" get funding and "[the federal government is] going to fund other things over health promotion any day of the week because they get more bang for their buck. E-Health for example" (#21/Medicare Local). E-Health (electronic health records) was thought to be more politically important as it was a federal election promise to enhance clinical care. This demonstrated that initiatives that serve biomedical and clinical services were clearly not seen to be soft targets.

Following on this, issues surrounding HP financing were not only linked to the state economic environment by many participants, but also to power and politics. The following quote exemplified the commonly held perceptions that the power of the biomedical establishment was significant in an election year:

> So the state has to do something about its economic balance sheet and health was seen as the biggest problem and so the health budget had to be cut. You can't in a lead up to an election cut doctors or nurses or the acute health sector so there doesn't leave a lot of other places to go. So they started cutting what they saw as basically out of hospital services and that included a lot of primary health care positions as you would well know. So I think that was the bigger political agenda (#14/SA Health).

Another example of this perspective was given by Local Health Network participants who agreed with others that it was political expedience that was the ultimate reason for the HP cuts: "I guess [the state government] needed to look somewhere but politically it's really hard

to cut back on intensive care beds, so they're just looking at every option that's a good political option" (Local Health Network group interview). Interviewee #2 (NGO/Health Service) stated that for the new state Health Minister, "the great hole in the Health budget" was his primary concern and cuts to HP were a "quick political win" in an election year.

Another perspective shared by stakeholders was that cuts to HP funding were 'easy' because of the relatively small proportion of the health budget allocated to HP services in relation to biomedical and clinical services. Local Health Network group interviewees stated that "there's been a lot of work done on where the money is going. The money is going to the high-end of care" and that "primary health doesn't use much money at all".

Interviewee #4 (Local Council A) saw that cuts to HP were an "easy target" because "it's less noticed" in the health care sector. Participant #38 (NGO Health Service) explained that the power of the medical community drives the unsustainable health care costs, including salaries and end of life care and not HP: "we're not just talking about doctors and consultants' salaries … we're talking about the phenomenal amounts of costs associated with what's increasingly called futile care". Further to this, the assumption of lack of resources was challenged by several participants. For example,

> [t]he thing is there is money … more money went into neonates [neonatal care] recently. Some more money went to the ambos [ambulances]. Which is classic, that's the high tech stuff. That's what also drives the health dollar." (#25/NGO Professional Association)

From a critical perspective, the relative lack of power of HP advocates compared to the power of the medical establishment appeared to negatively influence HP financing, policy and practice.

It was not just health care spending that participants discussed but also the way in which state funding decisions were made. For example, "some things seem to pass with little controversy like enormous new ovals [stadium] we don't need in the middle of the city, while small amounts of money are cut" (#46/NGO Professional Association) and "there's a sense that financially we've really got to tighten our belts but there hasn't been, I don't think, a broad proper look at how would we do this for long term benefit" (#22/NGO Professional Association). These points echoed what others insisted; there was a need for a broad

conversation about state expenditures because HP received such a small proportion of the health budget and cuts to HP would not move the needle in reining in health care costs (#35/NGO Professional Associations).

The lack of agreement over funding for health care in general and between the federal and state government was described as a "mish-mash" (#13/ Medicare Local) and this was considered to be a factor in HP being an easy target. While on paper Medicare Locals were positioned as key organisations to deliver HP services, funding arrangements were not in place. It was observed that in the *Review* (2012) "every second line was that the [Medicare Local] will pick it up. If we weren't picking it up, the local council was" (#21/Medicare Local). A key worry among Medicare Local participants was the state government's "very cut-throat" and "very abrupt approach to slashing funding … they're cutting their nose off to spite their face because of their focus on a balanced budget" (#9/Medicare Local). One interviewee (#19/Medicare Local) suggested that things got "nasty" in terms of relations with other organisations because people thought the Medicare Local would take a lead in funding HP when clearly there was no intention or capacity to do so. Interviewee #31 from a state government department agreed that the economic environment was forcing the state government to do less as "they cannot sustain the expenditures that they currently have", but suggested that the real problems were with federal-state health care reform agreements. This is consistent with the analysis in Chapter 5.

6.2.8   Health promotion is like a "poisoned chalice": fear of cost-shifting and leadership-shifting from state to local governments

A common theme in interviews was the fear of shifting leadership and financing for HP from the state to local governments as a result of the *Review* (2012) and *SA Health's Response* (2013), and the centrality of the *Public Health Act* (2011). However, there was no discussion of this or of HP financing by SA Health group interviewees.

Local Health Network group interviewees agreed that while the *Public Health Act* (2011) articulated goals for primary prevention they considered it was not going to facilitate action at the regional and local level:

> … it's certainly not going to take the place of primary prevention. It may address some social determinants a bit, like local governments are going to be able to work on built environments and they may put on immunization or some of those sorts of things, but I don't think it's actually going to make a big difference (Local Health Network group interview).

The main reason Local Health Network stakeholders felt that the *Public Health Act* (2011) would not make a difference was because local councils were "bundling up a lot of stuff they already do" and including these activities in public health plans, therefore "they're not going to do anything different." The main reason for this was because of a lack of financing to take a leadership role. The individual interviewee from SA Health reiterated this and although s/he acknowledged that there were opportunities to "make some difference" at a regional level, the caveat was that "you're only going to be able to deal with local government and what they're prepared to do" (#14).

Local Council participants agreed with these perspectives and reported their fear of being left solely responsible for HP leadership and financing at the regional or local level. For example, although the *Public Health Act* (2011) was seen as promising "it's all a bit clandestine … people are so suspicious as to what the ultimate purpose is" (#4/ Local Council A). This was elaborated upon further: "I see a lot of cost and expenses which frightens the bejesus out of people. So no one is looking to really take it [HP] on board because they know that it's like a poisoned chalice" (#4/ Local Council A). These findings appeared to cloud the seemingly clear directions that SA Health group interviewees saw in terms of partnering and acting intersectorally with respect to the *Public Health Act* (2011).

Even when there was optimism because HP was moving up the agenda (e.g., "it's exciting times … it's almost as if our time has arrived" [#33/ Local Council D]) there was caution:

> Is there an ulterior motive behind this to say well hey, we're running out of money in the State government, it's your community, you guys do all the work [and provide financing] … we're a bit hesitant to actually embrace it fully because we're not exactly sure what it means for us. (#33/ Local Council D)

Thus, a pressing concern among local council participants was cost-shifting, that is, the rising expectation to take an increased HP leadership role and the lack of financing to do so. Interviewee #11 (Local Council A) stated that "the federal government does it to the state

government and the state government does it to the federal government … and the local government is the last in line". The federal government was described as "cash strapped", SA as "one of the more economically disadvantaged states", and that local government is likely seen by the state government as "a reasonably affluent sector" and potentially "ripe for the picking" (#15/ Local Council D). There were other examples of this perspective such as:

> [y]ou can write as many policies as you want, you can analyse the evidence, you can talk about social determinants of health, you can talk about early intervention as long as you want, if the funds aren't there to provide those services, nothing is going to happen. (#2/NGO Health service)

Interviewee #4 (Local Council A) reported that without clear roles and financing there was a fear of being left accountable for outcomes without resources and this was a risk management issue. Interview #17 (Local Council D) argued "if we're going to have to do public health and have a more structured program, I'm not going to be able to do it on the budget I've got". And finally, another participant questioned whether "is it right to push [HP decisions] to local government level where you may get varying investment due to elected members being able to influence what you [the city] invest in when it really is a universal issue?"(#17/ Local Council D)

6.2.9 "Who in local government is going to do this?": the need for workforce capacity

There were divergent perspectives regarding the need for a HP workforce. On one hand, SA Health group interviewees related that they had no workforce capacity to work regionally or locally on HP initiatives, however, their division had leadership roles and responsibility for 'governance for health' through intersectoral and intergovernmental collaboration. They described this as "an architecture of people that will relate to local government regionally and will relate to government departments and NGOs in terms of central policy making. And it will be about trying to operationalize public health planning" (SA Health group interview). Thus, the SA Health workforce had a leadership role in HP, but group interviewees were silent on the need for a distinct HP workforce in the regional health system and clearly perceived HP services (practice) to be the purview of other system elements.

The need for a knowledgeable and skilful workforce was reinforced many times over by local council participants. There was agreement among these participants that local councils would not be receiving or allocating increased funding for HP staff and this was of concern, for example, "I'm scared of it because I'm thinking I've got all this other work to do and how am I going to fit that in?" (#27/Local Council C). The general sentiment was that no funding for HP would be forthcoming (from the state or from local councils), however, if funding were to become available local councils were receptive to increasing workforce capacity. Workforce capacity in this case relates to not only the number but also the skill of people.

Three of the four local councils had a small workforce working on healthy eating and active living initiatives (funded through term limited federal and state grants) and it was unanimous that without external grants the workforce would not be funded. When I asked participants what was needed for the future, it was generally agreed that building workforce capacity in local government was needed in terms of dedicated staff with knowledge of public health and skills/expertise in HP. This view was shared by participants in other sectors and questions were posed about existing local government workforce capacity:

> Who in local government is going to do this? Do they have positions that are funded and secure with people who are well trained? Who's going to network? (#34/NGO Professional Association)

Local Health Network group interviewees reported that the most significant impact of the *Review* (2012) and *SA Health's Response* (2013) was the elimination of positions with community development roles and the repositioning of some HP staff to work one-to-one in chronic disease management. The loss of the HP workforce in the Local Health Network was felt to affect the implementation of the *Public Health Act* (2011) as local council participants spoke about the loss of HP expertise. For example, participant #24 (Local Council C) found it "really, really hard" to deal with the loss of Local Health Network participation in Intersectoral Networks. Local Health Network staff were told that it was no longer permissible "to be spending their time attending regional networks … which they're all very, very disappointed about and quite concerned about because they see the interagency collaboration is actually not optional. It's actually core to how you get joined up responses" (#24/ Local Council C). It was noted that the loss of these relationships inhibited not only developing partnerships and intersectoral collaboration, but also the ability to work in an

interdisciplinary manner (e.g., social workers and dieticians working together). It appears that there were significant changes away from the local autonomy of the Local Health Network workforce to a more central command and control environment.

The loss of Local Health Network colleagues in shared leadership positions was also felt strongly by participants who led NGO Intersectoral Networks because "if people are no longer able to attend, and put time and energy into that, it will seriously deplete that regional dialogue, and the projects and the initiatives" (#50/NGO Intersectoral Network). Leadership in existing Intersectoral Networks was left to NGOs and local councils and this was particularly hard because the region was known for working together:

> I think one of the things people are lucky about in the [regional health system] is the level of networks … where workers would come together to explore issues of common concern … they often didn't bring money to the table, what they did bring was their expertise and their time within their work context. (#13/NGO Intersectoral Network)

The consequences of the cuts to the Local Health Network were also discussed by NGO Professional Association participants in terms of lost corporate knowledge (#46, #47), skill (#22, #25) and community and cultural awareness (#47). There was a sense that funding cuts reflected "backward thinking" because "it is very difficult to build systems from scratch" (#47). Another participant summed it up this way: "… the McCann Review has had a very large impact on shaping the personnel available for delivery of HP services" (#46/ NGO Professional Association).

The loss of the Local Health Network workforce was lamented by Medicare Local participants (#9, #21) because these people were seen to be the HP experts in the regional health system. Further concern was expressed because "there was no discussion with [Name of Medicare Local] about whether they had any capacity to pick up HP" (#21/Medicare Local) following the funding cuts and the Medicare Local clearly did not pick up HP. Although participants suggested that HP was part of everyone's work, HP practice was described as "vague" and "wishy-washy" by one participant (#13/Medicare Local). This finding appears to exemplify the adage that if it's everybody's business, it can easily become nobody's business, particularly given the lack of leadership, governance and financing for the workforce.

A final discussion point regarding the need for HP workforce capacity was that pressing population health issues were not going away:

> The needs are not going anywhere. So if we lose all the people that know what it is we need to do about them, out of the sector or into other roles or into other states, for example, that's going to have a longer term impact on our ability to pick up and move forward when eventually the governments work out who's going to try to actually provide the funding for these services. (#46/NGO Professional Association)

6.2.9.1 *"Under siege": A demoralised and disempowered workforce*

Beyond the need for HP workforce capacity, the needs of the remaining workforce were addressed as well. The policy directions of 2013 resulted in the "demoralization of the HP workforce" (#34/NGO Professional Association) and this was a clear theme among participants from all system elements, except for SA Health group interviewees who did not discuss this at all. NGO Professional Association participants were particularly vocal about HP becoming politically unimportant because health promoters were not seen as providing an urgent service, for example, "they're not patching up the person that hops out of the ambulance" (#46/NGO Professional Association). From a critical perspective, this clearly relates to the perceived power and dominance of the biomedical model discussed above.

Interviewee #50 (NGO Intersectoral Network) thought that "there are many people in the health services who actually know very well what the benefits of an early intervention approach are. And I suspect that they are very frustrated that they can't implement what they know to be best practice". Best practice was considered to be working in terms of Ottawa Charter strategies.

The HP practice environment was felt to be under siege because some participants had lost their positions (#22/NGO Professional Association), were living in fear of being next (#35/NGO Professional Association), or had colleagues who lost their positions (#25, #40/NGO Professional Association). The discussion was at times very emotional as illustrated in the following comments by other NGO Professional Association participants: "I think it's been really difficult for the HP workforce" (#25); "I think for the workers it's a very stressful time" (#35); "So it was quite an emotive time as well in terms of the reactions to the perspectives on policy … people are passionate in public health" (#40); "There is an awful lot

of trauma for individuals … there's very much a sense when you talk to HP professionals of being very much under siege at the moment" (#46); and "You're just a number on a page and you're gone, that was so harmful to people" (#46).

One participant was afraid of being identified as a 'health promotion person' and starkly emphasised this in the following quote:

> [y]ou know, from a personal point of view I'm called a health promotion person, I didn't even want to announce my [Award] because I didn't want to bring focus to it in case somebody goes, 'Oh, my God, there's a few health promotion staff left out there' … If you think of a barren nightmare of an atomic bomb has gone off … and there are a few little people kind of hiding down in the caves. (#35/NGO Professional Association)

The emotional outcry echoed what so many other interviewees felt, that is, HP no longer had value. For example, one participant stated that

> [p]ersonally it's made me not feel confident for a career in HP. I don't feel that government values HP and I've started study in a different specialization in public health that has nothing to do with HP … just really upset that there isn't a bigger respect and understanding of prevention. (#16/NGO Health service)

As a health promotion person myself, I was heartened to some extent to hear from many participants that you cannot take HP out of people; that is, many people in the workforce had embraced HP and therefore no matter where people ended up working, the potential for services and programs to be implemented in a HP manner was possible. Thus, opportunities, not just challenges, were identified in terms of people with HP knowledge and skill moving to work in other sectors and it was this potential infiltration of HP into other sectors that seemed to be most promising for the future. As the Local Health Network group interviewees noted "A lot of our staff have been with us for a long time and they're still carrying that health promoting way of thinking, so it's certainly the way they would work, the clinical practice would still be health promoting". However, in light of the findings regarding workforce capacity, it is clear that few new workers would be entering the regional health system and this would be required to ultimately build workforce capacity.

6.2.10 "There are a whole lot of unanswered questions": the lack of information regarding evidence of health promotion effectiveness

Stakeholders reported that the lack of information regarding acceptable evidence of HP effectiveness was a key factor that influenced why leadership and 'health governance' for reorienting health services toward HP was unsupported and a central factor in the *Review* (2012) and *SA Health's Response* (2013). This is consistent with the discussion in Chapter 5 and reiterates this as a HP challenge as described in Chapter 2. Participants from all system elements discussed that this was critical, except for those from SA Health who did not discuss this at all. The question I asked in all interviews was: what are the key factors that have influenced primary prevention and health promotion policy and practice in SA over the past few years?

On one hand, it was reported that the *Review* (2012) found "no evidence to suggest that [HP and non-hospital based services] actually made any impact on the population's health" (#40/NGO Professional Association) and on the other hand, it was argued that the *Review* (2012) was "dreadful in terms of HP" because the numbers used did not tell the story (#31/ State government department). Many participants shared concern over the lack of an appropriate evaluation framework based upon HP principles and practices, the lack of transparency in the evaluation methods used, and the lack of engagement of practitioners and academics in conducting the *Review* (2012).

It was notable that a few participants suggested that not all cuts to HP services were seen as negative. For example, one interviewee stated that some services should have been cut because they were focused on individuals and did not build community capacity:

> Now some of those programs should well and truly have been sliced. They were not effective … they weren't population-based, they were individual education … the [Do It for Life] Lifestyle Counsellors. There's a place for that and that's in the Ottawa Charter, there's a place for individual capacity building, but the issue with those is that they weren't necessarily connected to community and community capacity building to support people in a settings approach. (#35/ NGO Professional Association)

Evaluation of HP initiatives was considered difficult. Several Medicare Local interviewees identified that HP and prevention efforts suffered from a lack of good evaluation and this was

also highlighted by participant #30 (NGO Health Service) in that "there are a whole lot of unanswered questions" with respect to HP effectiveness. The difficulty in obtaining evidence was considered to be a great barrier among participants and the following are examples:

- "[HP] is very difficult to measure and provide what we call sort of, you know, quantitative evidence of results" (#13/Medicare Local)

- "It is hard to quantify outcomes" and "when you're trying to justify what you're doing, it's really tricky". (Local Health Network group interviewees)

- Monitoring, evaluating and reporting is "one of the most difficult things that I think we deal with in government agencies" (#31/state government department) particularly given that funding to do anything other than rudimentary collection of output measures at the program level was very challenging.

Another participant explained that "it doesn't mean that it [HP] is ineffectual, it just means that no one has actually been measuring it" (#49/NGO Professional Association) and went further to say that HP was not well resourced and therefore it was unfair to expect effective results:

> [y]ou will see a couple of nurses who work in community health basically under a lot of pressure with very little resources who are trying to implement all sorts of projects and programs to help promote good health and healthy eating. I don't believe they are properly resourced or adequately supported in order to actually deliver that to the community. I think part of the problem is there has not been any—well it is very difficult in any event, but there is not, to my knowledge, much material on measuring what they were actually doing. (#49/ NGO Professional Association)

Thus, not only was it considered difficult to evaluate HP, but it was thought that initiatives were poorly resourced to carry out effective HP practice and therefore expecting to generate evidence of effectiveness was perhaps futile.

It was also suggested that "we don't respect the knowledge that we actually do have" (#30/NGO Health service) and "[we don't] articulate our experience well enough, or the evidence well enough" (#38/NGO Health service). The rationale was that although there is an awareness of the "magnificently complicated scenario" (#38/NGO Health service) of HP and the levers that are going to have the most impact, effective dissemination was lacking. Another echoed the dissemination challenge:

> [p]eople in HP often aren't the best at evaluating or selling what they're doing or finding the outcomes or measuring the outcomes and that's always been a real gap. The medical outcomes are easy to measure because we have milligrams of something, numbers and quantitative data. (#16/NGO Health service)

Interviewee #31 (State government department) reiterated that although the *Review* (2012) was not well done, HP was not doing a good enough job in dissemination, for example, "I mean I really think HP has been quite naïve in terms of its communication."

In looking ahead, results-based accountability (RBA) methods were being considered by some participants from NGO Intersectoral Networks to address the lack of evidence. RBA is a method or process to report on the achievement of results or desired outcomes of a program and was therefore seen as a way to address the lack of evidence. One interviewee talked about the need to get better at "documenting what we're doing and gathering data" (#12) and s/he hoped that future indicators would measure results from activities such as community development. Another interviewee (#48) discussed RBA and again hoped that "as those notions firm up into more robust structures … the work of the [Intersectoral Network] can make their contribution within those sort of RBA type frameworks". A common RBA framework was thought to help support efforts to "tell the story of the depth and breadth of what's actually occurring" (#12/NGO Intersectoral Network). For both of these interviewees it was the sense that collective results needed to be reported in an effective manner and this was considered a promising avenue for more evidence of HP effectiveness.

Following on the above, all interviewees in state government departments (#31, #32, and #39) identified the need for evidence to help develop policy and demonstrate outcomes. Interviewee #31 discussed the need to "provide advice based on public health evidence", however s/he acknowledged that evidence alone does not influence policy. The example given was with respect to the research on the potential impact of minimum floor pricing for alcohol and how the evidence was disputed by the SA wine industry. It was also suggested that although some tobacco reduction interventions had good evidence, these were still cut, for example, "[t]hey talk to us and it's insulting really and I can't see any evidence of evidence-based decision making on their part" (#22/NGO Professional Association).

6.3 "Limited" health promotion services (practice) in the regional health system

One question I asked all stakeholders was the role their organisation played in HP in the regional health system. Table 6.1 below lists the roles or services that stakeholders deemed to be HP according to three strategies (described in Chapter 2 and 3 as developing personal skills, creating supportive environments and building healthy public policy).

Table 6.1   List of health promotion practice reported by stakeholders (November 2013)

System element	HP practice by strategy		
	Developing personal skills	Creating supportive environments	Building healthy public policy
Health sector	Chronic disease management Facilitate access to health services	None reported	Whole-of-state government approach to HP/Health in All Policies
Other state government departments	School health curriculum development Tobacco reduction including a focus on Aboriginal communities Alcohol and drug treatment and social marketing Sport and recreation funding	Healthy canteens in schools	Smoke-free indoor and outdoor areas
Local government	Healthy eating and active living initiatives Dissemination of promotional materials from SA Health	Healthy eating and active living initiatives Provision of community infrastructure including libraries, parks, walking paths, sports and recreation facilities, playgrounds, bike trails, sporting grounds, skateboard parks, sheds [centres to gather] for activities	Healthy eating and active living initiatives Smoking bylaws and liquor licensing policies Food inspection, dog control, hoarding, burnoffs (air quality), noise control, water quality of swimming pools, infection control, sewage and waste control, and mosquito prevention

		Health protection services such as immunisation, food inspection, dog control, hoarding, burnoffs (air quality), noise control, water quality of swimming pools, infection control, sewage and waste control, and mosquito prevention	
NGOs	Homelessness and housing services

Health education regarding lifestyle risk factors

Individual health services including domestic violence and sexual abuse counselling, sexual health, mental health, aged care

Family health services including early newborn intervention, child and youth services, parenting classes, parent/adolescent counselling | Cultural events

Management of community, family, and youth centres | Homelessness and housing services

Advocacy (e.g., poverty reduction, food security, tobacco control) |

In the following sections I provide an in-depth explanation of HP practice by system element. I interchange the terms 'service' and 'practice' throughout the rest of this thesis.

6.3.1   Health promotion practice in the health sector

No services were described as HP by participants from the Medicare Local except for patient referral to Do It for Life lifestyle advisors (employed by the Local Health Network) as part of chronic disease management and it was indicated that these programs were being cut as a result of the *Review* (2012) and *SA Health's Response* (2013).

There was clear consensus among Local Health Network participants that HP services were refocused on individual management of chronic disease and there was hesitancy to describe these services as HP because of this narrow focus: "I would struggle to call it – I wouldn't naturally say we do health promotion now" (Local Health Network group interview). The

individual interviewee from the Local Health Network (#20) reported that their service was focused on advocating for Aboriginal and Torres Islander people to receive equitable access to medical care and did not provide HP services. S/he reported that the holistic way of delivering services was lost, for example, there were cuts to hosting community events to engage Aboriginal and Torres Islander people.

As discussed earlier, SA Health group interviewees stated that their role in HP was focused on the future potential of the *Public Health Act* (2011) and on building healthy public policy. They suggested that "it's hard to ask [local councils] to actually do much about" reducing health inequity and that SA Health was working on this "within the parameters that are set", that is the *Public Health Act* (2011):

> So there will be centres of inequity and tough areas, there'll be homeless people and what have you, but what we've got to try and do is build a system that actually does more for health and encourages those people that do have those policy levers to pull them in the direction for health, rather than against it. (SA Health group interview)

6.3.2 Health promotion practice in other state government departments

Intersectoral action was considered key to effective HP practice by the three interviewees in other state government departments. One example included partnering with schools, local governments and/or community associations to deliver sport programs and these programs had much to do with health outcomes. Another example offered was an "Ottawa Charter-type model where you're looking at strategies at multiple levels" and that "you can't do anything with something like alcohol or drugs without being intersectoral" (#31). Interviewee #39 used to have a close relationship with the former HP Branch (SA Health) regarding a physical activity initiative when his/her department had a leadership role. However, their department's leadership role was relinquished because responsibility for targets was found to be beyond the department's scope, in that strategies were geared to incidental active living, such as taking the stairs, as opposed to the department's mandate around sport and recreation. Conversations with SA Health about the continued use of slogans from social marketing campaigns associated with the initiative revealed that they would no longer be supported, thus, ties with the health department were severed. This links clearly with the discussion in section 6.2.4 where social marketing was negatively portrayed by SA Health participants.

One interviewee from a state government department discussed building healthy public policy and this was with respect to tobacco reduction: "the most important thing I can do is to maximize the numbers of people who are not smoking" and "funding a local new public health project will get me nowhere in that … policy's not going to cost me a lot, so that's a great tick" (#31). Tobacco reduction also included working with Aboriginal communities: "probably the most significant single behaviour contributing to lowered life expectancy for Aboriginal people" (#31). When I asked if tobacco use was a top priority for Aboriginal people s/he stated "absolutely not" and that "the data would suggest, whether it's tobacco or alcohol or other drugs, or blood-borne viruses … that's more about broad disadvantage than it is about Aboriginality" (#31).

6.3.3   Health promotion practice in local government

There were extremes in perspectives regarding the role of local government in HP practice. Local Council B participants stated that "preventative health" was "core business" in terms of "work on those social determinants that we have influence over" (#6, #36). Many services were thought to have public health outcomes (#6, #36) and many departments were thought to have a role in promoting health (#12). This perspective was also affirmed by the participant from the Local Government Association (#7). In contrast, Interviewee #15 (Local Council D) stated that s/he was "not sure that the local government has any role in public health. Yeah we don't do anything." Participant #33 from this same Local Council (D) was enthusiastic about expanding beyond mandated health protection services (e.g., immunisation, food and water quality), however, another suggested that even delivery of existing environmental and community services was a struggle in terms of capacity, let alone taking on further HP functions (#17/Local Council D). This perception builds upon my findings in section 6.2.9 on the need for HP workforce capacity.

Participants in Local Council A and C were somewhere in between these extremes. For example, it was suggested that services had "no badge of health" (#4/Local Council A), however, all services were designed to enhance community wellbeing and thus s/he could make links to HP. Similarly in Local Council C, it was questioned whether HP or prevention was core business, but enhancing community wellbeing was readily identified as a key

outcome of services (#10, #8). The linkage between the local government planning responsibilities with respect to the built environment (e.g., parks, walkways) and HP appeared to be well established. It was notable that some local council participants discussed important health protection services in terms of HP practice and this may reflect a narrower interpretation of HP as services such as immunisation, food inspection, air and water quality were included in the discussion.

6.3.4 Health promotion practice in nongovernmental organisations

An overall theme in interviews with NGO participants was the need for effective advocacy for HP as a key leadership function. Leadership was discussed in terms of needing "a strategic group that's around advocacy, strategic policy direction … hopefully influencing change and policy, but also at a level where you can make some decisions" (#50/NGO Intersectoral Network). It was reported that NGOs struggled to maintain leadership in advocacy, particularly when some participants were worried about losing their jobs and others worried about speaking out for fear of losing funding. From a critical perspective, the power imbalance that made HP an easy target was very clear and several interviewees wondered how effective advocacy could occur in this environment.

The lack of leadership within the NGO sector for taking a strong stand against the cuts to HP was of prime concern for Interviewee #38 (NGO/Health service). S/he was "struck by the degree of passivity" and the only explanation s/he could provide concerned power relationships where the NGO sector was so closely entwined with government that leaders would be very reluctant to say anything that might jeopardise existing funding. This was closely linked with the need for increased shared leadership where there is participation of civil society in decision making: "One of the things that we are advocating strongly is that civil society groups are at the table in all of the – in not just all of the social domains, but in all of the economic, structural, taxation conversations" (#38/NGO/Health service).

On the other hand, many participants talked positively about their advocacy efforts even if outcomes were disappointing. Interviewee #30 (NGO/Health Service) stated that there was an "outstanding advocacy group" that had the knowledge and skill to influence government, "to

keep them honest" and "to make sure they continue to invest in the things they need to invest in". An example of this was making a case for the reinvestment of funding for a tobacco reduction social marketing campaign.

Other participants from NGO professional associations reported that their HP activities were primarily advocacy at the state level and discussion centred on the 'McCann of Worms' alliance that was formed during the consultation period of the *Review* (2012). All interviewees from professional associations discussed this advocacy effort except one, however this participant also acknowledged an advocacy role: "I would describe it that doctors are aware of the health needs and health outcomes wished for and realistically are in a position to be able to lobby for some of those needs" (#47/NGO Professional Association). There were several discussions about the nature of advocacy work and it was suggested that building advocacy capacity was critical because some NGOs lacked confidence and readiness to respond quickly to government decisions or what is in the media. Interviewee #22 (NGO Professional Association) summed this up as follows: "when our jobs were going we weren't on the map as a powerful lobby". In another case it was not a matter of not having policies as one NGO "had a policy on almost anything you could want to think about" (#35/NGO Professional Association). Having a national office that advocates broadly was seen as helpful (#40), however, as Interviewee #46 stated (and what many others inferred) "we're almost always invited to make a submission on behalf of the organization but as for the actual impact, I'm not really sure".

6.3.4.1   NGO/intersectoral networks

The difficulty in collaborative planning because of the turmoil in the policy environment was a theme among participants from intersectoral networks. They all discussed the important work of bringing service providers together to share information and identify gaps in service and areas for collaboration. Examples of collaboration included one network that had working groups that addressed issues such as poverty reduction, food security, family violence, family fun, and celebrating Aboriginal culture. Another network brought together agencies and successfully obtained funding to launch an alcohol reduction strategy. Participant #50 discussed HP in terms of "dynamically responding to the changing needs of

people who are socially and economically disadvantaged" and through intersectoral action a range of services were provided:

> … from early intensive intervention with newborn babies, born into high-risk families, a lot of work with children, support of playgroups and effective parenting classes for our children and young people, sexual abuse counselling, parent/adolescent counselling, we're running family centres, community centres, youth centres. We do a lot of work with guardianship kids … and domestic violence services, homelessness services, just added recently mental health services. And in addition to those things, we have a housing division which is currently managing about 350 houses across the region, and we're currently building and expanding that area as well. (#50/NGO Intersectoral Network)

Many participants from intersectoral networks suggested that youth services were particularly affected by funding cuts resulting from the *Review* (2012) and *SA Health's Response* (2013). One example was the closing of a service in one community where youth would no longer be able to access services in a drop-in community setting that was comfortable, welcoming, and afforded youth the opportunity to establish relationships with health care providers. Services were to be centralised in another community and in a setting that was more institutional and this was cause for concern because it was thought that youth-at-risk do not just walk into health services, they need to be engaged. The focus of discussion in NGO intersectoral networks was ensuring individual and family health services were available and these were thought to be part of HP services in the health system.

6.3.4.2   NGO/health services

One of the NGOs provided health services ranging from partnering on social marketing campaigns, to raise awareness of lifestyle risk factors, through to advocating for healthy public policy. When I asked an interviewee from this organisation about action on the SDH s/he stated that "no we don't get into that … it's not our remit to try and solve the problems of people on low SES" (#30/NGO Health service). Conversely, an interviewee from another NGO stated that their "mandate [was] to advocate strongly and powerfully for the interests, not simply the interests of our member organizations, but more the interests of people who experience poverty and disadvantage in SA" (#38/NGO Health Service).

A third NGO provided services to "communities of interest identified on the basis of poor sexual health and sexual health outcomes that include Aboriginal people, people with a disability including mental health, GLBTIQ [gay, lesbian, bisexual, transgender, intersex people, queer] people" (#2/NGO Health Service). Although the NGO had a strong history of working on the SDH, constraints imposed by the current service delivery agreement for state funding had "become very narrow. They are around STIs [sexually transmitted infections] and young people. We have fulfilled them but we have had to leave behind so much of the other work that we were doing" (#2/NGO Health Service). The other "flagship" service discussed at length aimed "to build the capacity of high schools to do better or improve their approach to relationships in sexual health" (#16/NGO Health service). The practice environment had changed where "we have worked forever closely with community health, with youth health, with women's health. Again, all of which are being reasonably decimated at the moment" (#2/NGO Health service).

6.3.4.3   NGO/professional Associations

Interviewees mostly reflected on the challenging role of leading professional associations in the wake of the *Review* (2012) and *SA Health's Response* (2013). Interviewee #40 described the challenge in terms of the many demands of assembling knowledgeable people to comment on policies at a time when those were the very people who feared for their jobs. For example:

> you could really feel the role that we needed to play as well in terms of keeping that momentum happening and needing to respond to some of these things … there was such a dramatic cut to things and it was some of the worst that people had seen. (#40/NGO Professional Association)

Another participant discussed this work as "just holding the fort" at a time when "It would be easy to, almost to pack up and go home. I mean, there are branches [regional organisations of the NGO] that have dissolved" (#25/NGO Professional Association). The ability to carry on in this negative environment was questioned: "I did actually have to come to do some really strong reflection about whether I could stop being cynical and angry and work in a positive optimistic way because you can't be cynical and angry and do good" (#35/NGO Professional Association).

6.3.5 Health promotion practice and community participation

Facilitating community participation as a foundational HP action was discussed in terms of how it had fallen out of favour and one participant summed it up as follows: "community development, which kind of in South Australia, my understanding, dates back to the 70s, has become old hat and it is not seen as sexy, it is not seen as modern" (#2/NGO Health service). The lack of community development was also discussed as a retreat from a comprehensive approach to primary health care (#29/NGO Intersectoral Network) and that "former HP services have retracted from primary health services" (#50/NGO Intersectoral Network). As described in Chapter 4 the case (regional health system) had a long record of community development. One interviewee working in aged care where funding appeared to be stable, commented that the facilitation role in community development was a luxury now given that other sectors have lost this role: "I can get it going. I can write the project plan. I can come back to them, go, "What do you think?" and I can get things happening. Which is a luxury" (#37/NGO Intersectoral Network).

As discussed earlier, the Local Health Network group interviewees reported that a significant change in the HP practice environment was the elimination of community development roles and HP staff were repositioned to work one-to-one in chronic disease management:

> Well, I guess it's that move from our primary health teams working more in community health-type centres to now working in GP Plus Centres where services are coming out of the hospitals and outpatient settings and our staff more linking in with those kinds of services. (Local Health Network group interviewees)

They further reported that in the past "work was probably driven by the needs of the community, but now it's more that it's driven from the top" (Local Health Network group interviewees). Medicare Local participants described activities such as surveying community members as to health care needs.

Only one stakeholder explicitly discussed the importance of ensuring community participation in HP. S/he suggested that the biggest problem was that the most needed services were those for vulnerable populations and those populations had no voice or power to advocate for services in times of budget cuts: "I guess one of the difficulties we have is that many of these services are needed particularly in vulnerable and disadvantaged

communities, precisely the same communities that have difficulties getting their voices heard in general conversations about anything" *(#46/NGP Professional Association)*.

I asked SA Health group interviewees to clarify what organisations would have community development staff to work with disadvantaged populations and they reported that local councils were doing this work. However, this was not a theme in my interviews with local councils, but this may be a matter of not asking them directly because they did relate that a key role was responding to community concerns. When local council participants discussed HP and community participation, they focused on the *Eat Well Be Active Strategy* and its links to the OPAL (obesity prevention initiatives funded by federal and state governments in partnership with 5 local governments in SA) and Healthy Communities initiatives (physical activity and health eating initiatives funded through federal and state government short term grants to local government). These initiatives were not widely discussed except by Program Coordinators who were generally enthusiastic about working with a variety of community groups to encourage healthy eating and active living.

6.4 "Multiple circles, some larger, some smaller, some connected by a spoke but none completely connected to each other": A fragmented regional health system

In Chapter 2, I defined a health system as not only a health care system but also one that includes the broad social systems that influence human health and wellbeing. In this section I report on stakeholder descriptions of the whole health system. Questions I asked all stakeholders were as follows:

> There are many players and organizations involved in primary prevention or health promotion. When you think of this large system of organizations how would you describe it? What words would you use to describe it? Are there mechanisms and structures that link organizations together? What organizations are you most closely linked with regarding primary prevention and health promotion?

The following table (Table 6.2) lists verbatim descriptions of the regional health system by participants in the various system elements and this table illustrates a generally uniform perspective.

Table 6.2   Stakeholder descriptions of the regional health system for HP

System element	Stakeholder descriptions of the regional health system for HP
Health sector	
Medicare Local	Appalling lack of connectedness within the system; scattered; fragmented; disorganised.
Local Health Network	In a state of flux; It is a mess; I wouldn't even say there's lots of players. I'd say there's less players now, and I would say disconnected.
SA Health	Dispersed, networks.
Local councils	Chaotic in terms of everyone working in their own way; Complicated; Infant network; Little connection with other sectors and initiatives; Not linked up and no formalised way to share understanding; Some areas where there is duplication of effort and other areas where nobody's doing anything; Many arms; Not integrated; Uncoordinated.
State government departments	Scattergun; Disorganised; No one's coordinating; Everyone running off doing their own little thing.
Nongovernment organisations	Ad hoc; Complicated system; Discombobulated; Disengaged; Disjointed ; Dog's breakfast; Fractured; Lack of integration; Less coordinated, more dispersed; Messy; No ability, opportunity and space to actually sit back and go, how could we do this differently; Not an ingrained formal system; Not well-connected; Very complicated system; Very patchy; We're in an adversarial system rather than aligned for outcome.

Given the mostly dire descriptions of the HP policy environment that I reported at the beginning of this chapter, it was not unexpected to find that most participants reported a fragmented health system characterised by a collection of people and organisations in tenuous relationships. From a systems thinking perspective the lack of interaction among system elements reported by interviewees is significant because the nature of these relationships is thought to influence the behaviour of the whole regional health system.

A few stakeholders found it hard to describe the system and in these cases, the notion of a regional health system for HP seemed to be a foreign concept. For example, several participants from Local Council D were unclear about what I meant when asked about a health system for HP and were unable to offer a description. One participant from Local

Council D (#15) reported the health system to be "*fabulous*" because of the good access to doctors and hospitals, even though we had talked at length about a health system for HP. Some stakeholders questioned if there was a regional health system for HP at all. For example, a "system in my mind is organisations working together with a stated goal and objectives and knowing what the other parts are doing. And that's not what I feel we've got at the moment … it doesn't feel like a system" (Local Health Network group interview).

Another stated "There's not a proper system. It's all those bits trying to do good work with good people in them, doing the best they can and coming together where they can" (#2/NGO Health Service). The imagery of "multiple circles, some larger, some smaller, some connected by a spoke but none completely" (#19/Medicare Local) was evocative of a poorly connected regional health system.

SA Health group interviewees explained that the health system is "dispersed, yeah, it's about networks" and reported that the implementation of the *Public Health Act* (2011) would provide the necessary leadership and governance for health through developing partnerships and intersectoral collaboration:

> Yeah, it's certainly dispersed but again, we keep coming back to this, the [Public Health] Act and the plan that is being developed under the Act will bring greater coherence over time and the Branch that we're working in is not doing it by itself but it's pivotal to this. It's about forming greater and more expressed links across State Government agencies, but also in local government … you can't really do true health promotion, you can't preserve, protect and advance health without having a very good and solid partnership with local government.

This quote offers further explanation as to the need for a strategic policy framework as in section 6.2.2 and to enhance whole-of-state government approaches as reported in section 6.2.6. Many participants related that the fragmented regional health system was related to the lack of clear roles and responsibilities (as in section 6.2.1) and an absence of formal mechanisms for intergovernmental and intersectoral collaboration. Many participants questioned the ability to develop partnerships and intersectoral collaboration when there was a lack of formal mechanisms for intergovernmental and intersectoral collaboration.

NGO professional association participants argued that there was unclear state leadership, governance structures, and processes for developing shared public health plans and

facilitating collaborative action on the SDH (#46, #22, #34). This was echoed by NGO intersectoral network participants, who stated that although there were good working relationships among agencies and governments within the regional health system, a more collaborative approach was needed. There was agreement among these participants (#10, #11, #12, #13) that political and system-wide commitment was needed with strong governance structures for collaborative planning to foster a shared long term vision. This commitment should be among elected officials, executives, NGOs, business, industry, and university academics in order to raise understanding about population health and action on the social determinants of health.

One local council interviewee stated that intersectoral action cannot happen without "systems and structures" and summed up the mindset needed:

> We need to have an objective look about what actually is and isn't happening, that is impacting on the health and wellbeing of individuals, groups and communities. It starts there … vibrant communities don't happen by themselves … it doesn't work in a silo, it has to work through systems and structures … to address the social determinants of health. (#36/Local Council B)

There were other examples provided with respect to the lack of collaborative mechanisms in stakeholder interviews. Even when stated goals and objectives were explicit in policy documents there was suggestion among several interviewees that the silo effect was so strong that collaborative efforts were very difficult. The Local Health Network group interviewees affirmed that there were "some good partnerships, but a lot of silos" that inhibited collaboration. One example was the *Eat Well Be Active Strategy* (2011) where collaboration and coordination were organising principles. However, it was argued that everyone stuck to their own agendas: "There wasn't enough in it. Everyone comes to the table with 'What's in it for me?' There wasn't enough in it for them to collaborate. It was easier to do it on their own." (#39/State government department)

Another example was with regards to population health assessments. In 2013, SA Health and local councils were in the early days of developing public health plans and Medicare Local was developing a population health needs assessment. As one participant explained, this work was about "understanding the population, the needs, health care utilization, and the burden of disease" (#9/Medicare Local). Another (#13/Medicare Local) suggested that priorities would

be derived from the assessment. Several interviewees agreed that although this was similar work to the development of public health plans, there was little if any collaboration with local councils and no plans to join-up effort. Medicare Local participants used descriptors such as "silent partners" (#9) and "forgotten friends" (#21) to explain relationships with local councils and the lack of collaboration in the preparation of public health plans. It was noted that system capacity was needed for "federal, state and local policy to realign" and "come together as a whole" (#18/Medicare Local) and that this would require at the very least, the establishment of linking mechanisms and ideally, collaborative structures to solve issues of roles, responsibilities, and priorities for HP.

Even the NGO intersectoral networks were seen to be disconnected because of severed relationships with the Local Health Network workforce resulting from the *Review* (2012) and *SA Health's Response* (2013):

> So the managers of those health services [Local Health Network] I talked about, their attendance at the [intersectoral network] has virtually been non-existent in the last three to six months, because of them having to deal with all this other stuff [the *Review*]. So they're kind of disconnected, so we're sometimes trying to work out what's going on, who's where, what does this mean for our young people … So disconnected, disgruntled. (#13/NGO Intersectoral Network)

Figure 6.1 below is a map of the interactions or relationships between system elements created from stakeholder interview data (November 2013). As noted above I asked stakeholders what organisations they were most closely linked with regarding primary prevention and HP. This map helps to illustrate what most stakeholders perceived, that is, a regional health system for HP that lacks strong interactions. A limitation of this map is that it is based solely upon the boundaries, or the system elements selected and the perspectives of those who participated in my research. No one can study the entire system and in my research, there were inevitably people in the selected sectors or system elements who I did not interview who may have offered a different perspective.

Figure 6.2   Map of stakeholder perspectives of interactions or relationships for health promotion between system elements in the regional health system (November 2013)
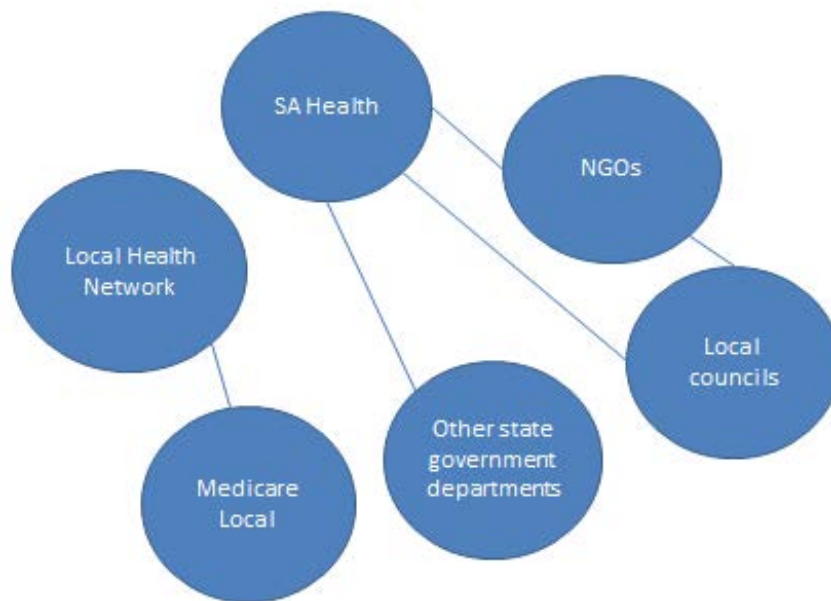
The following series of bullet points describes the map in detail:

- Stakeholders reported that the relationship between local councils (local government) and NGOs was strong, particularly because of their participation in intersectoral networks.
- Participants reported connections between local councils and SA Health but these were not strong.
- Local council stakeholders reported that their relationships had been severed with the Local Health Network and they did not have a connection with the Medicare Local.
- Medicare Local participants reported that the only connection they had with the Local Health Network was referral of patients to the Do-It-For-Life counsellors (and this initiative was being cut as a result of the *Review*).
- Local Health Network participants reported that they had no formal interactions with any system element for HP except the Medicare Local, not even SA Health.

- Connections between local councils and other state government departments regarding HP were not reported.

- SA Health stakeholders confirmed that establishing relationships with other state government departments was their role. However, stakeholders from state government departments indicated that past relationships had weakened.

- There was no indication from stakeholders that NGOs had connections with other state government departments for HP.

- There was some indication of SA Health linkages with NGOs, for example, stakeholders spoke of SA Health funding for the provision of health services.

6.5 What are the perspectives of key stakeholders within a regional multisectoral health system with respect to the extent to which health promotion goals and actions and health system building blocks are in place for health promotion?

In this section, I answer the sub-question: what are the perspectives of key stakeholders within a regional multisectoral health system with respect to the extent to which HP goals and actions and health system building blocks are in place for HP? Table 6.3 provides a summary of these perspectives.

Table 6.3   Summary of stakeholder perspectives regarding the extent to which HP goals and actions and system building blocks are in place for HP

HP goal, actions and system building blocks	Extent to which goals, actions and building blocks are in place for HP
Leadership and governance Reorienting health services (health governance) and developing partnerships and intersectoral collaboration (governance for health)	Lack of 'health governance' due to the lack federal and state leadership, roles, governance structures and policy directions and the potential effect of state-level leadership changes.
	Emphasis on 'governance for health' for whole-of-state government approaches through state leadership for the *Public Health Act* as the strategic policy framework.
Financing	Lack of leadership for HP financing at any level of government; Lack of financing due to cuts to HP and fear of cost-shifting from the state to local governments due to state economic circumstances and rising health care expenditures.

Workforce	Lack of leadership for a strong HP policy environment for financing a formal HP workforce; Lack of workforce due to cuts to financing, repositioning of regional health sector staff to chronic disease management; the demoralisation of the remaining workforce.
HP practice	Lack of leadership at any level of government for regional HP practice; Limited HP practice in the regional health system due to health sector cuts in financing and workforce.
HP practice and ensuring community participation	Lack of leadership, governance structures and discussion of community participation in HP in the regional health system; withdrawal of community development in the health sector due to cuts in financing, workforce and HP practice.
Information	Lack of leadership for practice-based HP research and evaluation; Lack of information regarding acceptable evidence of HP effectiveness.
Reducing health inequities	Lack of leadership, governance and stakeholder discussion around reducing health inequities as a HP or health system goal.

There was extremely limited discussion of the HP goal of reducing health inequities in any interview. I did not ask a question specific to the goal and there were only two interviews where health inequities surfaced to any extent. SA Health group interviewees mentioned health inequities once and referred to "centres of inequity" or areas where inequity occurs and that these would need to be addressed, however, this was not central to the discussions regarding directions for HP policy and practice. One NGO interviewee discussed the mission of an intersectoral network as seeking to meet the needs of the "*socially and economically disadvantaged*". This finding paralleled to some extent what I found in my review of state government documents in that the key driver for HP in 2013 was the *Public Health Act* (2011). The one suggested principle it contained was for equity to be considered in public health planning. This is a good example of the lack of leadership and governance structures for addressing this fundamental goal.

Stakeholders from all system elements identified that the dynamics of federal-state HP policy directions were a key influence on leadership and governance for HP. Stakeholder interviews

provided explanations for the policy context reported in Chapter 5 and brought to life the importance of the call for stronger intergovernmental relations.

There were divergent perspectives regarding the 'governance for health' framework of the *Public Health Act* (2011) to provide the needed strategic policy direction for HP. SA Health group interviewees strongly advocated for this while other interviewees reported the lack of a shared vision, the lack of clear roles and responsibilities in public health planning, and the need for a detailed strategic policy framework to facilitate coordinated action.

Many participants discussed the impact of political leadership changes and the lack of commitment to HP amidst the pressures of rising health care expenditures and the state's poor economic condition. The change in political leadership coincided with the withdrawal of state leadership, financing and 'health governance' for reorienting health services toward HP in the regional health system.

State-level political leaders and bureaucrats shaped the discourse of HP significantly by narrowly focusing on social marketing campaigns that were reported to embody wagging finger and nanny state approaches. Although social marketing campaigns may be ineffective if they are not rooted in multi-strategy initiatives, the key finding here was the ideology of individualism that appeared to prevail and direct HP policy and practice.

A related finding was state health department leaders' negative views of past HP financial allocations and this in turn reflected poorly on past HP leadership and health governance. It was reported that large sums of money were wasted on social marketing campaigns and these perceptions appeared to support the cuts to HP as a result of the *Review* (2012) and *SA Health's Response* (2013).

There was the perception among stakeholders that the whole-of government or Health in All Policies approach to 'governance for health' advocated by SA Health group interviewees had potential, however, it was not seen to have a strong presence in the regional health system. A key reason for this was the lack of formal governance structures or mechanisms for intergovernmental and intersectoral collaboration.

It was commonly held that HP was a soft and easy target and a casualty of politics in times of poor state economic circumstances and growing health budgets. HP service (practice) was cut in the Local Health Network and from a critical perspective this was largely considered to be influenced by the power of the biomedical model of health and political agendas in an election year.

The majority of stakeholders provided a clear perspective about fears of cost-shifting from the state to local governments for HP. These views presented important insights into how HP financing is integrally linked to developing partnerships and intersectoral collaboration and the 'governance for health' challenges that may lay ahead in realising the potential of the *Public Health Act* (2011).

Leadership and governance which ensures that there was an effective workforce for HP was clearly seen to be deficient by the majority of stakeholders. The cuts to the Local Health Network workforce evoked strong emotion and were seen to disrupt the work of the intersectoral networks and partnerships in the regional health system. Furthermore, the remaining workforce as at 2013 was demoralised because of the cuts and some participants commented that working in HP was clearly devalued as compared to clinical health services.

The lack of information regarding evidence of HP effectiveness in state HP services found in the *Review* (2012) was reported to be important in decisions to cut HP. However, the lack of an appropriate evaluation framework, the lack of transparency and the lack of engagement of stakeholders in the assessment was of great concern. Many stakeholders identified HP research and evaluation, and effective dissemination as the hardest aspects of HP.
HP practice in the regional health system was limited and here I summarise stakeholder perspectives of the HP practice environment. Most services deemed to be HP were focused on developing personal skills. Local government were the main stewards of creating supportive environments and participants from all system elements reported work on building healthy public policy. At the state level it was reported that there was potential in the whole-of-state government approaches regarding the implementation of the *Public Health Act* (2012).

The HP action of ensuring community participation was not explicitly reported by any stakeholders as part of HP practice. The cuts to HP financing and the redirection of the Local Health Network HP workforce to chronic disease management and away from community development left little community participation in the regional health system.

Leadership and 'health governance' through reorienting health services toward HP was reported to be severely depleted if not abandoned in the regional health system and this confirmed findings in Chapter 5. One HP service in the regional health system reported by the health sector (Medicare Local, Local Health Network, SA Health) was developing personal skills through chronic disease management, thus, the biomedical or clinical focus was a significant factor in shaping HP services.

Developing partnerships and intersectoral collaboration through leadership and governance for health in the regional health system was reported to be weak. When asked about relationships among system elements, stakeholders reported that the regional health system was fragmented with few formal opportunities to interact and engage in collaborative action.

In the next chapter I discuss the key findings from stakeholder interviews and the document review through the analytic lens of system thinking to help refine and answer my overarching research question: from a systems thinking perspective, what are the key factors that influence health promotion policy and practice in a multisectoral health system in one region of South Australia?

Chapter 7: Discussion

In this chapter I answer and discuss my overarching research question: from a systems thinking perspective, what are the key factors that influence health promotion policy and practice in a regional multisectoral health system in South Australia? As described in Chapter 3, I formulated three sub-questions in order to address this question:

1) Over a ten year period (2003-2013) to what extent does the policy context support HP and health system building blocks for HP?

2) What are the perspectives of key stakeholders within a regional multisectoral health system regarding the extent to which HP is addressed and health system building blocks are in place for HP?

3) What feedback mechanisms appear to influence HP policy and practice in the regional health system?

To set the stage for this chapter, I reported my findings with respect to the first sub-question in Chapter 5 and the second sub-question in Chapter 6. Table 7.1 provides a comprehensive list of all findings. This table also illustrates patterns with respect to findings, notably those findings that emerged from both document review and interviews and those that were found in either document review or interviews.

Table 7.1   Summary of key findings from Chapters 5 and 6

Key Findings	Document review (Chapter 5)	Stakeholder interviews (Chapter 6)
Lack of strong support for/discussion of reducing health inequities	✔	✔
Lack of support for community participation in HP	✔	✔
Federal-state-local government roles, governance structures and policy directions [Calls for enhanced intergovernmental relations (federal, state, and local); delineation of leadership roles and governance structures; impact of federal and state policy directions]	✔	✔
Cuts to/lack of HP financing	✔	✔
Cuts to/the need for HP workforce capacity	✔	✔
Cuts to/ limited HP services (practice)	✔	✔
Lack of information/evidence of HP effectiveness	✔	✔
Impact of state economic circumstances/budgetary constraints	✔	✔
Impact of state leadership changes		✔
Impact of HP discourse regarding past financing and services		✔
Dominance of biomedical model		✔
Demoralisation of HP workforce		✔
Fear of cost shifting from state to local governments		✔
Fragmented system elements		✔
Calls for/focus on whole-of-government approaches	✔	✔
Need for a strategic framework		✔
Support for monitoring and reporting on population health	✔	

Nine findings are discussed in Chapters 5 and 6 and I labelled these as 'dominant themes' with respect to key factors that influenced HP policy and practice in my research. The nine dominant themes are:

1) lack of strong support for and discussion of reducing health inequities;

2) lack of support for community participation in HP;

3) the impact of federal-state-local government roles, governance structures, and policy directions;

4) cuts to and the lack of HP financing;

5) cuts to and the lack of HP workforce capacity;

6) cuts to and the lack of HP services (practice);

7) lack of information regarding evidence of HP effectiveness;

8) the impact of state economic circumstances and budgetary constraints; and

9) calls for and a focus on whole-of-government approaches to HP.

Further to Table 7.1, seven findings from Chapter 6 shed light on the stakeholder perspectives of the HP policy and practice that would have been impossible to discern from document review alone. These seven findings are:

1) the impact of state leadership changes;

2) the impact of HP discourse regarding past financing and services;

3) the dominance of biomedical model;

4) the demoralised HP workforce;

5) fear of cost shifting from state to local governments;

6) fragmented system elements; and

7) the need for a strategic framework for HP.

There was one finding from document review (Chapter 5) that was not found to any great extent in stakeholder perspectives: support for monitoring and reporting on population health.

What is clear from Table 7.1 is that all system building blocks are articulated in the findings. and the links between these findings and the leadership and governance health system building block appear to be particularly pronounced. In Chapter 2, I defined leadership and governance as "effective oversight, system design, coalition building, and accountability through effective strategic policy frameworks, regulations and incentives" (de Savigny & Adam, 2009). Using this definition, all findings are interdependent and many are reciprocally related to some aspect of this health system building block. Leadership and governance for HP was central and this is consistent with the WHO conceptualisation of strengthening health systems to improve health outcomes. The following figure is adapted from a World Health Organization (2007) model but based upon my findings (Figure 7.1).

Figure 7.1   Model of health system building blocks for HP policy and practice (adapted from WHO, 2007)
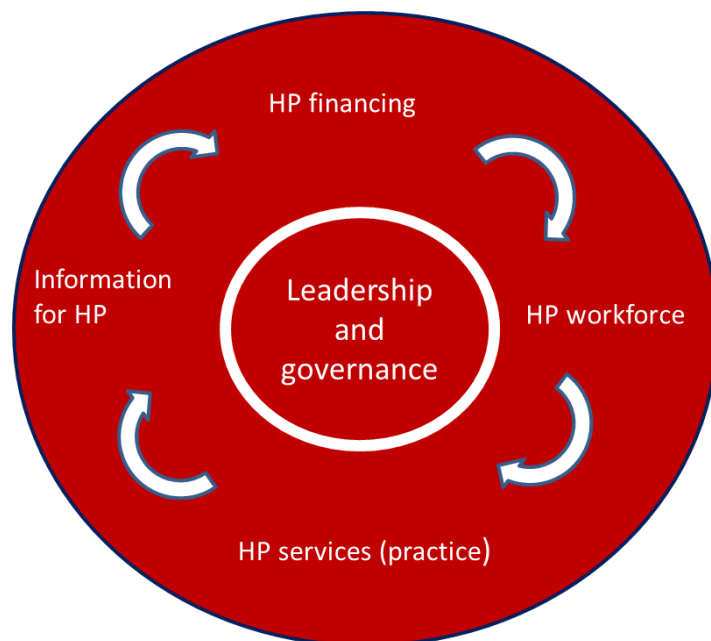
The World Health Organization (2007) reported that

> The leadership and governance of health systems … is arguably the most complex but critical building block of any health system. It is about the role of the government in health and its relation to other actors whose activities impact on health. This involves overseeing and guiding the whole health system … in order to protect the public interest. It requires both political and technical action, because it involves reconciling competing demands for limited resources, in changing circumstances (p. 24).

Reporting that leadership and governance as the superordinate building block is perhaps not surprising given my methods for data analysis (Chapter 3) where I linked the HP action of reorienting health services toward HP with *leadership and health governance* AND developing partners and intersectoral collaboration with *leadership and governance for health*. The HP action of ensuring community participation was also described as an element of effective leadership and governance in Chapter 2. Furthermore, I reported that a critical challenge to HP policy and practice was leadership and governance in Chapter 2 and my research provides data and a case study to further understand this system challenge.

Table 7.2 indicates the links I made with respect to findings and the two dimensions of leadership and governance. I do not go into detail here regarding each finding and the links to leadership and governance because this forms the organisation of my discussion in the following two sections.

Table 7.2   Summary of key findings and their relationship to two dimensions of leadership and governance

Key findings regarding factors that influence HP policy and practice	Document review (Chapter 5)	Stakeholder interviews (Chapter 6)	Leadership and governance	
			Leadership and health governance to reorient health services to HP	Leadership and governance for health through partnerships and intersectoral collaboration
Lack of strong support for /discussion of reducing health inequities	[grey]	[grey]	[green]	[red]
Lack of support for community participation	[grey]	[grey]	[green]	[red]
Federal-state-local government roles, governance structures and policy directions [Includes calls for enhanced intergovernmental relations (federal, state, and local); delineation of leadership roles and governance structures; impact of federal and state policy directions]	[grey]	[grey]	[green]	[red]
Cuts to/lack of HP financing	[grey]	[grey]	[green]	[red]
Cuts to/the need for HP workforce capacity	[grey]	[grey]	[green]	[red]
Cuts to/ limited HP services (practice)	[grey]	[grey]	[green]	[red]
Lack of information/evidence of HP effectiveness	[grey]	[grey]	[green]	[white]
Impact of state economic circumstances/budgetary constraints	[grey]	[grey]	[green]	[white]
Impact of state leadership changes	[white]	[grey]	[green]	[white]
Impact of HP discourse regarding past financing and services	[white]	[grey]	[green]	[white]
Dominance of biomedical model	[white]	[grey]	[green]	[white]
Demoralisation of HP workforce	[white]	[grey]	[green]	[white]
Fear of cost shifting from state to local governments	[white]	[grey]	[white]	[red]
Fragmented system elements	[white]	[grey]	[white]	[red]
Calls for/focus on whole-of-government approaches	[grey]	[grey]	[white]	[red]
Need for a strategic framework	[white]	[grey]	[white]	[red]
Support for monitoring and reporting on population health	[grey]	[white]	[white]	[red]

In the next section, I answer my third and final sub-question by interpreting my findings through the identification of feedback mechanisms and demonstrate how the two dimensions of leadership and governance are central to all other building blocks for HP policy and

practice in my case study. Following this, I discuss all feedback mechanisms and their implications and interweave relevant literature to provide a comprehensive discussion of my main research question: from a systems perspective, what are the key factors that influence HP policy and practice in a regional multisectoral health system? In the final section of this chapter I address limitations of my research.

7.1   What feedback mechanisms appear to influence health promotion policy and practice in the regional health system?

From a systems perspective, 'interaction' is a key characteristic of complex systems (as described in Chapter 2) and in my research there were numerous interdependent connections among levels and system elements (e.g., federal-state-local government roles, governance structures, and policy directions). The latter reflected the nested nature of heterogeneous system elements, another characteristic of complex systems. However, I go beyond using a metaphorical lens to view my findings and in this section I describe a causal loop diagram (Figure 7.1) that illustrates feedback mechanisms based upon all findings and dominant themes identified above in Table 7.2. The causal loop diagram demonstrates the interdependencies, reciprocal relationships, and self-organising characteristics of the regional health system with respect to factors that influenced HP policy and practice.

In Chapter 2 I introduced the concept of feedback mechanisms in systems thinking and in Chapter 3 I described in detail the process I followed to create feedback loops. Following this, Tables 7.4 through 7.8 provide detailed descriptions of each causal link and feedback loop. In Chapter 3 I not only described the process I undertook for creating the causal loop diagram but also indicated one way I labelled it to facilitate reading of an otherwise complicated diagram (e.g., the happy face to indicate that the feedback loop was going the right direction for desired HP policy and practice). Table 7.3 offers a legend of the ways I labelled the causal loop diagram and subsequent tables to facilitate reading.

Table 7.3   Legend for reading Figure 7.1 and Tables 7.4 through 7.8

Blue	Causal links and feedback loops that mostly relate to leadership and governance for HP policy and practice (both dimensions)
Green	Causal links and feedback loops that mostly relate to health governance and leadership for reorienting health services toward HP
Red	Causal links and feedback loops that mostly relate to governance for health and leadership through developing partnerships and intersectoral collaboration
Bold	Dominant themes (findings from both Chapters 5 and 6)
☺	Facilitating influence on HP policy and practice.
☹	Inhibiting influence on HP policy and practice.

In the next section I discuss each feedback loop systematically and organise my discussion in terms of:

- *leadership and governance* in terms of reducing health inequities, ensuring community participation, and federal-state roles, governance structures and policy directions (box at the bottom);

- *health governance* in terms of the dominance of the biomedical model, state economic circumstances and budgetary constraints, and information regarding evidence of HP effectiveness (left box) , and

- *governance for health* in terms of the focus on whole-of-government approaches, the need for a strategic framework and support for monitoring and reporting on population health status, fear of cost shifting from state to local governments, and fragmented system elements (right box).

Figure 7.2   Causal loop diagram of feedback mechanisms regarding key factors that influenced health promotion policy and practice in the regional health system

Table 7.4   Descriptions of causal links and feedback loops regarding leadership and governance, reducing health inequities and ensuring community participation in health promotion.

Findings	Document review (Chapter 5)	Stakeholder interviews (Chapter 6)	Leadership and governance	
			Leadership and health governance	Leadership and governance for health
Lack of strong support for/discussion of reducing health inequities				
Lack of support for ensuring community participation in HP				
Description of causal links and feedback loops				
Lack of strong support for/discussion of **reducing health inequities** negatively influences leadership and governance for HP policy and practice (+); lack of leadership and governance for HP policy and practice negatively influences support for/discussion of reducing health inequities (+).			Positive feedback loop that inhibits HP (vicious cycle)	
Lack of support for **community participation** in HP negatively influences leadership and governance for HP policy and practice (+); lack of leadership and governance for HP policy and practice negatively influences support for community participation in HP (+).			Positive feedback loop that inhibits HP (vicious cycle)	

Table 7.5   Descriptions of causal links and feedback loops regarding leadership and governance and federal-state-local government roles, governance structures and policy directions.

Findings	Document review (Chapter 5)	Stakeholder interviews (Chapter 6)	Leadership and governance	
			Leadership and health governance	Leadership and governance for health
Federal–state-local roles, governance structures and policy directions [Calls for enhanced intergovernmental relations (federal-state-local); delineation of leadership roles and governance structures; impact of federal and state policy directions]	████	████	████	████
Description of causal links and feedback loops				
Lack of **federal-state roles**, governance structures and policy directions negatively influenced leadership and governance (+) for HP; lack of leadership and governance for HP lead to the lack of clear federal state roles, governance structures and policy directions (+).			Positive feedback loop that inhibits HP (vicious cycle)	
Lack of **federal-state roles**, governance structures and policy directions negatively influenced HP financing, workforce, and services (practice) in the regional health system (+); the lack of HP financing, workforce, and services (practice) in the regional health system further lead to the lack of **federal-state roles,** governance structures and policy directions.			Positive feedback loop that inhibited HP (vicious cycle)	
State roles, governance structures and policy directions diminished leadership and health governance (-); lack of leadership and health governance diminished state roles, governance structures and policy directions for HP (+).			Negative feedback loop that inhibits HP (balancing cycle)	
State roles, governance structures and policy directions positively influenced leadership and *governance for health* (+); leadership and governance for health at the state level positively influenced state roles, governance structures and policy directions (+).			Positive feedback loop that facilitates HP (virtuous cycle)	
State-local roles, governance structures and policy directions diminished leadership and health governance (-); diminished leadership and health governance diminished *State-local roles*, governance structures and policy directions (+).			Negative feedback loop that inhibits HP (balancing cycle)	
State-local roles, governance structures and policy directions positively influenced leadership and governance for health (+); leadership and governance for health positively influenced state-local roles, governance structures and policy directions (+).			Positive feedback loop that facilitates HP (virtuous cycle)	

Table 7.6   Descriptions of causal links and feedback loops regarding leadership and health governance; state roles, governance structures and policy direction; information/evidence of HP effectiveness; state economic circumstance/budgetary constraints; and the dominance of the biomedical model.

Findings	Document review (Chapter 5)	Stakeholder interviews (Chapter 6)	Leadership and governance	
			Leadership and health governance	Leadership and governance for health
Lack of **information/evidence of HP effectiveness**				
Impact of **state economic circumstances/budgetary constraints**				
Dominance of biomedical model				
Impact of state leadership changes				
Impact of HP discourse regarding past financing and services				
Demoralisation of HP workforce				
Description of causal links and feedback loops				
Lack of **information/evidence of HP effectiveness** negatively influenced the **state roles,** governance structures and policy directions (+) for reorienting health services toward HP (+); state roles, governance structures and policy directions in health governance reorienting health services diminished information regarding evidence of HP effectiveness (+).			Positive feedback loop that inhibited HP (vicious cycle)	
Poor state economic circumstances/budgetary constraints negatively influenced **state roles**, governance structures and policy directions for HP (+); **state roles**, governance structures and policy directions for HP positively influenced state economic circumstances/budgetary constraints (-).			Negative feedback loop that inhibited HP (balancing cycle)	
Dominance of biomedical model negatively influenced **state roles**, governance structures and policy directions for HP (-); state-local roles, governance structures and policy directions for HP were negatively influenced by the dominance of biomedical model (-).			Positive feedback loop that inhibited HP (vicious cycle)	
*The impact of state leadership changes and the HP discourse regarding past financing and services were seen to influence **state-local roles** and governance structures. However there was no data to support this being a causal loop relationship. The demoralisation of HP workforce was seen to be a result of cuts to HP financing, workforce, and services (practice) in the regional health system, however this was not a reciprocal relationship.*				

Table 7.7 Descriptions of causal links and feedback loops regarding HP financing, workforce and services (practice) in the regional health system and the two dimensions of leadership and governance for HP.

Findings	Document review (Chapter 5)	Stakeholder interviews (Chapter 6)	Leadership and governance	
			Leadership and health governance	*Leadership and governance for health
Cuts to/lack of HP financing				
Cuts to/the need for HP workforce capacity				
Cuts to/limited HP services (practice)				
Description of causal links and feedback loops				
Dominance of the biomedical model negatively influenced **HP financing, workforce and services (practice)** in the regional health system (-); HP financing, workforce and services (practice) in the regional health system positively influenced the dominance of the biomedical model (-).			Positive feedback loop that inhibited HP (vicious cycle)	
Lack **of information/evidence of HP effectiveness** negatively influenced **HP financing, workforce and services (practice)** (+); the lack of HP financing, workforce and services (practice) negatively influenced the lack of information/evidence of HP effectiveness (+).			Positive feedback loop that inhibited HP (vicious cycle)	
Poor **state economic circumstances**/budgetary constraints negatively influenced cuts to **HP financing, workforce and services (practice)** (+); cuts to HP financing, workforce and services (practice) in the regional health system positively influenced the poor state economic circumstances/budgetary constraints (-).			Negative feedback loop that inhibited HP (balancing cycle)	
See descriptions below for links to leadership and governance for health.				

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Table 7.8　　　　Descriptions of causal links and feedback loops regarding state-local government roles, governance structures and policy directions

Findings	Document review (Chapter 5)	Stakeholder interviews (Chapter 6)	Leadership and governance	
			Leadership and health governance	Leadership and governance for health
Fear of cost shifting from state to local governments		███		███
Fragmented system elements		███		███
Calls for/focus on whole-of-government approaches	███	███		███
Need for a strategic framework		███		███
Support for monitoring and reporting on population health	███			███
Description of causal links and feedback loops				
State-local government roles, governance structures and policy directions heightened fears of cost shifting from the state to local governments (+): heightened fears of cost shifting from the state to local governments negatively influenced state-local government roles, governance structures and policy directions (-).			Negative feedback loop that inhibited HP (balancing cycle)	
Heightened fears of cost shifting from the state to local governments negatively influenced **HP financing, workforce and services (practice)** (-); lack of HP financing, workforce and services (practice) negatively impacted state-local government roles, governance structures and policy directions (+).			Negative feedback loop that inhibited HP (balancing cycle)	
Fragmented system elements negatively influenced state-local government roles, governance structures and policy directions (lack of collaborative mechanisms) (-); state-local government roles, governance structures and policy directions are negatively influenced by fragmented system elements and the lack of collaborative mechanisms (-).			Negative feedback loop that inhibited HP (balancing cycle)	
Focus on whole-of-government approaches positively influenced **state-local government roles** (+); state-local government roles, governance structures and policy directions was positively influenced by focus on whole-of-government approaches (+).			Positive feedback loop that facilitates HP (virtuous cycle)	
Need for a strategic framework and support for monitoring and reporting on population health were positively linked to **state-local government roles**, governance structures and policy directions (+); state-local government roles, governance structures and policy directions were positively linked to the need for a strategic framework and supported monitoring and reporting on population health (+).			Positive feedback loop that facilitates HP (virtuous cycle)	

7.2   From a systems perspective, what are the key factors that influence health promotion policy and practice in a regional multisectoral health system?

The above section provides a detailed interpretation of my findings using the systems thinking tool of creating a causal loop diagram and this forms the basis and organisation of the discussion of my main research question. The first part of this section is organised in terms of a discussion of findings that relate to the overall system building block of 'leadership and governance' for HP. I then focus on the two dimensions of this system building block as key factors that influenced HP policy and practice. Each section discusses a dominant theme and feedback mechanism, implications for HP, and how these fit with existing knowledge and literature.

7.2.1. Leadership and governance for health promotion policy and practice

This subsection is devoted to the discussion of 'leadership and governance' and the feedback mechanisms that link this building block to reducing health inequities, ensuring community participation, federal-state roles, governance structures, and policy directions. These feedback mechanisms are equally linked to both dimensions of leadership and governance as illustrated in Figure 7.2.

7.2.1.1   Reducing health inequity

The lack of strong 'leadership and governance' for the goal of reducing health inequities was a key factor that influenced HP policy and practice in the regional health system. It was a dominant theme in both Chapters 5 and 6 and as in Figure 7.2, it was a positive feedback loop and vicious cycle that inhibited HP policy and practice. The description from Table 7.4 is as follows:

Lack of strong support for/discussion of **reducing health inequities** negatively influences leadership and governance for HP policy and practice (+); lack of leadership and governance for HP policy and practice negatively influences support for /discussion of reducing health inequities (+).	Positive feedback loop that inhibits HP (vicious cycle)

Changing this feedback mechanism to a virtuous cycle to strengthen leadership and governance for reducing health inequities is therefore a key implication for HP policy and practice. Marmot and Allan (2014) maintain that reducing health inequities is a moral responsibility of governments and society. From my research this sense of responsibility appeared to not be at the forefront of HP policy and practice because reducing health inequities was not strongly presented in documents reviewed or in stakeholder interviews. The *Rio Declaration on Social Determinants of Health* (World Health Organization, 2011) calls for action to address health inequities in areas that I found in my research to be lacking: promote participation in policy-making and implementation; further reorient the health sector towards reducing health inequities; and adopt better governance for health and development. These action areas are a close fit with the dominant feedback mechanisms that reflect key factors that influenced HP policy and practice in my research and these are discussed below. Further to this, my discussion of research findings through this systems thinking perspective follows what Kickbusch and Gleicher (2014) advocate, in that "the actions needed to improve health and reduce health inequities require new systems-based governance and delivery mechanisms that take account of interdependencies, complexity and the need for whole-of-government and whole-of-society co-production of population health" (p19).

7.2.1.2   *Ensuring community participation in health promotion*

The lack of strong leadership and governance for ensuring community participation in HP was a key factor that influenced HP policy and practice in the regional health system. It was a dominant, positive feedback loop (Figure 7.1) and the description from Table 7.4 identifies this to be a vicious cycle that inhibits HP policy and practice:

Lack of support for **community participation** in HP negatively influences leadership and governance for HP policy and practice (+); lack of leadership and governance for HP policy and practice negatively influences support for community participation in HP (+).	Positive feedback loop that inhibits HP (vicious cycle)

Changing this feedback mechanism to a virtuous cycle to strengthen leadership and governance for community participation is therefore a key implication and opportunity.

Community participation in HP policy and practice was threaded throughout Chapter 2 in terms of a) health can in part be conceptualised in terms of a sense of belonging and/or contributing to community (Blaxter, 2010); b) increasing people's control over health is central to the definition of HP (World Health Organization, 1986) ; and c) strengthening community action through active participation is essential to effective HP practice (World Health Organization, 1978, 1986, 1991, 1997, 2000, 2003). Furthermore, societies that have high levels of social cohesion have better health (Wilkinson, 1996). Empowerment, ownership and control were identified as critical elements of community participation in HP and the Ottawa Charter described the work as "concrete and effective community action in setting priorities, making decisions, planning strategies and implementing them to achieve better health" (World Health Organization, 1986) .

If community participation is essential for HP then the main challenge in the regional health system is the lack of 'health governance' for reorienting health services toward HP and the opportunity lies with 'governance for health' through the implementing of processes and structures regarding the *Public Health Act* (2011). In the following two sections I discuss the challenges and opportunities with respect to community participation in terms of health governance and then governance for health.

In my research, many stakeholders reported that they were distressed because there were no HP policies, financing, workforce, services (practice), or leadership from the health sector to ensure community participation in addressing priority SDH. This was a key challenge to HP in the regional health system. Empowering communities can take the form of working with particular populations, in particular settings, and building capacity to identify and take action on priority determinants of health (Hawe, King, Noort, Gifford, & Lloyd, 1998). However I did not find this HP action was strongly endorsed in policy or evident in practice despite a history of such action in the region (as described in Chapter 4). Laverack (2004) states that

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ensuring community participation is needed for "social organization and collective action to redress the inequalities in the distribution of power (decision-making authority) and resources" (p13). The health sector in the regional health system was clearly not a leader or an advocate for this by 2013.

Kickbusch and Gleisher (2014) reported that there is empirical evidence of the need for local knowledge to validate, revise or reject expert knowledge in matters of health and well-being and this is a hallmark of health governance. They stated that

> The health sector must work with other policy sectors … but increasingly it must also engage with individuals in their roles as patients, consumers and citizens and in their everyday lives. Policy can no longer just be delivered – success requires coproduction and citizens' involvement and cooperation (Kickbusch & Gleicher, 2014, p. 144).

The lack of community participation in HP in the regional health system was consistent with what Baum et al (Baum, Freeman, et al., 2013) found in their study of comprehensive primary health care in South Australia. They found that the HP policy and practice had changed considerably: "In the 1980s and 1990s, the South Australian community health centres were recognised for the very innovative work that they did in developing health promotion programs that responded to local need in the context of a social understanding of health" (p. 13). A key difference in the HP policy and practice context were governance structures that changed from local boards that managed community health centres to the present day (2013) central regional management structures and this was considered to be of key influence in the limited community participation in HP (Baum, Freeman, et al., 2013).

A note of caution is due here as there was some evidence that Aboriginal and Torres Strait Islander people were being engaged by health sector stakeholders, however, this was mostly related to increasing access to health services. Although this is an important objective, it falls short of advancing health equity through community action on community identified determinants of health. Furthermore, some local council stakeholders (in partnership with the state health department) who worked on healthy eating and active living strategies drew attention to their community development work. This work appeared to be mostly community organisation according to Labonte's (1992) continuum discussed in Chapter 2 and perhaps coalition advocacy but there was no indication that political action on priority SDH was

evident. In these initiatives community members were engaged in building capacity to address and tailor healthy eating and active living strategies to their context. Although stakeholders from NGO/intersectoral networks discussed poverty reduction initiatives, I did not find specific reference to community development initiatives. This may possibly be due to the focus on a regional-level health system and not state-level.

Since at least the *Alma Ata Declaration* (1978), there have been calls for community participation in 'governance for health'. More recently and as above, Kickbusch and Gleicher (2012) highlight citizen participation in their definition of governance for health and stated that "the rise of the role of citizens as active participants in governance at all levels" is an important consideration however it is "often overlooked" (p. 5). They discuss this in terms of ensuring community participation in whole-of-society approaches to health and well-being. One example of this is the deliberate focus on community participation in the healthy settings (healthy cities) approach as described in Chapter 2 (Dooris, et al., 2007).

There was little to no indication in my findings that there was leadership and governance for health that included community members in a healthy community or city approach to health and well-being in 2013. This is surprising given that one city in the regional health system was designated a Healthy City where leadership and strongly supported community involvement were identified as indicators of sustainability in a study of the initiative (1987-2005) (Baum, Jolley, Hicks, Saint, & Parker, 2006). It appears that consistent leaders were present until 2005 and perhaps they have since left the initiative. No stakeholders in my research discussed the healthy cities initiative except one who briefly mentioned it but was unaware of its current directions and did not discuss community involvement.

There could possibly be potential in the public health planning processes being undertaken by cities in the regional health system to incorporate community participation. Community participation in strategic planning for health policy is reported to be important for the democratic legitimacy of policy processes and also for the development of better policies (Tenbensel, 2010). Furthermore, incorporating community participation in public health planning processes would ensure the coproduction of shared values or knowledge in setting strategic directions (Kickbusch and Gleicher, 2014).

Strong leadership and governance for health appears to be necessary for ensuring effective community participation in the regional health system and this is consistent with the

literature. Ensuring community participation is based upon system considerations such as governance structures and "in large part on the support provided by senior leaders" (Andersson, 2014, p. 40). Blas et al (2008) summed up the challenge and the potential of ensuring community participation in HP in terms of the following:

> [P]eople who are the intended beneficiaries of government policies and actions have a right to participate in their design, delivery and assessment. Evidence shows that successful engagement of target communities in decisions about how to address social determinants of health will increase the likelihood of policies and actions being appropriate, acceptable, and effective and can have a direct effect on individual health by raising people's sense of control over their lives (Blas et al., 2008, p1686).

7.2.1.3 Federal-state roles, governance structures and policy directions

This section is devoted to the discussion of one aspect of federal-state-local government roles, governance structures and policy directions that I indicated was a dominant theme in both Chapters 5 and 6. Here I discuss the 'federal-state' government roles as a key factor that influenced HP policy and practice in the regional health system.

In Figure 7.2, the lack of strong federal-state roles, governance structures and policy direction is shown to influence leadership and governance for HP policy and practice. It is a dominant, positive feedback loop and vicious cycle that inhibited HP policy and practice. The lack of strong federal-state roles, governance structures and policy direction are also shown to be linked to HP financing, workforce, and services (practice) in the regional health system in Figure 7.2 and these form a causal link that is a positive feedback loop and vicious cycle as well. The descriptions from Table 7.5 are as follows:

Lack of **federal-state roles,** governance structures and policy directions negatively influenced leadership and governance (+) for HP; lack of leadership and governance for HP lead to the lack of clear federal state roles, governance structures and policy directions (+). Lack of **federal-state roles,** governance structures and policy directions negatively influenced HP financing, workforce, and services (practice) in the regional health system (+); the lack of HP financing, workforce, and services (practice) in the regional health system further lead to the lack of **federal-state roles,** governance structures and policy directions.	Positive feedback loop that inhibits HP (vicious cycle) Positive feedback loop that inhibited HP (vicious cycle)

The implications here are the turning of these positive feedback loops into virtuous cycles however these implications are highly political ones.

Leadership and governance are needed for "strengthening the coherence" of policies between these levels of government (Brown & Harrison, 2013). The lack of policy coherence and shared 'health governance' for HP influenced the state government decisions to cut HP financing, workforce and services (practices). The potential role of the federal government in HP was unclear in 2013 and this provided a void or a policy vacuum for supporting HP financing, workforce and services (practice) in the regional health system. Hence, a vicious cycle. Baum and Dwyer (2014) report that "the problem of split responsibilities and overlapping roles has proved intractable" and "constitutional change or structural reform" (p. 200) are likely necessary for changes to occur. This intractability was abundantly clear in my research. On one hand the *Review* (2012) stated that "[t]he provision of primary prevention services such as health promotion and illness prevention are identified by the Commonwealth [federal government] as areas for Medicare Locals to address" (Government of South Australia, 2012, p. 23) and on the other, COAG's decision (Chapter 4) was to firmly place leadership for HP back to the state government.

The problem of split responsibilities was articulated through the *SA Health Response* (2013) to the *Review* (2012) and this can be further viewed as a form of health care reform based upon the "blunt instruments of budget constraints and cost-shifting" (Tuohy, 1999, p. 4). Tuohy (1999) argues that these blunt instruments need to be studied with a wide lens because "the dynamics of decision making cannot be understood entirely in terms of 'rational choice'

of the actors" (p. 6) given the myriad of historical, political and social factors at work at any given time. For example, federal-state historical and political factors were at work in the Australian state of Queensland for cost shifting HP from the state to the federal government. Through the electoral cycle in March 2012, the Queensland Liberal-National Party (LNP) formed government in a landslide victory over the Labor Party. Within the first few months in office the newly elected Premier, Campbell Newman, announced cuts to HP that foreshadowed the SA Weatherill government's cuts and based the decision upon the assumption that Medicare Locals were responsible for HP (Helbig & Miles, 2012; Hurst, 2012).

The decision in Queensland came precisely at the time that the *Review* (2012) was announced in SA. In fact, the *Review* stated that it was instructive to note that the Queensland Minister for Health announced on 24 September 2012 that the Queensland Government looked to the federal government for a greater contribution to primary promotion measures and to allied health. The Queensland Minister announced a range of cuts to state government programs including chronic disease prevention, which he said now fell within the domain of the Commonwealth Government (Government of South Australia, 2012). Thus, a precedent was set for cost shifting. The decision to cut HP in Queensland under a LNP government and in SA under a Labor government suggests that these decisions were not necessarily influenced by ideological values of the political parties (Navarro & Shi, 2001), but were driven by the opportunity to shift costs afforded by federal-state agreements.

Many stakeholders and almost all from the Medicare Local reported that federal health care reform agreements such as those relating to the establishment of Medicare Locals and including HP policy directions were not being implemented. The lack of implementation left a void in the health sector and resulted in a 'blame game' between federal and state governments as to who would lead and finance HP. This 'blame game' is discussed in Australian literature on health reform and is another way to discuss the intractable environment for HP. For example, Veronesi et al (2014) offered nuanced insights into the intricacies and chronology of the failed federal health reforms with respect to HP:

> The 2011 COAG Conference rejected the Rudd Government [federal government] proposal to transfer responsibility for state government-run primary health and community-based services over to the Commonwealth, along with a proportionate clawback of Commonwealth goods and services tax (GST) derived funding to states and territories (p.293).

They further explained that while most policy analysts believed it was "the clawback of GST revenue that was the sticking point, there were serious policy concerns raised that this could be a backward step for non-medical primary and community-based service" (Veronesi, et al., 2014, p. 293). This was because some services were considered well-established at the state level (Western Australia and Victoria were singled out, not SA). Therefore, in 2011 responsibility for HP was directed back to the state and this was a COAG (Council of Australian Governments including the Prime Minister, State and Territory Premiers and Chief Ministers, and the President of the Local Government Association) decision to keep non-medical primary and community-based services (including HP) under the jurisdiction of the states and not transfer responsibility to the federal government.

Despite this, one year later, the Weatherill government in SA withdrew funding, leadership and health governance for HP and this left what stakeholders in my research called a policy vacuum for HP. Veronesi et al (2014) reported the following with respect to the cutbacks:

> Having negotiated to maintain ownership of community health, these governments have subsequently adopted budgets and policies that seem to be based on the premise that funding can be withdrawn, compromising services in the process, and the Commonwealth will step in to solve emerging issues. This has created a new 'blame game' opportunity and an important failure in the rationalisation of relative roles of states, territories and the Commonwealth (p. 293).

The failure of federal health reform clearly created an uncertain political environment for HP and opened the door for the vicious cycle related above, the blame game, and cost shifting in times of budget constraints. My research provides a case study of how the broader political systems including the evolving state-federal roles and policy directions played out in a regional health system in SA. Leadership and health governance to reorient health services was a fundamental challenge and as Bennett (2013) stated, "the vertical fiscal imbalance and the re-emergence of the blame game cannot be ignored" (p. 253) if HP is to be taken seriously.

7.2.2 Health governance and health promotion

In the previous section, I discussed feedback mechanisms and key findings and their implications with respect to 'leadership and governance' for HP, that is, where feedback mechanisms and key findings addressed both dimensions of this health system building block. In my research, no level of government took a leadership role in 'health governance' (as discussed previously in terms of federal-state relations). In this section I discuss key factors that influenced HP policy and practice at the 'state' and 'state-local' government levels.

Health governance figured prominently in feedback mechanisms in Figure 7.2 where state roles as well as state-local government roles, governance structures and policy directions inhibited HP. At the state level, the roles, governance structures and policy directions (specifically the *Review* and *SA Health's Response*) followed a near abdication of health governance for reorienting health services toward HP and this formed a causal link described as a negative feedback loop. Further to this, state-local government roles, governance structures and policy directions diminished health governance (specifically the emphasis on the *Public Health Act*) and conversely, the lack of health governance diminished the state roles, governance structures, and policy direction. These feedback loops are described in Table 7.5 as follows:

State roles, governance structures and policy directions diminished leadership and **health governance** (-); lack of leadership and health governance diminished state roles, governance structures and policy directions for HP (+).	Negative feedback loop that inhibits HP (balancing cycle)
State-local roles, governance structures and policy directions diminished leadership and **health governance** (-); diminished leadership and health governance diminished *state-local roles*, governance structures and policy directions (+).	Negative feedback loop that inhibits HP (balancing cycle)

The *Review, SA Health's Response,* and the *Public Health Act* were linked to the balancing cycles and the lack of 'state' and 'state-local' government roles, governance structures and policy directions for health governance. All three policy documents created the conditions that emphasised leadership for HP services outside the health sector. The implications of

these negative feedback loops are that unless there is change in roles, governance structures and policy directions for reorienting health services, then the Local Health Network and the Medicare Local (Primary Care Network in 2015) will stabilise around the policy vacuum and nothing will change. In other words, changing one causal link in these negative feedback loops is necessary in order to disrupt the balancing cycle that inhibits health governance for HP in the regional health system. International documents have called for the health sector to reorient health services and lead HP practice since at least the *Alma Ata Declaration* (1978) and more recently the *Rio Declaration on Social Determinants of Health* (2011).

Before I discuss the three feedback mechanisms in Figure 7.2 and Table 7.6 that influenced health governance, I address two factors that influenced 'state' level health governance but were not found to be causally linked and these are 1) the impact of state leadership changes, and 2) the SA Health discourse regarding past HP financing and services.

First, the political leadership changes at the state level were identified by many stakeholders to be influential to changes in the HP policy and practice environment. As described in Chapter 6, these changes occurred in a re-election cycle and Irwin and Scali (2010) report that elections can pose challenges for long term objectives such as action on the SDH. Hughes et al (2015) found in an Australia study of governance for health development that "the annual budget cycle and the three to four year electoral cycle appeared to have a profound influence in shaping policy work" (p. 239). Changes in the premiership and Health Minister also coincided with the *SA Health's Response* (2013) to the *Review* (2012) and these documents emphasised that cuts to HP financing were in large part due to poor state economic circumstances and growing health care costs (discussed in section 7.2.2.2). Many stakeholders believed that with a state election pending in 2014, it was a political imperative to address state finances and health care expenditures.

Second, another interesting finding from my research was the unexpected discourse of SA Health managers on the topic of the politics and financing of HP. They reported that past HP initiatives were lavish, lacked strategic direction, and were based upon a 'wagging finger' social marketing approach and therefore HP had fallen out of favour. I was unable to determine HP spending in SA Health and therefore unable to comment on the extent to which it was lavish, particularly in light of no other stakeholder reporting excessive HP spending.

Further to this, these stakeholders were describing HP spending at the state-level and not specifically to the regional-level health system.

The idea that HP lacked strategic direction is puzzling given the rich policy environment I described in Chapter 5 particularly when taken together, the *Primary Prevention Plan* (2011) and the *Public Health Act* (2011) identified and supported HP and system building blocks to a great extent. This begs the question: why did these documents reviewed not provide strategic direction for leadership and health governance for HP? The need for a strategic framework was also a theme among other stakeholder perspectives and is discussed in section 7.2.3.2. However this was not in relation to health governance and had more to do with governance for health and intersectoral collaboration. Thus, Tuohy's (1999) discussion of blunt instruments of cost containment and cost shifting appear to be more of an explanation.

The view that HP was considered a 'wagging finger' social marketing approach appears to be related to an individualistic ideology where personal responsibility for health rules (Shiell & Hawe, 1996). However the negative portrayal of social marketing took a different turn from the common criticism of social marketing. The 'wagging finger' view appeared to suggest that no attempt to change individual behaviour would be favoured. Common criticism has been centred on the moderate impact of this approach on population health (Baum, 2016). Thus, in my research it appears that a negative view of social marketing approaches to HP is based more on ideology than evidence of effectiveness. The ideological perspectives found in my research may follow what Lee and Kotler (2011) describe as fears that social marketing campaigns might be associated "with socialism, manipulation, and sales" (p. 2) and these fears ignore their success in influencing behaviours in areas such as tobacco use and HIV/AIDS. Several stakeholders were of the opinion that social marketing campaigns were effective in influencing population health particularly when linked to other strategies, thus there was a clear contrast in perspectives. Stakeholder perspectives are supported by Wakefield et al (2010) who reported that social marketing campaigns are most effective when combined with strategies such as public policy through increased taxation to reduce tobacco use. Well-planned and implemented campaigns have been shown to be effective and therefore should not be completely dismissed because "campaigns on average have small but tangible effects" yet "it is crucial to remember that small percentage changes may affect very

large numbers of people in a community, state, or national campaign" (Snyder, et al., 2004, p. 89).

In the following sections I discuss three feedback mechanisms with respect to health governance indicated in Figure 7.2 and described in Tables 7.6 and 7.7. These are the dominance of the biomedical model; state economic circumstances and budgetary constraints; and information regarding evidence of HP effectiveness.

7.2.2.1 Dominance of the biomedical model

The dominance of the biomedical model was seen by stakeholders to be a key factor that influenced 'state roles', governance structures and policy directions particularly regarding changes to HP financing, workforce and services. In Figure 7.2, the linkages are represented by two positive feedback loops and vicious cycles that inhibit HP. They are described as follows in Tables 7.6 and 7.7 respectively:

Dominance of the biomedical model negatively influenced **state roles**, governance structures and policy directions for HP (-); state-local roles, governance structures and policy directions for HP were negatively influenced by the dominance of biomedical model (-).	Positive feedback loop that inhibited HP (vicious cycle)
Dominance of the biomedical model negatively influenced **HP financing, workforce and services (practice)** in the regional health system (-); HP financing, workforce and services (practice) in the regional health system positively influenced the dominance of biomedical model (-).	Positive feedback loop that inhibited HP (vicious cycle)

An implication of these feedback loops is that "reinforcing feedback can generate accelerating decline" (Senge, 2006,p. 79). This was borne out in my research where the momentum for reorienting health services toward HP was in such decline that support for HP in the Local Health Network health sector in the regional health system became nearly extinct.

The dominance of the biomedical model as a key challenge to HP policy and practice in my research is consistent with the literature described in Chapter 2. Individualism is one ideal of neoliberal ideology (Coburn, 2004) where the interests of the individual supersede those of

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the collective (Ayo, 2012). This appears to be a factor in the dominance of the biomedical model and the retreat from state level health governance for reorienting health services toward HP in the regional health system. As discussed above, cuts to HP financing, workforce and services (practice) in the regional health system signalled an end to support for collectivist approaches such as in ensuring community participation in HP by the Local Health Network. Instead resources were allocated to individualised chronic disease management services. Thus, it was not just individualism, but also a biomedical model of health that was evident (Bambra, et al., 2005; Huber, et al., 2011). The HP research I reviewed in Chapter 2 consistently pointed to the incongruity of this approach to achieve improved population health (Ashton, 2006; Berkman, et al., 2000; Raphael, 2004). It is not my intention to devalue chronic disease management services here, but to point out how "individualized practices become championed over other forms of well-established knowledge such as the social determinants of health" (Ayo, 2012, p. 102).

Furthermore, the evaluation of HP services through the *Review* (2012) and *SA Health's Response (2013)* that preceded the cuts to HP financing focused in large part on their effectiveness to reduce demand on hospital services and this too demonstrated that a biomedical, clinical and individualistic paradigm dominated policy directives. Tesh (1996) argued that it is easier for policy makers to view health individualistically (e.g., lifestyle or germ theory) as opposed to viewing health through a collectivist lens (i.e., through the social determinants of health) and Baum et al (2013) corroborated this in their study of former Australian health ministers. The dominant biomedical view of health places power with the medical establishment and responsibility with individuals and as Raphael (2011a) explained these "have a disturbing tendency to neglect the sources of adverse living circumstances to which individuals are exposed" (p. 226). Schrecker (2013) suggested that the focus on individuals and not the structural influences on health undermines the health equity agenda as advanced by the CSDH (2008).

The dominance of the biomedical model and the cuts to HP financing, workforce and services (practice) resulted in the remaining workforce feeling under siege. This is indicated on Figure 7.2, but is not causally linked and therefore not a feedback loop. The finding that the workforce was feeling under siege is consistent with what Sunderland et al (2015) reported in a study of HP practitioners in Australia and Canada. They found that practitioners

experienced their work as "a minority practice within a large dominant system that did not value their work" (Sunderland et al, 2015, p9). In Chapter 6 I reported that many stakeholders, particularly Local Health Network and NGO/professional association stakeholders discussed their anger and hurt regarding policy directions because HP was not considered to be valued as much as clinical practice based on a biomedical model. Constraints on professional practice such as those found in my research can give rise to negative and often painful feelings which have been characterised as moral distress (Sunderland et al, 2015).

In my research the workforce was feeling devalued and perhaps morally distressed because they were unable to work within the full scope of HP practice and furthermore, were directed to work narrowly from a biomedical paradigm in chronic disease management. This is consistent with what Baum et al (2013) reported, where people working within the SA state health sector found that pressures from health care reform and reorganisation in the health system diminished HP and that "the more centrally directed government agenda of responding to chronic disease appears to have come to dominate the work of the South Australian government managed services" (p.13). My findings regarding the demoralisation of the HP workforce is particularly salient and ironic given that stressful working conditions are well established as a critical determinant of health (CSDH, 2008; Karasek, 2004) and adds to the literature that an expected corollary of HP practice may be moral distress.

7.2.2.2   *State economic circumstances and budgetary constraint*

There are two dominant feedback mechanisms in Figure 7.2 that link state economic circumstances and budgetary constraints with state roles, governance structures and policy directions and also with HP financing, workforce and services (practice). These are both illustrated as negative feedback loops that act to balance or stabilise the system and in this case it is with respect to constraining health care costs through cuts to HP financing. These are described as follows as in Tables 7.6 and 7.7 respectively:

Poor state economic circumstances/budgetary constraints negatively influenced **state roles**, governance structures and policy directions for HP (+); **state roles**, governance structures and policy directions for HP positively influenced state economic circumstances/budgetary constraints (-).	Negative feedback loop that inhibited HP (balancing cycle)
Poor **state economic circumstances**/budgetary constraints negatively influenced cuts to **HP financing, workforce and services (practice)** (+); cuts to HP financing, workforce and services (practice) in the regional health system positively influenced the poor state economic circumstances/budgetary constraints (-).	Negative feedback loop that inhibited HP (balancing cycle)

The implication of these negative feedback loops is that the system adjusts towards the goal of budgetary constraints and away from health governance for reorienting health services towards HP and leaves a void in HP in the state and regional health systems.

My research points to how vulnerable financing for HP can be in health systems and lends support to calls for political will and leadership and governance structures to leverage dedicated funding for HP in Australia (Harris & Mortimer, 2009). A key challenge appears to be how to strengthen leadership and health governance in the health sector where a social view of health and sustainable funding for HP ascends in importance. This would lessen to a great extent what stakeholders perceived HP to have become, that is, a politically expedient, soft and easy target in times of budget constraints. Kickbusch and Gleicher (2014) sum up the challenge well:

> It is not simply about the allocation of new resources harvested from other sectors of the government budget; it is also about the fact that there has been little redistribution of resources in the health system. Why does it continue to be the case that public health is the mere stepchild of medical care and that resources for prevention and health promotion are low on the allocation table, even within the allocation of funding for public health? What specifically is the relationship between lofty value statements and resource allocation? The challenge is to change this picture, locally and globally (p.147).

Reining in health care costs in an area that was perceived to be the responsibility of federal and local governments was stated in the *Review* (2012)(Government of South Australia, 2012). The trend in rising health care costs in Australia was noted in Chapter 4 and as Duckett and Willcox (2011) state, "health expenditure and health financing policies are rarely off the policy agenda" (p. 42). They argue however, that health expenditures in Australia were "what would be expected given its GDP" (Duckett & Willcox, p. 42) and this

contradicts assertions, such as those articulated in the *Review* (2012), that health expenditures were inappropriately high. It is beyond the scope of this thesis to debate this, however, two points emerge from this discussion. Firstly, as minimal government intervention is central to neoliberal ideology (Ayo, 2012), austerity measures are favoured and legitimised (Labonté & Stuckler, 2015). The cuts to HP financing were seen by stakeholders as part of the state government's austerity agenda and represented a valuing of fiscal policy to reduce budget deficits over HP policy to reorienting health services to HP. Schrecker (2013c) examined how scarcities "are constructed and maintained" in health policy and referred back to Virchow's emphasis on political determinants of health. He stated,

> Against today's background of financial markets with global reach and widespread invocations of the need for austerity in which governments are seldom challenged as they ritualistically turn their pockets out and complain that the cupboard is bare, neither disease causation nor health ethics can sensibly be separated from politics and economics (Schrecker, 2013b, p.406).

The state government's primary concern was seen to be the reduction of budget deficits rather than the reorientation of health services to HP and this too follows Touhy's (1999) description of a blunt instrument. The budget constraint goals that political leaders adopted influenced HP profoundly as there was no explicit HP financing in the regional health system for a workforce and services (practice) except for time limited grants at the local government level focused on healthy eating and active living.

Stakeholders reported a void in policy documents and discourse regarding how health expenditures should be controlled. Duckett and Willcox (2011) pointed out that the main drivers of health care costs are the rise in the prevalence of disease (demand side of the health sector) and increasing costs of treatment (supply side). Cuts to HP financing would not reduce the prevalence of disease and demand for health care in areas such as chronic disease (Bauer, Briss, Goodman, & Bowman, 2014). With respect to the supply and cost of health care treatment, stakeholders could see that cutting HP would lower health care costs to a small extent, however they questioned why all health expenditures were not being discussed. For example, Elshaug et al (2012) conducted a study of health care interventions in Australia and identified over 150 potentially low-value health care practices that should be evaluated in terms of cost saving measures. Mackenbach, Meerding, and Kunst (2011) suggest that health

care and not HP should be the target for reducing expenditures and furthermore, where HP can support savings to the health care system.

The impact of short term thinking regarding cuts to HP and the long term impact on population health were uppermost in the minds of many stakeholders. It was a common theme among stakeholders that this scenario played well to a resurgent biomedical model. For example, a theme was the perceived continued support of individual clinical services and the power of vested interests (such as the medical community) – who receive and oversee the majority of health care expenditures – were maintained. It appears illogical for policy makers to target HP in an effort to control health care costs given that in Australia public health as a whole represents only 2% of all health expenditures (Duckett & Willcox, 2011; Oldenburg & Harper, 2008). I was unable to find a breakdown of SA health expenditures, however it seems safe to assume that SA would not be far off from the national average of expenditures to public health.

7.2.2.3 *Information regarding evidence of health promotion effectiveness*

In Figure 7.2 there are two dominant, positive feedback loops with respect to information regarding evidence of HP effectiveness. One links information regarding evidence of HP effectiveness with state roles, governance structures and policy directions, and the other with HP financing, workforce and services (practice). These feedback loops are described as vicious cycles that inhibit HP in Tables 7.6 and 7.7 respectively as follows:

Lack of **information/evidence of HP effectiveness** negatively influenced the **state roles**, governance structures and policy directions (+) for reorienting health services toward HP (+); state roles, governance structures and policy directions in health governance (reorienting health services) diminished information regarding evidence of HP effectiveness (+).	Positive feedback loop that inhibited HP (vicious cycle)
Lack **of information/evidence of HP effectiveness** negatively influenced **HP financing, workforce and services (practice)** (+); the lack of HP financing, workforce and services (practice) negatively influenced the lack of information/evidence of HP effectiveness (+).	Positive feedback loop that inhibited HP (vicious cycle)

The implication of these feedback loops is that they both accelerate the decline of health governance for orienting health services toward HP.

Evidence of HP effectiveness is linked to the information building block, specifically with respect to the production, analysis and dissemination of reliable and timely information on health determinants and health system performance. The lack of evidence of HP effectiveness was a significant factor that contributed to the state government's retreat from health governance, financing, workforce and HP services and this finding is important to understanding the role of information as a vital system building block for HP and its connection to all others.

The *Review* (2012) reported that there was a "shortage of research evidence demonstrating intervention effectiveness" (Government of South Australia, 2012, p. 15) and this is consistent with the literature presented in Chapter 2 in terms of this being a key HP challenge. Nutbeam (2004) stated several years ago that "there is relatively little research funded or conducted to assess the effectiveness of interventions to tackle some of the wider social, economic and environmental determinants of health" (p.138). Stakeholders reported that the lack of research resulted in a lack of an evidence base from which to draw upon to advocate for effective HP practice and this too has been reported in the literature (Lorenc, et al., 2013). For example, a recent systematic review of the best evidence to reduce SES inequality in obesity among adults found that although there was a large literature "the quality of the evidence found was largely observational and of moderate to weak quality" (Hillier-Brown, et al., 2014, p. 1489). Nevertheless, the abdication of leadership and health governance for HP found in my case study did nothing to address this challenge and is opposite to calls for health systems to work towards addressing the paucity of intervention research (Hawe & Potvin, 2009).

The challenge of the lack of evidence of HP effectiveness needs to be considered alongside the research and international documents discussed in Chapter 2 that clearly advocate for health sector leadership in HP to reduce health inequities (Bishai, et al., 2014; CSDH, 2008). International documents clearly show that there are evidence-based best practices for HP such as those articulated in the *Ottawa Charter* (1986). In my research I found a near abdication of health sector leadership for reorienting health services toward HP and little indication of a

suite of policies and programs that would be considered evidence-based practices for HP as described in the research and international documents. This is consistent with what Best et al (2003) described as "a large gap between the evidence-based best practices identified in the research literature and what is typically seen in practice and policy" (p. S207). Thus, my research illustrates a classic Catch 22 scenario (as illustrated in the negative feedback loop): how will HP address the challenge of evidence of HP effectiveness if health systems, and particularly the health sector, do not lead in the planning, implementation and evaluation of best practices?

I turn now to specifically discuss the *Review* (2012) and its methods and assertions that there was insufficient evidence that HP practice in SA had a positive impact upon three key policy objectives: chronic disease management, hospital avoidance and population health. I was not able to ascertain how the *Review* (2012) arrived at this finding because there was no transparency in terms of methods, no presentation of service goals or output or outcome data, no reference to population health data, and no collaboration with practitioners and researchers to conduct a broad review. I argue that this type of evaluation would not withstand the rigor of academic review and therefore, this finding might be explained in terms of the political nature of health policy processes (Bambra, et al., 2005). This is where not only do the blunt instruments of budget constraint and cost shifting prevail (Tuohy, 1999), but a power dynamic exists that relegates HP services in the regional health system almost into oblivion.

Another problem inherent in the *Review* (2012) was that HP services (practice) were in part evaluated on the basis of priorities rooted in the biomedical paradigm, that is, chronic disease management and hospital utilisation. Judging evidence of HP effectiveness against these priorities is unfair (Mackenbach, 2009) and side-steps the overall goal of reducing health inequities, therefore it is not surprising that evidence was not found (Baum & Fisher, 2014). Hawe and Potvin (2009) report on the worldwide movement toward population health intervention research that is not in evidence in my research, that is, using scientific methods to study policies and practices "that shift the distribution of health risk by addressing the underlying social, economic and environmental conditions" either inside or outside the health sector (p18).

Furthermore, the *Review* (2012) reported that there was little to no HP practice-based evidence that would help answer questions about effectiveness regarding population health

outcomes and the judgment was made that HP services were ineffective. I argue, along with many stakeholders, that while this was an unfair assessment, this finding might be better explained by the lack of strong leadership and health governance for the production, analysis and dissemination of reliable and timely information on health determinants and health system performance. This leads to the important leadership role in building information as a critical building block for HP (Kickbusch & Gleicher, 2014).

A final but integrally linked point made by stakeholders and confirmed through document review was the connection between the overall lack of evidence of HP effectiveness, the limited HP services (practice) based upon multi-level, multi-strategy approaches (i.e., best practices) in the regional health system, and the lack of state level policy implementation. If strong policies were not implemented into practice, such as the *Primary Prevention Plan* (2011), then questions arise as to why there would be the expectation of evidence of HP effectiveness. Hunter (2003) offers reasons for the lack of policy implementation in public health in the UK and Canada and these appear to be in play in my research. For example, he suggests that policies are often more symbolic than directed to real change and that policy attention is most often directed to the constant demand for ill health care services and powerful vested interests that cast a shadow over the public health concerns. However, it is Hunter's (2003) assertion that the political nature of health policy rather than lack of evidence which casts the darkest shadow over public health policy. This appears to be most salient in my research:

> [I]f there is genuine concern about implementation failure and its causes then attention has to be given to the politics of change and the power plays that exist. It is incorrect to allege that if only evidence existed in regard to which interventions worked then implementation would follow. Impediments to change often owe more to political than technical factors (2003)(Hunter, 2003, p26).

To summarise, addressing the HP challenge of lack of evidence of HP effectiveness will require leadership and health governance to allocate sufficient resources in the health system to implement evidence-based best practices and support continuous evaluation of processes and outcomes through population health intervention research (Best, 2011; Foster-Fishman, Nowell, Deacon, Nievar, & McCann, 2005). And yet, even if this was achieved, by itself it is

unlikely to be sufficient to foster greater evidence of HP effectiveness because of politics, power and ideology.

7.2.3   Governance for health and health promotion

Earlier in this chapter (section 7.2.1.3) I discussed the federal-state government roles, governance structures and policy directions that had negative impacts upon 'leadership and governance' for HP policy and practice and described how this feedback mechanism not only inhibited 'health governance', but also 'governance for health' (particularly vertical collaboration). Further to this, the lack of 'health governance' for HP (section 7.2.2) I found in my research had the potential to have a negative impact upon 'governance for health' in the health system and the associated aims of partnership development and intersectoral collaboration (Marmot and Allan, 2014). This is because the health sector can be seen to be "a defender of health, advocate of health equity, and negotiator for broad societal objectives" (CSDH, 2008, p. 111), although perhaps in aspiration more than reality. The question becomes: if the health sector does not champion efforts to reduce health inequity in the health system, then what sector would? Despite what the politics that negatively influenced HP suggested in my research, I argue that the strengthened health sector role in leadership and 'governance for health' that I found in my research may mitigate to some extent the lack of 'health governance' for HP. This could be because of the sector's potential to influence societal and political support for addressing health equity goals (Public Health Agency of Canada & World Health Organization, 2007).

However, in this section I turn my discussion to focus on feedback mechanisms that primarily relate to the 'governance for health' dimension of the leadership building block. Unlike the feedback mechanisms regarding 'health governance' discussed in the previous section that inhibited HP policy and practice for reorienting health services, the feedback mechanisms for 'governance for health' in Figure 7.2 generally facilitated HP and the development of partnerships and intersectoral collaboration.

Firstly, two feedback mechanisms causally linked 'state' and 'state-local' government roles, governance structures and policy directions with governance for health and are described as positive feedback loops and virtuous cycles in Table 7.5 as follows:

State roles, governance structures and policy directions positively influenced leadership and governance for health (+); leadership and governance for health at the state level positively influenced state roles, governance structures and policy directions (+).	Positive feedback loop that facilitates HP (virtuous cycle)
State-local roles, governance structures and policy directions positively influenced leadership and governance for health (+); leadership and governance for health positively influenced state-local roles, governance structures and policy directions (+).	Positive feedback loop that facilitates HP (virtuous cycle)

The implication regarding these feedback loops is to amplify the directions of the virtuous cycles in order to build upon the strengths in governance for health found in my research.

I found that the policy context (Chapter 5) was somewhat favourable for 'state' roles, governance structures and policy directions for developing partnerships and intersectoral collaboration. For example, I found in Chapter 5 state government documents which emphasised intergovernmental relations and all documents discussed partnerships and intersectoral collaboration to some extent. The influential *Public Health Act* (2011) offered clear policy directions for SA Health or state roles, and governance structures for partnership development with local government, state government departments and other organisations. The discussion of Health in All Policies addressed this as well. However, the *Review* (2012) and *SA Health's Response* (2013) severely limited the state role in HP at the regional-level health system and disrupted partnership development and intersectoral collaboration.

In Chapter 6, stakeholders reported that there was some state-level support for partnerships and intersectoral collaboration as well. This consistency in my research was significant because of the important first step (particularly for the health sector) in making a strong case for intersectoral collaboration (Gilson, Doherty, Loewenson, & Fancise, 2007). Leadership and 'governance for health' at the state-level through partnership development and intersectoral collaboration are critically important to HP policy and practice because of the complex interactions between factors that contribute to population health that are beyond the

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influence of any one sector in society. Therefore, leadership and action from many sectors is required (Commonwealth of Australia, 2007; CSDH, 2008; Public Health Agency of Canada & World Health Organization, 2008; World Health Organization, 1978).

Much appeared to hinge on the *Public Health Act* (2011) because it was the state's key driver of HP and inherent in the Act was legislation that embedded a second important role for the health sector: that of sharing responsibility for planning, implementing and evaluating initiatives (Gilson et al, 2007). The *Public Health Act* (2011) legislated the state health department's shared role with local government and other partner agencies in HP. This type of shared leadership and accountability among partners is a hallmark of effective collaboration (Public Health Agency of Canada & World Health Organization, 2007). SA Health stakeholders also spoke of their role in joining up action among various state government departments.

In the following sub-sections I discuss four feedback mechanisms that influenced 'governance for health' and leadership for HP, particularly focusing on the 'state-local' government roles, governance structures and policy directions. They are: the focus on whole-of-government approaches; the need for a strategic framework and support for reporting on population health status; fear of cost shifting from state to local governments; and fragmented system elements.

7.2.3.1 *Focus on whole-of-government approaches*

A positive feedback loop was illustrated in Figure 7.2 that causally linked the focus on whole-of government approaches with 'state-local' government roles, governance structures and policy directions. In Table 7.8 this was described as a virtuous cycle:

Focus on whole-of-government approaches positively influenced **state-local government roles** (+); state-local government roles, governance structures and policy directions were positively influenced by focus on whole-of-government approaches (+).	Positive feedback loop that facilitates HP (virtuous cycle)

This was a dominant feedback mechanism because it was a strong theme in both document review and stakeholder interviews. The implication from a systems thinking perspective is to maintain and/or amplify the positive direction of this feedback mechanism.

Whole-of-government approaches to HP have been called for since at least the publication of the *Lalonde Report* (Lalonde, 1974) and the *Alma Ata Declaration* (1978), both of which advocated for increased multisectoral responsibility for advancing healthy public policy. This was further emphasised in the *Ottawa Charter* (1986) with explicit attention to the strategy of building healthy public policy: "It puts health on the agenda of policy makers in all sectors and at all levels, directing them to be aware of the health consequences of their decisions and to accept their responsibilities for health" (no page).

Most state government documents reviewed in Chapter 5 described the need for leadership and governance structures to strengthen whole-of-government or what was commonly referred to as Health in All Policies (HiAP) approaches. This finding demonstrated that HiAP was a consistently important policy direction for building healthy public policy in SA. This was not surprising given the policy context was built upon a long history of SA government involvement in this work as noted in Chapter 2, notably with respect to the *Adelaide Recommendations on Healthy Public Policy* (World Health Organization & Australian Department of Community Services & Health, 1988) and the *Adelaide Statement on Health in All Policies* (World Health Organization & Government of South Australia, 2010). HiAP or a whole-of-government approach in SA describes the work of both the health sector and the work of other government departments "to deliver evidence-based recommendations to inform the decision-making process, to maximize gains in health and wellbeing, and to reduce or remove negative impacts or inequalities of programs or policies"(Government of South Australia, 2010b, p. 111).

It was interesting to find that SA Health stakeholders focused discussion on the implementation of the *Public Health Act* (2011) as a key support for a whole-of-government approach rather than discussing documents specific to HiAP such as *The South Australian approach to Health in all policies: background and practical guide* (Government of South Australia, 2011e). They reported that the *Public Health Act* would facilitate working with

non-health departments to pull policy levers that would have an impact upon upstream determinants of health. This is consistent with what Delaney et al (2014) reported:

> In the South Australian context, the Public Health Act was being developed during the early implementation of HiAP and its architecture was informed by HiAP principles. Now, it provides a legislative mandate for HiAP and provides a range of mechanisms that may allow HiAP approaches to be systematically adopted across the State and Local Governments thereby, possibly, increasing the scope and potential for HiAP work (p. 9).

While some stakeholders could see potential in the *Public Health Act* (2011) in terms of advancing HiAP, there were no stakeholders who I interviewed outside SA Health and one other state department who discussed HiAP processes or projects. This is perhaps to be expected given that the stakeholders I interviewed were largely drawn from the regional health system and the integration of HiAP processes with the implementation of the *Public Health Act* in local governments was just beginning. However, it is notable that one local government was involved in a HiAP project, yet stakeholders either did not have knowledge of this or did not link these processes to HP policy and practice in the interviews (Government of South Australia, 2016a).

Even though there was a platform for HiAP processes to be developed at the local government level through public health planning, without leadership and governance for health based upon shared understanding of complex Public health issues, relationships built on trust, and clear roles and responsibilities, the uptake of HiAP approaches may flounder. From stakeholder interviews it was clear that HiAP was not a central approach in the region at the time of my research. Furthermore, Carey, Crammond and Keast (2014) stated that a characteristic for success in what they called 'joined up government' entails the inclusion of NGOs because they are instrumental for on-the-ground support. South Australia is considered a world leader in this work and my research adds to the knowledge base in terms of uncovering how this work is understood and points to opportunities and challenges in HiAP at the local government level and in one regional health system in SA.

7.2.3.2   *Need for a strategic framework and support for monitoring and reporting on population health status*

In Figure 7.2 the need for a strategic framework to support HP policy and practice as well as support for monitoring and reporting on population health were causally linked to state-local government roles, governance structures and policy directions in positive feedback loops that facilitate HP. Table 7.8 described these as virtuous cycles:

Need for a strategic framework and support for monitoring and reporting on population health were positively linked to s**tate-local government roles**, governance structures and policy directions (+); state-local government roles, governance structures and policy directions were positively linked to the need for a strategic framework and supported monitoring and reporting on population health (+).	Positive feedback loops that facilitate HP (virtuous cycles)

Stakeholder from every system element identified the need for a strategic policy framework to support partnerships and collaboration and identified the *Public Health Act* (2011) as the key policy vehicle to provide such a framework. The *Public Health Act* was strongly portrayed by SA Health stakeholders to provide strategic directions, however, the majority of stakeholders were wary that it would be sufficient to strengthen HP services (practice) in the regional health system.

SA Health stakeholders in particular had positive perspectives regarding the potential of the *Public Health Act* to align state and local government public health plans. In Chapter 5 I reported that public health planning and reporting was being undertaken at the state and local levels and these were to be aligned through the identification of key priority areas. Neither document review nor stakeholder interviews revealed if priority setting would be a shared responsibility. Calls for a strategic framework for HP appeared to be answered with the implementation of the *Public Health Act*.

The literature is clear that strong 'governance for health' requires policy alignment (Kickbusch & Gleicher, 2014) and from my research this is a clear area to amplify or strengthen. This is particularly the case given that it was early in state-local government public health planning at the time of my research and there was cautious optimism on the part of other stakeholders that an outcome of planning would be an alignment of policies.

However, the question that remains is the extent to which state and local government policies align around not only HP services (practice) in the regional health system, but tackling health inequities through examining and taking action on the unfair distribution of priority social determinants of health such as income, education and employment.

Legislation can be a powerful driver for collaboration (World Health Organization, 2008a) and the *Public Health Act* provided a platform for aligning policies at state and local government levels simultaneously (Gilson et al, 2007). However, while there was vertical linking between state and local government levels, there was little collaboration between federal and state governments in relation to HP in the region (section 7.2.1.3). For example, at the regional health system level, the lack of a strategic framework to facilitate collaborative planning between the federally funded Medicare Local, SA Health, local governments, and NGOs was evident. This is clearly an area that the planning and implementation of the *Public Health Act* could rectify. Medicare Local participants reported that they were not partnering in state-local government led public health planning, yet they were undertaking population health planning. There was no collaboration in the two planning processes in 2013 even when stakeholders agreed that the activities were similar if not the same. This is consistent with what Horvath (2014) reported from a review of Medicare Locals where there was duplication of effort in population health planning.

In another study of Medicare Locals, it was found that "the lack of a more coordinated and integrated approach [to population health planning] was likely to have been at least partly due to insufficient nation policy directions" and concluded that "ongoing cooperation and partnerships are required between national and state level stakeholders in the primary healthcare policy space" (Robinson, et al., 2015, p. 6). Thus, once again the lack of strong state-federal relations appeared to be not only a factor in health governance but also inhibited governance for health and policy alignment. In sum, vertical collaboration is important because planning, implementation and evaluation are enhanced when they take place simultaneously at several levels "and especially if the work at each of these levels [is] integrated through policy or legislation" (World Health Organization, 2008b). Despite the lack of policy coherence at the federal-state levels, strengthening collaboration at the state-local government levels is a strong opportunity.

One component of public health planning is monitoring and reporting on the population health status and this was strongly supported in the strategic framework of the *Public Health Act*. As described above, this is a virtuous cycle that has the potential to be amplified to further strengthen HP policy and practice. At the time of my research (2013) stakeholders reported that public health planning at the state and local government levels was just beginning and document review revealed that planning was to be based upon assessments of the state of public health (including environmental, social, and economic considerations) and the identification of strategies for promoting public health. There was little attention to this aspect of the information building block in stakeholder interviews, except for a brief mention by SA Health stakeholders.

The planning and reporting aspects of the *Public Health Act* relate well to strengthening information as a health system building block and "these processes are essential for knowing the magnitude of the problem, for understanding who is most affected and whether the situation is improving or deteriorating over time, and for assessing entry-points for intervention and evaluating the impact of policies" (CSDH, 2008, p. 178). Although collecting, sharing and co-producing evidence of health inequities is only one factor that influences policy and practice, "it can move the dialogue away from pure political rhetoric to a convincing argument" (Hunt, 2012, p. S20) about action on the SDH. This is aligned with what Baum and Fisher (2014) stated, that "evidence is a crucial part of the public health jigsaw". However they maintain that "perhaps too little attention has been paid by public health actors to the importance of ideology in their efforts to translate evidence on the SDH into practical policy" (p. 220).

7.2.3.3 *Fear of cost shifting from state to local governments*

Despite the potential to amplify the positive feedback loops described above to further strengthen governance for health, the fear of cost shifting from the state to local governments regarding HP was casually linked to state-local government roles, governance structures and policy directions and illustrated as a negative feedback loop that inhibited HP in Figure 7.2. Furthermore, the fear of cost shifting from the state to local governments regarding HP was

causally linked to HP financing, workforce and services (practice) and was also illustrated by way of a negative feedback loop in Figure 7.2. Table 7.8 describes these feedback loops as follows:

State-local government roles, governance structures and policy directions heightened fears of cost shifting from the state to local governments (+); heightened fears of cost shifting from the state to local governments negatively influenced state-local government roles, governance structures and policy directions (-).	Negative feedback loop that inhibited HP (balancing cycle)
Heightened fears of cost shifting from the state to local governments negatively influenced **HP financing, workforce and services (practice)** (-); lack of HP financing, workforce and services (practice) have negative impacts upon state-local government roles, governance structures and policy directions (+).	Negative feedback loop that inhibited HP (balancing cycle)

The implications of these negative feedback loops are the balancing cycles that they create, or in other words, the feedback mechanisms that stabilise system goals or maintain the status quo that inhibits HP.

Stakeholders in all system elements (except SA Health group interviewees) and particularly those in local governments reported fears of cost shifting as a result of state cuts to HP financing, workforce and HP services (practice) as a result of the *Review* and *SA Health's Response* and the emphasis on the shared leadership roles inherent in the *Public Health Act*. These fears were pronounced when no financing was explicitly established for HP at any level of government.

This sense of cost shifting at the state and local government level is analogous to the discussion of federal-state roles, governance structures and policy directions above and the notion that cost shifting is a blunt instrument of health reform in Australia. Duckett and Willcox (2011) reported that the shared leadership and financing responsibilities at the federal and state levels create an environment of underlying tension and lack of trust and this appeared to be the case at the state and local levels in my research. Wu et al (2015) discussed the idea of policy capacity and suggested that "factors such as trust and available personnel and financial resources are critical determinants of organizational capabilities and thus of public managers' and analysts' ability to perform their policy work" (p167). In an empirical

study of Australian states (including SA), Hughes et al (2015) built upon Wu et al's (2015) work and found that "interorganisational trust and open communication within government and external organisations (NGO community)" (p. 240) were main factors for what they termed governance capacity for health development.

Stakeholders reported that the *Review* (2012), *SA Health's Response* (2013), the withdrawal of the *Primary Prevention Plan* (2011), the loss of the state health sector workforce (Local Health Network and HP Branch of SA Health) with HP experience, and the ascendancy of individualised chronic disease management services contributed to fears that the state was cost shifting to local government. Further to this, before my research was conducted Baum et al (2013) found that there was a decline in HP services (practice) in SA and thus, the cuts to HP as a result of the *Review* (2012) and *SA Health's Response* (2013) were a continuation of perhaps a long decline. However, from the standpoint of the HP policy environment, I found that there was an incremental trend toward HP with the publication of a series of strong HP policy documents up to 2011 (Chapter 5) and that this trend was abruptly disrupted as a result of the *Review* (2012) and *SA Health's Response* (2013). Stakeholders reported that it was a shock and the failure in policy implementation (with respect to the *Primary Prevention Plan*) was a factor that increased the fears and mistrust in the health system. Most stakeholders (except those in SA Health and one other state department) saw the reliance on the *Public Health Act* (2011) for HP direction as a window of opportunity for the state to shift responsibility to other levels of government (and other partner agencies) and this also lead to distrust. Thus, the health system building blocks of HP financing, workforce and services (practice) were missing and without these, fear and mistrust may continue in regional health system.

For example, local council participants expressed their vulnerability in terms of HP being a 'poisoned chalice' because of fears of being left to lead and finance action. The lack of trust that HP would be supported through the *Public Health Act* was in contrast to what was conveyed in the *SA Health's Response* (2013) to the *Review* (2012), which was "By re-focusing primary prevention, through the development of regional public health plans, and improving the interface across government and public health partner authorities, the South Australian community will continue to receive health promotion support" (Government of South Australia, 2013, p. 13).

In sum, Luhmann (1979) argued that trust is the glue in relationships, it reduces complexity, and that "one should expect trust to be increasingly in demand as a means of enduring the complexities of the future" (p. 16). Building trust particularly between state and local governments to alleviate fears of cost shifting is an implication of my research given the complexities of HP and the health system and would be fundamental to strengthening leadership and governance for HP. Trust appeared have eroded among system elements, particularly given the past history of the regional health system and HP practice. Building authentic trust appears to be necessary for solving complex public health problems (Riley, et al., 2015), however, in my case study the question remains as to how this will be accomplished given the dynamics of politics, financing, power and ideology.

7.2.3.4 *Fragmented system elements*

In this last section, I discuss stakeholder perspectives as to the fragmented nature of system elements and the lack of collaborative mechanisms in the regional health system. The causal link between stakeholder perspectives and state-local government roles, governance structures and policy directions are illustrated in Figure 7.2 as a negative feedback loop that inhibits HP. The description in Table 7.8 is as follows:

Fragmented system elements negatively influenced **state-local government roles**, governance structures and policy directions (lack of collaborative mechanisms) (-); **state-local government roles**, governance structures and policy directions are negatively influenced by fragmented system elements and the lack of collaborative mechanisms (-).	Negative feedback loop that inhibited HP (balancing cycle)

This balancing cycle keeps the system in a stable but undesirable state. The implication of this feedback loop is to disrupt the feedback mechanism with strong collaborative mechanisms for HP policy and practice.

Although developing partnerships and intersectoral collaboration is central to governance for health and to the *Public Health Act* (2011), stakeholders reported that this was not strong in practice. Thus, there is considerable potential to build relationships by strengthening vertical (state-local governments) and horizontal (across sector) collaborative mechanisms and enhancing trust in the health system. With respect to the latter, the literature is strong in

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emphasising that building trust is a vital element in partnership development and intersectoral collaboration (Finegood, 2011; Public Health Agency of Canada & World Health Organization, 2007; Riley, et al., 2015; Willis, et al., 2013). Kickbusch and Gleicher (2012) stated that collaboration often fails because of the "considerable but underestimated direct and opportunity costs in terms of the time it takes to build trust and consensus" (p.59).

Establishing and nurturing relationships is considered a central characteristic for effective collaboration to solve complex public health problems (Riley, et al., 2015). Part of relationship building is creating a shared understanding of complex societal problems and also of how each sector or organisational structure not only frames problems, but also their role and responsibility in relation to that problem (Commonwealth of Australia, 2007). There was a range in stakeholder understanding of the complexities of public health and HP in my research; from highly developed understanding of SDH and HP to uncertainty as to what Public Health means. Establishing strong collaborative mechanisms may ameliorate this uncertainty and help to clarify roles and responsibilities.

There is great potential to create a shared vision through public health planning, however, as noted earlier at the time of my research, only state and local government participants were involved in planning and other stakeholders (i.e., NGOs) had not been engaged in the regional health system. Therefore, my research points to the need for effective collaborative mechanisms to build relationships and share knowledge. Furthermore, engaging key partners at the beginning of collaborative processes is considered essential to successful intersectoral action in HP (Public Health Agency of Canada & World Health Organization, 2007). Therefore the inclusion of the key stakeholders identified in my study would have offered strong support for public health planning with key people and organisations contributing to creating a shared understanding and vision for HP in the regional health system. This is most notable with respect to NGO stakeholders (professional associations, health services and intersectoral networks) in my research as these organisations were not engaged in public health planning and therefore their knowledge, skill and experience was missing. NGOs have played a significant role in supporting intersectoral action for HP around the world (World Health Organization, 2008a).

These findings are similar to those of Anaf et al (2014), where intersectoral action at regional levels in SA primary health services (i.e., Local Health Networks) were constrained by the

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lack of financial and time resources and the wider political and policy context. In my research, the limited horizontal collaboration that existed appeared to be happening on the shoulders of poorly resourced NGOs and local councils struggling to come to terms with all that the *Public Health Act* entailed. My research points to not only the importance of shared understanding and adequate time and resources that are needed for effective collaboration, but also to the seemingly top-down approach of SA Health in the early days of public health planning. From a critical perspective, it appears that a power sharing approach and greater leadership and 'governance for health' on the part of the state health department are needed to establish collaborative mechanisms and stronger partnerships.

Networks are one type of collaborative mechanism reported in the literature that are thought "to have several advantages over isolated organizations, such as more efficient use of resources (financial and other), greater opportunities for learning, and improved capacity to address complex problems" (Willis, et al., 2013, p. 40). The fragmented system elements in the regional health system in my research would perhaps be well served to explore the formation of a formal network for public health and HP in order to fulfil such aims as leveraging resources, sharing risks, gaining efficiency, collective advocacy, building capacity through ongoing learning, innovation, and sharing responsibility and accountability (Popp, Milward, MacKean, Casebeer, & Lindstrom, 2014). Although there were five NGO/intersectoral networks that participated in my research, they lacked strong connections with the health sector and little to no engagement with local councils in public health planning, despite stronger links in the past (Chapter 4). A formal network may enable and formalise intersectoral action in order to advocate for the necessary leadership and governance for health to not only develop effective partnerships, but to ensure community participation and leverage HP financing, workforce and services (practice). In a study of 18 international case studies of addressing health equity through intersectoral collaboration, the World Health Organization (2008a) emphasised the importance of power sharing as key to successful collaboration:

> Successful intersectoral action requires the sharing of power. The creation of new entities, committees, or other bodies to formalize and institutionalize power sharing is helpful. Given a commitment to address social determinants, the development of intersectoral strategies occurred with greater ease in government cultures that had a tradition of diverse sectors working cooperatively (p. 20).

7.3 Limitations of my research

I conclude this chapter with a discussion of the limitations to my research. Firstly, in studying a regional health system it is obviously necessary to identify what is 'in scope' and what is 'out of scope' in the research. In Chapters 3 and 4 I described in detail the system elements, stakeholders and salient documents considered critical to informing my study. One limitation of my research design was the inability due to time and resources to include other system elements and stakeholders in the regional health system such as Aboriginal Community Controlled health services, schools, universities and social service agencies. I am cognisant that stakeholders in other system elements may have offered different perspectives. However, the boundaries set for my research served its aims well because of the leadership roles and responsibilities of the stakeholders in the regional health system.

Another limitation of my study was the need to limit the scope of state government documents reviewed because of time and resource constraints. The documents selected offered a clear picture of state health department policy directions with respect to HP in the regional health system. However, I am also cognisant that other state government department documents may have shed further light on HP, particularly with respect to whole-of-government approaches. Furthermore, if time and resources permitted, a review of local government documents might have provided a more comprehensive picture of the HP policy and practice environment.

I was aware that elite interviewees may not be entirely forthcoming with rich information, particularly given the sensitive nature of my research in times of budget constraints and cuts to HP. I needed to critically assess the value of all interview data by taking into account a range of factors during the interviews and in data analysis, for example, "style, manner, experience, and social position of the interviewee and the comprehensibility, plausibility and consistency of the testimony" (Tansey, 2007, p768). Harvey (2011) noted that elites may withhold politically sensitive information and/or present data in a certain way so as to conform to power structures and thus control the interview. As reported earlier, the SA Health group interview described the HP policy and practice environment in positive terms

and did not discuss the *Review* (2012) or challenges to HP. Therefore, Harvey's (2011) caution appeared to be in play in my research.

Finally, I was aware that some stakeholders in my study had a positive relationship with the Southgate Institute for Health, Society and Equity at Flinders University and this could be construed as a possible bias in the interview data. However, the number and diversity of sectors, organisations, and stakeholders was thought to overcome this concern.

Chapter 8: Conclusion

I began this thesis with a metaphor about how advocating for change is like surfing, where you need to be prepared to catch the big wave in order to ride it to shore. The main goal of this research was to contribute to the knowledge regarding how to be better prepared for advocating change in health promotion (HP) through a greater understanding of the factors that influence HP policy and practice. In this chapter I focus on recommendations and conclusions for HP by interweaving the aims of my research with the most significant findings and implications in terms of policy and practice.

This study has examined the historical policy context for HP in South Australia over a ten year period (2003-2013); investigated stakeholder perspectives in one regional health system; and applied a systems thinking lens to examine key findings in relation to feedback mechanisms and their potential to inform leverage points for desired system change. One of the most significant findings to emerge from this study is that leadership and governance from the health sector is a critical health system building block for effective HP policy and practice. All other building blocks were found to be integrally dependent on effective oversight of strong strategic policy frameworks for HP. Policy frameworks need to be based upon

- a social view of health;
- a system goal to reduce health inequities; and
- actions that include the reorienting of health services toward HP, developing partnerships and intersectoral collaboration both vertically and horizontally, and ensuring community participation in HP (Jackson, et al., 2013; Popay, et al., 2010; Scott-Samuel, 2003).

My literature review uncovered leadership and governance (Bambra et al., 2005; Kickbusch & Gleicher, 2012, 2014; Ziglio et al., 2011) as a key challenge for HP. I found that studying a regional health system in the midst of turbulence in HP policy and practice from a systems perspective highlighted fundamental challenges and opportunities for leadership and governance to strengthen HP.

This study identified that a social view of health and a system goal to reduce health inequities were not strongly evident in policy and practice in the regional health system. The paradigms and goals of systems are considered to be the most effective points to leverage system change [as discussed in Chapter 2 and indicated in Figure 2.7 Intervention level framework (Mahli et al, 2009)]. Therefore these findings point to significant implications and recommendations for leadership and governance. Findings regarding conceptualisations of health (paradigms) and system goals were particularly evident with respect to leadership and 'health governance' where the health sector, with assumed oversight responsibilities in the regional health system, nearly abandoned the aim of reorienting health services toward HP. The only formal HP workforce and services (practice) in the regional health system were based on short term financing for healthy eating and active living initiatives embedded in local governments. Key recommendations for strengthened leadership and health governance for HP in the health sector include the need to:

- disrupt the vicious cycle of the dominance of the biomedical model;
- disrupt the vicious cycle of the lack of acceptable practice-based evidence of HP effectiveness; and
- disrupt the balancing effect of addressing state budgetary constraints with cuts to HP financing, workforce and services (practice).

These recommendations require strong leadership and health governance at least in terms of state government roles, governance structures and policy directions. Kingdon (1995) describes policy entrepreneurs as leaders who influence policy or the agenda of government through an assessment of when a 'policy window' opens. In keeping with Kingdon's view, policy entrepreneurs need to be ready when the political context is favourable and be armed with a clear portray of the problem and practical solutions. My research highlights the need for such policy entrepreneurs to be prepared to champion the reorientation of health services toward HP. However, leadership and 'health governance' was not only shaped by state government policy directions, it was also shaped to a great extent by the vicious cycle and seemingly intractable politics of federal-state roles, governance structures and policy direction.

Despite the lack of 'health governance', this study has shown that there was overall support for leadership and 'governance for health' through developing partnerships and intersectoral collaboration in the HP policy context. A social view of health was evident to some extent in 'state' and 'state-local' government roles, governance structures and policy directions and this was demonstrated through several virtuous cycles. As noted above, however, the lack of a strong system goal for reducing health inequities was a clear weakness and this is an important recommendation and leverage point to further strengthen leadership and 'governance for health' for HP particularly for those in advocacy roles.

One dominant theme with respect to leadership and 'governance for health' was the positive focus on whole-of-government approaches that included horizontal collaboration within the state government, as well as hopes for future local government adoption of this approach in public health planning. Amplifying this positive feedback mechanism particularly with respect to local government leaders is another key recommendation. This study found that the expressed need for a strategic policy framework for HP and regular reporting on population health status were addressed to some extent through the *Public Health Act*. The implications from these findings for 'governance for health' follow those described above, that is, these virtuous cycles need to be amplified by those in leadership roles in state and local government to strengthen HP policy and practice. However, this needs to be coupled with the presence of equally strong 'health governance' with HP leadership, financing, workforce, services and information emanating from the health sector.

The examination of leadership and 'governance for health' as a key factor that influenced HP policy and practice in my research also revealed two balancing feedback mechanisms that negatively affected the regional health system. The first was the commonly held fear of cost shifting from the state to local governments and this led to a status quo in terms of HP. In other words, no system elements were taking a leadership role for HP for fear of being left holding the ball. This finding supports the recommendation that that HP financing for a distinct workforce to undertake HP service (practice) at the local level is necessary to not only build trust, but the capacity to move HP practice forward in the regional health system. This recommendation is particularly directed toward leaders at all levels of government.

The other balancing mechanism with respect to leadership and 'governance for health' was the fragmented nature of system elements, the lack of collaborative processes and structures, and the negative impact on partnership development and intersectoral collaboration. A key recommendation for leaders in all system elements is to establish and formalise networks in order to disrupt the status quo that inhibits HP policy and practice.

Finally, ensuring community participation through leadership and governance is an important recommendation from my research. This study identified that the lack of community participation in HP is a vicious cycle and therefore this is a key direction for HP in the future. This finding provides insights into how community participation in HP policy and practice can not only be overlooked (Kickbusch & Gleicher, 2012), but also how little importance can be placed on empowering communities to identify and take action on priority determinants of health and the right of citizens to co-produce strategic directions for health. This was particularly the case given the focus on public health planning at the state and local levels. Perhaps this was seen to have been accomplished through the reported extensive participatory approaches employed in the development of the *SA Strategic Plans*. However, this does not address the emphasis on community participation as a vital element of HP policy and practice. State and local government leadership is needed to advance genuine and ongoing community participation in HP

Findings from my research lead me to consider the recommendation of strengthening leadership in advocacy through the participation of community members and nongovernmental organisations. This was discussed by stakeholders in my research but there was a general sense of discontent because of the perceived lack of effectiveness of past advocacy efforts. Thus, the recommendation becomes not only the need to strengthen leadership but the building of a social movement and nongovernment organisations could play a key role. Marmot et al (2010) reported that building a social movement to reduce health inequities through action on the SDH was what the CSDH (2008) wanted to achieve. Ganz (2010) described social movements as emerging "from the efforts of purposeful actors, individuals or organizations, to respond to changes, to conditions experienced as unjust—not just inconvenient, but unjust—so as to assert new public values, form new relationships, and mobilize political, economic, and cultural power to translate those values into action" (p.1). Purposeful actors, according to Ganz, are leaders. On one hand, many participants in this

research discussed the need to be better advocates for HP, however, on the other hand, the obstacles to leading advocacy efforts were not clearly defined. Ganz (2010) stated that the leadership challenges lay in the very nature of social movements: "they are voluntary, dynamic, and interactive; participants are motivated by moral claims, but results depend on strategic creatively; and their capacity to make things happen depends on their ability to mobilize broad levels of commitment" (p.35).

To my knowledge this study provides the first comprehensive assessment of HP policy and practice in a regional health system using a framework of health system building blocks. The take away message is that without strong leadership and governance structures and processes for HP that help navigate the stormy waters of power, politics and ideology, HP will continue to remain extremely vulnerable in health systems. Even with strong leadership and governance, HP appears to remain vulnerable to the power of the biomedical model and neoliberal austerity agendas. This building block approach has proven useful to expand understanding of how leadership and governance is so integrally connected to HP financing, workforce, service (practice) and information, particularly regarding evidence of HP effectiveness. There were no clear new building blocks that emerged from this study regarding health systems for HP. However I recommend that future research should be undertaken to refine the definitions of each building block in order to describe the robust characteristics necessary for a health system for HP. For example, a strong statement regarding advocacy could be included in the leadership and governance building block.

Using a framework of health system building blocks coupled with systems thinking through the creation of a visual model of feedback mechanisms offered new insights into the study of a regional health system and HP policy and practice. I described how the literature calls for systems thinking and that it is in its infancy regarding HP research because there are few clear paths in terms of methods and tools. The unique approach in this study makes several noteworthy contributions.

Creating a Causal Loop Diagram was useful to visualise all key findings and their interdependence and causal pathways in a holistic manner. My approach to examining the building blocks through feedback mechanisms could prove to be valuable for others in their efforts to apply systems thinking to study the interdependencies and reciprocal effects of the

complex web of factors that influence HP policy and practice. Furthermore, feedback mechanism are considered to be important system leverage points (Meadows, 1999) and this study has gone some way towards understanding their use in relation to factors that influence HP policy and practice. Overall, my use of systems thinking was helpful in discovering patterns in system behaviour and specifically implications with respect to disrupting or slowing down positive feedback loops that are characteristic of vicious cycles, amplifying those that are virtuous cycles, and examining the strength of negative feedback loops relative to the effect they are trying to correct (Meadows, 1999).

Future studies would be useful to investigate key factors that influence HP policy and practice in two or more regional health systems employing participatory action research methods and systems thinking methods from this research. To contribute to knowledge development, studies that compare similarities and differences in the following areas are recommended:

- historical policy contexts;

- the perspectives of stakeholders in leadership positions;

- the perspectives of community members;

- strengths and weaknesses in the various health system building blocks, particularly with respect to leadership and governance for HP

- feedback mechanisms that positively and negatively impact HP;

- causal loop diagrams that show unique and holistic pictures of the interdependence of factors and a snapshot in time of emergent order; and

- implications and recommendations for action to strengthen HP policy and practice based upon distinct contexts.

I end this thesis with a reflection on a scene from Shakespeare's *The Tragedy of Julius Caesar* where Brutus challenges those around him:

> There is a tide in the affairs of men.
> Which, taken at the flood, leads on to fortune;
> Omitted, all the voyage of their life
> Is bound in shallows and in miseries.
> On such a full sea are we now afloat,
> And we must take the current when it serves,
> Or lose our ventures.

Even though this scene is taken from a tragedy, the lesson I take away is that there is a need to strongly advocate and nurture leadership and governance for HP at all levels, taking heed of the considerable challenges of power, politics and ideology that ebb and flow through health systems in order to be prepared to ride the tide of future opportunities.

Appendices

Appendix A: Nvivo Coding Nodes

A. INDIVIDUAL ROLE IN ORG
YEARS EXPERIENCE
B. CURRENT HP PRACTICE Serv Deliv
change in role
fed and state gvt
good quote re role
lack of clear roles
size of LC
C. CURRENT HP POLICY ENVIRO
D. PH ACT INFLUENTIAL POLICES
PH Act
E. CHANGES IN HP POLICY ENVIRONMENT
F. DESCRIPTION OF SYSTEM
difficulty understanding system
G. FUTURE CAPACITY ORGANIZATION
H. FUTURE CAPACITY SYSTEM
I. FACTORS THAT INFLUENCE HP
J. SYSTEM BLDG BLKS
B1 Finances
1 Change in finances (McCann)
2 Future financial need
3 Commonwealth
4 South Australia
cost shifting
quote re McCann
B2 Workforce
1. Change in workforce
2 Future workforce needs
3. Commonwealth
Medicare Locals
4 South Australia
B3 Leadership Governance
1 Change in leadership
2 Future leadersh govern needs
3 Commonwealth
Medicare locals
4 South Australia
Regional governance
5 Intergovt relations
B4 Service delivery

1. Change in service delivery
Change service delivery
2 Future serv del needs
3 Commonwealth
4 South Australia
PHC
5 Other
culturally appropriate
fragment integration (doc rev + interv)
B5 Information
1 Change in information
2 Future Information
3 Commonwealth
4 South Australia
K. HEALTH PROMOTION
1 HP values principles (doc rev) current prac (interv)
1 Population health perspective
2 Reduce inequalities
Action on SDH
Culture
Early child dev
Education
Employment
Food
Gender
Housing
Inclusion
Income and ses
Social support
Transportation
Gradient
Inequities
Most vulnerable disadvantaged
3 Community participation
4 Partnerships and intersectoral action
A Local govt
1. Advocate, mediate
2 Socio ecol appr (doc rev) curent prac (interv)
Bld healthy public policy
Whole of govt
Create supportive environmts
Dev personal skills
Lifestyle CD approach
Risk factors
Reorient health services

Strengthen com action
3 Other e.g., lifecourse
HP dirty word other words
L. CAPACITY DOMAINS
Organizational
Communication
Community demand need
Culture
Information
Knowledge and skills
Leadership
Partnerships
intergovernmental
intrraorganizational
issues
communication
participation
Policy
Procedures
Processes
Resource Allocation
System-level
1 Ideology
2 Politics
3 Economics
4 Values
5 Leadership
6 IS Collab Coordination
M. SYSTEMS CONCEPTS
General (Interviews)
Adaptability
Feedback loops
History dependent
Holism
Nonlinearity
Tighly coupled
Time delay Counterintuitive
N. DOC REV POLICIES OTHER
CPHC
DA Commonwealth
DB South Australia
GOOD QUOTES FROM POLICIES
REFERENCE TO OTHER POLICIES
SA STATS
SUPPORT FOR RESEARCH

Appendix B: Interview guide

1. Could you please give me a brief overview of your role(s) in ORG X?
2. How long have you been in this role(s)? How long have you worked in this field of work?
3. What role does ORG X currently play in primary prevention/health promotion? Has that role changed over time? If so, what are the key factors that have shaped the change to the role?
4. What policies (strategies, plans, programs, Commonwealth, state and/or local) are most influential to your work in health promotion?
5. How would you describe the health promotion policy environment in SA right now?
6. From your perspective, what has changed in terms of policy direction? In your position? In your organization? in the health system?
7. What policy or policies are shaping primary prevention and health promotion today? How are these policy directions shaping your organization's approach to health promotion practice?
8. There are many players and organizations involved in primary prevention or health promotion in SA (i.e., state health services, Medicare Locals, local government, NGOs, and other government departments). When you think of this large system of organizations - how would you describe it? What words would you use to describe it? What organizations? Who are your closest partners? Are there mechanisms and structures that link organizations together? What organizations are you most closely linked with regarding primary prevention and health promotion?
9. What needs to be in place in organizations for effective primary prevention and health promotion policy and practice?
10. What needs to be in place at the system-level for effective primary prevention and health promotion policy and practice?
11. Overall, what are the key factors that have influenced primary prevention and health promotion policy and practice in SA over the past few years?
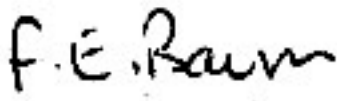
Appendix C: Letter of introduction

Dear

This letter is to introduce Ms. Lori Baugh Littlejohns who is a PhD student in the Faculty of Health Sciences, School of Medicine at Flinders University. Lori is a full time student in the Doctor of Philosophy Medicine (Public Health) program and her research is being conducted in association with an NH&MRC project examining comprehensive primary health care. Lori brings 25 years of health promotion experience in the Canadian primary health care system and in multiple roles including practitioner, manager, policy maker, and researcher.

She is undertaking research leading to the production of a thesis and other publications on the subject of health promotion policy implementation and its' influence on practice in multisectoral systems. The focus of her research is on studying the policy objectives of the SA Health Primary Prevention Plan (2011-2016) and the extent to which these are implemented. A Research Information Sheet is attached that highlights key aspects of the study. Lori will be contacting you to invite your participation in an interview.

I hope that you will be interested in working with Lori to assist her in conducting research. Please contact me if you have any questions or concerns.

Sincerely,

F. E. Baum

Fran Baum PhD, FASSA, LMPHAA, FAHPHA
Matthew Flinders Distinguished Professor & ARC Federation Fellow
Director, Southgate Institute for Health, Society & Equity and
South Australian Community Health Research Unit *(SACHRU)*
Flinders University of South Australia

Appendix D: Research Information Sheet

Project title:
Key factors that influence health promotion policy and practice in a South Australian region

My name is Lori Baugh Littlejohns and I am a doctoral student in the Southgate Institute for Health, Society & Equity at Flinders University. I would like to invite you to participate in a study about key factors that influence health promotion policy and practice in South Australia. My focus is on systems thinking and system level capacities for health promotion. Focusing on systems thinking in health promotion is in its infancy and therefore it is anticipated that much can be learned in South Australia to contribute to health promotion policy and practice that results in better health for all.

This study constitutes my doctoral thesis research and is being conducted in association with an NH&MRC project examining comprehensive primary health care. I bring 25 years of health promotion experience in the Canadian primary health care system and in multiple roles including practitioner, manager, policy maker, instructor and researcher.

What forms of data collection will be employed?

In this study, data will be collected in several forms throughout 2013 including:

1. **Document review –** This involves review of policy documents and media content that relate to factors that influence health promotion policy and practice.

2. **Interviews** – These focus on gaining an understanding of system-level processes and procedures in health promotion policy and practice. I hope to interview numerous people who have a variety of roles in health promotion. It is anticipated that interviews will take approximately 60 minutes and they will be audio recorded and then transcribed. Interviews will be arranged at a place and time of maximum convenience.

What are the benefits of this study?

The value and benefit of the project to participants is to aid in furthering knowledge development of the health promotion field, specifically in identifying key factors that influence health promotion policy and practice. It may also provide valuable knowledge for stakeholders about system-level capacities for health promotion and this may support their work. It is hoped that the research will have far reaching interest in regard to how regional multisectoral systems can improve population health.

How will confidentiality be ensured?

Information collected from interviews will be kept confidential, that is, no one who participates will be identified by name, position, or discipline. I alone will compile and analyse the data and will only include in my thesis and the academic papers themes that emerge from multiple sources of data (i.e., document review and interviews) and multiple interviews.

How will records be kept?

During the research, records will be kept in a security protected computer server and a secure locked cabinet located at Flinders University. Records will be kept for a period of seven years in a security protected computer server at Flinders University.

Are there any identified risks?

I anticipate few risks from involvement in this study. If anyone has any concerns regarding anticipated or actual risks or discomforts, please raise them with me or my Supervisors (listed below).

What happens at the end of the study?

The findings of this study will be published in my PhD thesis and disseminated through conference presentations and academic papers. In addition, a feedback session is planned for 2014 and everyone who participates will be invited to attend.

How do people agree to participate?

Contact me (Lori Baugh Littlejohns) either by telephone (04 0007 8129) or via email (baugh0004@flinders.edu.au).

If at any time you have questions or concerns about this study, you may contact me or one of my Supervisors as per below. They will be happy to address any questions or concerns that you have.

Fran Baum	Director, Southgate Institute for Health, Society & Equity	7221 8410	fran.baum@flinders.edu.au
Angela Lawless	Deputy Director, Southgate Institute for Health, Society & Equity	7221 8474	angela.lawless@flinders.edu.au
Toby Freeman	Senior Research Officer, Southgate Institute for Health, Society & Equity	7221 8468	toby.freeman@flinders.edu.au

Thank you for taking the time to read this information sheet!

Lori Baugh Littlejohns, BSW, MSc (Health Promotion)
PhD Candidate
Southgate Institute for Health, Society & Equity
Flinders University
baug0004@flinders.edu.au
P: 04 0007 8129

This research project has been approved by the Flinders University - Social and Behavioural Research Ethics Committee (Project Number 5836). For more information regarding Flinders ethical approval of the project the Executive Officer of the Committee can be contacted by telephone on 8201 3116, by fax on 8201 2035 or by email human.researchethics@flinders.edu.au

This project has also been approved by SA Health – Human Research Ethics Committee. For more information regarding SA Health's ethical approval (project number HREC/SAH//44) the Executive Officer of the Committee can be contracted by telephone 08 8226 6367, by fax 08 8226 7088 or by email hrec@health.sa.gov.au

Appendix E: Consent Form for Participation in Research - Interviews

> Key factors that influence health promotion
> policy and practice in a South Australian region.

I …...
being over the age of 18 years hereby consent to participate as requested in the Research Information Sheet for the research project on key factors that influence health promotion policy and practice in a regional multisectoral system.

1.   I have read the Research Information Sheet provided. Interviews will take approximately 60 minutes and will focus on my knowledge and experience in health promotion policy and practice.

2.   Details of procedures and any risks have been explained to my satisfaction.

3.   I agree to audio recording of my information and participation. Audio recordings will be transcribed and analysed for this research.

4.   I can request that the researcher (Lori Baugh Littlejohns) show me my specific interview transcript and I have the right to change or delete any or all comments from the researcher's records at any time. I do not need to provide a reason for this, nor will I experience any harm or retribution as a result of withdrawal of my information.

5.   I am aware that I should retain a copy of the Research Information Sheet and Consent Form for future reference.

6.   I understand that:
• I may not directly benefit from taking part in this research.
• I am free to withdraw from the project at any time.
• I am free to decline to answer particular questions, ask that the audio recording be stopped at any time, and I may withdraw at any time from the interview without disadvantage.
• While the information gained in this study will be published as explained, I will not be identified, and individual information will remain confidential.
• Raw data collected from this study will be coded and stored in a locked cabinet at Flinders University so that only the researcher (Lori Baugh Littlejohns) will have access.

Participant's signature…………………………………Date…………………...

I certify that I have explained the study to the volunteer and consider that she/he understands what is involved and freely consents to participation.

Researcher's name……………………………………………………….................
Researcher's signature…………………………………..Date………………………

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