

Health policy in South Australia 2003–10: primary health care workforce perceptions of the impact of policy change on health promotion

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Abstract

Issue addressed: This paper examines recent Australian health reform policies and considers how the primary health care (PHC) workforce experiences subsequent change and perceives its impact on health promotion practice.

Methods: Health policy documents were analysed to determine their intended impact on health promotion. Interviews were conducted with 39 respondents from four State-funded PHC services to gain their perceptions of the impact of policy change on health promotion.

Results: There have been a plethora of policy and strategy documents over the last decade relevant to PHC, and these suggest an intention to strengthen health promotion. However, respondents report that changes to the role and focus of PHC services have led to fewer opportunities for health promotion. Services are struggling to engage in health promotion activity, while funding and policy directions are prioritised to targeted, individual behaviour change.

Conclusion: The experience of PHC workforce respondents in South Australia suggests that, despite policy intentions, health promotion practice is much reduced. Our research suggests that rigorous evaluation of health sector reforms should be undertaken to assess both intended and unintended outcomes in terms of service quality and delivery.

So what? Health promoters are experiencing a contradictory policy and practice environment, and this research should assist health promoters in advocating for more government accountability in the implementation of policies in order to advance comprehensive PHC.

Key words: evaluation, health care reform, health policy, health promotion, primary health care.

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Introduction

Waves of reorganisation and policy change have been features of health systems in developed countries for several decades.^{1–3} In the late 1970s, changing ideas about health led to the WHO–UNICEF Alma-Ata Declaration on Primary Health Care (PHC),⁴ which called for more a comprehensive approach to primary care that included actions on disease prevention and health promotion. In 1986, the Ottawa Charter for Health Promotion⁵ elaborated several strategies for doing so, from improving personal skills for health to building supportive environments, strengthening community action and advocating healthy public policies. Also, central to the Ottawa

Charter strategies was a reorientation of health services towards a system that is community-based and controlled and which focuses on positive health rather than hospital-based, highly technological interventions for people who are already sick. In the early 1970s in Australia, foreshadowing these global developments, an Aboriginal community-controlled sector began pioneering comprehensive PHC,⁶ and a federal Community Health Program was set up that led to the establishment of multidisciplinary health centres.⁷

Globally, this period was quickly followed by an era of neoliberalism, emphasising private sector efficiency, including New Public

Management (NPM) 'reforms' in public sectors that focus on cost cutting, performance contracts and output measures for managing government agencies.⁸ Demographic changes and rapid technological advances in medical diagnosis and treatment have led to major cost implications for health services. In line with NPM reforms, health systems in many industrialised and developing countries have faced fiscal pressures to increase efficiency and to focus on demonstrating value for money.⁹ How these waves of policy change and reforms are implemented, and their impacts on service provision and health worker activities, are seldom evaluated, as the frequency of reforms means that efforts to evaluate one reorganisation are usually contaminated by the next.¹⁰

This paper aims to partly fill this gap by exploring the impact of policy and strategic planning reforms on health promotion. It does so through a review of health policy reform measures and an analysis of how a sample of the government-funded PHC workforce in South Australia has experienced these reforms. Research questions were:

- (1) What have been the major PHC organisational and policy reforms since 2003?
- (2) How has the PHC workforce experienced these reforms?
- (3) What is the workforce perspective on the impact of these reforms on health promotion?

Health promotion policy context

The Alma-Ata Declaration of 1978 remains the key document setting out a vision for a health system driven by comprehensive PHC¹¹ with health promotion as a key component. Although not elaborated upon in the Alma-Ata Declaration, health promotion separately has been defined as:

... a comprehensive social and political process, it not only embraces actions 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.¹²

However, widespread implementation of PHC (as envisaged by Alma-Ata) has not generally been realised because, even in countries which embraced PHC, unforeseen changes in the 1980s in the political and economic situation have hampered its implementation.⁹ Two models of PHC have evolved: 'selective PHC', focusing on reduction of specific diseases through curative treatments (with little community engagement or tailoring to local contexts), and 'comprehensive PHC', with a broader aim to improve overall health in individuals and communities using curative, rehabilitation, prevention and health-promoting strategies, engaging with communities, reflecting local issues, and acknowledging the political nature of health determinants.¹¹

Debates have also continued about the effectiveness of two broad approaches to health promotion practice.¹³ The first approach, based

on social marketing and education theory, leads to health promotion initiatives such as mass media campaigns to raise awareness of a health issue and educational materials aimed at increasing knowledge and skills. These activities are expected to produce behavioural change that increases healthy lifestyles and decreases individual risk factors. The second approach uses interventions such as advocacy, legislation, social action and intersectoral collaboration to affect socio-environmental determinants of health, that in turn facilitate behavioural change and increase supportive environments for health. These two approaches to health promotion can be complementary and often run concurrently. More recent developments that focus on health promotion systems^{14,15} attempt to combine the two; nonetheless, a 'slippage' to a predominantly individual behavioural focus is common.¹⁶

In Australia, health promotion activities occur through a range of organisations and providers. The Australian Government funds national health promotion and illness prevention programs, and (through Medicare) funds fee-for-service general practitioners to provide some health promotion and illness prevention through individual patient education, screening and health checks. State and Territory health departments, local government, and both for-profit and non-profit organisations are also engaged in health promotion activities. This paper focuses on health promotion as part of PHC activity in South Australian (SA) State-funded and State-managed community health services. For more detailed discussion of the health promotion activities conducted by these services see Baum *et al.* 2013.¹⁷ Although community health services differ among jurisdictions, in most there has been a shift to a focus on 'out-of-hospital services' and on chronic disease management rather than health promotion and community participation.¹¹ The Australian experience mirrors that of other countries, with comprehensive PHC continuing to be inadequately reflected in policy implementation.¹⁸

Methods

Background to study

The data presented in this paper were collected as part of a 5-year study evaluating the effectiveness of comprehensive PHC. The study is conducted in partnership with six services, including an Aboriginal-community-controlled organisation (Northern Territory), a non-government organisation focusing on sexual health, and four services directly funded and managed by the SA State government (including one Aboriginal Health Service). Services were selected based on established relationships with the researchers, and to reflect different governance models.

This paper concerns the four South Australian state government services only (services requested anonymity, see Table 1 for selected service characteristics). Data from the two non-government organisations are not included in this paper since they were affected differently by government policies and have a little more

Table 1. Characteristics of the four case study primary health care services

	Approximate no. of staff (FTE ^A)	Budget (p.a.)	Main source of funding	Governance	Examples of disciplines employed
Service A	16 (13.5)	A\$1.2m	SA Health	State funded and managed	Social worker, nurse, speech pathologist, occupational therapist, dietitian, cultural worker, lifestyle advisor
Service B	26 (20)	A\$1.1m	SA Health	State funded and managed	Medical officer, lifestyle advisor, PHC worker, podiatrist, nurse, speech pathologist
Service C	36 (22)	A\$1.7m	SA Health	State funded and managed	Nurse, dietitian, speech pathologist, psychologist, occupational therapist, cultural worker, social worker
Service D	12 (10.8)	A\$0.5m	SA Health	State funded and managed	Aboriginal health worker, primary health care worker

^AFTE – full-time equivalent.

independence from government. Two data sources are drawn upon: i) policy documentation relevant to health promotion and ii) interviews with key informants.

Policy document analysis

Federal and SA policy and strategic planning documents from 2003 (marking the election of a new SA Labour government and the subsequent ‘root and branch’ review of the health system) to 2010 (when key informant interviews were completed) were identified through monitoring of government press releases and websites and through alerts from research and professional organisations. Documents for analysis were then selected, based on their relevance to health promotion in SA. Full documents were read and content analysis was undertaken by the first author to identify the language and understanding of health promotion, and the intent of policy direction on health promotion activity.

Participant interviews

This paper draws on interviews with 31 managers and practitioners from the four SA services, and with eight regional Health Department executives (conducted as part of a broader project, giving a total of 39 interviews) (see Table 2). Managers and executives were invited to participate based on their position in the health system. Practitioners were selected to reflect the spread of disciplines employed across the sites and included dietitians, occupational therapists, speech pathologists, psychologists, social workers, Aboriginal health workers, medical officers, lifestyle advisors, nurses, and counsellors. Eight respondents (21%) were Aboriginal, and 32 (82%) were female. Most respondents (72%) had at least 4 years’ experience in PHC, with 42% having more than 10 years’ experience.

Interviews were conducted in 2009 and 2010, lasted from 1 to 2 h, and included a range of questions about improving health and reducing health inequalities. Topics included health promotion, action on the social determinants of health, advocacy, working with other agencies and sectors, and community work. Managers and practitioners were asked specifically: ‘How is your service being affected by current trends in health reform?’ Executives were asked: ‘What is your view on the proposed Australian Government reform

Table 2. Interview respondents by position and discipline (n = 39)

Position or discipline	n
Manager	4
Practitioner	27
Allied health	11
Aboriginal health worker/Cultural worker	6
Nurse	4
Medical Officer	1
Lifestyle advisor	4
Other primary health care worker	1
Regional Health Service/Health Department executive	8
Total	39

agenda and PHC?’ Data for this paper are drawn from responses to these questions and to responses relevant to health promotion throughout the interviews. The research team employed thematic analysis to develop a hierarchy of themes around PHC sector changes. Codes were discussed and revised during regular team meetings. Findings were fed back to participants for member checks and to the investigators for discussion of interpretations.

Ethics approval was obtained from the Flinders University Social and Behavioural Ethics Committee and the Aboriginal Health Research Ethics Committee, SA.

Results

Health policy changes

The major Australian Federal and SA State health sector changes from 2003 to 2010 are illustrated in Fig. 1. Results of the content analysis of policy documents are summarised in Tables 3 and 4 and presented below.

Nationally, there has been a consistent stated intention to put greater focus on health promotion and illness prevention, and this has persisted through a change of government. The National Partnership Agreement on Preventive Health and the establishment of the Australian National Preventative Health Agency¹⁹ has provided funding and direction, under Federal and State bilateral agreements, for interventions to address risk factors for chronic diseases. The

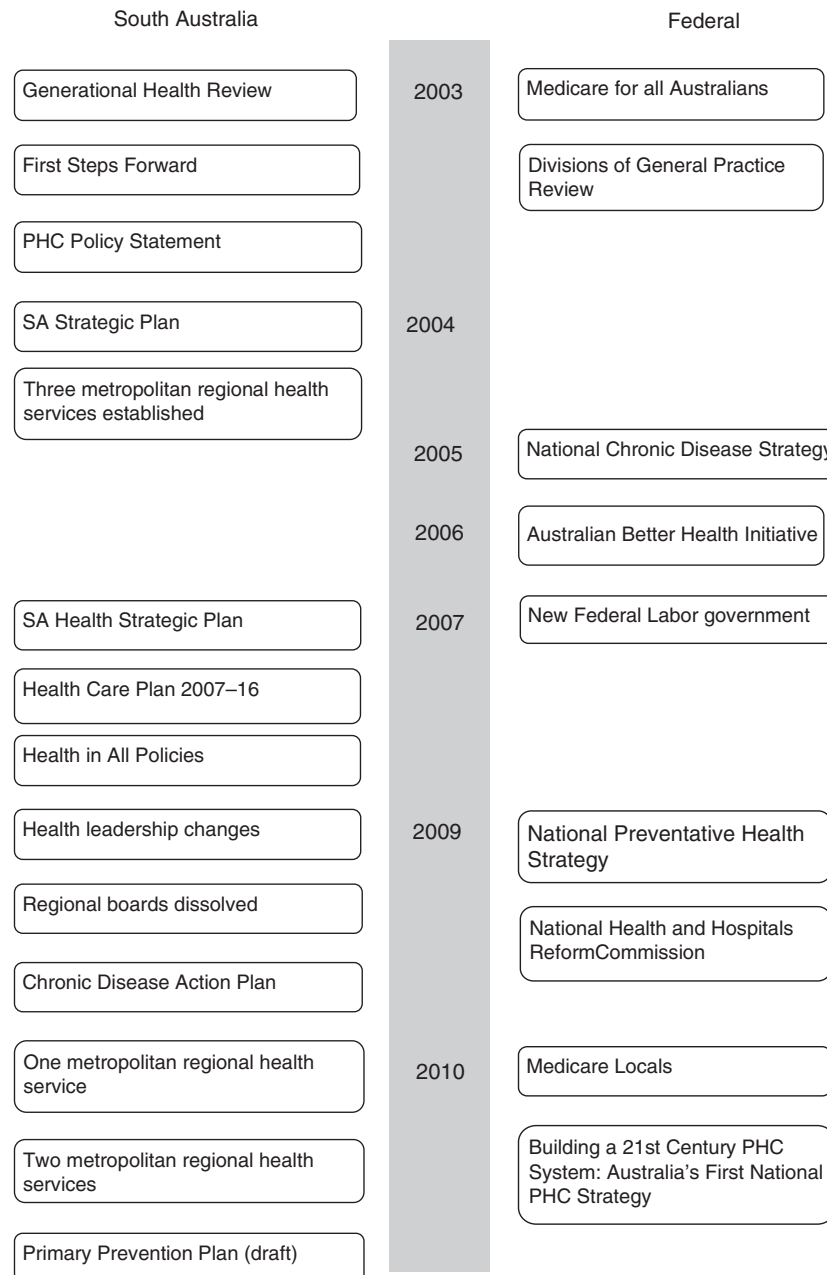


Fig. 1. Major health sector changes 2003–2010.

bulk of the funding is for interventions in local government and workplaces or with children as a population group. However, the extent to which the National Partnership Agreement on Preventive Health policy directions will support a socio-environmental approach to health promotion is unclear. For example, the performance indicators focus on behavioural change and healthy weight rather than assessment of changes in supportive environments for health. For the first time, Australia has a national PHC strategy and a network of PHC organisations, termed ‘Medicare Locals’. Nationally, 61 Medicare Locals have been established to identify gaps in PHC services at the local level, especially for high need and underserved

groups, and to better target services to respond to those gaps. However, Medicare Locals remain predominantly general practice based, with limited budgets and varying understandings of PHC and health promotion.^{20,21} Funding and governance continues to be a ‘political football’ between the Australian and State Governments.

Meanwhile, in SA, despite the strengthening of comprehensive PHC and health promotion suggested by the 2003 Generational Health Review²² and the PHC policy,²³ by 2007 the focus had, in part, shifted to individual lifestyle and behavioural programs to address chronic disease. For example, the SA Health Strategic Plan²⁴ claims

Table 3. Australian Government policy and impact on health promotion
PHC, primary health care

Document	Context	Intended impact on health promotion
Medicare – for all Australians, 2003 ³⁶	Budget statement: making prevention a fundamental pillar of Medicare. ‘A focus on prevention will help improve the health, lifestyle and productivity of our ageing workforce and ease cost pressures on the health system.’	Range of initiatives for making disease prevention and health promotion a fundamental pillar of the health system funding: collaborative work between health professionals to deliver better results for patients; helping patients manage lifestyle risk factors, including obesity; and renewed funding for a range of education and prevention programs
National Chronic Disease Strategy, 2006 ³⁷	Overarching framework for improving chronic disease prevention and care across Australia.	Principles include population health and reducing health inequalities, prioritising health promotion and illness prevention.
Australian Better Health Initiative, 2006 ³⁸	Major 5-year program to reduce the impact of chronic disease and to support a number of positions in PHC services.	A 5-year package designed to reduce the impacts of chronic disease through promoting healthy lifestyles, supporting early detection of risk factors and chronic disease, supporting lifestyle and risk modification, encouraging active patient self-management of chronic conditions, and improving coordination and communication between care services.
GP Super Clinics: Better Healthcare for Australians. National Program Guide, 2008 ³⁹	Information for intending applicants to set up one of the 31 clinics to be rolled out over the next 4 years (three in SA, including two with funding matched by State Government).	Governance to provide ongoing community engagement and input, with ‘greater focus on health promotion and illness prevention’ but essentially on primary care by GPs. Encouraging healthy lifestyles, addressing risk factors, early detection and management of chronic disease, self-management support and care planning are listed as the components of comprehensive PHC.
National Partnership Agreement on Preventive Health, 2008 ¹⁹	COAG agreement providing funds, primarily to States and Territories and local governments, to undertake: settings-based interventions focusing on nutrition, physical activity, smoking and alcohol; social marketing on obesity and tobacco; and associated monitoring and evaluation of infrastructure, including establishment of the Australian National Preventive Health Agency.	This agreement ‘aims to address the rising prevalence of lifestyle-related chronic disease by laying the foundations for healthy behaviours in the daily lives of Australians through settings such as communities, early childhood education and care environments, schools and workplaces, supported by national social marketing campaigns (MeasureUp and an anti-smoking campaign).’ The Agency supports the development of evidence and data on the state of preventive health in Australia and the effectiveness of preventative health intervention.
National Preventative Health Taskforce, 2008 ⁴⁰	Taskforce announced to develop strategies to tackle the health challenges caused by tobacco, alcohol and obesity.	Role to provide evidence-based advice on preventative health programs and strategies and to develop a National Preventative Health Strategy.
A Healthier Future for all Australians: National Health and Hospitals Reform Commission Final Report, 2009 ⁴¹	The Commission was set up by the incoming government with the reform goals of tackling major access and equity issues, responding to emerging challenges, and long-term sustainability of the health system.	Calls for: strengthened PHC services, policy and government funding of PHC to shift from the States and Territories to the Commonwealth, the establishment of PHC organisations to support better service coordination and population health planning, strengthened consumer engagement and voice, and the health system to be redesigned to ‘embed prevention and early intervention into every aspect of the health system and our lives’.
Australia: The Healthiest Country by 2020 – National Preventative Health Strategy, 2009 ⁴²	Prepared by the National Preventative Health Taskforce; sets targets on overweight and obesity, smoking, and risky alcohol use.	Seeks to address the unequal distribution of health and risk; to engage communities; to inform, enable and support people to make healthy choices; and to refocus primary health care on prevention. Following the National Preventative Health Taskforce recommendations, the Commonwealth committed to: establishing the Australian National Preventive Health Agency; to investment in general practice, research and evaluation; to tobacco, alcohol and obesity programs; to supporting children and families at risk of disadvantage; and to indigenous programs.
A National Health and Hospitals Network for Australia’s Future: Delivering Better Health and Better Hospitals, 2010 ⁴³	Government response to National Health and Hospitals Reform Commission Final Report.	Has a ‘focus on prevention and early intervention’; contains plans to shift policy and funding of PHC to the Commonwealth, for the establishment of Local Hospital (Health) Networks to take on hospital management, and for independent PHC organisations (Medicare Locals) to integrate general practice and PHC services. Prevention is noted as legislation and taxation measures on tobacco and alcohol, while PHC is linked to general practice.

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Table 3. (continued)

Document	Context	Intended impact on health promotion
A National Health and Hospitals Network for Australia's Future: Delivering the Reforms, 2010 ⁴⁴	Detailed plans, targets and timelines for Delivering Better Health and Better Hospitals from the incoming Prime Minister.	Plans for public forums and a website to engage consumers in reform. Continues distinction between prevention and PHC in general practice.
Building a 21st Century PHC system: Australia's First National Primary Health Care Strategy, 2010 ⁴⁵	Written on the understanding that the Commonwealth is to take full responsibility for PHC as per the National Health and Hospitals Network Agreement.	Identifies priorities in: improving access and reducing inequity, better management of chronic conditions, increasing the focus on prevention, and improving quality, safety, performance and accountability. National network of 'Medicare Locals'. There are no explicit strategies for community participation or health promotion (apart from tobacco control measures) and no reference to the social determinants of health.

a commitment to a broad PHC approach but is focused on individual clinical care. Implementation of health promotion as detailed in the SA Health Care Plan²⁵ is limited to providing information about healthy choices and lifestyles. The SA Government has committed to a 'Health in All Policies' approach that recognises the importance of the social determinants of health.²⁶ Implementation of the Health in All Policies initiative has, however, been driven by SA Health in conjunction with a range of other government departments and has had little engagement with PHC services.^{26,27} The 'Eat Well Be Active Strategy'²⁸ does take a more comprehensive approach that includes working collaboratively with other government sectors and non-government organisations, in a variety of settings, to address overweight and obesity.

Workforce perspectives on organisational and policy change

Two main themes relevant to health promotion emerged from the workforce interviews: (1) changes in the role and focus of PHC, and (2) changes in opportunities for health promotion.

Role and focus

The State health policy reforms and associated restructuring was noted by respondents as having had considerable influence on PHC services. An executive from the SA health department described it thus:

This is the first time in quite a while where the Department, from the centre, has driven a very focused, whole-of-health, primary care approach and articulated what it might look like. (Health Department executive)

Although from this executive's perspective centrally driven 'primary care' was positive, for most respondents there was a perception that policy changes had shifted the organisational focus away from comprehensiveness, including health promotion, to one that was more targeted to specific vulnerable population groups or chronic diseases and that the concept of universal access had been lost. Respondents reported that funding was more often directed at specific programs or populations and that they had less autonomy

in providing a variety of services to the community. A regional executive confirmed this view.

We don't provide a comprehensive PHC service any more; we're heading towards being a specialist service, because we have targeted priority populations and limited service focus, and our focus these days is heading to be much more around hospital avoidance. (Regional executive)

Loss of comprehensiveness was also illustrated by a perceived shift to clinical services at the expense of community development and broad health promotion activities. Respondents talked about the focus on chronic disease services and self-management and the move away from addressing social health issues.

We're becoming more clinically focused because of what the Department requires, and so our ability to do that kind of social action, really grassroots community development, is very limited. So I think if we did have a more comprehensive PHC, we would be doing things that more fit with what the community sees and needs, rather than just solely focused on this kind of chronic condition stuff. (Practitioner)

Many respondents expressed concerns about a shift to overly prescribed and centrally directed programs of care for addressing chronic disease. Concern was expressed about the loss of other services that take a broader remit:

We would actually be focusing more broadly on social determinants and a more integrated whole-of-life approach rather than what we are having to do at the moment, which is pulling back very much to chronic disease, and anything else that happens additional to that has to be tied back to its impact on chronic disease ... (Regional executive)

Opportunities for health promotion

The views above describe PHC services where the mix of direct care, illness prevention and health promotion has become unbalanced, with budgets increasingly tied to managing individuals and their risk factors and health-related behaviours. Thus, the focus is on medical and behavioural models without the socio-environmental approaches to health promotion that are the hallmarks of comprehensive PHC.²⁹ The perception of many respondents was

Table 4. Key South Australian (SA) Government policy documents and impact on health promotion
PHC, primary health care

Document	Context	Impact on health promotion
Generational Health Review, 2003 ⁴⁶	Incoming government-initiated review of health system.	Recommends 'significant shift from a system focused on illness to a health system re-orientated towards health promotion, illness prevention and early intervention'. Multiple recommendations towards community participation and health sector accountability and transparency. PHC policy to underpin and drive reform.
First Steps Forward, 2003 ⁴⁷	Government response to Generational Health Review	Statement of intent to 'provide services closer to home; and increase prevention, early intervention and healthy promotion', including strengthening PHC, community participation and networking of services.
PHC Policy Statement, 2003–2007 ⁴⁸	Following Generational Health Review, promised a 'vision for change', strong PHC foundation, better health and reduction in health inequalities, investment in PHC.	Recognised PHC as an approach with a broad range of strategies, which strongly reflected the need for partnerships and a whole-of-government approach, and for taking a broad scope for PHC services and community participation. However, the policy lacked implementation planning and resources, and a change of Health Minister in 2006 saw a loss of support for the policy and it was not renewed.
SA Strategic Plan, 2004 ⁴⁹	Establishing goals, targets, measuring tools and priority actions for the State Health and Wellbeing section, but no specific mention of PHC.	Focuses on being healthier, with an emphasis on preventative measures. Gives greater priority to prevention, early intervention and health promotion. Plan had a major impact on priority setting in government departments and aims to encourage cross-sector collaboration to achieve targets.
Eat Well Be Active Healthy Weight Strategy for South Australia, 2006–2010 ²⁸	Developed by the Healthy Weight Statewide Taskforce, this document proposes a coordinated approach to promoting healthy weight.	Focuses on prevention, on tackling inequalities and on working through environment and settings to achieve change.
SA Health Strategic Plan, 2007–2009 ⁵⁰	Following on from SA Strategic Plan: strategic aims to strengthen PHC, enhance hospital care, reform mental health care, and improve the health of Aboriginal people.	Engages communities and community agencies in program planning, development, implementation and evaluation. Makes a commitment to a broad PHC approach, but the objectives, strategies and performance measures focus on individual clinical care. Focus on lifestyles, information campaigns and behavioural health promotion.
SA Health Care Plan, 2007–2016 ⁵¹	Implementation plan for SA Health Strategic Plan.	Provides information about health choices and lifestyle. Less than 2 out of 28 pages devoted to PHC. Main focus on planned new hospital.
GP Plus Health Care Strategy, 2007 ⁵²	GP Plus Health Care Centres announced as main strategy for enhancing PHC.	Aims to increase investment in community and home care, and to keep people out of hospital or to reduce hospital stays by working closely with GPs and other private health care providers. The Strategy identifies an increase in health promotion, illness prevention and early intervention services as part of the Government's agenda, and rebadges of some PHC services to GP Plus Health Care Centres.
Health in All Policies, 2007 ²⁶	Arose from Kickbusch term as 'Thinker in Residence'.	Applies a health lens analysis to non-health sector policies and is intended to emphasise cross-government work in addressing the social determinants of health.
SA Chronic Disease Action Plan for South Australia, 2009 ⁵³	Following on from the SA Health Care Plan in addressing the rising burden of chronic disease.	Prioritises secondary prevention, early intervention and disease management. Focuses on those at risk or diagnosed with chronic disease.

that the workforce was being re-structured to deliver targeted and behavioural programs at the expense of broader health promotion and community development. For example, it was reported that community development positions had been lost by changing position descriptions or re-allocating staff to specific lifestyle programs. A regional executive confirmed the loss of community development activities:

I think some of the community development aspects of things are increasingly more difficult for staff to be able to do

because their role is being much more tied down to providing a specific service around a specific issue to a specific person or specific population group. (Regional executive)

Practitioners believed that a top-down approach compromised health promotion activity:

We have to get permission to do things, where I believe that over the last few years we were really able to work autonomously. It was never questioned. Now, you know, you have to be answerable, and I don't think it's wrong to be answerable, I just think some of the work we did falls into

health promotion, and it was OK, but maybe it's not anymore.' (Practitioner)

In general, little positive change was reported from the promised reforms, and there was a perception that the reality of health reform was very different from what was intended:

I guess there's a real contradiction in the health reform dialogue versus the reality of health reform ... because when we hear the dialogue behind the health reform it's very positive, and you think there'll be a lot of improvement; but we're not really seeing that on the ground ... as a clinician of 17 years' experience, my biggest sadness would be that I've seen community health shrunk in reality in those 17 years, rather than expand.' (Practitioner)

Discussion

Our monitoring of health reorganisation and policies over the period 2003–2010 highlights the significant changes that have affected health promotion in SA-funded and -managed PHC services. There has been much rhetoric about strengthening PHC and health promotion from the Federal and SA State Governments in policy and strategic planning documents. However, policy analysis reveals, in the main, a rather narrow interpretation of PHC that focuses on individual care and risk factor management for selected chronic diseases rather than broader population-based health promotion within the PHC services. Nationally, the Australian Government does continue to fund healthy lifestyle media campaigns, and the National Preventative Health Strategy has begun to address some risk factors at the population level while recognising health inequalities and the need for community engagement. However, these high level initiatives do not appear to have had much impact on local PHC services, and the Australian National Preventive Health Agency is now under review by the incoming Coalition Government.

In SA, policies designed to strengthen PHC do not seem to have been translated into change that is perceived as positive by those working in the services. They report that health promotion is no longer seen as the remit of PHC services. Many respondents expressed a sense of loss and frustration at the increased focus on individualised approaches to chronic disease at the expense of health promotion activities, community development and a social view of health. Budgets were reported as being more tightly tied to specific programs and to have become a mechanism for a narrowing of service focus to individualised care for chronic diseases, with an assumption that this will lead to reduced hospital admissions. This trend towards centralised decision-making has occurred in most Australian States and Territories.³⁰ Most recently, the SA Government implementation of the review of non-hospital-based services³¹ has led to budget cuts to almost all health promotion in PHC services and reinforces this change of direction. The Obesity Prevention and Lifestyle program (OPAL) is one of the few health promotion programs to escape cuts because it rests on a National Partnership Agreement on Preventive Health, but this

program is implemented through selected local governments rather than PHC services. It appears that the policy reform intended by the Generational Health Review²² has been disregarded in the search for short-term budget savings and a focus within health services on the management of chronic disease rather than its prevention.

The introduction of federally funded Medicare Locals is the latest reorganisation in the PHC sector. Medicare Locals are intended to improve PHC integration and to create more comprehensive PHC services that are responsive and accountable to local communities. Much of the rationale for the cuts to health promotion by the SA State Government is based on an assumption that Medicare Locals will take on this role. However, according to the AMA (SA), Medicare Locals are not currently in a position to take up many of the PHC services previously funded by the SA State Government, and if some Medicare Locals are able to take up programs while others are not, this is likely to lead to fragmentation and loss of effectiveness across the system.³² It is currently unclear how Medicare Locals will interact with State-funded PHC services and others with a role in PHC, non-government organisations and local government.

Conclusion

The overall assessment of the health reforms from our respondents was negative, in terms of their impact on health promotion. Many workers believe that services are becoming less accessible and less community driven. Respondents reported that services are struggling to maintain a comprehensive PHC approach, including health promotion, whereas funding and policy directions are prioritised to vertical chronic disease programs and centralised control. The implementation of the review of non-hospital-based service recommendations to cease funding of almost all health promotion programs³¹ confirms these workforce perceptions. The review suggested that Medicare Locals, local government and non-government organisations would fill the gap in locally driven community-based health promotion. It did this, however, without any formal assessment of the capacity and availability of resources for these organisations to do so.

Whatever the stated intention, there seems to be a continuing trend for health promotion in the PHC services to focus on individual lifestyle and to emphasise individual behaviours and risk factors rather than the social determinants of health.^{16,33} Challenges facing the implementation of broader health promotion include competition with medicine for funding, the medical dominance of health system policy and practice, and the apparent appeal to policymakers of the individualised approach, which poses less strategic and political issues in its implementation, despite evidence for its lack of effectiveness.^{34,35}

Our research suggests that rigorous evaluation of health sector reforms should be undertaken to assess both intended and unintended outcomes on service quality and delivery. There is a lack

of coherence between the policies committed to by governments and the programs and practices that arise. This research should assist health promoters to advocate for more government accountability in the implementation of policies in order to advance comprehensive PHC.

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