Addressing inequalities through primary health care: principles of effective practice

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Acknowledgements

- The PHC practitioners whose work is the focus of this research
- The Project Advisory Group
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Research context

- The problem: huge burden of disease associated with socio-economic inequality and social exclusion
- The explanations: social determinants of health (poverty, powerlessness, alienation, etc)
- The strategies and models of practice:
  - primary health care (PHC) and community development (CD)
  - amongst other diverse policies and programs

CDIH

- Initially “Community Development in Health” (1987-1994), later the “Centre for Development and Innovation in Health” (1994+)
- Concerns:
  - burden of disease associated with socio-economic inequality and social exclusion
  - policies and strategies of practice for addressing social determinants of health (poverty, powerlessness, alienation, etc)
- Focus: research, support and consultancy in primary health care and community development in health

CDIH publications

- CDIH: Resources Collection (1988)
- Case Studies in CDIH (1993)
- Innovation and Excellence in Community Health (1994)
- Best Practice in Primary Health Care (1996)

The research question: why is it so difficult?

- PHC as a policy model and CD as a model of practice
  - promise effectiveness, based on a particular analysis (logic and philosophy) and
  - supported by many exemplary case studies
  - but remains highly contested and
  - has proved hard to transplant
- Are the difficulties related to conceptual practices (the way practitioners think)?

What sort of evidence?

- To test the promises, explore the difficulties and answer the sceptics, we need further research:
  - Does it work or not?
  - And if it does work, what works?
- But what kinds of evidence and what kind of research is required in a field of practice which is highly context dependent?

Different kinds of practice and different paradigms of research

- Context-independent practice addressed through reductionist research (correlation, intervention, falsification) directed to proving causal links and producing evidence-based procedural algorithms
- Context-dependent practice addressed through interpretive research generating conceptual frameworks, generalised narratives and principles of practice

PHC and CD as context-dependent practice

- Context-dependence in PHC and CD
  - communities, within cultures, economies and polities at particular times, are unique
  - practitioners, collaborators and local stakeholders are unique
  - local organisations (within programs, policies and networks) are unique
  - purposes, goals and objectives (outcomes) are unique
- Research which controls out the specificity of context through aggregation of ‘like cases’ will exclude much of the detail which gives meaning to judgement and logic to practice
- Research for context-dependent practice will aim to produce a narrative of practice and principles of practice, rather than causes and algorithms; providing principles that practitioners can draw upon in accordance with their own judgement of the situation

Research objectives

To assemble:

- a **conceptual framework**,
- a **narrative of practice** and
- a **set of principles**

which will assist PHC practitioners (and managers, planners and policy makers) in developing and implementing PHC programs which will more effectively address inequalities in health

Stages of this project

- Stage One: From ‘syndromes of difficulty’ to hunches about effective practices
- Stage Two: From PHC and CD to MMI
- Stage Three: Study of practice

Stage One: From ‘syndromes of difficulty’ to hunches about effective practice

- Syndromes of difficulty
- Different ways of thinking about these issues
- Hunches about what might make for effective practice

Some ‘syndromes of difficulty’ (based on a review of our experience)

- Victim-blaming
- Big picture impotence
- Disempowerment of structural determinism
- Limited theoretical resources
- Singular totalising frameworks
- Dogma and stereotyping
- Coercive ‘helping’
- Paralysis through fear of being coercive
- Interventionism - lack of awareness of our own presence in the field of practice
- Between bureaucratic cypher and anarchistic rebel
- Paralysis of ethical complexity

Social theory debates

- Structure and agency
- Conceptions of power
- Incommensurable knowledges
- Causality and agency
- Listening and difference
- Non-coercive communication
- Reflexivity
- Ethics

Insights from post-structuralism

- Knowledge is usefully thought about as stories (multiple, partial and incommensurable), each with a teller and audience, rather than as representations of reality
- Power is integrally involved in knowledge creation; dominant knowledges contribute to reproducing power relations
- We are indelibly present within our own knowledges; our subjectivity is reflected in and shaped by the way we speak

Hunches about effective conceptual practices in PHC/CD

- Comfortable with contradiction
- Eclectic with respect to theory
- Free of the positivist's burden
- Own stories about links from self to social
- Open to personal reshaping
- Ethics of managing bureaucratic role pressures

Stage Two: replace PHC and CD as organising frameworks

- Our review of experience is pointing at the ways we think (conceptual frameworks, principles and precepts, conceptual practices) as key areas for understanding why it is so difficult
- Need to replace PHC and CD as central organising frameworks (because they are overburdened and conflicted)

PHC and CD – over burdened and deeply rifted concepts

- PHC
  - a policy model, a tier of service provision, a philosophy of practice
  - confused articulation in Alma-Ata (1978)
  - tightly contested since then (comprehensive versus selective, PHC versus ‘primary care’)
- CD
  - development: transitive or intransitive?
  - what is community?
  - can power be given?
  - “In and against the state”

Micro macro integration as an alternative organising framework

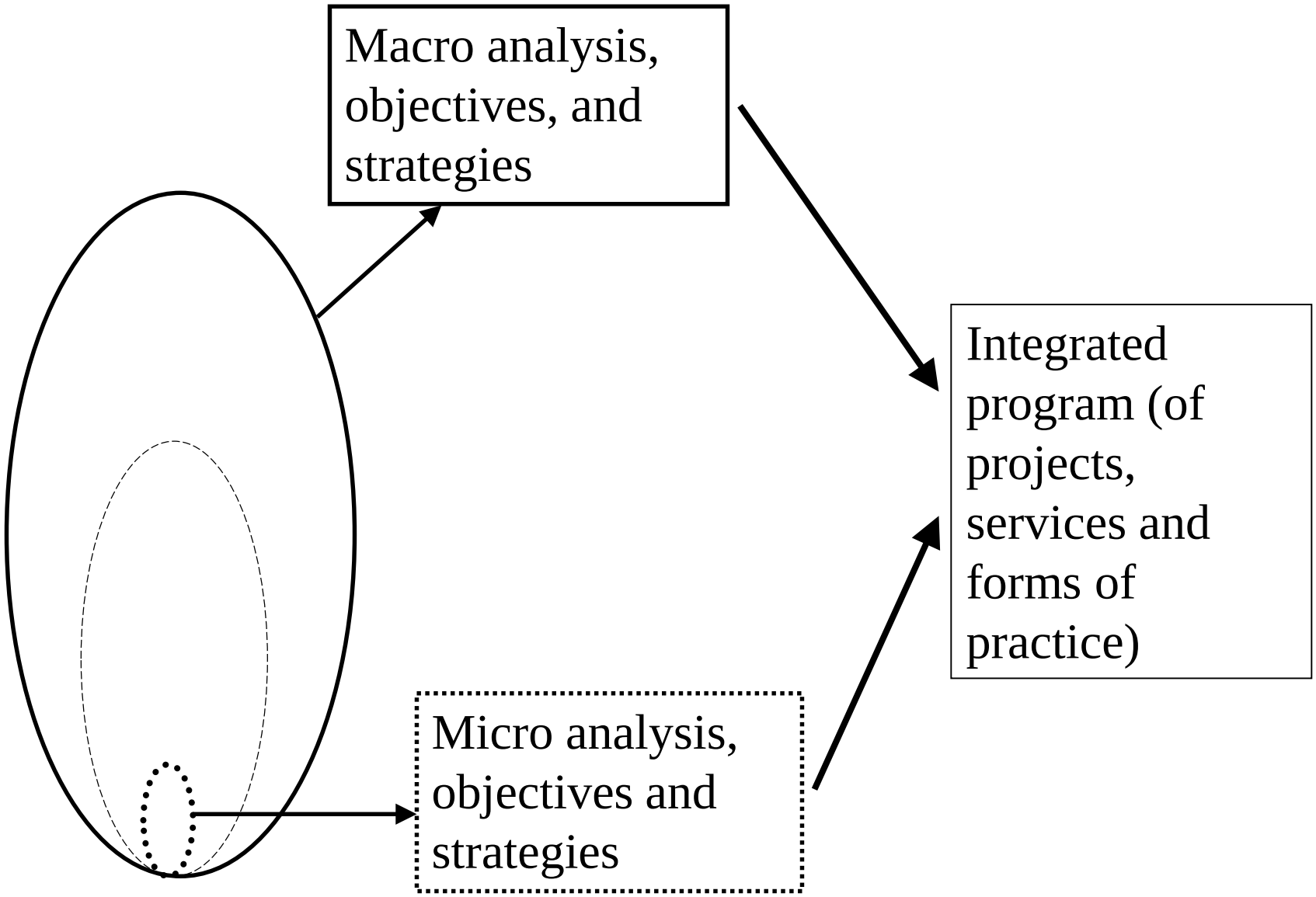
- The principle of micro macro integration provides an alternative organising principle for thinking about the practice of PHC and CD in health
  - encompasses much of what is difficult in PHC and CD
  - not overburdened with conflicting meanings
  - may serve as alternative framework for exploring the difficulties, debates and principles of practice

The principle of ‘micro macro integration’

Micro macro integration involves:

- addressing immediate (micro) health needs in ways which also contribute to redressing the larger scale and longer duration (macro) factors which contribute to reproducing those needs
- integrating analyses and strategies conceived at both micro and macro levels within a coherent program or set of activities

Principle of micro macro integration



The micro macro principle as interpretive template

- Encompasses the key purposes of PHC and of CD without the overburdened and conflicted meanings
- Logical in theory
- Provides a useful template for interpreting cases of good practice
- So, what do the difficulties, debates and principles of practice look like when viewed within this template?

Stage Three: check our theorising against practice

- So, where are we up to?
  - We have a number of hunches about the conceptual practices which might support effective practice in PHC
  - We have a ‘new’ organising framework: the principle of micro macro integration
- Next step: a study of practice to
  - explore the usefulness of the micro macro principle as a template for describing, interpreting and understanding PHC and CD practice
  - test our hunches about conceptual practices which support effective practice in PHC and derive more useful principles for program development and practice

A study of practice: research strategy

- A study of published accounts of projects undertaken in PHC settings, supplemented by interviews with the key practitioners involved
- A structured description of each case
  - Patterns of MMI
  - organisational context
  - individual styles of practice (including ways of thinking)
- Develop an interpretation of these data
  - conceptual framework, general narrative and principles of practice
  - iterate between interpretation, structured description and original data
- The tests are the resonance of the interpretation with experience and the usefulness of the principles in practice

Research plan

- Selection of three program areas where social factors are prominent: food and nutrition (for pilot), drug and alcohol, women's health
- Identification of 20 recently published reports of episodes and projects in PHC
- Reviewer evaluation of 20 published reports in each area
- Interviews with key practitioners from each of 8 projects in each area
- Analysis of cases

Data collection

- 40 reports reviewed (20 in Women's Health & 20 in Drug and Alcohol)
- 16 practitioners interviewed (8 in WH and 8 in D&A)
- 16 projects (8+8) analysed for micro macro integration
  - original article
  - other documents discovered or supplied
  - interview

The Women's Health projects

- Violence project for NESB women (WH1)
- Health and wellness centre for older women (WH2)
- Rural caregivers' support project (WH3)
- Aboriginal maternal and child health service (WH4)
- Women's primary sexual care program (WH5)
- Community birth centre (WH6)
- Community midwifery (WH7)
- Aboriginal women's health and birthing centre (WH8)

The Drug and Alcohol projects

- Needle & syringe disposal project (D&A1)
- Adolescent drinking and smoking project (D&A2)
- GP management of D&A problems (D&A3)
- D&A program for offenders (D&A4)
- Drug education course for parents (D&A5)
- Drug education for Aboriginal homework centre & education workers (D&A6)
- Outdoor recreation for young offenders (D&A7)
- Alcohol related violence project (D&A8)

Analysis - false starts

- Use of reviewers to generate an ‘objective’ (or consensus) judgement of the quality of outcomes and the degree of integration of micro and macro
- Use of discourse analyses of interview transcripts to learn about deep conceptual practices
- Use of a correlative analytic strategy (what styles of practice are associated with better outcomes and greater degree of MM integration)

Analytic strategy (final)

- In-depth analysis of structured case study descriptions (based on published data and interviews) describing
  - styles of practice
  - features of organisational settings
  - patterns of micro macro integration
  - commentary on how styles of practice and organisational context have contributed to or obstructed micro macro integration
  - reframe the descriptions; rewrite the interpretation
- Generalise across the 16 cases:
  - develop a general narrative of how styles of practice and organisational context contribute to or inhibit micro macro integration in PHC and derive principles of effective practice
  - iterate between cases and general narrative to rework and reframe the narrative and the principles

Findings

- Patterns of micro macro integration
- *Styles of practice*
  - *ways of speaking and listening*
  - *ways of thinking*
  - *theories and discourses*
- *Organisational contexts*
  - *organisational context and traditions*
  - *project design and management*
- Factors affecting the degree of micro macro integration (styles of practice, organisational factors)

Patterns of micro macro integration

- Immediate objectives
- Organisational and service system objectives
- Social change objectives
- Degree (and appropriateness) of integration

The objectives of the projects

- Micro level objectives (lowest level of analysis)
  - services provided to individuals
  - small group community education
  - creating supportive environments
  - institutional capacity building
- Macro level objectives
  - organisational and service system development
    - establishing or entrenching a service agency
    - strengthening local service systems
    - creating or demonstrating alternative models of service provision and
    - institutional systems reform
  - social change objectives
    - local – community capacity building
    - broader – social and cultural change

Micro (local, immediate) objectives

- Services to individuals (8W, 3D)
  - support groups for women victims of DV
  - improved treatment options for people with drug problems
- Community education (4D)
  - education of school communities about children and drugs
  - local community acceptance of NSEPs
- Creating supportive environments (3D)
  - reduce alcohol related violence in city centre
  - discourage tobacco sales to youth

Organisational and service system development objectives (beyond the micro)

- Establishing/entrenching service agency (3W,1D)
  - eg birthing centre
- Strengthening local service systems (5W,5D)
  - helping mainstream agencies to deal with DV
- Creating or demonstrating alternative models of service provision (4W,3D)
  - older women's wellness centre
- Institutional systems reform (2W, 2D)
  - lobbying for health insurance for independent midwifery

Social change objectives (beyond the micro)

- Community capacity building (5W, 2D)
  - resourcing local networks to support carers
- Social and cultural change (5W, 5W)
  - challenging sexist and ageist stereotypes of older women

Integration of micro and macro levels of analysis

- Projects which integrated micro and macro analyses into their goals, strategies and practice
  - institutional development (12)
  - social change (7)
  - both (7)
- Projects which did not fully integrate micro and macro analyses in their goals, strategies and practice
  - did not integrate institutional development very well
    - for strategic reasons (1 case); for lack of capability (3 cases)
  - did not integrate social change very well
    - strategic reasons (4); lack of capability (5)
  - did not integrate either very well:
    - strategic reasons (1); lack of capability (3)

Help for rural carers of people with mental illness (WH3)

- Immediate
  - meeting the needs of isolated carers
- Service development
  - resourcing local generalist practitioners
  - role modelling ways of relating to people living with mental illness
- Social change
  - challenging stigma
  - resourcing local networks to maintain the challenge

Violence project for NESB women (WH1)

- Immediate
  - setting up of facilitated support groups for abused NESB women
  - provision of information to women at risk
  - training program for practitioners and facilitators
- Service development
  - helping mainstream community health agencies to be better able to address NESB issues
- Social change
  - promoting community discussion regarding the cultural values which sustain violence

Health and wellness centre for older women (WH2)

- Immediate
  - activities and programs for older women
- Service development
  - demonstrating alternative model of service provision
  - engaging with local service providers
  - establishment of another OWWC
- Social change
  - challenging ageist and sexist stereotypes which restrict older women's opportunities and expectations

Factors affecting micro macro integration

- Project design and organisational context
- Organisational culture and traditions
- Individual styles of practice

Factors contributing to MMI: organisational context and tradition

- Project and auspice associated with a wider social or political movement
- Organisational culture familiar with MMI
- Organisational culture committed to social view of health and to engaging with social/structural causes
- Organisational commitment to community development and accountability
- Theoretical and disciplinary eclecticism vs narrow unidisciplinary or bureaucratic cultures
- Culture which supports research and evaluation

Factors affecting MMI: project design and management

- Investment in models of practice that realise MMI (eg. story telling, role modelling, training)
- Institutional support for project and practitioner
- Scope for flexibility in implementation
- Investment in building relationships
- Management of conflict and contradiction
- Investment in research and evaluation which contributes to MMI
- Positive feedback which sustains commitment and support

Factors affecting MMI: individual styles of practice

- Versatility of identity and subjectivity
- Listening
- Use of language
- Building (real) personal relationships
- Working in partnership; sharing ownership
- Managing contradiction
- Reflexivity
- Skills in implementing strategies which link micro and macro
- Management, entrepreneurship and leadership skills

Versatility of identity and subjectivity

- Having a repertoire of different personnae and being able to project them appropriately

…*you often find yourself – I'm not even sure if I was doing this consciously or not – the way in which you would talk with GPs would be slightly different from the way in which you would talk with a group of drug and alcohol workers or perhaps with a group of methadone clients (D&A3).*

Listening

Active listening: listening carefully for understanding, giving feedback and asking for clarification

…*we listen a great deal to what other people have to say… and we also make sure that we accept and value other people's perspectives even if they don't necessarily match our own (WH3).*

Listening

- Deep listening: listening across (despite) difference; engaging with different world views; being open to seeing the world differently (and then hearing the other more deeply)

... reaching out to listen deeply to angry and frustrated carers who see mental illness differently (and then reframing their experiences) (WH3)

Use of language

- Using empowering and non-stigmatising language; reflexive about language and power
- Using the vernacular; managing jargon

It's a way of demonstrating non-stigmatising behaviour. It's a way of perhaps undoing some of the stigma by using positive words instead of negative words, making sure that you don't make the disability or the problem that the individual has overtake the whole person (WH3).

Building (real) personal relationships

Reciprocal, multidimensional and rewarding relationships

…I would reveal something personal about myself…it wasn't just a working relationship we also had that personal connection as well and I think people appreciated the fact that I was willing to give a little of myself on that level and not just in a professional setting all the time (WH2).

Working in partnership; sharing ownership

- Sharing power with individual clients; community groups; other organisations

Well I guess it always went back to what did the client want or what did the women say were the important things about how they wanted to be treated…it was just getting information from the women and taking it from there and being flexible, you know, structuring the service around what they wanted…(WH7)

Managing contradiction

- Being at ease with complexity, multiplicity and uncertainty

Being able to work in a muddle…if you can deal with confusion and be adaptable and flexible and have a perception about what is going on, then I think that that is one of the best skills you can have (D&A6)

Reflexivity, managing oneself

- actively re-shaping myself; learning from experience

…there were those challenges to constantly monitor your own work, your own practice to make sure that you haven't fallen by the wayside somehow and you actually maintain the things you believe in (WH3)

Skills in linking micro and macro

- Skills in project strategies and activities which contribute to change at both micro and macro levels, eg.
  - story telling (WH7, D&A6)
  - role modelling (WH2, WH3) and peer education (WH2, D&A5)
  - training (WH1, D&A3, WH7, D&A4, D&A5)
  - use of symbolism as communication (WH7, WH8, D&A8)
  - preserving excellence
  - community development

Management skills, entrepreneurship and leadership

- Entrepreneurial spirit; finding her way around problems; exercising personal leadership, including leading the committees who were managing her (WH2)

Rural carers (WH3): design factors contributing to MM integration

- The workshops as speakouts: helping individuals, building networks, changing communities
- Role modelling respect for, and warm, multidimensional relationships with, ‘consumers’ – more effective because credible and also challenging stereotypes

Rural carers: practitioner style contributing to MM integration

- Use of language in countering stigma and negativity - understanding the realities of stigma and exclusion as being reflected in, and reinforced by, language – social change through sensitivity to language
- Role modelling respect for, and warm multidimensional relationships with, 'consumers'
  - more credible and effective education
  - also challenging stereotypes
- Reflexivity (watching myself)
- Ethics (actively re-shaping myself)

Community midwifery (WH7): organisational factors contributing to MM integration

- Building personal relationships in the course of providing services supported by the CHC (more appropriate individual services; makes the Centre a more effective advocate for system and social change)
- Community involvement and accountability
- MM principle prominent within the CHC organisational culture

Community midwifery: practitioner style contributing to MM integration

- Building personal relationships in the course of providing services
  - more appropriate services to individuals
  - laying the ground work for partnerships in system reform and social change
- Countering ethnic stereotypes by telling real life stories
  - part of system reform and social change
- Communicating across difference; professional stereotypes as a barriers to reform
  - being reflexive about overly simple analyses and personal investments which create stereotypes
  - learning to listen past professional stereotypes

Summary: the research context

- The problem: huge burden of disease associated with socio-economic inequality and social exclusion
- The explanations: social determinants of health (poverty, powerlessness, alienation, etc)
- The strategies and models of practice:
  - primary health care (PHC) and community development (CD)
  - amongst other diverse policies and programs

The research question: why is it so difficult?

- PHC as a policy model and CD as a model of practice
  - promise effectiveness, based on a particular analysis (philosophy) and
  - supported by many exemplary case studies
  - but remains highly contested and
  - has proved hard to transplant

Stages of this project

- Stage 1: From ‘syndromes of difficulty’ to hunches about effective practice
- Stage 2: Exploring MMI as an alternative organising framework
- Stage 3: Studies of 16 cases: principles for practice and infrastructure development for MMI

Stage One: From ‘syndromes of difficulty’ to hunches about effective practice

- Syndromes of difficulty
- Different ways of thinking about these issues
- Hunches about what might make for effective practice

What of our hunches?

- Being comfortable with contradiction
- Eclecticism with respect to theory
- Freedom from the positivist's burden
- Having personal stories about the links from the self to social
- Accepting the project of personal reshaping
- Having ethical practices for managing bureaucratic role pressures

Stage 2. MMI as an organising conceptual framework

- The principle of micro macro integration provides a meaningful organising framework for thinking about the practice of PHC and CD in health
  - encompasses much of what is difficult in PHC and CD
  - not overburdened with conflicting meanings
  - may serve as alternative framework for exploring the difficulties, debates and principles of practice

MMI: think program and network as well as project and organisation

- Micro and macro can be integrated within projects and within the work of particular organisations
- Sometimes contextual or strategic reasons for not achieving such integration, but
  - micro macro integration can still be achieved across programs and across networks of organisations
  - a consciousness of micro macro integration remains necessary for the program coherence and coordination

Stage 3. Studies of practice

- Sixteen cases of PHC practice have been studied and analysed in terms of the degree to which they integrate
  - local and immediate objectives with
  - service development objectives and social change objectives
- We have described
  - patterns of micro macro integration
  - organisational contexts
  - styles of practice
- Linkages are identified between degree to which the MM principle is realised and aspects of:
  - organisational context and traditions
  - project design and management
  - individual styles of practice

Conclusions

- The idea of MM integration provides a useful organising framework for exploring the practice of CDIH and PHC
  - however it must be understood at the program and network level as well as in the work of individual practitioners and projects
- We are developing a set of useful principles to guide policy makers, planners, managers, researchers, teachers and practitioners towards more effective programs and practices

Principles for policy and program management

- Long term investment is needed; capacity-building takes years (beware of short term project funding!)
- Invest in organisational capacity-building
  - building partnerships with communities and social movements
  - accumulating experience and understanding amongst staff and board/community
  - value theoretical and disciplinary eclecticism
  - build cultures which record and communicate to staff and community that we do see things at many levels, that we are ready to engage at many levels; that it is ok to do so
  - develop a culture of reflexivity and formative evaluation
  - develop organisational traditions of research and evaluation
  - building alliances with agencies with expertise in research and evaluation
  - developing a culture among researchers of conceiving research and evaluation at micro and macro levels

Principles for project design and management

- Select models of practice that contribute to MMI (eg. story telling, role modelling, training)
- Provide institutional support for project and practitioner
- Allow scope for flexibility in implementation
- Invest in building relationships
- Develop skills in the management of conflict and contradiction
- Invest in research and evaluation which contributes to MMI
- Cultivate channels of feedback which will sustain commitment and support to staff and other participants

Training priorities for effective practice

- Develop a repertoire of identities and subjectivities and the skills of deploying and enacting
- Skills of active listening; readiness for deep listening
- Skills in use of language (reframing, jargon busting, vernacular balance, non-verbal languages)
- Validating (real) personal relationships
- Developing partnerships; sharing ownership
- Managing conflict and contradiction
- Reflexivity (skills, time, systems)
- Knowledge of and ability to use strategies which link micro and macro (eg: story-telling, role modelling, teaching, giving support, communication, peer education, striving for excellence, community development)
- Management, entrepreneurship and leadership skills