



Strengthening
connections:

Clarence

FULL REPORT

ANTICIPATORY
CARE PROJECT



ACTION
LEARNING TO
IMPROVE HEALTH
IN TASMANIAN
COMMUNITIES



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The Anticipatory Care Action Learning Project research team acknowledges the palawa people of lutruwita upon whose lands we have conducted our research.

This project is funded by the Australian Government through the National Partnership Agreement on Improving Health Services in Tasmania.

The research reported here was produced by a collaboration between Clarence City Council and the Clarence community, the Tasmanian Government Department of Health, the University of Tasmania, and the Australian Prevention Partnership Centre. The Report was prepared by the University of Tasmania Anticipatory Care research team: Dr Susan Banks, Dr Robin Krabbe, Ms Miriam Vandenberg and Ms Thérèse Murray. We wish to thank Professor Richard Eccleston, Dr Therese Riley, Ms Flora Dean and Ms Sarah Hyslop for their insights and support throughout the project.

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Glossary

We use several acronyms in the report. They are listed here.

AC	Anticipatory care (see definition on p. 5)
H2H	Help to Health (the Clarence site project)
LG	Leadership Group (community members and service providers)
PSO	Project Support Officer – employed by the local lead organisations and working with them and with the UTAS team
CCWG	The Healthy Tasmania Chronic Conditions Working Group
SDoH	Social determinants of health (see definition on p. 5)
PPH	Potentially preventable hospitalisations (see p. 15)
CLD	Causal loop diagram
PHT	Primary Health Tasmania

In brief

Anticipatory care (AC) is a systematic approach to care designed to support people's current and future health needs. An effective anticipatory care system relies on a combination of accessible, locally appropriate services and facilities, and collaborative, trusting relationships between services and between services and citizens. It is undermined by poor access to resources due to stigma, cost and relationship disruption. The system is shaped by policy at all levels of government and within organisations but must reflect local ways of working and resources.

In Clarence, the AC system needs to be able to reach people across the municipality's 'villages', and to provide locally-relevant supports. Clarence City Council could play an important role. It can:

- reach across the municipality
- decide local policy and where to expend resources
- build on its existing role in community preventive health
- use its strong voice to lobby for better supports for the anticipatory care system, and
- support the necessary links between the many places and services, individuals, groups and organisations that make up the anticipatory care system.

Executive summary

Key points

Chronic illness is a major cause of ill-health and avoidable hospitalisations in Tasmania, and this burden is not equitably distributed. Chronic disease is linked with the social determinants of health: risk is reduced when people have reliable access to economic resources, secure and good quality housing, good diet, hygiene, health services, social networks and education. We need to reduce the risks for chronic illness and find better ways to manage existing conditions to keep people well. The Anticipatory Care (AC) Action Learning Project explored whether building a more effective local anticipatory care system could start to address this problem, in four Tasmanian sites. AC identifies who is at risk of developing an illness and aims to keep people well. Effective AC may reduce the need for expensive health and social services (Baker, Leak, Ritchie, Lee, & Fielding, 2012; Tapsfield et al., 2016).

This report documents the project's aims, processes, activities, and findings for the Help to Health (H2H) site in Clarence.

What was already known

People living in some parts of the H2H area have higher rates of chronic illness, and potentially preventable hospitalisations than Tasmanians overall. The three most common reasons for PPH from Clarence were diabetes, congestive cardiac failure, and chronic obstructive pulmonary disease. Clarence residents also have higher rates of risk factors for chronic illness, including smoking, and overweight or obesity. Some of these factors are linked with being older (Clarence's median age is 43), but many are the product of the negative social determinants of health. Local government has a role in the social determinants. Despite Clarence having an overall high median income, five suburbs rank in the most disadvantaged quintile, and one area is ranked in the most disadvantaged quintile in all four indexes, IER, IEO, IRSD and IRSAD. Clarence also has rates of diabetes, heart disease, depression and anxiety and asthma that are higher than for Tasmania overall (Clarence City Council, n.d.).

What our research has added

The Help to Health project enabled a Health Connector role to be trialled. The Connector role showed significant promise as a means to improve the function of the anticipatory care system. The findings support locating the health connector role in local government, an organisation that has an established health and wellbeing role and reach into local communities. Clarence's 'city of villages' nature calls for ways to share information and resources, and to enable collaboration across diverse communities.

Medical services (GPs) have historically been seen as central to AC, but in this community we have found that there are many other services that can play a part; examples include local council, neighbourhood houses, NGOs, pharmacies, public transport, libraries, local halls, clubs and community organisations, and infrastructure planners. Expanding our understanding of who is part of the AC system supports increased collaboration and coordination, and the overall effectiveness of the system.

The H2H project had four programs already operating:

- The Right Place (TRP)—training for front-line staff to build a welcoming, caring and well-informed culture to support the health needs of community members
- It's Okay To Ask (IOTA)—a health literacy training initiative to build people's ability to ask for and understand health information
- Clarence Talks—a program of locally targeted health and wellbeing information sessions in community settings, and
- Help to Health Friends (H2HF)—a network of interested community members committed to being health literacy advocates among their friends, family and broader community.

Of these programs, The Right Place and It's Okay to Ask had started, and Clarence Talks and the Help to Health Friends were rolled out in the early part of the AC project. The AC project aimed to build on all four programs through activities such as gaining greater understanding

of the AC system via data gathering and sharing, that were developed using a participatory action learning and systems thinking approach.

Some AC project statistics for the H2H site

H2H and research activities:

Data gathering and sharing activities	134 people
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Continuation of:

The Right Place training	41 people in 8 organisations
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It's OK to Ask training	6 sessions
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Clarence Talks (from January 2019)	17 Talks
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Help to Health Friends	22 Friends registered
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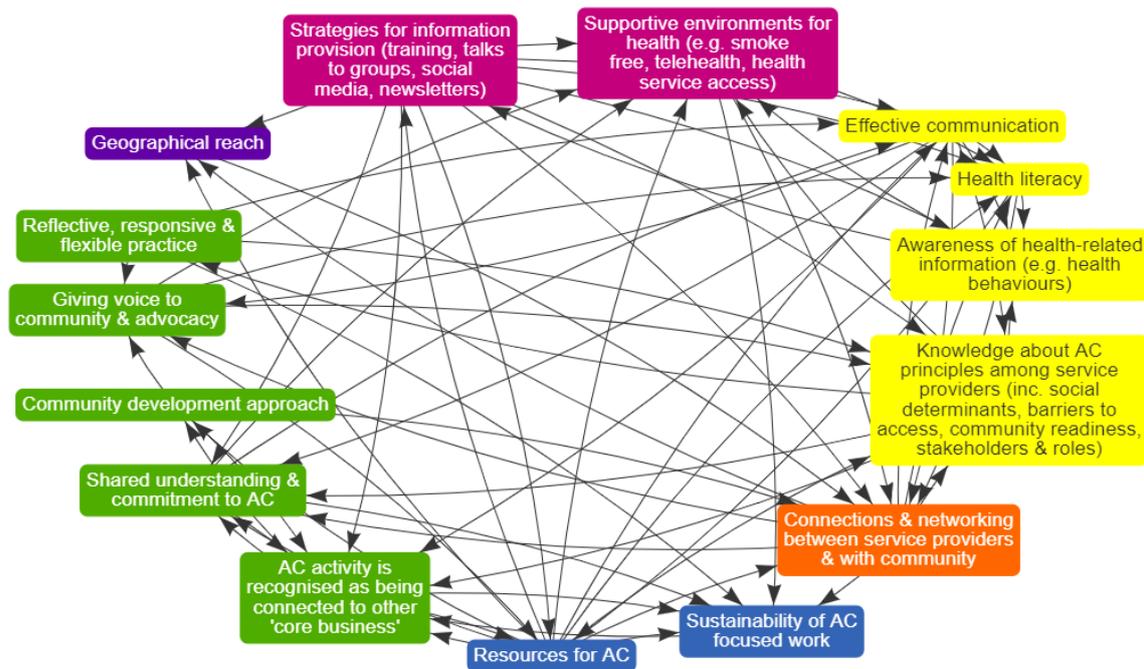
The LG	19 members, meeting six-weekly
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As well as developing the Health Connector role, H2H launched Clarence Services Online Forum after the project. Project activities identified a need for improved information sharing and collaboration amongst medical and service providers. The online forum aims to link GPs with other health and service providers in order to improve information sharing, navigation and access. The site launched on 12th August 2020.

Causal loop analysis showed that actions taken in the H2H AC Action Learning Project increased:

- connections and networks with other service providers and with the community
- effective communication through these connections/networks to share AC knowledge
- service provider capacity to create supportive environments for health (e.g. reception staff know about where people can get housing support), enabling more connections and networks between service providers and with community to be built
- capacity in H2H team to reach more community members and to work safely and effectively with them
- engagement of some previously hard to reach people in health-promoting activities, and
- the effectiveness and authority of the lead agency in health.

These gains from the project activities are difficult to measure in terms of chronic health outcomes within the life of the project, but they are important short to intermediate measures/markers that indicate positive changes to the AC system and a more enabling environment. A longitudinal study is needed to determine the full level of benefit from the changes to the local AC system.



Causal loop diagram, 2020

The project identified community-specific barriers to AC, including:

- historical stigmatising attitudes to some parts of the community that reduce external and internal opportunities to enhance equitable access to the AC system
- CCC's relative over-investment in a hard infrastructure (buildings, paths, services) approach to public health that overshadows support for the soft infrastructure (relationships, knowledge, collaboration) which is essential for effective AC
- government policies (e.g., for bulk-billing, welfare supports, and funding arrangement) that actively work against taking a social determinants of health—including mental health—preventive approach, and
- local government being a critical actor in an effective AC system; Council should develop and embed a long-term strategy for promoting and supporting health and wellbeing in the community.

The full report can be read alongside the local report prepared by the H2H team, and reports on the other three AC project sites: Launceston's northern suburbs (Our Community Our Care), Ulverstone and the 7315 postcode area (Connecting Care), and Flinders Island (Our Health Our Future). A final report, incorporating external evaluation, will be delivered in December 2020.

Methods, Processes and Findings

Why

In 2018, the Chronic Conditions Working Group (Department of Health) funded lead organisations in four Tasmanian communities and a research team from the University of Tasmania to undertake the Anticipatory Care (AC) Action Learning Project. We worked together to:

- map the local AC system
- find out how to make AC work better, and what might get in the way
- trial actions to enhance the system, and
- learn what role the local lead organisations play in AC and whether their role can be strengthened.

We also trialled the usefulness of action learning and systems thinking for understanding and enhancing AC. The Tasmanian AC project ran from July 2018 to December 2020. The local Help to Health (H2H) project in Clarence ran from February 2019 to January 2020.

Learning about anticipatory care

Anticipatory care is a population approach to health care that identifies and engages people who are at risk of developing chronic conditions with the aim of preventing or slowing health deterioration. Through relationship building and by recognising the social context in which they live, people are supported to be 'co-producers' of their health.

The project framed AC as a system. The AC system's parts must work together effectively so we can identify and support people who are at risk of developing a chronic condition and *anticipate* their needs. An effective AC system includes ways to reduce risks and better manage existing conditions. It aims to keep more people healthy. We have defined health broadly in this project, guided by the social determinants of health (SDoH) (Marmot, 2005; Marmot & Allen, 2014). This means that our mapping of the AC system was not limited to health services, resources, or infrastructure.

What are the 'social determinants of health'?

The social determinants of health are the conditions in which people are born, grow, live, work and age. These circumstances are shaped by the distribution of money, power, and resources at global, national and local levels. The social determinants of health are mostly responsible for health inequities—the unfair and avoidable differences in health status seen within and between countries. (World Health Organization (WHO), n.d.)

The four communities in the project have high rates of people being admitted to hospital for preventable conditions, including chronic illnesses. They also each have different demographical, social, cultural, and geographical characteristics, some of which may be

contributing to the chronic illness load. These differences are helping us to learn what local AC systems have in common, and what different agencies (services, groups, organisations) can do in the system to support better health outcomes. The Help to Health site is the southern Tasmanian municipality of Clarence. The site's lead agency is the Clarence City Council (CCC), represented in the project by the Community Planning and Development Officer. CCC employed two officers (a project officer (PO) and a project support office (PSO)) to work with the community and the UTAS team. The PO had already been part of the H2H team; the PSO was employed specifically for the AC project. There was also a Help to Health Leadership Group (LG) for the existing H2H project, and this continued for the AC work. The Leadership Group is chaired by Clarence City Council, and is made up of local residents and representatives from services working in the area. The leads, P/SOs, and LG members are the H2H team.

How

We used action learning and systems thinking. Action learning is participatory and invites people affected by a phenomenon to work together to learn about it, to make sense of what its causes might be, and to try out different ways to improve the situation. To understand the AC system, we gathered and analysed quantitative and qualitative data from, and about, people who live or provide services in Clarence. We wanted to know how they understood health, about their experience of the health system, and what supports or gets in the way of better health outcomes for the residents of Clarence.

Our analysis helped us to understand what makes up the AC system in this community (our understanding of the system is being revised as we continue the analysis). Then we used a systems thinking tool, causal loop analysis, to explore with the H2H team how the parts of the system affect one another, and to find opportunities where acting on one part of the system might have the greatest benefit for the whole system.

We identified that the major opportunity for change was through increasing access:

Geographical and physical (quotes are from local participants):

Look at South Arm, ... transport and getting around, because you've got an older population, you have people who aren't driving there ...

Emotional and psychological:

People have to feel safe. People have to know how to use it.

And to resources:

There's the whole—because people are economically disadvantaged—their only choice is the Royal. Their only choice is being on the waiting list to have their hip replaced or their knees replaced.

The findings show that place and belonging are very important for the effective function of the anticipatory care system. The research supports the description of Clarence as 'a city of villages'. Each village has particular characteristics, which affect how people think about or

act on their own health. In some villages, a large proportion of community members are highly educated, and have moderate or high levels of agency, and capacities that enable them to find their way into and through the AC system. In others, there is a heavier reliance on local resources (such as neighbourhood houses) and resourcefulness. Similarly, people in the villages have different expectations and experiences of the AC system. For too many, a fear of being judged affects how likely they are to attempt to use a service or visit a place. Poverty puts some services out of reach for some people, and fear of being judged plays a part, but the effects of personal poverty are made worse by lack of local services and infrastructure (e.g., sufficient GP services, low-cost or free and safe sporting or fresh food options), and a lack of personal and public transport. This was true in all the AC project sites, but in the Clarence municipality the residents' access to and through the AC system varied a great deal.

What does stigma look like?

Attitudes about a community or a person shape how they are treated and their expectations. These attitudes can be external (e.g., held by people outside the community), or internal (an expectation that you will be judged and found wanting). Stigma plays out in the lack of provision of services and supports to particular communities or people, in the demands that some communities or people do more for themselves, in judgmental responses to individuals, and in a person's unwillingness to approach particular services or places for fear of being treated poorly.

Trial actions to enhance the system

Each site developed action plans based on our shared understanding of where to intervene to strengthen or improve the system. The 'flagship' Help to Health activities were further developed, and the H2H team explored:

- successful navigation of systems and services to address community needs
 - sub-project: improving connections between GPs and community through a reference group
 - sub-project: expanding The Right Place training to pharmacies
- quality relationships between actors in the AC system to address community and service needs
 - sub-project: developing and describing the Health Connector role.

During the project, we have continued to gather data (more than 120 people contributed to our data) and to reflect on what we are learning with the H2H team. New knowledge helps us to review and adjust activities. Causal loop analysis (or causal loop diagramming, CLD) has been an important tool for this. In CLD sessions, members of the team identify variables and the causal links between them to find strengths and weaknesses, and places where adjustments can be made or have been effective. CLD is part of the action learning approach.

What do we know now?

Mapping the local AC system

The project has made some changes to how AC is understood in this community, and in the lead organisation. The researchers and local team have a better understanding of what makes up the AC system, and have shown the importance of place and belonging (as a key system part) and the impact of policy and processes; these two additional parts of the system were identified during the project.

Through the project, more people (and organisations) are seeing their role in supporting people's health *as part of* the broader AC system. There is also evidence among service providers of positive attitudinal shifts and practice changes aimed at supporting safer access to health for community members. This was evident in the data and demonstrated at our final CLD session, in May 2020, where participants included people with community development, health service and healthy policy roles.

What role do the local lead organisations play in AC and can their role be strengthened

Clarence City Council aims to strengthen and improve the physical, mental, and social wellbeing of the community taking into account both individual and community needs in accordance with the Social Model of Health. (Clarence City Council, n.d., p. 5)

The lead organisation in the H2H site, Clarence City Council (CCC), already has a role in preventive health. It does this through its responsibility for environmental health (water quality, sewage and sewerage, rubbish management), safe roads, immunisation clinics, parks, walking tracks and trails, swimming and other sporting infrastructure (formal and informal, e.g., Bellerive Beach pontoon), and land use management (including town planning decisions affecting housing, community halls and meeting places, incidental exercise, transport infrastructure and so forth). CCC also delivers multiple health and wellbeing-related programs (e.g., Age-Friendly City, Fitness in the Park, Dog's Day Out, youth services, asylum-seeker and migrant services, holiday Outside School Hours Care, guided walks). Many of Council's existing functions affect the social determinants of health, putting local government in an ideal position to support anticipatory care here. Further, local governments—both alone or as part of the Local Government Association Tasmania (LGAT)—can shape state and national policy.

CCC's strengths include its existing preventive health actions and its potential to reach communities and people who are not benefitting from services and supports—exemplified by the PSOs taking a Health Connector role. However, these strengths are undermined by:

- historical stigma attached to some parts of the community, which can impede equitable access to the AC system
- CCC's relative over-investment in hard infrastructure (buildings, paths, services) approach to public health that over-shadows support for soft infrastructure (relationships, knowledge, collaboration) which is essential for an effective AC system

- policy settings within CCC and other funding organisations, including short term funding, and planning decisions that do not take account of the social determinants of health
- local government is a critical actor in an effective AC system; Council should develop and embed a long-term strategy for promoting and supporting health and wellbeing in the community.

What did we learn; what could be changed to make AC work better (and for more people), and what might get in the way of improvement?

We learnt that:

- Some business models are preventing equality of access to the AC system. Many types of performance measures and KPIs privilege specific, tangible outputs rather than community outcomes, and do not capture the whole picture, leaving out things like new networks and relationships that are formed through activities. This includes models operating for GP and other health services, and for public transport. KPIs need to take account of the externalities, including social, environmental and community aspects of service provision. For example, an accessible, affordable local GP clinic not only supports acute and long-term health, but also has economic and social benefits for small communities.
- Local government is a vitally important part of the AC system as a key institution able to influence and shape the SDoH at the local level. CCC is already working to embrace a health and wellbeing agenda, as demonstrated by their involvement in the AC project and their Community Health and Wellbeing Plan (Clarence City Council, n.d.); there is now evidence to support the refining of existing strategies. Although they may not always identify 'health' as their core business, local government is actively involved in health, and so can act on the 'causes of the causes' of poor health. To do so would help strengthen the AC system overall.
- Project gains were supported by:
 - the provision of dedicated, AC-focused resources within the lead organisations: the PO and PSO
 - carefully listening to community members, and acting on what has been heard (e.g., Clarence Talks and TRP training)
 - very active outreach to services and residents, through the P/SOs, and
 - active engagement of a core of Leadership Group members and the project lead, Suzanne Schulz.
- Barriers to improvement of the system are at local, state and national levels:
 - key performance indicators and business models that do not factor in externalities, soft infrastructure measures, and experiential data cannot effectively support equitable access to health
 - local historical stigmatising attitudes to some parts of the community reduce external and internal opportunities to change

- CCC's centralisation means that communities need to 'do the reaching', rather than local government finding ways to reach all the municipality's 'villages' and ensuring equitable access; people in some parts of the city feel ignored
- some local, state and national policies and processes actively work against taking a SDoH preventive approach; this is evident in competitive and short-term funding models that reduce connection and collaboration between parts of the AC system, a lack of resources to support outreach, and continuing poor provision and distribution of necessary services (e.g., the continuing lack of adequate, local bulk-billing GP services).

Summary

The AC Action Learning Project in this site has resulted in increased:

- connections and networks with other service providers and with the community
- effective communication through these connections/networks to share AC knowledge
- service provider and H2H team capacity to create supportive environments for health (e.g. reception staff know about where people can get housing support), enabling more connections and networks between service providers and with community to be built
- engagement of some previously hard to reach people in health-promoting activities
- understanding of the importance of place and belonging in supporting anticipatory care and reducing the risk of and from chronic illness, and
- recognition of the effectiveness and health authority of the lead organisation.

Recommendations

The AC project has demonstrated that enhancing the AC system is possible at the local level through local government initiatives. The project has planted the seeds of new ways of thinking and working; we make the following recommendations to support long-term benefits to AC and the health of this community. There are opportunities to maintain and build on what has been gained.

H2H's four programs + Clarence Services Online Forum

The foundational H2H programs (The Right Place, It's OK to Ask, Clarence Talks, and H2H Friends) showed promise as activities that improve engagement, access to services and information for the community, and foster networks and partnerships across the system. Clarence Services Online Forum may build on this.

Partnerships and collaboration across the system are essential. The LG, supported by Council, has a role in building and sustaining collaboration across this site, and in shifting attitudes to support AC. They can also reach out to communities to understand local needs, people, and situations so that responses can be locally relevant, accessible, and meaningful.

- Council adopts and embeds a social determinants of health approach in all decisions and actions, including providing ongoing professional development in preventative health ways of working for all CCC staff and elected representatives

- Maintain the LG and links it is developing with services across Clarence (e.g., Community Nurses, health promotion groups)
- Encourage local service providers to incorporate outreach and collaboration as key tasks for all service providers working across the municipality, with a particular focus on the communities/villages with the weakest AC system

Performance measures or Key Performance Indicators (KPIs) have historically ignored qualitative measures of ‘soft infrastructure’ and change in favour of quantitative ‘number of services’ measures. These cannot adequately reveal how the AC (or other health and wellbeing) system is performing.

- Revise CCC and health service KPIs to reflect externalities, soft infrastructure and experiential dimensions of performance

P/SOs have supported the lead organisations and LG, reached out to community and to services, been involved in the research, and introduced new ways of working. Importantly, they have been the Council’s ‘eyes and ears’ in the ‘villages’ and have enhanced CCC’s ability to respond to local circumstances. They have developed capacity in action learning and systems thinking, and for gathering and interpreting evidence. Their links with the research team have been essential for our work, and for connecting the research with the reality and implementation:

- Establish the Health Connector as a dedicated function/role within CCC to support and enhance the AC system, including through:
 - physical activity, social connection and information sharing initiatives (e.g., Clarence Talks, H2H Friends, IOTA, outreach to ‘the villages’)
 - relationships with existing and new service providers and researchers to strengthen coordinated approaches to improve health and wellbeing across Clarence, and
 - innovation to address AC needs.

For local, state and national policy action

All levels of government have a role to play in efforts to alleviate chronic illness.¹ These recommendations to build on the gains from the AC Action Learning Project—and to spread those gains more widely—rely to a greater or lesser extent on recognising that shared role and shifting policy:

- Recognise that local government plays a central role as a system connector across local AC systems
- Prioritise creating dedicated Health Connectors in local government
- Local, state and federal governments need to develop KPIs that reflect externalities, soft infrastructure and experiential dimensions of performance

¹ These roles will be explored more fully in the final report.

- Factor the importance of place and belonging into policy decisions at all levels of government, including (but not limited to) infrastructure, service provision, town planning, and social housing
- CCC continue to advocate for funding arrangements that support and promote collaboration and long-term relationships.

Project-specific funding models are damaging the AC system. To better support the health and wellbeing of the community, we need:

- To replace competitive funding models that reduce connection and collaboration between parts of the AC system with models that promote and support collaboration
- Flexible funding over longer periods
- Funders should consider the adoption of community-level or place-based budgets where resources are pooled and invested to promote long term health and wellbeing
- Funders to work as partners, providing guidance and monitoring of process (e.g., community engagement, how resources are being utilised/targeted, without being prescriptive)
- Trusting local communities to identify their own priorities, and strategies to address those priorities.

GPs' potential role in the AC system can be supported if they adopt clear, transparent information and easily understandable guidelines explaining their bulk-billing policy and practices:

- Continue bulk-billed telehealth services, subject to evidence that this is improving access to GPs for members of marginalised communities
- Review national and state regulation of GP services to counter supply shortages and increase equity of access to bulk-billed telehealth (e.g., the recent guideline that only people who have a regular GP can use bulk-billed telehealth reduces access to this service for many who do not have a 'regular' GP)², and
- Review subsidies for GPs servicing rural and remote areas to include outlying and disadvantaged communities.

For future work on anticipatory care and preventive health

Gains from the project activities are difficult to measure in terms of chronic health outcomes within the life of the project. An overarching aim of the AC project was to use a systems approach to identify strengths and weaknesses in AC systems and to co-design community specific responses. Assessing the longer-term health dividends is beyond the scope of the study:

- A longitudinal study is needed to determine the level of benefit from the changes to the local AC system.

² Many people in areas with few GPs are not on a GP's 'books' and so may be excluded from bulk-billed telehealth.

Further flexible resourcing should be provided to build on this work.

Action learning and systems thinking have been effective here, but both rely on time and trusting relationships:

- Provide sufficient time in future anticipatory care work to develop relationships with local teams and communities, and to adapt processes and tools to maximise participation, and
- Introduce systems tools early and encourage their use—and adaptation—to suit local users. This could support the inclusion of more community members, first-hand learning about local systems (rather than through interpreters, such as researchers or members of the local site team), and thus support both genuine participation and local solutions.

There are clear mutual learning benefits for the university, the DoH and the H2H team in the approach taken here to working to enhance anticipatory care. The contributions made by each group are particular and cannot readily be 'swapped'. The ideal of equipping local communities to replicate the approach without these supports burdens them. Similarly, university researchers cannot ever become expert enough about a local site to work in ways that are inclusive and appropriate without partnering with locally embedded organisations:

- Future preventive health (including anticipatory care) projects should build in opportunities for mutual learning between community, university, and relevant government personnel.

Strengthening Connections: Anticipatory Care Action Learning Project Final Site Report, Clarence's Help to Health

Anticipatory Care at a whole of population level is concerned with reducing inequities through identification of geographic areas and/or specific target groups that are most at risk of preventable serious ill-health and/or deterioration of existing conditions. Key elements include screening, the provision of care pathways and appropriate interventions with monitoring and follow up.⁽³¹⁾ It could also potentially include assessment of preventative health needs across communities and at all levels of government to inform the development and implementation of plans to address identified needs.⁽³¹⁾ (Healthy Tasmania Chronic Conditions Working Group, 2018, p. 7)

Background

Chronic illnesses have replaced acute conditions as the major cause of ill-health and costs to the health system across the world. Chronic illnesses are conditions that are debilitating and long-lasting. Chronic illnesses can often be avoided, or managed so that people stay relatively well, able to participate in their community, and out of hospital. More than half of Tasmanians aged 15 years and over have three or more chronic health conditions. Only 15 per cent of Tasmanians reported having no chronic conditions (Department of Health, 2019). These rates are increasing. In 2017–18, there were 15,848 potentially preventable hospitalisations (PPHs) for chronic conditions in Tasmania (49.8% of PPHs). These rates are higher than for Australia overall, where chronic conditions account for 45.4 per cent of PPHs (Australian Institute of Health and Welfare (AIHW), 2019a).

Potentially preventable hospitalisations (PPH)

“PPH are certain hospital admissions that potentially could have been prevented by timely and adequate health care in the community. There are 22 conditions for which hospitalisation is considered potentially preventable, across 3 broad categories: chronic, acute and vaccine-preventable conditions”. Our focus in the AC project is on chronic conditions.

“The term PPH does not mean that a patient admitted for that condition did not need to be hospitalised at the time of admission. Rather the hospitalisation could have potentially been prevented through the provision of appropriate preventative health interventions and early disease management in primary care and community-based care settings (including by general practitioners, medical specialists, dentists, nurses and allied health professionals). PPH rates are indicators of the effectiveness of non-hospital care”.

Source: AIHW (2019b)

The COVID-19 pandemic adds to the risks for people with chronic illness. COVID-19 poses a particular risk to the elderly and people with chronic conditions (particularly diabetes, heart disease, kidney disease and chronic lung conditions); both groups have worse outcomes if infected (Bhatraju et al., 2020; Lippi & Henry, 2020; Yang et al., 2020). Tasmania's chronic illness rates and older population (Department of Treasury and Finance, 2018) make us more vulnerable to the worst outcomes from the virus.

Chronic conditions screening and management were identified as a priority in the Tasmanian Government's *Healthy Tasmania 5 Year Strategic Plan* (2016). The Healthy Tasmania Chronic Conditions Working Group responded by identifying and trialling new models of Anticipatory Care in Tasmania (Healthy Tasmania Chronic Conditions Working Group, 2018).

What is anticipatory care and how and why has this project been funded?

Anticipatory care models identify who is at risk of developing an illness and aim to keep people well. Anticipatory care is not a reactive system, but one that “anticipates health needs before they arise and that delivers continuous, integrated, preventive care with the patient as partner” (O'Donnell et al., 2012, p. e288). Effective anticipatory care reduces the use of expensive health and social services (Goodwin, Curry, Naylor, Ross, & Duldig, 2010). Historically, anticipatory care programs have been managed through general practices.

The programs combine:

a population approach with long-term productive relationships, between patients and professionals who know and trust each other, and who are guided by evidence and audit. (Watt, O'Donnell, & Sridharan, 2011, p. 2)

Anticipatory care relies on:

- trust and established relationships (between practitioners and patients)
- high quality data (about patients and their health)
- a non-fragmented system, and
- equitable access (Watt et al., 2011).

Anticipatory care involves health services and individuals (Martin, Sturmberg, Stockman, Hinkley, & Campbell, 2019), but the risk of developing a chronic illness is also produced by the social determinants of health (Marmot, 2005), the “material, social, political, and cultural conditions that shape our lives and our behaviors” (Marmot & Allen, 2014, p. S517). Julian

The social context

Along with the physical manifestation of disease, there is also a social context for people living with long-term poor health and their ability to engage fully in society. Many people experience:

- Disruption to daily life because of illness and or/disability
- Pressure on family and other personal relationships particularly where there is a reliance on informal care
- Regular or frequent contact with a range of health and community care providers particularly where assistance with daily living is required
- Difficulties in securing and retaining employment and maintaining an adequate level of income
- Increasing social isolation and loneliness
- Self-identity and self-worth issues potentially increasing the likelihood of mental health issues.

Source: Healthy Tasmania Chronic Conditions Working Group (2018)

Tudor Hart, regarded as one of the two founders of anticipatory care³ (Bonn, 1999; Tudor Hart, 1971; Tudor Hart et al., 1991; Watt et al., 2011), noted the problem of treating a patient but then sending them home to the conditions that had caused their illness. This link between social (and economic) factors and health is central to anticipatory care.

The Tasmanian Anticipatory Care Project

Preliminary work by the Healthy Tasmania Chronic Conditions Working Group (CCWG) suggested that anticipatory care in Tasmania was happening in many ways, not only in GP practices. The CCWG wanted to gain a better understanding of what is already happening in Tasmania, taking a broad view that accounted for the social determinants of health.

Aims

The Tasmanian Department of Health (DoH) received funding from the Australian Government to conduct research to better understand and learn from communities about different ways anticipatory care happens and what works well and why. Between late 2018 and June 2020, the Department and the University of Tasmania worked with four Tasmanian communities to apply an action learning approach to anticipatory care to:

- Increase our knowledge and understanding of how anticipatory care occurs in different communities
- Better understand the enablers and barriers to anticipatory care experienced by communities
- Increase our knowledge and understanding about how communities and health services can work together to engage 'at risk' Tasmanians in primary and preventative health care, including assessment and management of their health needs.

(Anticipatory Care, Project Guidelines, 2018)

The research questions

The CCWG engaged the University of Tasmania to work with the project site teams to learn how anticipatory care is operating in Tasmania, and what difference local factors, actions, and particular agencies make. The learnings and findings from the anticipatory care project will be used to develop best practice approaches, as information to support other communities to provide anticipatory care, and to inform future policies and funding models (Department of Health, 2018). There are overall research aims (see Box, above) as well as specific research questions. The research questions (RQs) for the whole AC project are:

Mapping	What does anticipatory care look like in each community? What are the shared elements and what are not? What is working, and who is it working for? What is not working, or who is not benefiting?
anticipatory care:	

³ The other is C. Van den Dool, a Dutch GP.

Opportunities for enhancing AC:	What elements in the existing system can be influenced (and are they within the capacities of local actors)? What gets in the way?
Actions and outcomes:	What actions are the sites implementing? What changes have the actions resulted in—what differences can be seen at individual, organisation, service and community levels?

In keeping with the broad scope of the project, the CCWG also wanted to get a better understanding of the roles of different sorts of agencies in anticipatory care. For this reason, there is an additional research question in each site. In Clarence, the lead organisation is the Clarence City Council, and the local research question is:

Help to Health RQ	What is the role of local government in Anticipatory Care, and can it be strengthened?
--------------------------	--

Choosing the locations and lead agencies

The Department selected four communities for the project on the basis of:

- Potentially Preventable Hospitalisations data over 3 years from 2012/13 to 2015/16 (inclusive of both the separation and actual rates)
- Australian Bureau of Statistics data including socio-economic indexes for areas (SEIFA)
- Qualitative criteria including for community development and readiness, local leadership and collaboration potential and ability to improve and innovate (see Farmer & Nimegeer, 2014; O'Donnell et al., 2012)
- Equity criteria, including ensuring a spread of sites across the three regions of Tasmania (north, north west and south) and a balance of urban and rural/remote sites

The selected lead organisations are a local government, a GP clinic, two neighbourhood houses, and an Aboriginal Community Controlled Organisation. This span of partners enables us to learn how an array of organisations support anticipatory care. This fits into a social determinants of health approach.

Ethics

Ethical approval for the project was gained from the Tasmanian Social Sciences Human Research Ethics Committee, with amendments approved as needed. The HREC project approval number is H0017669.

The characteristics of the Help to Health site

The Help to Health area takes in the municipality of Clarence (see Appendix 1). The project's lead organisation is the Clarence City Council (CCC). Clarence municipality is described as:

a city made up of a range of environments, from urban through to rural. Across the city there are a number of villages and activity hubs. You could call them community hubs. Over time these community hubs are becoming more distinct and have a variety of buildings, natural areas, parks and programs for the community to use and enjoy. (<https://www.liveclarence.com.au/about/village/community-hubs/>)



The municipality includes urban, rural and beachside areas, and pockets of affluence as well as real socioeconomic disadvantage. In Clarence, five suburbs rank in the most disadvantaged quintile, and one area is ranked in the most disadvantaged quintile in all four indices, IER, IEO, IRSD and IRSAD. However, six suburbs rank in the least disadvantaged, with the remainder clustering around the midway point.⁴ The table below (Table 1) sets out some characteristics of the site. It shows overall statistics for Clarence, for Tasmania, and for two suburbs: Clarendon Vale and Acton Park. These suburb statistics are provided to show the significant diversity across the municipality. There is clear evidence that people here are experiencing the social determinants of health very differently. You can read a more detailed community profile on pages 23–44 of the 2019 report (Appendix 4).

Table 1: Who lives in Clarence

	Acton Park	Clarendon Vale	Clarence	Tasmania
People	2,078	1,268	54,819	509,965
Age	43	31	43	42
Aboriginal	1.2%	13.1%	3.5%	4.60%
LOTE*	5.0%	2.2%	5.6%	6.50%
Income**	\$2,195	\$750	\$1,306	\$1,100
Living in rented accommodation	3.4%	63.3%	22.6%	27.3%
Highest level of education, Yr 10	14.4%	27.5%	15.8%	17.4%
Home internet	93.8%	34.2%	82.0%	78.0%
No car	0.0%	18.6%	5.9%	6.90%
Not in paid work***	3.3%	19.3%	5.2%	7.0%
Voluntary work	24.8%	10.7%	20.9%	21.30%

*LOTE = language other than English spoken at home. ** Median household weekly income. *** Full or part time paid work.

We gathered information about the location of GPs in Clarence (Figure 1). The maps show that GP clinics are clustered in the central business area of Clarence, around Rosny, Bellerive and Lindisfarne. This hub is well-serviced by public transport routes but is also distant from communities where chronic illness related to the negative social determinants of health is most evident. Rosny (median weekly income, \$1,447), Bellerive (\$1,175) and Lindisfarne (\$1,312) are also relatively wealthy parts of the city. One practice in a socioeconomically disadvantaged area (Risdon Vale—median income, \$960) bulk-billed some clients; this clinic was threatened with closure during 2019 but was reopened after community outcry. This is

⁴ Acton Park (5), Rokeby (1), Clarendon Vale (1; in the bottom 2% of Australian suburbs), Bellerive (3-4), Cambridge (3), Clifton Beach (5), Cremorne (5), Geilson Bay (5/2), Howrah (4/2), Lauderdale (3), Lindisfarne (3), Montagu Bay (3), Mornington (1), Oakdowns (3), Opossum Bay (3), Otago (4), Risdon Vale (1), Rose Bay (4), Rosny (4-5), Sandford (4), Seven Mile Beach (unranked), South Arm (3), Tranmere (5), Warrane (1).

one of a number of clinics offering limited bulk-billing, and there is also one clinic offering full bulk-billing.⁵ The Moreton Medical group provided a mobile health clinic to Clarendon Vale residents, but this has been affected by the COVID-19 pandemic; more broadly, the pandemic's effect on general practice makes assessing the current situation complex, as telehealth has changed bulk-billing options.

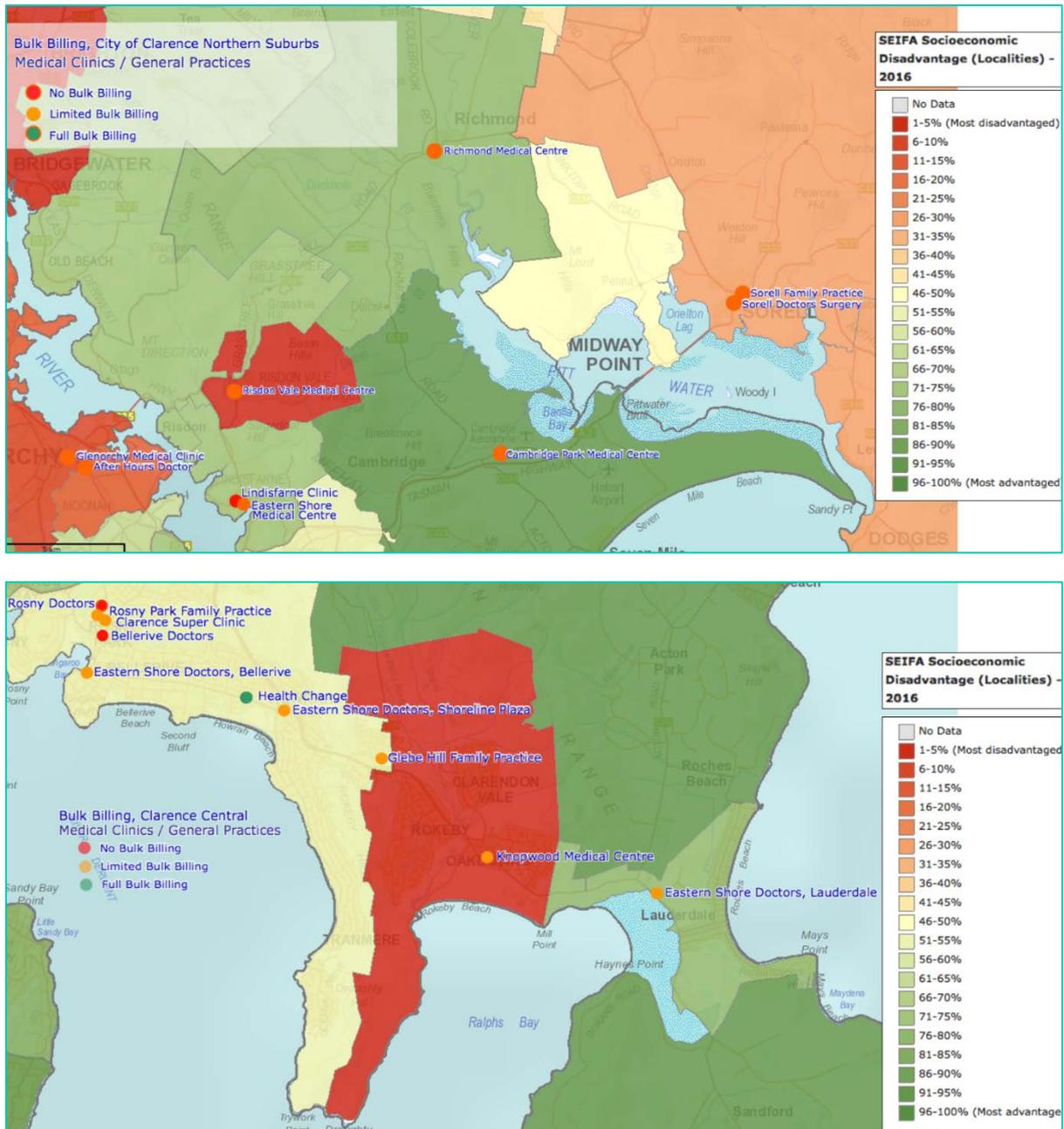


Figure 1: GP clinics and bulk-billing, Clarence northern (top) and central (bottom) suburbs, January 2019

Maps generated 08012019 <https://maps.thelist.tas.gov.au/listmap/app/list/map?bookmarkId=342082>
LandTasmania

⁵ Bulk-billing information for the map was gathered as if by a potential patient, using clinic internet sites and phone calls in early 2019.

It is hard to draw any overall conclusions about the community based on statistics, since the figures vary so significantly across Clarence, while overall data suggest the municipality is similar to the State as a whole. Access to several of the social determinants of health varies widely across the municipality; these include income, education, secure housing, employment, and access to health services (including bulk-billing health services). Further, the city has the State’s third-highest number of people per head of population with multiple chronic diseases, the Mornington–Warrane area has particularly high levels of potentially preventable hospitalisations, and Clarence was ranked second highest in Tasmania in average annual rates of alcohol attributable hospital separations for the period 2011 to 2015. In 2019, Risdon Vale was reported to have the second highest smoking rate in Australia (after Gagebrook) with 34.4 per cent of residents smoking (Mitchell Institute at Victoria University, 2019). Australia’s overall smoking rate is 14 per cent. We can also see the contrasting health outcomes in the potentially preventable hospitalisations data for Clarence (Figure 2). People in the H2H area are more likely to be admitted to hospital for things that could have been prevented (PPHs). The three most common reasons for these PPH were complications from diabetes, congestive cardiac failure, and chronic obstructive pulmonary disease.

People are good judges of their health. Researchers have shown a relationship between people’s (including children’s) self-report of poor or fair health and an increased risk of death (McGee, Liao, Cao, & Cooper, 1999; Miilunpalo, Vuori, Oja, Pasanen, & Urponen, 1997; Riley, 2004). People in Tasmania’s south are reporting slightly poorer health than Tasmanians overall (Table 2).

Table 2: Self-reported health in 2019. Southern Tasmania and Tasmania overall

	<i>South, overall</i>	<i>Tasmanians (aged 18 and over)</i>
<i>Excellent/very good</i>	38.3%	37%
<i>Good</i>	40.4%	41.1%
<i>Fair/poor</i>	21.1%	21.7%

Source: Department of Health and Human Services (2020)

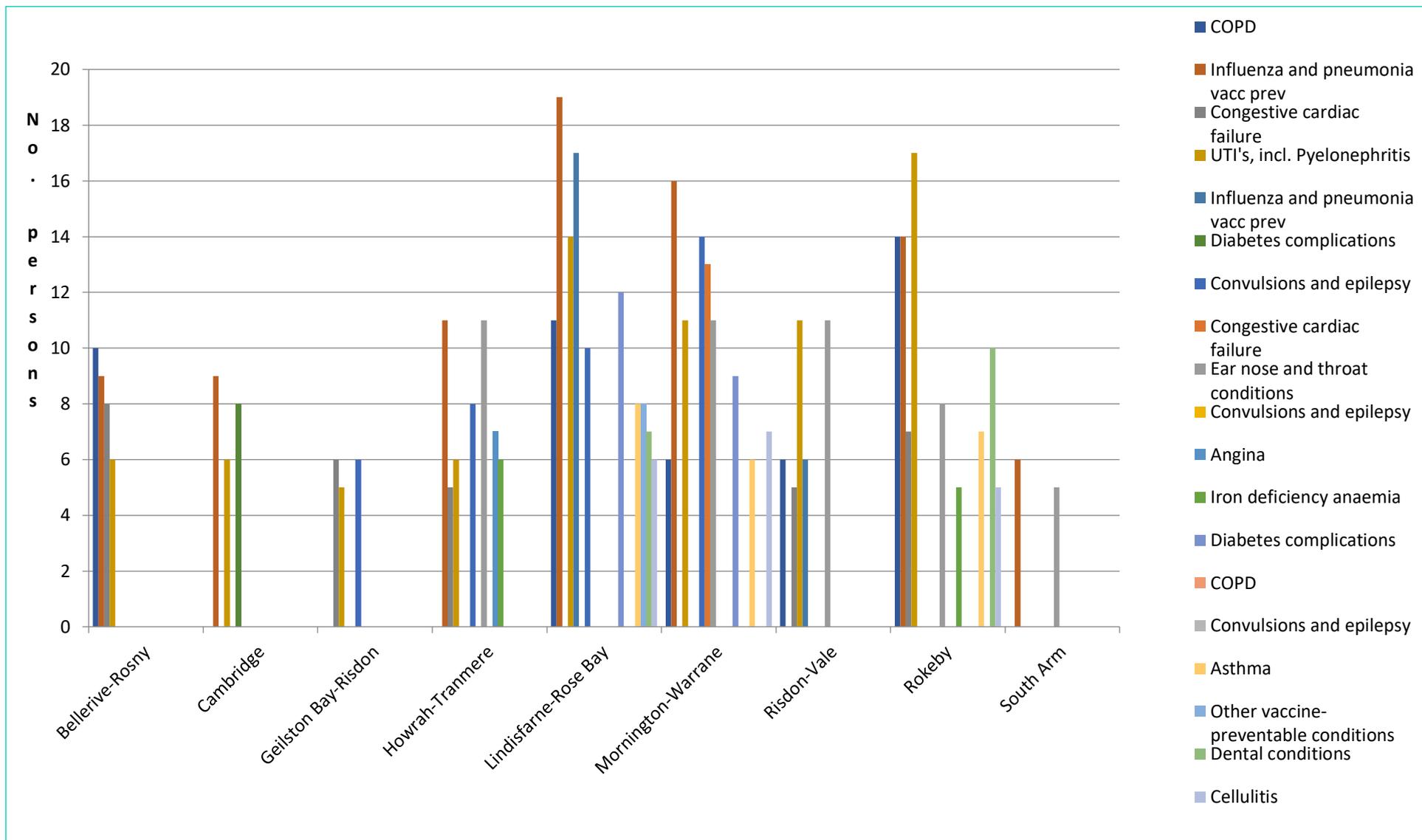


Figure 2: Potentially Preventable Hospitalisations 2017–18, Clarence (by location and number of persons)

Methodology—why we did what we did

Action learning + systems thinking

UTAS needed to find out what the anticipatory care system looks like in each site, and to work with the lead organisations to see whether the system could be made to work better through local actions. One of the CCWG's project aims was to test whether using systems approaches could give us better or more useful insights into this complex system and better understanding of how social determinants of health play out.



The CCWG engaged The Australian Prevention Partnership Centre (TAPPC) and Dr Therese Riley (Systems Consultant) as partners to help us apply systems methods. This supported mutual learning among researchers, the DoH Principal Project Officer, and the local teams. This learning was about the anticipatory care systems themselves and about ways to investigate those systems. Together, we identified six preliminary system parts to investigate (Figure 3).

Figure 3: The preliminary system parts

The CCWG proposed action learning as an approach that could help us learn together about the systems and about opportunities for intervention. The four parts of action learning are 'observe', 'reflect', 'plan', and 'act'. The diagram below (Figure 4) shows the action learning process. Action learning was used to find out whether the suspected system parts were present, to define them, and then to learn how the parts might be linked to or affect one another, and to learn about and adjust actions.

What can we find out about this system? What seems to be working-and what isn't?

What has our observation shown us? Is our view accurate? What and who are missing?

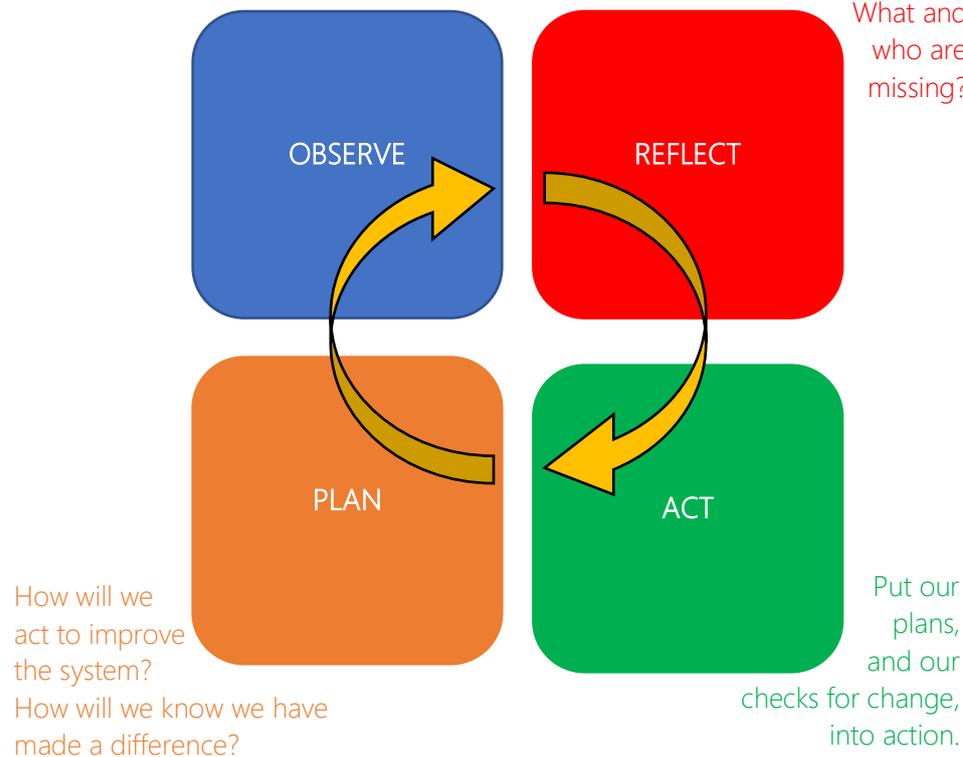


Figure 4: The action learning cycle

The theory behind action learning and systems thinking

A systems thinking approach looks at “all the connected and inter-related issues, at how changing one part will influence other parts and how relationships and behaviours change over time” (The Australian Prevention Partnership Centre (TAPPC), 2017, p. 3). The anticipatory care system is made up of multiple parts, interacting in different ways. We can use systems ideas to “. . . help us to conceptualise and work with complex issues” (Burns, 2007, p. 21) like anticipatory care. Systems thinking allows us to think about how anticipatory care operates, how the parts interact, and to learn what supports or hinders the system’s effectiveness. This ‘holistic’ approach means that the social determinants of health—as well as the structures and people—can be examined (Midgley, 2006). Once we understand the way the system works, we can plan actions to improve it (Hawe, Shiell, & Riley, 2009), and check on the effect of the actions taken (Trickett et al., 2011).

Interrelationships, boundaries and perspectives are important in systems thinking (Williams & Hummelbunner, 2010). In anticipatory care, interrelationships refer to the connections between health, social and community services, between professionals in the system, service users and local residents. Boundaries focus on who is considered inside or outside the system and the range of boundary judgements that are made by health professionals,

community, and researchers (see Ulrich and Reynold 2010). Perspectives pay attention to whose views or voices are deemed more or less important in determining the nature and extent of anticipatory care (see Williams & Hummelbunner, 2010). These ideas remind us that complex systems are dynamic and unpredictable (Midgley, 2010). (Appendix 2, taken from the project's PSO manual, gives some examples of interrelationships, boundaries and perspectives.)

Action learning and systems thinking are good partners (Burns, 2007). Action learning is part of a group of approaches that are participatory, collaborative, reflective and involve learning and action for change. Action learning, action research, collaborative enquiry and participatory research are related ways of working. These approaches are used to explore and—if necessary—change an existing system. To do that effectively, we need to understand the many worldviews and parts of a system (Dick, 2009); this is sometimes referred to as an holistic understanding. The processes of observation, reflection, planning and action, undertaken with the people in a system, mean we can gain that holistic picture, recognise opportunities for change, and see how change is affecting the system.⁶

Methods—What we needed to learn and how we gathered and analysed data

The site's lead agency is Clarence City Council (CCC). At CCC, the lead is the Community Planning and Development Officer, Suzanne Schulz. CCC had an existing Help to Health Community Development Project Officer, Kate Franke, and she was joined by Emily McKinnon (the project support officer, PSO) in early 2019 to work with the community and the UTAS team. Kate left her role in October 2019, and Emily in January 2020, before the contracted end of the AC project. Help to Health had an existing Leadership Group, made up of local residents and representatives from services working in the area; for the AC project, they were joined by the UTAS lead and the DoH Principal Project Officer. The LG has met regularly over the life of the project. The lead, PSOs, and LG members are the H2H team. The team, with UTAS researchers and the DOH Principal Project Officer, worked using an action learning approach. The project roles are shown in the 2019 report (see Appendix 4).

Action learning is a cyclic process that gives us repeated opportunities to learn, plan, act, and check on the effects of those actions.

 Observe: What can we find out about the system? What seems to be working and what isn't?

In each project site, we began by learning about the local anticipatory care system: who lives here, what are their characteristics, including their current health, and what attitudes, relationships, organisations or structures may be affecting their long-term health. In this 'observe' stage, we looked for a wide range of information in order to include different perspectives. We used census data (Australian Bureau of Statistics, 2016), health information

⁶ Dr Therese Riley provided much of the material about systems thinking in this section.

from Primary Health Tasmania (PHT) and State of Health reports, previous and current research in other projects, community audits and surveys, and interviews with local service providers (Appendix 3 details data gathered, and you can read more about the process in our first report, attached at Appendix 4).

R

Reflect: What has our observation shown us? Is our perspective accurate? What and who are missing?

We analysed (reflected on) the information from the perspective of the six system parts and created preliminary local system maps. We included the local community in our reflections. To do this, the maps were turned into posters (see Appendices 9 and 10), and a series of narrated videos, and shared at a community workshop (H2H held a workshop on 4th July 2019). This was another way to include more perspectives. The analysis processes are described later in this report.

At the workshop, community members were asked what was working, not working, confusing or could be changed about the anticipatory care system, for each of the six preliminary system parts. They were invited to use sticky notes to add their responses (examples, stories, or problems) to the posters. Research team members made fieldnotes during the sessions and collected the posters and sticky-notes and the butchers' paper notes made by participants. Researchers also identified potential interviewees and focus group participants who then contributed to the observation and reflection stages. The research team, a researcher from the Sax Institute, and the DoH Principal Project Officer, Flora Dean, wrote out their notes after the workshop. All the data from the workshops was included in the ongoing analysis of the system.

We found strengths in the system, as well as barriers and opportunities. The analysis results, including a revised system map, and the barriers and opportunities, were reported to each site in mid-2019 (the report for this site is attached as Appendix 4) and discussed with the LG). The LG was then invited to use this information to begin the planning phase.

P

Plan: How will we act to improve the system? How will we know we have made a difference?

We used four questions to support the planning process:

- Given the findings, what are the 3 top priorities that you think Our Community Our Care should work on? This includes who the project will target.
- Is there something that is achievable and sustainable that can be tried/done to improve or address one or more of the issues identified by the research?
- What difference do you think the proposed action will make in terms of improving the health of individuals and/or the community? How will it contribute to the prevention/better management of chronic conditions?
- What are the ripple or flow-on effects of the proposed actions?

Actions planned needed to respond to local conditions, people, needs and boundaries. For instance, how might particular groups be reached?

For some individuals, a mailed letter might suffice; for some, an advertisement on the radio; others will need a recommendation from a close friend or family member; others will need more concerted efforts and some may not respond to any type of approach and only be contactable when they attend for another reason. (Watt et al., 2011, p. 6)

The planning process resulted in a set of proposed activities intended to enhance part of the system or reduce barriers to it working well.

Planning was supported and refined using a systems thinking tool, causal loop analysis. We ran causal loop analysis workshops at each project site. The participants were local AC project staff (lead and PSOs) and members of the Leadership Group. The aim of causal loop analysis is to make sense of the system parts, discovering how they are linked and affect one another (the interrelationships) (Figure 5). The causal loop diagram (CLD) process can be used for the whole system, or for parts of it. Making a diagram of this system and its links is also useful for checking the accuracy of the system map and for predicting and testing the potential outcomes of any planned actions. The process is outlined at Appendix 5. At each session, the group focused on a particular barrier or opportunity in the anticipatory care system, identifying the supporting and confounding factors (variables) and causal links. We wanted to learn, in this process, how strengthening one factor might affect others, and where we can intervene for the greatest impact.

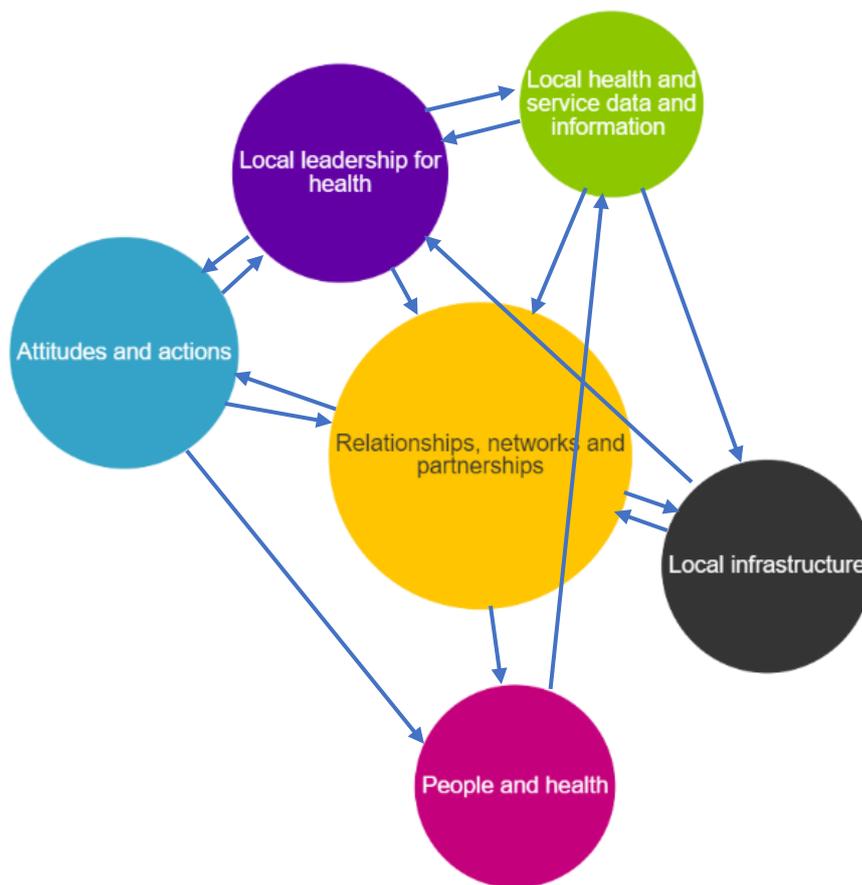


Figure 5: Linking the system parts

The PSOs, guided by the LG and causal loop work, made an action plan (see Appendix 7). The action plan⁷ set out:

- The FORM: A description of the activity, including information about the tasks/activities, as well as the timing, the responsibility, and the resources.
- The FUNCTION: Information about the intended outcomes, and the people it is intended to involve and affect, including a description of the deliverables/milestones.
- The possible RIPPLE EFFECTS: What might flow from the activity—the less-intended consequences (including risks as well as benefits), and
- The MEASURING: Measurements of effect for proposed activities; how will the activity's effects be measured, and how soon?

Causal loop diagrams were also used at the end of the Anticipatory Care project to reflect on the impacts of the activities on the system. We used a second systems thinking tool, systems traps (Meadows, 2008), in the PSO Community of Practice and with teams from across the AC project state-wide to look for and consider solutions to potential problems in the system and activities.

A Act: Put the plan—and the checks for change—into action

Planned actions were agreed to by LG and implemented. In some cases, implementation involved mainly the local PSOs; in others, actions involved other people within or outside the lead organisation.

 Action learning is a continuous process

During the life of each action, PSOs, the LG and leads reviewed progress, using the observe, reflect, plan and act process. Regular meetings between the leads, PSOs, UTAS researchers, DoH Principal Project Officer and LG members tracked how the actions were progressing, flagged successes and difficulties, and negotiated next steps to improve outcomes. Some adjustments were made to adapt the activity to the local circumstances and experience.

Project structure and roles

The project structure, roles and relationships are given in Appendix 4 (page 18).

Local activities

All sites took many actions. Some of these were formally planned, and some took advantage of opportunities that arose. Activities are discussed in the Results section below, in the final

⁷ The project action plan has been reviewed and revised as the project progressed.

report prepared by the H2H team (2020), and in the evaluation report prepared by Mel Maddock (2020). The box below presents some project statistics.

Some AC project statistics for the H2H site

H2H and research activities:

Data gathering and sharing activities	134 people
The Right Place training	41 people in 8 organisations
It's OK to Ask training	6 sessions
Clarence Talks (from January 2019)	17 Talks
Help to Health Friends	22 Friends registered
The LG	19 members, meeting six-weekly

These numbers do not, however, adequately show the broader potential impacts of the H2H work (e.g., impact on community members of more informed peers through Clarence Talks, or IOTA, more welcoming services through TRP).

R

Analysis: Reflecting on what our observation has shown us

The 'secondary data'—health statistics and previous research reports, for instance—were used to describe the context of the project. We then created preliminary system maps, and the community profile. Secondary data helped to inform the questions we asked in qualitative data gathering, and in the surveys. Some survey questions produced quantitative results, which were analysed statistically.

Qualitative analysis starts during the data gathering. Researchers conducting interviews, focus groups and observation are actively analysing what they are hearing, recording this analysis after sessions as fieldnotes. We also transcribed the interviews, focus groups and observations, qualitative survey responses, and reflections (e.g., from PSOs) and removed things that would link them with particular people (and, where needed, places). These documents were then entered into NVivo (version 12), a program that supports researchers to identify major themes (thematic analysis). Individual members of the research team are working on particular sets of documents, but each researcher is also analysing documents from other batches, to check whether we agree with one another's understanding of the material (this multiple coding, also called inter-rater reliability, is discussed in Armstrong, Gosling, Weinman, & Marteau, 1997; Barbour, 2001; Kitto, Chesters, & Grbich, 2008).⁸ We have regular whole- or part-team analysis discussions about what we are finding in the data. This has been a complex and dynamic conversation.

⁸ There are also arguments that researchers should "trust their judgements and be prepared to defend their interpretations and analyses" (Morse, 1997, p. 447) in the face of the push for inter-rater reliability.

Analysis will continue as we prepare the whole-of-project final report. We also review and revise our thinking in conversations throughout the project with the project lead, the DoH Principal Project Officer, Sax Institute and TAPPC researchers and Dr Riley, the LG and the P/SOs. These are all important opportunities for reflection.

Analysis informed our mapping of the anticipatory care system and identified opportunities for intervention in the system. We prepared a written report of the findings from the analysis to date in 2019 (see Appendix 4) and presented this to the LG.

Our other main analysis method is causal loop analysis, which is described above (and in Appendix 5). Causal loop analysis brings together the themes in the quantitative and qualitative data, as well as enabling participants to add what they know or have experienced to the diagram.

We conducted two causal loop diagram sessions (in 2019 and 2020). At the first session, we worked on one of the opportunities for intervention in the system identified in our analysis. At the second, we asked participants to review the system—its boundaries and interrelationships—bringing their experience of the project to the analysis. The CLD sessions in community are part of our ongoing analysis. The research team created activity-specific, opportunity-specific, whole-of-site, and whole-of-Tasmania diagrams of the variables and causal links in anticipatory care (the whole-of-site and whole-of-Tasmania analysis will be reported at the end of 2020). The diagrams enable us to understand the present state of the system, how various actions may cause changes in and across the system, and to later check what, if any, changes have taken place.

Findings

The results reported here are for the pre- and post-activity action learning cycles. The post-activity results include what we learned about activities in progress. We report the analysis results under the following headings:

- Survey data
- Thematic analysis: Interviews, fieldnotes, focus groups, reflections, and observations
- Systems work and causal loop analysis
- Project processes

The gathered data are described at Appendix 3. We reported on our use of health statistics and previous research (secondary data) in 2019 (Appendix 4). That material showed that people living in some parts of the H2H area have higher rates of chronic illness and potentially preventable hospitalisations than Tasmanians overall.

Context

Perhaps the most important thing about local government is that it is well positioned to address some of the geographical/local/place barriers. We know that Clarence City Council already understands and values the local, the 'city of villages' way of thinking about this

municipality—the geographically, demographically, and culturally diverse nature of its communities. This theme appears across many Council documents (e.g., The Community Health and Wellbeing Plan, Age Friendly City program). City councils are also the level of government closest to citizens, and are responsible and answerable (politically and legally) to the most local of concerns, communities and differences. As well, they have personal and historical linkages to local places and people, making council well-placed to reach into community and community institutions and organisations and have an impact on anticipatory care.

Survey results

Survey responses told us about how participants think about health, what elements in the system they use, and what gets in the way.

We designed the survey to learn about other perspectives of the system and what boundaries and interrelationships may be shaping it. Surveys were also a way to hear from people who might be unwilling to be formally interviewed about the anticipatory care system (see Appendix 3). Several approaches to gathering this information were suggested (for instance, a PSO in a different site proposed a way to gather information that did not require literacy). For pragmatic reasons, an interviewer-administered pen-and-paper survey was developed, piloted in two sites (Clarence and Flinders Island), and revised to meet Plain English guidelines by the Clarence P/SOs. This is an example of action learning; trialling the survey enabled the P/SOs to see what changes could make the survey more useable. The revised form was interviewer-administered by the local P/SOs and a member of the research team.

Forty-two people completed the survey in 2019. Although this number is fairly small, going out into the community to recruit possible participants had other benefits. The P/SOs and researcher were able to meet people in many settings, get a sense of what is available in various parts of Clarence, and of how people use their community. This outreach has been valuable for building an understanding of the community and the health system across this diverse site and for connecting with a wider range of community members. The results of the surveys in Clarence are reported in full at Appendix 6.

Main findings from the Connecting Care survey

We asked people very general questions about health and how they understood it. We needed to include all sorts of perspectives—what language people use, who thinks in what ways—so we could understand the AC system. We wanted to be as inclusive as possible of the ways people think about health, rather than asking only about medical or clinical health. People mostly defined ‘being healthy’ in non-medical terms. The overwhelming theme here was ‘being active’. Mostly this meant going for walks or getting some exercise. A second theme was “*being able to do what I want/need to do*”. Only a small proportion of people talked about the social aspects of health, and a similarly small proportion gave medically-focused definitions.

Two-thirds of respondents wanted to change something about their health, with getting fitter or building strength being the focus. There was also a theme of losing weight and eating “better”.

We also asked people how they would rate their health. Self-reported health has been found to be a reliable measure, including predicting a person’s likelihood of becoming ill (Miilunpalo et al., 1997). Slightly more than 70 per cent of the participants rated their health as ‘excellent’ or ‘good’. This is a slightly poorer result than has been reported by Tasmanians overall. In 2019, 78 per cent of Tasmanians, and 75 per cent of people in the State’s north, self-reported their health as ‘excellent’ or ‘good’ (Department of Health and Human Services (DHHS), 2020).

Talking about health

We asked participants “Who do you talk to about your health? (your ‘go to’ person)”, in the categories of family, friends, people who are not family or friends, and health care professionals. Most people said they spoke to family members (usually spouse/partner or children), and to health professionals (most frequently GPs/doctors, pharmacists, physiotherapists, and mental health professionals).

Health supports

We asked people about their social, physical, and ‘medical’ or clinical supports for health. Only one person did not report doing anything for their social health, eight did no physical activity, and eighteen did not seek medical support for their health. Walking was the most common physical activity (and respondents were enthusiastic about the many tracks and beaches for walking on). Almost a quarter said they were doing two or more regular physical activities (Figure 6).

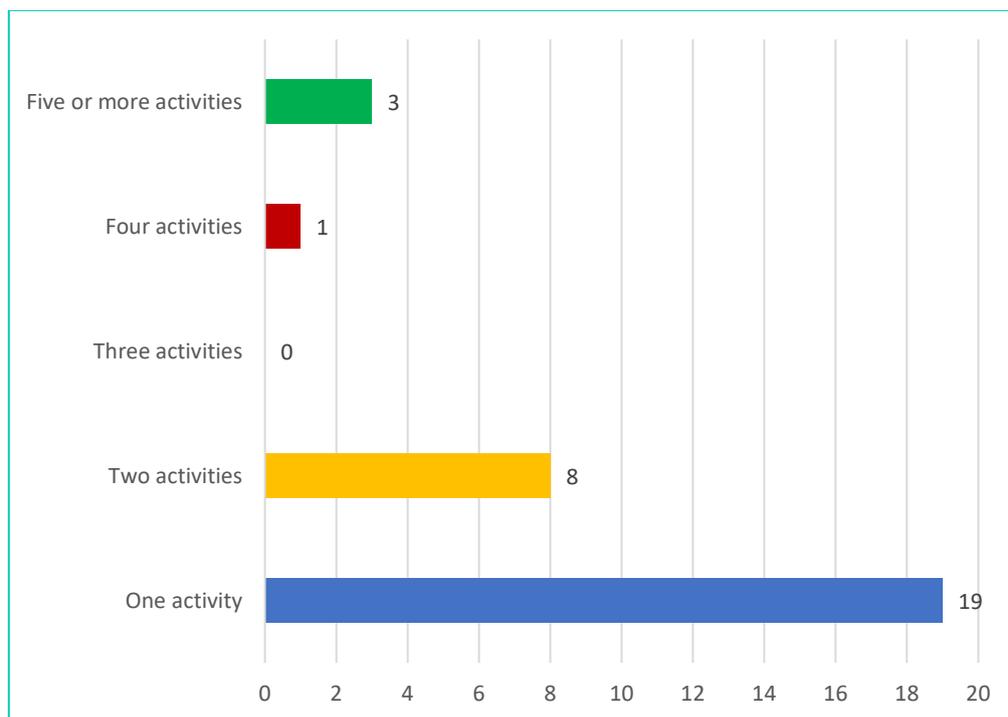


Figure 6: Number of physical activities reported by respondents

Most of those who sought medical support went to a GP. Figure 7 shows where people sought clinical health support.

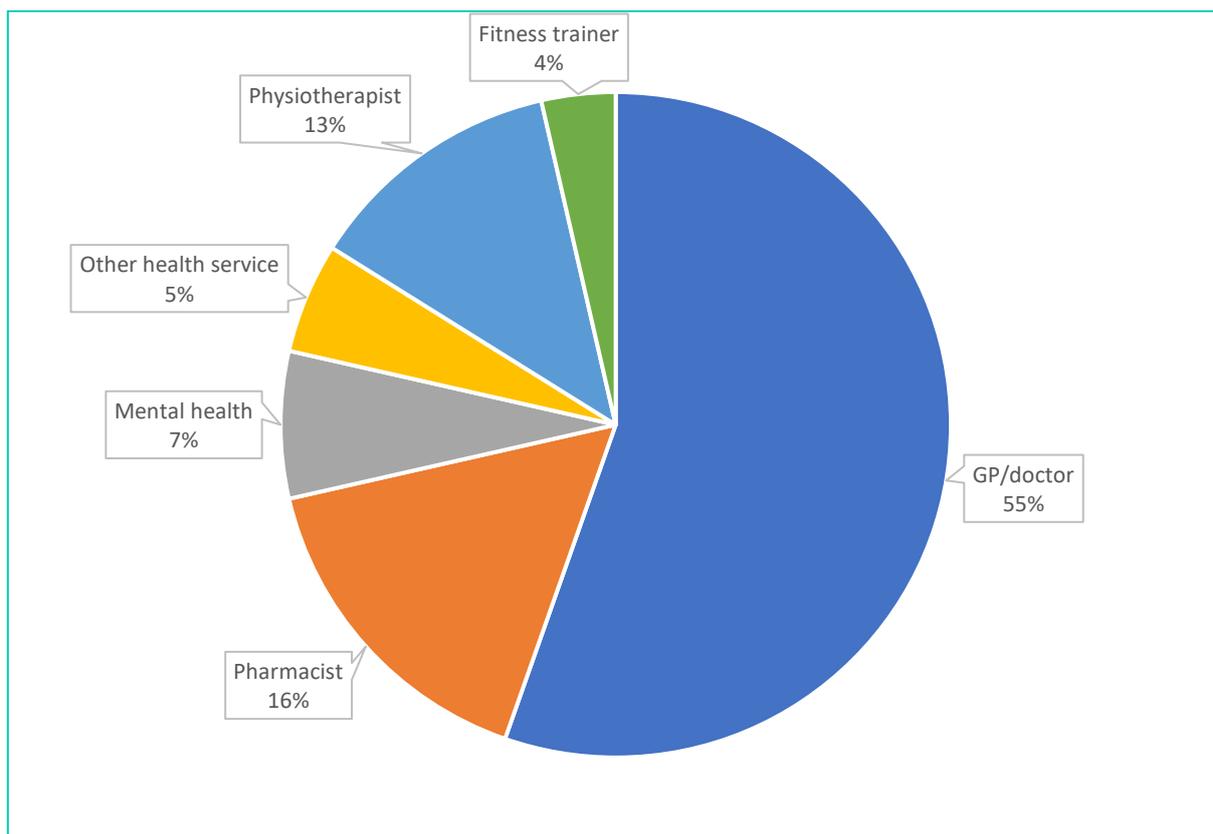


Figure 7: Where respondents go for clinical support

Barriers to maintaining your health

Participants were asked about things that get in the way of them maintaining their health. Cost was the greatest barrier. People were also invited to comment on this question or list other barriers. These responses sometimes re-iterated barriers ticked (e.g., “Bus timetable doesn’t suit”, “Need transport due to vision imp. Wife drives or bus”) or raised separate problems (“Difficulty walking from car parking”, “I am from interstate and find it difficult at times to integrate”, and “My age, for example, my knee stops me playing footy and indoor cricket”). We compared the barriers reported by people across the four project sites (Figure 8). It is evident that for this sample, there are fewer barriers than reported elsewhere. Of the barriers noted, cost and transport are the most common, but motivation and confidence also play a role.

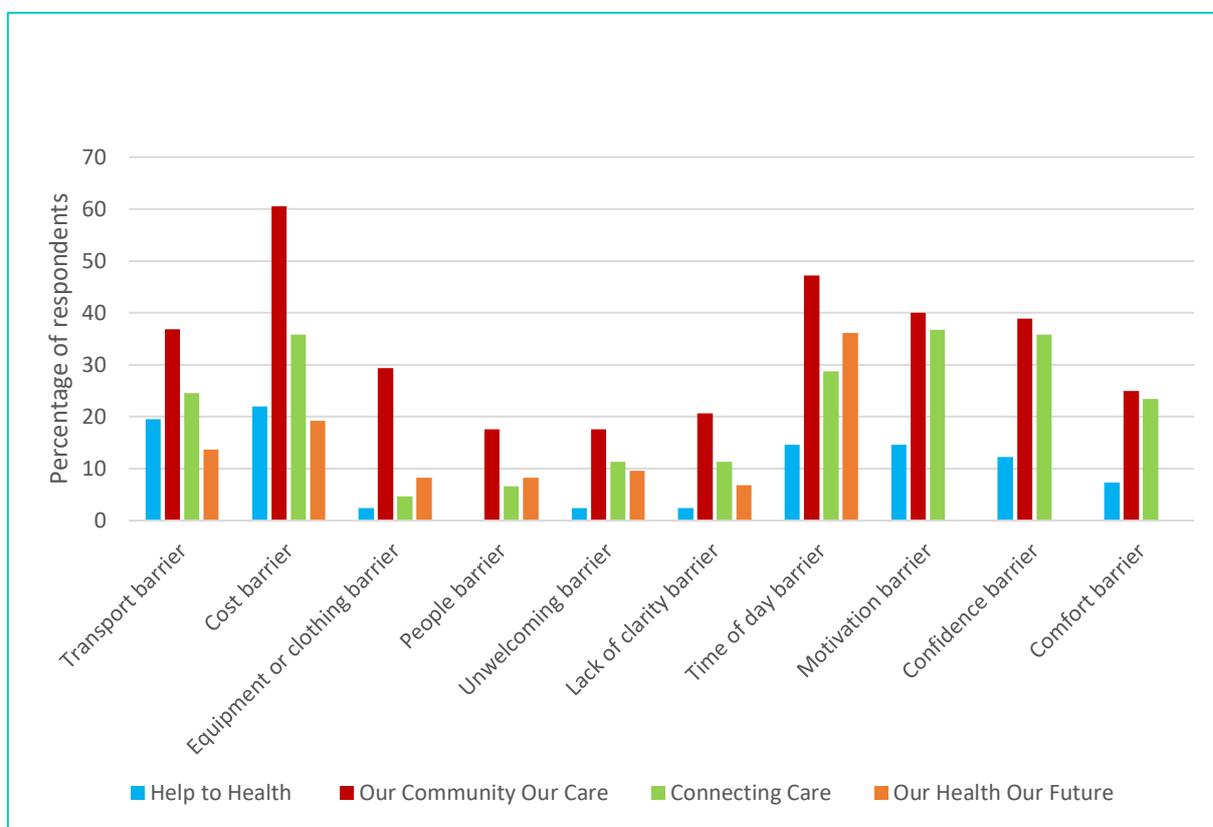


Figure 8: Barriers to using health supports across the four Tasmanian AC sites

These results are indicators only. The sample was small, and not representative of the community overall (including being much older than the local population and including a much higher proportion of women).

Thematic analysis: Interviews, fieldnotes, focus groups, reflections and observations

We are analysing the qualitative data by themes. These themes were both ‘given to us’ (the research questions, the system parts and the AC framework) and emerge from the analysis. Although the survey sample was not representative, several of the themes and barriers participants identified there are also present in the thematic analysis.

Themes in the data

Anticipatory care has been described as relying on ‘routine encounters’ where there is trust and established relationships, a non-fragmented system, and equitable access to those system parts (i.e. affordable services, that are within physical and social or cultural distance of citizens, and that have ‘humane’ staff) (Watt et al., 2011). The systems parts we used also enabled us to identify how these essentials appeared in Clarence. The last, equitable access, was the over-riding factor here, affecting whether the system works well. Acting to increase access is an opportunity to build a better system

Access takes different forms across the system parts. For instance, for the system part Place, access is about feeling safe, that you belong, and that the services or other infrastructure (e.g., parks or public spaces) are cared for and valued by locals, the broader community, and policy makers. This might be evident in the form of well-cared for paths, or public toilets, or play equipment. Attitudes and beliefs (another system part) also affect access. At the local level, the attitudes and beliefs of service staff can create welcoming places or build barriers through negative judgements and stigmatisation. Policy (whether organisational or governmental) is shaped by attitudes and beliefs; low cost, frequent public transport, town planning that follows social planning ideas, or health policy that takes an individual-responsibility or a social determinants of health approach are all products of attitudes and beliefs. Combining the knowledge we have gained of the system parts, access can be thought of as:

- Geographical and physical access—people need to be able to get to the services or places where a health-benefiting activity takes place, and once there, understand the signage, and get in (e.g., is the place usable by people with mobility or vision impairments).
- Emotional or psychological access—people need to feel safe and comfortable to use the service or facility, through welcoming, knowledgeable, and familiar staff, for instance. This combines with social access—people need to feel they are not being judged or stigmatised, and that the ‘culture’ of a place or service will be safe.
- Access to resources—access to many services, and even to places like parks or walking tracks, relies on resources. People need to have the right equipment to do an activity, whether that is shoes, bathers, a particular level of knowledge, or a bus fare.

These access themes overlap throughout the data analysis.

Geographical and physical access

Fit-for-purpose infrastructure is one of the system parts we identified through causal loop analysis. Fit for purpose infrastructure supports health by enabling access to AC services, places, and programs. It is locally available (e.g., fast, inexpensive, and reliable mobile and landline phone services and internet)⁹ or easily accessed (e.g., by walking or public transport), designed to meet the needs of everyone, including those with mobility, vision or other impairments, and is easy to find out about and use.

People in Clarence do not have equal access to fit for purpose infrastructure. This is partly a product of the city’s spread (378 square kilometres), the diversity of its geography, socio-economic differences, and its nature as a ‘collection of villages’.

A collection of villages, but services are centralised

Despite the dispersed population, many services are centralised in the Rosny/Bellerive area. Further, as well as physical divides between parts of the municipality, the Derwent River

⁹ TasCOSS has reported that access to the internet (‘digital access’) remains a significant problem for many Tasmanians (Tasmanian Council of Social Service Inc. (TasCOSS), 2019b). Three Clarence suburbs are among those in Tasmania with the poorest home access to the internet; this correlates with having the greatest socio-economic disadvantage.

separates Clarence from Greater Hobart and services there, expressed in terms of ‘a moat’ (a theme expressed more recently as a barrier to the spread of COVID-19 (see Figure 9)).



Figure 9: *The Mercury* hoarding, 20th March 2020

People who rely on public transport are disadvantaged by the centralisation of services in Rosny/Bellerive. For a resident of South Arm, for instance, the Metro Tasmania bus journey (35 km) into Rosny is infrequent and takes at least an hour and twenty minutes:

Buses take too much time. “Have to take an early bus to make sure [we’re] there on time”. Doctors’ appointments “can take all day with waiting and connections”.
(Fieldnotes)

People with mobility impairment are deterred by long walks to and from bus stops or services, especially where there is hilly terrain or poorly maintained footpaths (fieldnotes).

The scarcity of local services (particularly GP clinics) was emphasised by people at either end of the municipality, a concern that was exacerbated when the clinic at Risdon Vale faced closure in 2019:

I mean, if our health centre should close, there are over 600 people that need to be placed and they’re mostly older people. So, mostly those over 60 are the ones left down here and most of them would have chronic conditions. Where do they place them, I don’t know? There’s, you know, I don’t know, what can you do, the hospital’s overcrowded. We’ve rung five doctors on the eastern shore, they’re not taking new patients. (Interview)

“Not taking new patients” is a common problem across the AC project sites. GPs—even when physically accessible—may not have room for more people on their books, or have few appointments available. This sort of access problem also affects the timeliness of “elective” procedures, and of receiving aged care or disability support. Delay can be scary and genuinely dangerous for those with chronic, potentially life-threatening conditions. People seek other solutions, including (increasingly) asking pharmacists for treatment and medical advice:

...I know if you have an issue today, if you don’t have a regular GP, you probably can’t see anyone for a—not for a few days anyway. We have patients who want to see their own GPs and it’s a two-week waiting list to get in to see their own GPs. So that’s a bit of an issue as well. And maybe that’s another thing, pharmacies being fairly accessible, we’re getting asked to provide a lot more now because of that. (Interview)

During fieldwork, researchers spent time in various services, including a pharmacy, where they saw multiple examples of people seeking help—with wound dressing, and advice about blood pressure, for instance. There are also attempts to counter physical distance (or the cost of providing local services) via online offerings, but these are not necessarily reaching the disadvantaged:

The car park will be full of people accessing our free Wi-Fi. But you know, they can't afford – that's all like a luxury really. The internet....It really is. And it's one of those things that's an expectation and it used to annoy me with say the government has a two-step, do your reporting online for Centrelink. Do this online and people go, I don't have access on my phone. I don't have internet at home. (Interview)

Another program to address this need is the mobile GP clinics operating in Clarence since 2016 (see Box).

Geography and physical access are also linked with the system part Place and belonging. Clarence's village structure brings benefits. The analysis showed the value people gave to feeling connected to a smaller place, with its particular identity, community, topography, history and—as the moat idea shows—insularity. This village thinking is actively promoted by Council, but runs counter to the centralisation of services, and is not always supported by town planning decisions:

[Local] meetings are often small groups in small halls—these are local hubs that provide spaces for “village” community. When one is lost—the infrastructure—hall, the church—what is lost is that space/place to come together. In the case of the church—people still worship—but they have been spread out across different places. This breaks community bonds. Participants spoke about increasing fragmentation of communities and villages—this is a cause of isolation. Lack of helping each other (not the church specifically—more the loss of local connections, community spaces). Speaker calls this the “thoughtless destruction of community”—and the discussion goes on to talk about how these sorts of things—the intangibles—are not considered or perhaps valued in planning—private, church, NGO, Govt.. This is also to do with wanting local services—doctors etc. You come. You sit in the waiting room with people you know. Community. Your place—your services, safe because it is home. (Fieldnotes)

The loss or closure of local facilities like halls may seem a trivial concern, but social connectivity and inclusion are part of an effective anticipatory care system. Social inclusion is a determinant of health, and accessible, local places and services support people to remain active and connected to others in the community.

Box: Equitable access: The Moreton Group model

The Moreton Group's mobile clinic is one solution to the problem of mobility and access. It has been providing bulk-billed services at Rokeby Neighbourhood Centre and Clarendon Vale Neighbourhood Centre. The H2H PSOs made connections with this service and with the neighbourhood houses across Clarence, including supporting local capacity to advocate for services.



The program has been running since late 2016, and has demonstrated:

- “The importance of partnerships with community groups to reach those most in need and who are hard to reach using traditional methods.
- The challenge engaging GP’s to participate in clinics. GP’s who are established in private practice are, in many circumstances, already working to capacity. MGMS intends to offer positions for one session of four hours per week paid at a sessional rate in an attempt to address this issue.
- The advantages of providing community-based medical care in a non-judgemental environment where people feel safe and secure.
- The benefits of taking preventative healthcare to vulnerable people.
- The recognition of the link between social determinants such as poverty and homelessness with poorer health outcomes” (Healthy Tasmania Chronic Conditions Working Group, 2018).

Emotional, social and psychological access

Our analysis shows that emotional and psychological safety are key factors in access. Place and belonging can help people feel welcome and valued, and to avoid being stigmatised:

We need to be able to take them out more. We need to be able to get them out of the community. We have kids here on motorbikes and they were buggers ... We took the kids, the cops came in, we got all the kids together with their motorbikes and we took them down to [site] so they could have a ride. Well they just sat there. They didn't ride the motorbikes. Because we took them out of their comfort zone. And they didn't want to get on their bikes ... All the confidence in the world here, mate. They were little buggers and they'd mouth off at me, but if you take them out of the community, there's no confidence, there's no, they don't feel secure. (Interview)

I know [our suburb], a chunk of [our suburb] kids don't go [to school]. And they don't go because they don't cope with [high school in wealthier suburb]. They don't feel like they

fit in. And the school will tell you that. The kids, they said [our suburb] kids are different. They all stay together. [Wealthier high school's] got all these students that they don't mix. They're really funny. And if you take on one [our suburb] kid you take on the lot. They stick together like glue. But they don't fit in. (Interview)

Fitting in and feeling normal in a setting is important for the AC system. A pharmacist told us about their role in the needle and syringe program for intravenous drug users:

... the customers or the clients that use that service here, they see it as a point of normality. Because there's actually a primary outlet [in Rosny] where they get three supplied, but they don't want to use that because they're seen as being an intravenous drug user if they use that thing. Whereas coming to pharmacy is a normal activity, so they actually come and get their needles from us because it's part of a normal activity... [The person] running the primary outlet [...] said that that's why we see a lot of clients that she doesn't see—and often they might be taxi drivers, and you go, okay, we've got taxi drivers that are using drugs, or tradespeople that work on roofs and things. But they don't like to use an outlet because they see that as being a stamp, I suppose, that says they're a drug user. And then they actually mix with others that are using intravenous drugs as well at that site, if they come into pharmacy, they don't. (Interview)

The pharmacist felt that these customers wanted to feel they were part of normal life, and accepted, rather than using a centre that immediately identified them as IV drug users. They felt both welcomed and 'normalised' by the pharmacy experience.

Relationships

Box: The Health Connector

The project has provided planned ways of connecting and sharing information:

That's ...one of the biggest things about this project...I'm inadvertently connecting [groups and people] with one another and letting them know about one another and knowing about services. Such a simple thing, but actually it's a really, really needed thing. People really want to know what's out there. Yeah, and actually professionals don't know much of professionals and community members. ...we take it for granted because you just think that if they are in a role that they know, they're going to know. When are they going to get the time to start reading about all these different [information]? It's something that you don't just go and do, ...something you learn over time and if you've got a job to get on with and that's your primary role...

Anticipatory care relies on long-term trusting relationships. These can develop in general practice:

I remember talking to a young woman whose mother had just been diagnosed with diabetes and the young woman was in her mid to late 20s, I think; she bought up the fact that her mother had been diagnosed, I didn't tell her. We talked about the changes that she could make to prevent her going down that pathway. And she was one of my long-term patients and she did it. ...I looked after her for about 20 years, she didn't develop diabetes and there was an incredibly strong family history – you're talking about mother, and grandmother, and a couple of aunts, so they were all my shape, short and squat, but had the wrong genetic make-up. She kept her weight down, she

kept exercising, she didn't smoke and as I say, after about 10 years after that first consultation she still hadn't developed diabetes and in her family, most of them had developed diabetes by their early 30s, she didn't.And also the other thing is that because she was eating properly there was going to be less potential for her children to develop it as well because they were getting a better example of how you eat and how you exercise.

When such relationships are disrupted, so is anticipatory care:

My dad's been having long-term cancer treatment and he's had a doctor that he, [doctor's name] who he just has the total confidence in, he has kept him well, he explains, he likes, he obviously likes him, he turned up last time, so he's got a new cancer and he turned up last time and [doctor's name] has gone on leave for at least a year. And dad said, but he didn't tell us. I said that must be very disappointing, dad, not to have been told. And you have had such confidence in him, he said "Oh, I knew he'd have to leave because he's exhausted" so, but I think my dad felt personally upset that he wasn't told, it was just when he rocked up, he was told [doctor's name] left, you've got this new guy. And I know my dad, I know from what he said, the fact he mentioned it, he's a little bit rattled by that because he's living with this long, it's a terminal condition which has been managed really well and he's now a little bit anxious. [...] He is quite rattled, I thought he was quite rattled by that. (Interview)

Relationships are also derailed where there are 'silos' and gatekeeping practices in place. Reception staff are the first contact made with a service, but their welcome may be constrained. For instance, for GP clinics, the front desk staff may be "*in a position where they see their role as protecting the doctors rather than as a public service type role of helping people in the community who aren't well*" (Interview). Further, staff may be unaware of, or unprepared for, the needs of marginalised or nervous clients:

We particularly heard from people that had mental health issues, particularly if they suffered anxiety, the wait was pretty uncomfortable and often made them either not go in the first place or only wait a short time and then leave. So I think that whole environment of GPs, but any sort of health system, doesn't always allow for people that have those extra stressors. (Interview)

This safety element (or lack of it) may be a factor in some 'did not attend' (DNA) events. Services need to be aware of risks of stigma, shame, embarrassment, or of the need for privacy or avoidance of judgment:

But there's lots of young people, and because mental health has got such a stigma or they might have alcohol and other drug issues, or they may have sexual health issues, they don't want to do to the local place where mum and dad pays for my gap fee because mum and dad know that I'm going. (Interview)

This is an example of where a local service may present a greater threat than something located in a distant hub. These barriers to seeking help also demonstrate the importance of established relationships; familiar service providers can develop knowledge to predict a person's possible needs:

They're the activities, so home maintenance, and under that is gardening, social support, and under that is shopping. But other things, too, but shopping seems to be the thing that people are comfortable asking for. ...You don't tend to say I'm a bit sad

and lonely and I'd like someone to have a cup of coffee with. It's easier, I'm not saying people wouldn't, but I think it's easier to identify shopping as a task someone can assist you with and through that you get this social contact. (Interview)

Long-term local institutions, such as pharmacies or neighbourhood centres, can provide relationship continuity, as well as reaching community members who may be unwilling or unable to access medical services:

When I think of neighbourhood and community houses they...are an extension of that pulse, in fact they're a closer beat in the whole system of those communities, they're really effective hubs. I've learnt that through our work here and other places that if you want to reach a community go in through those established and trusted avenues because they will either endorse you or not endorse you. That's where it starts or finishes as far as that sharing of—not just sharing of knowledge and information but actually learning first from the community about what's their knowledge prior. Not just assuming that we know more and go in and deliver all this stuff that's completely missing the boat for that community. I think that's a big thing. (Interview)

There is some evidence that H2H's The Right Place has increased the emotional and psychological safety of some services (see box, The Right Place).

Box: The Right Place

"A man came into the library wanting literacy assistance. But it turned out he'd just got out of prison, didn't have any ID, didn't have anywhere to go, didn't know what to do, and so came in because that was something that they could do at the library.

The fact that we've done The Right Place training, we've done Its Okay to Ask – all that sort of stuff with the library meant that they went "Ah, okay", had a bit of a look at the directory and went, "Okay, Service Tas! We'll go over and get you some ID, and if you're looking for housing, we've got these contacts ...".

That guy comes back in in a couple of weeks—Okay, I've got some housing, I've got some work, and now he's looking at some other stuff.

But the fact we are supporting some of those other services to say, "OK, this is how you can help", is really a helpful thing in the community, and that man's health will have been impacted by that. Definitely. We now have somebody who is not homeless in the community. We now have somebody who is able to operate as a productive member of community. He feels supported in the community he is in rather than isolated from it" (PSO interview)



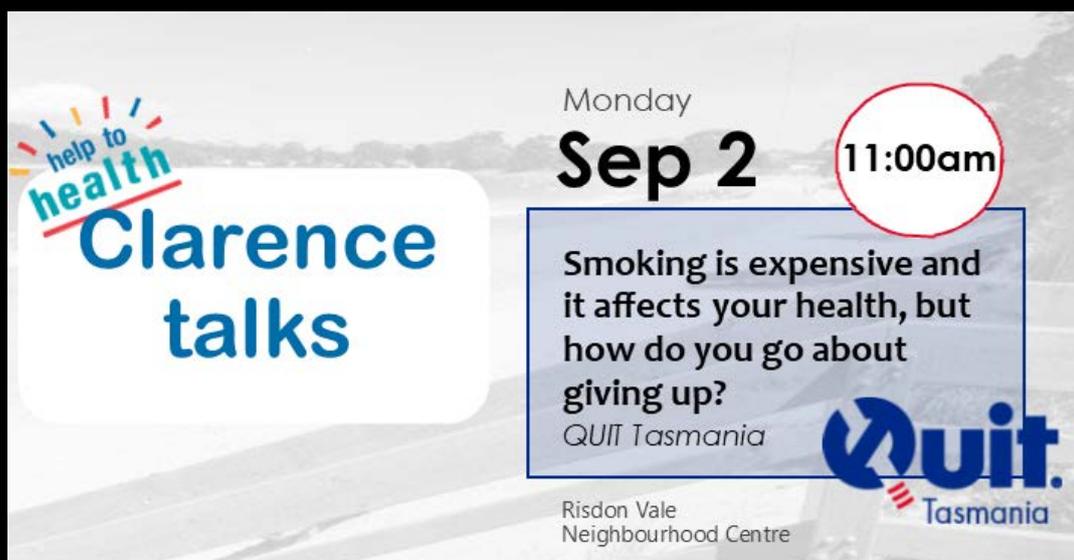
Clarence Talks have also built bridges between health services and the community. The PSOs and researchers have seen the benefits of simply turning up and listening, as the following fieldnote shows:

Smoko over—I go back into the garden with one of the men. He is a burly, blokey sort of bloke. We talk about the garden. We wander the garden beds and he points out the different plants—vegetable, herbs, flowers. Notes that some are ready to harvest. Picks basil, rosemary thyme—scrunches it and passes it to me to smell. Tells me how much he loves the smell of these plants—“here, try this one”. And how good they smell after rain.

This moves on to which plants he likes to eat—loves silverbeet, salad veggies, carrots—which in turn moves on to diet. Still not a small fellow but tells me he has been on a diet and lost 20kg. Eating lots of fish, and lots of veggies —and lots of fruit and good stuff veggie juice bought from health store (seems to have constructed diet himself—mix of good and bad info—i.e. the juice is costing him lots of money and is likely not helping—but still, working over all. Would better info help more? Could it be tied into the garden—which is where the connection seems to be? Regardless if it could be ‘better’—it is working and he is proud of himself for making it work) (Fieldnotes)

Box: The Health Connector: Council reaching out to help people to health

Emily, the H2H Project Support Officer, was at the Risdon Vale Neighbourhood House on the day some bad local smoking statistics were released. Risdon Vale was listed as having Australia’s second worst smoking rate (34.4% of residents) (Mitchell Institute at Victoria University, 2019). She had a conversation over coffee about what to do in response. At the same time, QUIT Tasmania was running a project trialling the effectiveness of nicotine replacement therapies. The relationship Emily had built with people at that site meant they could explore options together. One action was that QUIT Tasmania presented a Clarence Talks session at the Neighbourhood House.



That day, local government was in that room, trusted and working for a shared solution, not in a building at the other end of the municipality.

Risdon Vale’s nicotine replacement therapy trial used novel and highly local approaches tailored to the way the NH knew the community worked.

Although the H2H project has done good work to address safety and access, there were some criticisms about the representation and inclusivity of some of the project processes and activities:

I think the wider community of Clarence; you think of Clarendon Vale like you think about those areas, it's the people in those communities because they're sub communities within a group. And not sub by standard but sub as in they have their own culture, they've got their own community and different issues and they're not represented, they're not represented whilst we sit around and eat sushi as a leadership group. (Interview)

I felt like...whilst the Clarence group was really well informed from a lot of people around the sector both in health and community and not-for-profit I felt like it was a bit of deciding what the community needs not necessarily hearing from the community. And I understand Clarence City Council covers a really diverse area...so it's interesting. ...I think that's where we continue to trip over that stuff or we don't learn first, we assume and then go forth... (Interview)

Neighbourhood houses we are pretty well engaged with. Even though they're not on that group, they're on the big health promotion group. And we've engaged with them on all the project levels of help to health. So we've done 'It's Okay to Ask', we've fairly partnered with them on that community talks. So they've all done the 'Right Place' training. And they have been invited to the leadership group, but they're really feeling that it's too much. And that's fair enough. Disability, yeah, that's a fair call. We did actually invite a member of Charity because we had some connection with them through 'It's Okay to Ask'. But they're on our membership list, they just haven't been attending. (Interview)

Resources

Resources of all sorts affect access to the anticipatory care system and the system's functioning. There are geographical and physical resources (like safe local parks and walking trails, GP and other medical or health services), but this section focuses on what the data revealed about individual resources. Personal agency, skills, knowledge and capacities like literacy or numeracy, being a good cook, or being able to make do with relatively little are examples. Resources also refers to financial assets that make services more or less accessible: a person's individual financial position, or the budget constraints and decisions attached to a service or organisation that affect how expensive that service is.

Some in the community lack the resources needed to navigate through the system. This is hardly surprising as the system is very complex, with multiple parts and models of delivery. Health professionals, for instance, are often unaware of services, linkages, boundaries and processes. They have difficulty in finding services and information themselves and are therefore ill-equipped to assist community members with advice, links or referrals to other services:

Well I think, obviously there's lots of factors and it could boil right down to "I'm a GP and I'm really flat out and I don't really know what's available in the community because I get sent fifteen brochures a day and I can't get me head around it", right through to, "I need a new stage for all the services, I need an up to date, almost service

directory, again about, well, who does provide information, this specific information about mental health or ...who does that in the community". (Interview)

A lack of collaboration between services (working in silos) exacerbates poor navigation and lack of knowledge sharing prevents people accessing—or even knowing about available services:

GP's do not refer—as a group of people, they do not refer—people to [non-medical] services ... for example, we, sometimes, well I used to work at [name of NGO], and we would get people, we would talk to people whose situation has escalated and it would be like, "Didn't your doctor, did your doctor not talk to you about, for example, Carers, or Carers Tasmania, did your doctor not talk with you about the fact that you could get help with that cleaning?" ...Look at the reasons why people don't go to doctors and how do you engage doctors in referring. As a general rule, it is not doctors who have said to people you need to go to My Aged Care for your service. (Interview)

This is widespread:

But I think our understanding of what a doctor does might be quite different to what they say their role is. Even though they talk about a wholistic approach and all, I know that's why they have clinic nurses, you know, and nurse practitioners, or whatever phrase you use to try and take some of the pressure off but I think for years and years we have, only thinking like all those jobs I've had it's always like no referral from a doctor, no referral from a doctor. I think we have a role, I think our ideas of what our roles are, like my role of understanding of what a doctor is, is different to what they see, or is different to what they can actually do it, they might see, they might want to be like that but they just don't have the time, energy, people don't know them well enough. (Interview)

Knowledge of available services and how to access them affects community members, too. People may lack the skills, information, or physical tools to use systems that are increasingly online and which are perceived to offer little human support:

You try telling the old people that they've got to have a MyGov account... We had people that used to come in all the time just so we could help them.... Like Aged Care, if you come in and you say my pensions not right. And they've got to get—you can't talk to anyone in Tasmania about Aged Care, not face to face. It's got to be online, on the phone or online. So, it's really, really difficult... (Interview)

The cost of medical and other health services remains too high for many people. GPs argue that it is not viable to have a clinic that predominantly offers bulk-billed consultations, reducing the likelihood of operating in socio-economically disadvantaged communities:

Unfortunately the Medicare rebate has fallen and so for a GP to make a living in a bulk-billing clinic, they have to see a patient every seven or eight minutes, because the recommended AMA fee which is the one that has indexed since the Medicare rebate ... started freezing, recommends that the standard consultation is billed at \$80 and the Medicare rebate is \$37.60. (Interview)

Further, the business models operating appear to mean that were bulk-billing to be broadly offered, GPs would have to reduce consultation time in order to make a living, effectively

limiting consultations to the presenting problem and not allowing time for preventive and anticipatory health care.¹⁰ Publicly available information about bulk-billing is ambiguous; this allows for discretion on the part of service providers, but also fosters inconsistency and confusion. One result is that patients have to ‘tell their whole life story’ in the hope of being bulk-billed. This problem has been raised in other AC project sites where bulk-billing is not prevalent,¹¹ and also affects other services:

I think when you have a lot of staff changes. I’m a part time worker, so I’m a problem in that way. When you have someone who doesn’t know you, who has no history with you, the whole idea of My Aged Care, for example, is to minimise how often you tell your story and how long have they been saying that. Which is fine, but if every time, not every, but every few months you ring and it’s a new person who doesn’t say “Oh hi, hi Susan, oh yeah, oh yeah, last week, da da da da.” You just get someone you could be ordering you washing machine from. I think that impacts. (Interview)

In Clarence:

... there’s some very wealthy people and there’s some very, very poor people. And unfortunately, the wealthy people have good access to good services, good doctors, good gyms, good pharmacists, good physio services; all those people have good access to those. (Interview)

But for those with limited personal financial resources, the commonly-charged up-front fee, “... if they have to pay that, [...]—they’ll only go when they’re very sick. And they’ll probably leave it till it’s too late when they go. That worries me a lot. If they have to pay—even if you’re on a health care card you’ve still got to pay that money up front” (Interview). We heard many stories that showed how poverty was reducing people’s access to anticipatory care:

[Pharmacist] saw a man who had a cut on the back of his hand, typical 50-something year old man, so really not high level of—high consumers of healthcare anyway; but he had a temperature of 39 with this incredibly septic hand which I took one look at and called an ambulance. He was lucky not to lose his hand. I said, “Why didn’t you go to the GP?”: “I couldn’t afford it” (Interview)

This interviewee went on to comment that several of the people they saw with acute health needs had found it too difficult to use other medical services, including the Integrated Care Centre. In a second example:

Older man walks in [to neighbourhood house]. He is badly bruised and holding his arm, piece of paper in his hand. Has been to Dr? Has taken a fall doing a job. He has a referral for an x-ray but hasn’t gone because the place that he has been referred to does not bulk-bill. He can’t afford it—going into the DoCS to get another referral to someone who bulk-bills if possible. If not—won’t go or will have to go to emergency. (Fieldnotes)

¹⁰ This is despite prevention and collaboration with other services being identified as parts of the role of general practitioners, including in anticipatory care (Royal Australian College of General Practitioners (RACGP), 2015, 2019).

¹¹ Of the four project sites, Flinders Island is the only site where bulk-billing is the norm.

These are case examples, but the lack of preventive health interactions leads to costly hospital presentations—costly because they use multiple health services, and costly because delayed treatment too often results in declining health and wellbeing:

There's the whole—because people are economically disadvantaged—their only choice is the Royal. Their only choice is being on the waiting list to have their hip replaced or their knees replaced. So, for those that the Public Health System is their only option, I'm sure once they get to the Acute Phase, the level of care and support is equal to none in Tasmania. I think we are extraordinarily lucky. It's the getting there and what they've had to endure and how their health has deteriorated within that time. It's like the chicken and the egg. Yes, someone needs a hip replacement, they have to wait two years. They've gone from being on a stick, to being on a walking frame, to almost not being mobile at all. (Interview)

Local and state governments have looked for novel solutions (see Box: Equitable access) to these resourcing problems.

About a fifth of Clarence's suburbs are classified as socio-economically disadvantaged. Lack of economic resources (or being positioned low on the 'social gradient'; see https://www.dhhs.tas.gov.au/wihpw/principles/determinants_of_health) also restricts access to the other necessary social determinants of health, including education, nutrition, social connection, work, transport, housing and hygiene, and mental health and wellbeing (World Health Organization (WHO), n.d.). We learned of ways in which children, in particular, are being affected in Clarence by this clustering of disadvantage:

There are so many more kids with depression. There's so many kids with anxiety. [...] Now, currently down here, like you could imagine we have a lot of high needs kids. A lot. You're probably talking three or four in each class. Now the social worker's there one day a week. All she mainly does is to scratch the surface. So those kids are not getting any help, ... all she has time to do is follow up on the truancy. Ring the parents, "Why isn't she going to school, why is this happening?". ...So, all those mental health issues are going to escalate. So, by the time they get to high school, they won't be going! (Interview)

As we have seen elsewhere in the AC project, people in some disadvantaged areas are very resourceful. Faced with difficulties, people seek next-best solutions, including increasingly using pharmacies (where they also often have long-term relationships) for health needs like changing dressings, measuring blood pressure, or checking on health anomalies: "And maybe that's another thing, pharmacy is being fairly accessible, we're getting asked to provide a lot more now because of that" (Interview). Many pharmacies are now providing a range of services formerly offered only by medical practitioners.¹² Similarly, we heard stories about local business people who regularly helped people with transport and supplies. The village and sense of belonging and local connection allow people to work together to get what is needed,

¹² This has been a cause for comment by GPs in some AC project sites. They have questioned the capacity or qualifications of pharmacists, and whether it is ethical to offer medical advice or services from a clearly commercial setting, for instance.

whether it is the local activism in Risdon Vale to save their GP clinic, or clubbing together to give children opportunities:

They had Auskick down here. Lindisfarne, they came over to run it. But each child had to pay \$70, for an eight-week program. How many parents do you think in Risdon Vale can afford \$70 per child? Not many....And some of the—it's nice ... people in Risdon Vale that have a bit more money than others, they've actually paid for them to go. So, they take them and pay and one of the mums even bought them—not their kids—bought them a pair of shoes and—like even my volunteers here, buy socks for the kids and shoes for the kids, because they've got holes in their shoes and no socks. So, people are pretty good like that. As you know they can't afford sport. Like netball is quite expensive to play competition. Some of them do play, there's probably four that could afford it. Basketball is just as expensive to play competition. (Interview)

Summary

The thematic analysis of qualitative data identified three ways in which access affects the anticipatory care system here.¹³ These themes overlap and affect one another, as shown in the causal loop diagrams. They can be understood as things that assist or get in the way of the system parts working together: opportunities for change.

Clarence residents are resourceful, especially those with the fewest supports for their health. This makes apparent the inequity that is disabling anticipatory care. People at the top of the social gradient are rarely faced with the need to make the best of artificially scarce resources. Clarence's significant socio-economic divides present Council with resource distribution challenges.

We also mapped the data to the system parts—here are the summary phrases for them in Clarence:

People	This is a big place: people are very diverse, and it is hard to reach them all. It is also important to recognise their diverse ways of thinking about and acting for health.
Infrastructure	Infrastructure is concentrated; it needs to be more accessible throughout the municipality.
Information and data	Information sharing is essential but is hampered by funding models, and a lack of collaboration.
Beliefs and attitudes	Beliefs and attitudes shape policy (at all levels of government and in organisations). They also stop some people from seeking help, and stop some providers from designing or delivering to suit diverse needs.
Leadership	Leaders are harder to identify in very diverse communities (and in this city of villages model).

¹³ Analysis of the data is continuing and will be reported in December 2020, and in research papers.

Relationships	Relationships rely on trust, longevity, and familiarity. We have learned how necessary navigators or connectors are to help people find potential activities and services (a finding reflected in the Evaluation Report, Maddock, 2020).
Place and belonging	Clarence is indeed a collection of villages, each of which has a distinct identity and sense of place. The AC system will flourish where the importance of belonging is understood and factored into service and infrastructure provision.
Process and policy	Local, state and national policies can support or impede the AC system.

Systems work and causal loop analysis

System parts

We want to describe the AC system and see how the themes identified in the data analysis appear in the system and therefore where local actions can have an effect on that system. Our use of systems tools was informed by the data we gathered. The first round of analysis resulted in the initial system maps, using the identified six system parts. The system parts are:

People and health	People and health refers to the community and the residents' health profile, as well as to those involved in maintaining the health of the community.
Local infrastructure	The things—services, centres, businesses, programs, physical structures, environments—that support anticipatory care.
Data and information	Data and information regarding community members' health, and about health and community services: what exists and how it is shared.
Attitudes and actions	How residents and service providers think about health and the health system, and how these attitudes and beliefs affect what they do.
Relationships	What formal and informal networks and relationships support or hinder health in the community.
Leadership	People who are in formal leadership roles, as well as 'influencers' with symbolic power; people in 'authorising' roles.

We asked a graphic artist to create posters of each system part, for the Clarence community (Appendix 9 is the design brief for the graphic artist), and took these posters to the community forum at Clarence on 4th July 2019 (see Illustration 1 and Appendix 10). The H2H

team also converted the posters into a series of narrated videos, which were screened during the workshop.

Clarence : People and Health

WHAT WE ARE LEARNING

This refers to the demographics and health status of the community.

Illustration 1: Sample illustrations of the preliminary system parts in H2H (poster, top, and screenshot of video, bottom)

Eighteen people came to the community workshops. They were local residents and people providing services into the community. Analysis of the observations and notes made during the workshop (including summary documents and fieldnotes made by UTAS and Sax personnel, and by Flora Dean), combined with what we were learning in the other sites, led to the addition of two system parts: Policy and processes, and Place and belonging.

Place and belonging	The sense of belonging, identity, history/connection, roots, stories, stigma, neglect, pride, safety.
Policy and processes	Policy and bureaucratic processes, within organisations, and at the local, state and national government levels, that influence anticipatory care.

The system parts are a 'big picture' way of thinking about the AC system across all the sites. But we also wanted to look more deeply into the system to see where it was possible to change things locally (**research question 2**). To do this, we used the systems tool, causal loop analysis.

Causal loop analysis sessions 1 and 2

Two causal loop sessions were held with members of the LG and some additional participants. Participants created the diagram, and then the research team continued the analysis, using data from the workshops along with interviews, fieldnotes, project documentation, observations and conversations.

CLD 1 (2019) summary

We used the analysis to date to identify the site's major theme: access to anticipatory care. This was the focus of the first session. The qualitative data analysis had shown that access can determine whether the AC system parts work together. Change could be brought about by working on geographical and physical access, on emotional or psychological access (how safe a place feels for instance), on social access and reducing isolation, or on resources (e.g., what financial, or educational resources can people or services draw upon). Access became the driver for the action planning here in Clarence, and for the CLD discussion; this included people's ability to successfully navigate systems and services, identified as a key outcome in the CLD. This shows in the diagram we drew (Figure 10) with many arrows coming in to the variable "Access: successful navigating of systems and services". There was also significant emphasis on addressing the needs of the community in general, as well as of specific cohorts (e.g. young people and older Tasmanians); this was identified as another key outcome in the CLD.

Drawing the CLD (Figure 10) was informed by stories from participants, and other evidence from the data we had been gathering. For example, one of the session participants told a story about how Key Performance Indicators (KPIs) can be too narrowly focused, driving processes that put some people off attending a health service:

*[Participant A] spoke of “code-led” care—following a business and KPIs model. This was interesting, as it led to a discussion re what is not within the KPIs being excluded from practice. [Participant A] commented on the requirement that each of the people they see (clients) need to be registered. For some this is a real barrier. This sort of procedural stuff is supposed to be about measuring the service’s effectiveness—or in fact its performance against the KPIs (did you increase the number of people receiving the service? Etc.). But the risk is that other elements of effectiveness (like quality of the interaction in terms of support and change) were not in the KPIs. ... [Participant A] then talked about accounting for every instance of client interaction—“You are only allowed to do what’s measured”, and, as [other participant] said, the relationships and trust dimensions are **not** measured. (Fieldnotes)*

This story led to a discussion about the narrow, business model operating in several services, and its negative impact on access. A second story added weight:

[Participant B] described one health service as “just a disaster”. Gave example of a homeless man with several conditions. [Participant B] made an appointment (by telephone) but man couldn’t find the clinic. Fortunately, he rang [Participant B] and described where he was, so [name] could guide him in. Had he been having a bad day, it would have been a “no contact” experience. Discussion followed of the multiple impediments to using this service: Current labelling and signage of premises is not clear or plain language. This is affected by resourcing problems, “We make our own signs ... we’re tripping over them, there’s so many”, but they are not clear. [Participant C] felt this is significant – people need to know they can drop into the [service]. But, as [Participant D] then said, “people don’t know what’s there – even people working for [that service]”. Participants also spoke of attitude problems at the [service]: postman won’t even go to the front counter to deliver the mail. Also, [service] receptionists are physically stuck behind the front desk, so coming out and showing someone is difficult. People get lost in the building. (Fieldnotes)

These stories show several things about access to the AC system, including:

- That KPIs do not include measures of the person’s experience and needs
- Lack of attention to access in its physical, social and psychological dimensions (including literacy)
- Lack of attention (in service KPIs) to relationship dimensions (e.g., trust) of service provision and collaboration.¹⁴

The discussion also focused on “did not attend” (DNA) numbers for some services, a problem which has received some research attention (Campbell, Millard, McCartney, & McCullough, 2015; Hyndman, Holman, & Dawes, 2000; Nash, Kenway, & Mochloulis, 2014) and is important, as the DNAs in that literature include both people with mild illness and those at the other extreme, with severe illness (Minshall & Neligan, 2017). DNA statistics, like KPIs, let the system know little else about service users’ situation or needs.¹⁵

¹⁴ Building and sustaining relationships takes time; this needs to be recognised and accounted for in resourcing and funding.

¹⁵ UTAS researchers are interested in how we can better understand the role of ‘invisible’ people in the system: people who miss appointments, or who get support for their health or wellbeing from services without a health role, or from other lay people in the community. We hope to report in more detail about this phenomenon in the Final Report (December 2020).

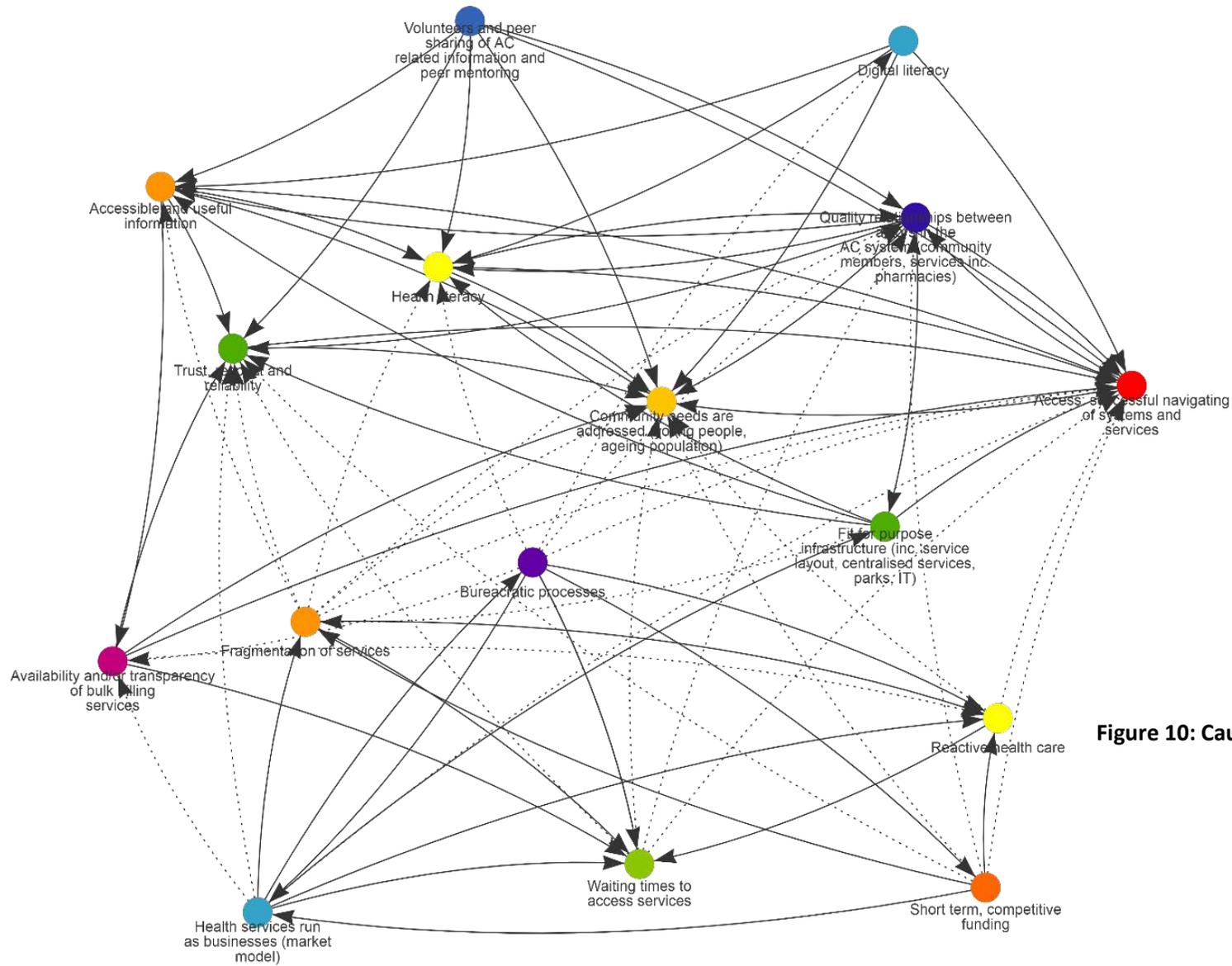


Figure 10: Causal loop diagram for Access in the AC System, 2019

This example (along with many others discussed at the CLD session) is represented in the CLD diagram (Figure 10). It shows how many interrelated variables play out to either support or block access to the AC system. For instance, **trust, respect and reliability**, linked closely with **quality relationships**, were key outcomes which relate directly to **AC access** and addressing **community needs**. Importantly **trust, respect and reliability** can be undermined by variables such as **health services being run as businesses, fragmentation between services, short-term competitive funding, bureaucratic processes and waiting times** to access services. These are driven by wider structural factors that may be beyond the scope of the project, but they present very real contextual barriers. **Reactive health care** and un-responsive **bureaucratic processes** also fall into this category – undermining the **availability of bulk-billing, health and digital literacy, quality relationships, and system/service navigation**.

The CLD identified that providing **accessible and useful information** is a key aspect of the AC system in Clarence. This involves sharing information between services, and between community members and service providers. Information may relate to issues like health needs (e.g., screening), availability of services, including what services offer, waiting times, alternative services that can support people during waiting, and information about bulk-billing. This raised the question of the potential role and points of influence of local government in enhancing this key aspect of the system. Council could be a key conduit between the various actors in the AC system to facilitate the flow of **accessible and useful information**; in this way they would also be fostering the development of **quality relationships**. **Relationship** development may flow on to other factors, such as improving infrastructure, down the track (e.g., improving the presentation/layout of the CICC – signage, desk height, waiting areas). Variables like **formal and informal information sharing (volunteers and peers), digital literacy, health literacy, fit for purpose infrastructure** and **quality relationships** are all important factors in providing accessible and useful information. Again, it is important to identify the barriers to this variable, in particular the **fragmentation of services**. It is also essential to recognise that simply providing people with good information – particularly if it is disguised as ‘enhancing health literacy’ – will not necessarily enhance health outcomes. Frameworks such as the Ottawa Charter for Health Promotion can provide useful guidance for building environments (e.g., infrastructure, policy and processes) that can support communities to use information to maximise health and wellbeing.

Accessible and useful information was identified as an important variable. Our focus is on how services meet the information and other needs of potential clients, rather than on the health literacy of citizens. This may include using Plain or Easy English in communication, providing information in locations that are accessible and familiar, or through trusted people. Accessible and useful information supports people to make decisions about their health needs and AC.

Results-driven action plans

The PSOs worked with the LG to develop an action plan informed by the results reported above. The action plan set out proposed actions to enhance the AC system using four guiding questions:

- The FORM: What action are we taking?
- The FUNCTION: What are the intended outcomes from the action?
- The possible RIPPLE EFFECTS: What other effects could the action have?
- The MEASURING: How will we know it is working?

The H2H action plan (Appendix 7) sets out activities to support:

- navigation of systems and services (7 actions)
- quality relationships between actors in the AC system (1 action).

The local report prepared by the H2H team (2020) describes all local activities, and they were evaluated by MadFinch Consulting (Maddock, 2020).

CLD 2 summary

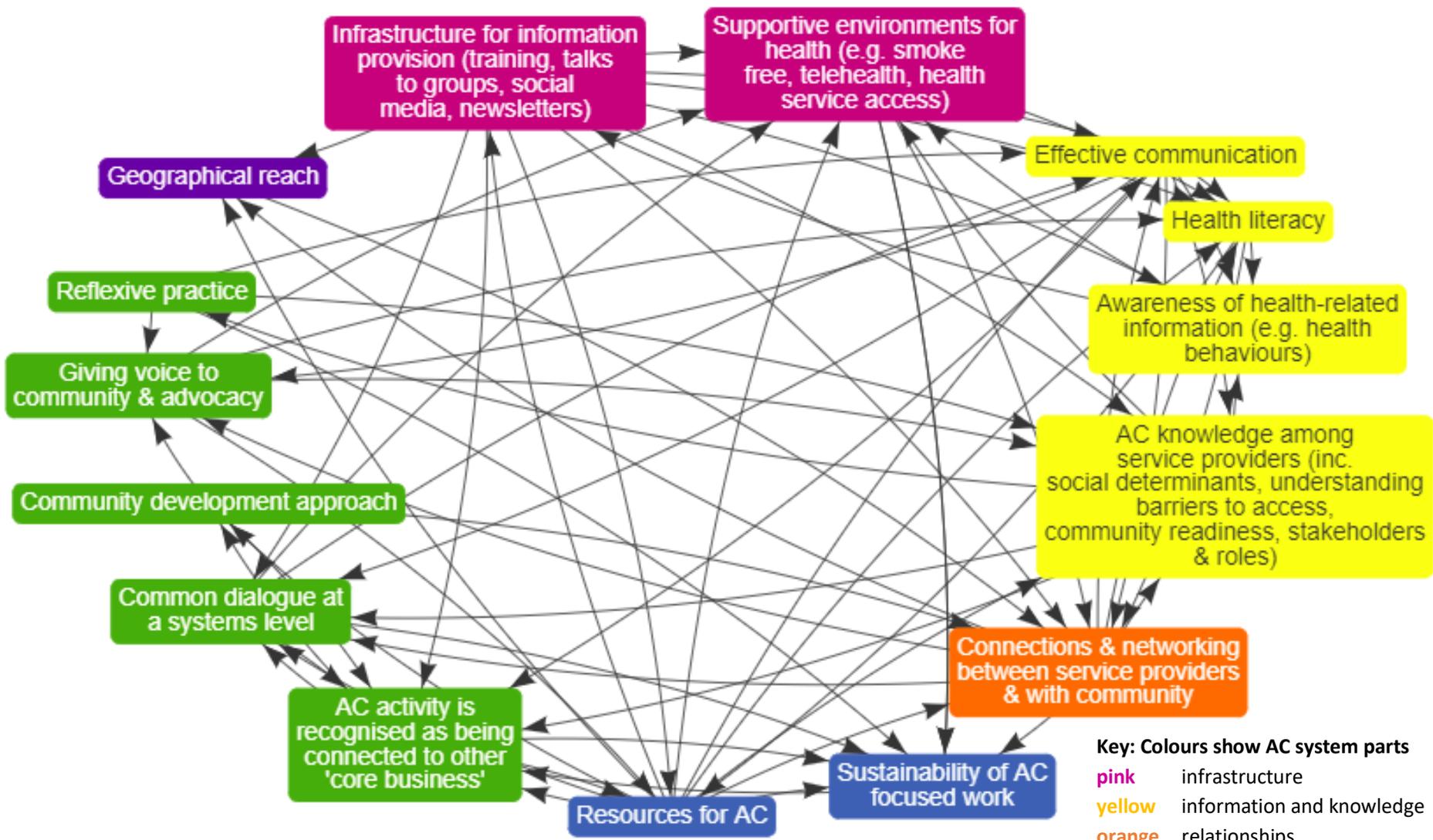
Drawing the causal loop diagram can reveal the ripple effects and other measures of impact. At the second CLD workshop, in 2020, we wanted to see whether the local activities had altered the way the system looks and works here. This was an important data gathering session and added to the knowledge we have of the project activities and impacts from our other sources. The second workshop was held using the Zoom videoconferencing platform.

The stories people told in the session were not the only way we learned about change in the local AC system. There was evidence in the language used and the ways in which participants framed issues and solutions indicated a shift in thinking from the first CLD session.

CLDs are an important tool for representing the feedback structure of systems. They are excellent for quickly capturing your hypotheses about the causes of dynamics; eliciting and capturing the mental models of individuals and teams; and communicating the important feedback processes you believe are responsible for a problem.¹⁶

CLDs are one tool being used in the AC project to help tell the story of the complexity of the AC systems in four communities in Tasmania. Importantly, the CLD has boundaries, and therefore will not capture everything that is going on, but it does draw our attention to the key focus areas of our work. Important contextual information will be captured by the findings from our other data analysis methods, and in our writing about the project.

¹⁶ The Systems Thinker, <https://thesystemsthinker.com/>



Key: Colours show AC system parts

- pink** infrastructure
- yellow** information and knowledge
- orange** relationships
- blue** policy and processes
- green** attitudes and beliefs and ways of working
- purple** place

Note: Boundaries between parts are blurred

Figure 11: CLD of the main components of H2H, 2020

The CLD (Figure 11) is a summary of the key components of H2H, as described at the workshop with stakeholders on 14th May 2020. It is also informed by other data collected during the life of the project.

When we developed the first CLD, last year, there was a strong focus on the need to enhance **access and service navigation** through variables such as literacy, fit-for-purpose infrastructure, norms and so forth.

In the first CLD, we also identified ‘connections between actors’, ‘relationships’, ‘health literacy’ and AC information among the key variables in the AC system, and 12 months on we can see that this was where H2H initiatives were generally positioned within the system. By reflecting on the project 12 months later, we can see that there is a clear focus on **attitudes and beliefs**, and **information and knowledge** generation. It may be that the primary focus on a single system part, access to health information, and the way it works in Clarence meant that a deeper and more nuanced understanding of accessibility and information was gained. This may lead to enhanced access and navigation however we would need further evidence to support this claim.

By looking at the model above, we can see that there are many connections between different parts of the AC system and there are literally thousands of loops in this model. For example, in this project:

- H2H implemented initiatives that helped to form **connections and networks with other service providers and with the community** (e.g. H2H formed relationships with GPs, the Pain Revolution, pharmacies, community groups, as well as community members directly);
- through **effective communication** (one-on-one, meetings, etc.) these connections/networks gained **AC knowledge** (including the social determinants of health, understanding about barriers to access and so forth) (e.g. health care workers said they had gained new insights into the importance of social barriers to accessing care)
- some service providers utilised this knowledge to create **supportive environments for health** (e.g. reception staff know about where people can get housing support)
- which enabled more **connections and networks between service providers and with community** to be built (e.g. through interaction with patients/clients in GP practices, and with social service providers).

This is an example of a **reinforcing loop** in the system i.e. increase in one variable increases another and so forth, which reinforces an increase in the original variable (+).

In the first CLD, a number of undermining variables were identified, including:

- Short-term, competitive funding
- Reactive health care

- Waiting times to access services
- Health services run as businesses (market model)
- Fragmentation of services
- Bureaucratic processes
- Availability and transparency of bulk-billing services.

These variables contributed to **balancing loops** in the system, i.e. where an increase in one variable leads to a decrease in another. While these variables are probably still part of the AC system, it was not clear in this second CLD workshop whether these variables were within the scope of H2H's initiatives. As a result, none of these potentially undermining variables appears in the second model, and all the relationships between variables are reinforcing.

What we learned about the project processes

The Sax Institute and the UTAS team are analysing the project structure, and local roles and ways of working. The Sax Institute's evaluation report will be delivered later in 2020. We report here on our understanding of the local project processes and roles through data gathered in:

- Attending, or reading minutes of, H2H leadership group meetings
- CLD, Systems Traps and other formal workshops
- Conversations with PSOs and project leads (including formal meetings, reflective conversations, and the state-wide PSO Community of Practice), and
- Conversations with service providers linked with H2H activities.

We made fieldnotes about these interactions, and this material also informed our causal loop analysis.

Research activities and project processes

The following table (Table 3) lists the project processes, what worked about them and what did not.

Table 3: What worked and did not work about the H2H project and research processes

<i>Activity</i>	<i>Who lead?</i>	<i>What worked about it?</i>	<i>What didn't work about it?</i>
<i>Timeline</i>	DoH	<p>Timeframes for the project were always a challenge, but this was well understood by all involved parties from the outset. Both the scope of the research and the project at each site was tailored accordingly</p> <p>The time for the project was extended, this supported us to deepen relationships and develop the activities further</p>	<p>Collaborative work relies on trusting relationships; these take time to develop. When this time is short, there is a greater reliance on long-term, well established relationships and connections of lead organisation, and with the community</p> <p>The short timeframe reduced opportunities to revisit the community and assess health or other impacts (including some system impacts and ripple effects), reassess situations and reorientate actions</p> <p>The short timeframe also factored into difficulty including people from marginalised groups in the interview and data collection process, since trust is needed if we are to gather rich information</p>
<i>Contracting between parties</i>	DoH, lead organisation/s, UTAS	Provided clarity about project goals and expectations	Some aspects of contracting were very time-consuming and remained a source of difficulty in the H2H site
<i>Ethics</i>	Social Sciences Human Research Ethics Committee	Provides accountability and guidance to researchers about how to do ethical work	Imposed some restrictions on the research component that may have reduced our ability to learn directly from some community members (consent concerns for children, for example)
<i>History of AC</i>	An approach from the British NHS	Takes a holistic and SDoH approach	Risk that too much effort is spent trying to reproduce a GP-centred model, which current Australian policy settings do not support
<i>Interviews</i>	UTAS researchers, PSO	<p>Support from leads to identify potential interviewees (this also helped build relationship between researcher/s and leads)</p> <p>Reached mostly 'usual suspects' very effectively</p> <p>Interviewees were willing and thoughtful</p>	Format only works for people who are confident, or where the interviewer could quickly establish a trusting relationship with the interviewee

		<p>Produced very detailed and ‘rich’ information</p> <p>Could be conducted when the opportunity (e.g., an existing meeting or shared activity) arose</p>	
<i>Focus groups</i>	UTAS researchers, PSO	<p>Allowed us to include people who were unwilling to be interviewed alone</p> <p>Group members prompted and encouraged one another</p> <p>Participants appeared to build new bonds over shared stories</p> <p>Could be conducted when the opportunity (e.g., an existing meeting or shared activity) arose</p>	<p>Method can result in one or two voices dominating the conversation (this was evident in some focus groups; a product of shyness but also of power dynamics)</p> <p>Can be hard to arrange</p>
<i>Observation</i>	UTAS researchers, PSO	<p>Increased collaboration between researchers and PSO</p> <p>Found new ways to learn about AC system and people’s interaction with it</p>	Requires a lot of time, which was short
<i>Surveys</i>	PSOs	<p>PSOs were able to reach and hear from more—and harder to reach—people, only some of whom completed a survey</p> <p>Gave us data about understandings and experiences, as well as barriers (in format directly comparable with other sites)</p> <p>Expanded PSOs’ knowledge of the H2H area</p>	<p>The sample was fairly small and unrepresentative</p> <p>Time was too short</p> <p>Administering the survey was time-consuming, making PSOs wary of inviting people to complete</p> <p>There is general scepticism in communities about ‘yet another pointless survey’</p>
<i>Community Consultation Workshops</i>	Sax Institute and TAPPC	<p>Brought together local residents and services</p> <p>Gave researchers an opportunity to become a little more familiar with and in the H2H site</p> <p>Identified additional potential interviewees and focus group participants</p>	<p>H2H workshop poorly attended (dominated by health professionals and researchers)</p> <p>Workshop location, format, language, and tools probably excluded some participants</p> <p>System parts videos somewhat promotional (of existing H2H programs) rather than enquiring about potential needs/change</p> <p>Risk that notes taken at group tables or added to posters were heavily influenced by ‘noisiest’, most powerful, or most literate people there</p>

			One intention was to ask participants to comment on how different parts of the system were linked; lack of time and difficulty of some of the concepts prevented this from occurring (this was a necessary adaptation for the group attending)
<i>CLD sessions</i>	UTAS researchers	<p>We were all learning as we went along: CLDs were a new tool and process for all involved (including UTAS) so it created a real opportunity for shared learning and co-design; there were no “experts”</p> <p>Process brought stories to the surface that enabled us all to better understand the AC system</p> <p>Process allowed for genuinely participative action learning</p>	<p>We were all learning as we went along, so process was at times difficult to navigate</p> <p>CLD is visually complicated and initially off-putting</p> <p>Several workshops are needed to make this a fully participative process</p> <p>There is a risk that CLD sessions may be more heavily influenced by the people present than by what the UTAS team has learned by other means</p> <p>‘Ownership’ and perceptions of the usefulness of the CLDs varied</p>
<i>Systems traps session</i>	UTAS researchers	<p>We were all learning as we went along</p> <p>Brought members of the project community from across the four sites together</p> <p>Opportunity to learn how systems traps were appearing in sites, and how participants understood and were responding to traps</p>	<p>We were all learning as we went along</p> <p>Session was probably of variable value to the participants other than UTAS</p>
<i>Community of Practice</i>	UTAS researchers and PSOs	<p>Brought members of the project community from across the four sites together</p> <p>Gave us all opportunities to reflect together on what was working and what was not</p> <p>Enabled UTAS participants to hear how work in general and on particular activities was going</p> <p>Built trusting relationships between PO and PSO, between the four AC project sites, and between PSOs and UTAS team</p>	<p>Logistics sometimes difficult</p> <p>Unsure whether too hierarchical (as in, too much UTAS and not enough PSOs) [analysis of session data is continuing]</p> <p>Disrupted by loss of some PSOs</p>

		Shared problem solving	
<i>PSO reflections</i>	UTAS researchers and PSOs	<p>Built relationship between PSOs and lead researcher</p> <p>Enabled lead researcher to hear how work in general and on activities was going, and do some shared problem solving</p> <p>Provided opportunities for critical reflection on UTAS researchers' role and project processes</p> <p>Provided evidence of growing systems thinking by PSOs</p>	<p>Variable engagement and sometimes too many other commitments (on both sides)</p> <p>Took a little while to find best means for reflection for each person</p>
<i>Project activities</i>	Leads, PSOs	<p>Some activities showed that local action can influence the AC system and address priorities for better function (see the AC Framework)</p> <p>Addressed some goals of AC system work</p> <p>Worked towards involving a wide range of community members and listening to them</p> <p>Built on some effective and trusting collaborations with services and institutions</p>	<p>Commitment to existing programs limited capacity and energy to respond to project action learning</p> <p>Heavy workload for PO, PSO, and leads</p>
<i>Project Support Officers' work</i>	PSOs (supported by leads)	<p>We were all learning as we went along; lack of a predetermined program of work provided space for responsiveness to local circumstances</p> <p>Enthusiastic and skilled; one had developed good links with community and some services; other came with 'fresh eyes'</p> <p>Had (and built) trusting relationships with leads, LG, and one another</p> <p>Engaged, observant, reflective, creative, skilled critical thinkers, and flexible (e.g., quickly understood AC in a broad and inclusive way, and saw opportunities to strengthen the system in small and larger ways)</p> <p>Training/ways of working that seek and build on strengths and relationships</p>	<p>We were all learning as we went along; presence of a predetermined program (H2H) appeared to reduce options for responding to the data</p> <p>Significant energy had gone into implementing and embedding the existing H2H program. There appeared to be reluctance to try new or different ways, or to take on additional activities beyond the original H2H program of work</p> <p>Some confusion about roles of each PSO, within H2H team and Council, and accountability of PO, PSO and UTAS research team</p> <p>Short-term H2H funding (and lack of certainty) created some concerns for PSOs about their futures; both PSOs left before end of project, effectively cutting it short</p>

		PSO, in particular, was highly activist in seeking ways to reach the hard to reach (e.g., prisoners)	
<i>Leadership Group (structure, makeup, how it worked)</i>	LG members	<p>We were all learning as we went along (opportunity for some)</p> <p>Membership somewhat fluid, with a core of health professionals/policy makers and administrators attending most reliably, and representatives from a range of services and the community attending as the need arose</p> <p>LG meetings followed clear processes</p> <p>A core group of members remained committed and actively sought solutions (e.g., Risdon Vale clinic closure; sustainability of AC outcomes)</p> <p>Opportunity for UTAS to learn about community, services, and approaches</p>	<p>We were all learning as we went along (frustrating for some)</p> <p>Transition from H2H pre-AC project to AC project difficult</p> <p>Some LG members left as AC project got started; more work was probably needed to draw them in and to engage with a wider diversity of community representatives</p> <p>Absence of community members' voices</p>
<i>Statewide AC Forums</i>	Representatives from all sites, UTAs, DoH, Sax/TAPPC	<p>Opportunity for sites to share their work and learnings</p> <p>Built confidence for many who were unsure about the project and "how they were performing"</p> <p>Ideas for different activities were picked up and adapted/modified and implemented in some other sites</p>	<p>Time—not enough time to get through the set agenda</p> <p>Content and format of some presentations/sessions</p>

The impact of the COVID-19 pandemic on the project and this site

In early March 2020, the World Health Organisation declared that the outbreak of a novel virus, SARSCoV-2 (now referred to generally as COVID-19), had become a pandemic. National and state governments in Australia responded by ‘locking down’ communities so that social activities, travel and visiting most public places were prohibited.

The pandemic has had a profound effect on the world, and of course on this project. People in the four Tasmanian communities participating in the AC project are at risk of bad outcomes due to high rates of chronic illness (Lippi & Henry, 2020; Yang et al., 2020) and a range of socioeconomic factors (aging population, poor housing, high unemployment, inequitable access to healthcare). Project team members in all sites have reported that local residents feel anxious, isolated, vulnerable, and distressed, with measures to stop COVID-19 making it harder to take part in social and physical activities outside home. Some are also reporting that getting good quality food has become a bigger problem; this has been most prominent in communities already affected by poverty. These experiences have also been reported in the findings from Health Consumers Tasmania (Banks, Churchill, & Leggett, 2020a, 2020b) and The Tasmanian Project (see <http://blogs.utas.edu.au/isc/category/the-tasmania-project/>) surveys. Below we make some observations about the impacts of COVID-19, including policy initiatives, and how the local AC project responded.

Policy changes that could benefit AC systems

Policy and processes are a part of the system often outside the control of local services or people. COVID-19 has produced two national policy changes (which may be temporary) that are affecting the AC system (though we are still learning how). More medical consultations can take place using telehealth (that is, by phone or video-link), and the JobSeeker payment has been increased for some months.

Telehealth consultations

Telehealth consultations with GPs, some allied health providers, such as dietitians, and some specialists are now more widely available. Health providers *can* apply bulk-billing to these consultations “where the service is provided to a concessional or vulnerable patient or a child under 16”

(<http://www.mbsonline.gov.au/internet/mbsonline/publishing.nsf/Content/News+2020-04-20>). This could be an important shift that supports AC, but there are several potential barriers still in place.

Firstly, it is not clear who will be bulk-billed, other than those who already qualify for bulk-billing as ‘concessional’, ‘vulnerable’ or ‘aged under 16’, and there is evidence that GPs are offering bulk-billed telehealth only to existing patients. This means that those people who do not have a regular GP—often the already hard to reach and at risk—are unlikely to be benefiting.

Secondly, telehealth relies on technology and the familiarity and confidence to use the technology for this purpose. People in several Clarence suburbs are more likely to be poor, and to have poorer access to the internet, than Tasmanians overall (Tasmanian Council of Social Service Inc. (TasCOSS), 2019b), including because of the cost of mobile phone data, and poor reception. They are also likely to have had less education, and there is some Tasmanian evidence that telehealth is more likely to be used by people who have more education (Banks et al., 2020b). About half of Tasmanians “do not have the literacy skills they need for work and life” (Tasmanian Council of Social Service Inc. (TasCOSS), 2019a, p. 10). This affects people in at least three H2H suburbs: Clarendon Vale, Warrane and Rokeby), where at least one-fifth of residents finished their education at Year 10.

Thirdly, telehealth—even where video is used—is an imperfect substitute for a face-to-face consultation where the doctor can assess not only what the patient tells them, but also other physical signs. For patients, the need to point at or gesture is part of communicating; this does not work on the telephone.

To date, there is no evidence that the introduction of more bulk-billed telehealth services is translating into more access to GP services. There are also reports (Daly, 2020; Knaus & McGowan, 2020; McKenna, 2020) that the reduction in numbers of people seeing GPs, including via telehealth, could force the closure of smaller GP clinics around Australia. This is not a good sign for AC in marginalised communities that struggle to attract GPs and where there is already a shortage of GPs.

Increased JobSeeker and other payments

The JobSeeker payment, formerly called ‘NewStart’, was increased in April 2020 by the addition of a ‘Coronavirus Supplement’. This roughly doubled the amount received by many people, including those on Youth Allowance, Parenting Payment, and some special benefits. Some H2H residents are likely to now be benefiting from this increase. The official unemployment rate in Clarence in 2016 varied between 3.3 per cent (Acton Park) and 19.3 per cent (Clarendon Vale), with six suburbs recording more than 10 per cent unemployment. In 2016, Tasmania’s overall unemployment rate was 7 per cent (Australian Bureau of Statistics, 2016). Unemployment has risen during and post-pandemic.

The increase to benefits is planned to be reduced in September 2020, with scaling back over the subsequent months (though things remain unpredictable). There are also predictions that many people on JobKeeper payments (for workers in any business that has suffered a 30% or greater reduction in turnover during the eligibility period compared to the previous year) will not have jobs to return to when the pandemic is over. Participants in the 2020 CLD session reported that increases to the JobSeeker payment, as well as people accessing JobKeeper, had changed the mix of people seeking emergency food relief. People for whom this change meant a rise in income were reported to be coping better, whereas new entrants onto either scheme, perhaps with mortgages or higher rents to pay, were now seeking help.

In Clarence, the project had officially ended by the time the pandemic was declared. Where possible, H2H activities continued and moved online (Clarence Talks; this was accepted by the community), and the H2H team believes that the COVID-19 pandemic created a suitable environment for the online services forum to be launched.

Box: The Clarence Services Online Forum

The forum was created to provide a channel of communication between health and support services to discuss community concerns relating to health and wellbeing. Its purpose is to improve communication and co-ordination so that Clarence residents have better access to health services and supports.



This forum is a place to raise, with a broader group, the social issue trends or service gaps you are seeing through your work, and it will provide a channel for information-sharing to support this. You can also ask about and share social and community activities to support your clients.

If you are a GP, health connector, allied health professional or service provider working in the Clarence municipality then we invite you to join our [Clarence Services Online Forum Facebook Group](#). Please feel free to share with any colleagues and appropriate networks.

The additional relationships and modes of delivery were supported by H2H's AC project, though a continuing PSO would have enabled greater responsiveness. We also have evidence that Clarence residents have been accessing GPs less, with possible long-term consequences from delayed screening and prevention.

Discussion—what does all this mean?

Chronic conditions affect too many people in the H2H site. People here do not have equitable access to health services and facilities, and some are much more likely to experience the negative social determinants of health. This increases their risk of having chronic conditions, and results in high rates of potentially preventable hospitalisation (PPH).

The H2H project, in its AC iteration, is a partnership between the H2H team, UTAS researchers and the DoH. We worked together to explore first the nature of the anticipatory care system, and then whether we could strengthen the system locally so it could address problems that contribute to the poor health outcomes. To do this, we mapped the AC system

here (*research question 1*), looking for successes and for opportunities for improvement (*research question 2*). We then planned actions to work for those improvements and, using action learning, checked how those actions were working, revised plans and adjusted actions (*research question 3*). We also wanted to learn what role the local lead organisation—Clarence City Council—plays in anticipatory care, and whether this can be strengthened (*research question 4*).

The AC project in Clarence ended almost six months early. This was largely the result of funding uncertainty; there was no sign that once the AC project funding was expended there would be financial support for a continuation of the H2H activities. The lack of sustainability was one driver for the early departure of the PSO (in January 2020). The H2H team had the project evaluated (see Maddock, 2020), and ‘wrapped up’ so it could be brought back into place should the opportunity arise.

This final part of the report discusses our findings and observations in response to each of our research questions. We then also reflect on the barriers encountered and the usefulness of the methods we used, action learning and systems thinking. We conclude with recommendations for anticipatory care in this site, and for future work.

Answering the research questions

Significant finding 1: Place and belonging matter a great deal to people’s health and help-seeking. The AC system’s effectiveness relies on recognising and catering to the local needs of a municipality’s distinct ‘villages’.

Significant finding 2: The project showed that the anticipatory care system is heavily reliant on relationships, and that a health connector (modelled on the AC project’s PSO role) with authority and reach could perform this function. Embedded in local government, the health connector could support Council’s health and wellbeing role through monitoring the health of the community, outreach, bringing services and influencers together to address health issues/concerns, advocating for their community, and building community capacity and connections across the locality.

Significant finding 3: The anticipatory care system relies on long-term relationships. Given that health and wellbeing are priorities for local government, funding needs to move from short-term, project-based models, to permanency, including for the Health Connector role.

Significant finding 4: Pharmacies are playing an increasing role in anticipatory care, as a first port of call for many residents. They also often have long-term trusting relationships with community members, good data on those people’s health, and offer equitable access through numerous free services, all of which are essential elements in anticipatory care.

Research question 1: Mapping anticipatory care here

A more connected and safer system

The initial AC system map, developed from pre-project scoping work by the CCWG, had six system parts: people and health; local infrastructure; data and information; attitudes and actions; relationships; and leadership.



Figure 12: Original systems diagram

The boundaries around the system in Clarence corralled it as a mostly medical or health service system. This is in contrast to our survey and other qualitative finding that people describe health in very broad terms that include their capacity to do things that matter to them, and speak of their essential supports being provided by family, community, work, and so on. Further, the system's function of keeping people well was often disrupted by a lack of access, some linked with the negative impacts of the social determinants of health (including poor housing, low income, and poor diet). It was also reliant on local resilience and resourcefulness, and on some local organisations that know and work with their community.

At the project's end, H2H was connected with more services, and people in those services recognise their role in reducing community members' risk of developing a chronic illness, and in supporting the better management of existing illness. The project allowed the H2H team to continue and develop existing programs, and to develop and trial additional locally-driven approaches. Through the AC project, the H2H team has worked with people and organisations in the system who were formerly not involved, and who now better understand their role in AC. This includes pharmacies, the Pain Revolution, library services, Housing Tasmania staff, community nurses, inmates at Risdon Prison, Karadi Aboriginal Corporation, and QUIT Tasmania. These relationships were formed in response to local needs for a stronger AC system, identified by PSO outreach and the research. The H2H team has also reached people at the 'far ends' of Clarence, with different health and social characteristics, and barriers to accessing the anticipatory care system. Importantly for AC, the H2H team has developed the Clarence Services Online Forum to link GPs with other

health and service providers, and to improve information sharing, navigation and access. The LG has been instrumental in developing the forum. The site launched on 12th August 2020.

There is evidence of a better connected and more accessible local AC system, and of attitudinal shifts and practice changes to support safer access to health for community members. These changes to the AC system are evident in data gathered, and are captured in the second causal loop diagram (Figure 11). Much of this change has been driven by the active engagement with communities of the Project Officer (Kate Franke) and the Project Support Officer (Emily McKinnon), supported by the H2H team. The new map of the AC system explicitly includes services and structures that affect the social determinants of health.

Project-driven changes to the AC system include:

- increasing support for people to navigate to get the help they need
- increased recognition of the importance of local identity and engagement
- better reach into formerly disconnected communities
- recognition that place and belonging, and policy and processes are part of the AC system.

An expanded set of system parts

Our re-drawn map of the AC system includes two additional parts: the importance of place and belonging, and the impact of policy and processes (Figure 3).

Place and belonging

Place and belonging matter because people want to feel safe and familiar, especially when they need help or support. Without safety, people do not access services or places that could help them to maintain or build health. Place is also important because of its particularity: local experiences are tied to local contexts in multiple ways, everything from the practical impact on access due to the steepness of a hill, or the presence of attractive local parks and walks (as mentioned by survey and workshop participants), to the complexities of belonging, and history. Access is supported by feeling familiar, safe, welcomed, trusted, and being connected with and proud of where you live and your community. The importance of place and belonging is symbolised by the intense and articulate local activism to retain the Risdon Vale GP clinic, for instance, by the engagement of South Arm locals, and by the distress residents expressed at losing local meeting places that enable connection (e.g., church halls).

The stigmatising labels attached to some Clarence suburbs—in media, in resource provision, and in how people were, or expected to be, treated by services—make places outside people’s own ‘village’ (and some inside) unsafe for too many. This perspective puts boundaries around the anticipatory care system, making it less effective. It also tells us that

locally-tailored rather than one-size-fits-all responses are essential if we are to support better health. We have also seen that some H2H activities and actions may be easing the boundaries between people and health services (e.g., through Clarence Talks) while supporting people's sense of place and belonging.

Policy and processes

Policy and processes, whether at the organisational or governmental level, shape how the whole AC system functions, but are largely outside the bounds of this AC project to change. The most prominent ways this system part affects the AC system are through:

- Short-term competitive funding
- Bulk-billing model, and
- The social safety net.

Short-term competitive funding models

At the governmental level, it is clear (across all sites) that short-term competitive funding is damaging and limiting to the AC system. The risk of losing competitive advantage discourages sharing, reinforces silos, and can prevent the all-important trusting relationships—between services, and between services and community members—from developing. Shifting national and state policy is a large task, but local sites can advocate for changes to this policy approach, and can—as the H2H Clarence Services Online Forum work may show—demonstrate the effectiveness of collaboration.

Bulk-billing model

The second policy problem is bulk-billing. The bulk-billing model operating in Tasmania makes GP and other medical and allied health consultations too expensive for many in the H2H area.¹⁷ The 'gap' is too large, and the upfront payment required can be beyond reach. This means that too many people do not seek preventive health or early intervention in health conditions—especially when access is affected by judgmental or stigmatising attitudes among providers, or processes that require people to repeatedly justify being bulk-billed. The lack of transparency about bulk-billing practices adds to this problem: too many community members are reluctant to seek GP appointments because they cannot easily find out the cost of a consultation.

Current funding arrangements and business models also constrain most GPs from reaching out into communities and engaging in local health promotion work. They also reduce the attractiveness to general practice graduates of working in poor areas where people have complex chronic and other health needs and little money, contributing to low local GP numbers. This is exacerbated by criteria for subsidising GP graduate placement that may exclude many areas that are in most need. It may be impossible for GPs to run a viable practice in some communities under the present policy settings. During the project, one

¹⁷ Dentistry, important for preventive health, is just one example of a part of AC that remains beyond the reach of many people.

practice in the H2H area was threatened with closure, and the COVID-19 pandemic may result in more such losses (Daly, 2020; Knaus & McGowan, 2020; McKenna, 2020).

The AC system relies on a strong preventive health role for GPs, and this is not possible with the present policy settings.

The social safety net

Poverty in some parts of the H2H area is affecting how people use the formal health system, as well as their access to health care resources. The social safety net, including social welfare payments and associated policies and processes, are also placing significant stress on recipients, and can reduce their trust in services making them unwilling to engage. Policy that leaves people poor, and processes and rules that are sometimes punitive, add to existing mental distress in communities, and undermine cooperation, collaboration, and safety. National and state policy settings are not something the H2H community can shift during the life of this project, but they shape how the system overall works and who it reaches.

Local government, though, has a role to play. Local actions can change internal organisational rules and processes, including those that respond to external policy and processes. Services can develop coherent processes that make the systems safer for all its users. By coherent, we mean processes that are easy to follow and make sense, that are delivered locally or by accessible means, and that use language that the audience is familiar with. Services can also adopt processes and rules that reduce stigmatising encounters, and increase trustworthiness and safety for users and providers.

Research question 2: Opportunities for enhancing anticipatory care here

The analysis showed that the different ways access is affected offered the H2H team opportunities to enhance the system.

Research question 3: What actions were implemented and what changes have they produced?

The H2H team further developed and trialled the four programs: It's Okay To Ask, The Right Place, Clarence Talks, and Help to Health Friends. They have also launched the Clarence Services Online Forum (August 2020) and demonstrated the necessity of the Health Connector role (there is good evidence for the importance of this role. See, for example, Eng et al., 1998; Nelson, 2020; Simpson, Hall, & Leggett, 2008, 2009). The project has found that these initiatives can improve the operation of the AC system for people in Clarence (Table 4). Activities or interventions are not the sole drivers of these changes, as the next section shows. The team's way of working, and the philosophy and approach of the Project Officer and Project Support Officer have been important drivers.

Table 4: Impact on AC system of some project activities

Clarence Services Online Forum (AC initiative)	<ul style="list-style-type: none"> • Launched after end of the project • Responds to the need to link community and health service providers, with potential benefits for better service collaboration and information sharing
Health Connector role (AC initiative)	<ul style="list-style-type: none"> • Strong evidence to support the benefits of a permanent health connector role with outreach from local government • PSOs built strong and trusting collaborative relationships across Clarence, reaching formerly hard-to-reach people and sites • Relationships supported community members to better access information and services for their health • Relationships provide a conduit from community to council and vice versa; citizens have evidence that council cares • Role focus is on being responsive to the health and wellbeing needs of Clarence’s communities through outreach, listening, working with CCC and community to find solutions, sharing CCC information • Increased local capacity to address AC system needs and support advocacy
Leadership Group (LG)	<ul style="list-style-type: none"> • LG engagement through PSO to find solutions, e.g., to potential loss of Risdon Vale GP clinic • Supporting local advocacy, and local capacity (e.g., through finding new ways to deliver Clarence Talks and IOTA)
The Right Place	<ul style="list-style-type: none"> • Follows model established in Huon Valley municipality, with local adjustments • TRP training has been extended to more organisations, including libraries, pharmacies,¹⁸ local government and a neighbourhood centre • Increased connection between service providers (an important outcome for the AC system) • Increased skills in PSOs: identifying and engaging participants, and managing and delivering the program

¹⁸ Our analysis found that pharmacies are playing an increasing role in anticipatory care, as a first port of call for many residents. They also often have long-term trusting relationships with community members, good data on those people’s health, and offer equitable access through numerous free services, all of which are essential elements in anticipatory care.

- It's Ok to Ask (IOTA)

 - Increased confidence among participants to support community members' health needs
 - Action learning resulted in adjustment of program to increase accessibility
 - Some increased sharing of IOTA advice and engagement with health professionals
 - Engagement with Risdon Prison and involvement in the health and wellbeing expo for male inmates. This is a significant action for reaching the hard to reach, and a population which is at greatest risk of many chronic illnesses
- Clarence Talks

 - Talks presented at a wider range of venues, increasing Council's reach and responding to local needs
 - Some evidence of reduced barriers between health professionals and community members
 - Clear benefits of local delivery in safe environments
 - Benefits for Council in increased knowledge of local concerns, more direct contact with community, and more ways of working with them
 - Increased local skills for identifying and organising sessions in response to need
- Help to Health Friends

 - Potential is large, but more work is needed to trial new meeting formats and venues (more local)
 - Can help CCC to identify local health information needs (and therefore increase access in the AC system)

Research question 4: What role does the local lead organisation—Clarence City Council—play in anticipatory care, and can it be strengthened

The selection of Clarence City Council as a lead organisation in the AC project recognised that local government can be important to the AC system. Councils deliver numerous programs that support health, including environmental health and hygiene, parks and playgrounds, sports facilities, and immunisation clinics.

Clarence has a Community Health and Wellbeing Plan (Clarence City Council, n.d., in revision). The Plan recognises the council's role in public health, and has a public health approach, building on collaboration. Local government also has reach; it is the organisation in any place that has the best chance of reaching its citizens. Local government is closest to the people; people can often point to what it has done for them or their locality.

However, there appears to be some ambivalence about this health role, and we identified some ways in which this ambivalence may act as a barrier to this local government taking a more active role in anticipatory care.

Barriers

The effectiveness of the H2H actions and activities has been affected by structural problems. We noted, above, the importance of policy and processes in the AC system; they can hamstring the system overall, as well as local initiatives. Policy settings are among the barriers discussed below.

Place and belonging—a weakness and a strength

We think there are some challenges for fitting the project with this very large municipal council. Some of this is geographical—a very large area (with a lot of people) like Clarence is a very different prospect from the other sites, which have smaller populations that are mostly more closely packed. But thinking about Clarence as a series of villages has helped us to understand some of the findings.

Clarence's villages have particular characteristics, so designing actions to improve access for all those different places and people is hard work. It can also be difficult to hear from those places—the experiences of a person in Risdon Vale are likely to be very different from those of someone on Bellerive Bluff, or at Richmond—and to know who is being heard, and who is missing. We heard that people like belonging to smaller places (and that they are often reluctant to cross the various 'moats' to go elsewhere). But many, many services are centralised, and that makes them alien for some people, and hard to get to for others. We also heard about the importance of local halls and local parks for people's physical and social health. These factors all make it difficult to identify the most effective system-level changes needed to enhance anticipatory care here.

Policy settings that reduce options for taking a SDoH preventive approach

There are numerous policy settings reducing the likelihood of building an anticipatory care system that takes the social determinants of health (SDoH) into account:

- Short-term competitive funding
- Narrow business models
- Lack of support for outreach
- Continuing poor distribution of necessary services (e.g., the continuing lack of adequate, local bulk-billing GP services) and increasing moves to online service provision despite problems with digital inclusion in Tasmania (Tasmanian Council of Social Service Inc. (TasCOSS), 2019b)
- Absence of flexible funding and a policy environment that supports longer term, community-driven and -designed approaches to improving health at the local level
- Continued difficulty reaching the ‘unusual suspects’ — people who are disconnected from services or community for various reasons
- The prevalence in policy, and some services, of a medical model of health, which excludes the full range of perspectives community members have about health, and limits what and how services are delivered
- Ongoing stigma attached to parts of Clarence— that some communities are not ‘deserving’ because of external attitudes that poor health is a personal problem or failing rather than a social problem. This was sometimes evident in the attitudes of some service providers’ who expressed a patronising “these people” approach to the community
- That GPs’ role in anticipatory care is contested; although they are expected to play a central role in preventive health, in fact the current policy settings mean there is little scope for GPs to work in that way
- Continuing lack of access to and availability of health resources and services, for example, access to GPs, ability to pay for health services
- Broader factors affecting health that require significant long-term strategies to address; namely housing, transport, food security, etc.

We now focus on two of these, short-term competitive funding and narrow business models.

Short-term competitive funding

Short-term, competitive funding has been found to be a barrier to the anticipatory care system across all the sites. Short-term funding refers to project- or activity-specific funding, for periods as short as six months to two years. This sort of funding means that work needed to create the right environment for the project intervention—linking people, gaining knowledge and informing people, reducing fragmentation, and building relationships—has often just started to take effect when the money runs out. And that destroys relationships, causes fragmentation, and undermines efforts to make larger changes to policy settings, for instance. It also leaves people feeling that they don't matter and reduces trust. Competitive

funding pits potential collaborators against one another, and takes resources from the on-the-ground service or activity to pay for developing funding submissions and evaluations (in other words, to compete). This undermines the AC system. The competitive environment also tends to gradually reduce the pool of organisations being funded (what the systems thinker, Donella Meadows calls “success to the successful”, Meadows, 2008), reducing the diversity of voices in the field, reducing opportunities for mentoring new leaders or collaborators, and reducing opportunities for new—and potentially better—approaches to develop.

In this project, the short-term funding appeared to act as a sort of threat. The AC project offered a way to continue the existing Help to Health work, but its goals were different. This demanded some shifts in thinking: from activities that were already underway and had been driven by different goals, to using the action learning process and causal loop processes to discern what activities might be trialled to enhance the AC system. A revision of ways of working was also needed for the members of the H2H Leadership Group, only some of whom welcomed the research component and the action learning approach. With more time, that transition may have been more successful; for example, the research team and LG could have negotiated towards more shared understandings earlier. A second factor may be that action learning’s cyclical and iterative nature may have been too indeterminate for the way local government operates, and so the change management that was needed to implement such an approach was more than tight timeframes would allow. Contract processes are also time-consuming for all parties. Finally, short-term funding (or uncertain funding) reduced job security for people in the project itself. This was a significant problem, contributing to both P/SOs moving to other work well before the project end-date and the early end of the project.

There is increasing evidence (from this, and other, work, e.g., Kavanagh, Shiell, Hawe, & Garvey, 2020) that to support local preventive health and wellbeing initiatives, communities—through carefully selected lead organisations—need to be funded and provided with resources (e.g., information, training/skills development, access to decision makers, as needed). The aim of funding should be to set broad goals, focus on outcomes (not outputs and activities) and then allow communities to get on with it. Projects or actions should focus on ways of working (e.g., partnership, trust, consultation, learning, sharing power, building on strengths), with funders acting as partners in the process.

Business models for services in the AC system

The business model operating in too many health services affects the anticipatory care system by reducing access to bulk-billing, reducing information sharing about the costs of services, and reducing the chance of health professionals doing outreach. As well, if planners (of health and other services) are not aware of this barrier, then planning will not meet local needs. While this policy is controlled at other levels of government, local government is a powerful lobby and does have oversight of planning decisions. One

example of the need for a review of policy is the model that determines where international medical graduates (IMG) can work in GP clinics. There is an argument that disadvantaged communities, especially those somewhat isolated from centralised services, should be categorised with rural or remote communities, increasing the options for clinic staffing in areas where Australian-trained GPs are reluctant to practise. This would not, however, address the discriminatory nature of the present policy; other models, including the Huon Council’s decision to operate GP clinics in outlying towns (Dover and Geeveston), may be a better solution. The Huon Valley Council’s decision took some ‘externalities’ into account. That is, the loss of a local GP service may have resulted in other services closing (e.g., pharmacy, banks), as people took their medical needs away from the towns (Julie Gordon, pers. comm.), with consequences for the towns’ viability. Providing GP services and allied health providers supported those communities in an otherwise centralised but large local government area. Their decision also acknowledged the particular characteristics of these communities.

Box: Clarence Talks bring people together

“At the Clarence Talks, I’ve watched as a barrier is broken down. The person giving the talk is much more informal. The audience sees that “They are not separate from us—they are people they’re just like me, and they have information about stuff I want to know about.”

And the health professionals’ perceptions changed—they are often quite nervous at the start but they are being exposed to a place they thought they would never be in (NHs). Being involved in the intimate group.

At a small level, this is a potentially important change. The more NHs have the talks, the more they say yes please to more. ... NH, prison, schools, particularly with IOTA, help people use the system better, and find ways to recognise some of the subtle impacts on health”
(Interview)

Clarence talks...free for everyone

help to health
Come and join us...
Everyone is welcome!
*Some nibbles will be provided

<p>Tuesday 24 July 2:00-3:00pm</p> <p>Rokeby Neighbourhood Centre 85 Tallard Drive, Rokeby</p> <p>Bulk billing: What does it really mean? Dr. Alice Frampton</p> <p>Why do I pay after appointments sometimes and other times it's free?</p> <p>Doctor Alice Frampton is a local General Practitioner who understands this can be confusing and will talk about what it really means for you and for doctors.</p>	<p>Thursday 26 July 10:30-11:30am</p> <p>Clarendon Vale Neighbourhood Centre 45 Mockridge Rd, Clarendon Vale</p> <p>Can a Nurse Practitioner help you? Lisa Sproule</p> <p>Did you know a Nurse Practitioner (NP) can prescribe some medications too?</p> <p>Lisa Sproule is a local Nurse Practitioner who will talk about how visiting a NP can be another helpful health care option for you.</p>	<p>Tuesday 7 August 1:30-2:30pm</p> <p>Rokeby Neighbourhood Centre 85 Tallard Drive, Rokeby</p> <p>Flu vaccination: To take or not to take! Scott Wood</p> <p>What are some of the pros and cons to taking the jab?</p> <p>Scott Wood is a Community Health Nurse Immuniser and will be talking about the flu shot. If you are unsure, this might be useful to help you decide whether to get immunised or not.</p>
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If you would like to come along, please let us know by phone or email:
0438 096 465
help@health@ccc.tas.gov.au

Hope to see you there!
These information sessions are a part of the Clarence City Council help to health project.

The business model operating within Council also relies on measures which cannot capture the *quality* of experiences. What, for instance, can we learn from the fact that around 100 people attended the 19 Clarence Talks over the life of the AC project here? An average attendance of about five people per session looks like a poor investment. However, other measures might reveal that those five people had never before attended a health talk, or other Council-delivered session, that they changed a health behaviour as a result, or that they each talked to five other people about what they had learned. Those sorts of measures would give a more accurate picture of the impact of activities. One useful measure, noted in the evaluation report, is that host organisations want more regular talks; this signals that the sessions are valued (Maddock, 2020).

Further, the H2H team has built relationships which mean that the Clarence Talks are being led by community-based organisations, demonstrating a more effective AC system.

The usefulness of the methods

Action learning

Action learning was a good fit for the AC project here; much of this learning took place in the PSOs sphere. The H2H team followed its cycles of Observe, Reflect, Plan, Act to review and adapt some of the actions and activities already operating here. The P/SOs in particular were alert to change or the impacts of actions, gathered new evidence or options (including from the ongoing research component), reflected, and consulted on how to respond to what they were learning. For the UTAS researchers, too, the action learning approach was effective overall, not least because action learning builds in periods of reflection that allowed us to revise the ways we were working. A good example of action learning was that the P/SOs reviewed and redesigned the project survey. Having tested the original version, they rewrote it using plain English principles, and this version became the one used in three of the four AC project sites.

There were things that took time to get right. For example, the design and delivery of the community workshop in 2019 was a poor fit for this community; it was partly driven by contractual elements. On reflection, we think a series of smaller, 'village-based' sessions is likely to have been more appropriate, and could have enabled us to hear from a more diverse group. Time pressures also contributed. More time should have been taken to work with the H2H team to co-design this early consultation and engagement process.

It was also not always easy to know the best way to communicate our analysis/reflections for the planning or other parts of the cycle, or how to bring in the systems thinking aspects of the project. A related problem was that there was some uncertainty about how best to balance and fund the research and outreach components of the PSO role.

Time, repeated contact (especially with the PSOs) and mutual reflection and support helped us build increasingly trusting relationships between the H2H team and the UTAS

researchers. It became easier to work effectively, to reflect together and understand what we were learning. We know our own capacity has been built, and this has also happened in the H2H team.

Although both action learning and systems thinking were being trialled in this project, the ways in which they were applied were not prescribed by the CCWG in the original project design. This was both a weakness and a strength. Early in the project, researchers and the H2H team felt some uncertainty about how to proceed, what, when, with whom and how to share what we were learning, and how to surface and incorporate local ways of working into the wider needs of the project. Action learning models demand that the participants shape the project, but there was necessary relationship work to be done to develop the level of trust between leads, PSOs, DoH Principal Project Officer and UTAS necessary for that agency to be taken on.

Systems thinking and tools

Systems thinking was warmly welcomed by the LG members, some of whom had some knowledge of systems approaches. Causal loop diagramming engaged participants in telling stories, which then informed how we understand the AC system and helped those present identify opportunities for change. This process also addresses a concern some researchers have with action research—that it is not genuinely participative, but instead runs the risk of imposing researchers' evangelical activism on communities. A second valuable systems thinking tool is 'systems traps' (Meadows, 2008). UTAS and the H2H team have used this tool to identify and find ways around real and potential stumbling blocks.

The systems processes can be very complex, and the language of systems thinking and CLD is not plain. A further risk is that the CLD process is shaped by the people present, by data gathered in other ways, and by particular perspectives on AC (e.g., across the AC sites in Tasmania, the 'problem' of the role of GPs in AC has sometimes dominated). If these sources are weighted towards the loudest voices (and missing the hard-to-reach), solutions can only ever be partial.

We need to work harder to find ways to introduce ideas such as systems thinking and tools such as the CLD process early and to encourage their use—or to build locally-relevant tools that can serve a similar purpose. If we can do that, it may be possible to reach more community members, learn much more about their experiences of the system first-hand (rather than through interpreters like researchers or members of the local site team), and thus support both genuine participation and local solutions.

Summary

In the H2H site, actions and activities have enhanced each of the elements that Watt and colleagues (2011) said are necessary for anticipatory care. The project has increased trust and built relationships, gathered and made use of high quality data, worked in ways that reduce

fragmentation of the system, and made access a little more equitable. Work by the H2H team has fostered collaboration across multiple sectors, increased Council's reach into its disparate villages and parts of the system, and increased understanding that tackling chronic illness is a complicated social endeavour, not one that rests solely with medical and health services. Further, there are structures in place that can be sustained and used to build on the changes.

The AC Action Learning Project has resulted in increased:

- Understanding that AC involves a wide range of people and services from different sectors
- Cooperative and collaborative relationships between a greater range of people and services at multiple levels
- Capacity (knowledge, skills, and capabilities) in key players and organisations to support safe access to the AC system
- Networks, with shared AC goals, language, and opportunities for health advocacy
- Clear evidence for the importance of a health connector (or connectors) to the AC system's function
- Support for the value of local government as a host for the health connector, and as an important element in the AC system.

Limitations

- Time
 - time limits mean that we cannot prove or be definitive about the health benefits delivered by the project
 - more time is needed to further develop connections with health service system providers (e.g., neighbourhood centres, schools, sporting facilities)
- Participation
 - although the lead organisations and collaboration with services extended the reach of the project into some of the more marginalised members of the community, there remained barriers to hearing from and including them in the project
 - some of the methods we used were not accessible to some participants (and potential participants).

Potential and future direction

- The LG is showing promise as a vehicle/‘scaffolding’ to connect services, and leaders, to keep a focus on health goals, and to drive health changes for this community
- The opportunity created through AC funding to develop the H2H initiatives has led to the identification of the centrality of the Health Connector role in supporting the anticipatory care system. The project has shown that strengthening local health systems requires concerted effort and dedicated resourcing
- The actions taken have set up foundations that could be built on with the right resourcing. The CLD also shows new areas of interconnectivity (and therefore potential impact) that provide future potential system focus points.

Recommendations

The AC project has demonstrated that enhancing the AC system is possible at the local level, through local government initiatives. The project has planted the seeds of new ways of thinking and working; we make the following recommendations to support long-term benefits to AC and the health of this community. There are opportunities to maintain and build on what has been gained.

H2H's four programs + Clarence Services Online Forum

The foundational H2H programs (The Right Place, It's OK to Ask, Clarence Talks, and H2H Friends) showed promise as activities that improve engagement and access to services and information for the community, and foster networks and partnerships across the system. Clarence Services Online Forum may build on this.

Partnerships and collaboration across the system are essential. The LG, supported by Council, has a role in building and sustaining collaboration across this site, and in shifting attitudes to support AC. They can also reach out to communities to understand local needs, people, and situations so that responses can be locally relevant, accessible, and meaningful.

- Council adopts and embeds a social determinants of health approach in all decisions and actions, including providing ongoing professional development in preventative health ways of working for all CCC staff and elected representatives
- Maintain the LG and links it is developing with services across Clarence (e.g., Community Nurses, health promotion groups)
- Encourage local service providers to incorporate outreach and collaboration as key tasks for all service providers working across the municipality, with a particular focus on the communities/villages with the weakest AC system.

Performance measures or Key Performance Indicators (KPIs) have historically ignored qualitative measures of 'soft infrastructure' and change in favour of quantitative 'number of services' measures. These cannot adequately reveal how the AC (or other health and wellbeing) system is performing.

- Revise CCC and health service KPIs to reflect externalities, soft infrastructure and experiential dimensions of performance.

P/SOs have supported the lead organisations and LG, reached out to community and to services, been involved in the research, and introduced new ways of working. Importantly, they have been the Council's 'eyes and ears' in the 'villages' and have enhanced CCC's ability to respond to local circumstances. They have developed capacity in action learning and systems thinking, and for gathering and interpreting evidence. Their links with the research team have been essential for our work, and for connecting the research with the reality and implementation:

- Establish the Health Connector as a dedicated function/role within CCC to support and enhance the AC system, including through:

- physical activity, social connection and information sharing initiatives (e.g., Clarence Talks, H2H Friends, IOTA, outreach to ‘the villages’)
- relationships with existing and new service providers and researchers to strengthen coordinated approaches to improve health and wellbeing across Clarence
- innovation to address AC needs.

For local, state and national policy action

All levels of government have a role to play in efforts to alleviate chronic illness.¹⁹ These recommendations to build on the gains from the AC Action Learning Project—and to spread those gains more widely—rely to a greater or lesser extent on recognising that shared role and shifting policy:

- Recognise that local government plays a central role as a system connector across local AC systems
- Prioritise creating dedicated Health Connectors in local government
- Local, state and federal governments need to develop KPIs that reflect externalities, soft infrastructure and experiential dimensions of performance
- Factor the importance of place and belonging into policy decisions at all levels of government, including (but not limited to) infrastructure, service provision, town planning, and social housing
- CCC continue to advocate for funding arrangements that support and promote collaboration and long-term relationships.

Project-specific funding models are damaging the AC system. To better support the health and wellbeing of the community, we need:

- To replace competitive funding models that reduce connection and collaboration between parts of the AC system with models that promote and support collaboration
- Flexible funding over longer periods
- Funders should consider the adoption of community-level or place-based budgets where resources are pooled and invested to promote long-term health and wellbeing
- Funders to work as partners, providing guidance and monitoring of process (e.g., community engagement, how resources are being utilised/targeted, without being prescriptive)
- Trusting local communities to identify their own priorities, and strategies to address those priorities.

¹⁹ These roles will be explored more fully in the final report.

GPs' potential role in the AC system can be supported if they adopt clear, transparent information and easily understandable guidelines explaining their bulk-billing policy and practices:

- Continue bulk-billed telehealth services, subject to evidence that this is improving access to GPs for members of marginalised communities
- Review national and state regulation of GP services to counter supply shortages and increase equity of access to bulk-billed telehealth (e.g., the recent guideline that only people who have a regular GP can use bulk-billed telehealth reduces access to this service for many who do not have a 'regular' GP)²⁰
- Review subsidies for GPs servicing rural and remote areas to include outlying and disadvantaged communities.

For future work on anticipatory care and preventive health

Gains from the project activities are difficult to measure in terms of chronic health outcomes within the life of the project. An overarching aim of the AC project was to use a systems approach to identify strengths and weaknesses in AC systems and co-design community specific responses. Assessing the longer-term health dividends is beyond the scope of the study:

- A longitudinal study is needed to determine the level of benefit from the changes to the local AC system.
- Further flexible resourcing should be provided to continue to build on this work into the future.

Action learning and systems thinking have been effective here, but both rely on time and trusting relationships:

- Provide sufficient time in future anticipatory care work to develop relationships with local team and community, and to adapt processes and tools for maximising participation
- Introduce systems tools early and encourage their use—and adaptation—to suit local users. This could support the inclusion of more community members, first-hand learning about local systems (rather than through interpreters like researchers or members of the local site team), and thus support both genuine participation and local solutions.

There are clear mutual learning benefits for the university, the DoH and the H2H team in the approach taken here to working to enhance anticipatory care. The contributions made by each group are particular and cannot readily be 'swapped'. The ideal of equipping local communities to replicate the approach without these supports burdens them. Similarly,

²⁰ Many people in areas with poor supply of GPs are not on a GP's 'books' and so may be excluded from bulk-billed telehealth.

university researchers cannot ever become expert enough about a local site to work in ways that are inclusive and appropriate without partnering with locally embedded organisations:

- Future preventive health (including anticipatory care) projects should build in opportunities for mutual learning between community, university, and relevant government personnel.

Appendices

Appendix 1: The H2H project site



Source: google maps

Systems thinking can help us better understand complex problems; where boundaries are unclear and solutions are either too simple (and often unlikely to work) or the course of action is not clear. Chronic disease prevention is a complex problem unlikely to be solved by a single solution.

Why give systems thinking a go?

Rates of chronic disease are on the rise. Diabetes is the fastest growing chronic condition in Australia. Many public health researchers, policy makers and practitioners lament the lack of progress in reducing rates of chronic disease. Some believe its because we are blinkered in how we understand the complexity of these problems. We tend to only focus on individual behaviour and fail to see the complexity of people's lives that influence the decisions they make about their health. Systems thinking offer a different way to think about problems and potential solutions. There are also some promising studies showing the benefits of taking a systems approach. In one study, the authors reviewed type 2 diabetes programs and found that those that applied complexity (or systems thinking) principles in their design such as interconnectedness, were associated with better outcomes for patients. That paper is attached.

What does a systems approach mean for the AC project?

The Anticipatory care projects take the local AC system (rather than an individual) as its starting point. Research is currently underway to surface local practices and identify important parts of the system such as the AC workforce or the range of programs and initiatives currently being implemented. It will surface new and missing perspectives on anticipatory care and elevate local knowledge to create a more comprehensive picture of the system. It will extend traditional "health service" boundaries to include community infrastructure such as community houses, schools and social services. A more comprehensive picture of the AC system will also surface new and unexpected opportunities to intervene to strengthen relationships, draw new players into the system, modify practices to be more inclusive and so on.

Along with systems thinking, various tools and methods will be applied to the AC project such as systems mapping. But most importantly, it is built on the premise that knowledge about the local AC system can only be created from within the local AC system and this is where the most relevant and potentially long-lasting solutions will emerge.

Source: *Therese Riley, in Anticipatory Care: An action learning project in Tasmanian communities of place and culture—A manual for community project support officers (UTAS, 2019, pp. 17–18).*

Appendix 3: Data sources in the Help to Health site

We used quantitative and qualitative data sources.

Table A3a: Quantitative data—from existing sources

<i>Source</i>	<i>What</i>	<i>How used</i>
<i>2016 Census data</i>	Population profile statistics for each suburb in the CCC catchment: ages, sex, diversity, employment, income, education, volunteering, households, etc.	Data is being used to understand the demographics of the area. This data also enables comparison with Tasmanian averages, and with the other project sites.
<i>Primary Health Tasmania, the Australian Health Atlas</i>	Health status and health behaviours information for the area (e.g., smoking or physical activity rates, prevalence of diabetes); data on location of GP services	Data is being used to map health status and behaviours and to compare this with Tasmanian averages and with other project sites.
<i>UTAS literature review</i>	Location of non-GP health or wellbeing services in the area; availability of bulk-billing; numbers of GPs; research findings about the area (e.g., previous H2H evaluation report, GP Access project documents, emerging literature on local government, etc.)	Published research reports and other literature is being used to collate what is known about the presence of the social determinants of health and use of services, for instance.

Table A3b: Data gathered in the Help to Health area by UTAS researchers, to June 2020

	<i>Participants/documents</i>
<i>Interviews and focus groups</i>	61 people
<i>Community workshop</i>	16 people (+ researchers)
<i>Survey</i>	42 people
<i>CLD workshops</i>	15 people
<i>Reflections with/by PSOs</i>	27 documents
<i>Fieldnotes (from community and CLD workshops, LAG and exec meetings, site visits)</i>	20 documents

A note on surveys

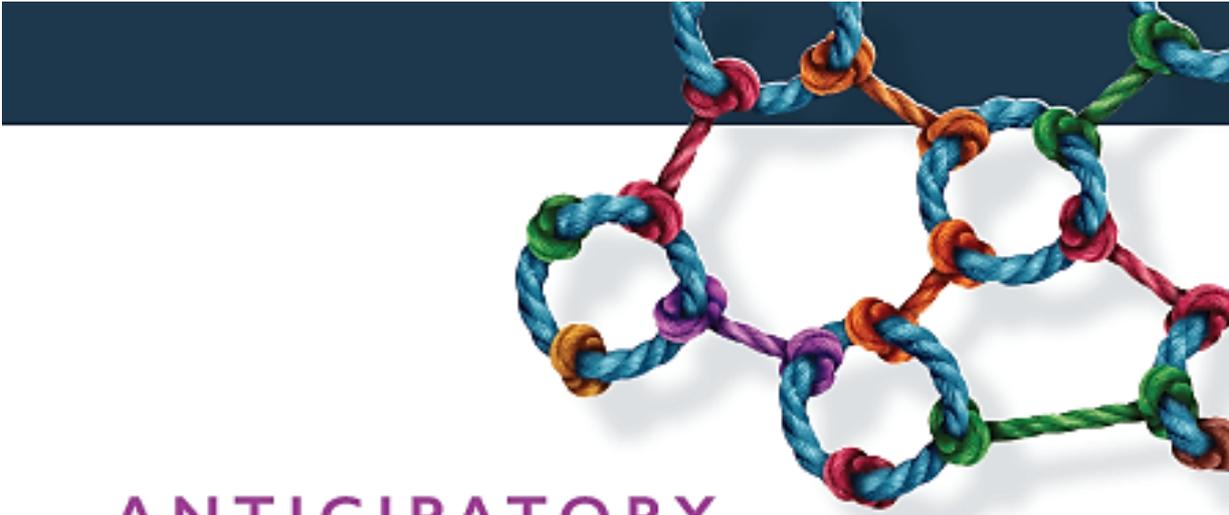
We needed to understand how people in the AC Action Learning Project communities experienced anticipatory care, and the health system more broadly. Interviews and focus groups were appropriate for some members of the community; they rely on potential participants being identified, those people trusting in the process and having time, skills and desire to participate. However, we needed to find out how people who are ‘hard to reach’ experience the system, and this is also the population for whom interviews or focus groups are least appropriate (Rockliffe, Chorley, Marlow, & Forster, 2018). We discussed ways to engage with this group with the leads and PSOs, and surveying was suggested.

A survey was designed and trialled. There are personal and infrastructural constraints on surveying, including literacy, access to the internet and to data.²¹ This meant that the surveys were handed out—mostly by the PSOs—for completion at various places in the communities, rather than offered online. After a short period, the PSOs and the research team reflected on how this process was going and the survey was revised, in keeping with action learning processes (by the H2H AC project team), to use Plain English and more tick-box response options. We also decided that the survey should be interviewer-administered. There is good evidence that using ‘peer interviewers’ (in this case, the PSOs) or people already embedded in a group or community can increase engagement (Bonevski et al., 2014; Devotta et al., 2016). In each site, the PSOs had connections into the communities. The surveys asked people for quantitative and qualitative answers.

PSOs were encouraged to support and prompt participants to provide detail about the sorts of people and places that are involved in their health behaviours and care. Conducting surveys significantly increased PSOs’ engagement with community, and familiarity with different community settings.

²¹ Some novel methods were proposed (by a PSO in the Launceston site) that would not require literacy; they were not pursued.

Appendix 4: Previous report (2019)



ANTICIPATORY CARE PROJECT

ACTION
LEARNING TO
IMPROVE HEALTH
IN TASMANIAN
COMMUNITIES

PRELIMINARY FINDINGS FOR CLARENCE

Report prepared by UTas Institute for the Study of Social Change, July 2019



Department of Health



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Report on the findings in Community 1: Help to Health

Prepared by UTAS Institute for the Study of Social Change researchers: Dr Susan Banks (Project Chief Investigator), Dr Robin Krabbe, Thérèse Murray, Sarah Hyslop and Miriam Vandenberg (Researchers)

The project aims and structure

In Tasmania, the number of people with chronic conditions such as cancer, heart disease, diabetes, arthritis, stroke and asthma has continued to increase over the years. This project will identify and support new models of anticipatory care as an approach to the management and prevention of chronic conditions.

Anticipatory care is a population approach to health care that identifies and engages people who are at risk of developing chronic conditions with the aim of preventing or slowing health deterioration. Through relationship building and by recognising the social context in which they live, people are supported to be 'co-producers' of their health.

The Tasmanian Department of Health (DoH) has received funding from the Australian Government to conduct research to better understand and learn from communities about different ways anticipatory care happens and what works well and why. Over the next 18 months, we are working with four Tasmanian communities to apply an action learning approach to anticipatory care to:

- Increase our knowledge and understanding of how anticipatory care occurs in different communities
- Better understand the enablers and barriers to anticipatory care experienced by communities
- Increase our knowledge and understanding about how communities and health services can work together to engage 'at risk' Tasmanians in primary and preventative health care, including assessment and management of their health needs.

(Anticipatory Care, Project Guidelines, 2018)

Roles of the participating organisations and groups

The project is a collaboration between the Department of Health (DoH), the University of Tasmania (UTAS), and lead organisations in four Tasmanian communities that were selected by DoH because of their chronic health and preventable hospitalisations profiles.

The University of Tasmania is working with each community lead organisation through the 'local project lead' (in this case, Suzanne Schulz and Kate Franke) and the Project Support Officer (PSO) (Emily McKinnon). UTAS is also working with each community directly through data gathering (e.g., interviews, focus groups, workshops, observations) and through the Local Advisory Groups.

The project design, processes and effectiveness overall are being evaluated by The Australian Prevention Partnership Centre and the Sax Institute. The structure of the project, and the broad roles of the participants are shown in Attachment 1.

Attachment 2 illustrates the task of the community lead organisations, University and evaluation partners. The project processes are summarized in Table 1 below.

Table 1: Project processes in brief

1.	DoH identifies appropriate project sites and engages a local lead organisation
2.	Lead organisation appoints Project Support Officer(s) and recruits a representative Leadership Group
3.	UTAS commences mapping anticipatory care in each community, with the help of the PSO
4.	PSO supports UTAS research and works with lead organisation to engage the community in the project and enhance anticipatory care
5.	UTAS reports findings of the mapping process at community forums/workshops and seeks response from the community members present and more widely
6.	UTAS collates and analyses all data about the nature and experiences of anticipatory care in each community and reports local findings to each CRG
7.	Leadership Group and local project steering committee determine how the findings (and DoH funding) can be used to develop a project or projects to support and enhance anticipatory care in the community, with a particular focus on those people who are most at risk of developing a chronic illness
8.	Local project steering committee (lead organisation, including project lead and PSO/s), on the advice of the Leadership Group, implement action (with UTAS support as needed)
9.	UTAS continually monitors (with support of the PSOs) impacts of the action/s, reporting to the lead organisation and Leadership Group to support adjustment (as per the action learning methodology)
10	UTAS reports outcomes and overall findings to the Leadership Group and lead organisation, the community, and the government

The research questions

There are overall research aims (see Box, above) as well as specific research questions.

The research questions (RQs) are:

Mapping anticipatory care:	What does anticipatory care look like in each community? What are the shared elements and what are not? What is working, and who is it working for? What is not working, or who is not benefiting?
Opportunities for enhancing AC:	What elements in the existing system can be influenced (and are they within the capacities of local actors)? What gets in the way?
Actions and outcomes:	What actions are the sites implementing? What changes have the actions resulted in—what differences can be seen at individual, organisation, service and community levels?

There is also a research question tailored to each community. In Clarence, this question is:

Help to Health RQ	What is the role of Local Government in Anticipatory Care?
--------------------------	--

The research approach and methodology

Health can be thought of in a variety of ways and from a number of different perspectives. This multi-factorial perspective fits with the definition from the World Health Organisation that health is "*a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity*".²² Some people, within and outside the health system, think of health as measurable by the presence or absence of a diagnosable condition; we can (often) determine whether a person has high blood pressure, diabetes, a tumour or a cold, for instance. Health can also be about the actions people take to maintain or improve their wellbeing: like doing sufficient physical activity, not smoking, eating a range of nutrients and not too many of them, and so on. Increasingly health is also understood to have psycho-social and socio-economic dimensions. The 'social determinants of health'²³ is a framework that brings together the evidence that health is shaped by exposure to disease and by social, economic and psychological risks over a lifetime. These quantifiable and experiential aspects of health are reflected in the Anticipatory Care project's

²² Preamble to the Constitution of WHO as adopted by the International Health Conference, New York, 19 June - 22 July 1946; signed on 22 July 1946 by the representatives of 61 States (Official Records of WHO, no. 2, p. 100) and entered into force on 7 April 1948.

²³ Sir Michael Marmot's work was first reported in the Lancet:

[https://www.thelancet.com/journals/lancet/article/PIIS0140-6736\(05\)71146-6/fulltext](https://www.thelancet.com/journals/lancet/article/PIIS0140-6736(05)71146-6/fulltext)

Discussion Paper (January 2018),²⁴ which states that the characteristics of anticipatory care include:

- “Reaching people who need care most (for example, through effective community partnerships and outreach models)
- Early identification and assessment of future risk (for example, by combining assessment of psychosocial as well as physical and biomedical risk)
- Enabling people to improve their health (for example, by joining up health and social services to address social determinants of health and using self-management approaches)
- Improving the personal experience in the healthcare system (for example, through integrating care, care coordination and supporting consumers to navigate health systems)
- Planning care using local health data and consumer input (for example, by using population data, shared client records and consumer involvement in planning)” (pp. 5–6).

This is represented in the Tasmanian Anticipatory Care framework, which guides the project and is presented in Attachment 3.

To map the existing anticipatory care system in each community, we therefore need to rely not only on statistical information about people’s circumstance and health status, but also on finding out what people’s experiences of health and the health system are, and what attitudes people have to their health. Collecting and analysing this information will also enable us to see whether there are any opportunities for change, and to measure improvements resulting from actions each community takes in this project.

A note on Action Learning

The research process is continuous over the life of the project (see Attachment 4); we want to understand what the initial situation is, use that to inform planning for change, and then monitor what happens when the actions are put into place. This is a cyclic process of observing, reflecting, planning and acting.

Data Sources

UTAS researchers are responsible for the bulk-of the data gathering in this project and for the data analysis and reporting.

²⁴ Available on request.

Confidentiality

Where individual, identifiable information is provided, the usual approach to confidentiality has been applied. Similarly, responses to focus group issues, workshop data and reference group advice have been aggregated into themes by way of established academic practices to avoid the identification of individuals. The UTAS procedures have been approved by the Tasmanian Social Sciences Human Research Ethics Committee [H0017669].

Two complementary data gathering approaches are being used in this project.

Quantitative data sources

Quantitative data enables counting and measurement and can answer questions like “How many?” and “Where?”. Table 2 lists the main quantitative data sources.

Table 2: Quantitative data—from existing sources

<i>Source</i>	<i>What</i>	<i>How used</i>
<i>2016 Census data</i>	Population profile statistics for Clarence: ages, sex, diversity, employment, income, education, volunteering, households, etc.	Data is being used to understand the demographics of the area. This data also enables comparison with Tasmanian averages, and with the other project sites.
<i>Primary Health Tasmania, the Australian Health Atlas</i>	Health status and health behaviours information for the area (e.g., smoking or physical activity rates, prevalence of diabetes); data on location of GP services	Data is being used to map health status and behaviours and to compare this with Tasmanian averages and with other project sites.
<i>UTAS literature review</i>	Location of non-GP health or wellbeing services in the area; availability of bulk-billing; numbers of GPs; research findings about the area (e.g., reports on the GP Access Project, etc.)	Published research reports and other literature is being used to collate what is known about the presence of the social determinants of health and use of services, for instance.

This information is being used to help create a statistical picture of anticipatory care in the area; it was also used to select the Launceston northern suburbs area as one of the suitable project sites. Some parts of this statistical picture are provided at Attachment 5 and were reported in the July 2019 Community Workshop videos and posters.

Qualitative data sources

Qualitative data is about the nature of a phenomenon. It is used to answer 'how', 'why' or 'what is that like' questions. Table 3 (below) sets out the qualitative data gathered so far. It is used to find out what an experience is like, how people understand something or what it means to them, or what motivates or prevents a behaviour, for example.

UTAS researchers are using qualitative data to find out how people in the Help to Health area experience and understand health, the health system in general and anticipatory care in particular. We are gathering qualitative data using interviews, focus groups and observations, as well as at community workshops (held in July 2019 at Clarence on the Bay). In each of these processes, the researcher also takes notes about the session and these fieldnotes are included in the overall data. To date, qualitative data has been collected from 32 people; 12 people attended the community workshop. Finally, 15 surveys have been completed by community members. Observations include community audit work (e.g., observing what events or services are advertised and where, where people are active physically or socially in the community, attending a meeting at Risdon Vale, etc.). Observation fieldnotes were also made by researchers at the workshop, to capture what topics people responded to, as well as to record any stories or examples that were discussed at the tables, but not shared via post-it notes or feedback to the wider workshop.

Interviews and focus groups gather in-depth information and are usually between 45 minutes and 2 hours in length. They are opportunities to gather detailed information. Data gathered at the Community Workshop is less in-depth but gives an indication of the prevalence of particular concerns or views among those present. Workshop material has been included in data reported here. We are currently working to include more people who are living with higher than average risk of developing a chronic illness in our data. This includes older people, and people of all ages who experience socio-economic disadvantage and/or isolation, or who rarely use medical services but also don't access non-medical health and wellbeing supports and hence may be at risk of developing a chronic condition. We are also

using informal conversations, conducted by the research team and the PSO, to develop our understanding of anticipatory care in Clarence.

Survey data

The project PSOs are gathering survey data. While surveys often gather quantitative data (e.g., the national Census), this survey combines quantitative and qualitative questions. Kate Franke and Emily McKinnon revised the original pilot survey, and their version is being used in three of the project communities. We want to find out not only “What”, “How many” and “Where”, but also experiential information, like how people think about health, who they go to for different sorts of information or help, why they go there or what barriers they encounter. The PSOs are encouraged to prompt participants to provide detail about the sorts of people and places that are involved in their health behaviours and care. The survey is part of our efforts to include people who are ‘hard to reach’, a key parameter of the project brief. The survey is useful because for some people non-identifiable surveys are less daunting than a recorded interview or focus group, meaning they are more likely to open up and provide useful information about the barriers they face. Often people are embarrassed about their own difficulties in overcoming social, economic, psychological or physical barriers; this personal information is crucial in identifying less obvious barriers encountered by marginalized individuals (with often significant consequences for their health). The survey is also intended to gather data from people in other groups or categories that have not so far been included. Two further functions of the survey are to increase the PSOs’ engagement with the community²⁵ and to enable UTAS to build ‘social network maps’. The surveying is intended to continue over the life of the project, and survey responses are being analysed by the UTAS team.

Data analysis and synthesis

Bringing together the data that have been gathered and working to analyse and make sense of them is a complex task. The statistical and literature review material has been collated and used to:

- (1) describe the human, informational and infrastructural elements of the anticipatory care system, its potential users and the community
- (2) help in the design of the qualitative data gathering (e.g. to inform questions and prompts about particular aspects of anticipatory care)

²⁵ PSO engagement with all parts of the community will support implementing (and adjusting) actions to enhance anticipatory care.

Qualitative data are being analysed thematically. This involves researchers reading and rereading all the material and noting common themes. In the analysis, we have been coding for predetermined themes. Examples of these are:

- How people define anticipatory care
- The system parts (i.e. how people explain or understand the system and its sub-parts)
- Who plays what roles in anticipatory care
- What supports anticipatory care and what barriers to anticipatory care exist

We are also alert to themes that emerge in the data, to surprises or anomalies, and to ways in which the themes are related. The findings from the quantitative and qualitative analysis are also considered together, to reveal similarities and contrasts, and to build as complete a picture of the anticipatory care system as possible. This method has enabled us to add to the statistical map of anticipatory care, to understand more about and more accurately define the factors (system parts) that contribute to anticipatory care, and to reveal how individuals and organisations experience and understand health and anticipatory care in the Help to Health area.

Preliminary results

UTAS is reporting these findings as part of our role in providing evidence to the local community, through the Leadership Group, to support planning for enhancing anticipatory care in Clarence.

Our first report of the findings was made at the July Community Workshop, where what we knew so far was shared with community members, using the idea of system parts. Anticipatory care can be understood as a system, made up of linked sub-systems. UTAS researchers worked with a systems theorist to identify six anticipatory care system parts: People and health, Infrastructure, Attitudes and Actions, Relationships, Leadership, and Health Services Information.²⁶ Since the workshop, the observations, table- and post-it notes have all been transcribed and added to the project data. Posters summarizing the main themes are being prepared for circulating.

The reporting here is two part. The first part describes what we know about the anticipatory care system as it 'looks' in Clarence ("The system parts", see below).

²⁶ Workshop participants responded to what was working, not working, confusing or could be changed about those system parts. This information has been included in the data analysis.

The second part describes how this information can be used to enhance that system (“Using the evidence to plan for enhanced anticipatory care”, pp. 13–16).

The system parts

The analysis and synthesis findings show that there are system parts (individual, infrastructural, attitudinal, and informational) that research participants recognized as working (e.g., the multiple opportunities for physical activity), as well as things that do not work or are confusing (e.g., the clustering of services in Rosny/Bellerive, bulk-billing decisions, or a lack of coordination among services). It was clear from the data synthesis that two additional themes or system parts are important: “Place and belonging”, and “Policies and systems”. Interestingly, these themes are common to all project sites. How residents and service providers think about where they live (sense of belonging, knowing the place, pride in place) shapes actions or behaviours. And policies and systems can be transparent and coherent, or complicated, opaque and impede the use of a service or services. The following section reports the main data findings for each of the system parts, before we turn to a discussion of the opportunities for intervention. There is overlap between these system parts.

The revised system parts

People and health	Community members and their health, life events and pressures, capacity and identity People experience health in different ways and have differing expectations. While some people are very actively engaged in ‘being healthy’ for others personal health can be a low priority, but the health of a loved one is taken seriously Examples from the data include “Young men—those are the clients who are not turning up”; “I feel healthy when I can live the life I want to live”; and “Keeping people safe in their environments matters” ²⁷
Attitudes and actions	Individual and organisational motivations, assumptions, and judgments, and understandings of their role in the

²⁷ Examples are not direct excerpts from the data but are encapsulations of multiple instances in the data.

health system. This includes expectations and norms, stigma and judgement

Beliefs and attitudes shape how people and organisations behave and what they expect of themselves and others

Examples from the data include “People in services need to respond well the very first time, because it takes so much courage to pick up the phone”; “People don’t want to be tagged with a particular condition, so they go to neutral services, rather than ‘drug’, or ‘mental health’ places”, and “Referral pathways are really blocked—by attitudes and processes”

Infrastructure

The geography and topography, as well as facilities and services and the people who staff them

Infrastructure is where health happens. It can be cohesive, accessible and safe, or restricted to those on-the-inside. In Clarence, services are clustered in some areas and distant from others

Examples from the data include “I know there are services out there, but I can’t get to them”; “The physical environment is just not safe for people with mobility issues”

Health services information

Health services information includes statistics about health *conditions*, risk and the prevalence of chronic illnesses, as well as information about health *services*, and how to access them

Health services information can support health practices but is not always accessible or focused on community needs

Examples from the data include “Sharing information starts with learning from the community about their knowledge”; and “Asking the wrong question could end badly for me”; “It is hard to navigate the system to get

the care I/the patient needs”; and “Is there something local?”

Leadership

In the Help to Health area, leadership takes the form of people who are good sharers, navigators, and networkers who have credibility and expertise and are trusted

Leadership can be linked with a role (e.g., Neighbourhood House leader, GP, councilor, school principal), but leadership can also come from a person who solves a problem and then shares that solution with others

Examples from the data include “I realized that my way of dealing with a health problem could be useful for others and found ways to share it”; and “We get together and support one another”; Leaders are very local”; and “Good leaders listen”

Relationships

Relationships may be between individuals, between individuals and organisations, or between organisations

Relationships rely on effective communication, consistency of staffing, leaders who share, processes that support connection and care, and policies that support collaboration not competition

Examples from the data include “It’s hard to break through the organisational silos around here”; “I know I can come here and that I will be respected”; and “You need to have someone who knows you, who has a history with you” “I’d love to go somewhere else, but I dare not get off that bulk-billing doctor’s list”

Policies and processes

The rules and approaches that apply in all sorts of settings

Organisation-level policies and processes reflect the attitudes and beliefs of the people creating and using them, as well as State and federal legislation and policy.

They can support or inhibit relationships, information sharing, leadership and the effective use of information

Examples from the data include “Short-term competitive funding damages the system”; “Multiple staff changes are a disaster for service users”; “There’s a lot of mixed-up referral processes”; and “Our policies are making it hard for us to work with others”

Place and belonging

Place and belonging are about the connections people feel to an area or a facility; it includes feelings of pride, of security and the sense that others share that attitude

Place and belonging are linked with people’s likelihood of using a local service, wanting to support or nurture local infrastructure (e.g., parks or neighbourhood houses) and relationships, and reluctance to go ‘outside’ the locale for health-related services. The data clearly shows that Clarence is experienced as a collection of centres or ‘villages’ rather than having a coherent identity

Examples from the data include “I won’t go there; it’s not my sort of place”; “It’s pretty obvious what the government thinks of us—they don’t look after the infrastructure and keep taking things away”; and “We’re losing the places people where used to meet”

It is difficult to directly change some of the system parts (e.g., infrastructure, some policies or processes, attitudes and beliefs, or leadership) within the scope and timeframe of this project. However, there are opportunities to make a difference by working to increase *access* for community members and services.

Using the evidence to plan for enhanced anticipatory care

For the purposes of planning to enhance anticipatory care, it is useful to concentrate on the ‘biggest’ idea, and groups who are at greatest risk of chronic illness. The ‘biggest idea’ in Clarence is **access**. Barriers to access can be seen to be contributing to the way chronic illness is clustered in the city; these are set out in the next section.

Overall, Clarence has relatively good health outcomes, but the city has the State’s third-highest number of people per head of population with multiple chronic diseases, the Mornington–Warrane area has particularly high levels of potentially

preventable hospitalisations, and Clarence was ranked second highest in Tasmania in average annual rates of alcohol attributable hospital separations for the period 2011 to 2015. More pointedly, Risdon Vale was recently (2019) reported to have the second highest smoking rate in Australia (after Gagebrook) with 34.4 per cent of residents smoking. Australia's overall smoking rate is 14 per cent (see Attachment 5 for more details).

Opportunities for intervention

Clarence City Council, our project partners in the Anticipatory Care project, has considerable capacity to act on the health of its residents. It makes multiple policy and planning decisions that affect a large population (55,000+) and it also has opportunities to influence policy at State level. The data analysis reveals opportunities to build on Council's existing leadership (e.g., Community Health & Wellbeing Strategy) in health and wellbeing.

The analysis suggests that the strengths of the present anticipatory care system in Clarence are the presence of a policy focus and multiple facilities and services that can support health,²⁸ but that such positives are reduced by problems with access. Clarence is very geographically and socioeconomically diverse, and spreads over a large area. Services are mostly clustered in the Rosny/Bellerive area. While the location of services is difficult to change in the short-term, Help to Health's focus on access can be strengthened with potential benefits for the anticipatory care system in this local government area.

There are four domains within access in Clarence: geographical and physical (e.g., can the person get to and use the facility or service); emotional or psychological (e.g., does the person feel emotionally safe at that service or place); resources (e.g., what financial, or educational resources can they draw upon); and social (how isolated from others is the person). These domains are possible foci for plans and actions to enhance anticipatory care in Clarence.

Access

Clarence has been described as a collection of villages, and this sense of multiple separate clusters is supported in the data. It affects all sorts of access.

²⁸ This includes the H2H programs that build access—The Right Place, It's Okay to Ask, Clarence Talks and the H2H Friends.

There are geographical and physical barriers to access

The data provides several examples of physical or geographical barriers that exclude or restrict people from an activity or service, as well as where accessibility could be enhanced. For instance, there is a reported unwillingness to 'cross the bridge' (go outside own geographical area or 'village'), coupled with lack of transport options (barriers include no vehicle, no service, or cost). Some communities have lost (sometimes temporarily) a local service and non-local options are harder to get to. The temporary closure of the Risdon Vale clinic and the loss of a GP service in Richmond are examples of service loss, as is the closure or sale of local meeting places including churches and halls. These losses contribute to a sense in those communities of not being valued by the broader society (and affect the 'Place and belonging' system part).

There are emotional or psychological barriers to access

The sense of Clarence as a collection of villages may contribute to some insularity. Access relies on people trusting and feeling safe in the services or facilities that support their health (whether that is an exercise opportunity, a place for a social card game, or a medical clinic). Safety includes ensuring that people feel welcome and individually cared about, interact with familiar people, and do not feel anxious because of a lack of useful information, uncertainty about the physical environment or the risk of being stigmatised. Examples of stigmatising behaviour²⁹ include a person having to explain why they should be bulk-billed, low service provision in particular already-disadvantaged areas, or people's wish to not use services that are known to support people with stigmatised conditions (e.g., drug addiction, mental illness).

There are resource barriers to access

People need financial, educational and technological resources to interact with or enter services; alternatively, services and facilities should adapt to local capacity and needs. Access to financial or economical resources affects individual citizens as well as organisations providing health-related services. One strong theme in the data is that for some people in Clarence, the cost of a non bulk-billed GP visit is prohibitive.³⁰ For some services, competitive funding, short-term contracts, and business models leave no room for outreach or collaboration. A third resource access

²⁹ Whether 'real' or perceived, stigma has similar consequences. To cite Thomas Theorem, "If people define situations as real, they are real in their consequences".

³⁰ This may be driving people's use of the RHH Emergency Department (people not using a GP for preventive or early intervention, then experiencing an acute episode).

problem relates to the capacities people need to enter or interact with services. Many services rely on a literate population.

Table 4: Highest level of educational attainment of largest group

Area	Highest attainment of largest proportion of the residents	Proportion
Tasmania	Year 10	17.4%
Clarence	Bachelor degree or above	18.8%
Risdon Vale	Year 10	17.4%
Mornington	Year 10 and Certificate III	18.5% each
Warrane	Year 10	20%
Rokeby	Year 10	21.9%
Clarendon Vale	Year 10	27.5%

Table 4, above, shows that in Clarence overall, those who have a Bachelor degree or higher make up the largest group in the education attainment statistics (Census 2016) (18.8% in Clarence compared with 16.2% for the State). This overall figure obscures a significant variance within the city. There are several suburbs in Clarence where the most common level of educational attainment (the mode) is Year 10. These results align with the SEIFA measures of disadvantage. It is likely that literacy in these areas is poorer.

Literacy enables people to access and make use of information. It is important to ensure that any information provided is responding to a community need and uses language or images that meet the needs of the intended audience. Further, information that supports people’s health is increasingly provided online, but up to a quarter of people in some Clarence suburbs do not access the internet at home. Mornington–Warrane (24.1%), Risdon Vale (25.6%) and Rokeby (23.7) have poorer rates of access than do Tasmanians overall (19.5%) (Census, 2016). The problem is particularly pressing for people who must use online portals to access services (e.g., Centrelink, MyAgedCare and the NDIS). This is exacerbated where the population is older or not digitally literate.

There are social disconnection barriers to access

Access relies on involvement with your community or peers, and knowledge of what is available. Strengthening and diversifying the Help to Health Friends program is one means to break down this barrier. Social isolation reduces access to and the use of facilities and services that support health (including mental health). People who are socially isolated do not hear about relevant supports and may be unwilling to venture out to find or try them. Increasing the connectedness, between

services and between individuals has significant benefits for health, but connectedness also makes use of services more straightforward. The findings show that people want to see familiar health or social care providers (e.g., so they do not have to explain themselves repeatedly), but also value social connections and want to reduce isolation.

Summary

The analysis suggests that the anticipatory care system in the Help to Health area can be enhanced by adjusting processes so that access, in multiple forms, is enhanced. This is a possible focus of plans and actions by the Leadership Group. Of the lead organisations in the Anticipatory Care project, the Clarence lead organisation has the greatest power to shape anticipatory care. Several of the access barriers can be impacted upon by planning and resourcing decisions made at the local government level, and by Council's capacity to lobby State and Federal governments, including through LGAT. Clarence City Council is one of the few local governments in Tasmania to take a proactive approach to health (over and above their traditional role in environmental health, and the provision of parks and other recreational opportunities). Anticipatory care—including the access domains discussed here—in Clarence could be an explicit consideration when planning and resourcing decisions are being made.

Next Steps

The next step in the project is to use the findings to decide on actions or interventions that can make the greatest difference. The following questions may be a useful decision-making guide:

- Given the findings, what are the 3 top priorities that you think Help to Health should work on? This includes who the project will target.
- Is there something that is do-able, achievable and sustainable that can be tried/done to improve or address one or more of the issues identified by the research?
- What difference do you think the proposed action will make in terms of improving the health of individuals and/or the community? How will it contribute to the prevention/better management of chronic conditions?
- What are the ripple, or flow-on, effects of the proposed actions?

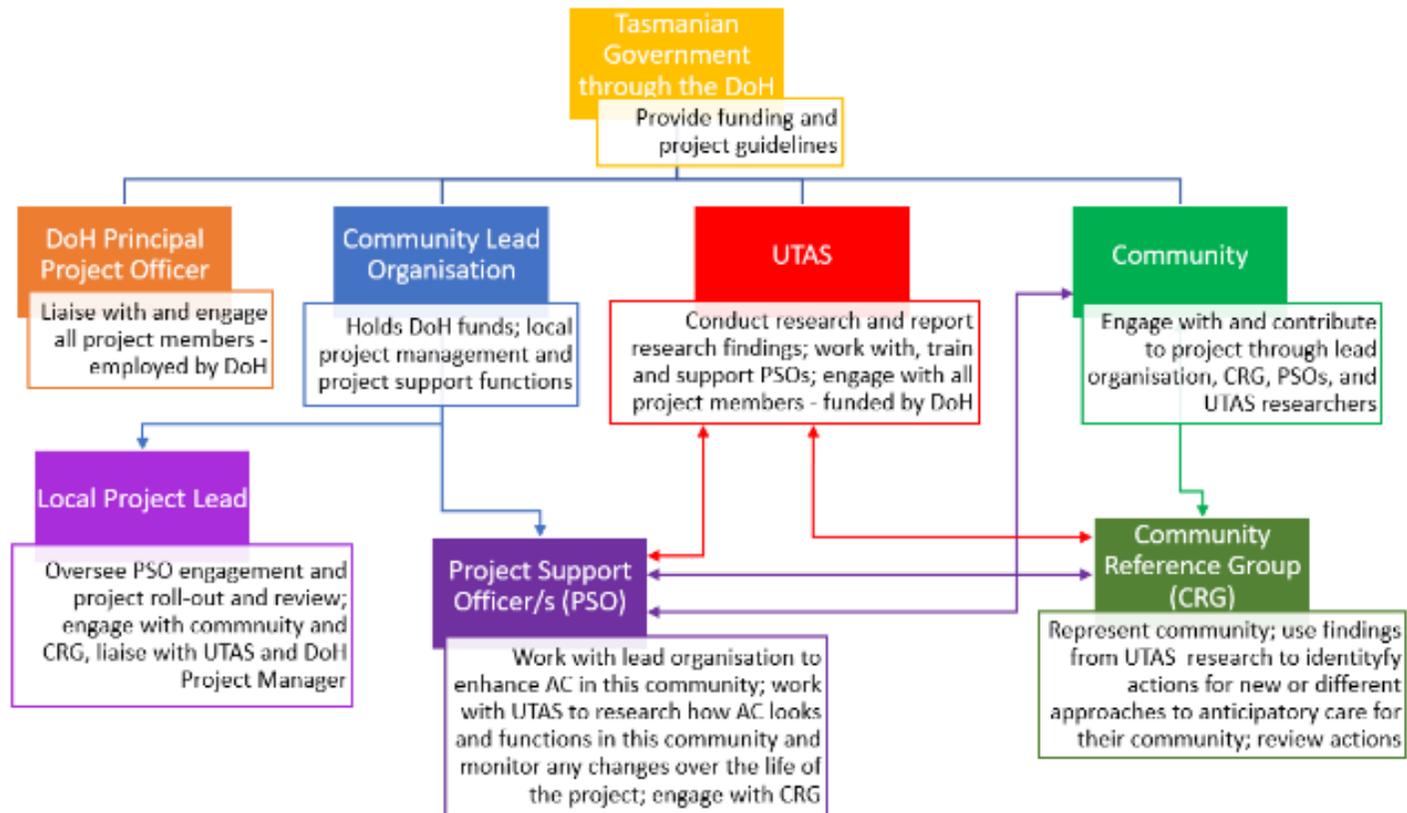
Action plans need to consider the available resources and feasibility, and how those actions will contribute to the health of individuals and the community, and to the

prevention or better management of chronic conditions. Actions can be thought of in terms of form (what the action is), function (why those activities or actions are taken), and ripple effect (what are the flow-on effects and who might experience those ripples).

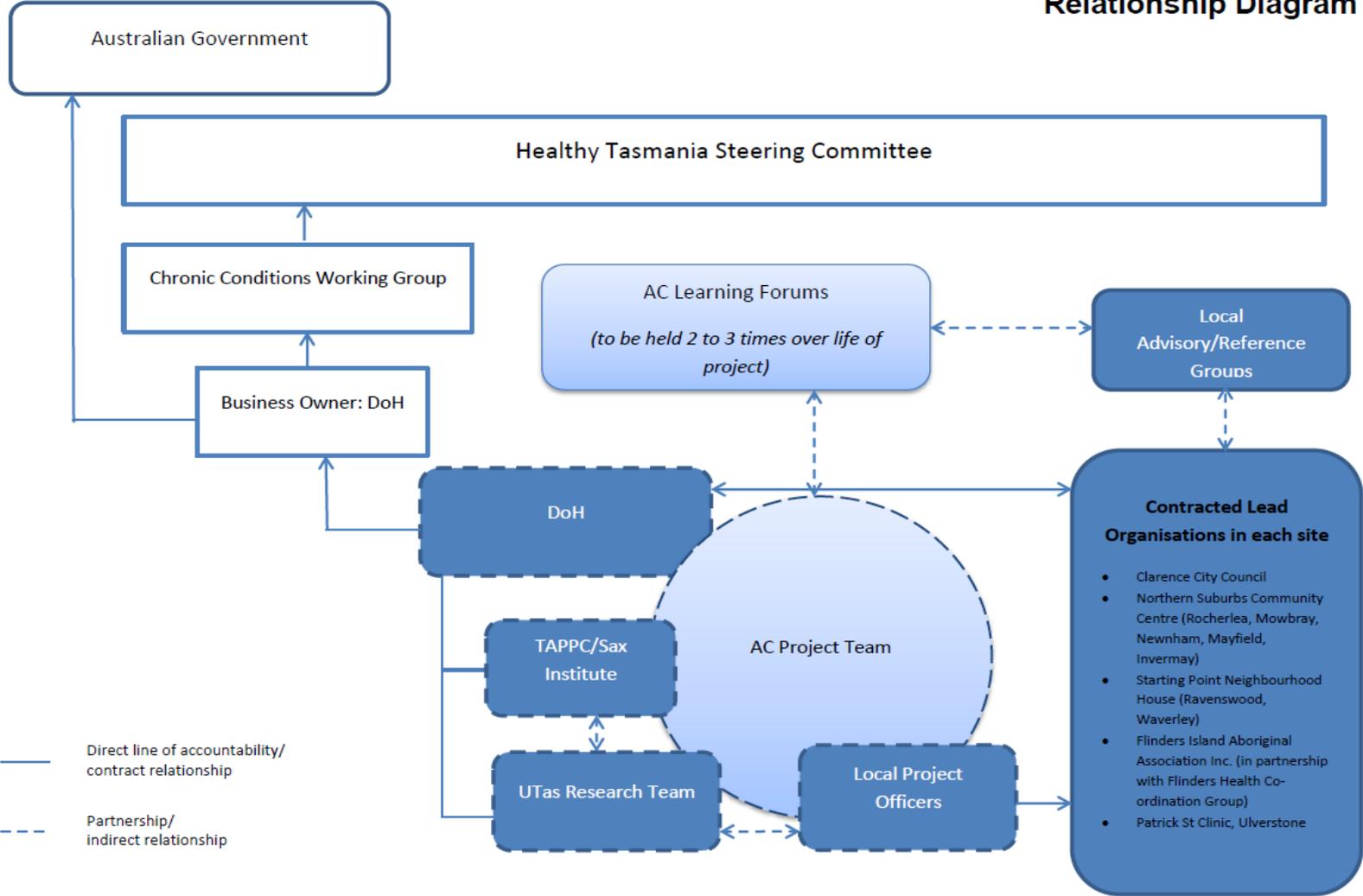
A note on completeness

There are participant types and areas of anticipatory care in the Clarence area that we still have relatively little information about; the experiences and potential solutions they will offer are important for the project's aims and are being sought now and over the life of the project (including via the survey). The action learning process means that as new data is included and analysed, those findings will be reported to the Leadership Group and executive for use in the planning or modification of actions to enhance anticipatory care.

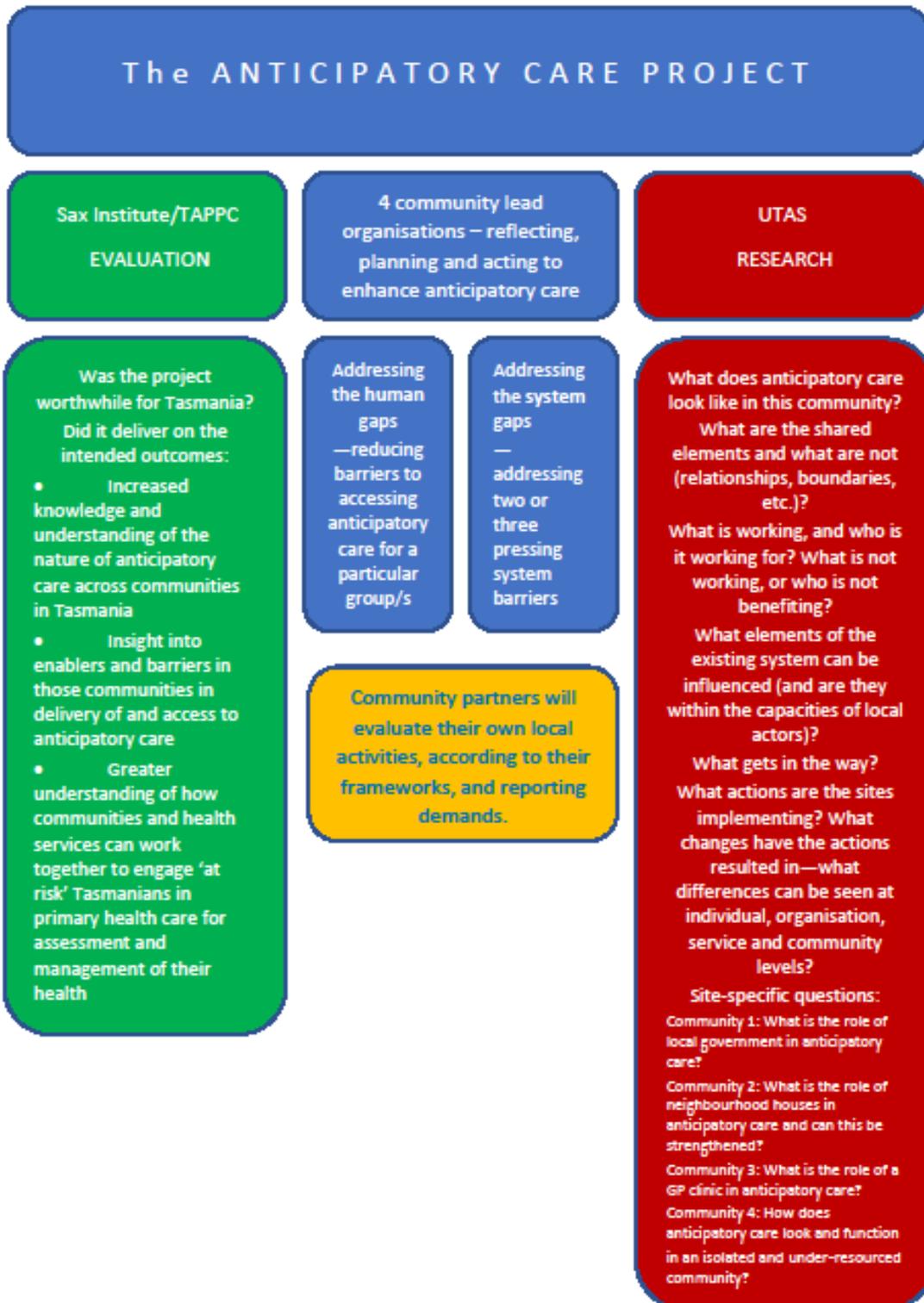
Attachment 1: Anticipatory Care project roles and relationships



Tasmanian Anticipatory Care Project: Relationship Diagram



Attachment 2: Evaluation, Research and Community lead tasks



Attachment 3: The Anticipatory Care framework

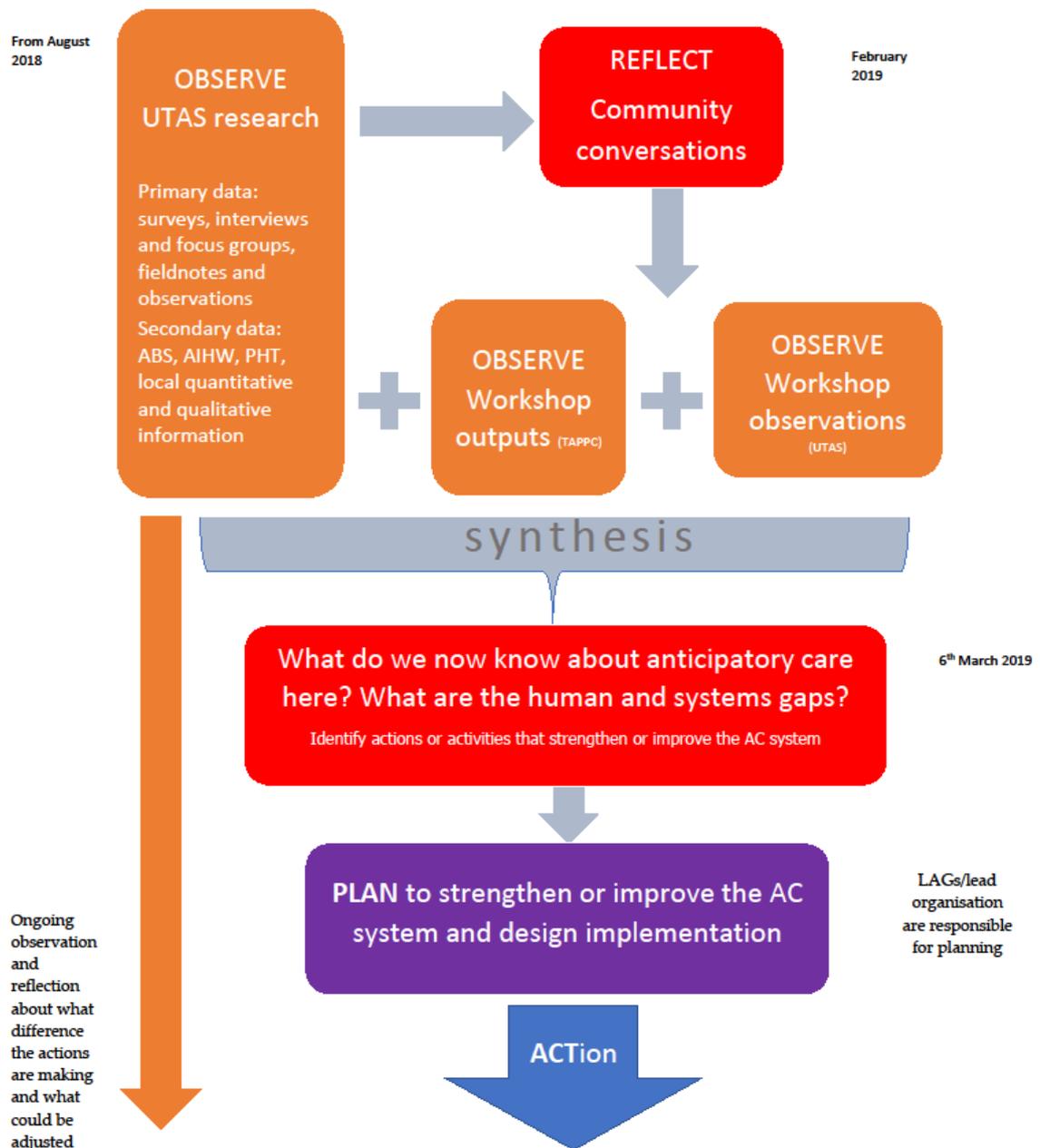
Priorities	Description	Elements	Enablers/ supports	Consumer outcomes	Population outcomes
<p>Outreach to people who most need care</p>	<p>Focus care on individuals and their carers who are hard to reach and who have the greatest need in the community</p>	<ul style="list-style-type: none"> → Use proactive outreach strategies → Use population and disease registers and do 'case finding' → Develop partnerships with community → Seek opportunistic ways to engage people in their health care 	<p>Governance and leadership</p> <ul style="list-style-type: none"> → Support and leadership → Joined up health and social services (acute to community) → Local area coordination → Partnerships with services who can outreach → Consumer engagement <p>Health workforce</p> <ul style="list-style-type: none"> → Identify needs and attitudes → Training and resources (health promotion, self-management) <p>Health literacy</p> <ul style="list-style-type: none"> → Easy to understand education resources → Health literate organisations <p>Data and information</p> <ul style="list-style-type: none"> → Data sharing agreements → Community health profiles → Local community knowledge <p>Technology</p> <ul style="list-style-type: none"> → Patient registration → 'flagging' systems → EHealth Resources → funding models → Screening & assessment tools → Chronic Disease self-management programs <p>Research & evaluation</p> <ul style="list-style-type: none"> → Action Learning projects → Monitor patient outcomes and population → Effective outreach models 	<p>My community encourages me to adopt a healthy lifestyle.</p> <p>I am supported to make good proactive choices about my health and wellbeing.</p> <p>I am able to participate in purposeful and meaningful activities.</p> <p>My informal carers are recognized as an important support element in my life, and are included in my care.</p> <p>I can access and use tools to make decisions about my health.</p> <p>Any illness I have is picked up early and I get help managing it.</p> <p>My health care is tailored to my needs.</p> <p>Everyone in my care works together as a team, considering the many factors that keep me healthy and well.</p> <p>With my consent, my care team can easily access information about my contact with different parts of the health system.</p>	<p>Tasmanians have good physical health.</p> <p>Tasmanians have good mental health.</p> <p>Tasmanians at risk of poor health or living with chronic conditions are supported to stay well for as long as possible.</p> <p>Tasmanians are supported to overcome addictions.</p> <p>Tasmanians are supported to overcome crises, addictions and adverse life events.</p> <p>Tasmanians have a voice and choice in decisions about their health and wellbeing.</p> <p>Tasmanians can access the support they need in a timely manner from a well-working service system.</p> <p>Tasmanians are aware of important public health issues.</p> <p>Tasmanians have resilience to overcome adversity.</p>
<p>Early identification and risk assessment</p>	<p>Work with people to assess and anticipate risk: life circumstances and psychosocial factors @ lifestyle factors @ clinical risk factors @ impact of disease</p>	<ul style="list-style-type: none"> → Develop long term trusting relationships → Identify individual care needs (psychosocial and physical health) → Use many ways to engage people in assessment (e.g. proactive, system reminders and opportunistic screening) 			
<p>Enable people to improve their health</p>	<p>Strengthen personal skills and create connections with social and community services to enable people to influence the determinants of their health</p>	<ul style="list-style-type: none"> → Strengthen health literacy and consumer engagement → Develop self-management skills → Provide evidence based care across the disease prevention continuum → Help people address psychosocial and physical care 			
<p>Improve the personal experience in the health care system</p>	<p>Develop teams around people with support and planned pathways of care to respond to their prevention needs at different life circumstances and different stages of disease</p>	<ul style="list-style-type: none"> → Multidisciplinary team based care → Include informal carers → Integrated and coordinated care → Support care pathways which are easy to navigate → Use shared health records 			
<p>Plan care using local health information and consumer input</p>	<p>Use local health information, consumer records and consumer input to identify local health needs and focus proactive care</p>	<ul style="list-style-type: none"> → Use local health data and practice, population and disease registers to identify health need → Provide proactive care focusing on need → Involve consumers in the planning of services 			

Attachment 4: The action learning process in the Anticipatory Care project

Action learning involves cycles of observation, reflection, planning and acting (Figure uses Launceston site

Cycle 1 – Anticipatory Care Action Learning Project (observe, reflect, plan, act ...)

This is an outline of the first action learning cycle in each site, using Launceston’s northern suburbs as the example. Observe, reflect, plan and act are continual; new observations and reflections spark new planning and adjusted action.



example).

Attachment 5: Indicative statistical material about the Help to Health area

Table 1: Demographic data for Clarence city, Census 2016

Characteristic	Number	Percentage (in city)	Tasmanian comparison
Population total	54,819	(10.75% of state)	509,965
Female	28,232	51.5%	51.1%
Male	26,587	48.5%	48.9%
Median age (national = 37)	43		42
Pre-school age (0–4)	3,197	5.8%	5.6%
School age (5–19)	9,821	17.9%	18.2%
Working age (18–64)	30,810	56.4%	57%
Post-work (65–84)	9,513	17.4%	17.2%
85 and older	1,497	2.7%	2.3%
Aboriginal people	1,937	3.5% of city	4.6%
Female	955	49.2%	50.9%
Male	988	50.8%	49.1%
Median age (national = 23)	25		24
Language spoken at home			
English (only)	49,469	90.3%	88.3%
Greek	237	0.4%	0.2%
Mandarin	214	0.4%	0.8%
German	170	0.3%	0.3%
Nepali	102	0.2%	0.2%
Spanish	95	0.2%	0.2%
Children per family (all families)	0.7		0.7
Children per family (families with children)	1.8		1.8
Housing			
Private dwellings (occupied)	22,053	91.6%	86%
Separate house	19,640	93.3%	87.6%
Owned (outright or mortgaged)	15,602	74.1%	69.2%
Rented or other tenure	5,460	26%	30.7%
Average people per household	2.4		2.3
Median weekly household income	\$1,306		\$1,100
Median monthly mortgage repayments	\$1,452		\$1,300
Median weekly rent	\$265		\$230
Health care card holders (% of pop)		7.5%	9.4%

Average motor vehicles per dwelling	1.8		1.8
Private dwellings without a motor vehicle		6.3%	7.5%
Internet accessed from dwelling	17,267	82.0%	78.0%
Work (aged 15 and over)			
Worked full-time (paid)	14,176	54.7	52.3%
Worked part-time (paid)	9,017	34.8%	35.0%
Away from work	1,385	5.3%	5.7%
Unemployed	1,338	5.2%	7.0%
Did voluntary work through organisation or group	9,381	20.9%	21.3%
Education—highest level attained			
Nationally, 22% of people have a Bachelor or higher qualification and 15.7% have completed year 12.			
Eligible population completed year 10 or higher		89.4%	86.3%
Bachelor or above	8,440	18.8%	16.2%
Advanced diploma/diploma	3,961	8.8%	7.5
Cert IV	1,397	3.1%	2.9%
Cert III	6,630	14.7%	14.8%
Year 12	5,789	12.9%	12.0%
Year 11	2,129	4.7%	4.7%
Year 10	7,107	15.8%	17.4%
Year 9 or below	3,705	8.2%	10.3%
No educational attainment	106	0.2%	0.4%
Industry of employment (top responses)			
State government administration	1,024	4.2%	2.7%
Hospital (other than psychiatric)	939	3.8%	3.6%
Primary education	791	3.2%	2.6%
Central government administration	716	2.9%	1.6%
Supermarket and Grocery Stores	649	2.6%	3.0%
Religious affiliation			
No religion	20,704	37.8%	37.8%
Anglican	12,205	22.3%	20.4%
Catholic	10,149	18.5%	15.6%
Not stated	4,818	8.8%	9.7%
Uniting Church	1,627	3.0%	3.8%
Travel to work			
Car, as driver	16,427	66.9%	65.3%
Car, as passenger	1,499	6.1%	5.8%

Bus	1,228	5.0%	2.4%
Walked only	453	1.8%	3.0%

Source: Statistical information is from the Australian Bureau of Statistics, 2016 Census QuickStats: http://quickstats.censusdata.abs.gov.au/census_services/getproduct/census/2016/quickstat/LGA61410?opendocument%20, and Australian Bureau of Statistics, Census of Population and Housing: General Community Profile, Australia, 2016, Cat No 2001.0 (Canberra, Australia: 2017).

Table 2: Health risk data for Clarence and Tasmania

	Clarence	Tasmania
% self-assessed health fair or poor (2013)	15.8	19.0%
% current smoker	10.8 ³¹	15.7%
% daily smoker	9.6%	16.9%
% smoking during pregnancy	11.0%	13.8%
% low birth weight babies	7.2%	7.1%
% overweight/obese BMI	35.9%	37.3%
% obese BMI	26.5%	25.6%
% Alcohol consumption levels causing occasional harm => 4 standard drinks at least yearly	42.4%	45.4%
% Alcohol consumption levels causing lifetime harm => 2 standard drinks at least weekly	19.6%	38.5%
% insufficient moderate/vigorous activity, <150 min moderate/75 min vigorous/week or combination	12.8%	14.9%
% insufficient muscle strengthening activity, <twice weekly muscle strengthening activity	73.6%	70.2%
% inadequate fruit consumption, <2 serves daily	58.7%	59.6%
% inadequate vegetable consumption, <2 serves daily	91.6%	91.0%
% psychological distress high or very high	10.1%	13.4%
% persons with three or more chronic conditions	25.4%	21.5%
COPD [avoidable] deaths (ages 45-74)	11.7%	13.7%
diabetes [avoidable] deaths	5.4%	7.9%
suicide and self-inflicted injuries [avoidable] deaths	8.8%	13.3%

Source: The most recent data available has been included and is from Ahmed et al. (2017), the AIHW National Drug Strategy Household Survey (2016), and the Australian Bureau of Statistics 4364.0.55.001 - National Health Survey: First Results, 2017-18

Table 3: Top ten PPH admissions and allied health provision, for Clarence LGA, 2015-16

³¹ Note, Risdon Vale was recently (2019) reported to have the second highest smoking rate in Australia (after Gagebrook) with 34.4% of residents smoking (<http://www.mitchellinstitute.org.au/media-releases/smoking-rates-australia/>). Australia's overall smoking rate is 14%.

Potentially Preventable Hospitalisations	Primary diagnosis on admission	Allied health provided in hospital
Diabetes complications	(Z49) Care involving dialysis	Pharmacy
Congestive cardiac failure	(z51) Other medical care	Physiotherapy
Chronic obstructive pulmonary disease	(R07) Pain in throat and chest	Social work
Urinary tract infections, incl. Pyelonephritis	(O80) Single spontaneous delivery	Occupational therapy
Convulsions and epilepsy	(Z45) Adjust & mgmt drug delv / impl dev	Dietetics
Asthma	(Z38) Liveborn infants accord to plc of birth	Speech pathology
Pneumonia and influenza (vaccine preventable)	(Z75) Prob rel med facilities oth health care	Diabetes education
Ear nose and throat infections	(R10) Abdominal and pelvic pain	Pastoral care
Angina	(J18) Pneumonia organism unspecified	Psychology
Dental conditions	(E83) Disorders of mineral metabolism	Prosthetics and orthotics

Source: PHT (Primary Health Tasmania, n.d.)

Table 4: Potentially Preventable Hospitalisations for Clarence, for the four years from 2011/12 to 2015/16

Area	Potentially preventable hospitalisations, age standardised rate per 1,000 population (2011/12-2015/16)
Clarence	22.3
Tasmania	21.2

Note: The data shows particularly high levels of PPHs in three Tasmanian locations, including Mornington–Warrane, in Clarence. Clarence is also in the top-three Tasmanian areas with large estimated cohorts of people per head of population with multiple chronic diseases, ranks fourth in terms of highest hospital separations due to mental disorders, and was ranked second highest in average annual rates of alcohol attributable hospital separations from 2011 to 2015.

Attachment 6: Help to Health—Identifying priorities for action

Summaries of the local themes that have been identified from the community workshop and research.

	ATTITUDES AND ACTIONS	INFRASTRUCTURE	PEOPLE AND HEALTH	RELATIONSHIPS	LEADERSHIP	HEALTH SERVICES INFORMATION
BIG LOCAL THEMES	<ul style="list-style-type: none"> No afterhours service to outer areas, and not many free afterhours health services; Call doctor not available in outer areas People call ambulance afterhours as no other service available; need 24-hour centre or be able to call for advice Don't want to cross the bridge – should have city services in Clarence; parking, cost, commuting all make process of going to Hobart city difficult Isolated people; too many people we can't keep track of or who are 'missing' and either isolated or stigmatised Distrust in system – people not engaging or using services; people only go to places they trust Trust is undermined by stigma, assumptions, discrimination (sense of 'those people') 	<ul style="list-style-type: none"> Services are concentrated in Rosny/Bellerive Outreach is too rare The edges—less well serviced Transport—direction of bus, e.g., going across bridge and to Rosny Park rather than between suburbs; indifference of Metro to this Breaks in tracks/walks (e.g., Rokeby to Lauderdale) and some sections (e.g., Oakdowns to Rokeby) dangerous for cyclists Belonging—localisation and sense of belonging to a community; strong in some places but lacking in others (e.g., Montague Bay lacks sense of belonging) Council taking more control over what developments they support—should be more inclusive Not everyone knows about neighbourhood centres Access to suitable sporting equipment to participate 	<ul style="list-style-type: none"> Knowing the language and how to communicate matters We don't know who is missing/how many and where they are Build community connections—decentralising Safe, inclusive, welcoming spaces The local not being valued—culture, sense of belonging Changing focus from 'taking people away from Clarence' to 'what is here' Culture can be a barrier Stigmatised conditions shape service use (e.g., drug treatment) 	<ul style="list-style-type: none"> Communities of fellowship have been lost—neighbourhoods are missing the church's role in prevention isolation and bring people together Bringing older and young ones together—normalising Some wide gaps in the integration of or collaboration between services for health People seek health and wellbeing support where the service has consistent and friendly staff (Threats of) loss of services reduce community sense of pride and being valued Relationships within the 'villages' can be very strong; between villages is 	<ul style="list-style-type: none"> Local leaders in neighbourhood houses or Men's Sheds are important conduits and supports Council not playing role; reactionary; silos in CCC and between them and other agencies; not agile or innovative Lack of co-ordination CCC could overtly value health and wellbeing Little explicit presence of GPs in leadership for health 	<ul style="list-style-type: none"> Too much conflicting info that is hard to navigate People giving up when faced with queue or waiting list People want to interact with a (preferably familiar) human Are services/professionals being 'in the moment' with community members or pre-judging? People don't understand health info—is it meeting the needs of all community members? Difficult to find out about health and wellbeing Some sense that CCC is 'set in its ways', has a focus on the more urban centres, and does not truly engage with community People only going to ED because they don't know where else to go Complexity of service model leads to competition and duplication; models not set up for community needs Privacy and confidentiality – healthcare in Tas doesn't have complete confidentiality esp. for those who work in sector

Below is a summary of things that are working or could be further strengthened to support the health and wellbeing of the community.

	ATTITUDES AND ACTIONS	INFRASTRUCTURE	PEOPLE AND HEALTH	RELATIONSHIPS	LEADERSHIP	HEALTH INFORMATION SERVICES
THINGS THAT COULD BE STRENGTHENED/ BUILT ON	<ul style="list-style-type: none"> Promotion of health by Clarence active aging committee (incl. role in advising CCC) Other options for social and medical health promotion? (e.g., State government) Achieved WHO age friendly city status Men's shed – working with university re dementia Opening school playing fields up to community Informal learning networks 	<ul style="list-style-type: none"> Increase community transport Co-ordinating ride share More local hubs Clarence activity trails: walking tracks, coastal walk/other walks, biking, kayaking Sporting opportunities– Bellerive oval, beaches, pools, etc. Sports and fitness in the park (incl. exercise stations) Increase access to existing halls and community centres Local villages e.g., Bellerive are valuable when they have adequate resources, are safe and inclusive Men's shed/women's shelter and community/neighbourhood centres support health and wellbeing 	<ul style="list-style-type: none"> People are signing up to more community activities Heaps of fun activities Flexible, child centred experience – with GPs Volunteer driving program (MRC) 	<ul style="list-style-type: none"> Uni of 3rd Age to bring young and older people together; experience; time; interests; Word of mouth is how people find out about options Men's sheds – working with schools for kids who don't want to turn up Risdon Vale Bike Collective an example of relationship building and health support 	<ul style="list-style-type: none"> A council committed to health and wellbeing Schools can provide leadership for health (and promote it in students, parents and staff) Great local leadership through Sheds, Neighbourhood Houses, CFCs and community centres 	<ul style="list-style-type: none"> H2H a great connector but what happens if it stops (sustain H2H connector roles) People do go to places they trust

Below are areas that have been identified as areas for further investigation.

THINGS FOR FURTHER INVESTIGATION	<ul style="list-style-type: none"> The 'missing' and how best to engage them. This includes young people (from school age and into early adulthood), particularly men and boys Aboriginal services, mental health services/supports Buck passing by services Bulk-billing (un-clear processes and rationales) and access to GPs in different parts of Clarence Literacy/education and impact on being able to navigate health information/services—is existing information appropriate for audiences? (includes the need for cultural sensitivity, access to and usability of information about local services e.g., health, sport, community, LOTE (Language Other Than English)) How integrated is the Integrated Care Centre? More learning opportunities not targeted to getting people into work
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System Thinking & Causal Loop Diagrams

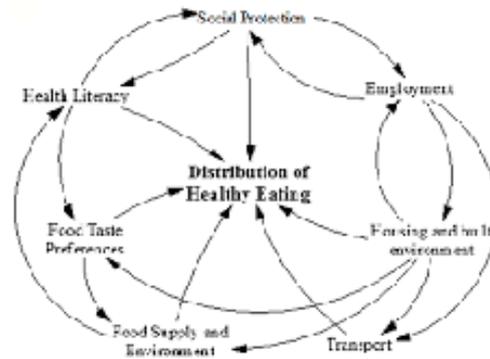
WHAT!

Systems Thinking is a process that can help us understand how different things are related to each other to create a whole.

In the case of Anticipatory Care (AC), Systems Thinking can be used to identify different parts of the AC system in each community, how these parts relate to each other, and if there are patterns across the system.

Systems Thinking is sometimes described as 'big picture' thinking.

Causal Loop Diagrams are a tool that can help tell a clear story about [this?] complex reality.



AIM

We would like to invite you to help develop a Causal Loop Diagram to clarify and communicate the interconnections between different parts of the AC system in your community.

HOW

Collaborative group modelling—we will work together to identify different parts of the AC system in each community, the casual connections between different parts that system, feedback loops and potential leverage points.

We will draw on our collective knowledge and understandings gained throughout the project to date.

HOW DO WE DO THAT

We will spend about two hours together working our way through an interactive and creative process. We will consider:

- Why are we doing this? What is the key question and the outcome we are interested in?
- What are the boundaries of the system? Note: we can't draw the whole system.
- What is our sphere of influence?
- What are the key drivers of the outcome we are interested in—the key parts of the system?
- How do the different parts influence each other? And how might they be influenced?

WHAT NOW

We will make a time with teams in each community to undertake this process.

If you'd like to find out more about Systems Thinking and Causal Loop Diagrams, here are some useful links:

- [Systems Tools for Complex Health Systems: A Guide to Creating Causal Loop Diagrams](#)
- [Introduction to Collaborative Conceptual Modelling](#)

Appendix 6: Survey results, H2H

The survey was conducted over 2019, with 42 people responding. Not all participants completed all survey questions. Given that this number is small (from a possible population across the site of almost 56,000), these results are useful more for their qualitative content and cannot be generalised to the whole area. However, there are other benefits from the survey: the PSOs were able to meet people who may not be involved with the lead organisations, to get a sense of what is available and how people use their community. This outreach has been valuable in building an understanding of the community and the health system here and for connecting with a wider range of community members.

Age

The average age of participants is 67.1, with the youngest person being 33, and the oldest 85. The median age is 70, which is higher than for the Clarence local government area (median = 43). It is also higher than for Tasmanian overall (median = 42). The survey respondents are significantly older than the general population.

Home location

Most participants gave their home location (Table A6a).

Table A6a: Where do the respondents live?

Clarence	Bellerive	Clarendon Vale	Howrah	Lauderdale	Lindisfarne	Mornington	Opossum Bay	Rokeby	Rose Bay	Sorrel	South Arm	Tranmere	Warrane
1	3	2	7	3	1	2	1	4	1	1	12	2	1

Not all these locations are within the Help to Health area.

Sex/gender

Twenty-five women (68%), and seventeen men (32%) completed the survey. The sex ratio in Clarence is 48.5% men and 51.5% women.

'Being healthy'

Participants were asked "What does 'being healthy' mean, feel or look like to you?", as well as whether there were things they wanted to change about their health, and what those changes were.

The overwhelming theme in the responses to the first part of this question was 'being active' (20 responses: 48.8%). Although some spoke in terms of fitness, mostly being active was about going for walks or getting some exercise. Respondents also defined healthy as involving a good diet, fitness, and social activities (nine people commented on the importance of social connection). Being able to do what they want to do is a common theme:

thirteen people (31.7%) talked about being “able to do what I want/need to do”. The social aspects of health were mentioned by eight people (e.g., “Eating all the right foods, doing exercises, walking, mixing with people and enjoying life”). Being free of pain or a medical condition was mentioned by seven people. Finally, “Feeling good about yourself” was also a prominent theme (e.g., “being Healthy is feel good in yourself and you look happy”, and “A feeling of wellness and contentment”) (7 people). Three people mentioned the need to not be overweight.

Twenty-seven (64.3%) of respondents wanted to change something about their health. Fourteen of them (almost half) wanted to get fitter or build strength; many mentioned walking more. Improving their eating habits and a desire to lose weight was mentioned by nine people and reducing or stopping smoking by two. Two expressed a wish for a cure for a chronic condition: diabetes and fibromyalgia. One person wanted better access to dental care, and one person praised the Live Well classes.

Self-reported health

All respondent (n = 42) answered the self-reported health question. People who responded had poorer self-reported health than other Tasmanians (Table A6b).

Table A6b: Self-reported health

Excellent	Good	Fair	Poor	Total
5	25	11	1	42

Grouped into two broad categories (better or worse), 71.4 per cent rated their health as excellent or good, and 28.6 per cent as fair or poor. This is a somewhat worse result than for Tasmania as a whole (Department of Health and Human Services (DHHS), 2020). In 2018, 21.1 per cent of Tasmanians reported their health as fair or poor. It may reflect the older median age of the sample.

We also reviewed the survey self-reported health results by age clusters. The method was sorting the data by age, and then grouping those respondents in age groups (as shown in Table A6c); the groups are not of equal size. Although the numbers are too small to draw any conclusions from, being older does tend to correlate in this sample with poorer self-reported health. As we saw in other sites, however, the ‘fair’ and ‘poor’ self-report is higher in middle age than in older age. The sparklines illustrate this neatly.

Table A6c: Breakdown of self-reported health by age clusters (youngest to oldest)³²

Age	Excellent	Good	Fair	Poor	No of participants in calculation	Mean reported age	Average self reported health	
31-40	1	1	0	1	3	35.7	2.33	
41-50	0	1	1	0	2	44	2.5	
51-60	0	3	3	0	6	55.3	3	
61-70	3	6	2	0	11	67.3	1.91	
71-80	1	10	4	0	15	75.7	2.2	
>80	0	4	1	0	5	83	2.2	
	5	25	11	1	42			

Sources of support

We asked respondents “Who do you talk to about your health? (your ‘go to’ person)”, in the categories of family, friends, people who are not family or friends, and health care professionals.³³

Talking about health

Family members

Thirty-five of the forty people who answered this question spoke to family members (11 spoke to more than one) about their health (87.5%). The most common family member mentioned was husband, wife or partner (14), followed by a child or children (9 people), parent (4) or sibling (6).

Other people, including health professionals

Forty people responded to the question about whether they spoke with friends about health. Of these, eleven did not speak with friends (and two of these eleven had also not reported speaking with family). Almost half (21) of those responding (39) said they did not talk to other, non-health people about their health. Most people (38 of 42) reported speaking with health professionals, most of whom were GPs/doctors (32), pharmacists (9 people), physiotherapists (9), and counsellors or other mental health professionals (4). No one mentioned dentists. The most commonly mentioned health professionals were doctors (by

³² Average self-reported health here was calculated by assigning values as follows: ‘excellent’ = 1, ‘good’ = 2, ‘fair’ = 3, and ‘poor’ = 4. Thus, in the top row, the ‘score’ for the cohort was 21 (1 x 1, + 5 x 2, + 2 x 3, + 1 x 4 = 21), and dividing it by the number of scores (people in the cohort): 21/9 = 2.33. An average score closer to 1 indicates more participants rating their health as excellent or good; closer to 4 shows more participants rating their health as fair or poor.

³³ In some instances, responses to questions appeared in the ‘wrong’ place; i.e., people included friends or medical professionals in their response to the question about family. These ‘misplaced’ responses have been included in the ‘correct’ group of responses.

21 people), two people mentioned the dentist, two the pharmacist, and two people, nurses. Ten (of 39 responses) had a family member or friend with a formal health role, who they talked with about their health.

Health supports

Social health

We asked people what they were doing for their health and wellbeing: socially, physically and ‘medically’. Only one person reported being involved in no social activities (of 40 respondents to this question).

Physical health

Eight people (of 41 responders) did not do anything for their physical health. By far the most commonly mentioned physical activity was walking (24 people; 72.7%); many mentioned walking their dog, and/or walking on the beach or foreshore tracks. The second most common response (12 people; 36.4%) was involvement in formal physical activities like the gym, football, yoga or tennis. While most people who responded only listed one activity, 10 people were doing two or more activities.

‘Medical’ health

Eighteen of the 42 responders to the question about where they went for health care said they didn’t go anywhere. Most people said they went to a GP (23 people; 95.8%), one person said they went to the RHH, two mentioned physiotherapy, and two dentists.

Barriers to maintaining your health

Participants were asked about things that get in the way of them maintaining their health (see Table A6d). Cost was the greatest barrier, followed by transport (that is, getting to an activity or service). People were also invited to comment on this question or list other barriers. These responses sometimes re-iterated barriers ticked (e.g., *“Bus timetable doesn’t suit”*, *“Need transport due to vision imp. Wife drives or bus”*) or raised separate problems (*“Difficulty walking from car parking”*, *“I am from interstate and find it difficult at times to integrate”*, and *“My age, for example, my knee stops me playing footy and indoor cricket”*).

Table A6d: Barriers to health

Transport	Cost	Lack of equipment or clothing	People	Unwelcome	Lack of clarity	Time of day	Motivation	Confidence	Comfort	Other
19.5	22.0	2.4	0	2.4	2.4	14.6	14.6	12.2	7.3	43.9

The transport result appears to reflect the fact that a large proportion of respondents living at South Arm.

We compared these survey results with those from other project sites (Figure 1); they suggest that the respondents here in Clarence are experiencing fewer barriers than those elsewhere.

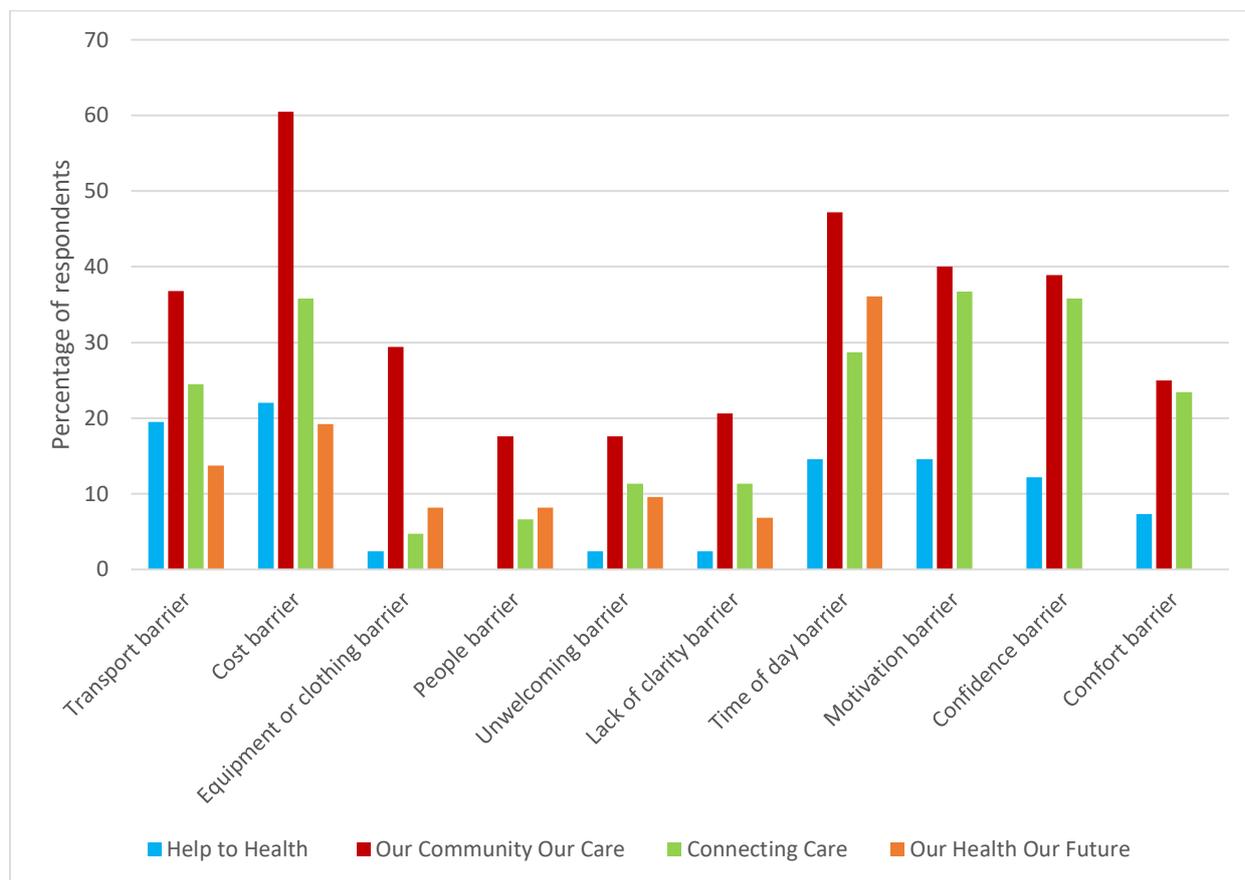


Figure A6: Barriers to using health supports across the four Tasmanian AC sites

Participants were invited to make other comments. These comments (made by 21 people) are provided below (spelling errors have been corrected).

Concerts live music swimming pool—learn to swim fitness

For my age, I feel my health is good. I don't eat 'junk' food, I have plenty of fresh vegs and red meat. I drink alcohol occasionally, but in moderation!

Good access to health care and activities. Specialists mostly on western side

Happy and healthy—eat well and do lots of walking and never really get sick.

Home care to help with housework. Wife carer. Taxi vouchers.

I am aware that there are many barriers to servicing or anticipating the current and projected (if possible) health needs. Most noticeable is the lack of 'community' based core hubs (both physical and mental) and a seeming lack of character and resolve of politicians of all levels to acknowledge that what is currently available and projected in their eyes is limited by economics + desire for

short-term popularity not planning for reality. As a smoker, I am aware that there may be problems down the track.

I don't like hospitals, almost like a phobia. I've had some bad experiences there. "Men are big sooks!"

I feel fortunate to live in Clarence, close to beaches and the wonderful Bellerive Bluff Walking track. The Physio Pool [name] is great. My GP, [name], whilst booked out for weeks ahead, will always see me in an emergency. Her receptionist is fabulous—very understanding. We've thoroughly enjoyed the 12 week course "Live Well Live Long" sponsored by Clarence Council benefiting from each presentation. Thank you Clarence Council!

I feel I am very lucky to have a lovely group of friends. They are always happy to help in any way.

I think as you get older you need to make more effort to do things and exercises and classes to keep well and fit and keep yourself active

Limited access to local GP

More playground facilities for children and teens desperately needed

Social isolation due to past (things in life). Use meditation—mindfulness for health and wellbeing; caring for others—housemates—friends who now live with to help care for. One has [COPD] and [cognitive problem] other is [substance abuser] who is not doing too well.

South Arm is a wonderful community to live in. People look after others.

The bike track is an excellent asset in Clarence, plus many benefits.

The community bus that is used needs to be actually located nearby – i.e. South of Lauderdale

There is plenty to do in the community. Some people like to stay home

Transport is a huge issue in our community. A local wine festival/and have people out of the surrounding area run their own stall talking about their community

Would be able to keep my health up if more dog friendly places available such as beach local market, etc.

Would be nice to get waiting lists for surgeries and even get in to see them at hospital – i.e. waiting 6 months to see specialist about gall bladder.

Reference

Department of Health and Human Services (DHHS). (2020). *Report on the Tasmanian Population Health Survey 2019*. Hobart, TAS: DHHS.

Appendix 7: Help to Health Action Plan, 2019

Category	Function	Form	Ripples	Resources	How will we know it is working?	Sustainability?	Risks – of doing the action, or of not doing the action
<p>Successful navigating of systems and services,</p> <p>Community needs are addressed</p>	<p>Improved connections and understanding between GPs and community</p>	<p>Steps:</p> <ul style="list-style-type: none"> • Work with GPs on establishment of reference group, how to best set up and best way of disseminating to right people. (In progress)* • Use reference group and promotion of when speaking to groups and individuals about GP visits (Q: how do we get responses back to the community – videos on Facebook (GP Q and A), emails to stakeholders etc) • Speak to GPs to determine understanding and communication barriers and issues from GP perspective. (In progress) • Develop 'Improved Connection Between GPs and Community' plan (In progress) 	<p>Increased consultation on and ability to answer questions the public has on function, access and how to get most out of GP appointments to have positive experience</p> <p>Increased community awareness of what a standard GP visit is about</p>	<p>People: Franke, Em, Suze</p> <p>Tools:</p> <p>Budget:</p>	<p>Measurables: Engagement and response of GPs to questions posed via reference group</p>		<p>Continuation of issues in understanding and possible avoidance of GP appointments</p>

		<ul style="list-style-type: none"> Finalise bulk-billing video and confirm with GPLO Distribute video via Facebook, website, other?? ??? Develop 'A visit to the GP video' (GP perspective, community perspective) ??? 					
Successful navigating of systems and services	Pharmacy: The Right Place training	<p>Steps:</p> <ul style="list-style-type: none"> Contact through Pharmaceutical Society of Australia to determine if TRP can form part of Quality Care Pharmacy training. (In progress) Training to be scheduled either as event or with individual pharmacies (depending upon outcome of above) 	Increase of pharmacy staff being able to assist community with locating and accessing appropriate assistance	<p>People: Em, Franke</p> <p>Tools: TRP materials</p> <p>Budget:</p>	Measurables: TRP surveying of staff in pharmacy pre and post training		
Quality relationships between actors in the AC system Community needs are addressed	Health Connector role	<p>Steps:</p> <ul style="list-style-type: none"> Name up all aspects, actions and skills involved in being a Health Connector Develop detailed job description, including relationships and outreach, externalities 	Increased awareness of and connection between services and services and community.	<p>People: Franke, Em, Suze</p> <p>Tools:</p> <p>Budget:</p>	Measurables: Detailed job description encompassing benefits of role to Council		Lack of clear awareness of actions, importance of role and what it entails

Trust, respect and reliability		<p>(being seen, using soft skills and soft power)</p> <ul style="list-style-type: none"> • Map how this has evolved this year • Build on and track how this is progressing <p>(need more points and detail here)</p>	<p>Increased community knowledge of availability of and how to access health and wellness supports and services</p> <p>Increased ties between community, health and wellbeing services and supports, and Council</p>	<p>Evaluation via case studies (half page)</p> <p>Note range of organisations involved</p> <p>Proof of concept – evaluate this, what effect role is having, how is this addressing community needs</p>		
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Appendix 8: Examples of CLDs for H2H

Causal loop analysis tries to identify how parts of a system are linked and then how changing one part might affect the others. Doing causal loop analysis involves:

1. Identifying what the parts of a system are
2. Deciding how they are connected
3. Seeing if there are feedback loops
4. Testing these loops using 'real-life' examples

In this appendix, we work through this process for some of the Our Community Our Care projects.

Below is a complete (2019) causal loop diagram for Anticipatory Care in the H2H project.

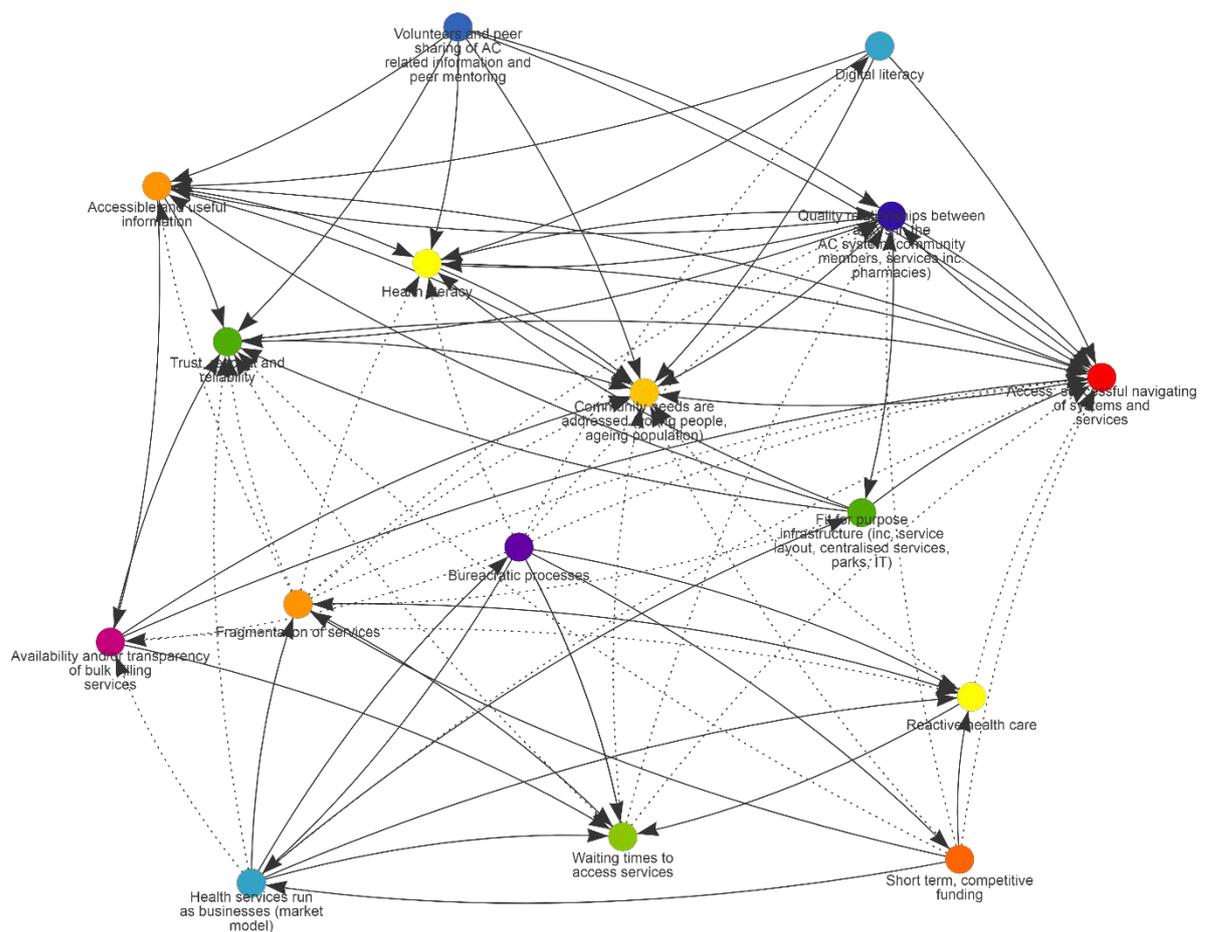


Figure A8a: H2H CLD 2019

The nodes around the circle are parts of the anticipatory care system in this community. The arrows show the links; solid lines show a positive relationship, and if the line is dotted, there is a negative relationship.

The discussion that produced this diagram centred on access to AC and people's ability to successfully navigate systems and services in CCC; this was identified as a key outcome in

the CLD (i.e. many arrows coming in). There was also significant emphasis on addressing the needs of the community in general as well as specific cohorts (e.g. young people and older Tasmanians)—this was identified as another key outcome in the CLD.

We can also look at project activities using the CLD process. The projects we have done a causal loop analysis for Clarence Talks, as a worked example. The example was prepared *before* the actions were started.

Clarence Talks

We prepared a causal loop analysis for the Clarence Talks activity. The figure shows the loops and what parts of the system are involved. It is clear, from diagram 2, that providing accessible and useful information has benefits for individual agency, for access and navigation, and for volunteers sharing information. One reinforcing relationship that is apparent is between accessible information, peer sharing and connections between services and community.

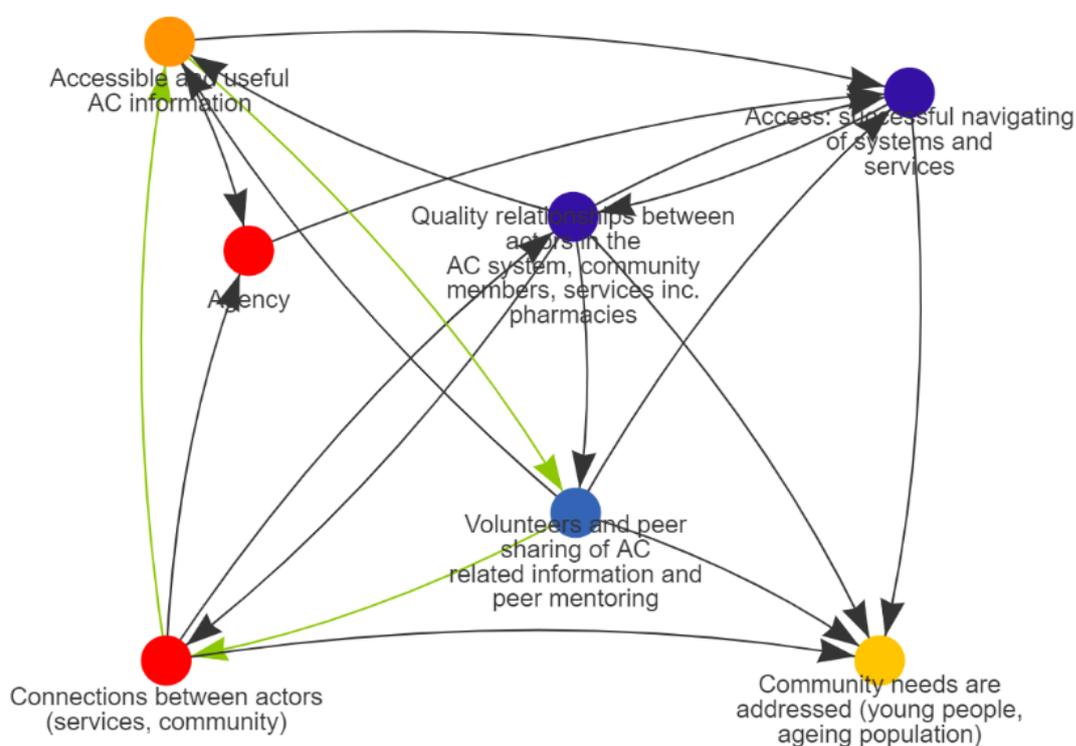


Figure A8b: First reinforcing loop

However, there are other reinforcing loops, which suggest wider benefits of the Clarence Talks program. Diagram 3 shows additional reinforcing loops.

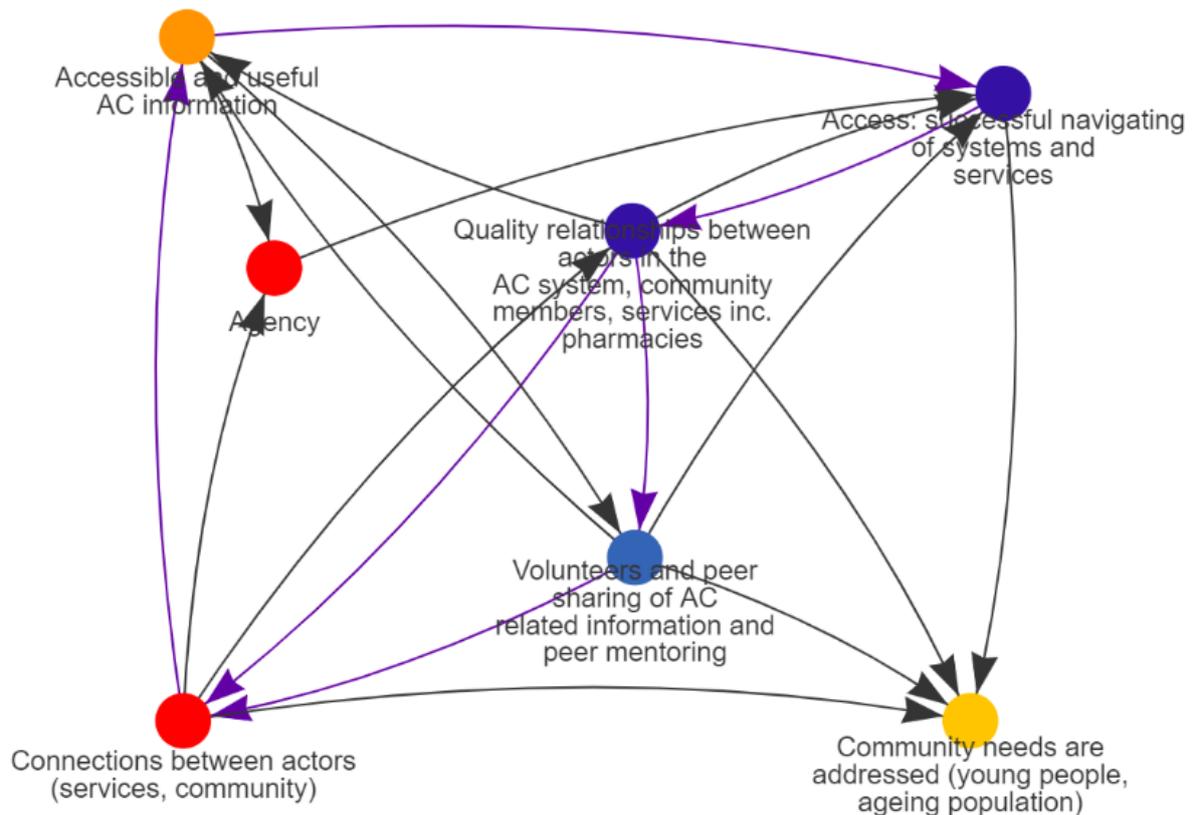


Figure A8c: Additional reinforcing loops

For instance, the purple loops show a possible reinforcing relationship between providing accessible information (through Clarence Talks), easier navigation of systems and services, quality relationships within the system (as well as connections between people), volunteer and peer sharing, and greater access to AC information. There are also many small loops in this diagram (e.g., between **Quality relationships** and **Connections between actors**, between **Volunteers and peer sharing** and **Accessible and useful** information, and so forth). Each action/activity in H2H can be analysed in this way.

Table A8a: Some definitions of variables:

Accessible and useful information	
Ability to act on complex health and social problems	People need to be able to act—alone or with others—on health problems. In this community people are falling through the gaps, and they shouldn't be. They should be able to get the help they need
Coherent bureaucratic processes	Because if processes are not coherent it makes it difficult for people to navigate the system and access resources, supports and services. Coherent bureaucratic processes need to be a common goal across the system that processes align with
Community empowerment	Because people who feel empowered are more likely to exercise agency and will have greater capacity to navigate the system

Community engagement and collaboration knowledge and skills among staff	People will feel welcome and included and ask questions and go places and become less socially isolated
Extent to which people's skill/knowledge/capacity are valued	Agency. Recognises individual's role in the system and their strengths/that they have something to offer. Includes volunteering
Feelings of pride to belong to this place	Innate empowerment. People will look after each other. We are in it together. Collegiality. Mutuality. Unity
Fit for purpose infrastructure	Supports healthy living. Enables access to AC services, places and programs
Formal knowledge of who/where/how	
Mutual trust, respect and reliability	Fosters relationships, maximises capacity. Includes continuity of staff. Acknowledges history
Peer sharing	People have knowledge (of many sorts) and it's valuable. Benefits from peer education
Quality of relationships	Because people and services need to work together to achieve outcomes. Relationships are pivotal in action
Safe places in community	To connect. To be present. To be valued. To have a break. To feel cared for. To have coffee. To be culturally safe and inclusive
Social inclusion	Gives people the capacity to engage in society and have a quality life. Social inclusion is the process of improving the terms on which individuals and groups take part in society, improving the ability, opportunity, and dignity of those disadvantaged on the basis of their identity



Anticipatory Care Design Brief: Community Conversations Systems Parts Videos and Posters

Overview of the project

The purpose of the conversation is to share data about the health systems in the community, enable participants to add their own insights, and then collectively make sense of all the different parts together to see the 'whole system'. The research team will share what they have learned about the health system, and then create space for the participants to question this information, add their own insights, and think about ways to improve the system.

The data and required illustrations

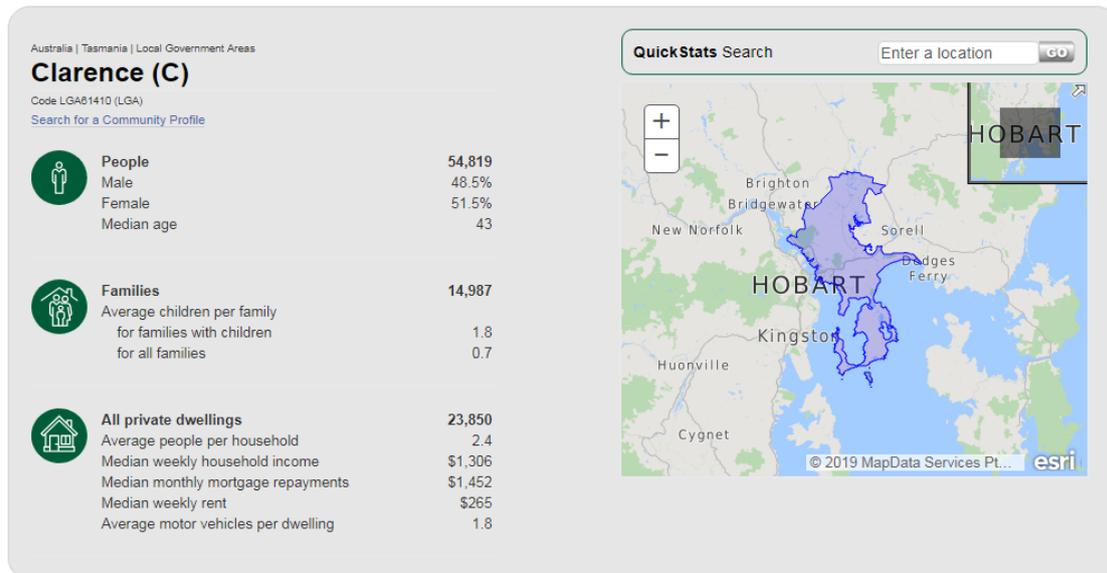
Primary and secondary qualitative and quantitative data is being collected in relation to health and wellbeing in the Clarence City Council Local Government Area.

This incorporates completed reports, government department statistics, interviews and focus groups, community surveys.

The overarching question for the Clarence City Council area is "What is the role of local government in Anticipatory Care."

Key points in information and data gathered so far has been grouped into one of 6 themed systems parts. Each system part will become a short video and poster, illustrating the research we have gathered regarding that systems part. The purpose of the illustration of individual system parts is to support participants in making sense of the data in a more meaningful and accessible way. Presenting in this way should also

2016 Census QuickStats



assist participants in making inferences about how information in different systems parts interacts.

For each system part there are 3 areas of information to be illustrated: “what we are learning’, what is emerging’ and what we are exploring’.

Snapshot of Clarence City Council Local Government Area

The Clarence Local Government Area (LGA) is a city characterised by demographic and geographic diversity. Features of Clarence include:

- 25 identified suburbs
- Population: 54,819
- Land area of 386km and 191km of coastline – Clarence includes urban and suburban, rural and beachside areas
- Median age is 43 (Tasmania 42, Australia 37), but the municipality’s diversity shows in the fact that the median age is 31 in Oakdowns and Clarendon Vale, but 55 in Opossum Bay and Risdon; people of different ages have different health needs and different things get in the way of (or help with) getting health care
- Access to resources is very unequal across Clarence. There are clusters of people in some suburbs who are very well off (in terms of health, wealth, work and income) and other groups in other suburbs who have quite poor access to health, wealth, work and incomes. [SEIFA indexes for suburbs in Clarence range between the first and tenth decile]
- The state’s only prison is located in the LGA

- Popular features: beaches, vineyards, trails, leading sports venues, Hobart International Airport
- Clarence has every industry (other than heavy industry–machinery manufacturing, mining) represented – this shows diversity of both industry and employment

People and health

Refers to the demographics and health status of the community

e.g. who lives here? Community and health profile data

What we are learning

- Clarence has a very broad and diverse population – socially, geographically and economically. Some people find it hard to find or use services that would help them to be healthy
- Access to health and wellbeing is extremely varied across Clarence for a variety of reasons including availability of support, services, transport, knowledge, cost, personal/social barriers, etc.
- Statistical data (e.g. social, economic, health) are not a true representation of Clarence as a whole. e.g. the median weekly overall household income varies from \$750 to \$2195, with the median for ‘Clarence’ as a whole being \$1306. It would be more helpful to look at statistics per suburb/region than Clarence as a whole ‘community’. This highlights some major equity problems.
- Clarence people volunteer in many ways and places – and many of the volunteers have been active for a long time
- There are lots of activities happening throughout Clarence that support health and wellbeing. For example:
 - Social groups
 - Free activities to support health and wellbeing, like “Fitness in the Park” (Clarence City Council), literacy programs (e.g., at the Rosny Library), walking groups, “Live Well, Live Long” (a Tasmania Health Service Health Promotion activity)
 - The Neighbourhood Centres run groups, programs and initiatives (4 Neighbourhood Centres, located at Risdon Vale, Mornington Warrane, Rokeby and Clarendon Vale)
 - Clarence Plains Child and Family Centre programs (located at Clarendon Vale)
 - Faith–based activities and programs
 - One Community Together – Collective Impact project in Clarence Plains
- A bigger proportion of people who live in Clarence rate their health as excellent or good than is true for Tasmanians overall, and fewer people here smoke, drink alcohol in dangerous quantities, or get too little exercise. But, compared with

Tasmanians overall, some other risk factors for chronic illness are more common in Clarence:

- There is a higher proportion of overweight and obese people in Clarence
- A higher proportion of Clarence residents do too little muscle-strengthening activity
- A higher proportion have 3 or more chronic conditions
- There are slightly higher rates of potentially preventable hospitalisations among Clarence residents (that is, more people are going to hospital for conditions that could have been treated before they became acute). The top three reasons for these potentially preventable hospitalisations are:
 - Diabetes complications, Congestive cardiac failure, and Chronic obstructive pulmonary disease (COPD)
- It is likely that these rates are different in different parts of Clarence, as the risk factors for developing a chronic illness are related to social and economic factors.

What we are starting to find out about

- It has been suggested that Clarence is a 'drive through' area. Some reasons might include the lack of retail, café, cultural, activity hubs throughout local suburbs. Aside from driving to the beaches, vineyards or Eastlands, people don't appear to drive to/stop in Clarence for anything else (and many services have shop-fronts but not of headquarters in Clarence). Is this a correct? Is it that Clarence is a very Urban area? Or is it the case for certain parts of Clarence but not for others?
- It is fairly easy to find out about people who are active and use lots of services for their health; we are still trying to find out about those people who rarely use the services that might support them to be healthy

Questions

- We know that there are many things happening in Clarence that are often free or minimal cost for the community, but many people aren't utilising this. Why might this be? Is this more the case for particular sections of Clarence?
- How do we best reach those not engaged, or even connected, with community or health and wellbeing related services and supports?
- Why is health a priority for some people and not for others?

Local infrastructure

This refers to the services, professionals, centres, businesses, environments and programs that support health

What we are learning

- Health and wellbeing services are concentrated in the built-up areas of Clarence such as Rosny Park and Shoreline:
 - this is true for medical services and allied health
 - also true for fresh and affordable food
- Lack of bulkbilling GP's
- Transport is frequently mentioned as a barrier (e.g. frequency of buses, cost, accessibility) to accessing all sorts of services (social, health, food, activity, etc.) with people requesting more access to community-based transport
- Lack of local community 'hubs' (this includes health centres, cultural and social activities, retail stores, etc.)
- There are many accessible and well-maintained local parks, walking tracks, skate parks, outdoor fitness equipment located across the LGA, and they are mostly well-used
- There is a lack of youth health and wellbeing services. Most are outreach and only available some days (e.g., Headspace psychology appointments 2 days a week out of Clarence Integrated Care Centre).
- People value consistent and safe services and processes
- There is a need for welcoming, accessible and affordable services and options for people living with an impairment (people with a disability or older people):
 - there are 8 residential aged care facilities in Clarence and they are centralised
 - there are 3 organisations providing disability support in Clarence (one is residential)
 - some older people are living alone in large homes with the desire to downsize but are unable to move into a local and affordable aged care facility (this has implications on the health and wellbeing of the older person, and contributes to the broader housing crisis in Tasmania).

What we are starting to find out about

- Investing in community-based care and activities improve residents' health and wellbeing
- Pharmacies may increasingly be a first port of call for people seeking medical or health care
- There appears to be a lack of clear layout and signage, safe and easy entry making accessibility to shops, businesses, health centres, etc. difficult for some people (even in Rosny Park where everything is predominantly centralised)
- People report feeling isolated from health services and afterhours assistance (availability and accessibility of transport, mobile doctor, wait and availability of ambulances)

- There may be a need for increased health and wellbeing services (e.g., GP service, oral care, allied health) in the south of the LGA to support a growing and aging population
- Clarence's geography and spread and diversity of population make meeting the needs of the whole population complex
- Staff in community and health and wellbeing roles report that to provide support required they are often having to 'work off the side of their desk'.

Questions

- How do we best support community and individuals to seek and access care outside their immediate area?
- Who is using the outdoor spaces, equipment and activities and how often? What reasons are there for people utilising or not utilising?
- What stops people from accessing the activities, spaces and services they wish or need to use? How can these barriers be addressed? Are the problems of travel distances to services/activities perceived or actual?
- Where can people go when the best support/services for their needs are at capacity (due to short supply of professionals, e.g., OTs), or long wait lists for specialists are a barrier to pursuing required assistance:
 - Are there services to help manage pain and mobility whilst awaiting further specialist appointments?
 - Are there other service providers/specialists available other than the one they have been referred to?

Local health and service information

This refers to data collected by organisations about the health of the community and information about health and community services. What exists and how is it shared?

What we are learning

- Service awareness: there is a lack of knowledge of what services/support is available in and to Clarence and the extent of what those services can offer and who they are available to. This is a common theme throughout the listed reports, community conversations.
- Community awareness: There is confusion and a lack of community awareness of what services/support is available, who is eligible, what the process is for accessing them.
- The Help to Health project initiatives are currently instigating, facilitating and supporting connections to improve service awareness and connections. e.g. The

Right Place, Clarence Talks and Its Ok to Ask addresses knowledge of services, process of access and building connections between both services and community. Help to Health Friends supports and encourages the sharing of information amongst community members.

- There are many services available to people in Clarence, however a limited amount of services are *based* in Clarence. This outreach health and wellbeing service system is affecting access to and continuity of care.
- Some pharmacists and pharmacies are important providers of monitoring, support and information for individuals and communities.
- Brochures and health related information is available in many locations across Clarence, including clinics, pharmacies, GP offices, community centres and neighbourhood centres and allied health offices, but
 - Services and organisations do not always tailor their information or the way it is delivered to the needs of the whole Clarence population.
- There are a lot of services and supports that are engaged and interested in connecting with the community and seem to be doing this through information sessions in many different places (e.g. neighbourhood centres, Salvation Army, Thursday's at Alma's etc.). These services often have an employed 'community engagement worker' and are very willing to connect with community and their initiatives

What we are starting to find out about

- Information on health, wellbeing and local activities is shared via social media platforms (including council website, Live Clarence Website, Facebook and Instagram). How many is this reaching? Who accesses?
- There are online health and wellbeing support and advice options (e.g. Health Direct, online service guides, symptoms checker) – who is using them and who is not?
- Lack of information sharing between and about services means that people needing health supports and services may be 'hand-balled' through several unsatisfactory options
- How accessible is the information that is being shared—to both community members and health professionals?
- Facilitation and bringing providers into spaces trusted and known by community to connect with community encourages two-way sharing of information.

Questions

- What would be helpful for people when they are told that a support/service is at capacity (e.g. wait list is too long)? e.g. know what else is available as an alternative?

- There are a lot of community engagement coordinators and workers for a myriad of services and organisations who are working hard at raising community awareness of their services and supports. Why does there seem to be a disconnect with the community finding out about this? Is there something missing for information sharing to be more effective? Can we support this?
- Is there a need for more information about the roles of specialists and allied health professionals, tests and procedures? Would community understanding in this area assist in demystifying the 'health system' and increase access?
- Does encouraging the asking of questions and supporting time for answering increase sharing of information?
- What is your source of information about what is happening in your community?

Attitudes and actions

This refers to the beliefs and attitudes about health and the health system. It also refers to how these attitudes inform practices and actions

What we are learning

- Going to GP can be stressful and overwhelming, particularly for individuals experiencing mental health issues or/and lacking close/trusted supports (family, friends, etc)
- People may delay taking preventive action because of beliefs about the costs or fears of the outcomes
- Some people are using the Emergency Department or pharmacies as their first option
- Attitudes and beliefs form a large part of both an individual and community's identity.
 - It takes time, trust and rapport to understand what these are, how to assist individuals and communities to make changes and modify behaviours and to support them in making these changes. There is no quick fix.
 - Trust is very important and is built on approachability, consistency, reliability and time.
- For many the statement 'Hobart is close and easy to get to' for services does not ring true. This is also the case for access within/across Clarence. Distance is relative and personal, affected by individual, health and ability, social and structural elements.

What we are starting to find out about

- Issues of trust may be discouraging people from travelling out of their local area to attend health services.

- Many people say that health is about feeling good and being able to do the things you want to do
- Walking and outdoor activities are popular activities that people understand as good for their health
- Some people have a 'just get on with it' attitude to their health and do not seek health and wellbeing support when it would be beneficial. How pervasive is this? Is it more true for certain demographics?

Questions

- Does helping people understand why they make the decisions they make help them to make better decisions? What would this look like?

Relationships, networks and partnerships

This refers to formal and informal networks, partnership and relationships that enhance or enable the health of the community. Here we are referring to community members and their networks as well as professional service providers and agencies

What we are learning

- Help to Health initiatives are creating and supporting relationships and partnerships between service providers and community members and community organisations such as neighbourhood centres
- There are many strong community and government based networks and partnerships throughout Clarence
- One Community Together – building strong relationships, networks and partnerships between council, Child and Family Centre, faith-based organisations, police
- Neighbourhood centres are points of connection and commonality for partnerships and relationships within communities – connecting residents, schools, local services.
- Lack of knowledge by providers of what other providers are out there and what services they offer, desire to change this and build relationships and networks, time is an issue.

What we are starting to find out about

- Vital role of council and facilitators in connecting and supporting relationship building between organisations and community

- Integration is important for continuity and transfer of care. What are the challenges of/for integration of services? How can we best maintain privacy and confidentiality while also sharing information to support health and wellbeing?
- In areas without neighbourhood centres, other community places and organisations can fill the gaps (e.g. relationships, networks and partnerships of SAPRA, South Arm Community Centre (containing community built library, op-shop and history room), South Arm Pharmacy, local school on the South Arm Peninsula).

Questions

- How can we better build and support partnerships to improve continuity of care?
- Is there a need for 'hubs' in different areas of the LGA for services (e.g. north, middle, south)?

Local leadership for health

This refers to the people and organisations that are influential in supporting the health of the community

What we are learning

- Leadership plays a critical and integral role in creating and maintaining momentum, optimism, direction and action in driving positive local change in a sustainable and inclusive way
- Leaders listen and learn, then seek and share solutions. Leaders also help with integration and collaboration among services, connect people, and can smooth pathways. They find ways to address health needs and gaps
- Clarence City Council plays an integral role and responsibility in ensuring the health and wellbeing of the LGA community — through planning, provision of public assets, health and wellbeing / social planning. Socially, Clarence City Council works best by facilitating partnerships
- There are many groups who are leading within the LGA, including:
 - Neighbourhood centres: Integral part of the lives of many people within their community who use them– they are a 'hub' to suit all forms of community need. e.g. support, food, advice, social gathering space, social connection, activities etc.
 - Clarence Plains Child and Family Centre
 - Clarence Plains One Community Together
 - Community organisations [e.g. South Arm Peninsular Resident Association (SAPRA)]
 - Men's Shed Association (Clarence)

What we are starting to find out about

- There are a vast amount of local leaders either paid or unpaid individuals, groups or organisations who we are yet to discover
- Leadership is fundamental to sustaining positive social change around health and wellbeing

Questions

- How can we find the leaders among groups who are not obviously engaged and involved?
- What resources or supports do these cogs in the wheels of information sharing and health support need to be most effective?
- Does the broader Clarence community need to know who the key leaders, groups and organisations are? If yes, how do you think this information can be shared? Why would we want to know who these people are? Is this helpful for connecting and creating change systemically across Clarence or is it helpful for community members too?

Appendix 10: Community workshop posters

Clarence : People and Health

WHAT WE ARE LEARNING

LESS PEOPLE - Lots of people who live in Clarence are that have to assist or need BUT there are more people in Clarence at risk of...

Higher rates of people - Higher rates of people have to assist for things that could have been prevented...

Broad & diverse population - Some people find it hard to use areas of Clarence or services that would help them be healthy...

Some organisations in Clarence - Some organisations in Clarence who have a number of community purposes include...

The health and wealth of - Some of these groups include...

Statistical data for the whole of Clarence - Statistical data for the whole of Clarence shows there are differences...

It is more helpful to look at - It is more helpful to look at statistics per suburb...

This refers to the demographics and health status of the community.

Clarence : People and Health

WHAT WE THINK IS HAPPENING

People who are prevented from participating in programs, activities & programs that require their willingness and health are more likely to engage with...

It is often difficult to engage with people who are less engaged in these activities...

not every one is higher risk of developing long-term illnesses.

This refers to the demographics and health status of the community.

Clarence : People and Health

WHAT WE WOULD LIKE TO LEARN MORE ABOUT

We have lots of information about people who are accessing health & community services BUT...

Why don't they access services? What can be done to improve their health and well-being?

How do we find the ways to engage with these people?

We don't have good information about people who are not accessing services.

Many of our low-cost things happening in the community. But many people aren't using this.

Why might this be?

Is this more the case for particular areas of Clarence?

What do the people of Clarence think about health?

Is it a hot topic for this community?

This refers to the demographics and health status of the community.

Clarence : Local Infrastructure

WHAT WE ARE LEARNING

Many community members think that there is not enough access to health buildings.

Many accessible and well-maintained road parks, walking tracks, skate parks, outdoor fitness equipment nearby.

Health and wellness services are concentrated in the high-rise areas including...

Appears to be a lack of health services in water suburbs.

Transport is frequently mentioned as a barrier.

People are requesting more access to community-based transport.

Is connecting all sorts of services (social health care) activity etc?

Lack of youth health & wellbeing services.

Services are existing but only available on some days.

3 Organisations providing disability support BUT need for voluntary, accessible & affordable service supports.

8 Businesses and cafes BUT other people are having what is a big barrier with the need to exercise but are unable to find a local & affordable gym or one facility.

Registration on the health buildings of the older person contribute to the greater health crisis in Clarence.

This refers to the services, professionals, centres, businesses, environments and programs that support health.

Clarence : Local Infrastructure

WHAT WE THINK IS HAPPENING

Community based clubs & activities play an important role in supporting residents to health & wellbeing.

It is often difficult to reach the needs of the most people in Clarence who have long-term & progressively changed conditions.

Services are not there.

Many services exist in Clarence but are not based here.

Clarence is a "one through" area.

Serious of road works, water & road works.

Need for transport health & wellbeing services but 100 services and are often based in the north of Clarence.

Need to connect health & wellbeing services to the north of Clarence.

Pharmacies are increasingly a thing that is a call for people looking for health care.

Need to be closer to the shops & other points to improve accessibility to shops, businesses & health centres.

Need a more walking based than health services & other services.

Need a variety of outdoor...

Service providers are often not enough time to do preventative health work.

This refers to the services, professionals, centres, businesses, environments and programs that support health.

Clarence : Local Infrastructure

WHAT WE WOULD LIKE TO LEARN MORE ABOUT

How can we better support individuals & communities outside the main centre of Clarence to access health care & services?

More accessible & well-maintained road parks, walking tracks, skate parks, outdoor fitness can be more located across the city.

Why not have better support individuals & communities outside the main centre of Clarence to access health care & services?

What other services & activities are available to people of that age, sex & of which they are not willing to go to a GP, pharmacist or other health professional?

This refers to the services, professionals, centres, businesses, environments and programs that support health.

Clarence : Relationships, networks and partnerships

WHAT WE ARE LEARNING

How to health initiatives are created & supported: relationships & partnerships

There is still a lot to be done

Each of knowledge in practice of what other partners are out there & what services they offer

Need to change this & build relationships & networks

But time & cost are an issue

There are many strong community & consumer based networks & partnerships throughout Clarence

Regional level entities are points of connection and connecting the partnerships & relationships with consumers

LOCAL SERVICES

This refers to formal and informal networks, partnerships and relationships that enhance or create the health of the community.

Clarence : Relationships, networks and partnerships

WHAT WE THINK IS HAPPENING

help to health program

social planning

Clarence City Council

Some services work well together to create a better life for people

AGED CARE, GOVERNMENT SERVICES, SCHOOLS, CLUBS

COMMUNITY CENTRE

In areas without regional level centres other community partners & organisations are filling the gaps

Can we hold on and strengthen that?

This refers to formal and informal networks, partnerships and relationships that enhance or create the health of the community.

Clarence : Relationships, networks and partnerships

WHAT WE WOULD LIKE TO LEARN MORE ABOUT

How can we improve care coordination and support services to work better together?

Are there other relationships, networks, partnerships or pieces that are important to health & wellbeing?

This refers to formal and informal networks, partnerships and relationships that enhance or create the health of the community.

Clarence : Local leadership for health

WHAT WE ARE LEARNING

Clarence City Council is playing an important leadership role in health and wellbeing

social planning

Clarence City Council

Other groups across Clarence who are leading projects and activities to improve health and wellbeing

Men's sheds associations

Clarence Involvement Care Centre

Clarence Young, Child & Family Centre

Neighbourhood Centres

Community organisations

the Community Together

by working in partnership with local organisations, services and businesses

This refers to the people and organisations that are essential in supporting the health of the community.

Clarence : Local leadership for health

WHAT WE THINK IS HAPPENING

Leadership is fundamental to sustaining positive social change around health & wellbeing

There are local leaders, either paid or unpaid individuals, groups or organisations who we are yet to discover

This refers to the people and organisations that are essential in supporting the health of the community.

Clarence : Local leadership for health

WHAT WE WOULD LIKE TO LEARN MORE ABOUT

Who is influential in improving the health and wellbeing of the community?

FORMAL LEADER

Are there other leaders or people who hold key information?

What does leadership for health look like?

How do we better support leaders? (including ones that are not obvious/formal leaders)

This refers to the people and organisations that are essential in supporting the health of the community.

Appendix 11: Presentations and papers

Policy reports and papers

2020

Final project report, Community 1: Help to Health, Clarence.

Final project report, Community 2: Our Community Our Care, Launceston.

Final project report, Community 3: Connecting Care, Ulverstone and the 7315 postcode area.

Final project report, Community 4: Our Health Our Future, Flinders Island.

Community workshop (reporting findings), Community 2: Our Community Our Care, Launceston, 17th June (via zoom).

Community workshop (reporting findings), Community 1: Help to Health, Clarence, 6th August (via zoom).

Community workshop (reporting findings), Community 3: Connecting Care, Ulverstone and the 7315 postcode area, 25th August (face-to-face).

Community workshop (reporting findings), Community 4: Our Health Our Future, Flinders Island, 27th August (via zoom).

2019

Interim project report, Community 1: Help to Health, Clarence, 2019.

Interim project report, Community 2: Our Community Our Care, Launceston, 2019.

Interim project report, Community 3: Connecting Care, Ulverstone and the 7315 postcode area, 2019.

Interim project report, Community 4: Our Health Our Future, Flinders Island, 2019.

Posters/findings briefs

2020

Access to affordable general practice care, FINDINGS BRIEF NO. 1

Action for prevention FINDINGS BRIEF NO. 2

2019

The Anticipatory Care Project (project overview)

Senior government briefings

2020

UTAS AC team (2020). Findings to date report (delivered with DoH Principal Project Officer, Flora Dean) to the Healthy Tasmania Chronic Conditions Working Group, Hobart, 20th February.

UTAS AC team (2020). Health Promotion & Public Health Sharing seminar, Public Health Services, DoH, 21st February.

UTAS AC team (2020). Discussion regarding reporting, with the Healthy Tasmania Chronic Conditions Working Group, Hobart, 25 June.

2019

Statewide Anticipatory Care forum 1, 16 May 2019.

UTAS team (2019). 'What do we now know about anticipatory care in our sites and overall'. Presentation to the Healthy Tasmania Chronic Conditions Working Group, Hobart, 8th August.

UTAS AC team (2019). Bulk-Billing and GP Access, discussion with the Healthy Tasmania Chronic Conditions Working Group, 12 September.

UTAS team (2019) Causal loop analysis session with the Healthy Tasmania Chronic Conditions Working Group, Hobart, 24 September.

Statewide Anticipatory Care forum 2, 18 November 2019.

External consultations and meetings

2019

Wynne Russell (TasCOSS)

Peter Barns, CEO HR+ (health workforce consultancy)

UTAS AC team (2019). 'What systems affect our health?'. Presentation to Our Community Our Care Community Forum, Ravenswood, 13th February.

UTAS AC team (2019). 'What systems affect our health?'. Presentation to Our Community Our Care Community Forum, Newnham, 14th February.

UTAS AC team (2019). 'What systems affect our health?'. Presentation to Our Health Our Future Community Forum, Whitemark, 28th March.

UTAS AC team (2019). 'What systems affect our health?'. Presentation to Connecting Care Community Forum, Ulverstone, 1st April.

UTAS AC team (2019). 'What systems affect our health?'. Presentation to Help to Health Community Forum, Clarence, 4th July.

Healthy Tasmania Community Forum, 13th August 2019, Hobart.

Pain Revolution, 10th September 2019.

TBRI training, SPNH, 8th November 2019.

2020

Tasmanian Wellness Framework—Situation Analysis Part 1, presentation and workshop, 27th February, 27th March, and 29th May (Strategic Purchasing and Funding, Planning, Purchasing and Performance, DoH).

Dean Cracknell (Town Teams/Neighbourhood Leadership, City of Launceston)—22nd May 2020

Internal policy engagement

2019

Dr Elspeth Stephenson and Dr Helen Yost (UTAS) (re trauma informed approaches in health and education)

Ms Sandra Murray (UTAS) (re food security)

2020

Mr Robert Alderson (UTAS) (re community engagement with UTAS)

Media engagement and public lectures

Media engagement

2019

Willard, J. (2019a). The State of Health: anticipating care needs in Launceston's Northern Suburbs, *The Examiner*, 26 March.

ABC Radio (Northern Tasmania), Interview with Piia Wursu, 20 November 2019.

Willard, J. (2019b). Supporting Better Health, *The Examiner*, 24 November, p. 6.

2019

Public lectures/presentations

Banks, S., Krabbe, R., Vandenberg, M., & Murray, T. (UTAS AC team)(2019). 'Anticipatory Care: An action learning project—Getting a sense of the system that supports our health'.

Presentation to the Tasmanian Health Service forum, *Accessible Services: It's in our hands*", Hobart, 30 October.

UTAS AC team (2019). 'Anticipatory Care: An action learning project—Getting a sense of the system that supports our health'. Presentation to the Tasmanian Health Service forum *Accessible Services: It's in our hands*", Devonport, 6 November.

UTAS AC team (2019). 'Anticipatory Care: An action learning project—Getting a sense of the system that supports our health'. Presentation to the Tasmanian Health Service forum *Accessible Services: It's in our hands*", Launceston, 14 November.

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