



Engaging communities for future health:

# The Anticipatory Care Action Learning Project

FULL REPORT

**ANTICIPATORY  
CARE PROJECT**

ACTION  
LEARNING TO  
IMPROVE HEALTH  
IN TASMANIAN  
COMMUNITIES



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Learning Project. Full Report





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## Glossary

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

AC	Anticipatory care
ACCHO	Aboriginal Community Controlled Health Organisation
CC	Connecting Care (Ulverstone and 7315 postcode AC project)
CCWG	The Healthy Tasmania Chronic Conditions Working Group
CLD	Causal loop diagram
DoH	(Tasmanian) Department of Health
FHO CM	Flinders Island Health Organisation Coordination Meeting (community members and service providers)
H2H	Help to Health (Clarence AC project)
LAG	Local advisory group
OCOC	Our Community Our Care (Launceston AC project)
OHOF	Our Health Our Future (Flinders Island AC project)
PHT	Primary Health Tasmania
PPH	Potentially preventable hospitalisations
PSO	Project Support Officer—employed by the local lead organisations and working with them and with the UTAS team
SDoH	Social determinants of health



### Vignette. When AC isn't working—Anne's story

Anne is in her forties and has recently been moved into the community by Housing Tas. She's come from a social housing estate in another part of the state, with her partner and children. This isn't the first move she's made; her whole life has been lived in insecure housing around the state. It means she knows very few people here in her new place. She is also affected by some physical impairments, and doesn't have a driver's licence, or a car. *"I can't go on the bus in wintertime with sick kids—it's a 10 minute walk to get to the bus in the rain. There's hardly any bus shelters when you do get to the stop. If my kids are sick, I have to pay for a taxi and most of the time I just don't have that money"*. Despite her impairments, she hadn't heard of the NDIS and so was not being supported. When told about the NDIS, she was a bit nervous—filling in forms and telling people about your circumstances is an uncomfortable space for her. Anne can't read or write. She quietly said she had left school without these skills.

Because she is new in this community, she hasn't got a regular GP. She *"can't afford it. Most of them don't bulk bill anymore. ... Couldn't get into [local clinic] because they weren't taking new patients. Didn't bulk bill if they did take new patients."* She's also worried that, as has happened many times before, the doctor will ask lots of questions, that make her feel ashamed, in order to decide whether to bulk bill her. All these reasons mean she is much more likely to just go straight to the local hospital, where at least she knows she, or the kids, will eventually be seen.

The other problem is that one of her kids is *"acting up"*. Like her, he has been affected by trauma: they both witnessed a violent crime. Now, *"my son's behaviour is getting out of control. He's not learning. He's behind with his spelling, writing, ... That's his self-worth going down the toilet. And that is a bad thing, because his mental health is affected by his perception of his own worth. So that mental health is deteriorating. He's got anger control issues, impulse control issues, ..."*. Other people told us that *"... so many of the women [...] can't leave the house, they're scared to leave the house with their child because their child is so off the show. And they're isolated, [this situation is] very, very isolating"*.





# The Full Report

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. 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.[1]



## Background to the Anticipatory Care Action Learning Project

Anticipatory care (AC) identifies who is at risk of developing an illness and works to keep people well. AC 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” [5]. Effective anticipatory care reduces the use of expensive health and social services [6]. Historically, AC programs have been managed through (medical) general practice, and 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” [3].

Anticipatory care involves health services and individuals [7], but the risk of developing a chronic illness is also produced by the social determinants of health [8], the “material, social, political, and cultural conditions that shape our lives and our behaviors” [9]. Julian Tudor Hart, regarded as one of the two founders of anticipatory care<sup>i</sup> [3, 10-12], 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.

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## Structure of this report

The 2020 local site reports provide full detail of the background, methodology and methods, local findings, conclusions and recommendations. In this document we report on the project overall, in five parts:

Part 1 presents the project aims, their relationship with the research questions and their operationalisation

Part 2 reports what has been learned about the three project aims

Part 3 reports on the project processes

Part 4 is the discussion and conclusion, with implications and suggestions for further work

Part 5 presents the recommendations.

In this report, we present vignettes that tell the stories of how people in the four project communities experience the anticipatory care system.



# Part 1: Project aims and research questions



## How the project worked

The CCWG engaged the University of Tasmania to work with project site teams to learn how anticipatory care is operating in Tasmania, what enables or disrupts the system, and what difference local factors, actions, and agencies make (see Box, below).

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 project aims were operationalised through four research questions. This relationship is depicted in Figure 1.

The research questions (RQs) for the AC project are shown in Table 1.

**Table 1: Research questions**

<b>Mapping</b> 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?
<b>Opportunities</b> 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?
<b>Actions and</b> <b>outcomes:</b>	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 gain a better understanding of the roles of different agencies in anticipatory care. Hence, there is an additional research question in each site:

<b>Help to Health</b>	What is the role of Local Government in Anticipatory Care, and can it be strengthened?
<b>Our</b> <b>Community</b> <b>Our Care</b>	What is the role of Neighbourhood Houses in Anticipatory Care, and can this be strengthened?
<b>Connecting</b> <b>Care</b>	What role can a GP clinic play in Anticipatory Care, and can it be strengthened?
<b>Our Health Our</b> <b>Future RQ</b>	How does anticipatory care look and function in an isolated and under-resourced community?

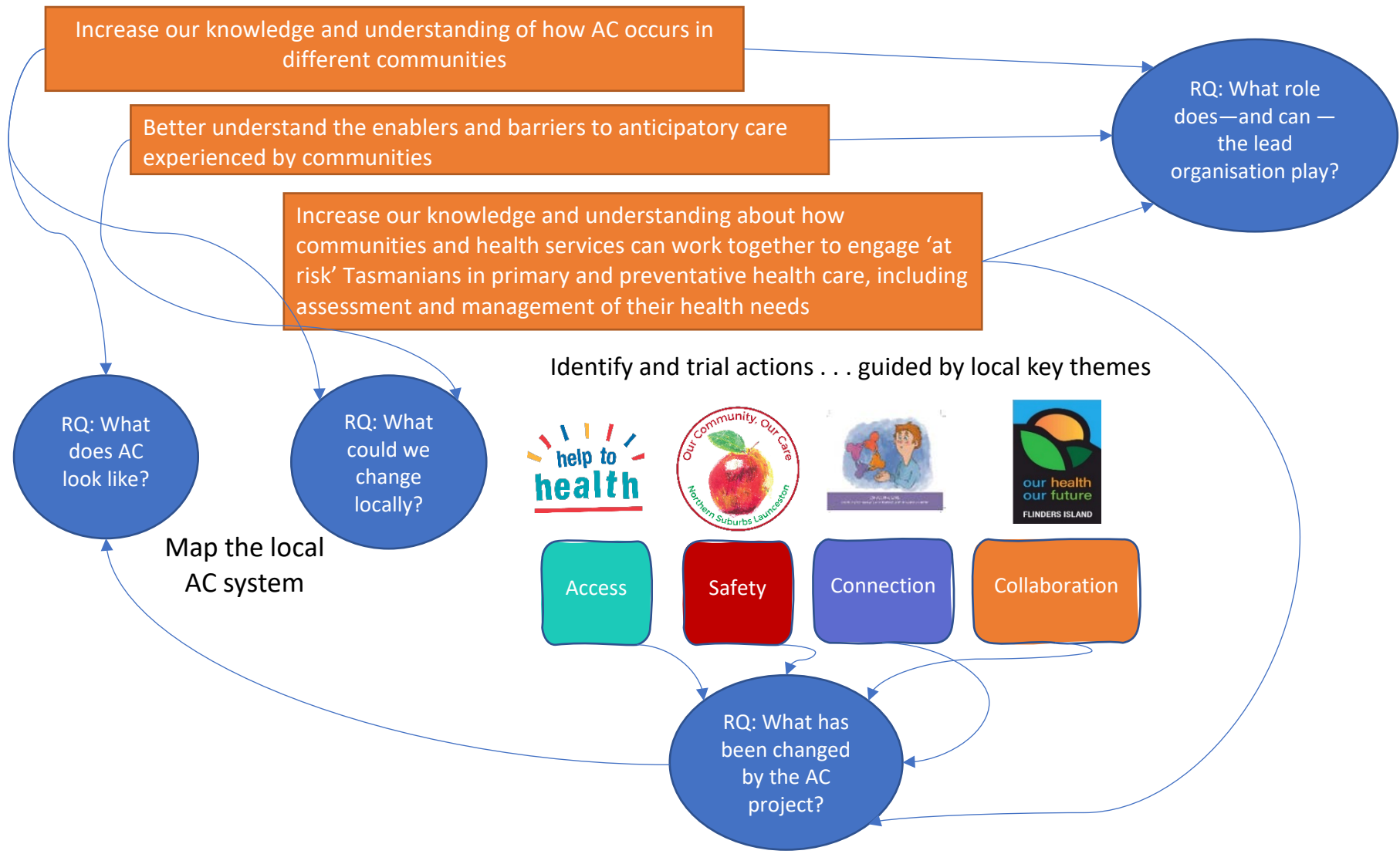
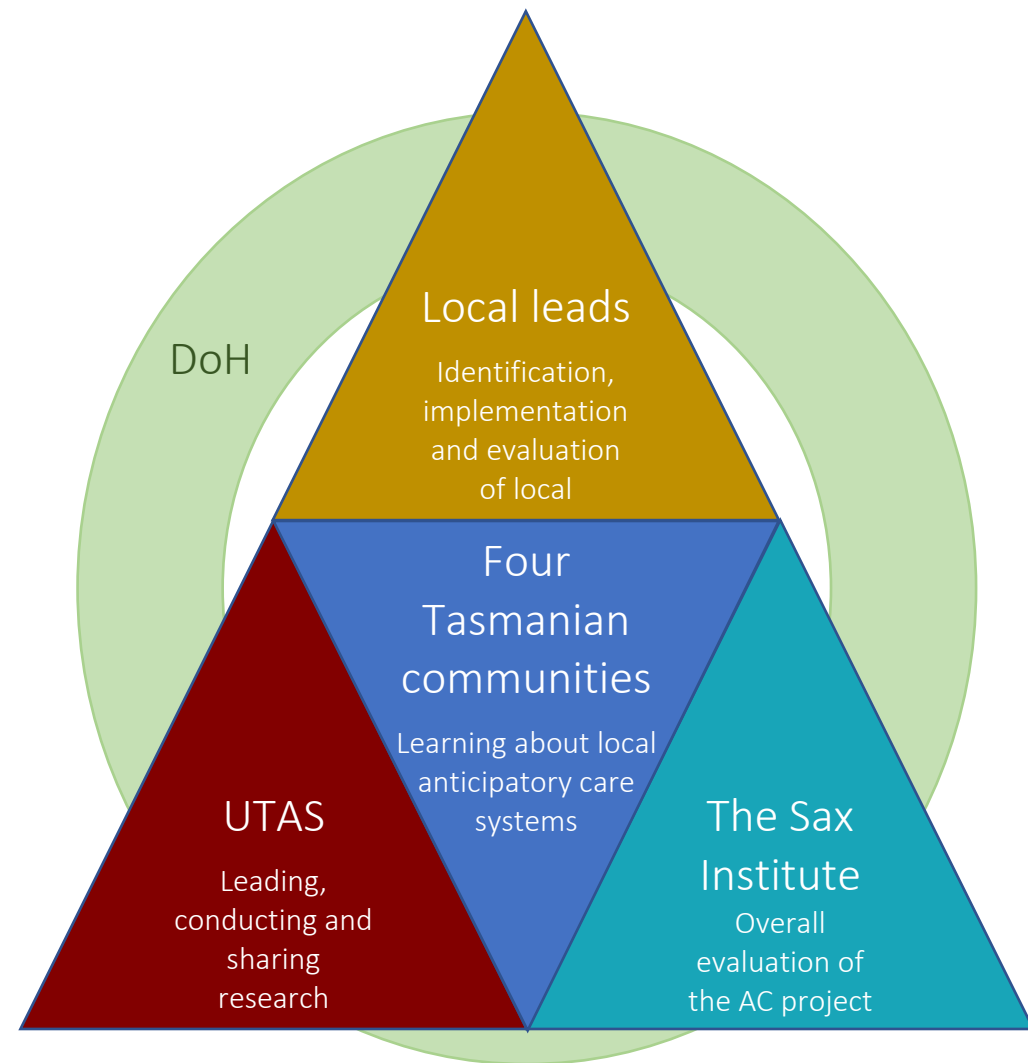


Figure 1: Operationalising the project aims



## The project was a collaboration

Meeting the project aims required a collaboration between local lead organisations, researchers, and evaluators. The collaboration was supported by the DoH Chronic Conditions Working Group and the Department of Health's Principal Project Officer. The roles played by the collaborators are illustrated in Figure 2. Appendix A lists the project outputs from UTAS. The other collaboration partners are also reporting their findings.



**Figure 2: The Anticipatory Care Action Learning Project collaboration**

## Methodology—why we did what we did

The UTAS Chief Investigators gathered a group of researchers for the AC project. The UTAS team was made up of the lead researcher (a health sociologist), an experienced public health researcher and consultant, a human geographer with significant private sector management experience, a social sustainability researcher, and (for a short time) a Social Work Masters student.

The DoH wanted 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 a Systems Consultant as partners to help us apply systems methods, supporting 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. Action learning could help us learn—with the project site teams—about the local anticipatory care system and about opportunities for intervention. The four parts of action learning are ‘observe’, ‘reflect’, ‘plan’, and ‘act’ (see Figure 3). 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 or affect one another, and to learn about and adjust actions. Action learning and systems thinking are good partners [13]. Action learning is part of a group of approaches that are participatory, collaborative, reflective and involve learning and action for change.

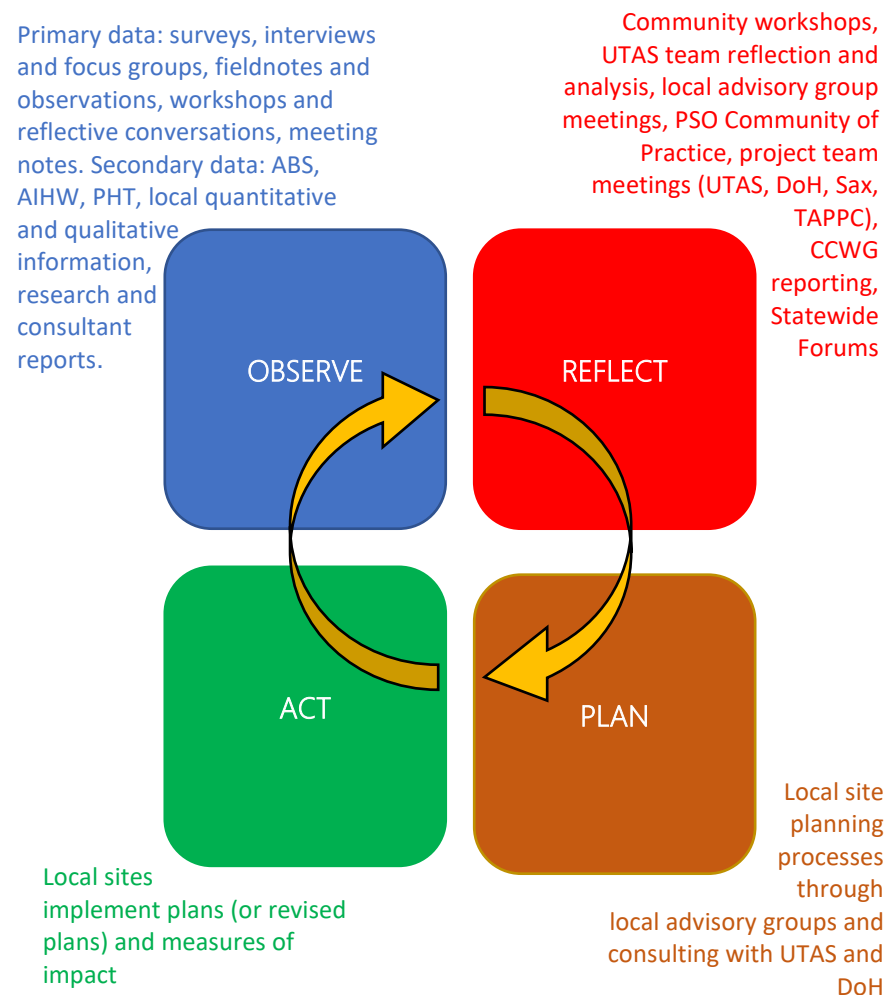


Figure 3: The action learning cycle

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.<sup>ii</sup>

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” [14]. 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” [13] like anticipatory care. The local site reports (2020) provide more detail about these approaches and tools.

The UTAS research group used multiple types of primary (gathered by the researchers) and secondary (pre-existing) data to answer these research questions. We used statistical information from the census and from Primary Health Tasmania, reports about the participating communities [e.g., 15, 16-19] (Figure 4), and research about chronic illness. We also gathered new data using surveys, interviews, focus groups, workshops, and observations, notes of meetings, and from reflective conversations with local project support officers in each site. Almost 770 people contributed directly to the data, through formal data collection processes (Appendix C). Many more were indirectly involved, through observation. Project support officers (PSOs) contributed more than 170 reflections, some written, some audio-recorded and some provided in reflective conversations with the lead researcher.



Figure 4: Examples of local reports that informed the mapping

## 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 in each site. We then created preliminary system maps and a community profile for each site. Secondary data helped to inform the questions we asked in qualitative data gathering and in the surveys. Some survey questions produced quantitative results; these were analysed statistically.

Qualitative analysis started 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 worked on particular sets of documents, but each person also analysed documents from other batches, to check on whether we agreed with one another's understanding of the material [this multiple coding,

also called inter-rater reliability, is discussed in 20, 21, 22].<sup>iii</sup> We have had regular whole- or part-team analysis discussions about what we are finding in the data. This has been a complex and dynamic conversation, as Figure 5 illustrates. We have also reviewed and revised our thinking in conversations throughout the project with the project lead, the DoH Principal Project Officer, Sax Institute and The Australian Prevention Partnership Centre (TAPPC) researchers and a

systems thinking consultant, the local advisory groups and the PSOs. These are all important opportunities for reflection. Analysis also drew on fieldnotes prepared by research group members, notes on meetings and other site visits, and records from the causal loop and community workshop sessions. The Principal Project Officer and a Sax Institute staff member also made notes and collated information from the community workshops. All these data were used in answering the research questions and meeting the project aims.

Analysis informed our mapping of the anticipatory care system and identified opportunities for intervention in the system. We provided a written report on the findings from the analysis to date to each site in 2019 (see Appendix A) and presented them to the local teams. We also delivered short presentations about the data and about the processes to the teams

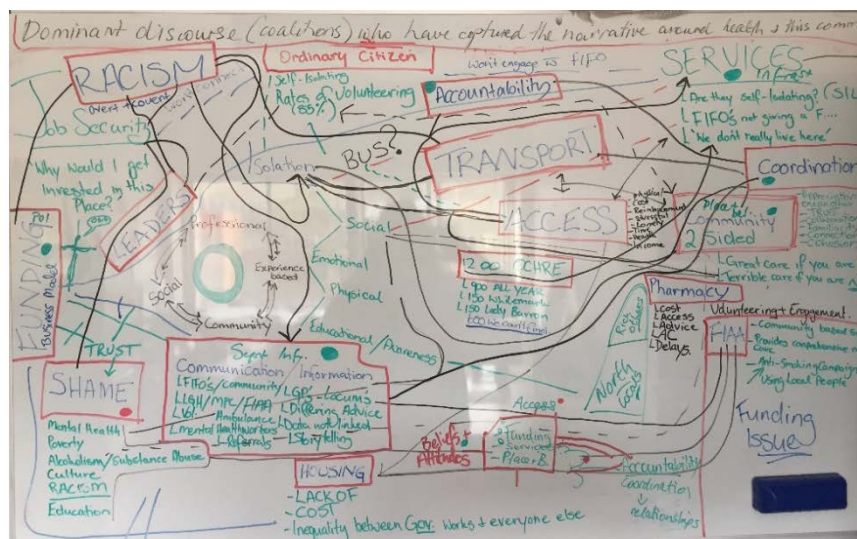


Figure 5: Part of the UTAS analysis process: identifying system parts

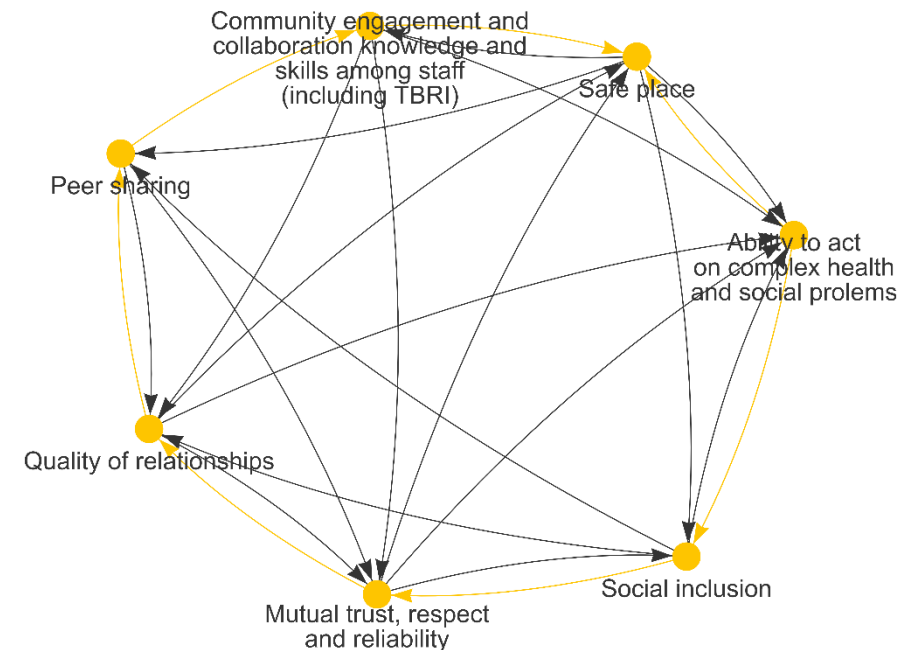
across the project period, including at two State-wide Forums in 2019.

Our other main analysis method is causal loop analysis. Causal loop analysis (drawing causal loop diagrams) is a form of collaborative group modelling. Participants work together to identify different parts of the anticipatory care system in their community, the causal connections between different parts of that system, feedback loops and potential leverage points (Figure 6 is an example, tracing the possible impacts of the Adventure Play program in the OCOC site). It 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 analysis. Guiding questions for the sessions were:

- Why are we doing this? What is the key question and the outcome we are interested in?
- Given we cannot draw the whole system, what are the boundaries of the system we will focus and work on?
- 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?

We conducted two causal loop diagram (CLD) sessions (in 2019 and 2020). At the first session, we worked on one of the opportunities for intervention in the system—the themes—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 were part of our ongoing analysis. The diagrams enabled 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.



**Figure 6: Causal loop diagram (possible impacts of Adventure Play)**



## Part 2: Meeting the project aims





## Aim 1: Increase our knowledge and understanding of how anticipatory care occurs in different communities

All research questions contributed to meeting this aim. We used systems thinking to frame how we investigated and understood the nature of anticipatory care in each site, informed by ongoing analysis of qualitative and quantitative data.

### The surveys added breadth to our understanding of the anticipatory care system

#### How the surveys were developed and administered

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 [24]. We discussed ways to engage with this group with the leads and PSOs, and surveying was suggested.

We designed a survey which PSOs trialled in their communities. There are personal and infrastructural constraints on surveying, including literacy, access to the internet and to data. This meant that the pilot 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 by the H2H project team, in keeping with action learning processes, 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 [25, 26]. The surveys asked people for quantitative and qualitative answers.

PSOs were encouraged to ‘roam’ their community, talking to residents and inviting them to complete the survey. PSOs could support and prompt participants, including transcribing the responses on the form, to gather detail about the sorts of people and places that are involved in health behaviours and care. Conducting surveys significantly increased PSOs’ engagement with community, and familiarity with different community settings. Surveying functioned not only to collect individual (non-identifiable) data, but also to increase PSOs’ knowledge of what infrastructure existed in their site, and how people were using those things. Their observations (in the form of written reflections) were included in the data.

#### Results

We reported the survey results for each site in the local site final reports. Table 2 gives some information about the sample in each site and overall. Three hundred and forty-one people completed the survey. More women than men participated, and the mean age for the sample was older in each site than the local mean age. The samples are not representative. However, the results correlated with what we learned through reliable statistical reports, and from the

qualitative data we gathered. It is also interesting that the results across the sites are fairly consistent, suggesting they may be reasonably trustworthy.

**Table 2: Survey sample characteristics**

Site	Total participants	Mean age	Female	Male	Excellent or Good self-reported health
H2H	42	69.5	59.5%	40.5%	30 (71.4%)
OCOC	48	42.6	79.2%	20.8%	25 (52.1%)
CC	146	52.7	58.2%	41.1%*	92 (63.4%)
OHOF	73	56.8	78.1%	20.5%	54 (74%)
OHOF	32 (school)	12.7	34.4%	65.6%	28 (86.7%)
<b>Total</b>	<b>341</b>	<b>50.2</b>	<b>65.5%</b>	<b>36.2%</b>	<b>229 (67.2%)</b>

\*One person did not identify as male or female.

### *Participants were in poorer health than Tasmanians overall*

People who responded to the survey (with the exception of the Flinders Island participants) self-reported considerably poorer health than for their region or for Tasmanians overall. Seventy-eight per cent of Tasmanians self-reported ‘excellent’ or ‘good’ health in 2018 [27]. The AC Project’s (small) Launceston sample reported the worst health (only about half reporting ‘excellent’ or ‘good’ health). They were also the least likely to see a health professional. In Clarence, Ulverstone and on Flinders Island, the proportion of people who saw a health professional was between 85 and 95 per cent, but in Launceston (where the respondents’ home locations were mostly in the most disadvantaged parts of the project site), only 62 per cent of

people reported seeing a health professional. For all participants, when they did see a health professional it was almost always a GP (around 90% of respondents in all sites).

### *Health is not seen in medical terms*

The survey also asked people “What does ‘being healthy’ mean, feel or look like to you?”. People’s way of thinking about health is important if we want to design an effective anticipatory care system. If people think in medical terms, it would make sense to focus efforts there; but this is not the case. The overwhelming response to this question showed that health was understood in terms of function: *Can I do the things I want to do, without pain or other restrictions*. People wanted a balanced life: to have the fitness, mobility, energy, and mental wellbeing to go about their daily lives. The sources of support for their health were manifold; getting out and about with other people was prominent, and family and friends were important health supports. Medical and other health services played a role, but not the central one. In Ulverstone and Launceston, mental wellbeing was a prominent part of how people described health.

### *Social and physical activity is important*

Family is an important source of social support for most respondents (80%). Women were almost twice as likely to be mentioned (wife, mother, sister, daughter) as men. The higher proportion of support sought from women is consistent with the ‘naturalisation’ of care roles to women [e.g., 28].

More than 90% of people said they were involved in social activities, while physical activities were undertaken by around 80%; this was higher on Flinders Island (98% for both social and physical activity).

There were clear correlations between better self-reported health and more activity, but the direction of causation cannot be determined.

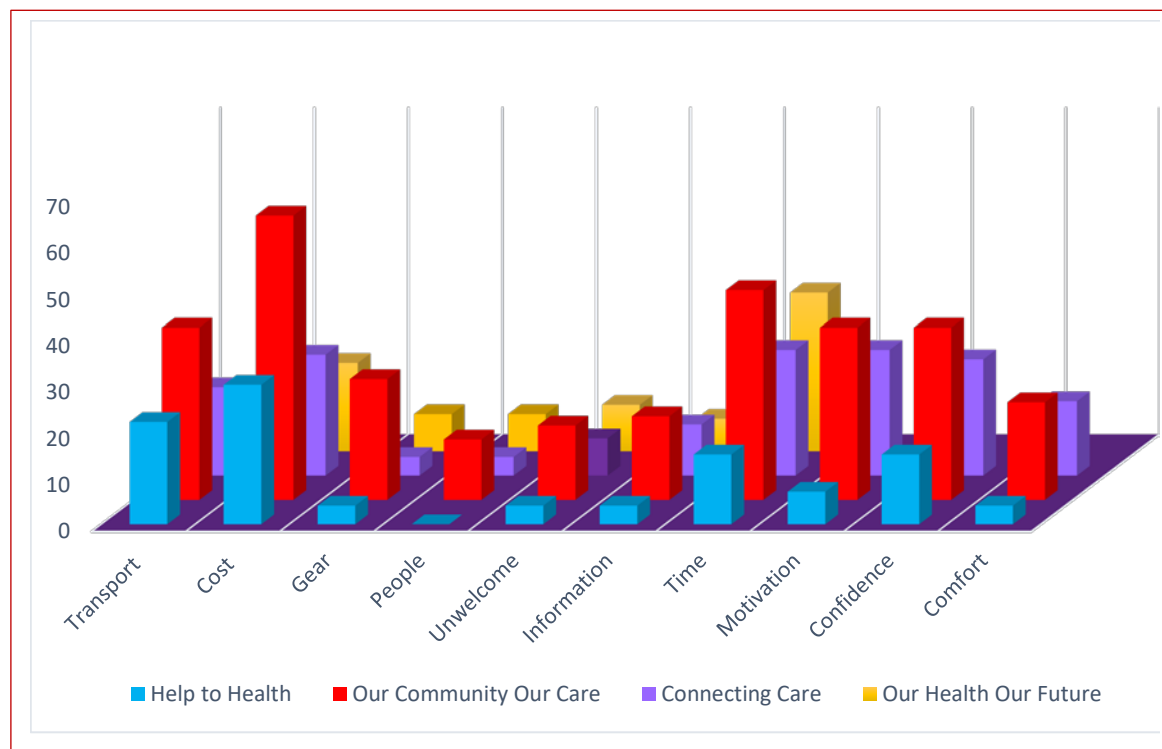
*Cost, motivation, and confidence are significant barriers to involvement in health-benefiting activities*

In all sites, cost was the largest single factor preventing people from engaging in beneficial activities. There were 682 responses to our question about barriers (people could tick as many barriers as applied). Of those, 227 (one-third) were transport or cost; transport may be a proxy for cost. The next largest barrier was 'time' (121; 17.7%). Motivation, confidence, or comfort barriers were also prominent. They attracted 71, 77 and 41 responses, respectively. Flinders Island surveys did not include these three barriers. The results can be grouped into *resource* barriers (transport + cost + gear) and *psycho-social* barriers (people (I don't like the people who run it) + unwelcome (I don't feel welcome) + motivation + confidence + comfort) (though people could tick as many barriers as they wished, so there is overlap). Of all responses, 269 (39.4%) were for resource barriers and 364 (53.4%) for psycho-social barriers (Figure 7).

*People's 'write-in' comments underline the importance of these barriers*

The 'write-in' comments made by respondents are dominated by these barriers. The cost of fuel, or of entry to an activity/health

service was prominent. A second theme was lack of time (because of work, child or other care responsibilities).



**Figure 7: Barriers to health activities, all sites' survey results**

In many comments, people expressed a wish to go to activities, on walks, and so forth, with another person. They felt uncomfortable or isolated and unwilling to try things alone. And people reported that mental illness (depression or anxiety) was preventing them from accessing health supports.

Interestingly, there was also a strong theme of ‘need for a local pool’, across all sites other than Clarence. We speculate that ‘local pool’ is a proxy for (i) nice place to exercise and socialise, and (ii) signal from local government that this community is valued. Shortly after surveying was completed, this theme of the importance of local pools was also taken up by the ABC and Guardian News.

### What are the anticipatory care system parts?

To help us describe and conceptualise the anticipatory care system, we drew on systems theory and thinking, the WHO *Building Blocks of Health Systems* [29], the Anticipatory Care Discussion Paper [1], and the CCWG’s Anticipatory Care Framework (Appendix B), and preliminary discussions with local lead agencies and TAPPC systems experts. Early in the project the anticipatory care system was described as being comprised of six system parts (as represented in Figure 8).



**Figure 8: Original systems diagram**

#### Initial anticipatory care system parts

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 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 ‘authorizing’ roles.

We used initial data analysis to describe how these parts appeared in each site, and that information was illustrated by a graphic artist in a series of site-specific posters (see Figure 9 and local site reports). The posters were used in local community forums, designed by a TAPPC systems facilitator, to gather additional data on each of the system parts and how they might affect one another.





## What we know now about the anticipatory care system across the AC project sites

Context shapes the local anticipatory care system, so while the same set of system parts was applied across the four project sites, there are important distinctions beneath the surface. We provide examples of each system part, showing how it manifested in one or more sites.

### People and health

*"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'."*

Diversity is the key factor when considering this system part. People do not share the same conditions, culture, and expectations, even in the smallest or most apparently homogenous places. On Flinders Island, for example, which has a very small population of around 900 people, people's income, education levels, cultural backgrounds and histories are very varied. At the other end of Tasmania, the H2H site, Clarence, has a population of more than 55,000 people; they are geographically very spread out across the municipality's many 'villages' and experience very different levels of economic security. We found that health was a high priority for many of the people with access to resources, but very few people felt comfortable using services outside their local village, much less "crossing the moat" (the Derwent river) to the western shore.

### Information and data

*"I can't work the MyAgedCare site"*

*"Why do I hear one thing from one place and something different from another?"*

*"Asking the wrong questions could end badly for me"*

*"It is hard to navigate the system to get the care I/the patient needs"*

*"I didn't know that service existed, or I could use it"*

Services and community members need to find out about things that support health. 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.

*"Like I can't read and write very well. I don't want people to know that. So, I will say, oh yes, I know where I'm going. And I just won't go."*  
(Interview)

People in most sites told us how hard it was to 'navigate' their way through the anticipatory care system. This applied to both community members and to service staff.

*"When diagnosed with diabetes, I walked out of the doctors, I literally had no idea where to go."* (Interview)

## Place and belonging

Place and belonging is integral to health. It is about the connections people feel to an area or a facility, and includes identity, culture and history/connection, roots, stories, stigma, neglect, pride, and safety. 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. The importance of place and belonging was made apparent at our first community

*"I won't go there; it's not my sort of place"*

*"The Ravenswood sign is such a great thing for this community"*

workshop, in Launceston.

## Attitudes and actions (or beliefs)

Individuals and organisations have motivations, make assumptions and judgments, and have differing understandings of their role in the

*"Respect is at the heart of a good health system"*

*"There is stigma around mental illnesses, including dementia"*

*"If people knew more about what is healthy behaviour, they would act differently"*

*"Individual and organisational beliefs and attitudes about health and the health and social care system [...] are highlighting our reluctance to take responsibility for our own health and to truly put individuals, rather than organisations and systems at the centre of health and social care."*

health system. This includes expectations and norms, stigma, and judgement. Attitudes and beliefs shape how people and organisations behave and what they expect of themselves and others.

## Policy and processes

Policies and processes reflect the attitudes and beliefs of the people using them, as well as legislation and policy. They can support or inhibit relationships, information sharing, leadership, and the effective use of information.

*"I've been on short-term contracts for x years; you don't know each year whether you'll be back"*

*"It's taken a long while for me to feel strong enough to access this service and trust the person ... What if they don't keep funding it?"*

Direct impacts of policy were evident, for example, in the funding mechanisms for anticipatory care services on Flinders island (see box below). Policy is also what directly shapes the availability of bulk billing.

*"So you've got your books closed here, next door are welcoming patients but I mean they're just over the top for their charging"*

*"We're a non-bulk billing practice, so we don't bulk bill anybody, but in practice, we bulk bill 50%. You wouldn't know that either, if you phoned up to make an appointment here, you wouldn't know that and that decision, maybe if we decided to bulk bill you, that would be made in the doctor's consulting room"*

Policy also can create considerable anxiety for individuals in relation to meeting welfare or social security requirements. The direct impacts of policy were evident in the funding mechanisms within the anticipatory care system on Flinders Island, but they are also what shape the availability of bulk billing, and drive people's anxiety about meeting welfare conditions.

## Leadership

Leadership includes effective priority setting and actions that support and enhance anticipatory care. It also brings people or services together, and is essential in advocacy. It is heavily reliant on relationships, data and information, resources and attitudes and beliefs. 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, school principal), but we also saw the importance of informal leadership such as people who solved a problem based on their own experiences and then sharing that solution with others.

In the Connecting Care workshop we heard about a group of volunteers who make connections with people undergoing treatment for a chronic condition, with social workers, specialists and others who play a role in the treatment, and with services like social security, support groups, home help, and so on. They're taking the pressure off; providing a point of connection for community members with the condition, smoothing the way for them through the system.

## Local infrastructure

Infrastructure, here, refers to the geography and topography, as well as facilities and services and the people who staff them. In some sites, there is a wealth of such infrastructure, with beaches, parks, GP clinics and other health services; in others infrastructure is inadequate, hard to get to, or unsafe. This matters, since infrastructure is where health happens. It can be cohesive, accessible, and safe, or restricted to those on-the-inside. Infrastructure can also signal to communities how much they are valued, as the following example from the OCOC site shows.

*"It's pretty obvious what the government thinks of us—they don't look after the infrastructure and keep taking things away"*

## Relationships

*"Yeah, and you might know what the programs are through emails and posters and all that, but who are the people? So, me as a service manager, I don't want to spend three days trying to find who's the person I'm going to talk to, to say, 'Look I've got this idea and there's a real community need to run a CBT group for young people that live on the eastern shore, we've been working in this facility. We need access to another room, and we need your staff to start promoting it for us, who do we go to?"*

Relationships are at the heart of an effective anticipatory care system. They may be between individuals, between individuals and organisations, or between organisations. Relationships rely on the local, on effective communication, consistency of staffing, leaders



who share, processes that support connection and care, and policies that support collaboration not competition.

### The similarities

For each community, individual system variables synergised to form overarching system parts relating to the themes: people and health; local infrastructure; data and information; attitudes and actions; relationships; leadership; 'place and belonging'; and 'policies and processes' (Figure 10).



Figure 10: The prototype anticipatory care system map

Our research showed that place and belonging matter because it is closely tied to how safe people feel. Without safety, people do not access services or places that can help them to maintain or build their health. People need to feel safe and familiar especially when they need help or support.

Policy and processes, whether at the organisational or governmental level, have a structuring effect in the system, shaping how the whole anticipatory system functions.

Examples of policy and processes include organisational funding models, bulk billing practices by health services and social safety net policies, operational policies such as how people are treated when they contact a service, or whether a service will outreach to those who are 'not the usual subjects'.

### The differences

There are important differences in the way the anticipatory care system is understood across the project sites, which is reflected in what stakeholders included and excluded when describing the system, and how they viewed the connections between different system parts. These insights and differences in understanding can be attributed to differences in historical developments of communities or organisations, culture, ideologies and attitudes (e.g., towards health equity), resources, and the knowledge and skills (e.g., engagement, listening, collaboration, flexibility) of lead organisations, project staff, and other stakeholders (including partner organisations and community members) involved in the project.

Multiple 'worldviews' are an important part of understanding the complexity of the anticipatory care system. We found that different

stakeholder attributes influenced how the anticipatory care system was defined in each of the project sites, how boundaries were identified, as well as the actions that were implemented to influence the system. For example, in some communities the boundaries around the system corralled it as a mostly medical service system, with a focus on health education, whereas elsewhere health was viewed in very broad terms and actions took on a community development approach.

### How do the system parts fit together?

We worked with the project sites to define a locally relevant *boundary* for the anticipatory care system as a means to manage the scale of the system and prevent it from becoming unwieldy given the project timeframe (2019-2020). Using the findings from our first phase of data analysis and insights from the community forums, we identified a small number of ‘systemic’ themes in each of the communities, which were understood as barriers or enablers to effective anticipatory care system function (Table 3). These themes were reported to the sites in mid-2019. Bounding the local system according to a systemic theme enabled the local AC teams to develop actions in areas that were of greatest importance to them. In this regard it was a “system of relevance” [30].

**Table 3: Local site guiding themes and exemplar actions to address them**

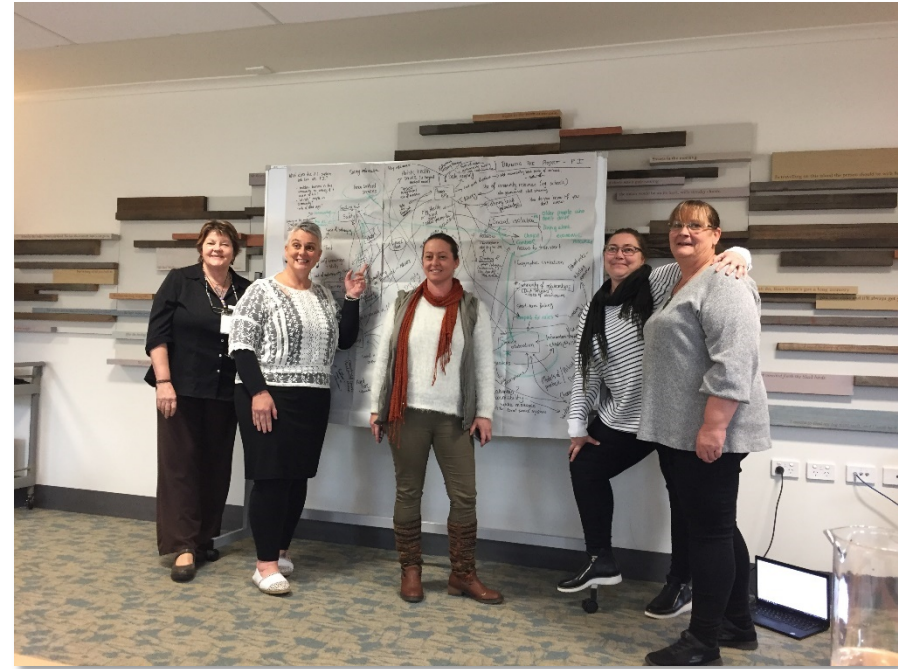
<i>Site</i>	<i>Guiding theme</i>	<i>Elements of the theme</i>	<i>Exemplar actions to address the theme</i>
<i>H2H (Clarence)</i>	Access	<p>The anticipatory care system is unavailable to some people (including in services) because of barriers to access that are:</p> <ul style="list-style-type: none"> <li>• geographical and physical, emotional, and psychological,</li> <li>• or that require financial, educational, or other resources to surmount</li> </ul>	<ul style="list-style-type: none"> <li>➤ The Right Place program that supports multiple sites to provide information for improved preventive health</li> <li>➤ The Health Connector role that links people and services, including through information exchange</li> </ul>
<i>OCOC (Launceston's northern suburbs)</i>	Safety	<p>The anticipatory care system is unsafe for some people (including in services) because of:</p> <ul style="list-style-type: none"> <li>• stigma, exclusion, and restriction</li> <li>• precarity</li> <li>• poorly targeted and delivered information</li> </ul>	<ul style="list-style-type: none"> <li>➤ Adventure Play/BOOM program to create safety for traumatised young people</li> <li>➤ Engagement with local GP clinic to reduce barriers</li> </ul>
<i>CC (Ulverstone and the 7315 postcode area)</i>	Connection	<p>The anticipatory care system is fragmented for some people (including in services) because of:</p> <ul style="list-style-type: none"> <li>• beliefs and attitudes about health and the anticipatory care system that focus on individual responsibility</li> <li>• poor quality information</li> <li>• poor communication and collaboration</li> </ul>	<ul style="list-style-type: none"> <li>➤ Shop-front health information hub</li> <li>➤ Services directory portal (process and product)</li> </ul>
<i>OHOF (Flinders Island)</i>	Collaboration	<p>The anticipatory care system is undermined by:</p> <ul style="list-style-type: none"> <li>• inadequate collaboration and coordination of services</li> <li>• a lack of cultural safety and competency among providers</li> <li>• social norms around risky alcohol consumption</li> </ul>	<ul style="list-style-type: none"> <li>➤ Cultural competency training</li> <li>➤ Collaboration with FIFO service</li> </ul>

## What can be changed at the local level?

The site themes became the focus of sites' causal loop analysis sessions. We used causal loop analysis, within the research team and with site teams to visualise and begin to understand how the system parts operated in each site, and what links existed between them. Causal loop analysis is a systems thinking tool. 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, or causal links). Making a diagram of the 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 described in each UTAS local site report.

The causal loop diagram (CLD) process can be used for the whole system, or for parts of it; our focus was on guiding themes in each site. At each session, the group (members of the local project team) focused on the site theme, identifying the supporting and confounding factors (variables) and causal links (Figure 11). We wanted to learn, in this process, how strengthening one factor might affect others, and where we can intervene for the greatest impact. The developing causal loop diagrams (CLD) of the anticipatory care system were extremely complex, with multiple variables and thousands of causal links and loops.

The four AC sites developed and trialled local actions to address the identified site themes (Table 3 and Table 4). These are detailed in the local site teams' final reporting, and in the UTAS reports to each site. We analysed the potential (Figures 12– 19) and actual impacts of the



**Figure 11: Some participants in the first OHOF CLD session, and their CLD**

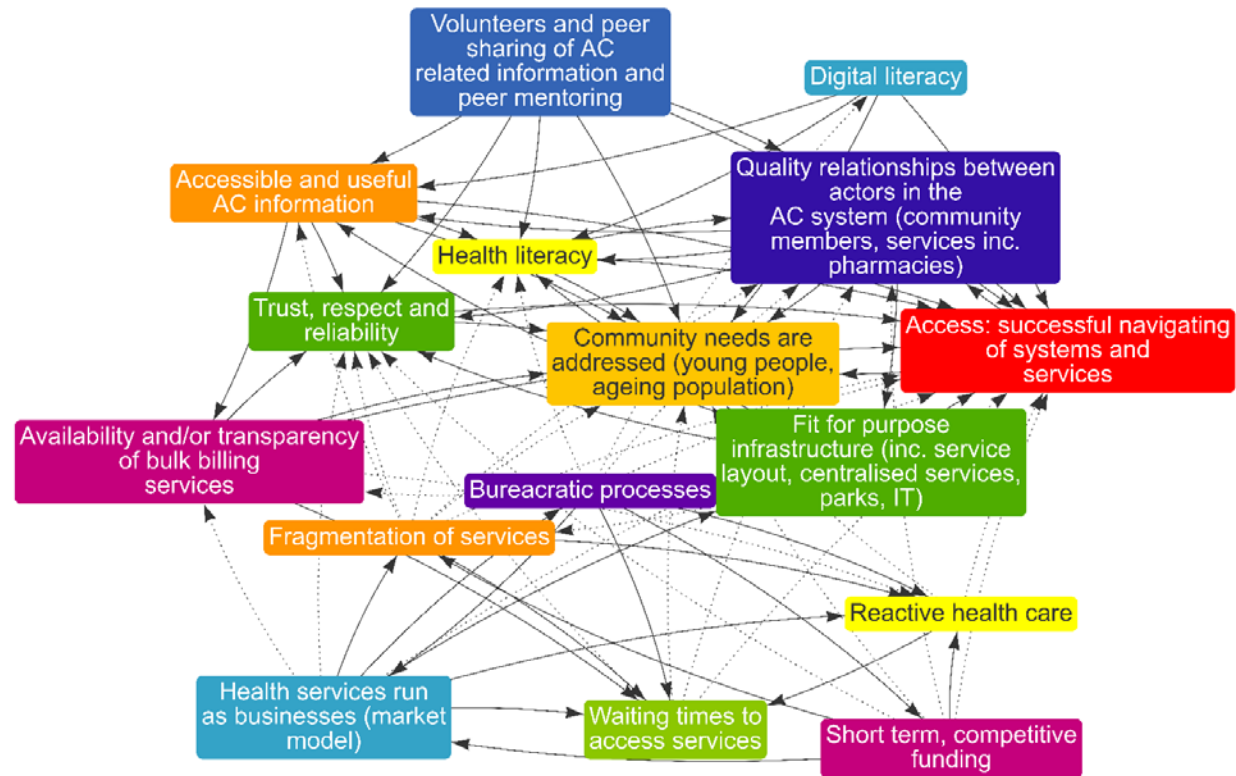
actions, using the causal loop diagram process in each site. This process was informed by both those present, and by ongoing data gathering and analysis. The following section shows the initial CLDs for each site.

At the end of the project, we returned to the causal loop diagrams prepared in mid-2019. We wanted to see whether the local actions had had any impact upon the anticipatory care system.

Opportunities for change identified in 2019

*H2H Clarence: The Anticipatory Care System in Clarence requires accessible and useful health information*

The Help to Health team identified that providing accessible and useful information was a key aspect of the anticipatory care system in the Clarence municipality. The team identified Council’s role as a key conduit between various actors in the anticipatory care system to facilitate the flow of accessible and useful information and build quality relationships. The diagram (Figure 12) shows the potential variables (rectangular boxes) involved in access, and the causal links (arrows) between them. Improving access involved 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.



**Figure 12: Causal loop diagram for CC’s focus—anticipatory care is shaped by access, 2019**

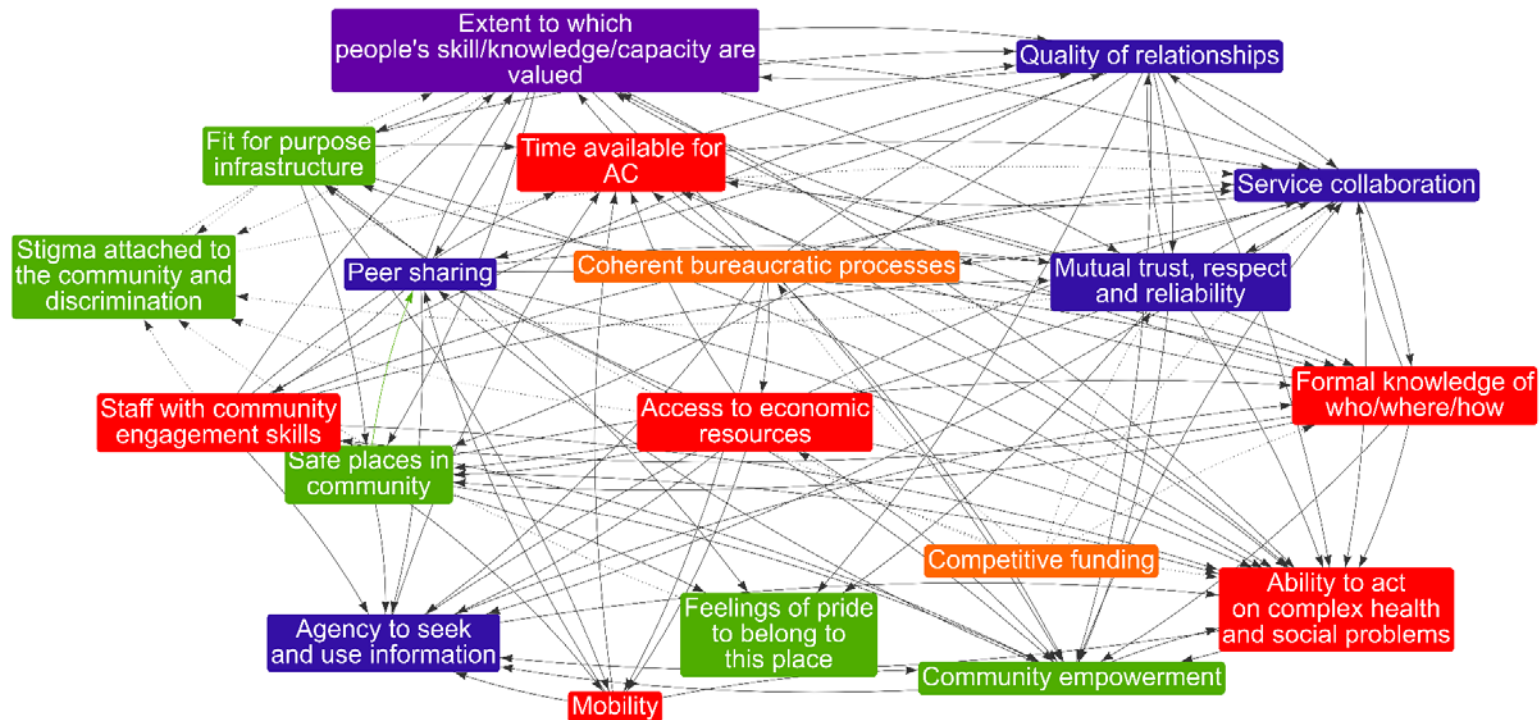


*OCOC Launceston: A safe anticipatory care system in Launceston's northern suburbs*

The Our Community Our Care team in the northern suburbs of Launceston developed a CLD that identified safety as a key component of the anticipatory care system. The diagram (Figure 13) shows the potential variables (rectangular boxes) involved in safety, and the causal links (arrows) between them.

Stigma was a significant theme in the OCOC site data, as a major barrier to people accessing services or places that could support better health. We found that too many residents' fear of being judged affected how likely they were 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 sporting or fresh food options), and a lack of personal and public transport. Creating safe

places (places where people can seek comfort, feel cared for and where they are included and feel culturally safe) and building pride in community were identified as being important to counteract stigma and for empowering and valuing the community. Trauma-informed approaches were implemented to increase safety. Fit for purpose infrastructure, including appropriate transport and access to health services, was also an important element of place.

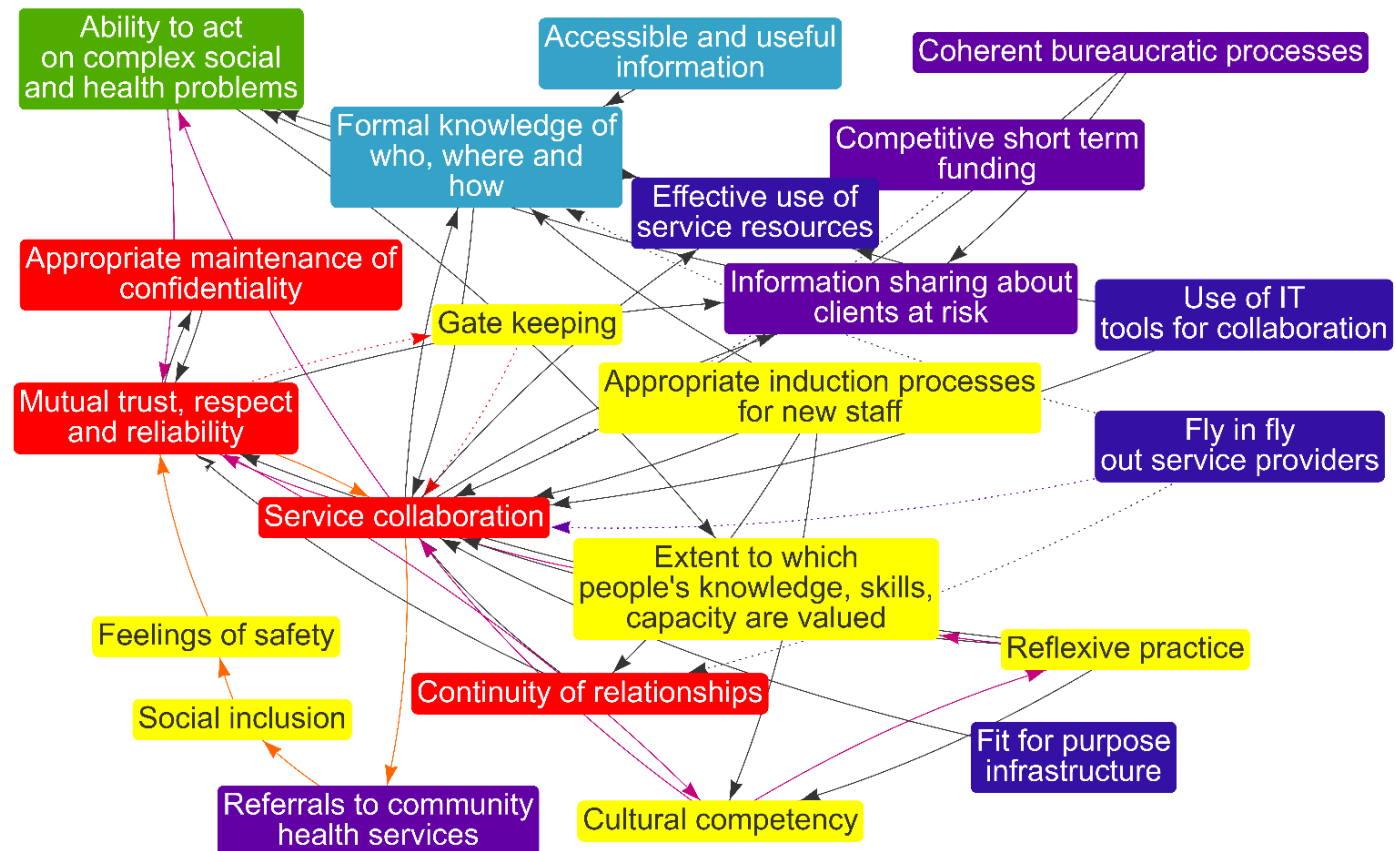


**Figure 13: Causal loop diagram for OCOC's focus—anticipatory care is shaped by safety, 2019**



*Community 4: Service collaboration as a key component of the anticipatory care system on Flinders Island*

The Our Health Our Future team identified service collaboration as the overarching priority for enhancing the anticipatory care system on Flinders Island. FHOCM was established in recognition of the need for better collaboration, reflecting both the specific challenges of a system that relies on on-island and fly-in fly-out services, and the collaboration problems that were evident in all AC project sites. Service collaboration became the driver for the action planning on Flinders Island, and for the CLD session in 2019. The diagram (Figure 15) shows the potential variables (rectangular boxes) involved in access, and the causal links (arrows) between them. The causal loop diagramming process also revealed that many other variables in the system support effective service collaboration, including cultural competency, mutual trust respect and reliability, relationships with visiting services, and so forth. OHOF's cultural competency training was one activity undertaken.



**Figure 15: Causal loop diagram for OHOF's focus—anticipatory care is shaped by collaboration, 2019**



### Vignette. Changing the anticipatory care system at the local level is possible—Brian's story

*"I haven't been here that long, but I've never been to an event where there wasn't alcohol". "I don't think it's just [this town]. It's probably remote communities that have access to alcohol are more likely to be because it's part of like Australian culture is quite a drinking culture".*

Drinking is part of the culture where Brian lives, and he always enjoyed a beer after footy, or at the pub after work. But then he had an accident, and he started drinking more. He was in a lot of pain; he couldn't exercise, play footy or do things around the house to keep it nice: *"... with being in pain I drink, I drank, way too much, I have liver problems, the start of liver problems, and diabetes"*. He's put on a lot of weight, what he calls *"the diabetic square chunky body"*. It's hard to socialise—partly because he fears his problem with alcohol will be obvious (there's a bit of stigma around not drinking: you *"cannot go to a social event, cannot play [sport], go to the clubhouse and have a non-alcoholic drink without the blokes taking the Mickey out of you"*, and partly because of the pain. He feels pretty ashamed about it, and doesn't have much to talk about anyway, since he can't do much. He's become very isolated. *"It took me ages to realise there was a problem; I was just staying home and drinking; feeling lonely"*.

But, Brian steeled himself and made an appointment with a doctor who'd been at the clinic for a fair while. They'd nodded to one another in the street once or twice, and Brian felt it could be okay to talk to him. The doctor referred Brian to the Alcohol and Other Drugs worker, who's on a short-term contract. *"It took me ages to realise there was a problem; I was just staying home and drinking; feeling lonely. [...] Getting the courage to come and see someone about it ... God, I hope they don't disappear!"*.

The site PSOs reached out to the AOD worker and developed a trusting collaborative relationship. The AOD's position has been funded to continue. The team has been working on raising awareness about alcohol, trying to see if some of the unsafe norms can be shifted. Some locals reckon that now *"there's lots of conversations around the traps around reasonable drinking. Even if it doesn't meet the guidelines, they are thinking "Maybe drinking before 5 is not a good idea"*, and Brian feels supported and safe. *"Well I've been talking to AOD about my pain. Yeah, we call it pain. I just, just share everything with Kat. [Partner] said to me this morning, you're seeing AOD worker again?! Are they your new best friend?! Yeah, my paid best friend."*

## Project activities to address local site themes

Each site developed and implemented a range of activities to address the local site themes. These are listed in Table 4 and discussed in detail in the local site reports prepared by UTAS and by the sites.

**Table 4: Local site themes and actions**

<i>Site</i>	<i>Guiding theme</i>	<i>Exemplar actions to address the theme</i>	<i>Additional actions</i>
<i>H2H (Clarence)</i>	<i>Access</i>	<ul style="list-style-type: none"> <li>➤ 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; sub-project: It's Okay To Ask; sub-project: Help to Health Friends; sub-project: Clarence Talks)</li> <li>➤ quality relationships between actors in the anticipatory care system to address community and service needs (sub-project: developing and describing the Health Connector role)</li> </ul>	<ul style="list-style-type: none"> <li>➤ PSO outreach to community and services</li> </ul>
<i>OCOC (Launceston's northern suburbs)</i>	<i>Safety</i>	<ul style="list-style-type: none"> <li>➤ transport access (physical/financial) (sub-project: bus services, Green Cards)</li> <li>➤ access to GPs (sub-project: working with local clinic to increase information sharing)</li> <li>➤ physical activity and social connection (sub-projects: Ravenswood Basketball Bins, Clean-up Walks)</li> <li>➤ social connection and information sharing (sub-project: Facebook page, videos, LAG)</li> <li>➤ safe responses to people experiencing trauma (sub-project: Trust Based Relational Intervention Professional Learning session)</li> <li>➤ community pride, local positive identity, and engagement (sub-project: community arts projects, clean-up walking group).</li> </ul>	<ul style="list-style-type: none"> <li>➤ PSO outreach to community and additional services</li> <li>➤ PSO collaboration with services, for advocacy (to politicians, media)</li> <li>➤ Inclusion of new LAG members</li> </ul>
<i>CC (Ulverstone and the 7315 postcode area)</i>	<i>Connection</i>	<ul style="list-style-type: none"> <li>➤ information sharing through health and social care information hubs (the CC portal, social media, and printed resources, as well as pop up hubs)</li> <li>➤ health literacy training for staff and volunteers (based somewhat on The Right Place model operating in the Clarence Help to Health project site, and in the Huon Valley)</li> <li>➤ the effectiveness of (and potential improvements to) responses to chronic conditions by GPs (practice audit)</li> </ul>	<ul style="list-style-type: none"> <li>➤ CRG collaboration for resource directory (new collaborations, reflexive services)</li> </ul>

*OHOF (Flinders Island)*

- developing a framework and governance model to sustain enhancements of the anticipatory care system in this site (the Roundtable).
- Collaboration
  - direct health impact and service collaboration (sub-project: Alcohol Awareness program)
  - social and physical health impact (sub-project: G. A. M. E. (gear access made easy) On Flinders)
  - service collaboration (sub-project: Increase clarity and reliability of referrals; sub-project: Community groups booklet/online app; sub-project: Cultural competency training (and development of the training))
- PSO collaboration (across FIAAI and MPC) and with Ochre services
- Fluvax clinic
- PSO outreach to FIFO services

## Project activities made an impact on the local anticipatory care systems

We returned to communities to re-draw the CLDs at the end of the project (May/June 2020), using evidence in the data and presented at the sessions. The following section shows the 2019 and 2020 diagrams, in double-page spreads, and list the impacts on the system for which we have evidence. These differences show what impacts the site actions and activities had on the local anticipatory care systems. More detail is provided in the local site reports prepared by site teams and by UTAS in 2020.



Emily, the H2H PSO, was at the Risdon Vale Neighbourhood House on the day some bad local smoking statistics were released. She had a conversation over coffee about what to do in response. The relationship she had built with people at that site meant they could explore options together. In effect, local government was in that room, trusted and working for a shared solution, not in a building at the other end of the municipality.

Emily, the H2H PSO, was at the Risdon Vale Neighbourhood House on the day some bad local



Cultural competency was identified as essential to collaboration across services, and more generally to the wellbeing of community members. The OHOF team worked to deliver cultural competency training to FIAAI and other services across

Flinders. Participants spoke of having experienced: *“powerful and significant learning around inter-generational trauma; the workshops were moving, poignant and enlightening. We need to keep [cultural competency] at the forefront”*

## Connecting Care



As part of their work on the portal resource directory, CC’s community reference group (CRG) members contacted services and organisations to include. Through working on the directory, new relationships have been formed, with information being shared that supports the directory but also supports organisations and services to provide a more locally appropriate and accessible service and to find collaborators.

The big wins are finding people who could work together to produce the directory, reaching out to organisations and services to get the information, and the mutual learning and reflection that took place in that process.



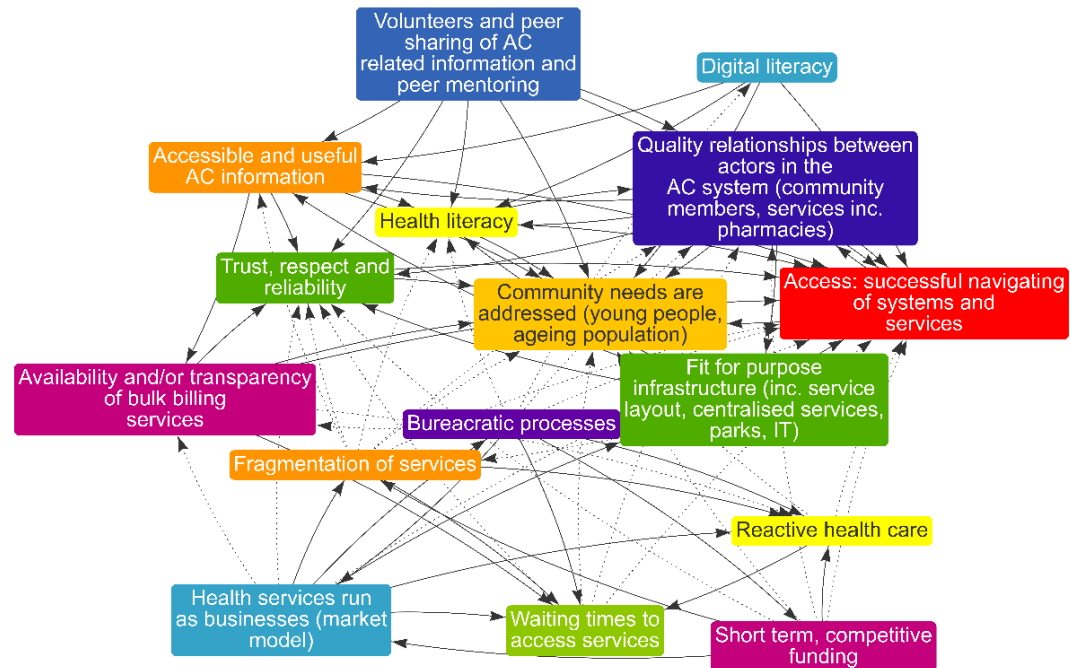
Multiple new networks of individuals and groups—formal and informal—have been created, breaking down barriers, increasing inclusion, understanding and opportunities for novel fixes for barriers. Networks are key to the ‘getting things done’ that has characterised the way the PSOs are working, with police, with the GP clinic, with schools, with social workers, with Metro Tasmania, and so on.

*Clarence, Help to Health. Aim: to increase access to and through the anticipatory care system*

The H2H project team wanted to improve access in and through the system.

In the 2020 CLD workshop, we used our analysis of the data, and the evidence presented in the workshop, to redraw the CLD of the local system, in terms of the key intention, increased access. 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.



The variables and causal links in the 2020 diagram (Figure 16) are those for which we have evidence of change. They do not necessarily mirror those in the 2019 diagram (this page).

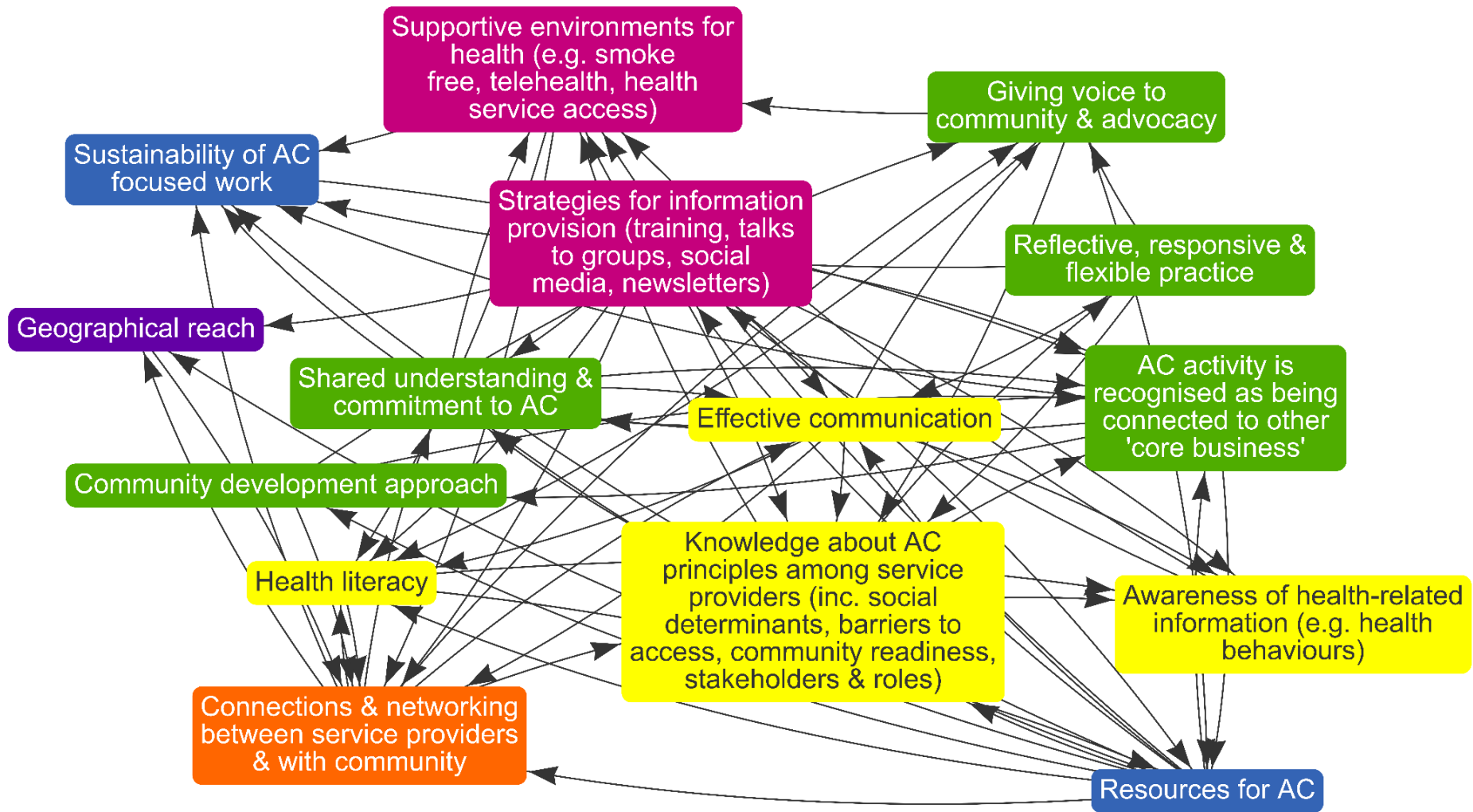


Figure 16: Causal loop diagram for CC's focus—anticipatory care is shaped by access, 2020

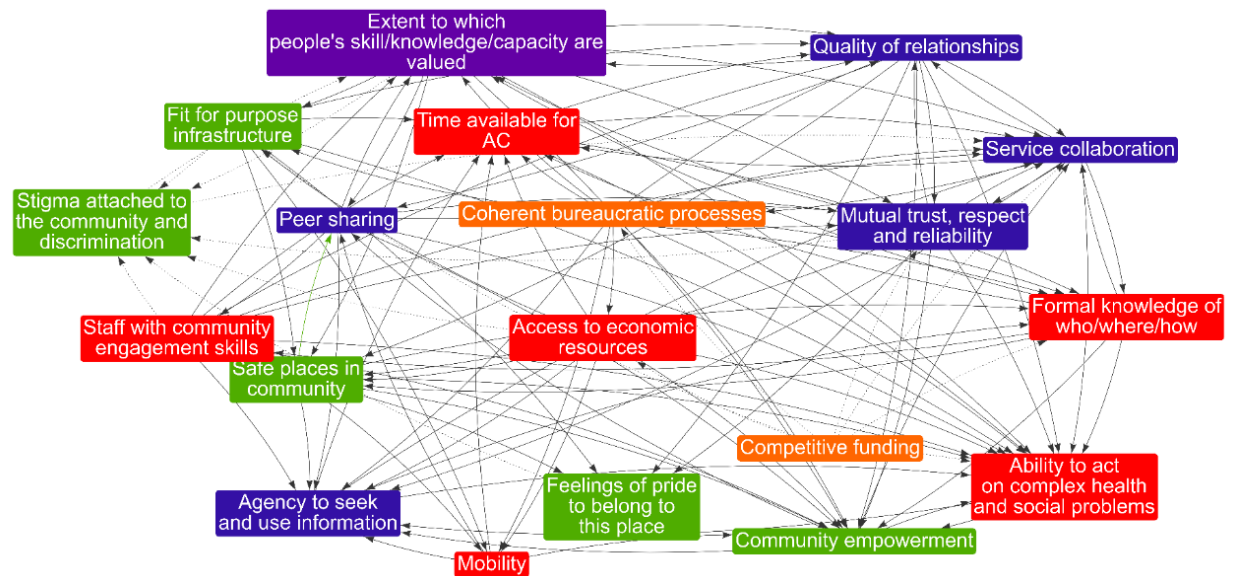
*Launceston's northern suburbs, Our Community Our Care. Aim to increase safety in the anticipatory care system*

The OCOC project team wanted to increase safety in the anticipatory care system. In the 2020 CLD workshop, we used our analysis of the data and the evidence presented in the workshop to redraw the CLD of the local system, in terms that key intention (Figure 17).

The diagram shows that project actions and activities in the Actions taken in the AC Action Learning Project have increased:

- Understanding that AC involves a wide range of people and services and their interconnectedness, and built new collaborative relationships with shared goals, language, and ways of working for health advocacy
- Capacity in key players and organisations to work safely and effectively with community members
- Engagement of some groups (including previously hard to reach people) in health-promoting activities
- ‘Good news’ media stories about the OCOC community (with potential reductions in stigmatising of community and individuals)
- The effectiveness and authority of the lead agencies in health.

The variables in the 2020 diagram (Figure 17) are those for which we have evidence of change. They do not necessarily mirror those in the 2019 diagram (this page).





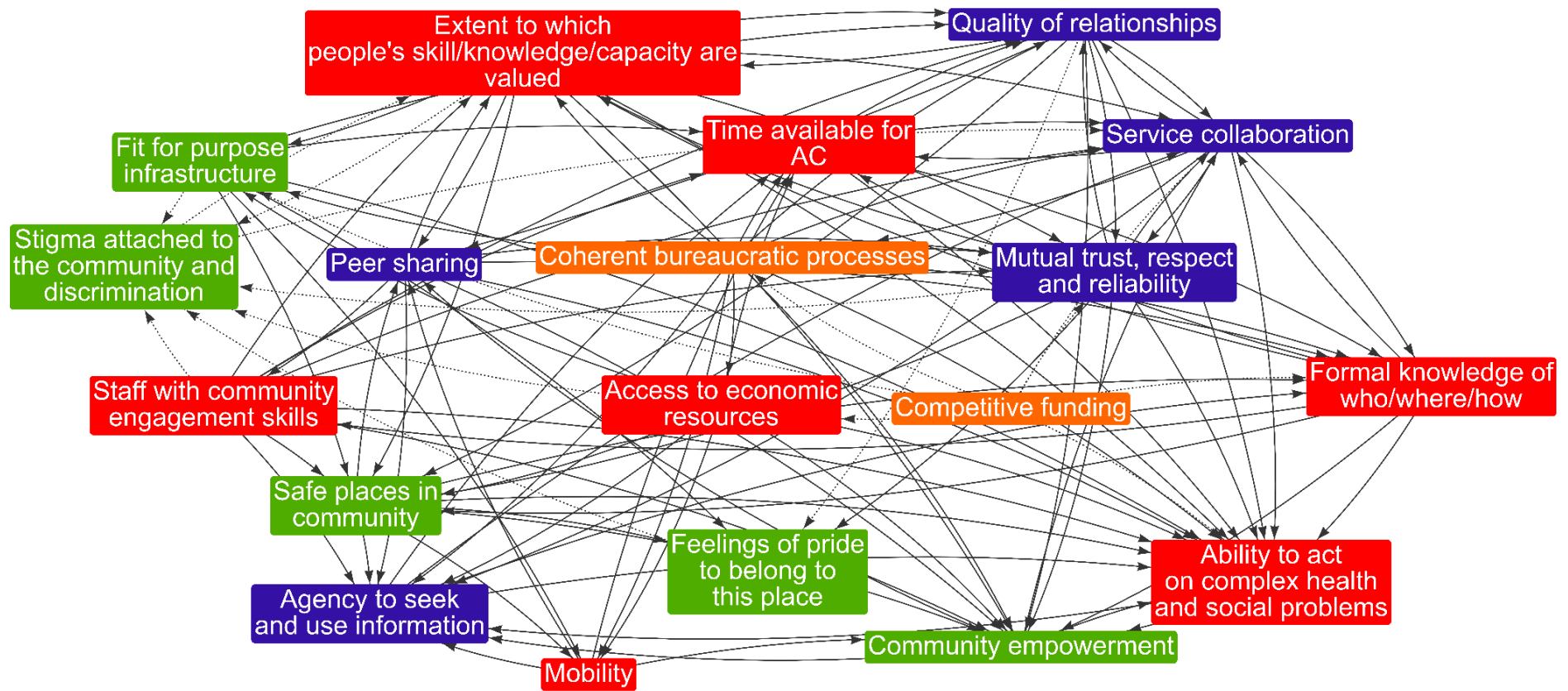


Figure 17: Causal loop diagram for OCOC's focus—anticipatory care is shaped by safety, 2020



*Ulverstone, Connecting Care. Aim to increase connection in the anticipatory care system*

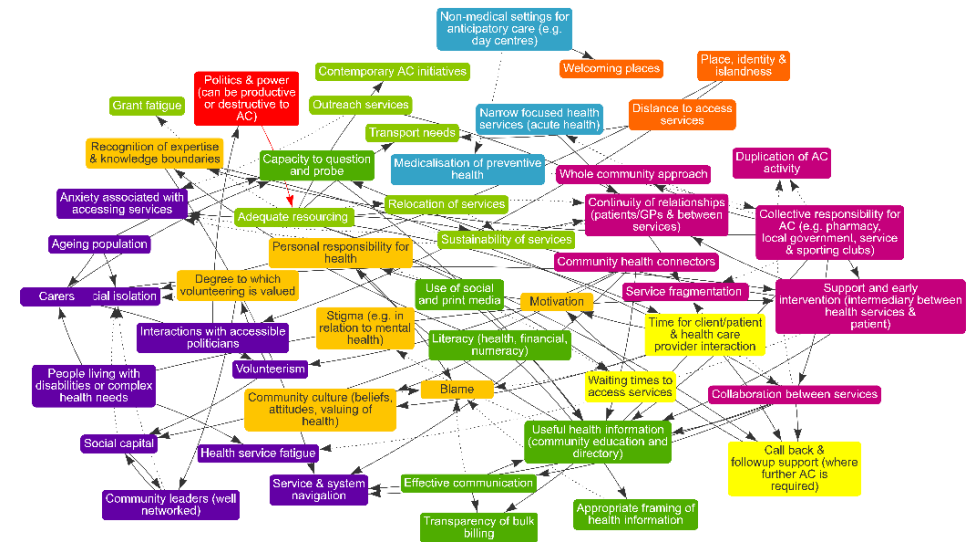
The CC project team wanted to influence connection in the system, through changes to attitudes and beliefs, better access to health and social care information, and improved collaboration and communication.

In the 2020 CLD workshop, we used our analysis of the data and the evidence presented in the workshop to redraw the CLD of the local system, in terms those three key intentions. In the diagram (Figure 18), the links for which we have evidence are green, while those for which there may have been change are shown in orange.

The diagram shows that project actions and activities in the CC AC Action Learning Project increased:

- connections and networks between service providers and with the community
- effective communication through these connections/networks to share AC knowledge
- awareness of AC services/programs among service providers
- service provider awareness of need to create supportive environments for health
- AC beliefs and attitudes about the need for collaboration across the system
- the likelihood of sustaining AC project gains through the proposed Central Coast Community Wellbeing Governance Model (for the Roundtable).

The variables and causal links in the 2020 diagram (Figure 18) are those for which we have evidence of change. They do not necessarily mirror those in the 2019 diagram (this page).



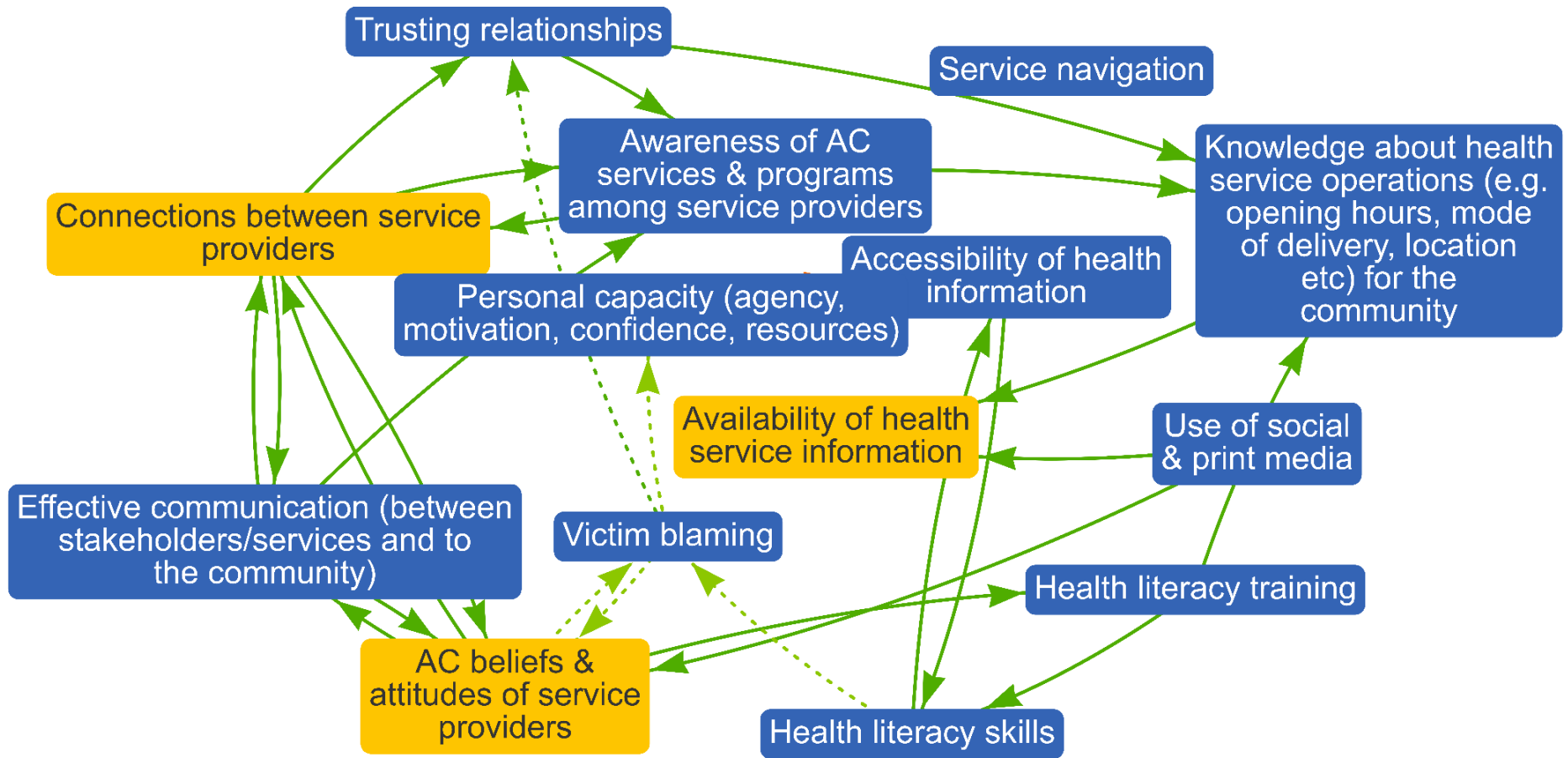
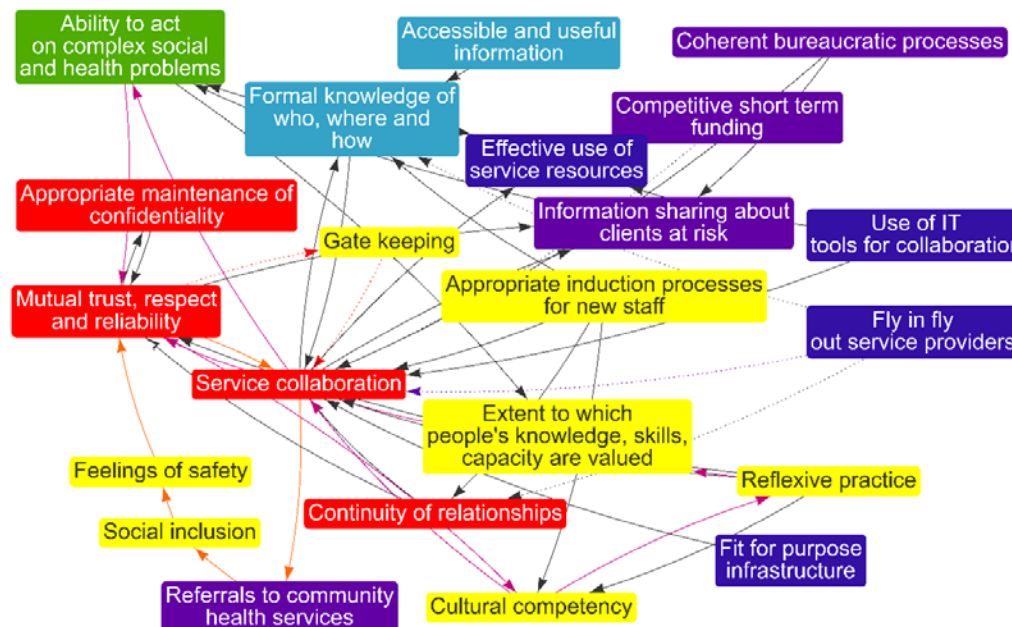


Figure 18: Causal loop diagram for CC's focus—anticipatory care is shaped by fragmentation, 2020

*Flinders Island, Our Health Our Future. Aim to increase collaboration across the anticipatory care system*

The OHOF project team wanted to increase collaboration in the anticipatory care system. In the 2020 CLD workshop, we used our analysis of the data and the evidence presented in the workshop to redraw the CLD of the local system, in terms that key intention (Figure 19). Actions taken in the AC Action Learning Project have increased:

- understanding that AC involves a wide range of people and services and inter-connectedness between services and people involved in AC across the Island (extending to Cape Barren Island) and collaborative relationships with shared goals, language, and ways of working for health advocacy, including with some fly-in-fly-out service staff
- skills for anticipatory care and strengthened relationships and collaborations among service providers such as FIAAI, MPC and Ochre; part of this is person-dependent through the PSOs and GPs, who are remaining in their substantive roles
- cultural competency among FIAAI and other services staff to work safely and effectively with community members, and the engagement of some groups (including previously hard to reach people) in health-promoting activities
- awareness and support from a key funder of visiting services to the Island about the need to include collaboration in role descriptions for providers visiting the Island (and Cape Barren Island)
- service provider and community awareness of alcohol consumption as a key risk factors for chronic illness and initiated some changes in access to alternatives
- the effectiveness and authority of FIAAI in health and anticipatory care.



The variables and causal links in the 2020 diagram (Figure 19) are those for which we have evidence of change. They do not necessarily mirror those in the 2019 diagram (this page).

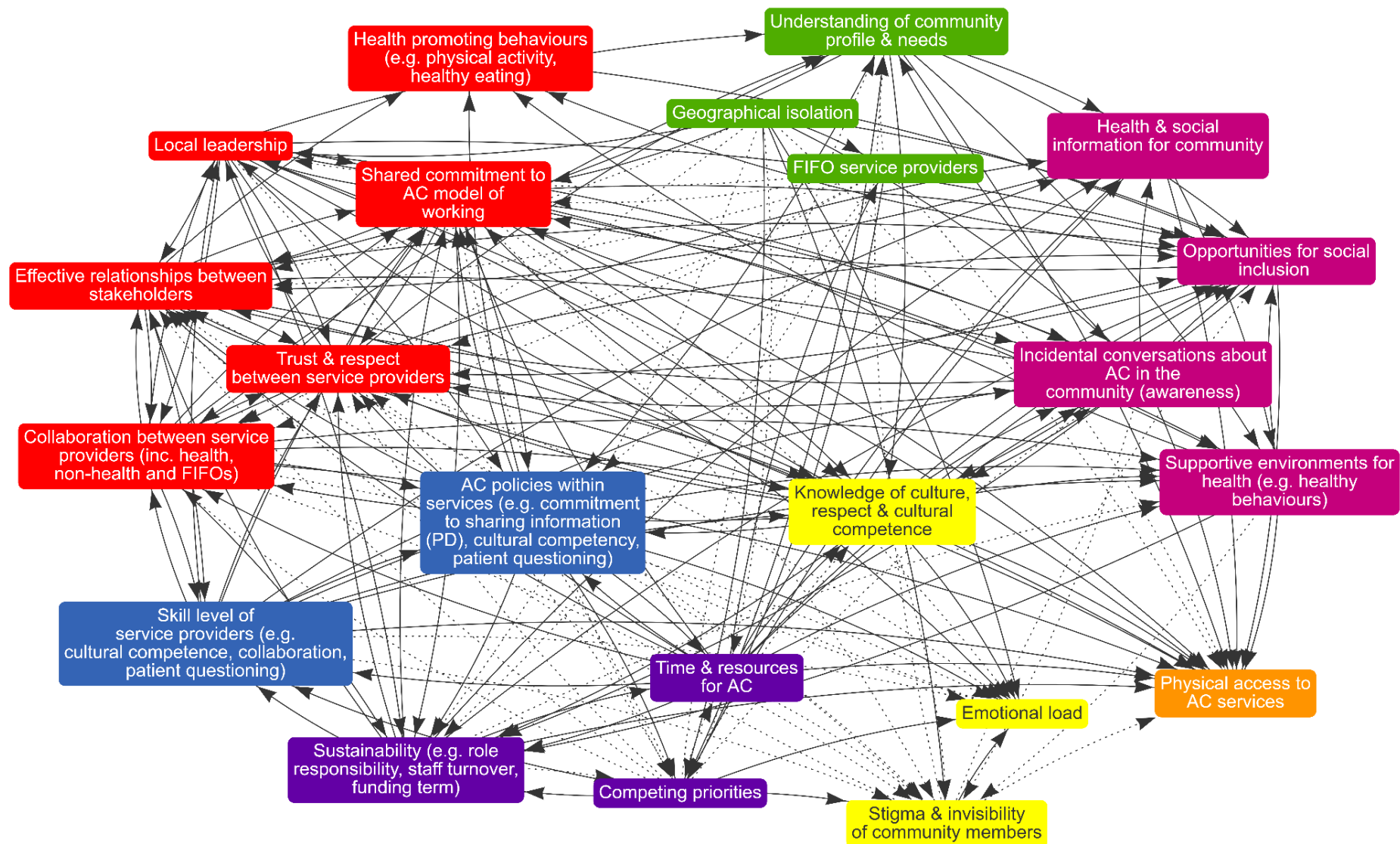
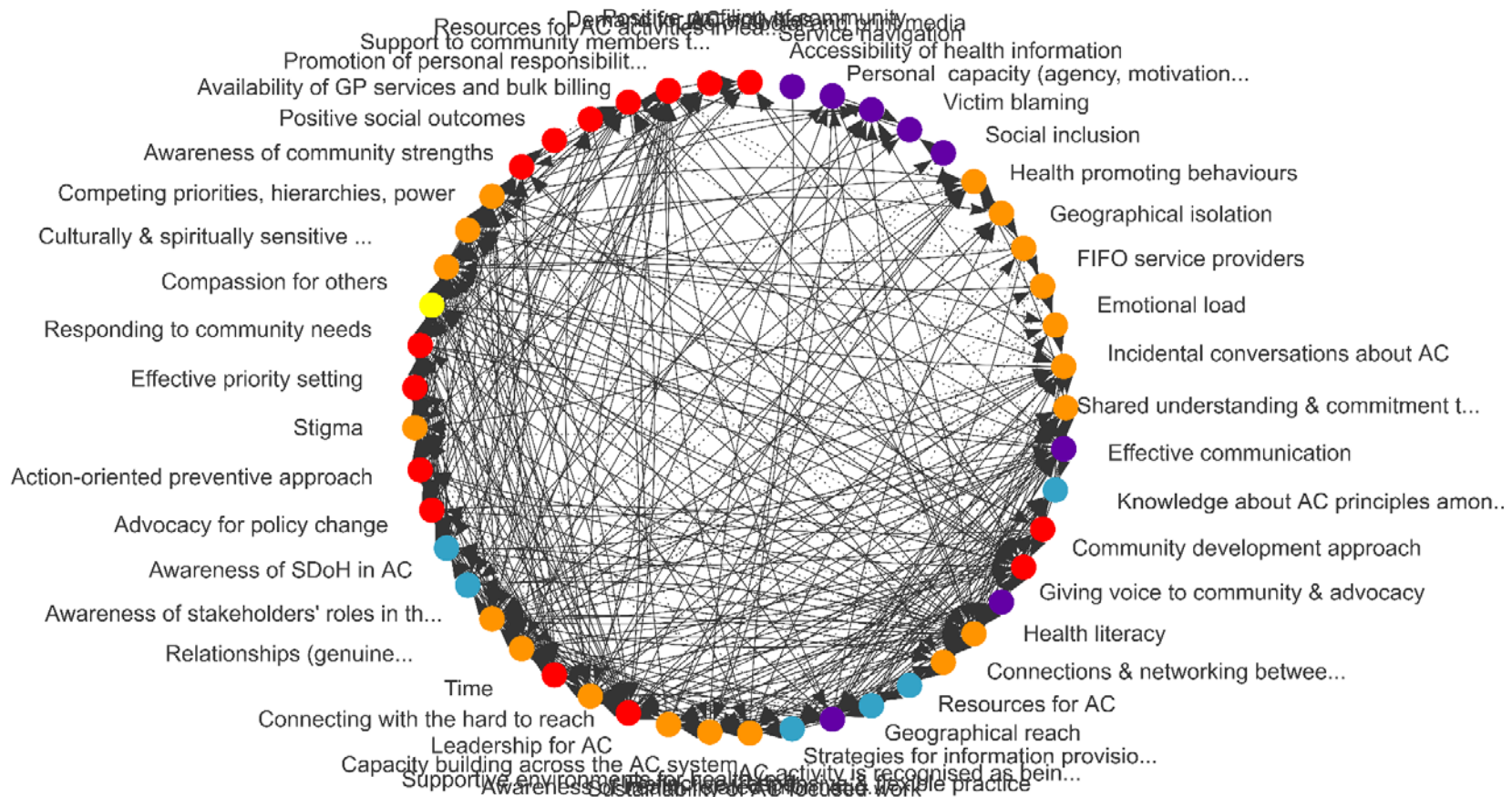


Figure 19: Causal loop diagram for OHOF's focus—anticipatory care is shaped by collaboration, 2020



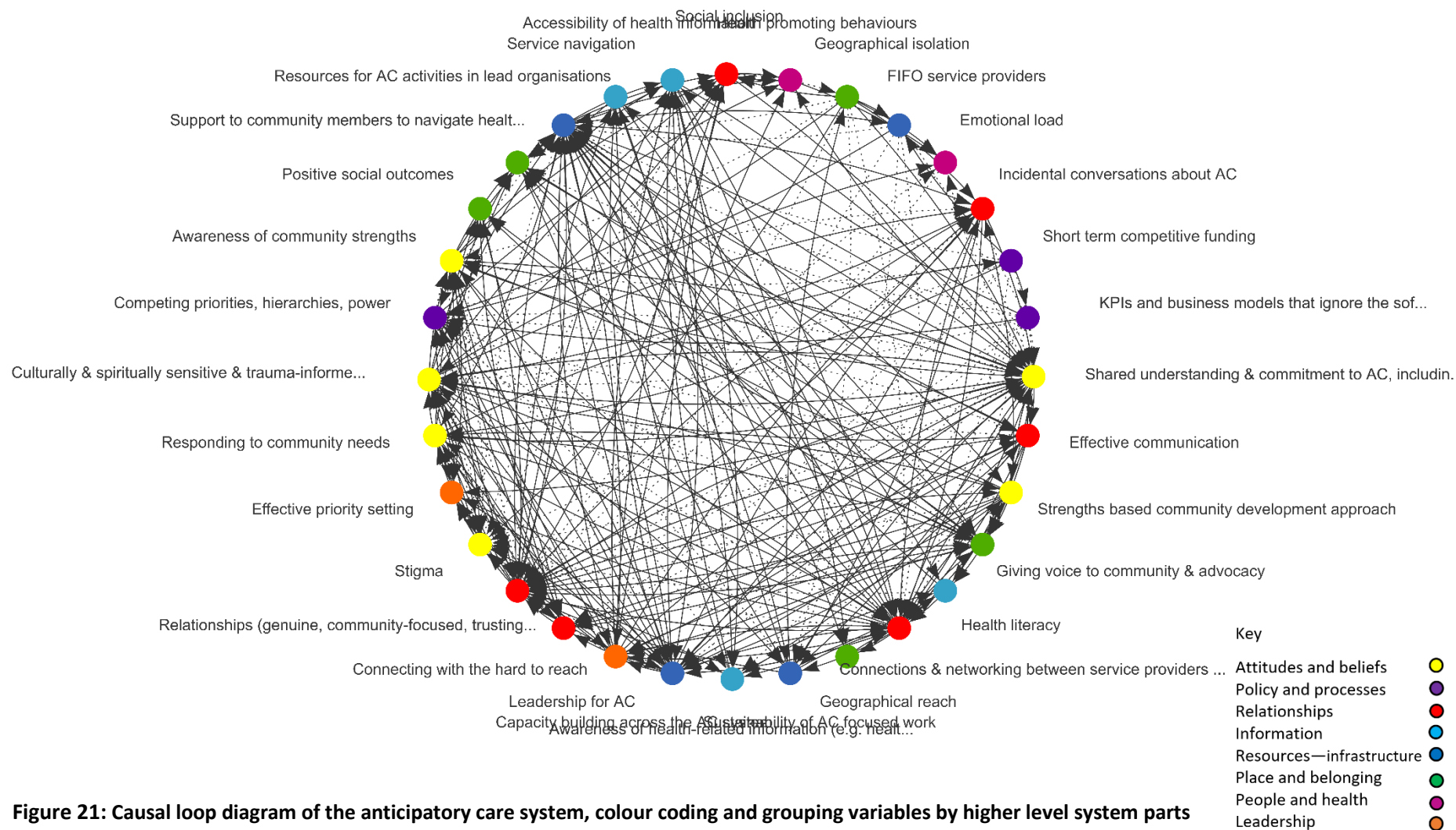
## What the local CLDs show about the anticipatory care system

We have 'stacked' the local site diagrams to create a diagram (Figure 20) of the individual system variables that have been affected by project initiatives in the four sites. This accumulation of variables demonstrates what the sites have in common, and therefore which variables appear to be necessary to the anticipatory care system. The variables revealed do not present a complete picture since each site focused only on a significant local theme so as to reduce the potential complexity, and we include only those variables for which there was evidence of change.



**Figure 20: Causal loop diagram of the anticipatory care system, 2020**

Figure 20 is a map of the anticipatory care system (bounded by the local site themes), including the variables that comprise the system parts. We collapsed variables whose characteristics overlapped (see Appendix D for this process, and for a list of the variables in Figure 20) and revised the colour coding to identify the resulting variables by system parts (Figure 21).



**Figure 21: Causal loop diagram of the anticipatory care system, colour coding and grouping variables by higher level system parts**

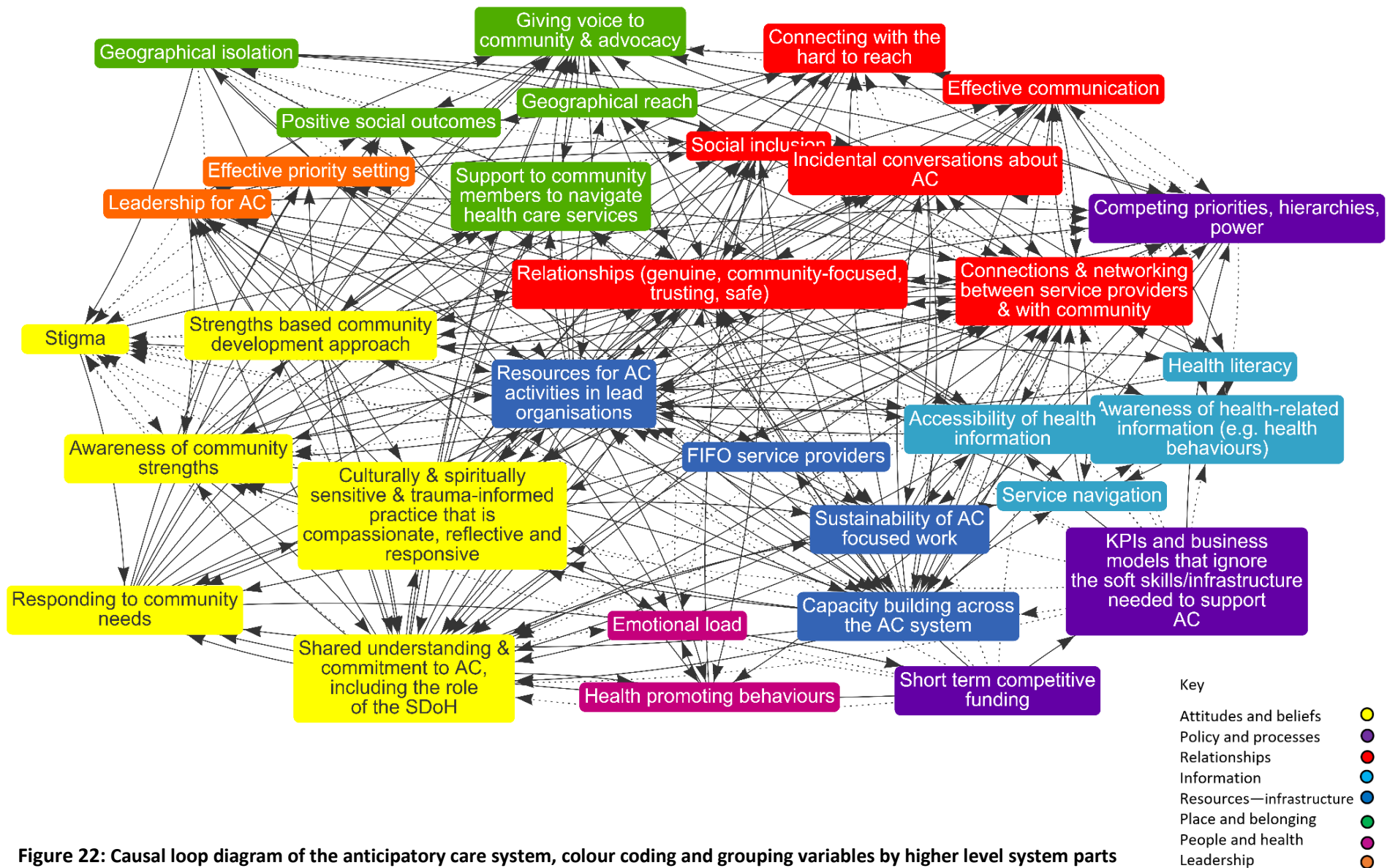


Figure 22: Causal loop diagram of the anticipatory care system, colour coding and grouping variables by higher level system parts



## Vignette. Causation is complex

We met Andy. He's a retired carpenter and has had a tough time as his wife deteriorated with dementia. They went from being an outgoing, sociable couple, going to the local bowls club, having meals with friends, spending time with their children and grandchildren, to *"more or less hiding"*. It wasn't that Jen didn't want to socialise any more, but that she became more and more aggressive and people weren't sure how to handle that. Andy wanted to protect her, but he was also worried that she'd hurt herself or someone else—and he was ashamed. Andy told us that he had spent the ten years leading up to her death (in 2018) becoming more and more isolated. *"I basically didn't go out"*. The kids stopped visiting, they stopped going out and friends dropped off *"I lost a lot of my friends because of dementia"*. He didn't talk to anyone about it and didn't get any supports from MyAgedCare. He felt too ashamed, for himself and for Jen to tell his story to anyone other than the GP, and that was a one-off when she was diagnosed. There were some days when he was suicidal. When Jen died, he had no friends at all, and had lost touch with their kids. He felt that he had *"forgotten how to be with other people"*.

A few months before we met him, he saw a notice about the Men's Shed; it took a few weeks to get up the courage, but eventually he went along. It's been a *"life-saver"*. Since joining the Men's Shed, he's starting to feel a bit more connected. *"Look we'll, we'll sit around this table and catch up about what happened to you that morning and yep, and [...] you know, sometimes we've got a project on with 8 or 10 people here"*. His old skills are getting a run; he used to run his own small business and now he's working with some of the men to write a grant for a piece of machinery they want, a thicknesser; the one they have is on its last legs. Andy's thoughts of suicide have receded; he still feels a bit tentative about socialising: *"It'll take a while, I reckon"*. And he's connecting with kids—not his own, but with some local kids from the school, who come in and use the shed:

*"First up, we signed the school up as a user of the Shed, and they would bring along a couple of kids. Started off with about six. And they're disengaged boys, [...] boys with no father figures in their lives. [...] And they were the naughtiest ones of the lot, basically. They loved coming here. The school could see a lot of benefit out of it. [...] I have a good relationship with them. It's not about making money out of it; it's about including the boys into something, social inclusion. It's good for us."* He said he still feels pretty *"stuffed"*, but things are looking up.





## Summary: What we know now about the anticipatory care system across the AC project sites


The causal loop diagram (Figure 22) shows:


- the clustering of causal links around particular variables, indicating importance in the project sites
- the beneficial, reinforcing links across the system, indicating change resulting from project activities
- the detrimental impacts of some variables on the system.


Variables, system parts, links, and their impacts on the system


 **Relationships** underpin the system. Relationships enable social inclusion, collaboration, and coordination (“connections & networking”), effective communication, connecting with the hard to reach and incidental conversations about anticipatory care.


 **Attitudes and beliefs** shape relationships. Attitudes and beliefs need to support inclusion and collaboration, seek and value the diversity of knowledge and perspectives and needs present and the importance of cultural and spiritual sensitivity and recognise strengths. This system part is closely linked with place and belonging. Attitudes and beliefs also shape policy and processes. For instance, an individual-responsibility view of health does not factor in the impacts of the social gradient of health or the social determinants of health [31], and so can miss opportunities for prevention through, for example, secure housing, universal public education, or bulk billed medical, dental and psychological consultations.

 **Place and belonging** includes giving voice to community (listening to local needs and advocating for them), the impacts of geographical isolation and the importance of reach, using local knowledge to support community members to navigate the system, and positive social outcomes (in place and for place and community).

 **Information and data for health** comprises the accessibility of health information and people’s awareness and use of that information to better coordinate or navigate the anticipatory care system. Accessible information is supported by health literacy of community and service providers.

 The **People and their health** system part includes health promoting behaviours and the emotional load—of community members and of service providers. It can also include social outcomes, and overlaps with attitudes and beliefs, and relationships, for example.

 Individual actions and experiences are **Leadership** (orange variables) includes effective priority setting and leadership that supports and enhances AC. It is heavily reliant on relationships (red variables), data and information (aqua variables), resources (blue variables) and attitudes and beliefs that support AC (yellow variables).

 **Infrastructure** for anticipatory care refers to the resources needed to support and sustain anticipatory care. Both ‘hard’ infrastructure (services, facilities, technologies, housing, transport and roads, etc.) and ‘soft’ infrastructure, the interpersonal skills that support people’s engagement in the anticipatory care system are

needed. Soft infrastructure includes trust, self-efficacy, governance, safety (including cultural or spiritual safety), and identity [32].

● **Policy and processes** are to some extent external to the system, though a powerful force shaping it. It includes the funding models that enable or constrain the effectiveness of the other system parts. Funding models, though at a higher level, also drive key performance indicators (KPIs) and business models that do not factor in the importance of soft infrastructure (e.g., that measure instances of service rather than outcomes and qualitative dimensions).



Figure 23: Recent research reports on funding models

### Vignette. Fly-in-fly-out? The implications of short funding cycles

Short-term competitive funding has advantages. It can stimulate rapid implementation of new ways of working, or push service providers to reinvigorate their delivery. It also has disadvantages. It can undermine the “long term productive relationships, between patients and professionals who know and trust each other” [3], and the opportunities for collaboration and care coordination that AC relies upon. For many service providers, their role in the anticipatory care system is insecure.

*“Each financial year it just changes; the pots of money get moved around [...] what I see is that for 18 months they might be employed by one organisation, and then it all comes up for review again, and then that organisation might get that money to provide the service”*

*“I think also a lot of people, including myself, for me to be here I need to have multi-funds [...] So I have to kind of have a bit of clinical work and a bit of health promotion and a bit of private work to actually sustain [my role] and have enough funds to work here.”*

*“And so I guess to be able to better support and help people you have to be able to have that space, for some it's going to take six months, 12 months depending on your degree of trauma and history and we if we have not got the time or the, you know, the funding to be able to sit in that space [...] We [are] kind of expected to deliver and get certain outcomes, but we don't actually recognize a lot of the tiny little outcomes, tiny little achievements, goals that are being achieved and some of them are so tiny, but they're there. We should not be dismissing those because each little thing kind of builds on to something and then you know, you don't just get that big beautiful shiny [cure].”*

## Aim 2: Better understand the enablers and barriers to anticipatory care experienced by communities

Mapping the anticipatory care system (reported in the previous section), revealed that:

1. There are eight system parts, manifested in multiple variables, each with particularity to local sites.
2. There are significant barriers to the effectiveness of the system—for providers and for citizens.
3. Access, safety, connection and collaboration—the local site ‘themes’ or focus areas—are enabled or disabled by factors that seem to occur **at the intersection of system parts.**

*“A lot of our families are in—you know, it’s four children in a two-bedroom home. So already throughout winter, [...] it can be a really tough place here, because of heating, leaking rooves, dark mould. All sleeping in the one room. There’s quite a few houses where they all sleep in the lounge room. Or go through winter without any heating at all. Or go through with one little heater because they took wood fires out because that’s causing asthma. It’s not good for the environment, but neither is relying on one little bar heater. And then they’ll be doing the pay-as-you-go thing with Aurora, which costs more. And they’ll get \$5 worth of power. You’ll not get much for \$5 worth of lollies, let alone \$5 worth of power. But the heating’s more of a problem because of [...] pay-as-you-go. [...] it’s actually dearer per unit on the pay-as-you-go system than what we pay. They then have to walk to the [shops] with all five of their children [to pay], out in the cold.”*

### What is and isn’t working—and for whom?

*“I think over time I’ve been able to empathise a lot more with - because when I first started here, I had no understanding of what someone with three children living in the heart of Rocherlea - I suppose I came into the job - particularly with just that child care focus of oh, you know, this is what I’m going to do. Yeah, I work with children. But I came into that from a very nice, safe background where—[...] Things didn’t go wrong and the world was beautiful and rosy, and it took a while for me to actually think oh wow, there’s this other side here and here’s this struggle that people go through just to survive, and it very quickly changed the way in which I view people. I mean, that sounds awful, doesn’t it, but yeah, from day one there probably was a bit of judgment - not judgment but there was that lack of understanding involved and so that, once I had that lightbulb moment, it was like okay, all right, I really want to understand your world a lot better so that I can do anything that I can that might work with you.”*

Our research identified that an effective anticipatory care system requires adequate resourcing and strong connections between system parts and the people in it; and it needs to be accessible and safe for all. There were examples in the project of effective anticipatory care system engagement and access for those able to mobilise social, cultural, and economic capital resources (such as social networks and relationships, knowledge and skills, and financial resources). There are also many for whom the local

anticipatory care system is not working, as shown by the high incidence of chronic conditions and potentially preventable hospitalisations in the four project sites and in evidence of health inequities across Tasmania, lack of strategic leadership and long-term investment in preventative health, system navigation difficulties (both for community members as well as service providers wishing to collaborate), and incidents of crisis management (presentations at emergency departments) [33, 34].

Our data provided a narrative about people who may 'belong' in one part of the system but not in another. For example, parts of the H2H site (Clarence) were labelled by some informants as 'sub-communities' with lots of local strengths, but people from those

*"So [connecting with other services is] important, but it's hard and we have to think creatively around how do we build that communication and that collegial aspect, because it can be very isolating over here as a [chronic condition] worker, so knowing how to support each other is important."*

communities were not engaged in the Anticipatory Care Project leadership group that "sit around and eat sushi". Similarly, a man in the OCOC community (Launceston's northern suburbs) was 'in the right place' when accessing the neighbourhood house, but he encountered unnecessary barriers when trying to access mental health support. In Ulverstone (the CC site), quantitative data shows that some community members are able to access social support services, yet they are not using local GP practices. In the OHOF site (Flinders Island), our data revealed strong on-island working

relationships among service providers yet collaboration with fly-in-fly-out services remains challenging.

Broadly speaking, the anticipatory care system is not operating effectively for those who unfairly experience socially determined barriers to accessing the system, such as low income, limited transport options, low literacy levels, lack of access to information technology, lack of confidence and self-efficacy, real and perceived feelings of being unsafe (physically, emotionally and psychologically), stigma and other forms of social exclusion and isolation. Many of these barriers operate at a broader societal level (as 'social structures'), determining not only access to the anticipatory care system, but wider opportunities to lead a fulfilling life. However, within the context of the Anticipatory Care Project, our research revealed that the anticipatory care system can also compound many of these barriers, for example, through funding models, attitudes and beliefs, policies, bureaucratic processes, and rigid service delivery models. Among the four project sites, for example, we identified lack of place-based service models,





fragmented and siloed services, varied levels of ambivalence towards the social determinants of health and the power of the medical model of health, lack of bulk billing and/or transparency of bulk billing provisions, a strong personal responsibility narrative in isolation of supportive environments for health, services with closed books, stigmatising, “handballing” and ‘buck passing’.

All of these system components can reinforce health inequities, and while the project identified some important system shifts that may help overcome these barriers (e.g. engagement with a broader audience), it is clear that further effort is required to create a unified, more effective and accessible anticipatory care system.

For instance, a lack of local infrastructure (e.g., a local sporting facility, or GP clinic) can disrupt anticipatory care, and this disruption is compounded when information about alternatives—including cost—is unavailable or uses unclear language, when transport to available services is costly or poorly scheduled, when the non-local service is unwelcoming or stigmatising, or when there has not been the needed sharing or collaboration between services to ensure that the person’s journey has not been wasted. Many of these intersection problems affect the providers of services as well as the

... the attitudes and prejudices of primary care workers influence selective (and unrecognised) rationing of access, particularly where workers belong to different demographic backgrounds from their clients. This is important because Lipsky suggests that despite good intentions, the function of public services may ultimately be construed as one that serves to maintain established divisions and inequalities within society. [2]

users of them. In this section we detail these intersections: the places where the anticipatory care system can be enabled or disrupted.

### Policy: underpinned by beliefs, attitudes, and worldviews

Policies, whether governmental and organisational, that constrain or enable aspects of the anticipatory care system, reflect choices made by policy makers and those who implement them; they are shaped by attitudes and beliefs. As the CLD analyses show, policies and associated processes come together in complex interactions and affect people, communities, and places in particular and often uneven and inequitable ways. Further, just as the effects vary, the responses of individuals or organisations to those policies and their effects also vary depending on attitudes and beliefs, resources, and capacity.

Examples of such policies in the project data include AC elements as diverse as: the provision of low cost, frequent public transport; state and local town planning that creates or mitigates geographical clustering of disadvantage; centralisation of services; privatisation of primary and allied health services; privatisation or outsourcing of government services; increasing digitisation of health and government services; service processes that are compliance focused and sometimes punitive; a service’s preferred performance indicators; or the availability, amount, and regulation of welfare and housing support.

Both within clinical and community-based systems there is a perception of a scarcity of resources, particularly funding, as a barrier to AC; for example, GP’s not having enough time and not enough resources being allocated to bulk billing. Health related policies are failing to assist disadvantaged people, and perpetuating exclusion.

Underpinning the numerous, often incompatible policies are two world-views: that health is predominantly an individual responsibility; or that health is the product of a set of social and economic circumstances, only some of which are controlled by individual citizens (a social determinants of health model).

*“It’s abstaining from responsibility. I’ve noticed it’s, “I’ve just got this, I can’t help it, it’s just the way I am.” You can have a lot of self-serving, reinforcing statements, “Oh well, you can’t enjoy life if you can’t have a drink,” or, “I’d love to give up smoking, but it’s only six a day”. That sort of thing. It’s easy to come up with throwaway lines. [...] It’s got to be challenged, and if you don’t visit your doctor very often, then you’re not going to get challenged. And then, “Oh, that doctor, what a freak, he was real rude to me. Told me I was overweight”.”*

### Business models

A common example across sites of policy choices interacting to form barriers to anticipatory care was the combination of policies of privatised primary health care, the complexity and structure of Medicare item coding, and the freeze of the Medicare rebate coming together in disadvantaged communities (places of clustered socio-economic disadvantage that are also the product of the intersection of multiple policy decisions and implementations). In response, many GPs feel constrained to make choices that support the for-profit business model and business viability; this impacts on their willingness and scope for bulk billing, consequently excluding people who are unable to pay. When such choices are made in disadvantaged communities, they prevent or limit access to medical

services for the many who cannot afford to pay. Associated gatekeeping processes may obscure practice bulk billing policies making attendance a gamble, or risk shaming and stigmatising the patients by making them prove that they “deserve” to be among the minority to be bulk billed. Medicare codes structures and fear of punitive Medicare compliance measures may also limit the services that are offered, and rebate levels may reduce consultation time and therefore opportunity for AC. In some cases, socio-economically disadvantaged communities risk having no access to local doctors, as GPs argue that it is not viable to have a clinic that must predominantly offer bulk-billed consultations.

*One community member told us that, “Sometimes it feels like I am being handballed around the place. No one seems to want to fix all of these tests” ... but, although she was not complaining about her GP, she did not agree that she was having a “good” experience. She has been unable to get a diagnosis and has been ‘handballed from specialist to specialist. She feels as if she is looked at as “bits and pieces” and doesn’t think they talk to each other. She is very frustrated. She wonders, “What if it is something bad?” This has been going on for ages; she feels she is no closer to a resolution.*

## Punitive or incoherent processes

*“The last time I went, I didn’t pay my rent so I could go to the doctor ... I had to have bloods checked, eyes checked, blood pressure checked, the complete overhaul check, [...] and then I have to wear glasses to drive now [...] So, I had to find the money, go to the doctor within 14 days. I had to get an appointment, and it’s hard to get an appointment. [...] So it’s all, just one thing goes out of whack, and everything falls over.” (Interview)*

Policy settings and associated processes that affect welfare, health and SDoH more broadly such as those governing Centrelink services, public housing, NDIS, and My Aged Care, all present challenges to access in terms of complexity, communication and literacies, stigmatisation, compliance, and fear of punitive measures. The policy of increasingly moving access to such agencies and services online creates barriers to already disadvantaged people who may lack foundational or computer literacies, are unable to navigate the bureaucratic complexity alone, fear the consequences of mistakes, lack confidence, or who simply cannot afford internet access [18].

*“For example, I tried to change a doctor’s appointment myself today and the receptionist was rude. She obviously didn’t know who I was because I suspect she wouldn’t have been rude to a doctor trying to change an appointment with a doctor, but she was rude. And my first response was to cancel that appointment, which I didn’t do because I’m not stupid; but that sort of response to a person who, without my training, is likely to end in that result.”*

Neighbourhood houses and other community services provide examples of enabling responses to such policies, bridging gaps and making up the shortfall of policy, system and processes by providing advocacy with local services; practical help and training, and emotional support in navigating systems; and by mitigating some of the effects with material support such as on-site meals, cheap take home food, and transport.

## Policy and processes



*“Practitioner’s attitudes! And I don’t just mean doctors there. I mean receptionist staff—I mean the right place program is great but only got into a small number of practices and also things—so it needs to go everywhere with the right ... process the right door. Anyone who is going to ask a question that there isn’t a dumb question, and they can be reflected to the right place.”*

Policy shapes access to human resources. Such access is enhanced when those resources are provided locally, including by visiting services, both because they are easier and quicker to get to and because remaining within community is often culturally, psychologically, and emotionally safer. (There is also evidence for the importance of face-to-face interactions for mental health [35].) A



shortage of local doctors with available appointments, and an even greater shortage of affordable (i.e., bulk-billed) appointments is a common problem across the AC project sites. Another common factor that affects access to services is the attitudes and skills of workers. Good relationships were considered essential to address complex health and social challenges and to ensure that community members felt welcome, socially included, and safe to access services. There are numerous examples of gatekeeping, stigmatisation and disrespect that act as barriers to access.

In contrast, FIAAI, neighbourhood houses and men's sheds represent strong local presences where the paid and volunteer staff actively work to ensure that people are not judged and feel safe and welcomed. This enables a sense of community and sharing to develop. People spoke about strong sense of family in these settings, and that they look out for each other. They describe these characteristics as making the community resilient in the face of hardship; people have a sense of solidarity and care for each other. Examples include local businesspeople who regularly helped people with transport and supplies. The sense of belonging and local connection allows people to work together to get what is needed.

*"I mean I'm quite aware that there's a whole lot of people out there that we don't see, and I've always said that, there is a whole lot of people out there that we don't see ... Yes, they're the people that possibly are socially isolated for lots of reasons around health, and that could be mobility, that could be no way to get out and about; it could be around anxiety, it could be around depression. It could be a range of things that people just can find it too hard to walk out their door, for lots of reasons."*

## Relationships

*"I'd like to socialise and interact with people. I want to know about groups in the area, to get my foot in the door somewhere as I want a group to be part of or people to know. I'd like a connection to something out of the house with likeminded people."*

Good relationships are perhaps the most vital ingredient directly or indirectly impacting all the elements of the anticipatory care system. This accords with the emerging finding that social relationships increasingly appear to be the single most important factor influencing health, wellbeing and life expectancy [36]. More broadly the quality of relationships in the anticipatory care system affect levels of collaboration, the willingness of particularly disadvantaged people to seek help for chronic conditions, and to engage in actions that prevent them from occurring in the first place.

Many examples of less than functional relationships were evident however in the anticipatory care system, including a pervasive "othering" or marginalisation of people linked with particular characteristics, creating a significant barrier to AC. One consequence for example of sub-optimal inter-personal relationships is 'silo'ism' and fragmentation, whereby the different stakeholders fail to capitalise on the many advantages—and arguably the imperative—of collaboration. The dominant medical model of healthcare tends not to recognise the social determinants of health, and hence appears to have limited effectiveness in addressing mental health problems, stress-related problems, and chronic ill-health. We learned through the survey data in particular that a lack of confidence and motivation was a very significant barrier to engaging in health-benefiting

activities. In the comments made there, and in interviews and focus groups, people repeatedly told us they wanted someone to go with, to share the activity, to reduce their isolation.

People do indeed have some role to play in maintaining or improving their health, but the evidence of the role of the social determinants (and of genetics) is strong [31]. This means that an individual responsibility way of thinking about health risks blaming unwell people for their condition; sociologists refer to this problem as ‘victim blaming’ [37, 38]. The individualist paradigm is partly based on a belief (evident in some of the project data) that health damaging behaviours are the product of ignorance. But this “politics of ignorance” serves to “reproduce power relations in which particular groups are constructed as lacking capacity to act on knowledge, whilst maintaining others in privileged positions of knowing” [39]. Even among people who follow ‘healthy lifestyles’ there are class based patterns of ill-health, and lifestyle factors (including diet, smoking, alcohol consumption and exercise) may only account for a quarter of health inequalities [40]. Furthermore, the literature argues, and the survey and qualitative data has revealed, behaviours and choices about diet and exercise are constrained by resources, the behaviour of peers, and by motivation and confidence.

## Leadership

Formal and informal leadership and having a shared vision to unite people is important for addressing gaps and ineffectiveness in the system. Leaders are people who are influencers, providing

opportunities and encouragement to others to participate in things that support health and wellbeing. They are also good navigators, and networkers who have credibility and expertise and are trusted. Leadership can be linked with a role, but leadership can also come from people who have no formal role but through their actions and the respect and trust they earn in their communities. Where financial resources are constrained for paid formal leadership positions, lower cost, often volunteer, and more informal community-based leadership can fill the gap. However, leadership can also be a barrier if recognized as leaders do not actively support the enablers of the anticipatory care system, or worse create conflict actively undermine key attributes such as a SDoH approach to AC.

### Vignette. We're in this together—The formal and the less formal leaders

The local gym operates on a buddy system. People sign up, learn how to use the equipment, and then use the gear with a friend. A physiotherapist, who is recognised as a local leader of physical activity initiatives in the community, ran some programs at the gym as part of a funding package, taking people who had been advised to do some post-surgery rehab through some programs. *“So, there’s a group of blokes and a couple of women but group of blokes come in they get on the bike, they’re chatting away, they don’t even know they’re exercising. They do a half hour on the bike, you know, it’s serious like [specific medical conditions]. Yeah, and they’re coming and before they know it it’s nine o’clock. They’ve done the weights, and ... a bit of boxing ... And then they’re off for the rest of the day. Well and some more blokes started coming because it’s now okay for blokes to come in.”*

After the money for that ran out, the physio was still turning up, on a weekday morning, checking in with the rehab group. The physio’s leadership, though, is being supplemented by the activism of one of the rehab group. In his eighties, Pete had a quadruple bypass and returned from hospital with a referral to the physio for rehabilitation. The two took advantage of Pete’s enthusiasm, and he launched in, learning how to use the gym, and checking on his progress. But he also wanted to share the benefits. So, he kept his ears open and got in touch with other people who’d had surgery or injuries, encouraging them to come along to the morning sessions. *“Yeah these guys they’ll know straight away who’s been off for the surgery, they’ll hound them and say if you know what’s good for you and you want to live a long life—they just tell them how it is—you get to the gym when we’re there”.*

When we visited, the gym was humming—people in their 70s, 80s and 90s were racing on the bikes and treadmills, “pumping iron”, triceps, and doing timed high-intensity intervals. Several of the gym-goers told me about the milestones they were hitting—lifting more weight, rowing farther, swinging the kettle bells—and about the changes to their health. But they were also catching up on the news, telling jokes, socialising. As one said, *“I was fifteen kilos heavier, pre-diabetic and pretty depressed. I’ve lost that weight now, and the pre-diabetes has disappeared”*. Now, *“... even the doctors say, we know who’s going to the gym, because they come in, the blood sugar’s reduced, blood pressure’s better”*.

Aim 3: 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

### What keeps people out of the system?

The design of an anticipatory care system must meet the needs of a diverse range of people. How—or indeed whether—people think about their health will affect how they interact with the system. If people think in medical terms, it would make sense to focus efforts there, for instance.

At the start of the project, we wondered how prominent health (and health care) was in the minds of community members, and how they thought about it. The literature has provided examples of ‘health’ being a low priority for many people negatively affected by the social determinants of health [e.g., 41]. We gathered some information about people’s attitudes to health in the interviews and focus groups and included a question about it in the surveys conducted by PSOs. Overwhelmingly, community members were not focused on a medical understanding of health. They wanted to be able to get on with their lives, do the things they needed or chose to do with their time, unhindered by pain, lack of fitness, or depression and anxiety. This ‘disengagement’ from ‘health’—and, indeed, apparent flouting of health advice—was seen as irrational by many providers, for whom health is the major focus. Here, attitudes and beliefs are shaping the system. There was an often-stated belief that health should be a personal focus, and that individuals have agency to effectively manage their health.

To fail to do so was a sort of abrogation of responsibility—to oneself, but also to the health system they would likely burden.

A second form of ‘othering’ was speaking about community members as if they were inherently different (and lesser) than the providers themselves.

*“So we do have attitudinal failures. [...] “Oh, well it’s going to [cost]” Well, so what? Why do you expect that it’s going to cost nothing? I mean it costs me \$75.00 or whatever when I go to the doctor now, and I get half of that back, but I really can’t complain too much, because I’m in a good income bracket. There are many though that can’t, but if I would go through their accounts, they’d still be putting money to registrations on too many cars, or Netflix subscriptions, or mobile phone plans that are too expensive, and personal budget is not being looked at hard enough. They’ll still have Foxtel, but they won’t go to the doctor.”*

Such ‘othering’ hampers the way some services work with community. Yet, as Lawlor et al, (2003) note, “behaviors that may otherwise be difficult to understand are rational within the particular cultural contexts in which they occur” [41]. At least some of the ‘disengaged’ had other things taking their attention, particularly where money was short, housing was insecure or sub-standard, they

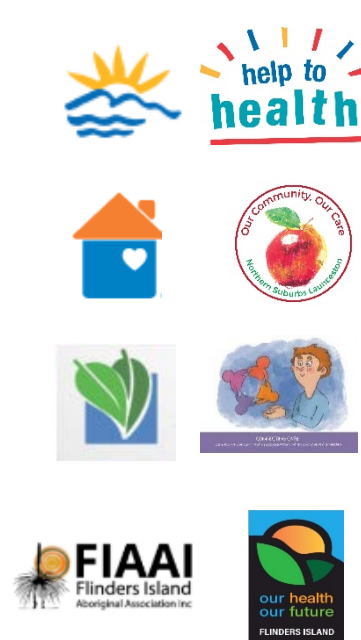
were looking for work, or juggling children’s needs. Lawlor et al. continue, describing circumstances that we witnessed in project sites:

Conversely, among individuals from lower socioeconomic positions, the balance is shifted toward improving the immediate environment and removing hazards. Poor housing conditions, occupational hazards, and environmental dangers are more immediate threats to the health of those in lower socioeconomic positions than is smoking. Smoking cessation may become a priority only when these other hazards have been reduced. (p. 269)

In this section, we consider the role of the lead organisations in the anticipatory care system. What do we know about how they work to engage ‘at risk’ Tasmanians in primary and preventive health care?

#### Aim 4: The role of the lead organisations

The AC project considered anticipatory care as a system, with interconnected system parts and the participation of multiple organisations including many that may not be traditionally understood to be part of the ‘health system’. This reflects an understanding that health is shaped by social and economic factors: the social determinants of health. Selecting diverse local lead organisations enabled us to gain insights into the strengths and weakness of these organisation as leaders (or actors) in anticipatory care, particularly with relation to disadvantaged and hard to reach people and communities.



The participating organisations were a local council (Clarence), a General Practice (the Patrick Street Clinic, Ulverstone), two neighbourhood houses (Northern Suburbs Community Centre and Starting Point Neighbourhood House, Launceston) and an Aboriginal community-controlled association (FIAAI, Flinders Island). Each organisation was selected based on their readiness, capacity, and willingness to lead the project in their local community. The system parts are evident in the nature of these organisations and in their focus in the project. Each has particular people, attitudes and beliefs, knowledge, information, and information sharing

mechanisms, infrastructure, policies and processes, leadership, and relationships, which are embedded in and shaped by their specific place and community. These differences amongst the lead organisations can be understood both as organisation- and place-specific and potentially more generalisable strengths and weaknesses of leadership within anticipatory care.

Using a systems thinking approach, these attributes also represent organisational boundaries that have implications for understanding situations and people, ethical and social justice issues of othering and marginalisation, resourcing, and ways of approaching situations, problems and for improving the anticipatory care system [42]. In light of what we have learned about the lead organisations, we argue

that there are characteristics that can enable or impede their effectiveness in the anticipatory care system. These could apply equally to other service and organisation types. They are role and scope, attitudes and beliefs, legitimacy, approach, community engagement, relationships, influence and power, the enabling context, and their knowledge, skills, and expertise.

### Role and scope

Role and scope differs according to the type of organisation, its role in the AC system, external constraints, and the scope of its responsibilities and accountabilities. The lead organisations (neighbourhood houses and FIAAI) that are overtly place-based, philosophically aligned with community development principles, and with direct accountabilities to their communities through their governance structures were better placed for community engagement and for reaching an understanding how the AC system is experienced by those most at risk. FIAAI has the advantage of combining its health services focus with being directly in place and deeply involved with the wider community.

*“The system as it is now, if you go and see your GP, generally, if you’ve got a healthcare card or a pension card you get bulk-billed, and that’s good, at a lot of clinics. At some clinics they don’t, you have to go and pay and claim the gap back afterwards anyway, which also makes the process more traumatic for people, because they really will be waiting on that rebate, for when it goes into the bank”*

Local government is able to provide geographic and population wide reach; diverse functions and connections across communities; and

policy and decision-making powers that directly impact AC and social determinants of health (SDoH). On the other hand, the general practice (GP) has responsibility primarily to their patients and so is able to provide those patients with the continuity and long term relationships that are key to successful AC. Role and scope can also present barriers in that they exclude anything considered irrelevant to the role, or out of scope. When AC was considered non-core, activities were not prioritised or supported and this may have contributed to local government seeming to find deep rather than broad community engagement difficult.

The role of general practice as a commercial business, operating within the constraints of government policy and funding models, restricted bulk billing to a modest commercially viable level. This situation creates barriers to access for the few who are bulk billed, and effectively places the majority of poor community members ‘out of scope’. This last is a barrier not only for the GP lead organisation but for the majority of GPs and other health professionals interviewed and encountered across multiple sites during the ACP.

### Attitudes and beliefs

Attitudes and beliefs are shaping organisational approaches to AC, to people and to communities. The attitudes and beliefs held by the lead organisations shape approaches to AC, to local people and to their communities. They were expressed in the boundaries around what is considered important, relevant, and within the responsibility of the organisation. For instance, compassion and a concern for people’s emotional safety underpins successful, deep engagement and inclusion in marginalised communities. This was most evident in an understanding that multiple factors shape health and wellbeing; a



commitment to addressing the SDoH is therefore an important part of leadership for AC.

*“... that sort of goes across the breadth of what [FIAAI] does, because there’s so many facets of the work that’s done here. So, at every level—I think that you can physically see anticipatory care happening here. Because everyone draws on everyone else’s strengths and experiences to facilitate the best care, whether they be in mums and bubs, or whether they be in aged care. And regardless of what your job title says that you are a part of, everyone works together to make all cogs work.”*

Organisations such as the neighbourhood houses or FIAAI, whose core concerns and values are aligned with a commitment to addressing the SDoH, were more easily able to incorporate them into an approach to AC. On the other hand, an apparent privileging of a medical model of health and quantitatively evidenced knowledge within the GP lead organisation, coupled with a belief in mainly personal responsibility for health, created barriers to approaching AC from a SDoH perspective.

*“I think because people know that sometimes it’s tough growing up in [this community] or it’s had that stigma so a lot of people have come together and try to help each other out. That’s what the Neighbourhood House is really good for. Certain groups look out for mostly everybody [...] Now it’s starting to get to the point where all organisations are starting to collaborate with each other which is really good.”*

## Legitimacy



**Figure 24: Still from a COVID-19 information video, Patrick Street Clinic**

The legitimacy of AC leadership is grounded in contribution and alignment within the system, and attributes that support an organisation’s capacity to lead *in some way* [43]. Legitimacy included perceptions and attitudes about the status of the organisation, social respect for roles, organisations and people, credibility and trust, insider/outsider status, recognition of expertise and experience, history, and political and social capital. Neighbourhood houses and FIAAI are seen as legitimate representatives of their communities, as is local government in a political sense. Local governments also have the power to effect change through policy, regulation, and planning. Doctors have acknowledged health expertise, social status and influence and have been trusted to provide leadership in health provision and information (Figure 24).

However, legitimacy can be undermined by competing values, such as the way negative perceptions of outsiders affects the local perception of legitimacy of some fly-in-fly-out practitioners on Flinders Island. Legitimacy is also undermined by perceived lack of integrity – when council “consultation” is believed to be just lip service or when the community discourse frames GPs as caring more about money than health.

### Approach

The approach to AC leadership taken by organisations arises in part from their role and scope, and attitudes and beliefs. Enablers for a successful approach include flexibility and adaptability, curiosity, managed risk taking, reflection and learning, collaboration, and genuine responsiveness to local place and people – and their needs as expressed by *them*. The opposites are barriers. Organisations with a community development and SDoH approaches to AC were better able to engage with communities, to see and explore the situatedness and complexity of AC, and to identify power imbalances, inequity, and potential change. A scientific approach with a focus on quantitative evidence was also an important component in approaching and understanding the anticipatory care system.

However, approaches that emphasised a primarily medical model of health without consideration of SDoH tended to minimise system complexity, and a lack of respect for other types of knowledge created barriers to collaboration.

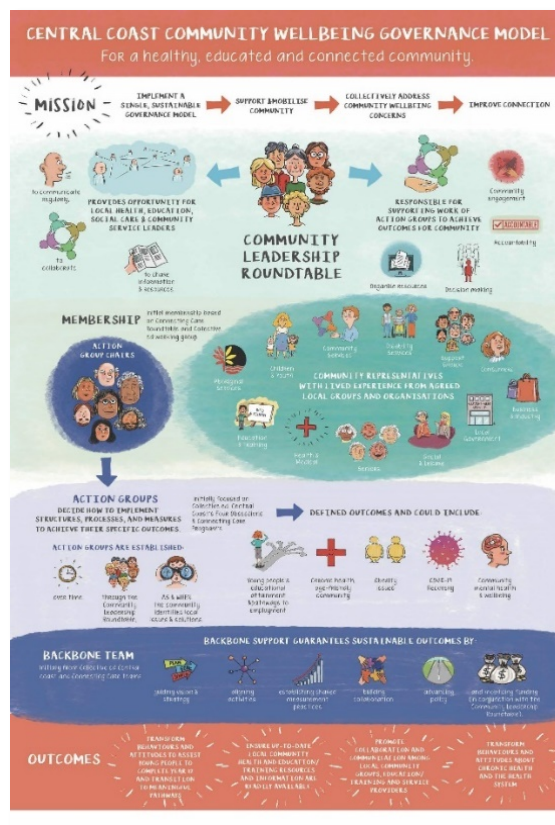


Figure 25: CC’s Roundtable model

### Community engagement

The most effective community engagements – those places where we were able to reach the most diverse groups – were based in pre-existing and continuing trust based, non-judgmental and culturally competent relationships with at risk communities. Embedded organisations worked *with* and *for* communities, using and strengthening existing networks, and *trusting* community experience and knowledge rather than imposing solutions from a position of perceived greater knowledge. Engaging with affluent and well-connected people has benefits that should not be ignored. People with skills and power are important agents for change. The greater awareness of anticipatory care as an approach to preventive health, evident in all sites, means that influential health practitioners, educators and others can now both advocate for systemic supports and work for change in their local communities. An example is the Connecting Care Roundtable initiative (Figure 25).



Engagement varied by organisation, reflecting that roles and values shape not only approach to engagement, but also *who* is seen to be *their* community ranging from the quite affluent and highly engaged to people who are at high risk and marginalised. The result is that each organisation engaged with a *slice* of the local community but not always deeply or with those at most risk, leaving many people “out of scope” and unheard, including those who continue to be hard to reach.



Figure 26: Examples of media advocacy, OCOC team

## Relationships, influence, and power

In addition to their engagement with target communities, all organisations have their own networks and relationships that provided opportunities for influence, communication, collaboration, and sometimes mediated connection with harder to reach people and communities. Relationships and networks were strengthened and expanded during the project and show evidence of changing and strengthening the anticipatory care system. Each of the organisations was also able to wield influence and power in the system in bringing diverse people to work together, influencing external organisations, lobbying, and advocating for change directly and via the media (Figure 26).

During the project, the NHs/OCOC project team wanted to find ways to increase access to GPs. As a result of reaching out to local clinics, one local practice manager became part of the local advisory group, bringing the GP perspective to the team. A GP in the practice also advocated for an anticipatory care model to state and national politicians, in support of better access to medical supports in the local anticipatory care system.

Barriers to effective relationships for AC include lack of diversity in networks, competition for market or funding that reduces collaboration, mistrust of outsiders, and attitudes that devalue the expertise and knowledge of others—including community members. There are links here with the theme of stigma, which is a prominent barrier to an effective anticipatory care system. Uneven power dynamics amongst organisations and individuals were a barrier to collaboration, trust and information sharing, and a source of marginalisation within the system.

## The enabling context

Enabling contexts can support the exercise of leadership [43]. Enabling contexts for leadership in the Anticipatory Care Project included a commitment to the vision for the project and lived and practiced organisational commitment to anticipatory care and SDoH as approaches to health. Additional enablers are flat structures, flexible bureaucracies, a degree of autonomy or empowerment for participating staff, and a bottom-up approach that trusted local communities to understand their own needs and priorities. Enabling contexts prioritised AC and therefore provided support, time, space, and resources for leadership, creative, and operational management activities. Barriers included a lack of alignment with SDoH approaches, and a lack of clarity, commitment and alignment with project and AC vision and goals.

## Knowledge, skills, and expertise

The knowledge, skills, and expertise of the lead organisations in the project reflects their diversity. Community development knowledge and soft skills (or soft infrastructure) such as relationship and network building, facilitation and mentoring, community engagement, communication, and collaboration were key enablers, along with deep knowledge about multiple aspects of place, community, and local expressions of the anticipatory care system. Cultural competency was also important, not only for Aboriginal people on Flinders Island, but across all communities and settings. However, more technical and specialist knowledge is also needed. A broad range of medical and health related expertise, an understanding of policy, processes and systems implicated in AC

and SDoH, and skills in managing resources, time, activities, people, and projects were all necessary for effective leadership of ACP. Knowledge and skill barriers to organisational AC leadership lie in gaps in such knowledge that is bounded by the scope, role, and approach of the organisation. Such barriers are mitigated by collaboration with diverse organisations and by diversity within the organisation such as the breadth of skills provided by a volunteer workforce.

## What the lead organisations can, and cannot do

### Local government

The selection of Clarence City Council as a lead organisation in the AC project recognised that local government can be important to the anticipatory care system. Councils deliver numerous programs that support health, including environmental health and hygiene, parks and playgrounds, sports facilities, and immunisation clinics. They had an established leadership group, with significant health service expertise and a familiarity with research. Further, Clarence has a Community Health and Wellbeing Plan [16, 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. Local government needs to clarify its role, find new measures that can capture ripple effects or unseen impacts of its work, and consider the scale of interventions.

However, there appears to be some ambivalence about Council's 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. Performance measures generally place more value on numbers and participation rates but this means the 'unseen' benefits such as the attendance at a Clarence Talks session by a small number of people, none of whom had previously attended a health talk, or other Council-delivered session? Further, we need to know – if possible – whether those people then changed a health behaviour as a result, if they each talked to five other people about what they had learned, or whether their trust in Council increased. Those sorts of measures would give a more accurate picture of the impact of activities.

The effectiveness of the H2H actions and activities was affected by structural problems. There are local government policies and processes that can hamstring the system overall, as well as local initiatives. There were 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. Thinking about Clarence as a series of villages has helped us to understand some of the findings, as well as accentuating the importance of place and belonging to anticipatory care.

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.

### Neighbourhood houses

The selection of NSCC and SPNH as lead organisations in the AC project recognised that they may be important to the anticipatory care system that relies on interrelationships. Neighbourhood houses deliver numerous programs that support health, but do not necessarily see themselves as 'health organisations'. This perspective may have made it easier for them to draw other organisations without a formal health role in to learn together about building a more effective, broad spectrum anticipatory care system. Linking and collaboration are important parts of the neighbourhood houses' usual business: the two managers and their teams have long histories in their communities, an established role in relationship building across sectors, and a 'get in and do it' attitude. These factors mean that the lead organisations have the trust of large portions of the community and networks that increase their ability to hear from the community, to advocate, but also to rapidly see the impacts of what they do and adjust accordingly. The lead organisations here are trusted, reflexive, nimble and flexible, characteristics that are a good fit for the cyclic engagement of action learning.

Importantly for this project, the managers had the skills and experience to appoint, nurture, trust in and embed the creativity and enthusiasm of four effective PSOs. The PSOs had existing ties with the community, with one another, and with the leads. These ties reduced the time needed to build the sort of relationships—between the PSOs, the PSOs and leads, and the PSOs and community—that are necessary for working together on a complex project. They were also allowed to take risks. PSOs were able to try things, to fail and to learn from that experience. The project created a supportive environment—through the OCOC team, UTAS researchers and the DoH Principal Project Officer, and through the action learning framework which is predicated on mutual learning, reflection, and revision. The culture of care, empathy, and compassion evident in the lead organisations was extended to PSOs and their work.

Neighbourhood houses do not, of course, reach everyone in their community, and the lead organisations began the project with only partial links with some important players in the anticipatory care system. Links with GPs and health services, for instance, were weak (not ‘core business’); the project, through the engagement of the diverse local advisory group, nurtured several relationships, some of them completely new: with schools, with a GP clinic, youth workers, politicians, and police.

### GP clinic

In the UK, GPs have a central role—through the number of patients they see and through their knowledge of new developments via the scientific literature—in identifying emerging population and public health issues in their communities. At the Patrick Street Clinic (the lead organisation in Ulverstone’s Connecting Care project), these

capacities are enhanced by their training role for medical students and the research those students undertake while at the practice. The clinic and its GPs are respected as medical experts and advocates for health in the north west. The general practice peak body, the RACGP, confirms that GPs work for preventive health (and in anticipatory care) through conducting screening, treating the presenting problem as well as spending time on planning and prevention and on building trusting relationships with patients [44, 45].

It is not possible, however, to re-create the ideals of the UK model here. Establishing long-term, trusting relationships with patients is only possible where those patients can afford to continue the relationship, and where there is an adequate supply of general practitioners to support community needs. With inconsistent and unclear bulk-billing, affordability is a problem. This financial problem is largely driven by national regulatory frameworks and restrictions set by policy; bulk-billing, rules controlling where and in what circumstances international medical graduates can work, and a dearth of item numbers to allow for ideal care are all policy-related problems. These factors mean that those hard to reach people, usually people who are poor, or who have other difficulties, are unlikely to get the preventive medical health care they need, because the up-front payment is too great, they are not sure they will be bulk billed, there’s not enough time in a bulk-billed consultation for anything other than the presenting problem, or there is a shortage of GPs. And their relative absence from the GP setting means that GPs may know too little about the forces shaping people’s health to be truly anticipatory in their approach. These are barriers to reducing the risk of and from chronic illness. Finally, business models operating in many general practices reduce GPs’ opportunities to



reach out into the most at-risk populations. And people with chronic illness or with disability are much more likely to be living in poverty.

### Aboriginal health organisation

FIAAI is a community-controlled organisation, with clear accountability to the local Aboriginal community. Their central role in the Aboriginal community is acknowledged by a broad spectrum of the Flinders Island community, and its CEO is recognised as an effective advocate for Aboriginal people. FIAAI has previously trialled new ways to support community health; the Tasmanian arm of the national “Tackling Indigenous Smoking” campaign, using local people as the campaign’s face, is an example [the program has been evaluated: 46].

FIAAI has a whole-of-life way of thinking about wellbeing that seeks to improve the social determinants of health. Thus, their role includes the medical, alongside country and culture, housing, education and training, employment and so on. This meant they were already prepared for thinking about a broad and inclusive system that reduces risk of chronic illness.

The AC project was intended to learn more about how the anticipatory care model (largely developed in the United Kingdom) might operate in Tasmania. In the UK model, anticipatory care is built on ‘routine encounters’, a non-fragmented system, and equitable access to a range of services [3]. It also places GPs at the centre of a web of health and social services. FIAAI’s way of working does not focus on GPs, but does share key anticipatory care characteristics:

- community members are likely to have ‘routine encounters’ with FIAAI staff, including health staff, through formal and informal encounters at FIAAI or in the community, supporting relationships and longitudinal knowledge
- FIAAI’s suite of services and supports mean that engagement is potentially less fragmented than would be the case through other provider models
- Health and other service interactions with community are not time limited (as they are in many GP consultations elsewhere), and preventive health checks are a norm
- FIAAI is funded in ways that support community members to have equitable access to a range of services

Nonetheless, across and beyond the island, there have been historical problems with coordination—and instances of discriminatory and unsafe interactions—with other services. FIAAI’s history demonstrates its willingness to tackle challenging circumstances.

FIAAI is a member of the FHOCM group, and the two collaborated in the OHOF project. The OHOF executive group brought together the CEO of FIAAI, the Director of Nursing at the MPC, the Ochre Medical Centre practice manager and a consultant with experience in working with Aboriginal communities. The OHOF team employed a project manager and a project support officer (PSO), seconding the FIAAI Health Service manager and MPC community nurse, respectively, into these roles. This was an astute decision, linking the two major health providers on the Island. The project role distinction was sometimes blurred, with both taking on PSO tasks, like outreach, data gathering, planning and review. There were advantages of the choice of these two staff:

- during and after the project, the PSOs retained their substantive roles, making embedding and sustaining changes more straightforward
- they were already well-known in their respective communities and their collaboration made them more familiar across services and supported collaboration between their organisations
- were energetic, creative and respectful in their outreach and engagement for anticipatory care
- their training (as Registered Nurses) meant they shared many ways of thinking, and also shared new knowledge gained during the project.

### What is needed to support working together to engage ‘at risk’ Tasmanians in their health care?

Each lead organisation has particular strengths that matter in the system. The factors described here—role and scope, approach, legitimacy, community engagement and so on—are all needed (Figure 27). For instance, local government has very wide reach—they have responsibility for the wellbeing (broadly understood) of whole communities. They have political legitimacy, an existing role in health, and can have significant influence on anticipatory care through planning and infrastructure decisions and through their capacity to lobby higher levels of government on behalf of their citizens. GPs have the legitimacy that comes with expert medical knowledge. We saw in Launceston, Ulverstone and on Flinders that with the emergence of COVID-19, people were listening to what their local GPs and health services were telling them.

But systems thinking offers us a way to also see that each is bounded—by their values, attitudes, and perspectives. For instance, Neighbourhood houses and FIAAI both have a strengths-based and direct community engagement approach and embedded in and answerable to their communities. That means they are more likely to be able to reach at least some of the ‘hard to reach’—and we saw that in this project. The same is true for Men’s Sheds, for instance, and we think there are other organisations with that capacity. Being directly accountable to a community is important. They also have the legitimacy of being embedded in and controlled by their communities—at least to some extent. And these organisation types tend to have a social determinants or holistic sense of community health and wellbeing. These organisations tend to have SDoH sense of community health and wellbeing rather than a medical focus, taking into account access to food, to work, to housing, to training and employment, to child wellbeing, and so on. But this does not mean their reach is comprehensive; there are people who will never visit a neighbourhood house, Men’s Shed or Aboriginal health service, despite being in the target population.

How connected the organisation is to others in the community or that deliver services to that community is very important, as is the different groups within the community they connect with. For instance, some leads have quite good reach into the most disadvantaged and at risk community members, while others are better linked with the broad middle of the community. If the lead cannot make those links with diverse parts of the system—whether services or community members—then they need to have ways to work with organisations and people who can.

Lead organisations make choices and decisions driven by their attitudes and beliefs, which groups or communities they are answerable to, and by the regulatory environment in which they operate.



**Figure 27: Diagram of the elements of leadership for AC**

This regulatory environment is part of the **enabling environment**. GPs for instance are constrained by policy settings that affect decisions to bulk bill people, and what they can and cannot offer (e.g., social prescribing is still difficult in Australia). During the project, the NHs/OCOC project team wanted to find ways to increase access to GPs. As a result of reaching out to local clinics, one local practice manager became part of the local advisory group, bringing the GP perspective into the collaboration.

We identified a number of characteristics as key to anticipatory care leadership. No single organisation embodies all characteristics; the anticipatory care system instead relies on the collaboration, cooperation and coordination of multiple organisation types and cultures. If the anticipatory care system is to meet the needs of the greatest diversity of citizens, and reach the ‘unusual suspects’, leadership must be understood as coming from a broad span of sectors. The characteristics here helped us to identify relative strengths and weaknesses of the lead organisations. In doing so, it was clear that such strengths weaknesses, along with organisational roles, scope, and perspectives, are often complementary amongst organisations:

- Collaborate with an openness to multiple perspectives and respect for different types of knowledge.
- Deep connection with and responsiveness to at risk communities and cultural competency in those communities.
- A lived and practiced organisational commitment to the principles of social justice, equity and compassion.
- Flexibility, adaptability, creativity, risk taking, self-reflection, and an openness to learning.
- Established networks of relationships and influence.
- Breadth of expertise, knowledge, and skills.
- Ability to manage resources, time, activities, people, and projects.
- Commitment to SDoH and an AC approach.





## Part 3: The project processes



## Action learning and systems thinking

We used action learning and systems thinking as our methodological framework for the Anticipatory Care project. The processes and rationale are explained in detail in the local site reports, where they are also reviewed.

### Action learning

Action learning's cycle of observe, reflect, plan and act was somewhat familiar to the local site teams. Its iterative cycles resembled aspects of the community development approach that the H2H and OCOC sites use in their day-to-day work. Over the project's life, all sites followed at least some action learning processes. In Launceston's OCOC team, action learning underpinned the multiple actions they took. The 'basketball bins' mini-project provides a good example.



Figure 28: The prime minister liked the basketball initiative

### The Basketball Bins: Action learning in action

Michael at Starting Point NH observed that kids were using the new skate park, near the centre, but the basketball courts were empty. He reflected on this and realised no-one owned a basketball!

Plan? Michael used his contacts and social media to get donations of basketballs—in all sorts of condition and quality and bought tin garbage bins and chained the bins (full of balls) to the basketball goal posts. And he started getting out and shooting hoops—with whoever came by ...

Michael watched what happened and recorded the stories: The kids didn't only need *something* to play with, they also wanted *someone*. Parents and kids stop to play a bit of basketball on their way to or from the shops. Staff from the shops come out and play in their breaks. People in the shops keep an eye on the gear... And then, the prime minister heard about it and about one man who was shooting hoops instead of smoking ...

*"Before I forget, I figured I would tell you, Graeme told me that the balls from the ball bins are helping him quit smoking. He said he was always about to quit smoking when he was doing activities, but he picked it up pretty bad when he stopped playing footy. Now, he said whenever he has the urge to smoke, he just goes to the ball bin, has a few shots and run around while shooting a bit and then the urge goes away. He says he hasn't smoked for a while because of the ball bins, and a volunteer here, Cara, has also tried his approach now. Not sure if she is having the same success as him, but it is a pretty awesome ripple effect"*

People were getting an obvious health benefit from the physical activity, but this was also a chance to socialise in new ways and with new people, and to feel ownership and pride in what had been a dead space. This is rapid-fire action learning, showing that anticipatory care can take many forms.

There was also significant action learning (Figure 29) evident in the cross-fertilisation among sites brought about through State-wide forums and the PSO community of practice. For instance, Launceston's basketball bins were the spark for Flinders Island to trial GAME On Flinders (Gear Access Made Easy). The Flinders Island PSOs worked on adapting the principle of providing game equipment for public use to the Island. This required negotiation with Island agencies including the Council and Parks and Wildlife, as well as consideration of what equipment might best be placed at different locations. Before the COVID-19 lockdown measures, tennis equipment had been made available at the Lady Barron tennis courts and was in steady use by community members and people visiting the port there. One hundred and forty-three people had played tennis at the revitalised courts when lockdown began. Placing the GAME On bin of racquets and balls at the courts has also sparked interest from Council in some renovation of the site.



**Figure 29: Action planning session, Our Health Our Future, 2019**

Both these examples have multiple anticipatory care impacts (e.g., for physical fitness, social inclusion, and relationships, for infrastructure, and for place and belonging; in Launceston, the initiative may also have benefits for reducing stigma).

Action learning was also evident in other sites. H2H's The Right Place model showed potential to address the Connecting Care team's aim of reducing fragmentation and service navigation difficulties. The Right Place (a model operating originally in the Huon Valley) trains reception staff about health-related services and supports. The CC project lead spent time with Clarence's H2H team and adapted the model for Ulverstone's needs. The trial of CC's pop-up information hubs followed an action learning process, with different sites and modes of information

sharing tested and revised in a proof-of-concept process over the project's life.

## Systems thinking

Systems thinking, on the other hand, was not familiar to the researchers, nor to many in the project sites. This demanded rapid mutual learning, as sites and researchers came to grips with a way of thinking that echoed sociology's idea of structural forces but had several new elements. This process, however, enhanced both our collaboration and the ownership sites took. As the systems thinking tools (including CLDs, and systems traps) became familiar, local systems thinking 'champions' emerged; one in particular became an advocate for the CLD process, speaking at a State-wide health forum about its advantages. Further, the complexity of the emerging diagrams—the 'spiders'—became an in-joke amongst PSOs and researchers, building on our bonds.

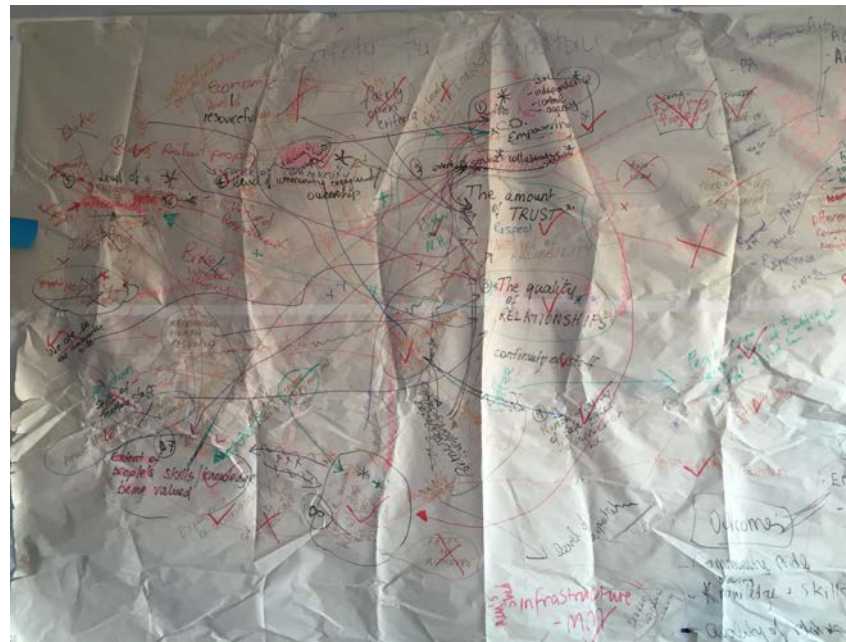
Surfacing this complexity has been a vital part of the AC project. The anticipatory care system is extremely complex; our mapping of it was deliberately bounded by the local site themes so as to somewhat contain that complexity and enable us to create rich knowledge of the variables at local site level. To do so, we drew on our collected data and the stories participants

brought to the causal loop and systems traps sessions (Figure 30). Participation from local actors was foundational to the process. At the second round of CLD workshops, in 2020 (most via Zoom videoconferencing technology), it was clear that—particularly in the OCOC and OHOF sites—participants understood the importance of story-telling and other forms of evidence for tracing the impacts of the multiple local actions and new ways of working.

### *A note on the role of cultural competency in our processes*

In all the AC project sites, it was clear that stigma and marginalisation (in various guises) were barriers to anticipatory care. The OCOC and OHOF teams developed actions to reduce this barrier, through trauma-informed training and Adventure Play in Launceston, and through cultural competency training on Flinders Island. Cultural competency matters because attitudes about a community or a person shape how they are treated and their expectations—in life generally, and

of the health system. This is important, and has major implications for anticipatory care: cultural competency is not just about thinking about and working with Aboriginal people or other marginalised



**Figure 30: Our first CLD—for the OCOC theme of 'safety' in the anticipatory**



groups; it reminds us that place and belonging, history and culture are all part of creating a safe system and trusting relationships. When a researcher enters a community, using academic, or policy language (including phrases like ‘anticipatory care’, or ‘systems thinking’), they are not a safe person. Everyone in the anticipatory care system—project or program leads, service providers, researchers, public servants—needs to learn about the place, people, and forces operating, and make themselves culturally competent for that place.

A lack of cultural competency was, perhaps, to be expected and was evident in some of the project processes. It reduced some opportunities for learning and demanded that we rapidly adjust our practice for each context. An example is the community workshops. At the first of these (OCOC), it was apparent that the language used by the facilitator and presenters was ‘culturally incompetent’; this was also true—for at least some present—for the system parts posters. Several participants, looking for the familiar, saw nothing they recognised in the images and found the poster’s wording inaccessible. We also worried that the ‘cartoony’ images were potentially infantilising. Photographs of familiar landmarks and services could have increased comfort with the process. (On Flinders Island, the PSOs supplemented the project posters with posters about being healthy created by school students, and with lots of images of island life; Figure 31.) We rapidly adjusted our planned process for the events, spending more time in conversation with participants, working to increase safety and understanding, rather than standing back and observing. The OCOC team had been effective in bringing a diverse group to the sessions, but some of our tools and methods created barriers between us and community members.

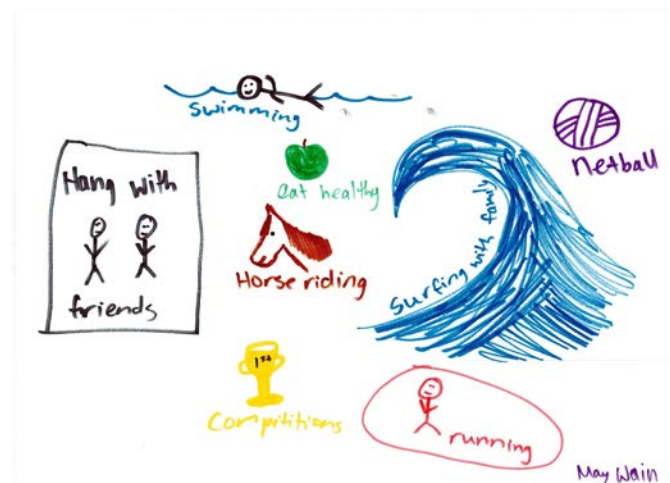
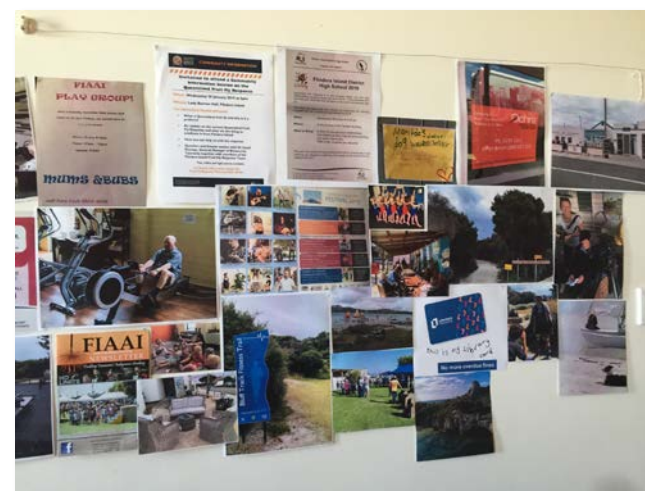


Figure 31: Getting it right on Flinders: Workshop ‘decorations’—local images (top right) and children’s posters (below)

In other sites, the importance of inclusive and accessible locations became apparent: the diversity of community, the ‘unusual suspects’ would have been more reachable had workshops been smaller, and held in safe, local places (parks, neighbourhood houses, or men’s sheds, perhaps) rather than central venues distant from the most disadvantaged people.



**Figure 32: Getting it wrong in Launceston, 2019 (wordy, academic, etc.)**

Finally, the UTAS team, including the lead researcher, was not always effective in providing ongoing research findings to the site teams. Chiefly, there were hurdles in the way of moving from the first observe (data gathering) and reflect (analysis) stages into sharing our emerging understanding of the system with site teams for the beginnings of the planning stage (Figure 32). These arose from

language use (e.g., the terms “silos” and “fragmentation” were not familiar to participants in one site) and, we think, from the tyranny of distance; working with sites needs to be—whenever possible—face to face. Videoconferencing has been effective in the latter part of the project, once trusting relationships had developed, but it reduced opportunities for developing trust when used early in the project in place of long journeys to sites.

Time plays a role here, too. Travel is costly in time and in financial terms and learning how to work in unfamiliar and culturally different sites is not a simple or rapid process. It required opportunities for reflection, within the research team and with local AC site teams. As the causal loop diagrams of the anticipatory care system show (e.g., Figure 20), time is a largely ignored resource in the system but is essential for gaining local knowledge, listening, developing trusting relationships and using locally-appropriate methods and language.

Anticipatory care’ is an obscure description and a mouthful. Many of the stakeholders struggled with the term, and wondered how it differed from ‘preventive health’. All sites made finding a local project name a priority.

Table 4 sets out what worked and did not work about project processes.





**Table 4: What worked and did not work about the OCOC 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>Contractual elements, including the timeframe</i>	DoH	<p>Project outline was not highly prescriptive which allowed for local flexibility; some elements were required (e.g., local workshops)</p> <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 (before COVID-19), this supported us to deepen relationships and develop the activities further</p>	<p>Absence of prescriptive project outline resulted in some concerns about 'are we doing this right'</p> <p>Unclear which elements were negotiable (e.g., local community workshops were prescribed; other ways to reflect collectively on the system parts could have been more effective)</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 relatively short timeframe reduces 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 time frame 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> <p>The COVID-19 pandemic had a significant impact on the project, curtailing some data gathering activities and many local site actions. No extension was granted to adjust for this change</p> <p>'Scope creep' added elements (e.g., substantial interim reports) to the researchers' workload, reducing time for other activities.</p>
<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 reduced our ability to learn

			directly from AP participants (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 GP focus was also evident in each site, where repeated efforts, only occasionally successful, were made to engage and understand their policies and culture
<i>DOH Principal Project Officer</i>	DoH	Principal Project Officer (PPO) had a strong trusting relationship with the lead organisations; this was very important to creating and sustaining links with the UTAS researchers and supporting mutual learning throughout the project, including in significant workshops, CLD sessions and other discussions about what we were learning  Strong collaboration developed between DoH officer and UTAS lead researcher which supported timeliness, reflection, and collaboration with other stakeholders	Collaborative relationship may have influenced some research team decisions
<i>Interviews</i>	UTAS researchers, PSO	Support from leads to identify potential interviewees (this also helped build relationship between researcher/s and leads)  Reached mostly 'usual suspects' very effectively  Interviewees were willing and thoughtful  Produced very detailed and 'rich' information  Could be conducted when the opportunity (e.g., an existing meeting or shared activity) arose	Format only works for people who are confident or where the interviewer could quickly establish a trusting relationship with the interviewee
<i>Focus groups</i>	UTAS researchers, PSO	Allowed us to include people who were unwilling to be interviewed alone	Method can result in one or two voices dominating the conversation (this was evident in some focus

		<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 arose (e.g., an existing meeting or shared activity)</p>	<p>groups; a product of shyness but also of power dynamics)</p> <p>Can be hard to arrange</p>
<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>PSOs made notes or reported their observations to the UTAS lead researcher</p> <p>Gave us data about understandings and experiences as well as barriers (in format directly comparable across sites)</p> <p>Expanded PSOs’ knowledge of their local site</p> <p>Was an opportunity for PSOs to have direct research experience; H2H PSOs revised the piloted survey tool and OHOF PSOs used novel methods to gather survey data, including with children</p>	<p>Sample sizes varied and none was representative</p> <p>There is general scepticism in communities about ‘yet another pointless survey’</p>
<i>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 sites</p> <p>Enabled researchers to see whether and how services interact with residents</p> <p>Made it possible for us to hear from some ‘unusual suspects’ (important for our data gathering, connecting, and future messaging)</p> <p>Identified additional potential interviewees and focus group participants</p>	<p>Very variable diversity across the sites; in some sites no ‘hard to reach’ people attended</p> <p>Initial workshop format, language and tools were targeted at service providers and probably excluded some participants</p> <p>System part posters were not ‘readable’ by many participants in some sites</p> <p>Risk that notes taken at group tables or added to posters were heavily influenced by ‘noisiest’, most powerful, or most literate person there</p>

		<p>Reflection on first workshops led to some re-design</p> <p>Brought positive media attention to the project</p> <p>Data gathered identified new system parts</p> <p>Resulted in feedback posters and revised thinking about messaging</p> <p>In some sites there was a broad representation due to PSOs' efforts to ensure local residents and service providers with broad range of perspectives were invited and supported to attend</p> <p>Research team members had to take facilitation roles (which helped us gain the confidence of some participants to share their stories)</p>	<p>Processes did not work as intended (e.g., we did not attempt to find links between the system parts during the workshops)</p> <p>Research team members had to take facilitation roles (which reduced opportunities for observation of the sessions)</p> <p>Each site had different 'best ways' to run workshops, and the approach was somewhat inflexible</p>
<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 an 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 anticipatory care system</p> <p>Process allowed for genuinely participative action learning</p> <p>Participants understood the nature of 'evidence' differently; this enabled inclusion of valuable knowledge</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; they were not possible in the project timeframe</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> <p>Participants understood the nature of 'evidence' differently; this sometimes reduced our access to knowledge</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>We were all learning as we went along</p> <p>Session was probably of variable value to the participants other than UTAS</p>

		Opportunity to learn how systems traps were appearing in sites and how participants understood and were responding to traps	
<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 PSOs and between PSOs and UTAS team</p> <p>Shared problem solving</p>	<p>Logistics sometimes difficult</p> <p>Unsure whether too hierarchical (as in, too much UTAS and not enough PSOs)</p> <p>Disrupted by loss of some PSOs</p> <p>Having more sessions would have been beneficial, but time and other pressures prevented this</p>
<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 share problem solving</p> <p>Provided opportunities for critical reflection on UTAS researchers' role and project processes</p> <p>Provided evidence of growing use of 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 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, with history in the local community as well as skills that were recognised as valuable</p> <p>Creative responses to the needs of the project (including research component of their role)</p>	<p>We were all learning as we went along; lack of a predetermined program (especially early on) was frustrating for some</p> <p>Ran the risk of 'spreading too thinly'. While pulling a little on many levers in the system can shift the system as a whole, time is needed to think through how the proposed range of actions will be linked and coordinated</p>

*Local Advisory Groups  
(structure, makeup, how  
it worked)*

	<p>Had (and built on) trusting relationships with leads, advisory groups, and one another</p> <p>Engaged, observant, reflective, critical thinking, 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>One PSO moved into two other local roles, spreading the AC way of thinking, and working to his new spheres of influence</p>	<p>Short-term funding (and lack of certainty) created some concerns for PSOs about their futures (and one left)</p> <p>Two PSOs in the CC site were not linked with the UTAS team and took no part in CoP or reflection; the contracting arrangement in that site also reduced opportunities for engagement with other CC PSOs</p>
LAG members (fluctuating)	<p>We were all learning as we went along (opportunity for some)</p> <p>In some sites, membership was fluid, with representatives from a range of services and the community attending as the need arose</p> <p>Advisory group meetings all followed clear processes, but were more or less formal in the different sites</p> <p>A core group of members in each site remained committed</p> <p>Strengthened relationship between researcher/s, DoH Principal Project Officer and members</p> <p>Opportunity for UTAS to learn about community, services, and approaches</p> <p>Local ownership, relationships between members strengthened over time</p> <p>Where Executive group existed (2 sites) they were well-run, with effective processes, engaged chairs, and provided mentoring opportunities</p>	<p>We were all learning as we went along (frustrating for some)</p> <p>Some community members' voices fairly 'down in the mix' with variable levels of diversity in membership across the sites</p> <p>Changing membership created some difficulty in maintaining and building on knowledge</p> <p>Delivering the research component effectively was sometimes challenging: we needed to find the best time and ways to present the research to the LAG</p> <p>Administrative functions to support advisory group were site-specific, e.g., minute taking and distribution</p> <p>Some 'hiccups' around action learning processes and sense making in some sites; more time/resources needed to better support this</p>



<p><i>UTAS northern suburbs Work-in-Progress symposium</i></p>	<p>Leads, PSOs, UTAS researchers, community members, City Council staff</p>	<p>People from a range of organisations presented on the work they are doing in the northern suburbs; helped link lots of research/projects happening across the OCOC area</p>	<p>No similar forums in other sites</p>
<p><i>Statewide AC Forums</i></p>	<p>Representatives from all sites, UTas, DoH, Sax/TAPPC</p>	<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 pitched at the wrong level</p>

## What we learned about the Anticipatory Care Framework

The Anticipatory Care (AC) Framework (Appendix B) guided the development of the overall AC project, and informed the identification of the initial set of six system parts. The Framework is evidenced based and emerged from a discussion paper [1] designed to adapt the UK model of anticipatory care to a Tasmanian context. The Framework has six domains:

- Priorities
- Description
- Elements
- Enablers/supports
- Consumer Outcomes
- Population Outcomes

The priorities describe what is considered to be the most important features of an anticipatory care model from ‘Outreach to people who most need care’ to enabling ‘people to improve their health’.

The AC project has provided a unique opportunity to review and consider the AC Framework in light of four different lead agencies and approaches to anticipatory care. The systems approach to the research provided another lens through which to consider the veracity of the AC Framework. We found that, overall, the range of actions and activities undertaken over the life of the project could be

mapped onto the existing AC Framework. However, the current AC Framework assumes a narrowly bounded ‘health care system’—one based on the health of an individual patient and their medical care.

On reviewing the AC Framework it was found that:

- The health care system focus of the Framework renders invisible the work of broader groups of professionals and organisations who are playing roles in anticipatory care and health and wellbeing in their communities. It is proposed that the Framework ‘boundary’ is expanded and the language modified to be more inclusive of multi-sectorial involvement in AC.
- While the person-centred model of care in the current AC Framework is important, it does not adequately capture the broader contextual factors that influence health and make up the anticipatory care system in communities. As such, it is proposed that the Framework be modified to reflect the importance of a) place and identity (namely the culture and history of a community and how this influences health and wellbeing); b) shared goals and values (how people in the anticipatory care system identify shared goals and work together to improve health), and c) adaptability and agility, referring to the way systems evolve and change. (See Working Paper, Review of the Anticipatory Care Framework, Riley, October 2020.)

Part 4: Discussion and conclusion, with implications and suggestions to further strengthen the anticipatory care system for preventing and managing chronic illness

### Vignette. Local change to the anticipatory care system is possible—Anne’s story

Anne’s child is in the Adventure Play program run by the OCOC team. His trauma was recognised by the local school, and he fitted the criteria for participation. We know that kids in the program are attending school more frequently (some were attending as little as 8%; for at least one participant this has risen to 70% attendance rate). They’re also gaining skills in self-regulation and confidence in physical activities. Their interactions with one another are also far more respectful and supportive:

*“... I would like to reiterate and congratulate the [ Team for making a huge difference in all the lives of all the participants. Providing recreational opportunities, broadening understanding of local facilities, building teamwork, and providing welcomed creative distractions from routine has been invaluable, empowering and physically stimulating for all the young people involved. I believe that the BOOM program has had a profound and life affirmative consequences for all the participants. Wonderful work and great outcomes. Congratulations.”* (email from staff member at participating school)

At the end of year BBQ in 2019, some parents joined their children for a few hours of games and food. For some, this was the first time they’d talked to another parent. They told us how great it was to meet new people and share their stories about Adventure Play. Anne is developing a social network in her new community. She’s also using BOOM “as an incentive for good behaviour”, and her son’s “*anxiety levels have gone down*”; there have been “*no phone calls from school for months –used to be daily/weekly*”.

We also talked to a local police officer who, through his involvement in the LAG, had developed a deep understanding of anticipatory care’s potential in reducing people’s risk of mental illness, or of episodes of dangerous mental illness. The police officer spoke of the OCOC project as an opportunity to collaborate in ways that would help understand and address crime in a more holistic way. He recognised how important the health (including mental health) of the community was to the work his team did, and that reducing crime could happen through collective approaches (including collective impact) (Fieldnotes). And other community members and local service providers who’d done the ‘complex trauma’ workshop run as part of the AC project, “talking about trauma”. The workshop had helped to spark “*an ongoing dialogue full of understanding about trauma and what they are going through—not about them being little shits*” (recorded in Fieldnotes).

These changes relied on the identification of a local need to better support local children who live with or have experienced trauma. There is clear evidence that childhood trauma has far reaching implications for individuals and communities. Trauma reduces educational attainment and is linked with poor long-term physical and mental health, homelessness and contact with corrections [4].

## Meeting the project aims

The project had three aims. They were 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.

We operationalised these aims through four research questions:

<b>Mapping</b> 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?
<b>Opportunities</b> 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?
<b>Actions and</b> <b>outcomes:</b>	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 agencies in anticipatory care. Hence, there is an additional research question in each site:

<b>Help to Health</b>	What is the role of Local Government in Anticipatory Care, and can it be strengthened?
<b>Our Community Our Care</b>	What is the role of Neighbourhood Houses in Anticipatory Care, and can this be strengthened?
<b>Connecting Care</b>	What role can a GP clinic play in Anticipatory Care, and can it be strengthened?
<b>Our Health Our Future RQ</b>	How does anticipatory care look and function in an isolated and under-resourced community?

In this section, we reflect on what answering the research questions tells us about the project aims.

## How does anticipatory care occur in different communities?

Anticipatory care is a complex system. The system's building blocks are People and their health, Leadership, Infrastructure, Information and data, Attitudes and beliefs, Relationships, Place and belonging, and Policy and processes. Of these, **two are novel**: the AC project identified *the centrality of place and belonging* to people's interaction with anticipatory care, and the often-*damaging action of policy and processes*.

Further, the system parts overlap and intersect; they rely on one another. That said, relationships—'soft skills/infrastructure'—is an essential system part, since it enables the coordination and trusting collaboration that both services and service users need in order to make sense of, and feel safe in, the anticipatory care system. It is also apparent that an effective anticipatory care system recognises, values and coordinates a diverse and inclusive array of variables within the system parts (following social determinants of health/ACCHO models).

The social determinants of health—the circumstances in which people grow and live—speak to the multiple factors that shape our lives. They are about *how* we live and *where* we live. The novel system part, Place and belonging—where we live and our connection to it—was identified first in the OCOC site, where community members told us about how unsafe they felt using some services and venturing outside their local community. Some of this was caused by experiences, or expectations, of being stigmatised as members of a poor and reputedly 'dysfunctional' community. As we heard in several variations, the perception of the northern suburbs of

Launceston is that people are "*all drug addicts or prostitutes or whatever it is—dropkicks and unemployed and nasty and whatever*". Residents had too many experiences of being treated without respect when they went outside their 'place'. Yet at the same time, they spoke proudly about their community, listing strengths like resourcefulness and neighbourliness. They belonged there. And they also knew where they didn't belong: where people had very different ways of being, and where they felt uncomfortable or alien.

We discovered that the strong connection with, and unwillingness to go outside, the places people felt they belonged was a feature throughout the project sites, and it wasn't tidily linked with poverty or disadvantage. Middle-class people in the H2H site did not want to leave their 'village' for health or social activities, let alone "*cross the moat*" to Hobart. They disliked that their local church hall or shop closed down because it disrupted their ways of being and of connecting. Ulverstone participants did not want to leave the town, and on Flinders Island there were several people who balked at leaving the island or travelling from one small town to another.

The importance of place, with its history and particularity, has close ties with the idea of cultural competency (a relational skill), identified on Flinders Island as necessary for collaboration between services. There, the competency needed is with the complex and terrible history of European invasion and its lasting impact on Islanders, whether Aboriginal or not. Carelessness of this legacy makes some services that could support anticipatory care unsafe—community members experience racism and can feel judged,

stigmatised, and blamed. Yet the stigmatising, discriminatory and unsafe experiences we heard about in other communities could be understood as evidence of a lack of cultural competency. Each community in the AC project (indeed, in any place) has particular characteristics, ways of doing things, in-groups, cultures and people for whom much of the anticipatory care system is not safe. And this is perhaps particularly exacerbated when people are worried about a symptom or health risk.

The COVID-19 pandemic presented an external threat to the anticipatory care system. We report in detail about its impact on the four project sites in the local final reports. Here, we note that one of the aims of the AC initiative was to see whether local systems could be strengthened. The unexpected challenges presented by the pandemic allowed us to examine whether the communities involved in the AC initiative were better placed and equipped to respond to such 'system shocks'. The AC initiative provided clear evidence that local communities in which strong, wellbeing-focused partnerships had been established under the AC initiative were equipped to adapt and respond to public health challenges. While beyond the scope of the current project to study, anecdotal evidence suggests that communities which have benefited for the AC project have been more resilient in the face of the COVID-19 challenge.

What do these findings mean for anticipatory care? The anticipatory care system needs to:

- Factor in and adapt to the local. Services, whether located in the community or visiting it, need to gain knowledge of place, becoming culturally competent. This takes time and a commitment to health equity and rights. It can also be supported by developing relationships with others who have deep

connections and cultural competencies, e.g., neighbourhoods houses, FIAAI.

- The anticipatory care system needs to be inclusive of a diverse array of services (reflecting the social determinants of health)
- The social determinants of health are a good guide to the diversity of services and other factors that those aiming to bolster anticipatory care need to include.

## What are the enablers and barriers to AC experienced by communities?

Tudor Hart's model of anticipatory care is "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" [3]. Taking this as a model, and informed by this project, it is clear that AC is enabled by relationships that are trusting and reliable, by an approach that pays attention to the social determinants of health, by services and supports being locally embedded and safe, and by a range of resources, including hard and soft infrastructure, time, and money.

Policy and processes can support or harm anticipatory care, and they are driven by attitudes and beliefs. Where individuals are presumed to be the authors of their fate, fully responsible for their health, policies can readily undermine anticipatory care by ignoring the overwhelming evidence accumulated in the social determinants and social gradient of health research, and by undermining the system parts that support relationships and the co-production of knowledge to support risk reduction.



Present policy tends to focus on acute care, rather than preventive health. This neglects the role GPs could be playing. The UK model of anticipatory care cannot work where people are choosing between conflicting demands on their meagre funds. In the absence of reliable bulk billing or low-cost consultations, people are avoiding GP visits where the medical parts of preventive health could happen. And bulk billed appointments, we were told, leave no time for the screening and other preventive measures needed in anticipatory care. GPs, in general, are, as one person told us *“not central to good anticipatory care. In fact, they’re a barrier to good anticipatory—if the only place you can get your health information is from your GP, that’s really limited”*. This is a significant finding: ***There are policy and practical barriers preventing GPs from being able to take a central role in anticipatory care.***

The focus on acute services means there is a scarcity in prevention. The lack of support for bulk billing is an example. Another is the prevalence of funding mechanisms that are competitive and short term. This competition—for a tiny fraction of the health budget and an even more miniscule part of the social determinants budget—reduces the longevity of relationships and fragments or cuts off the accumulation and sharing of knowledge. Short contracts bring new (potentially beneficial) players into the system, but they may come ill-equipped to operate in culturally safe ways, racing to catch up on any existing information that could aid preventive approaches or collaboration. Often there is no scheduled time to develop (or organisational valuing of) relationships—whether for collaboration and coordination across the system, or between service and community member.

Watt and colleagues [3], built on Tudor Hart’s work and examples of AC operating to propose that anticipatory care systems need to consider five factors (see below).

- Coverage—what proportion and sections of the target population have taken part?
- Continuity—have participants proceeded through each of the steps of anticipatory care?
- Co-ordination—do the component parts of anticipatory care work effectively and efficiently together?
- Balance—does the system maintain an appropriate balance, and investment of resources, between the serial stages of anticipatory care?
- Sustainability—have arrangements been established to maintain anticipatory care for the long term?

Policy too readily undermines these factors and ignores what we think may be the most important, those ‘long term productive relationships’.

## What do we know about working together to engage ‘at risk’ Tasmanians in primary and preventive health?

Julian Tudor Hart was driven in part by his concern that while he could treat a person’s presenting symptoms, he was also sending them home to the conditions that had contributed to their illness in the first place. He spoke of an ‘inverse care law’ [10]—the idea that *“The availability of good medical care tends to vary inversely with the need for it in the population served”*. The ‘at risk’ people in Tasmanian communities are, too often, being sent home to those conditions.

The foregoing has argued that working together, creating and sustaining the complex anticipatory care system, relies on time to develop trusting relationships, to recognise diversity and the particularity of place and belonging (including culture), and on equitable resources for physical, financial, cultural, psychological and emotional access to the anticipatory care system. The sites have demonstrated their resourcefulness in supporting the long-term health of community members; community members want to look after one another, make their ‘place’ safer, and took the opportunity to do so. In this project, community lead organisations were resourced to drive their own endeavours. Those closest to community, and most clearly accountable to that community, put that resource to use in ways community is directly experiencing (e.g., Adventure Play, cultural competency training, changes to Metro Tas bus routes, new ways of working with other anticipatory care system players).

But these successes, enabled by one-off, short term, project-based funding and driven by engaged and resourceful people and their ‘soft’ relational skills, begs the question: why are some communities in need of these (rare) buckets of money, with which they can then make some inroads into inadequate anticipatory care? Why does the inverse care law still apply? Chronic illness risks and prevalence and potentially preventable hospitalisations are driven in part by a lack of individual resources, but it is also the case that there is a lack of public—or private sector—infrastructure. There is a dearth of accessible health services on the ground, transport, appropriate and stable housing, fresh food and so on (yes, the social determinants of health). And the ‘soft’ infrastructure, which has been shown in this project to be so essential, is also being undermined by the same short-termism: staff and services come and go, jobs are insecure and projects look for gains that fit tick-a-box performance measures of number of services delivered, or reduction in complaints, missing the point. The model in which communities are given short term funding to patch up long term disadvantage demands an accountability from communities that is not reciprocated. We need to move away from these funding models, but also from the unreasonable inequities that leave some communities reliant on the energies and devotion of those people, like neighbourhood house, men’s shed or ACCHO staff and volunteers, hoping for the next time-consuming grant application to succeed.

## Applying systems thinking and complexity theory enabled real collaboration in the project and change in the anticipatory care system

UTAS was asked to trial the application of systems thinking to the complex health problem of high rates of chronic illness, in four Tasmanian communities. This required that researchers and project teams rapidly adopt a new way of understanding the circumstances of chronic illness. Early on, the systems approach—and the systems parts—were somewhat ‘imposed’ on the sites, who were invited to categorise things that they knew about their communities against preexisting themes. This process showed that the proposed system parts were useful; that information could be understood in those terms. And we were able to move from this uncomfortable, liminal space to identifying additional system parts from stories and other evidence, and to somewhat refine the meanings of existing parts. This process was necessarily incomplete: despite collaborative efforts to reach the most at risk people, we know there is more to be learned about the system, particularly about what—and who—remain missing.

With that background, we argue that *systems thinking approaches and tools can reveal the intricacies of the complex health problem of rising rates of chronic illness, identify opportunities for change and track the impacts of such change:*

- Systems thinking has enabled us, with the local site teams, to increase our understanding of the complex health problem of chronic illness.

- The value of systems thinking processes to engage multiple stakeholders at various levels—community through to government—opens the way for collaboration.
- Systems thinking can help identify resources (skills, knowledge, time, leadership, etc.) that can be put to good use in the system.
- Systems thinking highlights the role of the SDoH—for example, the importance of anticipatory care in crime prevention and school engagement in Launceston, or cultural safety on Flinders Island—in anticipatory care.

In demonstrating the complex interplay of the system parts and their echoes of the social determinants of health, systems thinking supported diverse actors, who shared the goal of greater health equity, to work together and draw in additional actors for that goal. Some sites were more ready than others for this task; for instance, the Flinders Island Aboriginal Association Inc.’s existing holistic approach to community wellbeing gave them a head start. Similarly, the advantages of strengths-based community development models for anticipatory care are apparent.

- Systems thinking allows for strengths-based, rather than deficit-focused, responses to emerge. Surfacing the causal links for better service collaboration revealed the necessity of cultural competency on Flinders Island, moving beyond a health education/health literacy focus. Further, it drove a set of new ways of working: with cultural competency, and with reaching out to FIFOs (rather than waiting for them to reach in). Similarly,

in Launceston systems thinking revealed that trauma-informed approaches might make local services safer, resulting in a workshop for community members and service providers as well as a commitment to exploring the potential of the trauma-informed Adventure Play model.

- Systems thinking pays dividends. Those working with complex health problems need the capacity to think in this way, use and adapt the tools it offers and find ways to engage others in the system in those practices. This demands time, commitment, and relational, soft skills.
- Systems thinking is a means to make action learning genuinely participative.

### Action learning is a good partner with systems thinking

We want to be able to produce knowledge in the context in which it could be acted upon. Co-production is a result of action research—but in the AC project our version was not rigid. We produced knowledge together—through social, mutual learning and a range of opportunities in which we could learn together. It was genuinely participative and was made so by the systems thinking tools we used. Project site teams and UTAS had a shared strategic intention of getting closer to understanding what was going on, and then reflexively act on opportunities. The local lead organisations, and project leads, made that possible.

In some sites there were multiple cycles of action learning, at small (basketball bins) and large (health connector role) scales. Bolstered by reassurance that the project was not demanding a fixed set of outcomes, the action learning process supported trialling

interventions that seemingly were not directly or obviously health related interventions or health service interventions. A good example is the new ways of working—and the new people worked with—through the alcohol awareness project (OHOF), the Roundtable (CC) and the Spiritual Pow Wows (OCOC); these delivered clear shifts in understanding the anticipatory care system, and different services and people’s role in it. In many cases, we saw evidence of people “acting their way into thinking differently”. As one PSO in the OHOF said, “I realised that it must be hard for the FIFOs coming here; it’s not all up to them to come and talk to us—we have to change the way we work, too”.

### The role of local project support officers

The last essential element, then, has been the role and skills of the local project support officers (PSOs). Where they were particularly successful, they were trusted by the lead organisation to venture out, listen and learn in their communities, experiment with ways of working and actions to enhance the system. They made novel contributions and were open to becoming researchers and sense-makers, skills that they rapidly developed and put to use. And they had and built soft skills: reaching out, listening, being trustworthy and trusting, giving voice and collaborating. Their successes prompted two sites to actively recommend that a ‘health connector’ role be embedded somewhere in the anticipatory care system to support:

- physical activity, social connection and information sharing initiatives (e.g., Clarence Talks, IOTA, outreach to ‘the villages’)
- relationships with existing and new service providers (e.g., the Roundtable, Spiritual Pow Wow) and researchers to strengthen

coordinated approaches to improve health and wellbeing across the community

- innovation to address AC needs.

Such a role needs to be supported, financially, and recognised by the multiple stakeholders in the anticipatory care system. Alternatively, services, having recognised that they have a role in anticipatory care could embed the outreach, connection and collaboration functions in their organisation and staff as a whole.

### The Anticipatory Care Framework needs revisions to reflect the system's complexity and breadth

The Anticipatory Care (AC) Framework (Appendix) guided the development of the overall AC project. The Framework is evidenced based and emerged from a discussion paper [1] designed to adapt the UK model of anticipatory care to a Tasmanian context. The Framework has six domains:

- Priorities
- Description
- Elements
- Enablers/supports
- Consumer Outcomes
- Population Outcomes

The priorities describe what is considered to be the most important features of an anticipatory care model from 'Outreach to people who most need care' to enabling 'people to improve their health'.

The AC project has provided a unique opportunity to review and consider the AC Framework in light of four different lead agencies and approaches to anticipatory care. The systems approach to the research provided another lens through which to consider the veracity of the AC Framework. We found that, overall, the range of actions and activities undertaken over the life of the project could be mapped onto the existing AC Framework. However, the current AC Framework assumes a narrowly bounded 'health care system'—one based on the health of an individual patient and their medical care. On reviewing the AC Framework it was found that:

- The health care system focus of the Framework renders invisible the work of broader groups of professionals and organisations who are playing roles in anticipatory care and health and wellbeing in their communities. It is proposed that the Framework 'boundary' is expanded and the language modified to be more inclusive of multi-sectorial involvement in AC.
- While the person-centred model of care in the current AC Framework is important, it does not adequately capture the broader contextual factors that influence health and make up the anticipatory care system in communities. As such, it is proposed that the Framework be modified to reflect the importance of a) place and identity (namely the culture and history of a community and how this influences health and wellbeing); b) shared goals and values (how people in the anticipatory care system identify shared goals and work together to improve health), and c) adaptability and agility, referring to the way systems evolve and change. (See Working Paper, Review of the Anticipatory Care Framework, Riley, October 2020.)

## The project research and evaluation teams

The inclusion in the broad project team of people with expertise – in public and preventive health, sociology, human geography, systems thinking, evaluation—helped UTAS and the local site teams build skills and try out ways of thinking and working. There was a continuum of approaches to the project methodology. In Clarence and Ulverstone, members of the H2H and CC teams had (in some cases) significant research experience; these sites tended to value traditional research approaches. On Flinders, the OHOF team was open to and readily adopted the systems thinking and action learning approaches and tools. This way of working, which also characterised the OCOC team’s work, included all of us in the enquiry. OHOF and OCOC were perhaps more open to the skills, resources, and opportunities the researchers and broader team could offer and recognised the power of qualitative evidence in understanding what was happening and how the anticipatory care system functions. The attitudes of the local project leads were instrumental in the level of openness to doing action learning on the scales needed.

## What hampered the project processes and findings?

### Capacity building

As Table 4 set out, several aspects of the project demanded that team members, in all categories, build their capacity and skills: in action learning, in systems thinking, in data gathering and analysis, and in collaboration and reporting. This takes time (of which there was relatively little) and was variable in outcome.

## Time

Time is a perennial challenge. This especially applies to the time needed to listen and become culturally competent in the community of interest, and to build the relationships upon which a collaborative project like this – and the anticipatory care system itself – both rely. And it takes time to develop knowledge of action learning and systems thinking. There were also additional demands on the research team’s time, perhaps consequent on the lack of time to build the levels of trust and valuing, around moving from the observe and reflect stages into the first round of planning. In all sites, this transition to the local teams developing action plans was difficult. We made several attempts to communicate what we had been learning in the UTAS team, but eventually prepared written reports for the local advisory groups and leads. This increased the workload considerably, chewing up time in the process. But the time taken was well-spent.

A second time-related limit is on assessing outcomes. Most sites’ activities ran for quite limited periods (weeks or months). This is too little time to find the sorts of quantitatively measured impacts a chronic illness prevention project might be expected to deliver. But it was sufficient time to see changes in the way people were working, working together and who they were working with. In most places, there was an expanded understanding of who was in the anticipatory care system, and greater reflexivity, as well as evident trusting relationships between the teams and service providers (and in some cases community members) participants who had not been there at the start.

Finally, more time may have enabled us and the local site teams to gain the trust and listen to more marginalised people. Building our



cultural competency is an important part of this trust-building; we suspect we remain relative novices.

### Personnel changes

Embedded local researchers (the PSOs) were essential to the project's effectiveness. Some sites (in particular, Connection Care) structured staffing in ways that reduces opportunities for the UTAS team to work with the local PSOs. Further, short term funding was linked with the loss from three sites of PSOs. In Ulverstone, the CC team had a total of six PSOs, only two of whom worked directly with the research team; those two both left the project after relatively short periods. Both Clarence PSOs left before the project finished; their reasons were mixed, but the need for secure employment, which the AC project did not offer, was prominent. In the OCOC site, a PSO also left to get full-time work (cobbled together from two organisations); fortunately, there, his new roles working with children and young people kept him in the community and working with the remaining PSOs. Both the H2H and OCOC teams sought funding/support to retain these team members, but were unsuccessful. As we have seen across the anticipatory care system, continuity of people and the relationships this enables, is an essential part of the system's function. This is as true for the PSOs as it is for other actors in the system. In Launceston and on Flinders Island, some PSOs are continuing in roles that allow them to maintain and grow their knowledge of and impacts on the anticipatory care system. The OHOF PSOs are returning to their substantive roles in health, and the OCOC PSOs are working in the expanded Adventure Play program (Adventure Play Across the Northern Suburbs,

APANS). In that work they are also maintaining connection with the UTAS lead researcher.

### Power dynamics in research and community

When a community joins a place-based, and place-driven, project, or just plays host to researchers, they are also acknowledging, whether explicitly or implicitly, that their 'place' may have a problem [47, 48]. Researchers all too rarely go into 'successful' (well-resourced, 'healthy') communities to see what is working; instead we land in places that have most likely seen multiple such interventions. In Launceston's northern suburbs, in particular, we were aware that we were just one of many teams conducting various sorts of research locally. There is a risk that being the "focus of repeated study may in turn reinforce wider assumptions and stigmatisation" (Neal et al. 2016, p. 493). Awareness of the multiple local projects in the OCOC site, the UTAS team drew together researchers, with the local OCOC team, for a day-long sharing of locally-produced research knowledge and experiences. As well, the action learning and systems thinking methods used may have gone a little way to reducing that risk. This is in keeping with Neal et al.'s (2016) case for the importance of "the role of participants as active, co-productive and 'research knowing'" [47]. They develop pertinent arguments, too, about how place factors into this co-production.

A second power dynamic was evident. Though led by a senior academic at UTAS, the active members of the research team are all early career researchers, two with PhDs, one in the midst of PhD study and one about to embark on a doctorate. We all had substantial experience in community and rural health-related research, but we were also going into communities where (i) we had



little or no 'cred', and (ii) there were substantially more established researchers in the local teams. This made for some tentativeness in establishing relationships. We think that—again—time is needed for this soft infrastructural work, and for the surfacing of all team members' expectations and understandings of the project.

### Spit and polish

How can we best compare the outcomes across the sites? They were very different – deliberately so – and had different goals (for their involvement), site themes, ways of thinking and working, skills, resources, values, attitude and beliefs, and so on. They are, ultimately not comparable, yet we frequently sense a whiff of friendly rivalry between them. The way they thought about evidence varied, their relative trust in the data gathering and analysis methods varied and their final reporting content and styles also varied.

There is a risk that these 'product' reports can skew how a site's performance is evaluated. Sites with experience of reporting to government funders and working with external evaluators presented professional documents, laying out their work and outcomes. It is important that we find equitable ways to 'read' the project outcomes so that how the reporting game is played does not shape how success is assessed. This, of course, plays into the matter of appropriate performance measures in the anticipatory care system more broadly.

The report now concludes with a series of overall recommendations. We have made project site-related recommendations in the local site reports.



# Part 5: Recommendations

## Preventing chronic disease through Anticipatory Care

Anticipatory care is an innovative community-driven approach to identifying and addressing barriers to better health and wellbeing, to reduce long-term chronic disease. The AC project has demonstrated that enhancing the anticipatory care system is possible at the community level through locally-developed and delivered initiatives.

We make six high-level recommendations to enhance anticipatory care and reduce the risk of potentially preventable hospitalisations. These six recommendations are supported by sub-level recommendations and steps to achieving recommended change (Table 5). The high-level recommendations are:

1. Reflect the complex and multi-disciplinary nature of anticipatory care in local, state and commonwealth policy
2. Develop place-based commissioning and whole-of-community outcome indicators (e.g., OECD “better life”) to measure progress towards addressing chronic illness
3. Create culturally safe health, education, and social services. (training, policy, engagement)
4. Ensure equitable access by addressing the structural and individual barriers and system road blocks to medical, psychological and dental services for preventive health
5. Increase awareness of the anticipatory care system and services
6. Revise the AC Framework in light of the AC Project findings.

Recommendation	Sub-level recommendation	Steps to achieving recommended change
<p>1. Reflect the complex and multi-disciplinary nature of anticipatory care in local, state and commonwealth policy</p>	<p>1(a) Embed systems thinking approaches in preventive health work</p> <p><i>(see UTAS Policy Brief: Systems Thinking, September 2020)</i></p>	<p>1(a)i. Factor specific time for developing systems thinking skills and capacity in practitioners and agencies</p> <p>Resource the adaptation of systems thinking tools to local applications.</p>
	<p>1(b) Reflect the complexity of AC in collaborations for preventive health</p> <p><i>(see UTAS Policy Brief: Funding Models for Preventive Health)</i></p>	<p>1(b)i. Include independent research support for evidence-based planning and action learning, systems thinking, ongoing reflection and review (i.e., university support) in collaborations.</p> <p>1(b)ii. Resource policy and relational contracting support and management, and access to tools and information (i.e., DoH support).</p> <p>1(b)iii. Work with community to identify and drive change based on local needs and ways of working, and using systems thinking methods</p> <p>1(b)iv. Build opportunities for mutual learning between community, services, universities and researchers, and relevant government personnel into future preventive health (including anticipatory care) projects.</p> <p>1(b)v. Create and resource long-term ‘Health Connector’ roles in communities to support and enhance the anticipatory care through:</p> <ul style="list-style-type: none"> <li>• Physical activity, social connection, and information sharing initiatives</li> <li>• Relationships with existing and new service providers, researchers and community to strengthen locally-based coordinated approaches</li> <li>• Innovation to surface and address AC needs</li> </ul>

	<p>I(b)vi. Incorporate outreach and system-wide collaboration as key tasks for all services operating in or to the community and find ways to coordinate with one another to support the anticipatory care system.</p> <p>I(b)vii. Factor time and establishing coordination mechanisms into collaboration planning, development and maintenance.</p>
<p>1(c) Support mutual learning in approaches to enhance anticipatory care</p>	<p>I(c)i. Build opportunities for mutual learning between community, universities and researchers, and relevant government personnel into future preventive health (including anticipatory care) projects.</p> <p>I(c)ii. Resource a longer-term trial of the Anticipatory Care Action Learning Project approach, with a focus on the complex health problem of mental illness.</p>
<p>1(d) Implement funding models that support multi-disciplinary collaboration for preventive health</p> <p><i>(see UTAS Policy Brief: Funding Models for Preventive Health)</i></p>	<p>I(d)i. Replace competitive funding models that reduce connection and collaboration between parts of the anticipatory care system and pool resources and develop models that promote and support collaboration between governments, universities and researchers, NGOs and communities.</p> <p>I(d)ii. Funding models need to be flexible, long term and adaptable to meet community need. This is because communities have different strengths, gaps and priorities. Proportionate universalism has been proposed as a suitable framework.</p> <p>I(d)iii. Funders to set broad goal/s (e.g., “improve OECD ‘betterlife’ indicators in a community, such as self-reported health and life expectancy”) and allow lead organisations, in consultation with their community, to</p>

determine what success looks like, how it will be measured, and how to allocate and manage the funding.

1(d)iv. Funders need to work as partners, providing:

- guidance and monitoring of processes (e.g., community engagement, how resources are being utilised/targeted, without being prescriptive)
- a conduit for knowledge, information, and evidence to support local activities, founded on principles of mutual learning and ongoing sharing of information.

1(d)v. Place relationships at the centre of funding models. Build time and “relational contract management” into funding to develop and nurture a shared understanding of the community and the initiative.

1(d)vi. Support collaborative governance arrangements in which government is a partner in the initiative rather than a top-down driver of process and outcome. In this model, shared goals and outcomes can be worked on together.

1(d)vii. Build into funding models regular opportunities for all project partners to reflect on their expectations, assumptions, values and biases that could inhibit the development of trusting relationships.



<p>2. Develop place-based commissioning and whole-of-community outcome indicators (e.g., OECD “better life”) to measure progress towards addressing chronic illness</p>	<p>2(a) Factor the importance of place and belonging (including cultural concerns) into policy decisions at all levels of government, including (but not limited to) infrastructure, service provision, town planning, and social housing and, potentially, mirroring or adopting the ACCHO model</p>	<p>2(b)i. Support ACCHOs to continue their central role in supporting the health of Aboriginal people</p>
	<p>2(b) Recognise, at State and federal government levels, that the Aboriginal Community Controlled Health Organisation (ACCHO) model, with its holistic approach guided by the social determinants of health and cultural competency is an appropriate framework for anticipatory care, and develop policy and funding models that supports this model being applied more widely</p> <p>The ACCHO/social determinants model demands a whole-of-government approach to preventive health</p>	<p>2(b)ii. Investigate ways to adapt the ACCHO model for other communities, including resourcing ACCHOs to support such adaptation.</p>
	<p>2(c) Include quantitative and qualitative performance measures to reveal how the AC (or other health and wellbeing) system is performing</p>	<p>2(c)i. Develop KPIs within local, state and federal government that reflect externalities, soft infrastructure and experiential dimensions of performance</p> <p>2(c)ii. Revise health and social service KPIs to reflect externalities, soft infrastructure and experiential dimensions of performance</p> <p>2(c)iii. Promote policy-level recognition of the SDoH factors affecting the community and continue to advocate for better provision of GP and other health and social services in disadvantaged communities</p>

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2(d) Work with existing place-based collaborations to support anticipatory care

*(see UTAS Policy Brief: Organisational Leadership for AC)*

2(d)i. Maintain and resource local advisory groups and revise terms of reference to reflect the social determinants of health (SDoH)

2(d)ii. Work to enhance the diversity of representation on local advisory groups, engaging community members and reflecting the social determinants of health (e.g., LAG should include, but not be limited to, agencies with roles in housing, education, health, Aboriginal organisations, etc.), whether locally-based or coming to the community from elsewhere.

2(d)iii. Where no local collaborative group exists, create and fund multi-organisation and long-term collaborative leadership groups that incorporate and take advantage of multiple roles, scope, perspectives, system entry points, and complementary leadership qualities.

2(d)iv. Resource local bodies to develop or maintain cultural competency, trauma-informed relational skills and knowledge of the anticipatory care.

2(d)v. Each local government needs to articulate and be accountable for their role in AC – to community and to other levels of government.

2(d)vi. Tailor local service delivery to suit the financial, educational and technological capacity of community members; this relies on services' capacity.

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2(e) Provide time, support, funding and facilitation to build leadership and collaboration

*(see UTAS Policy Brief: Organisational Leadership for AC)*

2(e)i. Create and fund multi-organisation and long-term collaborative leadership groups that incorporate and take advantage of multiple roles, scope, perspectives, system entry points, and complementary leadership qualities.

2(e)ii. Ensure that collaborative leadership groups include strengths-based and place-based organisations

with deep community connections and local cultural competency that can effectively engage with local communities.

2(e)iii. Ensure that leadership collaborations include organisations and mechanisms that are able to engage with, and draw in, groups and communities who are affected or marginalised by the system.

2(e)iv. Create criteria for the selection of leadership for preventive initiatives that incorporate identified leadership qualities and enablers across key organisational attributes.

2(e)v. Build senior level organisational alignment amongst partners across the system with a commitment to creating a shared vision and purpose, including core project approaches such as SDoH built into funding,[49] contract, and governance guidelines.

2(e)vi Create project initiation processes and events that extend organisational alignment and shared purpose further into the partner organisations.

2(e)vii Build and support relationships, trust, and understanding across all levels of participating organisations through flexible service agreements and funding arrangements, action learning processes, and relational contract management approaches.

2(e)viii Create shared governance and dynamic multi-level collaboration mechanisms[49] and processes, which support the key leadership qualities, and provide for ongoing flexibility, self-reflection, managed risk-taking, learning, negotiation, and change.

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3. Create culturally safe health, education, and social services (training, policy, engagement)

3(a) Resource place-based cultural competency

Note: Cultural competency takes into account history, place, and inter-generational or other trauma

3(a)i. Resource and collaborate with local communities (including local palawa) to develop and deliver place-based cultural competency training, and to design appropriate performance measures

3(a)ii. Involve people who are already culturally competent in development and delivery of training

3(a)iii. Build cultural competency into employment induction, professional development and organisational culture, policy, and processes

3(a)iv. Equip researchers and project officers working in community to work in culturally competent ways, through self-education and respectful engagement

3(a)v. Build cultural competency into employment induction, organisational culture, policy and processes, and performance reviews or evaluations for all agencies, institutions and services collaborating in anticipatory care

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4. Ensure equitable access by addressing the structural and individual barriers and system road blocks to medical, psychological and dental services for preventive health

4(a) Support the medical, social and economic health of communities, through all levels of government, by providing/subsidising GP, mental health and dental services where they are needed

4(a)i. Review national and state regulation of GP services to 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)

4(a)ii. Review subsidies for GPs servicing rural and remote areas to include outlying and disadvantaged communities

4(a)iii. Review national and state regulation of GP services (including regulation of international medical graduates (IMG) to counter supply shortages

4(a)iv. Implement different funding and contract arrangements for rural and remote GPs to do outreach and education, with ongoing evaluation of the effectiveness and reach for engaging those most unable to access services

4(a)v. Continue bulk billed telehealth services, subject to evidence that this is improving access to GPs for members of marginalised communities who may also have poor internet and telephone resources

4(a)vi. Adopt clear and transparent information and easily understandable guidelines explaining GP bulk billing policy and practices

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5. Increase awareness of the anticipatory care system and services

5(a) Ensure health service information is accessible

5(a)i. Invest in face to face delivery modes for information about health and services.

5(a)ii. Ensure digital infrastructure is available across the State, particularly where alternatives are limited, and provide appropriate technical and guidance supports for people to make use of this.

5(a)iii. Prioritise health literacy programs that address the design and delivery of information to support health and access; improvements in community members' literacy is a secondary—though important—goal.

5(a)iv. Use culturally competent processes, and co-design where possible, to collaborate with organisations with connections into communities (e.g., ACCHOs, neighbourhood houses) to identify appropriate mechanisms for delivering health information.

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6. Revise the AC Framework in light of the AC Project findings and conclusions	6(a) Include the complexity of the anticipatory care system in the AC Framework (see Riley, T. (2020). <i>Working Paper, Review of the Anticipatory Care Framework</i> )	6(a)1. Expand the Framework boundary and language to reflect multi-sectorial involvement in anticipatory care. 6(a)ii. Modify the Framework to capture the broader contextual factors that influence health and make up the anticipatory care system in communities, including: <ul style="list-style-type: none"><li>• place and identity (namely the culture and history of a community and how this influences health and wellbeing)</li><li>• shared goals and values (how people in the anticipatory care system identify shared goals and work together to improve health)</li><li>• adaptability and agility, referring to the way systems evolve and change.</li></ul>
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## Appendices

## Appendix A: UTAS 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, 17<sup>th</sup> June (via zoom).

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

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

Community workshop (reporting findings), Community 4: Our Health Our Future, Flinders Island, 27<sup>th</sup> 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/policy and findings briefs*

2020

Policy Brief: Systems Thinking for Health

Policy Brief: Funding Models for Preventive Health

Policy Brief: Sustaining System Change and the Shock of COVID-19

Policy Brief: Organisational Leadership for Anticipator Care

Findings Brief: Access to affordable general practice care (poster)

Findings Brief: Action for prevention (poster)

2019

Overview Brief: The Anticipatory Care Project (poster)

*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, 20<sup>th</sup> February.

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

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

2019

State-wide Anticipatory Care forum 1, 16<sup>th</sup> 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, 8<sup>th</sup> August.

UTAS AC team (2019). Bulk-billing and GP Access, discussion with the Healthy Tasmania Chronic Conditions Working Group, 12<sup>th</sup> September.

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

State-wide Anticipatory Care forum 2, 18<sup>th</sup> November 2019.

State-wide Anticipatory Care forum, 26<sup>th</sup> November 2020.

*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, 13<sup>th</sup> February.

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

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

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

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

Healthy Tasmania Community Forum, 13<sup>th</sup> August 2019, Hobart.

Pain Revolution, 10<sup>th</sup> September 2019.

TBRI training, SPNH, 8<sup>th</sup> November 2019.

2020

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

Dean Cracknell (Town Teams/Neighbourhood Leadership, City of Launceston)—22<sup>nd</sup> 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*

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.

### *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.

UTAS team (2019). Hosted and presented at the *Health Care Services Work-in-Progress Seminar* (presentations from UTAS researchers, Launceston City Council project staff, personnel from local health-related project), Rocherlea, 20 November.

### *Academic publications*

#### Presentations

Banks, S., Krabbe, R., Vandenberg, M., & Murray, T. (2020). The 'Aha' experience: Using systems thinking to map and tweak anticipatory care. Presentation to the Preventive Health Australia conference (virtual), 13–15 May.

Banks, S., Murray, T., Vandenberg, M., Krabbe, R., Preston, E., & Eccleston, R. (2019). The Anticipatory Care Action Learning Project: Working with government and communities. Presentation to the School of Social Sciences 'Brown Bag' seminar series, Hobart, 30 August.

#### Peer-reviewed paper

Boland, J., Banks, S., Henning, T., Krabbe, R., Lawrence, S., Murray, T., & Vandenberg, M. (2020, revise and resubmit). A pragmatic COVID-era literature review: Using zoom to engage in action learning work. *Public Health Research & Practice*.

## Appendix B: The Anticipatory Care Framework (2019)

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"> <li>→ Use proactive outreach strategies</li> <li>→ Use population and disease registers and do 'case finding'</li> <li>→ Develop partnerships with community</li> <li>→ Seek opportunistic ways to engage people in their health care</li> </ul>	<p><b>Governance and leadership</b></p> <ul style="list-style-type: none"> <li>→ Support and leadership</li> <li>→ Joined up health and social services (acute to community)</li> <li>→ Local area coordination</li> <li>→ Partnerships with services who can outreach</li> <li>→ Consumer engagement</li> </ul> <p><b>Health workforce</b></p> <ul style="list-style-type: none"> <li>→ Identify needs and attitudes</li> <li>→ Training and resources (health promotion, self-management)</li> </ul> <p><b>Health literacy</b></p> <ul style="list-style-type: none"> <li>→ Easy to understand education resources</li> <li>→ Health literate organisations</li> </ul> <p><b>Data and information</b></p> <ul style="list-style-type: none"> <li>→ Data sharing agreements</li> <li>→ Community health profiles</li> <li>→ Local community knowledge</li> </ul> <p><b>Technology</b></p> <ul style="list-style-type: none"> <li>→ Patient registration</li> <li>→ 'flagging' systems</li> <li>→ EHealth Resources</li> <li>→ funding models</li> <li>→ Screening &amp; assessment tools</li> <li>→ Chronic Disease self-management programs</li> </ul> <p><b>Research &amp; evaluation</b></p> <ul style="list-style-type: none"> <li>→ Action Learning projects</li> <li>→ Monitor patient outcomes and population</li> <li>→ Effective outreach models</li> </ul>	<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 recognised 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 healthcare 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"> <li>→ Develop long term trusting relationships</li> <li>→ Identify individual care needs (psychosocial and physical health)</li> <li>→ Use many ways to engage people in assessment (e.g. proactive, system reminders and opportunistic screening)</li> </ul>			
<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"> <li>→ Strengthen health literacy and consumer engagement</li> <li>→ Develop self-management skills</li> <li>→ Provide evidence based care across the disease prevention continuum</li> <li>→ Help people address psychosocial and physical care</li> </ul>			
<p>Improve the personal experience in the healthcare 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"> <li>→ Multidisciplinary team based care</li> <li>→ Include informal carers</li> <li>→ Integrated and coordinated care</li> <li>→ Support care pathways which are easy to navigate</li> <li>→ Use shared health records</li> </ul>			
<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"> <li>→ Use local health data and practice, population and disease registers to identify health need</li> <li>→ Provide proactive care focusing on need</li> <li>→ Involve consumers in the planning of services</li> </ul>			

## Appendix C: Participation data

**Table 5: Project site workshops, 2019**

<i>Site</i>	<i>Date</i>	<i>Number of people attending</i>	<i>Facilitator</i>
<i>OCOC: Starting Point Neighbourhood House</i>	13 March 2019	59	Dr Seanna Davidson
<i>OCOC: Northern Suburbs Community Centre</i>	14 March 2019		Dr Seanna Davidson
<i>OHOF</i>	29 March 2019	25	Ms Flora Dean and Dr Susan Banks
<i>Connecting Care</i>	1 April 2019	41	Ms Miriam Vandenberg
<i>H2H</i>	4 July 2019	16	Ms Miriam Vandenberg

**Table 6: 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 site: ages, sex, diversity, employment, income, education, volunteering, households, etc.	Data 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 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; availability of bulk-billing; numbers of GPs; research findings about the area (e.g., consultant reports, emerging literature on local government, etc.)	Published research reports and other literature used to collate what is known about the presence of the social determinants of health and use of services, for instance.

**Table 7: Data gathered in the AC project, to June 2020**



	<i>H2H</i>	<i>OCOC</i>	<i>CC</i>	<i>OHOF</i>	<i>Total</i>
<i>Interviews and focus groups</i>	22	73	61	29	185 people
<i>Community workshops</i>	16	59	79	25	179 people
<i>Survey</i>	42	48	146	120	341 people
<i>CLD workshops</i>	15	24	13	12	64 people*
<i>Reflections with/by PSOs</i>	27	112	8	27	174 documents
<i>Fieldnotes (from community and CLD workshops, and other meetings, site visits)</i>	20	38	56	32	146 documents

Note: some participants attended more than one activity.

## Appendix D: Collapsing the variables

The CLDs show what we have evidence for. This means that some variables which we had hoped to benefit through project activities may have remained unaffected or been only slightly affected. This is the case for “Connecting with the hard to reach”, an important aim of the project.

Variables were identified in CLD sessions with local site teams, using local labels. The full list of variables shown in Figure 20 (where some are obscured) is given below, starting from the centre right of the diagram.

Shared understanding and commitment to AC

Effective communication

Knowledge about AC principles among service providers (inc. social determinants, barriers to access, community readiness, stakeholders & roles)

Community development approach

Giving voice to community and advocacy

Health literacy

Connections & networking between service providers & with community

Resources for AC

Geographical reach

Strategies for information provision (training, talks to groups, social media, newsletters)

AC activity is recognised as being connected to other 'core business'

Sustainability of AC focused work

Awareness of health-related information (e.g. health behaviours)

Supportive environment for health

Capacity building across the AC system

Leadership for AC

Connecting with the hard to reach

Time

Relationships (genuine, community-focused, trusting, safe)

Awareness of stakeholders' roles in the system

Awareness of SDoH in AC

Advocacy for policy change

Action-oriented preventive approach

Stigma

Effective priority setting

Responding to community needs

Compassion for others

Culturally & spiritually sensitive & trauma-informed practice

Competing priorities, hierarchies, power

Awareness of community strengths

Positive social outcomes

Availability of GP services and bulk billing

Promotion of personal responsibility

Support to community members ...

Resources for AC activities

Demand for AC activities

Positive profiling of community

Use of social and print media

Service navigation

Accessibility of health information

Personal capacity (agency, motivation, confidence, resources)

Victim blaming

Social inclusion  
Health promoting behaviours  
Geographical isolation  
FIFO service providers  
Emotional load  
Incidental conversations about AC

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Further analysis showed that there were several variables that overlapped, and others that have very few causal links. To clarify what the CLD was revealing, we collapsed similar variables.

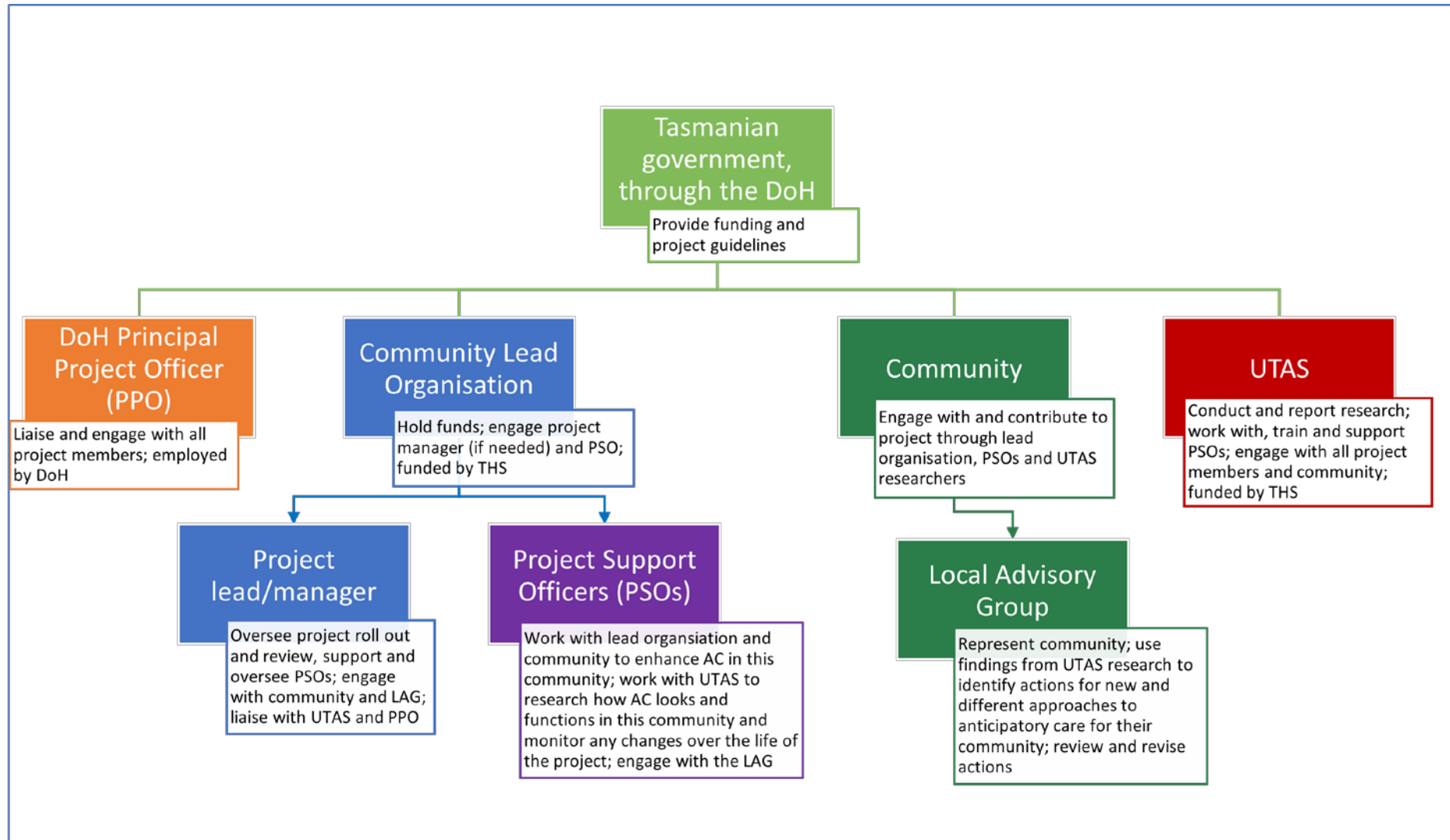
Variables collapsed are:

- Victim blaming, and Promotion of personal responsibility into Stigma (victim blaming, discrimination, marginalisation, and racism)
- Time, Supportive environments for health, and Availability of GP services and bulk billing into Resources for AC
- Compassion for others, and Reflective, responsive & flexible practice into Culturally & spiritually sensitive & trauma-informed practice that is reflective and responsive
- Advocacy for policy change into Giving voice to community & advocacy
- Awareness of SDoH in AC into Shared understanding & commitment to AC, including the role of the SDoH
- Action-oriented preventive approach into Strengths based community development approach

- Strategies for information provision (training, talks to groups, social media, newsletters), and Use of social and print media into Accessible information for AC (was Accessibility of health information)
- Action-oriented preventive approach into Strengths based community development approach
- Awareness of stakeholders' roles in the system into Shared understanding & commitment to AC, including the role of the SDoH
- Positive profiling of community into Strengths based community development approach
- Personal capacity (agency, motivation, confidence, resources) into Capacity building across the anticipatory care system
- Health literacy into Accessibility of health information

We also removed variables with very few links (e.g., “Demand for AC”); this does not mean they are not relevant, but we are looking for the most significant variables.

## Appendix E: Project roles and relationships structure





## References

1. Healthy Tasmania Chronic Conditions Working Group, *Anticipatory Care in Tasmania Discussion Paper*. 2018, Hobart, TAS: Planning Purchasing and Performance, Department of Health and Human Services.
2. Cooper, M.J.F., S. Sornalingam, and C. O'Donnell, *Street-level bureaucracy: An underused theoretical model for general practice?* British Journal of General Practice, 2015. **65**(636): p. 376-377.
3. Watt, G., C. O'Donnell, and S. Sridharan, *Building on Julian Tudor Hart's example of anticipatory care*. Primary Health Care Research & Development, 2011. **12**(1): p. 3-10.
4. Australian Institute of Health and Welfare, *Australia's children*. 2020, Canberra, ACT: AIHW.
5. O'Donnell, C.A., et al., *Delivering a national programme of anticipatory care in primary care: A qualitative study*. British Journal of General Practice, 2012. **62**(597): p. e288-e296.
6. Goodwin, N., et al., *Managing People with Long Term Conditions: An inquiry into the Quality of General Practice in England*. 2010, London: The Kings Fund.
7. Martin, C.M., et al., *Anticipatory care in potentially preventable hospitalizations: Making data sense of complex health journeys*. Frontiers in Public Health, 2019. **6**.
8. Marmot, M., *Social determinants of health inequalities*. The Lancet, 2005. **365**(March 19): p. 1099-1104.
9. Marmot, M. and J.J. Allen, *Social determinants of health equity*. American Journal of Public Health, 2014. **104 Suppl 4**(Suppl 4): p. S517-S519.
10. Tudor Hart, J., *The Inverse Care Law*. The Lancet, 1971. **297**(7696): p. 405-412.
11. Tudor Hart, J., et al., *Twenty five years of case finding and audit in a socially deprived community*. British Medical Journal, 1991. **302**(22 June): p. 1509-1513.
12. Bonn, D., *Julian Tudor Hart: bringing better health to South Wales*. The Lancet, 1999. **354**(9181): p. 842.
13. Burns, D., *Systemic action research: A strategy for whole system change*. 2007, Bristol: Policy Press.
14. The Australian Prevention Partnership Centre (TAPPC) *Preventing our greatest health problems*. 2017.
15. FTI Consulting, *Study of Economics, Business and Social Structure on Tasmania's Flinders Island*. 2019, Melbourne, VIC: FTI Consulting.
16. Clarence City Council, *Community Health and Wellbeing Plan 2013-2018*. n.d., Clarence, TAS: Clarence City Council.

17. Tasmanian Council of Social Service Inc. (TasCOSS), *Help to Health Evaluation Report*. 2018, Hobart, TAS: TasCOSS and Clarence City Council.
18. Tasmanian Council of Social Service Inc. (TasCOSS), *Understanding Digital Inclusion in Tasmania: Report on research findings*. 2019.
19. City of Launceston, *My Place. My Future. Preliminary Analysis Report Version 1, November 2018*. 2018, Launceston, TAS: City of Launceston.
20. Kitto, S.C., J. Chesters, and C. Grbich, *Quality in qualitative research: Criteria for authors and assessors in the submission and assessment of qualitative research articles for the Medical Journal of Australia*. *Medical Journal of Australia*, 2008. **188**(4): p. 243-246.
21. Armstrong, D., et al., *The place of inter-rater reliability in qualitative research: An empirical study*. *Sociology*, 1997. **31**(3): p. 597-606.
22. Barbour, R.S., *Checklists for improving rigour in qualitative research: a case of the tail wagging the dog?* *British Medical Journal*, 2001. **322**(7294): p. 1115-7.
23. Morse, J.M., *"Perfectly Healthy, But Dead": The myth of inter-rater reliability*. *Qualitative Health Research*, 1997. **7**(4): p. 445-447.
24. Rockliffe, L., et al., *It's hard to reach the "hard-to-reach": the challenges of recruiting people who do not access preventative healthcare services into interview studies*. *International Journal of Qualitative Studies in Health and Well-being*, 2018. **13**(1): p. 1479582.
25. Devotta, K., et al., *Enriching qualitative research by engaging peer interviewers: A case study*. *Qualitative Research*, 2016. **16**(6): p. 661-680.
26. Bonevski, B., et al., *Reaching the hard-to-reach: a systematic review of strategies for improving health and medical research with socially disadvantaged groups*. *BMC Medical Research Methodology*, 2014. **14**: p. 42.
27. Department of Health and Human Services (DHHS), *Report on the Tasmanian Population Health Survey 2019*. 2020, Hobart, TAS: DHHS.
28. Williams, F., *In and beyond New Labour: Towards a new political ethics of care*. *Critical Social Policy*, 2001. **21**(4): p. 467-493.
29. World Health Organization (WHO), *Monitoring the Building Blocks of Health Systems: A Handbook of Indicators and Their Measurement Strategies. Collection of indicators*. 2010, Geneva: WHO.
30. Midgley, G., *Theoretical Pluralism in Systemic Action Research*. *Systemic Practice and Action Research*, 2010. **24**(1): p. 1-15.
31. Wilkinson, R. and M. Marmot, eds. *The Solid Facts*. 2nd ed. 2003, WHO: Geneva.
32. Kavanagh, S., et al., *Resources, relationships, and systems thinking should inform the way community health promotion is funded*. *Critical Public Health*, 2020: p. 1-10.

33. Unwin, M., et al., *Socioeconomic disadvantage as a driver of non-urgent emergency department presentations: A retrospective data analysis*. PLOS ONE, 2020. **15**(4): p. e0231429.
34. Unwin, M., et al., *Investigating why young people from vulnerable communities are more likely to present to the ED with non-urgent conditions*, in *3rd Global Conference on Emergency Nursing and Trauma*. 2018: Noordwijkerhout, The Netherlands.
35. Teo, A.R., et al., *Does Mode of Contact with Different Types of Social Relationships Predict Depression in Older Adults? Evidence from a Nationally Representative Survey*. J Am Geriatr Soc, 2015. **63**(10): p. 2014-22.
36. Holt-Lunstad, J., et al., *Loneliness and social isolation as risk factors for mortality: a meta-analytic review*. Perspect Psychol Sci, 2015. **10**(2): p. 227-37.
37. Crawford, R., *You are dangerous to your health: the ideology and politics of victim blaming*. International Journal of Health Services, 1977. **7**(4): p. 663-80.
38. Crawford, R., *Health as a meaningful social practice*. Health (London), 2006. **10**(4): p. 401-20.
39. Farrell, L.C., et al., *Socio-economic divergence in public opinions about preventive obesity regulations: Is the purpose to 'make some things cheaper, more affordable' or to 'help them get over their own ignorance'?* Social Science & Medicine, 2016. **154**: p. 1-8.
40. Barry, A.-M. and C. Yuill, *Understanding the Sociology of Health: An introduction*. 4th ed. 2016, London; Thousand Oaks, CA: Sage Publications Ltd. .
41. Lawlor, D.A., et al., *Smoking and ill health: Does lay epidemiology explain the failure of smoking cessation programs among deprived populations?* American Journal of Public Health, 2003. **93**: p. 266-270.
42. Williams, B.T. and R. Hummelbunner, *Systems Concepts in Acron: A practitioners' toolkit*. 2010, Stanford, CA: Stanford University Press.
43. Nowell, B. and L.M. Harrison, *Leading change through collaborative partnerships: A profile of leadership and capacity among local public health leaders*. Journal of Prevention & Intervention in the Community, 2010. **39**(1): p. 19-34.
44. Royal Australian College of General Practitioners (RACGP), *Consultation paper: Vision for a sustainable health system*. 2015.
45. Royal Australian College of General Practitioners (RACGP), *Anticipatory care*, in *RACGP aged care clinical guide (Silver Book). Silver Book - Part B*. 2019.
46. Mitchell, E., P. Bandara, and V. Smith, *Tackling Indigenous Smoking Program: Final evaluation report*. 2018, Canberra, ACT: Australian Government Department of Health.



47. Neal, S., et al., *'You can't move in Hackney without bumping into an anthropologist': why certain places attract research attention.* *Qualitative Research*, 2016. **16**(5): p. 491-507.
  48. Clark, T., *'We're Over-Researched Here!'*. *Sociology*, 2008. **42**(5): p. 953-970.
  49. Roussy, V., T. Riley, and C. Livingstone, *Together stronger: boundary work within an Australian systems-based prevention initiative.* Health Promotion International, 2019.
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## Endnotes

<sup>i</sup> The other is C. Van den Dool, a Dutch GP.

<sup>ii</sup> Dr Therese Riley provided much of the material about systems thinking in this section.

<sup>iii</sup> There are also arguments that researchers should trust "trust their judgements and be prepared to defend their interpretations and analyses" 23. Morse, J.M., *"Perfectly Healthy, But Dead": The myth of inter-rater reliability.* *Qualitative Health Research*, 1997. **7**(4): p. 445-447. in the face of the push for inter-rater reliability.