Reviewer’s report

Title: The potential for multi-disciplinary primary health care services to take action on the social determinants of health: actions and constraints

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Reviewer: Denise Fry

Reviewer’s report:

This is a very useful paper that researches and discusses important issues that receive insufficient attention in Australia and internationally. The title and abstract adequately convey what has been found. The manuscript meets the relevant standards for description and reporting of data.

The question the paper addresses is an important one and has been well posed. Overall, the paper is well written and the findings clearly derived from the data. The Introduction and background material acknowledge the work on which the research rests.

Major Compulsory Revision

1. P22 Discussion

Second sentence – ‘Our study has documented some of these dilemmas and also demonstrates the potential of PHC to play a constructive role’. I think the paper has documented the dilemmas, but needs to demonstrate more clearly PHC’s potential for action on SDH. It would be easy for some readers to conclude ‘it’s too hard’. The paper should clarify and strengthen its arguments that PHC can have a constructive role in addressing SDH, and include examples of successful actions taken by PHC teams, to demonstrate that such roles are possible.

Minor Essential Revision

1.P23 ‘the discourse on SDH itemises a number of conditions (mimicking behavioural epidemiology and its lists of specific risk factors......potentially adding to workers’ sense of being able to make much of a difference’

I think ‘not’ has been left out of this sentence.

Discretionary Revisions

I have made some comments and suggestions to strengthen the paper’s arguments.

1.P 5- top paragraph, last sentence ‘The role of the health sector..... requires a comprehensive approach that goes beyond service provision’.

The debate over and contest for resources between selective and comprehensive PHC and the alignment of selective PHC with neo-liberal projects are certainly relevant in explaining challenges to comprehensive PHC, but they
are not the only factors that have inhibited the development of comprehensive PHC, particularly in Australia.

In Australia in the early 1990s federal Labor governments (which can be seen as generally reformist) chose to give resources and policy attention to developing primary medical care over strengthening comprehensive PHC, setting a continuing pattern. As the paper describes, state governments in Australia have retreated from community participation and/or management in most PHC services. Perhaps the tension between health systems and comprehensive PHC reflects a more general tension between bureaucratic and community perspectives over how health issues are conceptualised and discussed in the public domain. I think the growth of managerialism in the public sector means governments are less comfortable with independent voices whose perspectives may compete or conflict with governments’ chosen narratives. The authors could add material on these points to the introduction/background and to the later discussion.

2. As well, I suggest the authors further develop the discussion on the goals and content of comprehensive PHC. Ref 35 (Labonte et al, 2008) identifies meaningful community participation, multidisciplinary teams and action across all sectors as key features of comprehensive PHC. It’s a bit unclear if the last point implies advocacy for action across all sectors or if it extends to cover the actions themselves. Also how ‘multi’ should multidisciplinary teams be? Which disciplines or ways of working should be added to achieve comprehensiveness? I think developing the discussion on key characteristics of comprehensiveness is worth doing because it may give some more scope to talk about what PHC needs in order to address SDH in the Discussion and Conclusions sections.

3. I would also add a point on the relatively low position PHC managers tend to occupy in the bureaucratic hierarchy. Not only do they have limited influence to extend and develop PHC, but they are also not well positioned to influence or make decisions on broader healthy public policies addressing SDH in the health sector or beyond. They can be advocates, but have to persuade others (who may have other interests) to take action.

4. P 6-7 ‘The adoption of selective models is also underpinned by the lack of any serious research or policy attention to what comprehensive models of PHC look like in practice’.

This is an important point, but the paper’s next sentence underplays its significance by focusing on the selective vs comprehensive PHC tension. A suggested rewording of the previous and next sentence is:

‘The adoption of selective rather than comprehensive PHC models is also underpinned by the lack of any serious research or policy attention to what comprehensive models of PHC could or should look like in practice. In the 2008 Now More Than Ever WHO report on PHC, there is no attempt to articulate or describe possible practices of comprehensive PHC. Nor does the report suggest how such practices could evolve from more selective PHC models. This presents PHC practitioners and managers with dilemmas, reminiscent of Hoggett ....etc
P7 Broom’s book. I think more can be made from Broom’s insights here – can be they summarised, do they have applicability for comprehensive PHC?

It may be helpful to add some examples from ref 37 (Legge et al) and/or other international refs to illustrate successful PHC projects on community involvement and/or addressing SDH, to demonstrate that some ways of addressing SDH in PHC are possible. I think the paper’s the background/introduction gives a nuanced account of the constraints on PHC when addressing SDH (as do the findings and discussion section), but some readers may presume the arguments are indicating that addressing SDH is ‘too hard for PHC’. A discussion that unpacks which particular aspects of SDH PHC teams may be better placed to address later in the paper may help.

5. I would place the sentence (bottom p7) ‘This paper reports on research... etc’ at the beginning of a new paragraph.

6. P8 Methods
The methods used are appropriate and sound and this section is clearly written. The findings have been clearly derived from the data.

7. P10 Findings
Conceptualising, understanding and developing a practice in relation to SDH

The paper describes the SDH as a heterogeneous group of factors influencing health that differ in scale, the extent to which they are contested, and the extent to which PHC can directly address them. Given this, is it possible to unpack the heterogeneous factors and identify some that are more possible and/or amenable to change by comprehensive PHC? This implies it may be possible for PHC teams to develop practices to address SDH, rather than ‘a practice’, as the heading above describes.

P15. Add a reference if possible on the Community Foodies program,
P16- last sentence above paragraph on Advocating for access to services. A suggested rewording is marked in track changes.

These examples indicate how PHC service staff see their role as going beyond the provision of services to one in which they create welcoming spaces in which people feel comfortable, and provide opportunities for social connection and link them to other (non-health) services and programs.

In this way they were increasing opportunities for clients to use services, and especially for clients who faced barriers to using services for cultural, gendered or other social reasons.

P17 Advocates for policy change.

Is it possible give more detail on these advocacy campaigns? Are there references (papers or online reports) for the People’s Alcohol Action Coalition, and the other examples of advocacy by Congress? What about the NT Intervention by the federal government – did Congress make submissions on
Is there a reference for Shine SA’s school-based sexual health program?
P20 – last paragraph on a balance between immediate needs and action on SDH. A suggested reworking is marked in track changes.

One of the crucial factors which mitigated against the services undertaking action on SDH was the difficulty balance reported by respondents of their attempts to strike a balance between concentrating on peoples’ immediate needs as opposed to and taking action on underlying determinants. Immediate clinical needs usually won out.

8. One factor not discussed that could explain some of the difficulties PHC services had in taking action on SDH is capacity. Table 1 gives examples of the disciplines employed by the six services. Did any service employ workers who did not have clinical or managerial responsibilities, and therefore could focus on innovative programs and/or advocacy work? What sort of knowledge and skills are needed for PHC teams to take effective action on SDH? Should PHC teams be including and/or developing new occupational categories (as the Community Health Program did in the 1970s)? These points should be included in the discussion.

9. P23

The paper refers to the interesting concept of ‘dilemmatic space’ which PHC are required to traverse. There are many tensions within this ‘dilemmatic space’, including tensions between clinical and health promoting perspectives, and bureaucratic and community based perspectives on needs and legitimate responses. Can the concept of ‘dilemmatic space’ be extended to refer to the public realm (at local, state and national levels) where debates on issues and contests between responses are played out? This idea underscores the need for advocates of comprehensive PHC to be able to speak publicly without fear of loss of PHC funds or position.

P23 ‘the discourse on SDH itemises a number of conditions (mimicking behavioural epidemiology and its lists of specific risk factors.......potentially adding to workers’ sense of not being able to make much of a difference’

This is an important point, deserving of more detail.

10. There are different types of limits to action on SDH from PHC. They include:

- The lack of capacity/resources in most comprehensive PHC teams to do long term work to address SDH, and that links local issues and state/national actions
- The limited extent of any health sector response without involvement of other key sectors – although some advocacy and/or action is possible on some issues (eg the Health in All Policies work in South Australia, and the recent submission from a health promotion team in Sydney South West Local Health District to the Senate Committee considering the adequacy of the allowance payments for jobseekers)
- Potential conflicts with other interests and practices in other sectors of
government, and corporate or private sectors.

It is reasonable for the paper to acknowledge that it is likely that PHC will not be able to effectively address all SDH, and/or will need to be part of a much wider alliance of advocates to do so. One way to put a stronger argument for a role for PHC in addressing SDH may be to identify which issues and strategies PHC may be better placed to address. Such issues may include:

- Creating awareness of the impact of SDH on health issues experienced by the communities which PHC teams serve
- Advocacy for and involvement in developing local responses to these issues
- Advocacy for developing higher level responses to these issues
- Inter sectoral health promotion programs (at local and wider levels) based on socio-ecological perspectives.

This reflects the point made above that it may be easier to develop a series or range of practices through which PHC teams can address SDH, than aim to develop ‘a practice’.

The Ottawa Charter’s framework of five action areas (building healthy public policy, creating supportive environments, strengthening community action, developing personal skills and reorienting health services) may be helpful language and categories for PHC teams to describe and explain their local and other work on SDH to funders and community members. There are examples of successful health promotion and PHC programs in all five action areas. This body of evidence can be used to demonstrate that such actions are possible and effective, even politically desirable.

11. As the paper states on p24 building alliances and the development of PHC as a social movement is an important strategy. In Australia advocacy for comprehensive PHC has been eroded because government support was withdrawn. Other agencies with competing perspectives on PHC and other health issues have enjoyed independent funding and so have maintained their voices and consolidated their position in public and political debate. A revived comprehensive PHC advocacy body would probably need to be similarly independent of government funding. These points should be included.

12. P25 Conclusion

I suggest that the authors consider adding to their conclusion the points in regard to:

- Some SDH issues and strategies may be more suitable/feasible for PHC teams to address than others
- It may be more feasible to develop a range of practices, rather than ‘a practice’
- Could further research identify examples of effective work on SDH by PHC teams, and then seek to describe the types of policy, resource and managerial environments that made them possible?
**Level of interest:** An article of importance in its field

**Quality of written English:** Acceptable

**Statistical review:** No, the manuscript does not need to be seen by a statistician.

**Declaration of competing interests:**

I declare that I have no competing interests.