

Primary health care reform, dilemmatic space and risk of burnout among health workers

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Abstract

Health system changes may increase primary health care workers' dilemmatic space, created when reforms contravene professional values. Dilemmatic space may be a risk factor for burnout. This study partnered with six Australian primary health care services (in South Australia: four state government–managed services including one Aboriginal health team and one non-government organisation and in Northern Territory: one Aboriginal community–controlled service) during a period of change and examined workers' dilemmatic space and incidence of burnout. Dilemmatic space and burnout were assessed in a survey of 130 staff across the six services (58% response rate). Additionally, 63 interviews were conducted with practitioners, managers, regional executives and health department staff. Dilemmatic space occurred across all services and was associated with higher rates of self-reported burnout. Three conditions associated with dilemmatic space were (1) conditions inherent in comprehensive primary health care, (2) stemming from service provision for Aboriginal and Torres Strait Islander peoples and (3) changes wrought by reorientation to selective primary health care in South Australia. Responses to dilemmatic space included ignoring directives or doing work 'under the radar', undertaking alternative work congruent with primary health care values outside of hours, or leaving the organisation. The findings show that

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comprehensive primary health care was contested and political. Future health reform processes would benefit from considering alignment of changes with staff values to reduce negative effects of the reform and safeguard worker wellbeing.

Keywords

burnout, health care reform, health promotion, primary health care

Introduction

Reform is a feature of health systems globally (Braithwaite et al., 2005). Health reforms can increase job stress (Denton et al., 2002) and reduce health workers' motivation and performance (Franco et al., 2002). The 'Comprehensive primary health care in local communities' project partnered with six Australian primary health care (PHC) services in 2009–2014 and occurred at a time of considerable change in PHC in Australia. In a previous paper, on services' ability to act on social determinants of health (Baum et al., 2013), we concluded that partly as a result of these changes, PHC workers were traversing 'dilemmatic space', a concept explored by Hoggett et al. (2009) in development work in the United Kingdom. 'Dilemmatic space' emphasises that dilemmas are not events, but reflect ever present turbulence, conflicts and difference (Honig, 1994). Hoggett et al. (2009) applied this concept to the tension development workers faced in working for the state while, as part of their jobs, championing those in disadvantaged circumstances, which sometimes placed them in opposition to the state. Development workers were, thus, not faced with discrete dilemmas, but constantly resisted, negotiated or otherwise dealt with this tension. Dilemmatic space can be defined as the presence of ongoing conflict between workers' values – the morals and ethos they bring to their work – and the ways in which they are required to work. Fransson and Grannäs (2013) note the importance of the relational aspect of dilemmatic space, and that it results from the dynamic relationship between structural conditions and individuals' values, such that conditions give rise to dilemmatic space differently from individual to individual.

There is extensive documentation of conflict between structural conditions and workers' values in the community development and health promotion literature (e.g. Ife, 2013; Laverack, 2004; Schneider et al., 2008; Stern and Green, 2005; Werner, 1981). The concept of dilemmatic space may be useful for capturing these conflicts and examining the effects on workers.

Health or social service reforms can increase dilemmatic space for workers. Schram and Silverman (2012) found that US welfare and drug treatment reforms that introduced performance management focusing on treatment adherence and disciplining clients for non-compliance meant workers were unable to act on their community and altruism values, and were instead forced largely to police and discipline their clients. Newman and Lawler (2009) documented changes that led to increased conflicts and decreased morale for nurse managers. Denton et al. (2002) reported that a restructuring of home care in Canada increased home care nurses' workloads and job stress, and reduced their ability to do 'caring' work.

Burnout

‘Burnout’ is a condition arising from prolonged exposure to chronic stress, characterised by feelings of emotional exhaustion, depersonalisation (developing cynical, negative attitudes towards clients) and reduced personal accomplishment (feeling there is little they can do to help; Maslach et al., 1986). Burnout is associated with poorer physical and mental health (Ahola and Hakanen, 2014) and a strong predictor of turnover and intention to leave an organisation (Mor Barak et al., 2001). Organisational factors such as participation in organisational decision making and peer and management support can affect rates of burnout (Maslach and Jackson, 1984; Nahrgang et al., 2011).

Hoggett et al. (2009) hint at burnout-like symptoms from dilemmatic space – workers being ‘beset by anxiety’ and ‘passivity and a feeling of impotence’ (p. 30). They argue that dilemmatic space can lead to demoralisation and feelings of depression and despair (Hoggett et al., 2009). The potential for a link between health reforms, dilemmatic space and burnout has not been explored in the literature.

Current study: comprehensive PHC

This study examines the relationships between health system changes, dilemmatic space and burnout among PHC workers. Comprehensive PHC is an approach to health care and health promotion that emphasises a social view of health, community participation, equity and action on social determinants of health. ‘Comprehensive’ is used to distinguish this approach from ‘selective’ PHC (Walsh and Warren, 1979) which focuses more on specific diseases and selected biomedical interventions and less on equity and social determinants. Comprehensive PHC is inherently political and contested (Baum, 2008). The advocacy and action on social determinants principles of comprehensive PHC can challenge existing power structures and place practitioners in opposition to the governments that fund their work (Labonte et al., 2008). This suggests that comprehensive PHC is ripe for dilemmatic space. However, there have been no published studies on dilemmatic space among PHC workers.

In Australia, comprehensive PHC is most evident in the 150 Aboriginal community-controlled health services nationwide (NACCHO, 2014), and in certain states, multi-disciplinary community health services that had their roots in a 1973 national community health programme. Our study partnered with one Aboriginal community-controlled health service, four state-managed services and one non-government organisation (NGO) to examine comprehensiveness, using programme logic models to capture their implementation of comprehensive PHC (Lawless et al., 2014), and methods including workshops with community members (Freeman et al., 2014), staff surveys and interviews (Baum et al., 2014; Freeman et al., 2016), and case studies of intersectoral action (Anaf et al., 2014) to evaluate services against the logic models. However, during the research, state government policy changes increasingly affected the state-managed services, putting into question the services’ comprehensive PHC value base (Jolley et al., 2014). We have previously noted (Baum et al., 2013) that as the services in our study became subject to increasing change, workers’ dilemmatic space was possibly increasing. The state-managed services have since been reoriented even more heavily towards selective PHC,

with their health promotion funding and mandate cut, a curtailment of community development, intersectoral collaboration and social determinants work, and a strong focus on seeing individuals, particularly for chronic conditions such as diabetes and heart disease. This article examines a survey, and interviews with practitioners, managers, regional executives and state health department staff, to explore the effect of these changes in terms of the following:

1. Whether workers experienced dilemmatic space, and whether this was related to feelings of burnout;
2. The conditions associated with dilemmatic space;
3. How workers responded to dilemmatic space.

Method

Case study services

The research was conducted in partnership with six PHC services from 2009 to 2014. All services had a pre-existing relationship with the research team and were selected to maximise diversity. Central Australian Aboriginal Congress Aboriginal Corporation ('Congress'), an Aboriginal community-controlled service, and SHine SA, a sexual health NGO requested to be identified in publications. The state government services are anonymised as Services A, B, C, D (an Aboriginal health team) and E. Service B withdrew in 2012, due to high staff workloads, organisational change and change of manager. Such turnover was not unexpected for a 5-year project occurring in a time of substantial change. Service E, another state-managed PHC service, participated as a replacement service.

Staff survey

An online survey of practitioners and managers was conducted between October 2012 and February 2013. Managers at each service invited all practitioner and management staff to participate via email and were invited to complete the survey themselves. Each manager sent two reminder emails to staff over the period the survey was open. Staff were also provided with a hard copy of the survey with a reply paid envelope in case they preferred to complete the survey in hard copy. There were a total of 154 responses (response rate 58%) from Services A ($n=5$, response rate 38%), C ($n=20$, response rate 65%), D ($n=10$, response rate 77%), Service E ($n=24$, response rate 86%), Congress ($n=59$, response rate 45%) and SHine SA ($n=35$, response rate 66%).

The survey questionnaire was developed drawing on PHC literature and previous findings from staff interviews, with a total of 86 items. The survey questions used here are included as online supplementary material. Workers' values in relation to key comprehensive PHC attributes (prevention and health promotion, community participation and addressing social determinants of health) were measured using nine items with responses on a 5-point Likert-type scale (1=*strongly agree*, 5=*strongly disagree*). Dilemmatic space was measured by items on satisfaction with the balance of treatment, prevention, promotion and administration work, and with balance of individual, group

and community work (yes/no for satisfied and spend more time/spend less time/or no change for each type of work). Burnout was assessed using the item 'How often did you feel burned-out by your work in the last year?' (most days, weekly, monthly, occasionally, never). The need to cover multiple PHC topics precluded the full Maslach Burnout Inventory, and single item measures of burnout have been found to perform adequately (Rohland et al., 2004; Schaufeli et al., 1993). Existing single item measures were found to be overly long, and given the understanding of the term burnout among health professionals, we judged the item above to be an appropriate, quick self-report measure.

The questionnaire was piloted on three staff from a non-participating PHC service. Ethical approval was received from the Southern Adelaide Clinical, SA Health and Aboriginal Health Research Ethics Committees. Due to low staff numbers at the small government services, the three non-Aboriginal-specific state-managed services were grouped together for analysis. Rates of burnout were compared across services using an analysis of variance (ANOVA), and satisfaction and desire to do different kinds of work were compared across services using chi-square tests. Independent sample *t* tests were used to examine differences in burnout between staff who wanted or did not want to alter their work balance. Cohen's *d* was calculated for each *t* test to measure effect size (Cohen, 1977).

Staff interviews

From June 2013 to March 2014, 63 interviews with practitioners and managers from the services, and regional executives and health department staff, provided an opportunity to further investigate dilemmatic space. Participants were staff who had been interviewed in a first round of interviews in 2009–2010. The 2013 interviews sought to examine changes in PHC practice since that time. Of the 60 original staff interviewees in 2009–2010 (excluding administrative support staff, as they were not relevant to the aims of the follow-up study), 33 (55%) were still employed at the same organisation, with only minor variations in roles. For the remaining, the practitioner in the previous interviewee's role was requested, or in the role closest to that of the original interviewee when that role no longer existed. Service B, though withdrawn from the study, consented for the three original interviewees still employed at the service to participate in the 2013 interviews (five original interviewees were no longer at the service and management did not consent to invite alternative interviewees). For Service E, which did not participate in the initial interviews, a mix of disciplines was sought that included representation from the different work teams in the service. The characteristics of the services are summarised in Table 1, and the interviewee characteristics are summarised in Table 2.

Interview questions were developed by the research team based on the attributes of PHC (e.g. equity of access, health promotion, action on social determinants) and data collected on PHC changes during 2009–2013. Interview questions were piloted on two practitioners and one manager from non-participating PHC services. The interview questions are included as online supplementary material. Interviews were conducted at the interviewees' place of work, taking between 30 and 70 minutes. Interviews were audio recorded, transcribed and de-identified. Ethics approval for the interviews was received from the Southern Adelaide Clinical Human Research Ethics Committee and the Aboriginal Health Research Ethics Committee, South Australia.

Table 1. Characteristics of the case study PHC services in 2013.

	Budget (p.a.) \$AUD		Main source of funding	Approximate no. of staff (Full time equivalent)		Examples of disciplines employed
	2010	2013		2010	2013	
Service A	\$1.2m	\$0.5m ^a	SA Health	16 (13.5)	10 (8.1)	Social worker, speech pathologist, occupational therapist, dietitian
Service B	\$1.1m	\$1.3m ^b	SA Health	26 (20)	28 (15.7) ^b	Nurse, doctor, podiatrist, social worker, PHC worker, speech pathologist, lifestyle advisor, dietitian
Service C	\$1.7m	\$1.6m	SA Health	36 (22)	25 (15.3)	Nurse, dietitian, speech pathologist, psychologist, occupational therapist, social worker
Service D	\$0.5m	N/A ^c	SA Health	12 (10.8)	N/A ^c	Aboriginal health worker, Aboriginal PHC worker Aboriginal primary mental health support worker, youth workers
Service E	N/A ^d	\$1.7m	SA Health	N/A ^d	21 (16.6)	Social worker, dietitian, psychologist, speech pathologist, nurse, occupational therapist, community health worker
Congress	\$20m	\$20m	Dept. of Health & Ageing	320 (188)	310 (204.5)	Medical officer, psychologist, social worker, youth worker, midwife, nurse, Aboriginal health worker, pharmacist
SHine SA	\$6.1	\$5.8m	SA Health + Dept. of Health & Ageing	100 (55)	68 (50.7)	Medical officer, nurse, counsellor, education coordinators, disability worker, Aboriginal youth support worker

PHC: primary health care.

^aApproximate – budget was combined with another site. Budget for two sites was \$1.1m.

^bAs of 2011, due to service withdrawing.

^cService was restructured and merged with another service, cannot calculate a comparison with 2010.

^dNot available, as service joined study in 2012.

Analysis

Transcripts were checked and imported into analysis software (QSR NVivo). Initial codes based on the PHC topics covered in the interviews were developed, discussed in regular team meetings and expanded upon as new themes were identified. Once the coding scheme was developed, four interviews were double-coded or triple-coded, and the remaining

Table 2. Characteristics of interviewees.

Characteristic	n (%)
Regional executive	3 (5%)
South Australian Health Department staff	3 (5%)
Service	
Service A	7 (11%)
Service B	3 (5%)
Service C	8 (13%)
Service D	7 (11%)
Service E	8 (13%)
SHine SA	9 (14%)
Congress	15 (24%)
Role at service	
Manager	15 (24%)
Board member	3 (5%)
Practitioner	39 (62%)
Aboriginal health worker	6 (10%)
Nurse	6 (10%)
Medical officer	4 (6%)
Social worker	6 (10%)
Speech pathologist	2 (3%)
Occupational therapist	2 (3%)
Psychologist	4 (6%)
Dietitian	2 (5%)
Lifestyle advisor	2 (3%)
Other	4 (6%)
Total	63 (100%)

interviews split between researchers, who met to discuss themes regularly. Organising the data by service allowed themes to be compared and contrasted across services (Bazeley, 2013). Emerging findings were discussed in research team meetings, and alternative explanations considered, ensuring rigour through constant monitoring of analysis and interpretation (Morse et al., 2002). TF led the analysis on dilemmatic space and burnout.

Results

The survey provided findings on staff alignment with comprehensive PHC principles and the extent of dilemmatic space and burnout. The interviews provided detail on the conditions associated with dilemmatic space, and how staff responded to dilemmatic space.

Extent of dilemmatic space and burnout

A strong majority of staff's values aligned with comprehensive PHC tenets of prevention, health promotion, community participation and action on the social determinants of health (see Table 3).

Table 3. Comprehensive PHC values reported by service staff (N= 154).

	<i>Strongly agree (%)</i>	<i>Agree (%)</i>	<i>Neither agree nor disagree (%)</i>	<i>Disagree (%)</i>	<i>Strongly disagree (%)</i>
Prevention and health promotion					
Assessing and treating individual clients is an optimal way for me to function professionally	16	37	25	15	7
Given the scarcity in resources, existing resources should be used for treatment programmes rather than preventive programmes	4	5	16	44	32
Primary prevention is a value to our service	56	35	5	1	4
Community participation					
Participation of community in the planning, delivery and evaluation of PHC is important to the quality improvement of PHC services	49	45	6	1	0
The planning and operation of PHC services are professional functions which should not be influenced by pressures from the community	3	7	12	47	30
Social determinants of health					
With limited professional resources, it makes more sense to use established knowledge to treat clients rather than trying to deal with social conditions which may cause health problems	0	12	18	43	27
My professional mandate is to treat individual clients and not the social conditions influencing health	3	10	19	41	27
PHC services should give a high priority to lowering the rate of new cases in the community by reducing harmful social and environmental effects	39	43	15	1	2
PHC services do not have a responsibility to address the social determinants of health	2	4	10	28	57

PHC: primary health care.

Table 4. Satisfaction with balance of work (yes/no), desire to do different types of work (yes/no) and average rates of self-reported burnout (ranging from 1 = never to 5 = most days), by service.

	Congress (n = 50)	SHine SA (n = 34)	Service D (n = 9)	Government services (A, C, E) (n = 44)	χ^2 (df = 3)	p
Satisfied with health promotion/prevention/treatment/administration balance	64%	71%	78%	56%	2.77	0.43
Wants to do more health promotion	32%	26%	20%	36%	1.64	0.65
Wants to do more prevention	27%	20%	10%	26%	1.80	0.61
Satisfied with individual/group/community work balance	71%	74%	67%	67%	0.51	0.92
Wants to do more group work	19%	17%	30%	14%	1.56	0.67
Wants to do more community work	20%	26%	30%	26%	0.80	0.85
					F	P
Average rate of self-reported burnout	2.86 (SD = 1.39)	2.82 (SD = 1.22)	3.11 (SD = 1.62)	2.59 (SD = 1.11)	0.60	0.61

SD: standard deviation; df: degree of freedom.

There were no differences between services on satisfaction with balance of work, desire to do different work or burnout (see Table 4). At each service, the majority of workers were satisfied with their balances of work, but a sizeable minority (10%–36%) wanted to do more health promotion, prevention and group and/or community work. Very few wanted to do less prevention ($n=2$, 1%), health promotion ($n=3$, 2%) and group ($n=1$, 1%) or community work ($n=2$, 1%). Further analysis comparing managers with practitioners indicated that practitioners were more likely to be dissatisfied with their balance of treatment, prevention, promotion and administrative work (practitioners: 41% dissatisfied, managers: 15%), and their individual, group and community work (practitioners: 30%, managers: 13%).

With the exception of Service D, the Aboriginal health team, who reported an average burnout rate greater than once a month (mean > 3), the average rate of feeling burned out was less than monthly (mean < 3), but more than ‘occasionally’ (mean > 2).

As shown in Table 5, staff dissatisfied with their balance of treatment, prevention, health promotion and administration work reported higher rates of burnout than those who were satisfied (small-to-medium effect size). Those who wanted more prevention or more health promotion work reported higher rates of burnout than those who did not

Table 5. Average self-reported frequency of burnout (ranging from 1 = never to 5 = most days) by desire to do more prevention, health promotion, group work or community work.

	n	Burnout		t (df)	p	d ^a
		M	SD			
Satisfied with balance of treatment, prevention, health promotion, administration	85	2.59	1.27	2.3 (131)	0.023	0.41
Not satisfied with this balance	48	3.1	1.19			
Satisfied with balance of individual, group, community work	91	2.54	1.17	3.26 (129)	0.001	0.62
Not satisfied with this balance	40	3.27	1.24			
Wanted more prevention	34	3.26	1.21	2.62 (135)	0.010	0.52
Did not want more prevention	103	2.62	1.25			
Wanted more health promotion	46	3.09	1.21	2.03 (135)	0.045	0.37
Did not want more health promotion	91	2.63	1.28			
Wanted more group work	27	3.44	1.25	3.13 (135)	0.002	0.65
Did not want more group work	110	2.62	1.27			
Wanted more community work	36	3.31	1.24	2.97 (135)	0.004	0.59
Did not want more community work	101	2.59	1.23			

SD: standard deviation; *df*: degree of freedom.

^aCohen's *d*, effect size, where 0.2 = small effect, 0.5 = medium effect and 0.8 = large effect (Cohen, 1977).

(medium effect size and small-to-medium effect size, respectively). Similarly, those who wanted more group work, or more community work, reported higher rates of burnout than those who did not (medium-to-large effect size and medium effect size, respectively). Staff wanting more prevention, health promotion and group and/or community work on average reported burnout more than monthly ($M > 3$), while those not wanting more of such work reported burnout less than monthly on average ($M < 3$).

Qualitative accounts of dilemmatic space

The qualitative accounts were consistent with the survey results. There was evidence of considerable stress, burnout and turnover amongst staff at the South Australian services. There was a high level of reported dilemmas and interactions between them, indicating the PHC environment was not an easy space to work in. In particular, many staff reported how they valued doing disease prevention, health promotion, group work and community work, but were unable to continue to do this work, as a critical dilemma, supporting the selection of indicators of dilemmatic space in the survey analysis. It was clear to staff that the dilemmas were contributing to high stress, burnout and turnover, for example,

I think that's been very stressful here to be involved in [high turnover of staff], because I think the people in those roles, all of them actually, ones who are current and ones who have left have been very pro community health perspectives and they're slowly being eroded to reflect what the new way things are going to look, and they're having to pass that on to staff who they've

had a long history with of working in a different way. And that incongruence I think has been a big effect. (Practitioner, state-managed service)

Conditions giving rise to dilemmatic space

Three conditions that were giving rise to dilemmatic space when they conflicted with some workers' values were identified in the interviews: (1) conditions inherent in comprehensive PHC, (2) service provision to Aboriginal and Torres Strait Islander peoples and (3) changes wrought by reorientation to selective PHC in South Australia:

1. Conditions inherent in comprehensive PHC

Because of the political nature of comprehensive PHC, and its aims of challenging systems to reduce inequities, there is likely to be a level of dilemmatic space that is always present in comprehensive PHC work. Staff values of improving health and wellbeing in the community came into conflict with the limitations of what the health service could achieve, and the systems contributing to ill health in the community. For example,

People who are newly arrived refugees ... or overseas students without Medicare cards ... We try and cater for them. It was always tricky and always hard, but we tried to devise a way in which we could make contraception more accessible for those people. ... We try and advocate for them, try to get the drug companies to give us more supplies for free. It didn't work. But anyway, we tried. (Practitioner, Shine SA)

Some staff felt this was exacerbated by the fact that comprehensive PHC, compared with other areas of the health system such as tertiary care, received less political regard and support:

Sitting around with people for a good long while to really talk through how vulnerable and how terrible they're feeling and what are the referral options – particularly if you've got multifacets, a chronic disease or a couple of issues, which most of our clients have – isn't popular, isn't okay, it's not deemed looking efficient. ... The throughput of the acute sector, as poor as it is, is considered the pinnacle. (Practitioner, state-managed service)

Because of these factors, it is highly likely that some staff will experience dilemmatic space in comprehensive PHC work.

2. Aboriginal and Torres Strait Islander health care provision

Hoggett et al. (2009) describe the tension between being employed by the state and serving those in disadvantaged circumstances. This tension is particularly applicable to workers providing services for Aboriginal and Torres Strait Islander peoples in the face of ongoing colonisation, racism and discrimination. There was conflict evident at the two Aboriginal PHC services between staff trying to improve Aboriginal and Torres Strait Islander health and the challenge of addressing multiple, complex adverse social determinants of health:

I've got a lot of staff who sometimes are in tears because of some of the cases they're working with and frustration, and with DCF [Department of Children and Families] and some of the systems. ... It can be very draining. It can cause a lot of burnout of staff. (Manager, Congress)

There was a sense from some staff that they were trying to improve Aboriginal and Torres Strait Islander health while other government actions undermined health, for example,

I think the NT, behind Western Australia, have got the highest incarceration rates of Aboriginal people, for our mob, and here we have got a government that is going to lock more of our mob up. It is just very sickening. (Manager, Congress)

Being a community-controlled organisation, Congress had more control over their ways of working than the state-managed service, but being funded by government still generated some dilemmas for Congress, such as short-term funding leading to 'program uncertainty ... some of our best programs being under threat' (Congress, Manager) and short-term contracts for staff. However, managers had a voice in negotiation around funding and performance indicators that was not present for the state-managed services.

3. Changes wrought by reorientation to selective PHC in South Australia

Health department staff, regional executives, managers and practitioners described a reorientation from comprehensive PHC work rooted in a history of community health to a selective PHC focus on supporting individuals with chronic disease. All South Australian services experienced funding cuts, both defunding of specific programmes, especially health promotion and community development programmes, and reductions in core funding. This is in contrast with a history of strong policy support for comprehensive PHC, such as the 1988 Social Health Strategy (South Australian Health Commission, 1988).

SHine SA was moved under the sexually transmitted infections and blood-borne virus branch of the health department, and entered into a new service agreement with the department that reoriented the service to focus more on sexually transmitted infections, and less on family planning and other services.

Many workers' roles changed, and the kinds of work staff were able to do changed dramatically. Turnover was substantial, as evinced by only 55 per cent of the 2009–2010 interviewees remaining at their service by 2013. Responses in the survey and interviews painted a negative evaluation of most of the changes over the preceding 5 years, as well as considerable uncertainty over the future. Low morale and high distress was evident. Workers referred to 'a traumatic time of change' (Practitioner, state-managed service), and 'a lot of anger ... a lot of sadness' (Manager, state-managed service). Staff went beyond just change fatigue (of which there was a lot) to articulate how the changes had caused their work to contravene their values.

Congress also experienced changes. There was a change in CEO, composition of the board and election of board members, and in how the organisation was incorporated.

The service expanded into new sites around the town, resulting in movement of staff and programmes between buildings. Reflections on changes were milder in tone, however, when compared with South Australian staff, with comments such as 'People don't like change, it's been a bit disruptive, but I think it's all been fairly positive' (Practitioner, Congress), and 'Morale is pretty low at the moment ... it affects the well-being of the staff and in the long run it affects productivity' (Manager, Congress). The differentiating factor at Congress was that changes were not centrally imposed, and no staff reported that changes went against their values, or created dilemmatic space.

The reorientation to selective PHC in South Australia conflicted with staff values of working from a social view of health that took into account the social determinants of health, and of preventing ill health and promoting health in the community as well as treating ill health. The changes created dilemmatic space in the following ways.

Confinement to individual approaches. Staff were faced with the dilemma of wanting to promote health and wellbeing through working with individuals, groups and in the community, whereas the reorientation to selective PHC only permitted individual work, which they perceived would not on its own be effective: 'I don't think the one-on-one model is an effective model when trying to support people around their social determinants of health' (Practitioner, state-managed service). One dietitian reflected,

I've got clients coming for nutrition counselling where the whole premise is based on 'tell me what you're eating and let's work out where we can improve that'. So these people are coming with 'I've run out of money for food this week', 'I don't even have any food in the house' or people who are struggling to live off their partner's wage because they can't work at the moment because of their health, or people who are on disability support pensions, due to their mental health or disability, so people are coming with these very real needs and then it's all very good for them to be referred for nutrition counselling, but nutrition counselling isn't really going to meet that need. (Practitioner, state-managed service)

The dietitian contrasted this with an example of a past intersectoral collaboration that was felt to be more effective:

There's some great programs out there with SA Housing as a collaboration, where they would fund for a utensil kit, so not only are they doing hands on cooking classes and getting recipes that were cheap and affordable, but each week you'd get a utensil that you get to keep, that you used to make that recipe with, and then you're equipping them with knowledge, information, skills and equipment. (Practitioner, state-managed service)

Almost all state-managed service group activities ceased, including those on cooking, exercise, domestic violence support and groups for Aboriginal Men, Women and youth. Examples of the community work that ceased included community events, the Community Foodies peer education nutrition programme, and talks at agencies such as schools, kindergartens and community centres.

Two of nine SHine SA staff reported a heavier focus on sessions with individuals at the expense of group and community work. One SHine SA worker highlighted a

potential side effect of the focus on individuals on workers' risk of burnout in addition to creating dilemmatic space:

There was research to identify that the burnout in vicarious trauma was higher for workers who didn't also get involved in social action and community development and advocacy and research in other areas, because they're not feeling like what they're hearing behind closed doors can be effective on another level. (Practitioner, SHine SA)

Indeed, there is research that diverse caseloads and opportunities to participate in social change activities can help prevent vicarious trauma among human service workers who see clients with high levels of trauma (Bell et al., 2003), as workers at PHC services would. It is these kinds of social change activities that have been removed from the mandate of the state-managed services. While SHine SA did experience curtailing of some activities due to service agreement specifications, they reinstated some of these through sourcing alternative funding. For example, pap smears were a prevention activity valued by staff and clients. When the service agreement did not fund pap smears, SHine SA was able to set up a fee for service pap smear clinic.

Congress did not report pressure to alter their balance towards individual work. This was not reflected by higher satisfaction scores in the survey (32% of Congress staff were not satisfied with their balance of health promotion, prevention and treatment work, and 25% were not satisfied with their balance of individual, group and community work), suggesting that Congress struggled as much as any other comprehensive PHC service to balance these different aspects of work. Nevertheless, in contrast to the state-managed services, Congress staff reported support from management to undertake community and advocacy work, and workforce planning to ensure a staffing model with capacities in community work as well as clinical work.

Lack of support for a social view of health. Even in individual work, which will always be a component of comprehensive PHC, the selective PHC changes saw an almost exclusive focus on chronic physical conditions, which conflicted with staff's social view of health that seeks to encompass many health and wellbeing issues:

I just think that there are so many people who aren't going to get any service. What about the people with domestic violence? What about the people with childhood sexual abuse, or abuse issues? What about people who have got a lot of trauma in their life over a long period of time? What about people who have got financial problems, or housing problems? Who is going to see the normal round of people that we see? I don't know. No one that I can work out. And it just seems like a very sad state of affairs. (Practitioner, state-managed service)

The early childhood teams were not as affected by this refocus on chronic disease as the adult services. This may have been partly due to the exclusion of early childhood services from the scope of the key review driving change. There are also indications from international literature that early childhood services tend to be spared the worst of budget costs or negative changes because 'investing' in early childhood is politically palatable and garners support across the political spectrum (Frankish et al., 2007). However, the push towards onsite one-to-one services did affect early childhood teams:

We used to run community talks and go to kindies [pre-school kindergartens] and be able to do more work off-site, whereas now all of our work is based here and there's definitely more one-to-one work. (Practitioner, state-managed service)

The focus on chronic diseases was not reported at SHine SA or Congress.

Lack of prevention and promotion work. The narrowed focus on working with people with chronic disease created dilemmatic space for staff by making them work in a way that went against their values of trying to prevent illness and promote health, for example,

Sooner or later it's going to set something off - the people that we're not preventing now. In 10 years' time they will be here in our chronic disease pool and everybody will be happy! That's what I can't understand. We'll have more work to do, it's not about that. I really thought we were there to prevent. (Practitioner, state-managed service)

Outcomes being valued. The outcome privileged in the reorientation to selective PHC was hospital avoidance, which conflicted with the broader health and wellbeing outcomes valued by staff. This resulted in staff facing dilemmas in the limitations of hospital avoidance, for example, 'You sit at home miserable and depressed but you don't come to hospital, that's fine' (Manager, state-managed service).

Conflicting with Aboriginal and Torres Strait Islander service provision. For the Aboriginal health team, the reorientation to selective PHC exacerbated the dilemmatic space arising from working to improve Aboriginal and Torres Strait Islander health. Issues such as heavy restrictions on off-site work were particularly stressful for some Aboriginal workers, as it put constraints on their ability to engage in culturally respectful ways:

The girls, the women here in this community are going, 'oh you're back', 'yeah', 'will you be able to follow me up still with [hospital]?'. Well I can't do that, because these days we can't even get a car. The stuff you've got to go through just to get a car and how you've got to justify every little thing you're doing during the day. You can't even breathe. (Practitioner, state-managed service)

This tension and risk of isolation placed Aboriginal staff members in potentially greater dilemmatic space than non-Aboriginal staff:

It's gone the white way, straight up ... it's like we're pleasing the government which is all run by white fellas, you might as well say, and we're not getting anything out for our community anymore ... I might as well just go out and be with my community members, at least we'll be together! I could be your fighter out there again! (Practitioner, state-managed service)

The tension was not evident at Congress, which was less subject to state-imposed changes.

Dilemmatic space embodied in buildings. As part of the reorientation to selective PHC in South Australia, Services C and E, one of Service D's two sites and a number of SHine

SA's clinics and offices moved into newly built PHC centres, and many Service A staff and programmes moved across to a new nearby PHC centre. While many staff were grateful for the new, purpose built centres, the buildings were for some staff a physical embodiment of the dilemmatic space they were experiencing, that their design 'correlates with a little bit of less focus on primary health' (Practitioner, state-managed service). The buildings were more clinical in nature than the previous community health buildings, especially Service E, whose previous building had been designed in close consultation with the local community in the 1980s. Some staff felt their new location contributed to changing their service from being a friendly point of entry and a place to empower people and promote community health to being a service that receives referrals for ill people:

the [old site] was a bit of a 'go to' place for people that weren't really sure where to go to. And so it was a great opportunity to give people lots of information about, 'If this is not the service for you, then maybe try this sort of service'. And so we still do have intake but it's certainly not a building – the feedback you get is that it's not a very welcoming building, so people aren't going to flock into it and go, 'What do you offer here, how can I be involved?' (Practitioner, state-managed service)

How the building went against the values held by staff and contributed to dilemmatic space was summarised by one worker as,

It's a get them in, get them out, fuck them off building. It's not welcoming, it's not soft, it's a hard building, it's a tough little – with its cold little corridors, and its little hand washing stations. It's a cold building and it doesn't help people to feel encouraged, or supported, when they are going through a hard time. (Practitioner, state-managed service)

Responses to dilemmatic space

Staff reported strategies for reducing dilemmatic space arising from the conditions described above. Staff undertook activities outside of work time that accorded with their comprehensive PHC values. Some staff had started an unfunded, volunteer-run community health organisation in their spare time. Another staff member continued to do domestic violence advocacy work in their own time. One staff member provided exercise classes in local community centres based on PHC principles of affordability and accessibility.

Staff described doing comprehensive PHC work 'under the radar'. They talked of 'working surreptitiously' and trying to 'sneak in a little bit of health promotion'. One worker described,

So if someone doesn't have transport to get to an appointment, I'm more than happy to go and visit them at home, or go and pick them up. If someone doesn't have a [blood glucose] meter, I'll go and chase up a meter. If someone wants to go to a group but they are feeling a little overwhelmed about going to a group, I'll chaperone them. Again they're just things that I would probably do under the radar, until such time I'm told not to do it, I'll continue to do it. (Practitioner, state-managed service)

At times, the work appeared to be less under the radar and more explicitly ignoring directives:

I have had directives that I am not allowed to leave the workplace without permission ... And of course I've taken no notice of that, because if I can't go to see other agencies, or to make connections with places and services that aren't here, I wouldn't be any good to people. (Practitioner, state-managed service)

Some staff rebranded comprehensive PHC work to fit under the new service priorities. For example, 'I'm still doing some community education just on general wellbeing. I couch it under the portfolio of either chronic condition management, or pre-diabetes'.

Part of the turnover at the services was people resigning because of the extent of dilemmatic space:

a lot because their jobs have gone, and some because they can't do it, or they don't want to do it anymore because it's not right. (Practitioner, state-managed service)

Some senior staff with a commitment to comprehensive PHC had left due to the extent of dilemmatic space, with one worker commenting on heads of discipline:

I think the people in those roles, all of them actually, ones who are current and ones who have left have been very pro community health perspectives and they're slowly being eroded to reflect what the new way things are going to look, and they're having to pass that on to staff who they've had a long history with of working in a different way. And that incongruence I think has been a big effect. (Practitioner, state-managed services)

Discussion

The findings demonstrate that staff were grappling with structural conditions that gave rise to dilemmatic space, and this was linked to rates of self-reported burnout. Dilemmatic space was exacerbated by the reorientation to selective PHC in South Australia that went against workers' comprehensive PHC values. Comprehensive PHC was indeed contested and political, often putting workers at odds with the government changes. Dilemmatic space arising from the reorientation to selective PHC was observed when staff dissatisfaction went beyond change fatigue to articulate how their work went against their values. This finding highlights the dynamic, relational aspect of dilemmatic space; the interactions between its different sources; and how these system changes were constricting the space to manage value conflicts, limiting the ability of workers to manage the burnout and work satisfaction issues typical of even well-functioning PHC practices.

The study drew on data from a survey and in-depth interviews. Although there were only four months between the closure of the online survey and the commencement of the staff interviews, there were significant changes in the intervening period. The government cut the health promotion funding to the state-managed services, and reoriented the services more towards assisting individuals with chronic diseases. Thus, the survey paints a more positive picture than the subsequent interviews. The survey indicated the

majority of staff were satisfied with their balance of work, and those experiencing dilemmatic space were a minority. In the subsequent interviews, however, workers reported generally low morale and high stress and rates of burnout.

The tension between Aboriginal ways of working and structural conditions has been observed for Aboriginal health workers (Dollard et al., 2001) and Aboriginal drug and alcohol workers (Roche et al., 2013). There are risks of considerable negative effects on Aboriginal workers' health and wellbeing, when they are forced to balance work expectations with their desire to help their community, and the community's expectations of the workers (Roche et al., 2013). It is not surprising that Aboriginal staff from the community-controlled service in this study did not report this tension to the same degree as the state-managed service. The Aboriginal community-controlled movement can be seen to a degree as outside and challenging colonial system pressures, although the requirements of funding bodies and other regulations limit this autonomy.

SHine SA experienced change largely through a new, prescriptive service agreement with the health department that they had little input into, and led to reorientation of the service. There was less evidence of dilemmatic space because, having the greater independence as an NGO, SHine SA could seek alternative funding sources to maintain the work that aligned with the organisation and staff's values. The lack of evidence of change-related dilemmatic space at Congress, despite some considerable changes and some external pressures, such as the requirements of funding bodies, is potentially attributable to not only its non-government status but also being community controlled, meaning the service was driven by community values and needs, not just the health system's needs. This difference may potentially reduce the likelihood of organisational changes that went against staff's values. Both SHine SA and Congress retained an explicit values base of comprehensive PHC, which the state PHC sector no longer acknowledged.

Reform of PHC is ongoing and global. Future reforms could benefit by having open communication with staff about the changes and alignment with their values. Practitioners' varied responses to the changes, including doing work under the radar and circumventing directives, indicates the importance of considering staff values as part of the change process in order to predict the effects changes will have on workers. The example of how the new buildings contributed to some workers' dilemmatic space indicates how far-reaching efforts for understanding alignment with workers' values needs to be, encompassing design of buildings and other major factors that might shape staff's work.

The limitations of the study are that it involved a small number of case study services in order to maximise depth. A broader survey of PHC services could examine the generalisability of the conditions associated with dilemmatic space. The survey was custom designed to understanding the issues that affected the PHC staff in our study. This provided the opportunity to explore a broad range of issues specific to the PHC landscape at the time of the study, at the expense of using established measures. The value items, burnout measure and dilemmatic space indicators were not validated. However, there are no established validated surveys on comprehensive PHC values or dilemmas, and there are significant context factors such as PHC terminology and local health system, community and health considerations that vary considerably between countries and across time that would be barriers to establishing validated measures. Our survey findings were corroborated in the qualitative accounts in the interviews. However, because of the lack

of validated measures and the cross-sectional nature of the survey, it can be seen as a preliminary exploration of the relationship between dilemmatic space and burnout that requires further investigation to establish causal relationships.

Conclusion

Dilemmatic space is a feature of comprehensive PHC work, particularly for Aboriginal and Torres Strait Islander PHC services. The reorientation to selective PHC in South Australia increased this dilemmatic space and affected the stress and morale of the state-managed service staff, and to a lesser extent, the NGO staff. Given how ongoing and unavoidable health reform is global, consideration of staff values and dilemmatic space is critical to improve the implementation of reforms and safeguard worker wellbeing.

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Supplementary Material

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