ACIL ALLEN CONSULTING

REPORT TO
PRIMARY HEALTH TASMANIA
31 AUGUST 2016

SOCIAL DETERMINANTS OF HEALTH PROGRAM EVALUATION

FINAL REPORT

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EXECUTIVE SUMMARY

The project was always very ambitious and did suffer with some unforeseen setbacks. However, all things considered it did achieve some remarkable outcomes in terms of community capacity building, skills and learning and has created a strong foundation for further interventions to address those social determinants of health which impact on diet, cooking and the use of locally grown produce.

Community Leader survey respondent June 2016

Purpose

ACIL Allen Consulting was commissioned by the then Tasmania Medicare Local and subsequently Primary Health Tasmania, to undertake an evaluation of the Social Determinants of Health Program. The Program was established to address the level of disadvantage in Tasmania with the aim of fostering local and sustainable solutions to improve health and wellbeing outcomes for communities. The evaluation was undertaken concurrent with implementation of the Program which commenced in September 2014 and concluded in June 2016. It was expected that the evaluation would contribute to an evidence base for future action on reducing inequalities in health and improving health outcomes across Tasmania.

Background

The concept of the 'social determinants of health' has been championed under the banner of the World Health Organization, which regards the determinants as potentially avoidable health inequalities that contribute to inequities in health outcomes. Health equity relates to the right to access services and supports such as health care, schooling and housing, as well as the opportunity for employment. It is recognised that to overcome health inequality, a holistic approach is required working across sectors and across community to address the social determinants of health.[1]

In 2012, the Australian Department of Health funded the Tasmanian Health Assistance Package aimed at strengthening health services in Tasmania and improving health outcomes. The then Tasmania Medicare Local received funding under the Package from the Australian Government for the Social Determinants of Health and the Health Risk Factors projects. Following stakeholder consultations in 2013, it was agreed that the Social Determinants of Health Program would be implemented through a place-based approach to address locally identified priorities utilising locally relevant strategies. 'Communities of priority' were identified across Tasmania that met the criteria of high levels of disadvantage and a sufficient service infrastructure to enable a collective approach to addressing the social determinants of health. Following an EOI process, a small number of communities were funded $50,000 each to further develop their proposals through a comprehensive

[1] World Health Organization (WHO) 2008, Closing the Gap in a Generation: Health Equity through action on the social determinants of health

project plan. Upon satisfactory completion of the planning, eight communities were approved for further funding of $300,000 to proceed to implement their projects over the 22 month period commencing 1 September 2014.

The Social Determinants of Health strategy developed by the then Tasmania Medicare Local also included support for state-wide workforce capacity building in the health and human services sectors, which was available to the selected communities. Training was specifically targeted at addressing the social determinants of health through a variety of modalities.

Community projects

The eight social determinants of health community projects were largely concentrated in the North West Region and Southern Region of Tasmania with one project in the Northern Region. All projects sought to better connect communities and impact levels of poverty in the short to longer term. Five of the projects addressed food security in community using a variety of strategies that included skills development, creation of formal training opportunities and building health literacy. Two other projects aimed to impact school retention rates, and a final project to improve access to services for youth by creating a hub of integrated services. Projects were supported by strategic partnerships that formed the project steering committee, and led by prominent service providers in community that included local government councils, community/neighbourhood houses, and non-government organisations. These organisations were well placed to take on leadership and coordination roles.

Method

The evaluation approach included:

- Development of an agreed program logic model for the overarching Program and establishment of a data collection framework to measure performance of the community projects
- Support to community projects to build evaluation capacity including development of individual program logic models aligned to the overall model, and use of a common tool for progressive reporting on activity and expenditure
- Stakeholder consultation strategy involving consultations in 2015 and again in 2016, including interviews, focus groups, site visits and a survey of nominated community leaders
- Value for money analysis to provide information about the efficiency of projects and an estimate of the value generated from the grant funding.

Key achievements

Key achievements have been assessed against the Program outputs and outcomes and reported on against the following outcome areas:

- Enhancement of sector worker skills to address the social determinants of health
- Increased collaboration by sector workers on addressing causes of health inequality
- Increased support available for community members to overcome causes of health inequality
- Increased community member participation
- Improved evidence base and data collection mechanisms.

Enhancement of sector worker skills to address the social determinants of health

An important enabler of community projects was the ability to provide a platform for building capacity of sector workers to address the social determinants of health. The value of the capacity building program supported by Primary Health Tasmania was in providing an additional resource for projects to access that was aligned to their core purpose. The program provided quality training and professional development, and a consistent message within and across sectors and locations about the issues, challenges and strategies related to the social determinants of health.

Projects accessed the Primary Health Tasmania supported events to a different extent with some projects able consistently to involve a number of other community partners and stakeholders.

A number of projects were able to demonstrate that their relationship with stakeholders in the design and planning of their involvement in aspects of the project had resulted in an improved understanding of the social determinants of health. In addition, 'on the job' training was a common feature of projects and is part of the flexible approach that is possible at the community level to optimise learning opportunities.

Structured training also occurred through projects such as accredited courses or units delivered as an integral part of activities Skills development also occurred as part of professional development for stakeholders internal and external to the projects utilising existing opportunities and leveraging from community resources such as project mentors.

Capacity building opportunities were also important to changing culture and practices, for example, exposure to good practice in moving beyond food relief to establishing sustainable access to affordable food, and envisioning the opportunities for social enterprise.

The 2016 survey of community leaders showed that over 80 per cent of respondents agreed that projects had made a difference to the level of awareness and understanding about the social determinants of health, and the capacity for service providers to use a range of different strategies to address the determinants. Only 10 per cent of respondents strongly agreed with the extent to which the projects had made a difference to awareness and understanding suggesting that further work could be done in this area.

Increased collaboration by sector workers on addressing the causes of health inequality

A large part of the efforts of projects has been in making information about their projects accessible to a wide range of community members and organisations, and exposing stakeholders to practices of co-design, evidence informed planning, and collective impact.

The strength of the collaborations was in identifying the way in which partnerships would be mutually beneficial. Through their association with the community projects, partners were able to progress their own objectives, such as students working to create a safe school environment, schools able to provide flexible learning opportunities to improve student retention, and training institutions able to design learning frameworks relevant to vulnerable groups.

Community projects also largely operated to facilitate collaborations enabling relevant and potentially sustainable arrangements. A wide range of strategies were used including dissemination of newsletters to update key stakeholders, use of community mobilisers model to engage the sector and coordinate opportunities, and ensuring an active role for partners.

Feedback from community leaders surveyed showed that most respondents believed projects had made a difference to the extent to which organisations worked together to address the social determinants of health. In addition, there was strong agreement that projects had made a difference to opportunities for community members to contribute their skills and goodwill.

Increased support available for community members to overcome causes of health inequality

There was evidence that projects had increased support in the community in areas such as food literacy, youth services, school retention and establishment of new employment pathways. These gains had come about through collective approaches and significant effort to design new ways of working, new programs to meet local need and circumstances, and new opportunities for skills development and social inclusion.

Just over half of community leaders surveyed agreed that projects were appropriately targeted to the needs of the community. A majority of respondents believed that projects had contributed to a change in the level of support available with 48 per cent indicating strong agreement and a further 51 per cent agreeing.

Increased community member participation

Projects used a variety of strategies to assist in extending their reach into community and making the activities accessible to all groups. These included a presence at community events, media interviews,

providing free quotations for work, offering training, and systematic engagement of the wider community including business, service clubs, and philanthropy in achieving their goals.

Planning for projects included understanding the priority issues for community and the areas of the community most affected. For many projects this enabled an initial focus on segments of the community, especially areas of unmet need. Environmental scans, service provider consultations and community surveys had assisted some projects to proactively target groups with different approaches to engagement.

An important avenue for accessing new participants had been through partner networks providing a source of referrals into services and projects.

Having a visible entry point into a project was considered important to engagement.

A majority of community leaders surveyed considered that there had been a good response to projects from the target population with 54 per cent strongly agreeing. Similarly, respondents considered that the response to projects, generally, from community had been good.

Improved evidence base and data collection mechanisms

Projects collected data to a different extent with some obtaining activity and output data, client satisfaction, and others able to utilise surveys and environmental scans. Some tools developed will have relevance beyond the life of the projects and reinforce new ways of working.

In order to strengthen the legacy of projects, support was provided by Primary Health Tasmania for projects to develop 'stories' illustrating their successes. This response reflects the limitations of the Program timeframe in generating quantifiable data, and the importance of qualitative information in demonstrating the potential for systemic change.

Projects contributed to the evidence base about the community profile and areas of high need, strategies that worked well with target populations, and approaches to social enterprises.

Over 80 per cent of community leaders surveyed agreed that projects had generated new information about the influence of social determinants of health. All but one respondent considered that their organisation had been able to share its information, and that of other organisations about the target population through the projects and had benefitted from an improved understanding about the community profile and strategies to engage the community.

Key achievements highlights

Key achievements of community projects can be identified at the individual, community and system level. These include:

Individual

- Jobseekers and volunteers successfully secured employment after accessing skills development and formal qualifications as part of projects
- Community participants grew in confidence and leadership capability within projects
- Increased social inclusion
- Young people able to access integrated services in a safe environment
- Young people engaged in flexible learning options
- Young people progressed to mentoring roles
- Young people envisioning employment pathways
- Improved skills of staff, volunteers, partners and other stakeholders related to the social determinants of health
- Community members benefitted from increased supports available in the community.

Community

- Community beautification projects built community pride and contributed to social inclusion and connectedness
- Better targeting of community supports

— Establishment of social enterprises with multiple benefits to community
— New integrated service model that improves service provider access and supports to young people
— Providing a community voice
— New service provider partnerships widening access to supports.

System

— Data capture system able to map trends in service utilisation and needs, and support service planning
— On-line presence providing information about the social determinants of health at an area level
— Embedding new learning opportunities in school curriculum
— Establishment of infrastructure for increasing access to fresh food, providing skills development opportunities and facilitating inter-sectoral collaboration
— Formal training opportunities developed and linked to recognised qualifications in a range of areas including building, horticulture, marketing, food preparation, hospitality
— Regional level development of strategic approaches to food security.

Value for money

Five of the eight community projects were able to undertake activities worth more than the original funding provided, either by utilising in-kind contributions, generating funds from the project which could be reinvested, or accepting donations (resulting in a funding uplift). Project size or dollar value of activities undertaken, ranged between just over $235,000 up to almost $966,000.

Overall, projects were able to undertake activities worth 1.6 times the grant funding of $300,000 they received from Primary Health Tasmania. That is, for every dollar provided by Primary Health Tasmania, projects were able to leverage an additional $1.60 from other sources.

All the projects have shown positive early outputs and outcomes, although these have been subject to little quantification. With additional time for projects to become more established and gather data, future evaluations may be able to overlay analysis of costs with that of project outputs/outcomes to place a value on changes to health and wellbeing outcomes of communities.

Future directions

The Social Determinants of Health Community Projects have demonstrated significant strengths in developing and implementing place-based approaches to effect systemic change to complex problems. Challenges for projects were notably the entrenched nature of the social determinants of health and the charter to impact determinants in a way that contributed to lasting change. The legacy created by projects will continue to benefit communities but in some instances also provide working examples that will inform collective impact strategies beyond the community. The legacy includes:

— Model of integrated service provision that improves client access and effective use of resources
— Innovation in flexible learning to retain the interest of children and young people in education and training
— Leveraging from community members to build resilient communities through social enterprises
— Commitment of key partners to progress initiatives, especially Council and schools aligned to their objectives for community and students
— Relationships with state-wide research and not for profit groups.

The extent to which the momentum created by projects can be sustained without dedicated resources is questionable. In many ways, projects are a demonstration of what is possible with a small amount of seed funding, however, the need to better embed change at all levels will be difficult to achieve within existing community resourcing and organisational priorities.

Leadership to achieve lasting change in communities will need the continuing support of state and Commonwealth governments with a central role in driving change to come from local governments. Continuing education about the social determinants of health will be important to securing the level of

support that is above and beyond food relief and meeting the other immediate needs of disadvantaged communities.

On a one to one approach this project has empowered and gave me so many a reason to get up a feeling of connection to the community as well as the skills and knowledge of how to cook and to lessen waste and the great feeling I get when I'm mentoring someone to the point where they are the mentor to new people is fantastic to see and be a part of. This project changes lives as well as health and I thank you for funding us as without I would not have met so many great people.

Project Steering Committee member 2016

I

PART ONE
BACKGROUND

1 INTRODUCTION

1.1 Context

The concept of 'social determinants of health' refers to potentially avoidable health inequalities that contribute to inequities in health outcomes. This disparity in outcomes can occur within places that make up local communities and impact a person's longevity and quality of life. Health inequities have been attributed to 'the circumstances in which people grow, live, work and age, and the systems put in place to deal with illness'. Health equity is related to the right to access services and supports such as health care, schooling and housing, as well as the opportunity for employment. To overcome health inequality requires a holistic approach working across sectors and across community to address the social determinants of health.[2]

In 2012, the then Tasmania Medicare Local (now Primary Health Tasmania) received funding from the Australian Department of Health for the Social Determinants of Health and Health Risk Factors projects. These projects formed part of a suite of initiatives supported under the Tasmanian Health Assistance Package designed to improve the health of Tasmanians and strengthen health services in Tasmania. Planning for the Social Determinants of Health project was undertaken in 2013 and included stakeholder consultation and review of the evidence base and related policies and programs in place across the state. This process resulted in a strategy to work with identified 'communities of priority', based on need and readiness, through a place-based approach to address locally identified priorities related to the social determinants of health. The strategy also included a statewide approach to building workforce capacity to address the social determinants of health.

Communities of priority were selected on the basis of high levels of disadvantage and community capacity to respond through existing service infrastructure. Eighteen communities were invited to submit an Expression of Interest resulting in 59 proposals. Communities were expected to identify projects, which would increase or improve access to services relating to housing, education, health literacy, employment, food security, and transport. Eight proposals were confirmed following an initial grant of $50,000 each to develop a detailed project plan. A further grant of $300,000 to each of the selected communities was allocated for implementation of projects commencing 1 September 2014 and concluding 30 June 2016. Because of the transition from Medicare Locals to Primary Health Networks funding was initially only confirmed to end June 2015 providing some uncertainty at the time about project tenure.

An overview of the selected social determinants of health community projects is provided in Table 1.1, which includes their location, area of focus and approach. Connecting community and reducing poverty are strategies and outcomes common to all projects.

[2] World Health Organization (WHO) 2008, Closing the Gap in a Generation: Health Equity through action on the social determinants of health

TABLE 1.1 SOCIAL DETERMINANTS OF HEALTH COMMUNITY PROJECTS: LOCATION, FOCUS AND APPROACH

Community Project (Host organisation)	Region of Tasmania (LGA)	Population (ABS 2011 Census)	Average age	Service access (social determinants) focus	Approach
Community Blitz (*Brighton Council*)	Southern Region (*Brighton*)	3,495	33 years	Employment / Food security / Health literacy	Property maintenance and garden development in community spaces, public buildings and public housing
Devonport Food Connection (*Devonport City Council*)	North West Region (*Devonport*)	25,546	41 years	Food security / Health literacy	Connecting vulnerable residents to services and addressing systemic issues associated with food security
Hilltop Fresh Produce (*Burnie Community House*)	North West Region (*Burnie*)	2,032	33 years	Employment / Food security / Health literacy	Pilot social enterprises related to food security including horticulture, retailing and catering
Junction Hub (*Youth Family and Community Connections Inc.*)	North West Region (*Devonport*)	25,546	41 years	Health literacy / Housing / Education/ Employment	Integrated youth support services
Ravenswood Growing Together Initiative (*Starting Point Neighbourhood House*)	Northern Region (*Launceston*)	3,974	33 years	Employment / Food security / Health literacy	Local mobilisers build collective engagement on food security related activities
Tree2Sea (*Derwent Valley Community House*)	Southern Region (*Derwent Valley*)	9,997	42 years	Education / Employment / Health literacy	Alternative formal training for students and jobseekers
Waterbridge Food Co-Op (*Jordan River Service Inc*)	Southern Region (*Brighton*)	7,400	32 years	Food security / Health literacy	Community kitchen, garden and pantry with associated training and community events
Wynyard School Community Partnerships (*The Smith Family*)	North West Region (*Waratah-Wynyard*)	5,990	45 years	Education / Health literacy	Create safe school environment for students, and improve community engagement with schools

SOURCE: ACIL ALLEN CONSULTING

1.2 Evaluation objective

The Social Determinants of Health Evaluation was required to assess the extent to which the then Tasmania Medicare Local *Social Determinants of Health Program* (the Program), achieved its objectives. The overarching aim and objectives of the Program were (Request for Tender (RFT) March 2014):

- Aim
  - To address the social determinants of health both across Tasmania and in identified communities of priority
- Objectives
  - To reduce inequalities in health and improve health outcomes across Tasmania
  - To improve Tasmanian health system efficiency
  - To reduce Tasmanian health system pressure.

Specifically, the RFT detailed that the overall aim was to be progressed utilising a place-based and capacity building strategy in partnership with Tasmanian communities. The role of Tasmania Medicare Local was to:

- Identify the communities of priority that would be supported to address social determinants of health through the development of locally relevant strategies
- Facilitate the development of strategic responses through community engagement, planning and establishment of stakeholder networks
- Support workforce and community capacity building including to strengthen sustainable approaches
- Evaluate, communicate and promote the work of the Social Determinants of Health Program to contribute to an evidence base for future action.

This evaluation was required to:

- Support the selected communities of priority to build their evaluation capacity
- Conduct an evaluation of each of the communities of priority funded under the Program
- Assess the overall performance of the Program, drawing from the individual community project evaluations.

A Steering Committee was established by Tasmania Medicare Local to provide advice on the Social Determinants of Health Program, including receiving periodic reports on progress of the evaluation.

The evaluation project was undertaken over a two-year period commencing in September 2014. Community projects were implemented from September 2014 to end June 2016.

1.3 This report

This evaluation report is divided into three parts:

- Part I provides background to the evaluation project and includes the methodology
- Part II presents the overall findings of the evaluation
- Part III details the scope and findings of the value for money analysis for the Social Determinant of Health Program.

The following chapters report on the findings of the overall achievements of the Social Determinants of Health Program mapped against the Program outcomes:

Part II

- Enhancement of sector worker skills to address the social determinants of health (Chapter 3)
- Increased collaboration by sector workers on addressing causes of health inequality (Chapter 4)
- Increased support available for community members to overcome causes of health inequality (Chapter 5)
- Increased community member participation (Chapter 6)
- Improved evidence base and data collection mechanisms (Chapter 7)
- Final commentary on evaluation findings and future directions (Chapter 8)

Part III

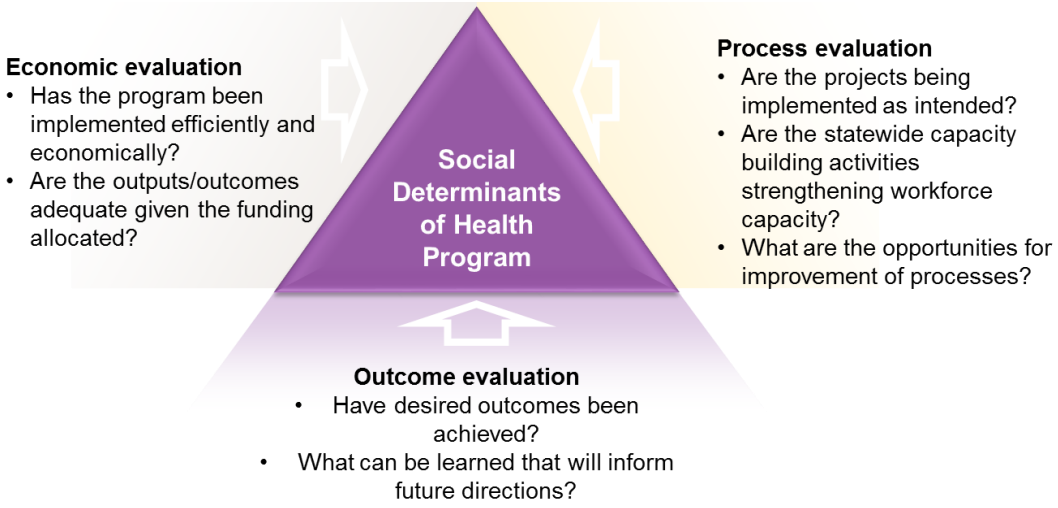
- Detail is also included on an assessment of value for money of the community projects (Chapter 9)

Evaluation findings are informed by the individual assessments of the eight community projects in receipt of a Program grant and the results of consultations with key project staff and community leaders.

2 METHODOLOGY

The evaluation design included process and outcome evaluation, and economic analysis in order to investigate the appropriateness, effectiveness and efficiency of the Social Determinants of Health Program in building community capacity and momentum. The evaluation approach is summarised in Figure 2.1.

FIGURE 2.1 THREE COMPONENTS IN OVERALL EVALUATION DESIGN



SOURCE: ACIL ALLEN CONSULTING 2014

2.1 Community projects

Evaluation of community projects included a number of streams of discrete and ongoing activity. This included:

— Design of the overarching evaluation, including an agreed program logic model (see Figure 2.2) and a data collection framework (see Appendix A) aligned to the expected Program outcomes

— Building the evaluation capacity of community projects through:

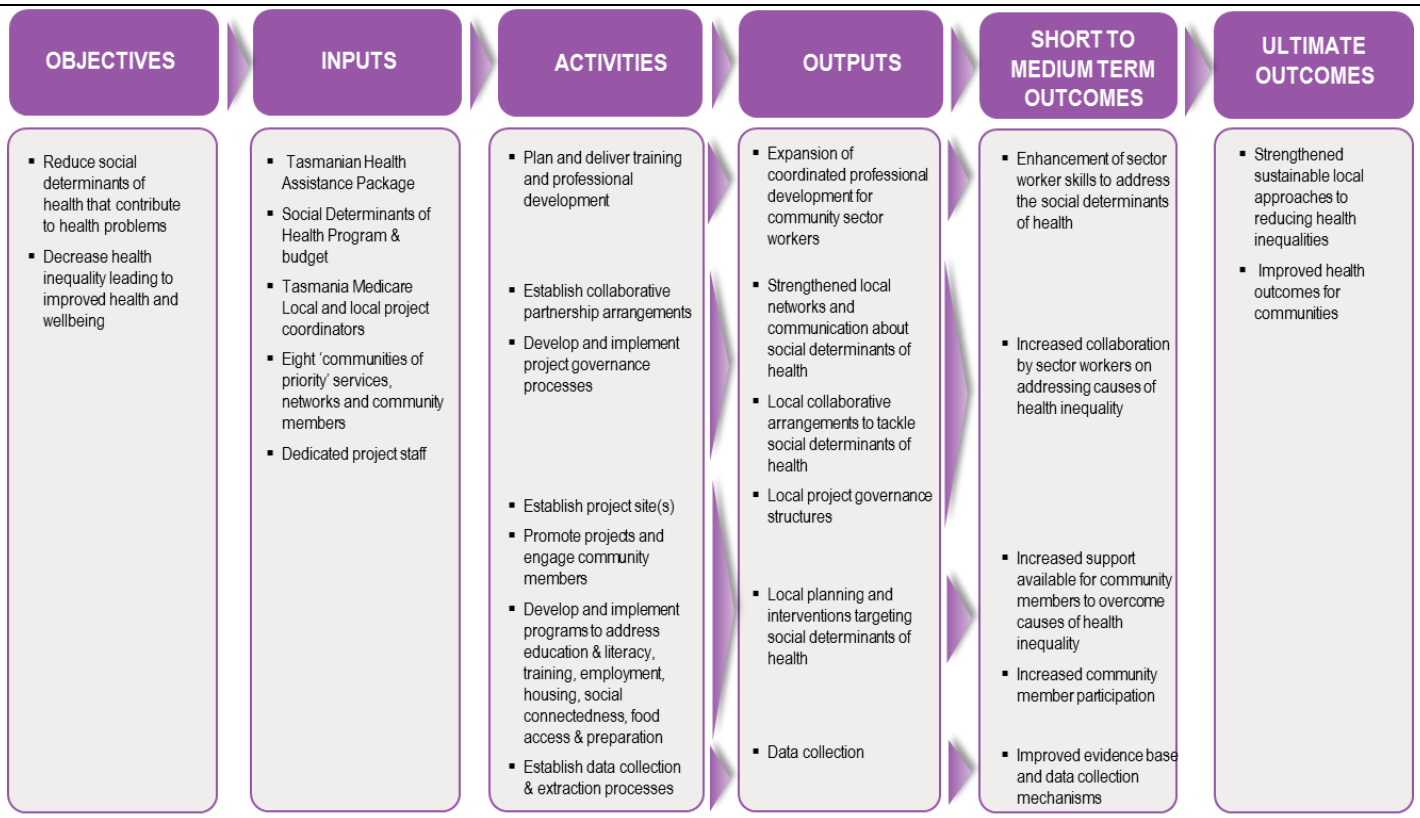
- Support to build program logic models (see Appendix B) nested under the overarching program logic model, data collection strategy, and data capture tools including activity and expenditure progress reporting, and a common tool for steering committee members to assess the appropriateness and strength of the partnership arrangement
- Access to evaluation advice initially through workshops, site visit and WebEx presentations/discussions, and for the life of the project through an open invitation to individual community projects to participate in monthly evaluation teleconferences and use of a project email for additional communication

— Consultations in 2015 and again in 2016 with community project stakeholders consisting of:

- Wave 1 site interviews with project staff, Steering Committee members and other community leaders nominated by community projects
- Wave 2 consultations with project managers/coordinators and a survey of community leaders reviewed and refreshed by community projects. The survey was completed by approximately 70 per cent of invitees with the majority relating to five of the eight community projects. One community project was not represented. Respondents (n=28) included members of project steering committees (36 per cent), local government (14 per cent) and schools (14 per cent). Responses were also received from not for profit organisations and community volunteers.

Presentations were made to the Project Steering Committee on progress and preliminary findings, and reports were provided to Tasmania Medicare Local and latterly, Primary Health Tasmania on project progress and planned activity.

FIGURE 2.2 PROGRAM LOGIC MODEL FOR OVERARCHING EVALUATION OF SOCIAL DETERMINANTS OF HEALTH PROGRAM



SOURCE: ACIL ALLEN CONSULTING 2014

2.2 Value for money

The aim of the value for money assessment was to provide information about the efficiency of projects and the value generated from the grant funding in terms of project outputs and outcomes. The project

activity and financial progress report templates were designed to also support data collection for the economic analysis as well as other qualitative information reflecting on the achievements of projects.

The proposed approach to this component of the evaluation comprised:

- Inputs
  - Data on expenditure and in-kind support collected from each project through periodic progress reports in order to determine whether significant input differentials existed among projects
- Outputs and outcomes
  - Given the difficulties associated with developing uniform quantitative figures for health outcomes across projects, a suite of agreed output and outcome measures would be compiled with a focus on measuring change. Examples include access to nutritious foods, access to transport and participation in education
- Analysis
  - Focus on assessing change in outputs and outcomes, given project inputs. Analysis of the value for money for each individual project as well as an assessment of the Program as a whole.

Limitations in the data and the ability to reliably and meaningfully quantify change in terms of impact on targeted social determinants of health, restricted this component of the evaluation to review of expenditure data for project performance and differentials, and assessment of the value for money in terms of the additional support leveraged by projects to enhance the value of the grant funding. Commentary is also provided on the early impacts of the projects as it informs future opportunities for economic analysis.

2.3 Limitations

There were a number of challenges to evaluation of the Social Determinants of Health Program. These included:

- Two year timeframe to achieve change using new methods, establishing new partnerships often requiring organisational culture shifts, and targeting entrenched social issues with partners and communities vulnerable to a wide range of external influences beyond the control of projects
- Ability to appropriately value in-kind contributions that underpin a collective approach and co-design elements of projects, rather than limit project contributions, for example, to gifts, volunteers, cash donations and host or partner organisation shared administrative infrastructure
- Difficulties for some projects to extract information from different management systems to input to the detail in the financial reporting template
- Demands on project time of regular meetings with the grant funding body, Primary Health Tasmania supported training and development, and feedback sought from stakeholders by other advisory/research bodies.

Some projects have internal data collections that could be used more appropriately to provide greater insight to achievement of change, such as service utilisation and improved outcomes associated with a hub of youth service organisations. This approach would effectively be a sub-study and would enable review over time to assess achievements against key performance indicators. Similarly, follow up review of social enterprises piloted under the Social Determinants of Health Program would potentially provide rich data about sustainability and feasibility of enterprises and their ability to effect systemic change in community. The early indications that projects might be positively tracking and their potential to improve health and wellbeing outcomes is canvassed in the value for money analysis reported on in Chapter 9.

II

PART TWO
KEY ACHIEVEMENTS

3 ENHANCEMENT OF SECTOR WORKER SKILLS TO ADDRESS THE SOCIAL DETERMINANTS OF HEALTH

The Primary Health Tasmania supported events have proven extremely useful in giving direction, support and advice to the project partners and assisted with the forward thinking of the group with regard to the project's future.

Community Project Progress Report May 2016

This is the best process we've ever been through – doing the proposal, the Program Logic, the seminars, and the reports has built capacity and has been beneficial for the project staff and collaborating partners.

Community Leader interview 2016

3.1 Social Determinants of Health Capacity Building Program

An important enabler of community projects was the ability to provide a platform for building capacity of sector workers to address the social determinants of health. To this end, Primary Health Tasmania provided a schedule of workshops and events to which projects were invited as well as a series of project forums and specific capacity building support that responded to the changing needs of projects over the course of the Program. It was a contractual obligation for projects to attend capacity building forums as stipulated by Primary Health Tasmania.

Issues covered in these workshops provided strategies and tools for addressing the social determinants of health, planning and program development skills, multi-sector discussion of new ways of influencing causes of poor health and wellbeing outcomes, and improved understanding of working with people affected by intergenerational poverty. TasCOSS was also supported to provide project mentoring during the latter part of the Program. This was used variously by projects to facilitate sustainability planning and for one project this consisted of producing a video about the successes of the initiative, contributing to the legacy of the project.

The value of the social determinants of health capacity building program was in providing an additional resource for projects to access that was aligned to their core purpose. The capacity building program provided quality training and professional development, and a consistent message within and across sectors and locations about the issues, challenges and strategies related to the social determinants of health.

The Bridges Out of Poverty forum, a key component of the capacity building program, provided the professional development planned for the stakeholders in one key area of activity for the Wynyard School-Community Partnership Project, with feedback indicating that the forum had provided 'a new lens for practitioners working with people from situational and generational poverty'. For the Devonport Food Connections Project, engaging Councils through a forum exploring healthy communities and the role for local government had stimulated discussion across Council departments to build working relationships and to consider ways to embed food security within Council.

With the maturing of projects, a number were represented at other training activities to speak about aspects of their projects such as Hilltop Fresh Produce Project's experience in establishment of social enterprises, and the Waratah-Wynyard Council sharing the successful partnership of Council, local school and businesses in a Work Inspiration initiative as part of the Wynyard School-Community Partnership Project. Linking to the capacity building program was an important input to consistent understanding and practice about addressing the social determinants of health. Projects accessed the Primary Health Tasmania supported events to a different extent with some projects able to involve a number of other community partners and other stakeholders. The challenge for stakeholders, especially Steering Committee members has been the ability to make the time for professional development on top of their commitments to the project and for many, their full time commitments in their place of employment. Where there have been changes to project partners, there has also been a gap in representation and consequently missed opportunities to participate in capacity building workshops.

Notwithstanding the differences in the extent to which project partner organisations are actively engaged in addressing the social determinants of health, to ensure a core shared understanding about the social determinants of health, a mandated requirement of partnerships, such as the community project steering committees, should be professional development as part of the partners' induction to committees and a first commitment of committees on formation. The extent to which additional development opportunities can be accessed should then be less of an issue, although an improved understanding through the mandated development activity may assist in giving these activities a higher priority.

3.2 Community projects training and development

A number of projects were able to demonstrate that their relationship with stakeholders in the design and planning of their involvement in aspects of the project had resulted in an improved understanding of the social determinants of health. This improved understanding was also reflected in the design of the activity, for example, Hilltop Fresh Produce's work with TasTAFE resulted in the development of Learning Frameworks appropriate to the needs of a diverse group of community members. Similarly, Community Blitz reported that they had worked closely with Workskills staff, education/training providers and collaborative partner organisations to increase their understanding of the social determinants of health and the importance of working in a collective impact approach to address entrenched disadvantage. 'On the job' training was a common feature of projects and is part of the flexible approach that is possible at the community level to optimise learning opportunities.

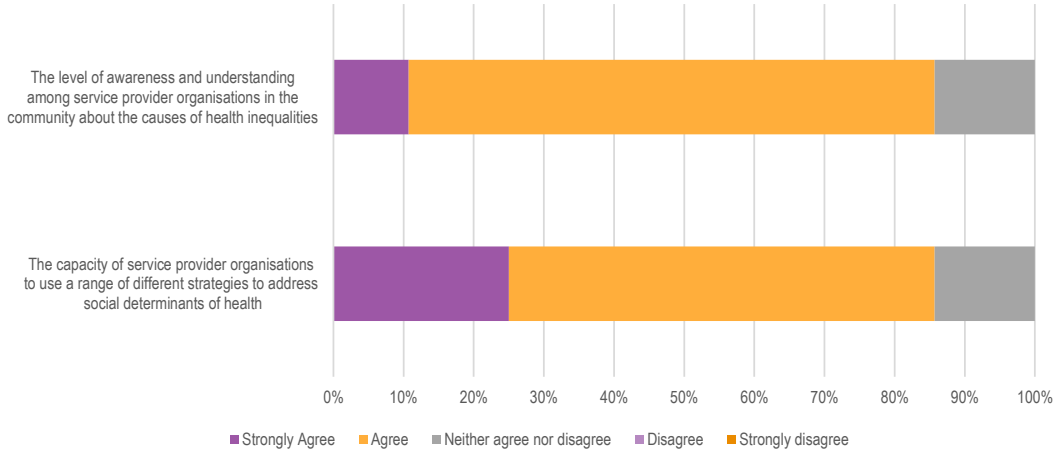
Structured training also occurred through projects such as accredited courses or units delivered as an integral part of activities, for example, horticulture associated with backyard and market gardens, food preparation as part of commercial enterprises, and water safety as part of a boat building course. Training also occurred as part of professional development for stakeholders internal and external to the projects utilising existing opportunities and leveraging from community resources such as project mentors. Skills development for staff and volunteers was focused on building capacity to better work with vulnerable groups and included gaining a better understanding of mental health issues. Staff provided numerous opportunities to their project staff, partners and volunteers to increase knowledge of social determinants of health and service provision in the area. Ravenswood Growing Together Project had a progressive training and education agenda and observed that the project was successful in increasing the confidence and skills of sector workers around the social determinants of health as demonstrated in their ability to take on leadership roles. The project staff and partners from Waterbridge presented a number of courses for other staff, volunteers and the community around relevant topics such as household budgeting including buying food on a budget and also worked with partners to provide training sessions on food safety, and tackling tobacco.

Capacity building opportunities were also important to changing culture and practices, for example, exposure to good practice in moving beyond food relief to establishing sustainable access to affordable food, and envisioning the opportunities for social enterprises.

Field trips were conducted by some projects to learn from working examples, such as those conducted by Devonport Food Connections related to organising a social enterprise, visiting Hobart food programs and attendance at a community environment park with a focus on community garden and fresh food markets.

Over 85 per cent of community leaders participating in a survey about the community projects agreed or strongly agreed that the community projects had made a difference to the level of awareness and understanding among service providers about the causes of health inequalities and capacity to use a range of strategies to address the social determinants of health (Figure 3.1**).** The strength of response varied with double the number of respondents strongly agreeing that the projects had built capacity in using appropriate strategies compared to their impact on awareness and understanding. This suggests that further work is required to ensure a consistent understanding of the causes of poor health and wellbeing outcomes, and achieve the collective response required to make a difference in communities.

FIGURE 3.1 RESPONSES TO THE QUESTION: THINKING ABOUT THE IMPACT OF THE PROJECT, THE PROJECT HAS MADE A DIFFERENCE TO



SOURCE: SDOH SURVEY, JUNE 2016

4 INCREASED COLLABORATION BY SECTOR WORKERS ON ADDRESSING CAUSES OF HEALTH INEQUALITY

This Project provided my organisation with the opportunity to reach a new audience, promote our services, attract new stakeholders, redesign our processes, build stronger collaborations, and strengthen our community.

This project has expanded our thinking around engagement opportunities and the consultation process has been invaluable to us.

Community Leader survey respondents 2016

4.1 Common purpose

Critical to galvanising sector workers to form new collaborations has been an improved understanding of the social determinants of health and the opportunities to work differently to achieve better outcomes. A large part of the effort of projects has been in making information about their projects accessible to a wide range of community members and organisations, and exposing stakeholders to practices of co-design, evidence informed planning, and collective impact. To that extent, the community projects have demonstrated collaborations beyond 'sector workers' to include local businesses, students, industry mentors, and food retailers. Shifting often entrenched disadvantage in small communities requires a whole of community approach with leadership drawn from diverse stakeholders.

4.2 Mutual benefit

Producing a project plan had required projects to scope stakeholders in particular key partnerships and the way in which they would contribute to project outcomes. These initial consultations had worked through collaborations that brought different expertise and resources to the project and identified roles and responsibilities that could be enshrined in formal agreements between the respective parties. The strength of the collaborations was in identifying the way in which partnerships would be mutually beneficial. Through their association with the community projects, partners were able to progress their own objectives, such as students working to create a safe school environment, schools able to provide flexible learning opportunities to improve student retention, training institutions able to design learning frameworks relevant to vulnerable groups, and Council taking leadership to provide infrastructure to support community health and wellbeing.

4.3 Facilitation

A strength of the community projects was that they largely operated to facilitate collaborations. For example:

— Devonport Food Connection was involved in the co-design of the Mersey Leven Food Hub which had included facilitating development of the Local Food Security Strategy involving a workshop attended by representatives of the local food system, community service organisations and sports clubs

— Junction Hub worked with providers of services to young people and families to develop common tools and referral pathways that promote an integrated and accessible service system

— Wynyard School Community Partnerships involved local businesses in the design of a Work Inspiration initiative that better met the needs of students and employers, enabling a regular commitment and collaboration between business, Council and school.

4.4 Supporting collaborations

A range of strategies were used by community projects to attract and sustain collaborations. This included:

— Community mobilisers to engage with the sector to plan and coordinate opportunities to engage the community

— Offering space for other providers to use to deliver services to the target population so that services were 'joined up' and referral pathways were strengthened

— Project newsletter to which partners were asked to contribute and which served to both provide exposure for the project as well as keep partners and other stakeholders connected to project developments

— Active involvement of the project steering committee partners to represent the project at public events and provide cross-membership of related networks and groups.

Community forums, service provider round table sessions, workshops and speaking engagements at community clubs offered appropriate ways to engage stakeholders and build relationships.

4.1 Challenges

Building and supporting collaborative arrangements takes time and some projects established relationships in specific sectors, such as education and training, while others were in a position to engage a more diverse range of stakeholders. An enabler in this regard was the leadership, mandate and connections that Council could provide.

For many projects, adopting a holistic approach to issues and realising the full potential of collective impact required collaboration with collaborating partners, other traditional partners including those where there had previously been poor engagement, and in many instances, non-traditional partners. Forging new relationships especially with non-traditional partners requires an understanding of the different sector cultures and key stakeholders, in addition to the time that might be required to establish working relationships.

Time was also a barrier for regular participation of partners, who had senior positions in their respective workplaces and less certainty about their availability, such as a school principal. Movement out of organisations and out of community was also a challenge to continuity of relationships, and an issue that was more common in small communities.

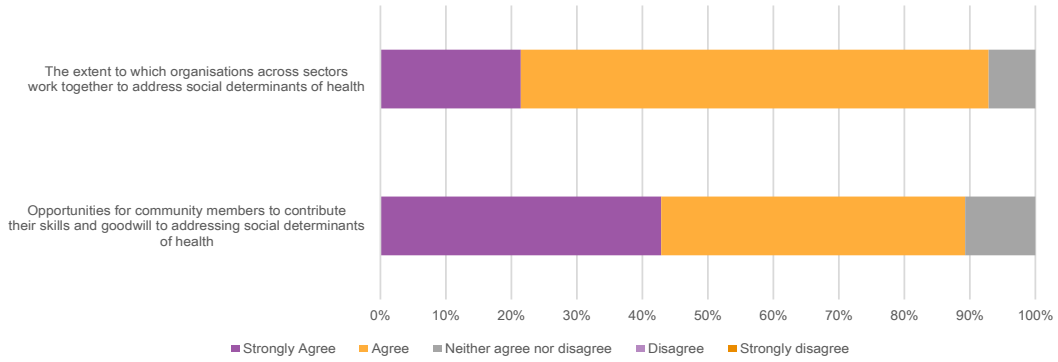
Ensuring a collective decision-making process at meetings was also seen as important to equitable input from partners, and a potential way of influencing cultural change required to adopt new ways of working to address the social determinants of health.

4.2 Sector experience

Community leaders responding to the survey of their experience of the project in their local community believed that the project had made a difference to cross-sector collaboration on the social determinants of health. Approximately 93 percent of respondents indicated that it had made a difference to the extent to which organisations worked together to address the social determinants of health, with 20 per cent of respondents strongly agreeing with the statement. (See Figure 4.1)

More emphatically, while a slightly smaller proportion of respondents (89 per cent) agreed that the project in their community had made a difference to opportunities for community members to contribute their skills and goodwill to addressing social determinants of health, this included almost 43 per cent of respondents who indicated strong agreement with the statement. (Also see Figure 4.1)

FIGURE 4.1 RESPONSES TO THE QUESTION: THINKING ABOUT THE IMPACT OF THE PROJECT, THE PROJECT HAS MADE A DIFFERENCE TO



SOURCE: SDOH SURVEY, JUNE 2016

5 INCREASED SUPPORT AVAILABLE FOR COMMUNITY MEMBERS TO OVERCOME CAUSES OF HEALTH INEQUALITY

[This project] has enabled access to more levels of support around health and nutrition, skill building and engagement.

Community leader survey respondent 2016

5.1 Food literacy

Aspects of food security have been a focus of five of the eight community projects. All of these projects are able to demonstrate that increased support for community members has occurred through the activities of the project. This support is often linked to a secondary focus on building the skills and knowledge of the community that has been an important extension of services giving effect to addressing the social determinants of health. This can be seen in the Devonport Food Connection Project, for example, where evidence of population groups in most need had resulted in leveraging from the Men's Shed program to access young vulnerable men with poor food literacy. The additional support available through this initiative had resulted in a tripling of demand for this service in a two month period. Similarly, building the capacity of the Food Shed to offer a wider choice of affordable products had increased use of the service. A survey of approximately one third of 240 households in a local area showed that almost two thirds of respondent households had used the Food Shed at the Community House and just over half said they had eaten more vegetables because of the service. The Project had been successful in attracting a grant to increase the storage capacity of the facility allowing expansion of the food program.

Waterbridge Food Co-Op was able to demonstrate that it was meeting the needs of the community through programs offered around improved food literacy. The nutrition literacy offered through the newly established pantry outlet resulted in an average of 256 visitors per month (open 14 hours per week) and a 70 per cent increase in vegetable consumption among those patrons. The Project reported that participants were 'making the link' between the activities (cooking classes, pantry and gardening) to improved health outcomes. Ravenswood Growing Together leveraged from support provided through community gardens to also provide education for the garden workers, families who accessed the produce and others through cooking classes and food safety training. It was reported that volunteers involved with the Project improved their confidence and social inclusion.

5.2 Youth services

The capacity to streamline and integrate local services for young people and families has significantly improved access to existing supports for youth in the Mersey Region through the Junction Hub Project and improved the use of available resources. The Project provided a 'safe' hub for young people to access a range of services and reported an increase in support available, referrals and uptake of services over the duration of the Project. The hub model has been documented and the Junction Hub

expanded to another location where the community was seeking a response to an identified need for improved services for young people.

5.3 School retention

A number of projects sought to provide innovative solutions to improve school retention rates as part of increasing literacy and numeracy, and prospects for future employment. Through inter-sectoral work with schools, connections to the wider community had provided opportunities for schools to participate in alternative learning experiences for students that built confidence, leadership and practical skills in a range of areas. These initiatives better linked schools to community resources and provided relevant development experiences for students at risk of disengaging with education.

Tree2Sea worked with New Norfolk High School to integrate a boat building course into its curriculum that was supported by strengthened networks of community service providers and education facilities. The initiative increased learning options available through secondary school and Workskills projects, provided appealing school holiday activity, and provided alternative referral pathways for vulnerable young people. Improved participation in education was also an aim of the Wynyard School Community Partnerships Project. The Project had increased support for community members through a strengthened role for the school community, Council and the wider community in addressing the safety, wellbeing and engagement and retention in school of children and young people. Key activities in this Project had been championed by other stakeholders ensuring a life beyond the Project. A survey of parents by the leading school in the project showed that perceptions of support available from the school had improved in 2015 compared to the previous year, in areas such as child's feelings of safety at this school, management of student behaviour, and involvement of parents in school planning and decision making.

5.4 Employment pathways

Many of the Projects provided formal skills development opportunities designed as part of meeting Project objectives to improve employment outcomes. Notably, the Hilltop Fresh Produce Project revolved around pilot of social enterprises designed to secure a sustainable local solution to access to fresh affordable food, which developed structured training programs in collaboration with TasTAFE as an integral part of the pilot. The enterprises developed new community resources in the form of a market garden, store and café, and increased the capacity of a catering venture. The pilot outcomes suggested that on current trends, the enterprises were viable and capable of generating a profit to be reinvested in community supports. Other projects also provided structured skills development in horticulture, literacy and numeracy, boat building, and research and marketing. The Community Blitz project focused on improving employment pathways for unemployed people by involving them in community work projects and giving them real life experience including conducting the work in the field (building gardens, installing play areas, etc), writing project bids and project plans and dealing with customers. At an early stage Community Blitz identified that literacy and numeracy were issues for the participants so they built in an innovative approach to deal with it by partnering with the local LINC who provided one-on-one assistance for participants by using the bidding and project planning they were doing as part of their work program as the tool to learn writing and math skills.

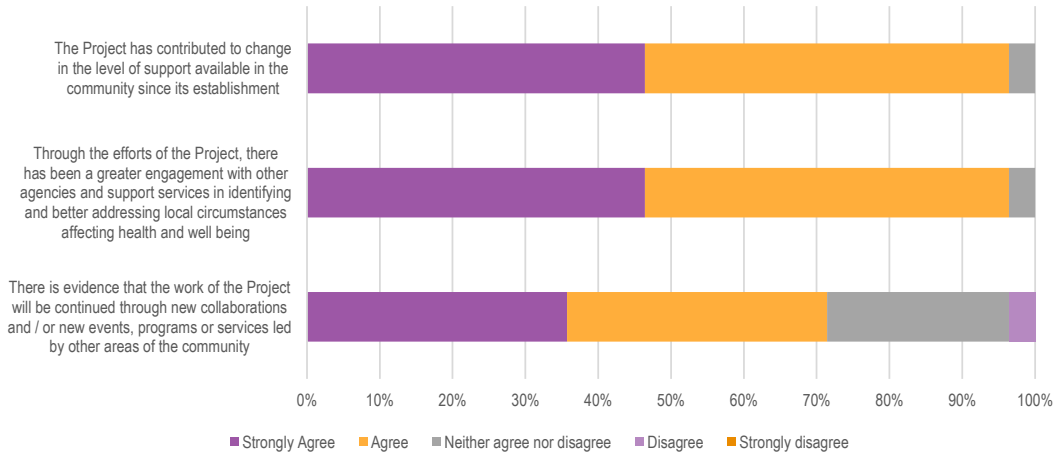
5.5 Perceptions of change

Just over half of community leaders surveyed agreed that the project in their community was appropriately targeted to the needs of the community.

A majority of community leaders believed that the project had contributed to change in the level of support available in the community since its establishment with 48 per cent indicating strong agreement and 51 per cent agreeing. A similar number of respondents considered that through the efforts of their community project, there had been a greater engagement with other agencies and support services in identifying and better addressing local circumstances affecting health and wellbeing. (See Figure 5.1)

While 71 per cent of community leaders surveyed considered that there was evidence that the work of the project in their community will be continued through new collaborations and/or new events, programs or services led by other areas of the community, there was less certainty for a further 25 per cent of respondents (see Figure 5.1). Those less certain neither agreed nor disagreed about the future leadership in this area, although this might be a reflection of not knowing rather than ambivalence. Additional comments provided suggested that respondents were unsure of the future while hoping that the support for the community would continue.

FIGURE 5.1 RESPONSES TO THE QUESTION: PLEASE INDICATE THE EXTENT TO WHICH YOU AGREE OR DISAGREE WITH THE FOLLOWING STATEMENTS



SOURCE: SDOH SURVEY, JUNE 2016

6 INCREASED COMMUNITY MEMBER PARTICIPATION

The community was able join in a wide variety of activities delivered through this project. Parents, students and politicians partook of the Kinship Walk.

Community leader survey respondent 2016

Engaging the community was easy – you need an entry point set within a community setting. Working in the gardens, working in the pantry and offering cooking classes brought in new people.

Project manager interview 2016

6.1 Reaching into the community

Projects used a variety of strategies to assist in extending their reach into community and making the activities accessible to all groups. These included a presence at community events, with a 'hook' to attract engagement, media interviews, providing free quotations for work, offering training, and obtaining feedback from participants about their level of satisfaction with services.

The Ravenswood Growing Together project's use of the Milton Keynes model of community development provided dedicated workers and community mobilisers with the ability to build relationships with community and service providers. This approach enabled them to systematically engage not only local residents as volunteers but also the wider community by engaging business, service clubs, and philanthropy in achieving their goals.

Through the production of watercraft, the Tree2Sea project attracted community interest in reinforcing the message of healthy lifestyle through use of waterways. The local football club suggested that use of the paddle boards be integrated into their training, providing a model for young people and the wider community.

6.2 Accessing target groups

Planning for projects included understanding the priority issues for community and the areas of the community most affected. For many projects this enabled an initial focus on segments of the community, especially where there was unmet need. Environmental scans, service provider consultations and community surveys had assisted some projects to proactively target groups with different approaches to engagement. This included the establishment of a mobile food cooperative to support isolated individuals and families in the community, creation of a youth services hub that improves access but also enables monitoring of the young person to ensure they receive the appropriate supports, and providing flexible learning opportunities that informed individual learning plans for students.

An important avenue for accessing new participants has been through partner networks providing a source of referrals to services and projects. Referring organisations have been service providers supporting disadvantaged groups providing an efficient method of leveraging from existing relationships. Referrals have included children, families and jobseekers using the services, for example, of Communities for Children, Workskills, and a Learning Precinct of educational institutions.

6.3 Points of entry

Having a visible point of entry into a project was considered important to engagement. This presented in a variety of forms with different purposes, such as the sale of kayaks and paddle boards that fostered community awareness, contribution and sustainability of the Tree2Sea Project. Waterbridge Food Co-Op stakeholders reported that community engagement was enhanced by having entry points set within a community setting. Working in the garden, working in the pantry and the cooking classes were seen as a key way of engaging new people.

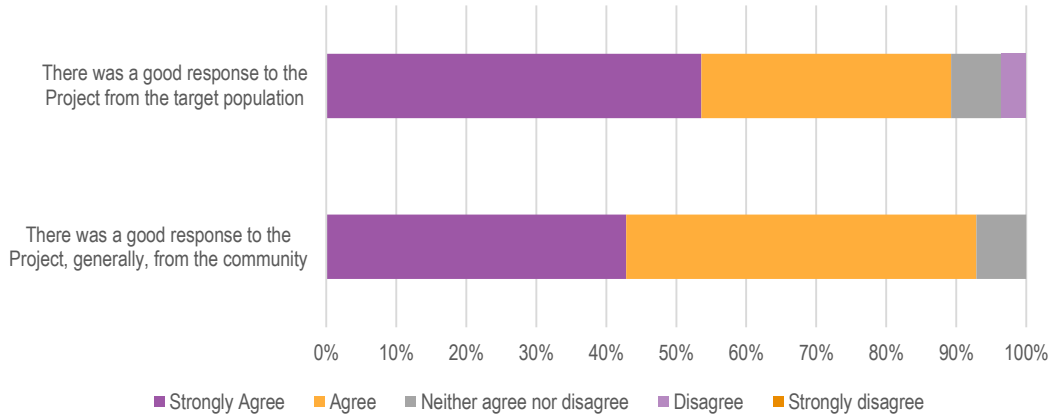
6.4 Stakeholder feedback

Much thought and planning went into the development of the project and, therefore, this ensured relevance and appropriateness to our target group

Community Leader survey respondent 2016

A majority of community leaders surveyed considered that there had been a good response to the project from the target population with 54 percent strongly agreeing. A similar proportion of respondents considered that the response to the project generally from the community had been good, although fewer indicated strong agreement. (See Figure 6.1)

FIGURE 6.1 RESPONSES TO THE QUESTION: PLEASE INDICATE THE EXTENT TO WHICH YOU AGREE OR DISAGREE WITH THE FOLLOWING STATEMENTS



SOURCE: SDOH SURVEY, JUNE 2016

7 IMPROVED EVIDENCE BASE AND DATA COLLECTION MECHANISMS

Through opportunities created by the Project, my organisation was able to generate discussion, gather data and influence other organisations specifically about the target group.

There has been constant information and knowledge sharing.

Community leader survey respondents 2016

7.1 Data collection

Projects collected data to a different extent with some obtaining activity and output data, client satisfaction, and others able to utilise surveys and environmental scans to provide more detailed information about community demographics, patterns of behaviour and early impact of project activities. Devonport Food Connection was able to capitalise on a Council omnibus community survey to include food security questions developed with advice provided by the Heart Foundation and aligned to related larger surveys. Other tools developed that will have relevance beyond the life of projects include Junction Hub common service provider data collection that enables a minimum dataset about service users, supports and referrals, and Waterbridge Food Co-Op's data capture system that can be used to identify trends in service utilisation and need in the area, which is shared with other organisations.

In order to strengthen the legacy of projects, support was provided through Primary Health Tasmania for projects to develop 'stories' illustrating their successes. This response also reflects the limitations of the program timeframe to allow quantifiable evidence of change, and the importance of qualitative information in demonstrating the potential for systemic change.

The project plan developed by all projects required a description of how the project's performance would be measured, however, very few of the projects went on to develop a data collection strategy that provided an agreed method, responsibility and level of resourcing for on-going measurement of project performance. The data collection strategy builds on the program logic map produced by all projects and is another mechanism for refining project scope and priority, and planning for strategic collection of data. This planning assists in best use of resources, staging of activities and generation of information that is fit for purpose.

For the purposes of program evaluation, projects completed activity and financial progress reports that prompted qualitative and quantitative information, and recording of in-kind contribution to the project. Activity progress reports were framed consistent with the overarching program logic map which in turn provided the basis for individual program logic maps.

7.2 Information dissemination

Both qualitative and quantitative project data was utilised in communicating about the project to community and other stakeholders. Media interviews were supported with data about project inputs and outputs, and newsletters for partners and other stakeholders highlighted activity data.

Projects contributed to the evidence base about the community profile and areas of high need, strategies that worked well with target populations, approaches to social enterprises and the project link to addressing the social determinants of health. Project staff regularly shared learnings with others and provided evidence of modelling a different – collaborative – approach in addressing the social determinants of health.

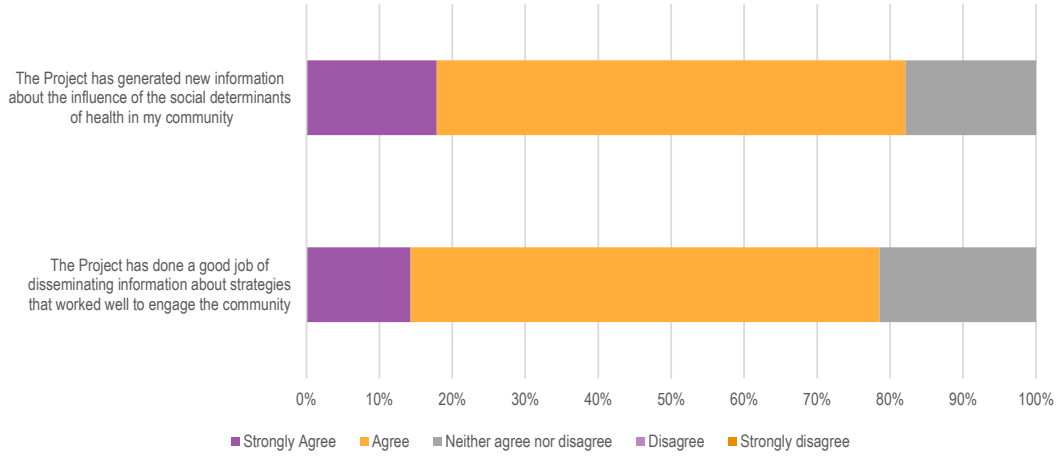
7.3 Stakeholder feedback

The expertise of the project workers has meant that all advisory group members have had an opportunity to build their individual capacity around community needs and issues.

Community leader survey respondent 2016

Around 80 per cent of community leaders surveyed believed that the project in their community had generated new information about the influence on the community of the social determinants of health, and that it had done a good job of disseminating information about strategies that worked well to engage the community. Less than 20 per cent of respondents strongly agreed with these statements. However, there was no disagreement suggesting that projects had been effective in communicating information about the nature of disadvantage and approaches to address these issues. (See Figure 7.1)

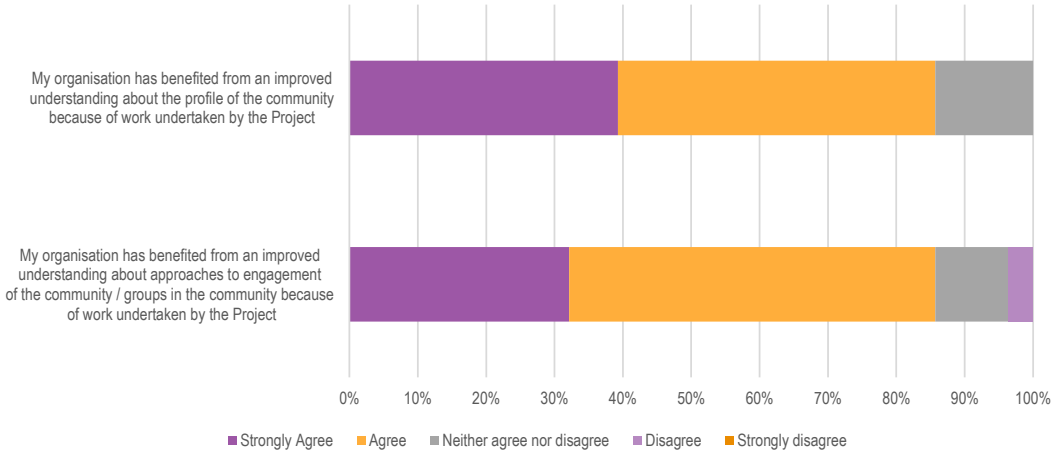
FIGURE 7.1 RESPONSES TO THE QUESTION: PLEASE INDICATE THE EXTENT TO WHICH YOU AGREE OR DISAGREE WITH THE FOLLOWING STATEMENTS



SOURCE: SDOH SURVEY, JUNE 2016

With one exception, all community leaders surveyed reported that their organisation had been able to share its information, and that of other organisations, about the target population through the community project. In addition, more than 80 per cent of community leaders surveyed reported that their organisation had benefited from an improved understanding about the profile of the community and approaches to engagement of community because of the work of the project in their community (see Figure 7.2).

FIGURE 7.2 RESPONSES TO THE QUESTION: PLEASE INDICATE THE EXTENT TO WHICH YOU AGREE OR DISAGREE WITH THE FOLLOWING STATEMENTS



SOURCE: SDOH SURVEY, JUNE 2016

Feedback from community leaders pointed to the benefits of partnerships in sharing and disseminating information, and to the opportunities for more targeted support and resources that can result from a stronger evidence base. An example provided was the support of the Waratah Wynyard Council in progressing investigation of establishment of a Community House and committing funds to develop a business case.

8 SUMMARY AND FUTURE DIRECTIONS

[This Project] has achieved more than anticipated and is now so valued and respected within our community that its possible loss will have a huge impact.

The project was always very ambitious and did suffer with some unforeseen setbacks. However, all things considered it did achieve some remarkable outcomes in terms of community capacity building, skills and learning and has created a strong foundation for further interventions to address those social determinants of health which impact on diet, cooking and the use of locally grown produce.

Community Leader survey respondents 2016

Strengths

The Social Determinants of Health Community Projects have demonstrated significant strengths in developing and implementing place-based approaches to effect systemic change to complex problems. These strengths have been variously emphasised by projects and include:

- Strategic alliances to steer the project with clear roles and responsibilities that are formalised at the organisational level
- Strong leadership amongst key partners aligned to the ongoing role in the community of the partner and legitimised by the partner organisation's vision and priorities
- Foundation documents that provide clarity, guide the project and provide a point of review and adjustment as appropriate
- Strong facilitation role to communicate key messages, leverage from partners, engage stakeholders, link to existing agendas and create new thinking about solutions
- A dedicated resource for project implementation to ensure components are aligned, learnings are transferred and relationships are maintained / strengthened / created
- Collaboration between sectors and an inclusive environment providing opportunities for both formal and informal relationships with traditional and non-traditional partners to be built, based on trust and cooperation
- Building in sustainability strategies from the start incorporating co-design elements and positioning activities with 'natural' leaders, such as Council and schools
- Ensuring an ongoing role for partners in engaging with community contributing to the profile of the project
- Achieving value for money through attracting in-kind and uplift funding estimated conservatively to be equivalent to an additional $1.60 for every dollar provided by Primary Health Tasmania.

8.1 Challenges and limitations

Challenges for projects were first and foremost the entrenched nature of the social determinants of health and the charter to impact determinants in a way that contributed to lasting change. Other challenges that were experienced by most projects flow from this overarching problem and include:

- Overly ambitious scope of projects with multiple streams of activity stretching project and community resources
- Timeframe for projects that was amenable to measuring outputs but too soon to impute change and especially lasting change
- Workforce churn in small communities that was just as likely to relate to senior positions as to the volunteer workforce, impacting leadership roles and disrupting stakeholder relationships
- Sustaining consistent commitment of partners, valuing their input and recognising demands on their time and competing priorities, without diluting the level of representation on the Steering Committee
- Strategic procurement of expertise to assist at critical points in the project, such as ensuring an enabling environment, generating the evidence for decision making and facilitating review of progress, barriers and risks.

Where these challenges affected projects it is not clear to what extent it was intrinsic to the wider appeal of the project, peculiar to the community or organisation's circumstances, or whether there were other risk mitigation strategies that might have been used, for example:

- Limited success in increasing community participation might have benefited from community consultation in the form of a street survey or forum
- Interruptions to strategic relationships important to project progress could be minimised with partner organisation formal undertakings such as a memorandum of understanding, or if an issue for the host organisation, a strategy incorporated into the project plan for risk mitigation such as agreed process for establishing interim arrangements
- Poor attendance at Steering Committee meetings could be followed up to determine ways of working that might better accommodate the member's availability, such as timing of meetings, input to agendas, capacity to feedback on meeting papers, ensuring an authorising environment in member organisations, personal briefing following meetings.

8.2 Future directions

It's a way of working – not just a program as such.

Host agency CEO interview

The legacy created by projects will continue to benefit community but in some instances also provide working examples that will inform collective impact strategies beyond the community. The legacy includes:

- Model of integrated service provision that improves client access and effective use of resources
- Innovation in flexible learning to retain the interest of children and young people in education and training
- Leveraging from community members to build resilient communities through social enterprises
- Commitment of key partners to progress initiatives, especially Council and schools aligned to their objectives for community and students
- Relationships with state-wide research and not for profit groups.

The extent to which the momentum created by projects can be sustained without dedicated resources is questionable. In many ways, projects are a demonstration of what is possible with a small amount of seed funding, however, the need to better embed change at all levels will be difficult to achieve within existing community resourcing and organisational priorities.

Leadership to achieve lasting change in communities will need the continuing support of state and Commonwealth governments with a central role in driving change to come from local governments. Continuing education about the social determinants of health will be important to securing the level of support that is above and beyond food relief and meeting the other immediate needs of disadvantaged communities.

PART THREE
VALUE FOR MONEY

III

9 ASSESSMENT OF VALUE FOR MONEY

9.1 Introduction

The value for money analysis seeks to answer questions such as has the program been implemented in an efficient and economical way, and are the outputs and other results generated by the program considered adequate, given the quantum of funds allocated to the program.

This chapter uses high level financial data provided by projects to analyse the scale of their activities, including cost composition and in-kind generated, and their funding composition. Finally, it considers their ability to generate income from alternative sources, and the early impact of the projects on social determinants of health in the community as it might inform future opportunities for economic analysis.

A summary of the key features of each project is provided in Table 9.1. This shows a diversity of communities and approaches aimed at addressing similar social determinants of health.

TABLE 9.1 SUMMARY OF PROJECTS

Project name	Location	Primary target population	Focus of activity	Relevant social determinants of health
Community Blitz	Brighton	Jobseekers	Property maintenance and garden development in community spaces, public buildings & public housing	Access to healthy food Increasing employment
Food Connection	Devonport	Community members School students	Vegetable gardens, vegetable box and bread delivery, educational food programs for students	Access to healthy food Connecting communities
Growing Together	Ravenswood, Waverley	Community members Service providers	Community gardens and other food related activities	Access to healthy food Connecting communities
Hilltop	Shorewell Park	Jobseekers Community members	Pilot social enterprises including: – Market garden – Store and café – Commercial kitchen	Access to healthy food Increasing employment

Project name	Location	Primary target population	Focus of activity	Relevant social determinants of health
Junction Hub	Mersey Region, Davenport	Young people Service providers	Integrated service delivery and referral hub for families and young people	School engagement Increasing employment Access to housing Connecting communities
Tree 2 Sea	New Norfolk, Derwent Valley	School students Early school leavers	Boat building embedded in school curriculum and jobseeker projects	School engagement Increasing employment
Waterbridge	Gagebrook, Herdsman's Cove, Bridgewater	Community members	Community kitchen, garden and pantry, with associated social events and training	Access to healthy food Connecting communities
Wynyard	Waratah, Wynyard	School students	Integrated approach to school engagement, including school walkways, and creating links between schools and other community organisations	School engagement

SOURCE: PROJECT PROPOSALS

9.2 Data collection methodology

Data was collected by community projects in four periods between September 2014 and May 2016, with the final set of data collected including reporting of cumulative expenditure and budget for the entire period. This final set of expense data was used to undertake the analysis in this section. Expense data collected in previous periods was used for validation purposes. Data on revenues and in-kind contributions for each project was reported on a by-period basis, the total of these figures was used in the following analysis. Original project budgets submitted prior to the start of each project were also considered.

It is important to note that as the host organisations of each of the projects possess different levels of sophistication and resourcing, the data provided as the result of this data collection exercise was not consistent in terms of completeness and quality. As a consequence, the following analysis may understate the activities of some projects due to under reporting, such as a failure to identify all in-kind contributions.

The scope of in-kind contributions is also of interest especially as the collective impact approach adopted by projects relies heavily on community co-design. This aspect is not traditionally accounted for. Similarly, training of students through the building of watercraft that may go on to be sold or form part of a hire fleet, has not been costed by the project, although anecdotally, the student hours spent on boat building in one term were calculated as equivalent to $900. Sales of the watercraft go back into the project and as such do not represent 'profit'.

9.3 Project analysis

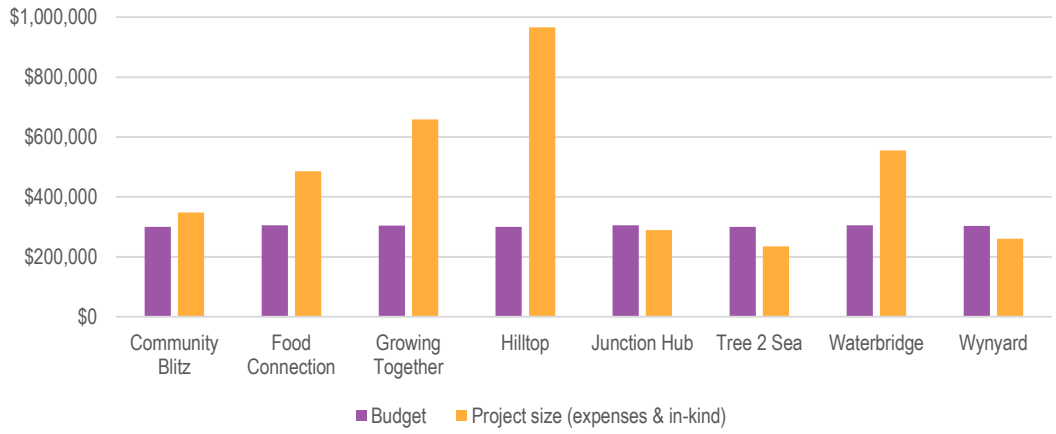
The eight projects funded by Primary Health Tasmania were provided with between $300,000 and $305,000 to undertake project activities. Project size or dollar value of activities undertaken, as measured by combining project expenses with in-kind contributions, ranged between just over $235,000 up to almost $966,000.

As shown in Figure 9.1, five of the eight projects were able to undertake activities worth more than the original funding provided, either by utilising in-kind contributions from the community, generating funds from the project which could be reinvested, or accepting donations (resulting in a funding uplift). Three of the eight projects, Junction Hub, Tree 2 Sea and Wynyard, undertook activities that were of a lower

dollar value than the funding provided. This may be indicative of projects that have not spent their entire budget (for example due to project delays or expenses that accrue late in the project). These delays may relate to project workforce changes disrupting project implementation, or be a result of external influences.

Furthermore, it should be noted that the expenditure period reported ended on 15 May 2016, leaving projects with a further six weeks in which to undertake activities before the end of the financial year.

FIGURE 9.1 PROJECT BUDGET (PRIMARY HEALTH TASMANIA FUNDING) AND PROJECT SIZE (EXPENSES AND IN-KIND CONTRIBUTIONS)



Note: Project budget was provided for the period 1 September 2014 to 30 June 2016, while reporting of expenditure, in-kind and cash uplift received by Projects is for the period 1 September 2016 to 15 May 2016. Project size refers to the dollar value of activities undertaken by the project, calculated by adding project expenses to in-kind received.

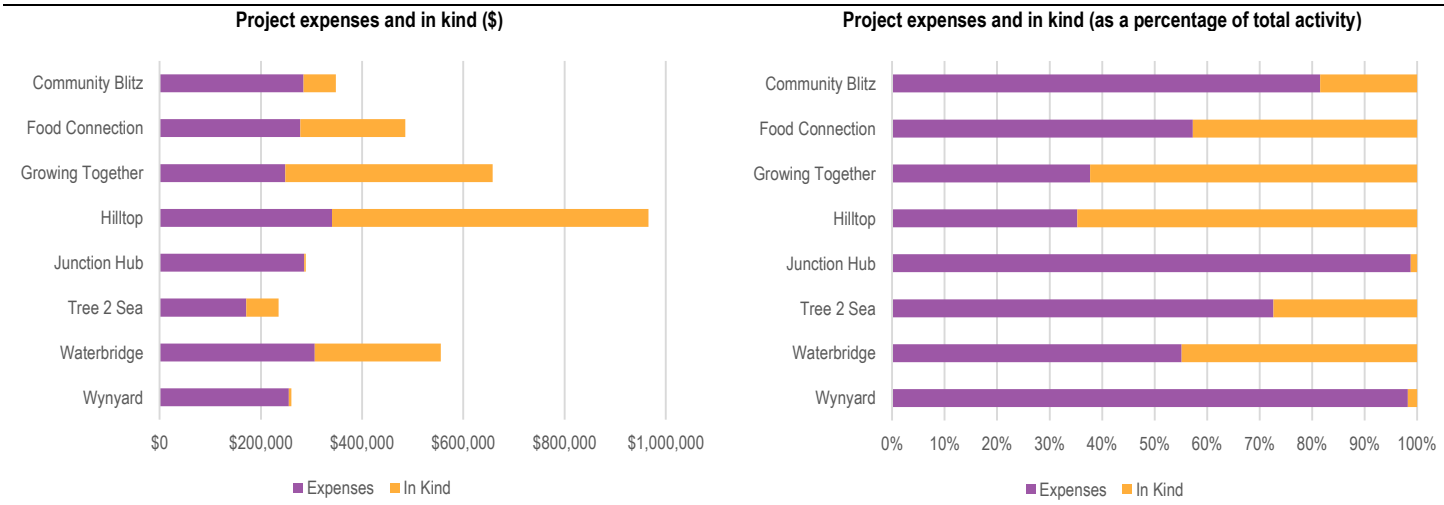
SOURCE: PROJECT FINANCIAL REPORTS, ACIL ALLEN ANALYSIS

All the projects were able to generate in-kind contributions to complement their spending on goods and services required for project service delivery. However, the proportion of project activities that were provided in-kind and those that were paid for varied greatly between projects (see Figure 9.2).

Hilltop, the largest project, was able to generate the most in-kind contributions over the course of the project ($625,091), and also had the highest expenditure ($340,745). This is contrasted with the smallest project, Tree2Sea, which reported $64,306 in in-kind contributions and spent $170,850. According to the financial reports provided, Junction Hub and Wynyard generated the lowest levels of in-kind contributions, $3,465 and $4,596 respectively. Only Hilltop and Growing Together were able to place a heavier reliance on in-kind contributions than on activities paid for to run their projects (between 35 per cent and 38 per cent of activity for these two projects respectively).

The level of in-kind received is likely to be reflective of the type of projects run by each community. For example, Hilltop piloted social enterprises and had planned for significant in-kind support up front, such as access to a parcel of land for use as a market garden. Differences in the level of in-kind recorded by each project may be due to variability in the way in-kind has been documented. For example, progress reports indicate that Wynyard was able to receive substantial in-kind contributions in the form of support from teachers, students, and parents, although this is not explicitly documented in their financial data as in-kind contributions.

FIGURE 9.2 PROJECT SIZE, EXPENSES AND IN-KIND CONTRIBUTIONS



Note: The Primary Health Tasmania budget was provided for the period 1 September 2014 to 30 June 2016, while reporting of expenditure, in-kind and cash uplift received by project is for the period 1 September 2016 to 15 May 2016

SOURCE: PROJECT FINANCIAL REPORTS, ACIL ALLEN ANALYSIS

9.3.1 Cost composition analysis

Project expenses were categorised as shown in Table 9.2.

TABLE 9.2 CATEGORISATION OF PROJECT EXPENSES

Category	Project expenses included
Establishment / one-off versus ongoing costs	
Establishment / one off costs	Equipment and capital purchases
Ongoing costs	Administration, consultants, engagement and communication, other expenses, professional development/capacity building, program delivery expenses, salary and wages, travel and accommodation, other contributions
Project administrative and running costs versus project service delivery costs	
Project administrative and running costs	Administration, consultants, engagement and communication, equipment and capital purchases, other expenses, professional development/capacity building, salary and wages, travel and accommodation, other contributions
Project service delivery costs	Program delivery expenses

SOURCE: ACIL ALLEN CONSULTING, ADAPTED FROM PROJECT FINANCIAL TEMPLATES

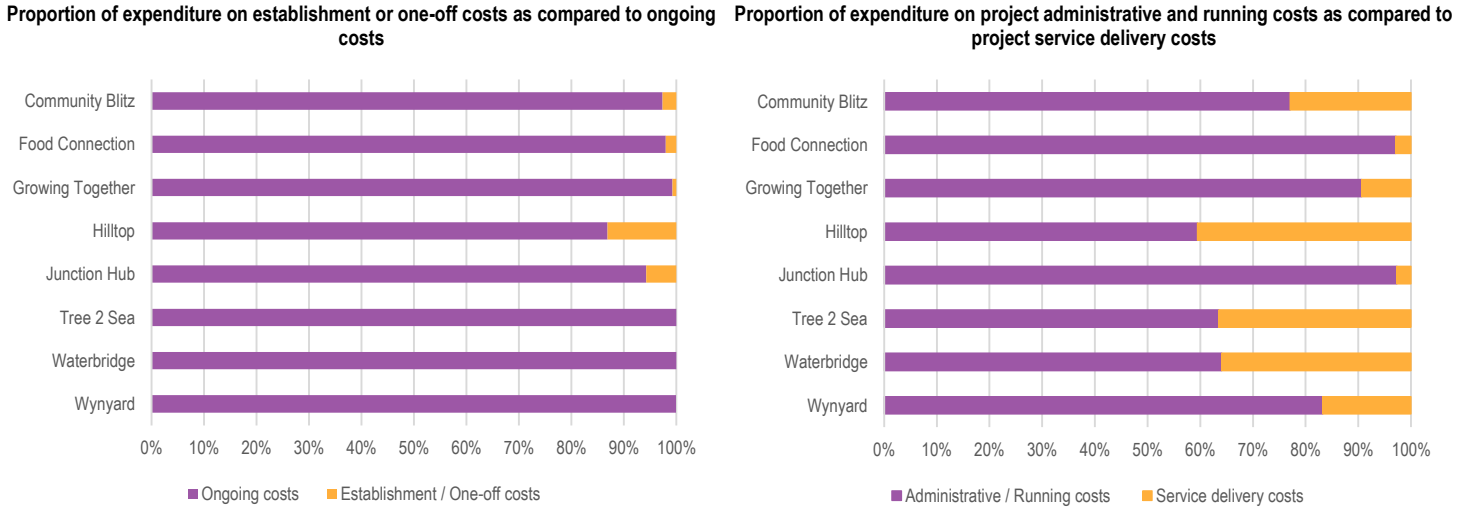
As shown in Figure 9.3, all the projects spent more on ongoing costs than establishment or one-off costs (0 to 13 per cent of costs were categorised as establishment or one-off costs), and spent more on administration or running of the projects than on service delivery (64 to 97 per cent of costs).

None of the projects required substantial capital expenditure out of their budget as part of establishment costs. This is attributed to the intention to leverage community resources, as part of a collective approach. Items representing large capital expenses were generally contributed in the form of in-kind, for example, land made available to Hilltop for use as a market garden.

Hilltop reported both the highest proportion of expenditure on establishment or one-off costs, and expenditure on service delivery, as compared to the other projects (13 per cent and 41 per cent respectively). Food Connection and Junction Hub reported the lowest proportion of expenditure on service delivery as compared to administrative and running costs, both reporting that three per cent of funds spent went to service delivery. Tree2Sea, Waterbridge, and Wynyard all reported zero one-off

and establishment costs. These differences are likely to be due to differences in the way each project was structured: for example, Tree2Sea is likely to have spent little on project establishment and one-off costs as they were provided with a fully kitted shed as an in-kind contribution; they were originally expecting to pay for this item. Furthermore, some 'capital expenditure' for this project has been categorised as a project delivery cost.

FIGURE 9.3 PROJECT COST COMPOSITION



Note: Establishment / one-off costs include capital expenditure and equipment purchase, all other costs are categorised as ongoing. Program delivery expenses are the only sort of expenses categorised as service delivery costs, all other expenses are categorised as administrative or running costs. The Primary Health Tasmania budget was provided for the period 1 September 2014 to 30 June 2016, while reporting of expenditure, in-kind and cash uplift received by project is for the period 1 September 2014 to 15 May 2016

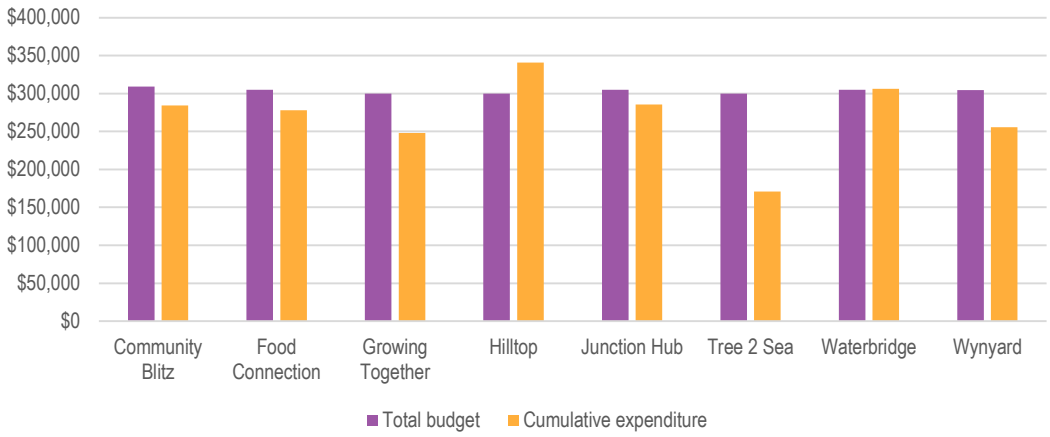
SOURCE: PROJECT FINANCIAL REPORTS, ACIL ALLEN ANALYSIS

Composition of 'over' and 'under'- spend

Only one of the projects, Hilltop, spent substantially more than originally budgeted (see Figure 9.4). In the case of Hilltop, the expenditure over budget was funded by income from the social enterprises run by the project. Tree2Sea was the only project that spent substantially less than budgeted over the period, with expenditure of $170,850 as compared to a budgeted $299,995 for the period.

Furthermore, as referred to above, it is noted that the expenditure period reported ended on 15 May 2016, leaving projects with a further six weeks in which to spend their budgets before the end of the financial year.

FIGURE 9.4 PROJECT BUDGET AS COMPARED TO CUMULATIVE EXPENDITURE



Note: The Waterbridge project expense budget breakdown is sourced from their proposal as the final file submitted included expense budget details for one year. The Primary Health Tasmania budget was provided for the period 1 September 2014 to 30 June 2016, while reporting of expenditure, in-kind and cash uplift received by project is for the period 1 September 2014 to 15 May 2016

SOURCE: PROJECT FINANCIAL REPORTS, ACIL ALLEN ANALYSIS

Most projects spent less than their budget on ongoing costs, apart from Hilltop (see Figure 9.5). Where projects underspent their budget, the underspend was between $0 and $50,000, except in the case of Tree2Sea. Projects generally spent close to their budget on establishment costs, apart from Hilltop (which spent $23,160 more than budgeted in this area).

All projects spent less than their budget over the period on administrative and running costs. This underspend, where present, was less than $50,000 for all projects. Only Hilltop spent substantially more on service delivery than budgeted, all other projects underspent on service delivery. Hilltop spent $47,721 more than budgeted, partially funded by social enterprise income. Tree2Sea was the most under-budget in terms of service delivery costs, spending $88,352 less than anticipated. This was reportedly due to personnel changes that impacted progress in critical areas of the project.

It could be expected that projects will decrease their level of underspend by the end of the financial year (six weeks following reporting date) and completion of their funded projects.

FIGURE 9.5 AREAS OF OVER- AND UNDER- BUDGET SPEND BY PROJECT

Note: The Waterbridge project expense budget breakdown is sourced from their proposal as the final file submitted included expense budget details for one year. The Primary Health Tasmania budget was provided for the period 1 September 2014 to 30 June 2016, while reporting of expenditure, in-kind and cash uplift received by project is for the period 1 September 2014 to 15 May 2016

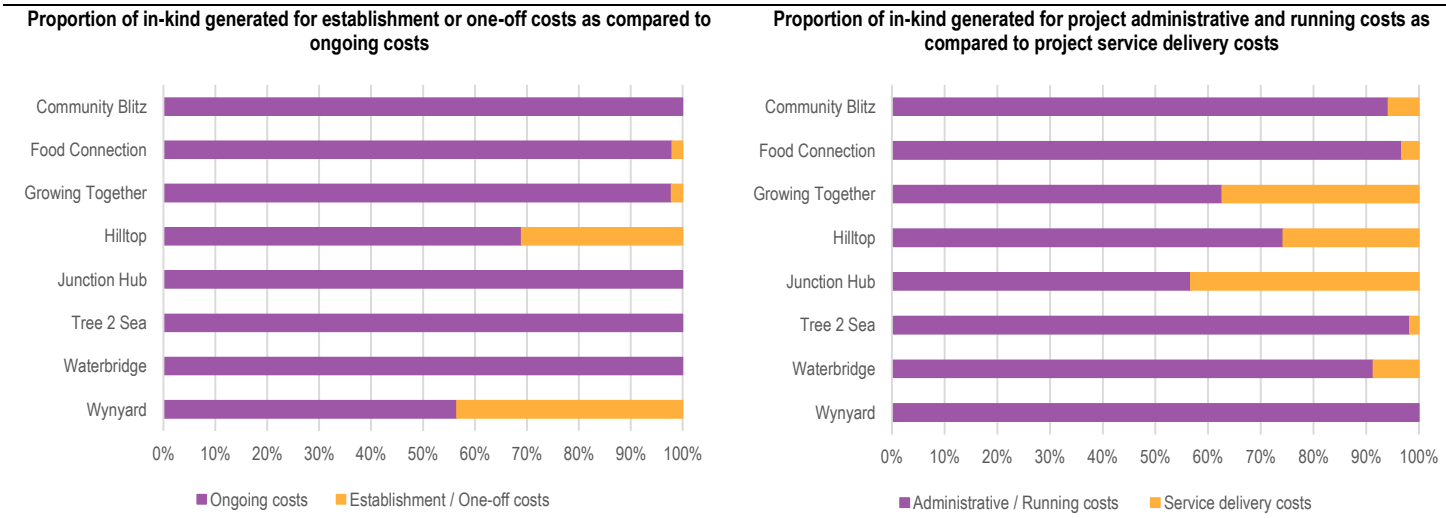
SOURCE: PROJECT FINANCIAL REPORTS, ACIL ALLEN ANALYSIS

9.3.2 In-kind contributions composition analysis

All projects received more in-kind contributions relating to ongoing costs than to establishment or one-off costs (0 to 43 per cent of in-kind contributions generated was categorised as establishment or one-off costs, see Figure 9.6). Six out of eight of the projects categorised on average one per cent of their costs as establishment or one-off costs. All projects also received more in-kind contributions in relation to the administration or running of the projects than in-kind contributions related to service delivery (57 to 100 per cent of in-kind contributions generated were categorised as related to administrative or running costs, see Figure 9.6). Six of the eight projects categorised on average four per cent of their costs as service delivery costs.

Wynyard reported the highest proportion of total in-kind contributions received to establishment or one-off costs (44 per cent of in-kind contributions were for establishment or one-off costs), followed by Hilltop (31 per cent of in-kind contributions were for establishment or one-off costs). Junction Hub and Growing Together reported the highest proportion of total in-kind contributions received to service delivery costs, 43 and 37 per cent of total in-kind contributions were for service delivery costs, respectively. Junction Hub, Tree2Sea and Waterbridge reported no in-kind contributions towards establishment and one-off costs, while Wynyard was the only project to report no in-kind contributions to service delivery costs. However, it is noted that the way in which projects sought to report in-kind qualitatively rather than quantitatively may have meant that, for example, in-kind contributed towards service delivery was understated.

FIGURE 9.6 PROJECT IN-KIND COMPOSITION



Note: The Primary Health Tasmania budget was provided for the period 1 September 2014 to 30 June 2016, while reporting of expenditure, in-kind and cash uplift received by project is for the period 1 September 2014 to 15 May 2016

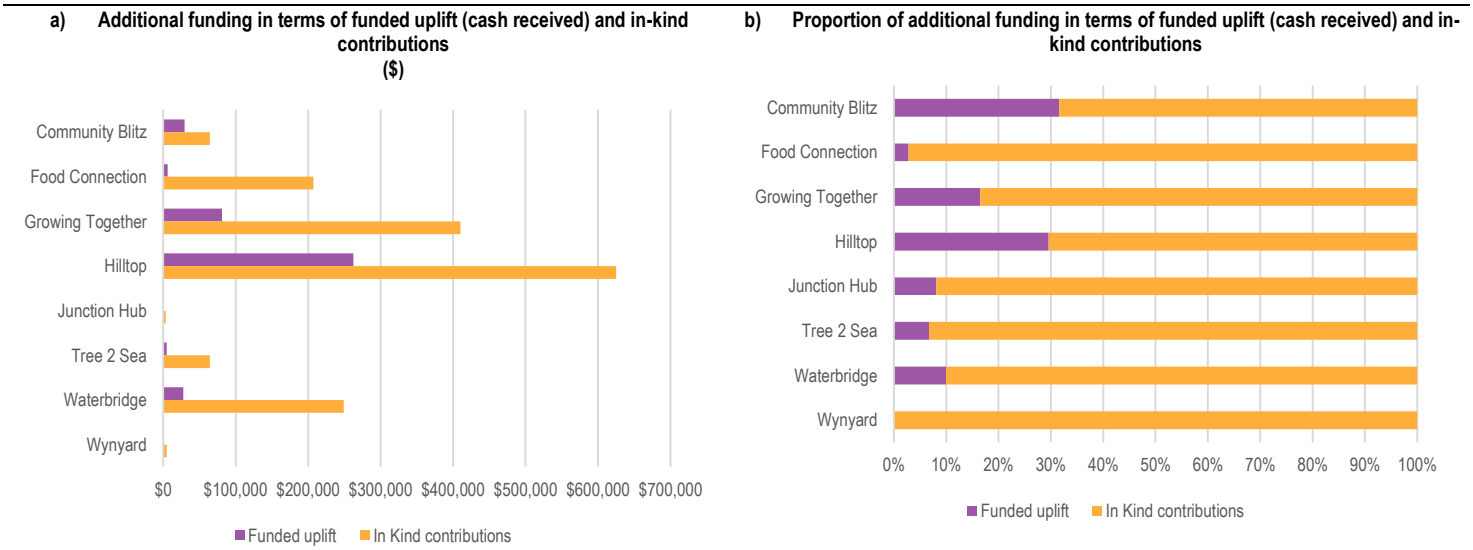
SOURCE: PROJECT FINANCIAL REPORTS, ACIL ALLEN ANALYSIS

9.3.3 Funding composition analysis

As discussed previously, projects were able to generate in-kind with varying levels of success. This also applies to cash funding, as illustrated in Figure 9.7. Hilltop was able to generate the highest level of additional cash funding (funded uplift), of $262,277, followed by Growing Together, which was able to generate a cash uplift of $80,985.

Not including Wynyard, all projects received more in-kind contributions than cash contributions (outside Primary Health Tasmania funding). Community Blitz achieved the lowest ratio of cash to in-kind contributions, raising 2.2 times the amount of in-kind contributions as compared to cash. In other words, for every dollar of cash contributed, Community Blitz received in-kind contributions valued at $2.20. Food Connection, on the other hand, received in-kind contributions of $34 for every dollar of cash received.

FIGURE 9.7 COMPOSITION OF ADDITIONAL FUNDING



Note: Primary Health Tasmania budget was provided for the period 1 September 2014 to 30 June 2016, while reporting of expenditure, in-kind and cash uplift received by project is for the period 1 September 2016 to 15 May 2016. Note that the funded uplift for Junction Hub is too small to register in Figure 9.7a).

SOURCE: PROJECT FINANCIAL REPORTS, ACIL ALLEN ANALYSIS

9.4 Value for money analysis

This section considers the value that each project was able to produce based on the provision of Primary Health Tasmania funding, in terms of both the project's size and the amount of funding each project was able to generate. Following this, early outcomes of each of the projects are summarised.

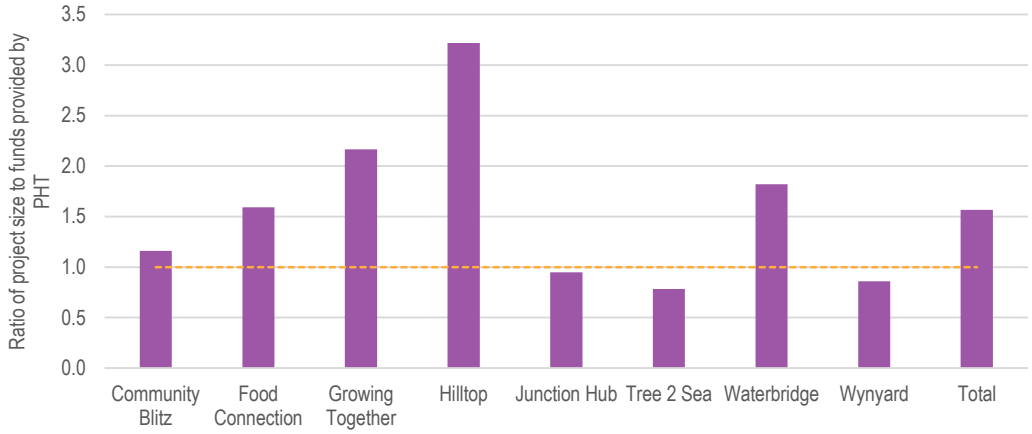
9.4.1 Value of project activities considering Primary Health Tasmania funding provided

On average, projects were able to undertake more activity, calculated by adding expenses and in-kind contributions, than they were funded for. Overall, projects were able to undertake activities worth 1.6 times the funding they were provided with by Primary Health Tasmania (see Figure 9.8). That is, for every dollar provided by Primary Health Tasmania, projects were able to leverage an additional $1.60 cents from other sources (including in-kind and cash contributions).

Hilltop was able to undertake the greatest amount of project activity, based on funding provided by Primary Health Tasmania, cash uplifts, and in-kind contributions. The Hilltop project was worth $965,836 by May 2016, 3.2 times the value of the funds provided to the project by Primary Health Tasmania. Growing Together was the second largest project by the end of the period; the project was able to grow to 2.2 times the amount of funding provided. Junction Hub, Tree2Sea, and Wynyard were not able to undertake as much activity as they were funded for. These projects had a ratio of size (expenses plus in-kind contributions) to Primary Health Tasmania funding of 0.9, 0.8, and 0.9 respectively.

Differences between the projects in terms of the activity they were able to undertake as compared to the funding received is related to project maturity and the type of projects that were undertaken. Successful social enterprises, such as Hilltop, can be expected to have grown larger than the initial seed funding provided as they were able to successfully generate income from enterprise activities to fund expansion. Projects such as Tree2Sea, which are relatively less mature, are less likely to be able to achieve such levels of growth in the same period due to delays in implementing the project.

FIGURE 9.8 RATIO OF PROJECT SIZE TO PRIMARY HEALTH TASMANIA FUNDING PROVIDED



Note: The yellow dotted line on the chart refers to the size of the project (in terms of activities undertaken, calculated by adding expenses and in-kind contributions), if size of the project equalled the amount of funding provided by Primary Health Tasmania. Funding was provided for the period 1 September 2014 to 30 June 2016, while reporting of expenditure, in-kind and cash uplift received by project is for the period 1 September 2014 to 15 May 2016

SOURCE: PROJECT FINANCIAL REPORTS, ACIL ALLEN ANALYSIS

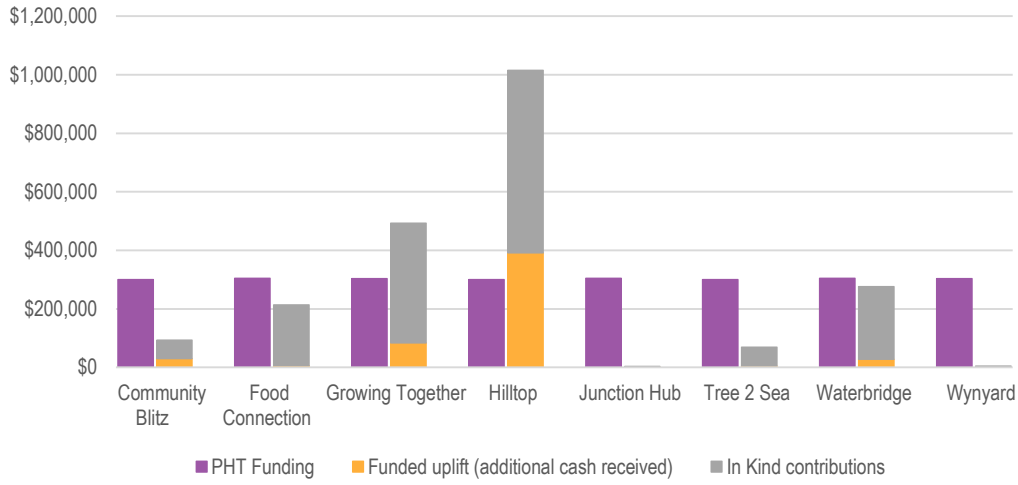
9.4.2 Leveraged funds (additional cash uplifts and in-kind contributions)

Hilltop was the most successful in leveraging additional funds from the community, raising $2.96 for every dollar provided by Primary Health Tasmania over the period (raising $887,367 of in-kind and additional cash uplift, as compared to $300,000 provided by Primary Health Tasmania, see Figure 9.9). Much of the additional contributions raised were in the form of in-kind services and goods that Hilltop was able to benefit from but did not have to pay for, such as five acres of land from TasTAFE worth $100,000. They were also able to raise almost $90,000 worth of income from the store attached to the project.

Growing Together was the second most successful in leveraging additional funds from the community, raising $1.62 for every dollar provided by Primary Health Tasmania. Growing Together raised most of these funds in the form of in-kind contributions, particularly in the form of community services they were able to receive in-kind (Certificate II and III in Community Services courses, worth a total of $127,000). They were also able to obtain grants from the community, including Commonwealth Bank community grants and a grant from the Cape Hope Foundation (worth $31,590 in total).

None of the other projects were able to generate more funds in-kind or in the form of a cash uplift than originally provided by Primary Health Tasmania. Two projects, Waterbridge and Food Connection, were almost able to match the budget provided by Primary Health Tasmania; Waterbridge was able to raise $0.91 for every dollar provided by Primary Health Tasmania, this figure stands at $0.70 for Food Connection. The remaining projects, Community Blitz, Junction Hub, Tree2Sea, and Wynyard, generated between $0.01 and $0.31 for every dollar provided by Primary Health Tasmania. However, these figures may have been understated if projects did not systematically report in-kind contributions received over the period.

FIGURE 9.9 LEVERAGED FUNDS: PRIMARY HEALTH TASMANIA FUNDING AS COMPARED TO FUNDS RAISED INDEPENDENTLY (CASH AND IN-KIND)



Note: The Primary Health Tasmania budget was provided for the period 1 September 2014 to 30 June 2016, while reporting of expenditure, in-kind and cash uplift received by project is for the period 1 September 2014 to 15 May 2016.

SOURCE: PROJECT FINANCIAL REPORTS, ACIL ALLEN ANALYSIS

9.4.3 Early outcomes

All the projects funded by Primary Health Tasmania have shown positive early outputs and outcomes as a result of their projects, although these have been subject to little quantification. This is because social determinants of health are expected to change slowly over time, while the projects have been running for only two years.

Table 9.3 briefly summarises the positive results of projects, in terms of their early outputs and outcomes as reported by projects. It then proceeds to consider which of the social determinants of health these outputs and outcomes may impact, supported by international literature.

TABLE 9.3 EARLY RESULTS OF PROJECTS AND THEIR EXPECTED IMPACT ON SOCIAL DETERMINANTS OF HEALTH

Project name	Outputs	Outcomes	Social determinants of health impacted
Community Blitz	– Contribution of volunteer labour to activities resulting in the distribution of garden grown food – 6 participants went directly from Blitz into employment, 1 was employed on a part time basis – Various volunteering activities in the community	Improved access to healthy affordable food, and increased employment in the local area has been achieved	Access to healthy food is associated with decreased susceptibility to disease generally, as well as in relation to specific illnesses. Furthermore, poor nutrition is associated with obesity which is strongly related to incidence of chronic disease[3]. Employment, and therefore income, is associated with improved health outcomes as it enables access to food, housing, healthcare, recreation, and opportunities for better education[4].
Food Connection	– Supply of healthy food through the Food Shed has improved access to food in the community – Improved education on healthy eating through school programs and other educational support – Volunteering involving various socioeconomic groups	Improved access to healthy affordable food has been achieved, increased community integration is expected	School based food and nutrition educational programs are associated with the prevention of chronic diseases, with relatively high cost effectiveness[5]. Access to healthy food is associated with decreased susceptibility to disease generally, as well as in relation to specific illnesses. Furthermore, poor nutrition is associated with obesity which is strongly related to incidence of chronic disease[6].
Growing Together	– Increased volunteering in the community – Improved access to fresh food through project food distribution activities and training – Creation of permanent community gardens improving accessibility of fresh affordable food	Improved access to healthy affordable food has been achieved, increased community integration is expected	Increased community integration and volunteering is associated with improved wellbeing and mental health among volunteers[7]. Access to healthy food is associated with decreased susceptibility to disease generally, as well as in relation to specific illnesses. Furthermore, poor nutrition is associated with obesity which is strongly related to incidence of chronic disease[8].
Hilltop	– 32 of the 55 jobseekers and volunteers involved gained work due to training provided – More than 20 community members involved in store and café, more than 30 in the catering business, more than 10 in market research activities – Latest round of jobseeker projects included 22 placements	Increased employment in the local area has been achieved	Employment, and therefore income, is associated with improved health outcomes as it enables access to food, housing, healthcare, recreation, and opportunities for better education[9].

[3] Australian Medical Association. 2007. *Social Determinants of Health and the Prevention of Health Inequities*
[4] National Rural Health Alliance. 2011. *The Determinants of Health in Rural and Remote Australia*
[5] WHO. 2013. *The Economics of Social Determinants of Health and Health Inequities: a resource book*
[6] Australian Medical Association. 2007 Op. cit.
[7] Musick, MA., and Wilson, J. 2003. "Volunteering and depression: the role of psychological and social resources in different age groups", *Social Science and Medicine*, vol. 56: 267; Borgovni, F. 2008. "Doing well by doing good. The relationship between formal volunteering and self-reported health and happiness", Social Science and Medicine, vol. 66: 2331
[8] Australian Medical Association. 2007 Op. cit.
[9] National Rural Health Alliance. 2011 Op. cit.

Project name	Outputs	Outcomes	Social determinants of health impacted
Junction Hub	– Increased support for referrals to youth services – Increased update of services among youth target population	Improved school engagement, employment, housing access among young people is expected due to improved referrals, but not reported	Increased school engagement and improved schooling outcomes is associated with better health into adulthood, particularly due to improved health behaviours. There is evidence that education has a protective effect against various health issues including mental health problems, chronic disease, and sexually transmitted disease[10].
Tree 2 Sea	– Increase in number of school students involved from 39 to 72 students, including additional participation from referrals – Improved awareness among students of employment pathways – Incorporation of literacy and numeracy tasks into project activities	Improved school engagement and upskilling of students is expected but not yet reported, current results show increased engagement with the project	Increased school engagement and improved schooling outcomes is associated with better health into adulthood, particularly due to improved health behaviours. There is evidence that education has a protective effect against various health issues including mental health problems, chronic disease, and sexually transmitted disease[11].
Waterbridge	– Training provided on budgeting to enable the purchase of healthy food, and home cooking / growing skills – Meetings, events and parties to increase community participation – Volunteer involvement in project activities	Improved access to healthy affordable food, and increased community integration are expected but not yet reported	Access to healthy food is associated with decreased susceptibility to disease generally, as well as in relation to specific illnesses. Furthermore, poor nutrition is associated with obesity which is strongly related to incidence of chronic disease[12].
Wynyard	– Increased collaboration between schools – Walkways built between schools to encourage cross-school communication – Improved connectivity between schools and local businesses, university, and other local organisations – Increased involvement of parents in the education of school students	School engagement is expected but not yet reported, current results show increased engagement between students and community players in the project	Increased school engagement and improved schooling outcomes is associated with better health into adulthood, particularly due to improved health behaviours. There is evidence that education has a protective effect against various health issues including mental health problems, chronic disease, and sexually transmitted disease[13].

SOURCE: PROJECT PROGRESS REPORTS, ACIL ALLEN ANALYSIS

[10] WHO. 2013 Op. cit.
[11] WHO. 2013 Op. cit.
[12] Australian Medical Association. 2007 Op. cit.
[13] WHO. 2013 Op. cit.

9.5 Key findings of financial analysis

All the projects funded by Primary Health Tasmania have presented positively trending results, which may be indicative of their future success. The extent to which positive outputs and outcomes have been reported is partially due to the relative maturity of each of the projects. However, these outputs and outcomes and their impact on social determinants of health cannot be quantified based on present data.

Financial and value for money analysis has been conducted in light of the data that was available to the evaluation for usage. This has likely resulted in the under-reporting of positive outputs and outcomes generated by projects. Some projects possess richer datasets which could be used for deeper analysis in future.

With additional time for projects to mature and gather data, future evaluations may be able to overlay analysis of costs with that of project outputs/outcomes. In order to conduct such analyses, enough time needs to have elapsed such that the outcomes of projects can be seen. For example, a future analysis considering the impact of projects on school engagement could analyse student retainment rates between Year 10 and Year 11 following the implementation of the project. Given the early positive outputs of the projects, it can be expected that such analysis would show improvements in social determinants of health over the long term if the project outputs can be sustained.

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