MOVING THE MOUNTAIN IN HEALTH SYSTEM REFORM: PERSPECTIVES FROM AUSTRALIA

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Presentation by Dr David Briggs
Professor of Health Systems Management
Naresuan University College of Health Systems Management
Director Hunter New England Central Coast Primary Health Network
Editor Asia Pacific Journal of Health Management
Introduction

- Australian Health Care System
- Overview and financing
- Workforce
- Performance
- Governance of the Australian Health System
- Organisation of Health Care – Past Approaches
  - Area Health Services
  - Divisions of General Practice
  - Medicare Locals
- Current structures
  - Local Health Districts
  - Primary health Networks
- Moving the Mountain – current approaches to health reform
Australia has had a lot of reform for health

- Australia has also had ‘Health reform without change and change without health reform’

There is much to be admired about the Thai health system

- We need to answer the questions: What problem are we attempting to resolve?
- What are we attempting to achieve?
- Before we attempt to move the mountain that is health reform
Australian Health Care System

- Commonwealth Parliament
- Eight States and Territories
- Each with their own elected government
- Divided responsibility for health
- Elected local government
- Highly urbanised coastal population
- 24 million people – 27% overseas born – 3% Indigenous
Australia – A Federation of States and Territories

Australia – Large geographically

Figure 1.6

People per square kilometre

- Less than 0.1
- 0.1 to <1
- 1 to <10
- 10 to <100
- 100 or more

Note: Figure shows population density by Statistical Area Level 2 based on the ASGS (see Box 1.1).
Sources: AIHW analysis of ABS 2011a, 2013m.

Population density, 30 June 2012
Population: Ageing

Figure 1.4

Population: Indigenous First People

Figure 1.5

Australian population, by age and sex, June 2013

Source: ABS 2013c.

Aboriginal and Torres Strait Islander population, by age and sex, June 2011

Source: ABS 2013a.
Australia – Leading causes of Death

- Coronary heart disease
- Stroke
- Dementia
- Lung Cancer
- COAD
- Breast cancer
- Prostrate Cancer
- Diabetes
- Colorectal cancer

Age standardised death rates

Figure 3.4

Deaths per 100,000 population

Year

Sources: ABS 2013d; AHW 2013c.

Age-standardised death rates, by sex, 1907–2012
International Comparisons

- In 2009, the overall mortality rate in Australia was amongst the lowest of all OECD countries at 687 deaths per 1,000,000 population, second only to Japan (613).
- In the two decades since 1990, Australia has seen its ranking among OECD countries improve greatly for colon cancer deaths (from 23rd to 7th) and chronic obstructive pulmonary disease deaths (from 27th to 16th).
- Australia’s change in ranking from 1990 to 2009 also improved for deaths due to lung cancer (16th to 10th) coronary heart disease (23rd to 18th), breast cancer (15th to 12th) and suicide (14th to 11th).
International Comparisons (Cont’d)

- The rate of deaths due to diabetes increased slightly between 1990 and 2009 (18.7 to 20.6 deaths per 100,000 population). Dropping below half of the OECD countries in 2009 (15th to 20th).
- Since 1990 death due to accidental falls worsened (10th to 13th).
- Deaths due to transport accidents (15th to 17th).
The Australian Health System - Structure

- Three levels of Government - Commonwealth (National) - State (Provinces) - Local Government

  - Commonwealth
    - Funds States/Territories
      - Funds/operates Hospitals/Community health and Public health Areas, networks or districts
    - Funds PHC, DGP, MLs, PHNs
    - Fund/reimburse general practice and specialists
      - Directly funds Aged Care providers
      - Medicare, subsidises health insurance, Provide PBS & MBS

Local Govt. water, food, buildings, Sanitation, roads
Governments fund about 70% of all health care expenditure
- 57% to public hospitals
  - 40% Commonwealth
  - 60% States & Territories
- In recent times spending on the health of Indigenous Australians was 25% higher than for other Australians
- In the last decade public expenditure had the greatest increase because of immunisation programs
Health Expenditure to GDP ratio

**Figure 2.2**

Health expenditure to GDP ratio (per cent)

**Health to GDP ratio OECD comparison**

**Source**: AIHW health expenditure database.

**Total health expenditure to GDP ratio, 1986–87 to 2011–12**

**Source**: AIHW 2013a.
Total Expenditure on Health 2011-12 ($ billion)

Figure 2.4

Total Health Expenditure by area of expenditure 2011-12

<table>
<thead>
<tr>
<th>Area of Expenditure</th>
<th>Subtotals</th>
<th>Components</th>
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<tbody>
<tr>
<td>Hospitals</td>
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<td>42.0</td>
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<tr>
<td>Public hospitals</td>
<td>11.5</td>
<td></td>
</tr>
<tr>
<td>Private hospitals</td>
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<td></td>
</tr>
<tr>
<td>Primary health care</td>
<td>50.6</td>
<td>18.8</td>
</tr>
<tr>
<td>Medications</td>
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<td>Administration</td>
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<tr>
<td>Capital expenditure</td>
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</table>

(a) Includes general practitioners and vocational registrar services, practice nurses, enhanced primary care services and other unreferred attendances.

(b) Includes recurrent expenditure not paid for directly by hospitals but that was not delivered in the primary health care sector, such as all medical services except general practitioner and vocational registrar services, practice nurses, enhanced primary care services and other unreferred attendances.

Source: AIHW health expenditure database.

Total expenditure on health, by area of expenditure, 2011–12 ($ billion)
Allocated health expenditure by disease group

Figure 2.6

Source: AIHW disease expenditure database.

Allocated health expenditure in Australia, by disease group and area of expenditure, 2008–09
Drivers of expenditure

- Expenditure on adults aged 85+ is almost 20 times as high as expenditure on children aged 5-14.
- Extent to which high expenditure is attributable to ageing is still being debated. Complex issue.
- Technology & Research – a driver of costs or a vehicle for more efficient use of resources.
- Health expenditure has risen faster than either population growth or ageing.
Drivers of expenditure (Cont’d)

- Total expenditure 2012-2013 $147.4 billion – 9.7%. Growth **slowing** (2011-12)
- Average annual growth over last decade was 5.1%
- Non-government spending grew by 7.2%
- Estimated per person spend on health averaged $6,430
- $17 less per person compared to 2011-12
Medicare – A national health insurance system

- A national health insurance system not a national health system and its continued existence is not enshrined in legislation but the Australian public has a high sense of ownership of Medicare

- Podger (2016) suggests it should have the following key principles:
  - Universal coverage:
    - all Australians should have access to health services according to their health needs.
Equitable financing:
- the health system should be funded according to people's capacity to pay.

Efficiency and effectiveness:
- government support for the system should be based on cost-effectiveness in terms of health outcomes.

Consumer and provider satisfaction:
- the system should be oriented to patients and consumers, providing safe, high-quality and convenient healthcare, while respecting the professionalism of those providing the service.
Medi-Scare – A recent political challenge

Let's set the record straight on 'medi-scare'

1. The Coalition extended the freeze on Medicare bulk billing rebates.
2. They raised fees on pathology and radiology.
3. They increased copayments on prescription medicines.
4. They had a task force to privatise the Medicare billing system.
5. They privatised Medibank.
6. They tried to charge a copayment for all GP visits.

And they wonder why we don't trust them?
Universal Coverage – Medicare Levy

- All Australian government funding comes from its general revenues through taxation, one part of which is notionally health related the Medicare levy.
- Funds about 18% of recurrent health funding by the Australian government.
- The levy was established in 1984 at 1% of taxable income.
- Increased a number of times and is currently 1.5%.
- Since October 1997 a further surcharge of 1% was added for high income earners who do not have private health insurance.
Universal Coverage – Medicare Levy (Cont’d)

- Through taxation government also subsidises private health insurance and provides incentives to those who self insure at an earlier age.
- There is also a reinsurance pool where an insurer finds they are insuring a disproportionate number of high cost patients.
- The levy has been increased recently but to pay for a National Disability Scheme.
Medicare arrangements for medical services

- Commonwealth government allows doctors to send the patient's bill directly to the government if they accept the Medicare rebate as full payment (70% of the prescribed/common fee).
- This payment can be made electronically at the GP through the use of the Medicare card.
- Alternatively, the doctor can charge the patient whatever amount they like and the patient pays and seeks reimbursement of that portion of the prescribed/common fee from Medicare.
Medicare arrangements for medical services (Cont’d)

- There has been a longstanding ‘freeze’ on any CPI increase by the government to the prescribed or common fee for each item in the medical benefits schedule.
- Episodes of care can be short or long or for care plans e.g. aged persons, diabetes.
- You cannot self insure privately for personal medical services unless they are deemed as part of an inpatient episode of care.
Private Health Insurance

- Private health insurance (PHI) is readily available and offers more choice of providers (particularly in hospitals), faster access for non-emergency services, and rebates for selected services.
- Government policies encourage enrolment in PHI through a tax rebate and, above a certain income, a penalty payment for not having PHI (the Medicare Levy surcharge).
- The Lifetime Health Coverage program provides a lower premium for life if participants sign up before age 31. There is a 2 percent increase in the base premium for every year after age 30 for people who do not sign up.
Consequently, take-up is highest for this age group but rapidly drops off as age increases, with a trend to opt out at age 50 and up.

Nearly half of the Australian population (47%) had private hospital coverage and nearly 56 per cent general treatment coverage in 2015 (Private Health Insurance Administration Council, 2015).

Insurers are a mix of for-profit and non-profit insurance providers. In 2013–2014, private health insurance expenditures represented 8.3 percent of all health spending (AIHW, 2015).
Private health insurance can include coverage for hospital, general treatment, or ambulance services but not personal medical services provided by GPs.

When accessing hospital services, patients can opt to be treated as a public patient (with full fee coverage) or as a private patient (with 75% fee coverage).

If a provider charges above the MBS fee, the consumer (in hospital) will bear the gap cost unless they have gap coverage.
Private Health Insurance (Cont’d)

- The patient may also be charged for costs such as hospital accommodation, surgery fees (implants and theatre fees), and diagnostic tests.
- General coverage provides insurance for dental, physiotherapy, chiropractic, podiatry, home nursing, and optometry services. Coverage may be capped by dollar amount or number of services.
- Private health insurance coverage varies by socioeconomic status. PHI covers just one-third of the most disadvantaged 20 percent of the population, a proportion that rises to more than 79 percent for the most advantaged population quintile.
This disparity is due in part to the Medicare Levy surcharge applied to higher-income earners (Australian Bureau of Statistics [ABS], 2013).

Some suggest that the cost to government of subsidising health insurance would be better spent on increased public sector direct provision-discussion point - public good pluralistic society.
Pharmaceutical Benefits Scheme

- Pharmaceutical subsidies are provided through the PBS.
- Pharmaceuticals need to be approved for cost-effectiveness by the independent Pharmaceutical Benefits Advisory Committee (PBAC) to be listed.
- War veterans, the widowed, and their dependents may be eligible for the Repatriation PBS (DHS, 2015)
- Out-of-pocket pharmaceutical expenditures are capped
In 2015 the maximum cost per prescription for low income earners was set at AUD6.10 (USD3.97) with an annual cap of AUD366 (USD238).

For the general population, the cap per prescription is AUD37.70 (USD24.55) per prescription, which reverts to the low income rate cap if they incur more than AUD1,454 (USD947) in out-of-pocket expenditure within a year.

Consumers pay the full price of medicines not listed on the PBS.

Pharmaceuticals provided to inpatients in public hospitals are generally free.
In 2013, there were 25,702 GPs, and a slightly higher number of specialists (27,279) (AIHW, 2015a).

GPs are typically self-employed, with about four per practice on average (DH, 2015, and DHS, 2015).

The schedule of service fees is set by the federal health minister through the MBS.

Registration with a GP is not required, and patients choose their primary care doctor.

GPs operate as gatekeepers, in that a referral to a specialist is needed for a patient to receive the MBS subsidy for specialist services.
Patients are able to choose which specialist they see, but must be referred by their GP to receive MBS subsidies.

The fee-for-service MBS model accounts for the majority of federal expenditures on GPs, while the Practice Incentives Program (PIP) accounts for 5.5 percent (ANAO, 2010).

The number of nurses working in primary care has been increasing, from 8,649 registered or enrolled nurses primarily working in a general practice setting in 2011 to 11,370 in 2014.

GPs are required to ensure that after-hours care is available to patients, but are not required to provide care directly.
Cost-sharing and out-of-pocket spending

  - (38%) was for medications
  - (20%) dental care
  - Gap Payments to GPs
  - About 83 percent of GP visits were provided without charge to the patient in 2014–2015.
  - Patients who were charged paid an average of AUD31 (USD20) (DH, 2015)
  - In January 2016, a new Medicare Safety Net will replace the previous Original Medicare Safety Net, the Extended Medicare Safety Net, and the Greatest Permissible Gap arrangements.
Out-of-pocket payments accounted for 18 percent of total health expenditures in 2013–2014. (Cont’d)

(Medicare will reimburse 80 percent of out-of-pocket costs (up to a cap of 150 percent of the MBS fee) for the remainder of the calendar year once annual thresholds are met.

In addition, patients with out-of-pocket expenses for disability aids, attendant care, or aged care can claim the income-tested Net Medical Expenses Tax Offset.

Co-payments can impose a serious obstacle to access to care in Australia than in most comparable countries (Podger – Commonwealth Fund).
Supply side controls

- The Medicare Benefits Schedule review taskforce was examining all the services on the schedule to see whether they were justified and whether the price reflected their effectiveness.
- A firm review of the Pharmaceutical Benefits Scheme, taking more advantage of generic medicines, could deliver significant savings.
- Avoidable and preventable admissions.
- Examining options to reduce the MBS's reliance on fee-for-service, which can encourage over servicing. Preference for blended payments and incentives e.g. Immunisation.
Supply side controls (Cont’d)

- Care for those with chronic illnesses or appropriate screening of high-risk patients.
- Stepped care – fitting the level of care to the level to potential indicators of morbidity and degrees of acuity from prevention and reducing need to access tertiary acute services.
- Hospital in the home to be trialled through general practice – enrolment/capitation.
Health Workforce

- Workforce increasing by 22% approx. in last two five year inter census periods
- Similar number of practising medical practitioners as OECD average
- Higher per capita number of practising nurses
- Higher concentration of health professionals in major cities than that for the broader population
- Ageing workforce
- Shortages and maldistribution actual and projected
- Dependant on overseas trained health professionals, particularly rural/remote GPs
Public hospitals

- organized into Local Hospital Networks (LHNs) or local health districts (LHDs), of which there were 138 in 2013–2014
- These vary in size, depending on the population they serve and the extent to which linking services and specialties on a regional basis is beneficial
- State governments fund their public hospitals largely on an activity basis using diagnosis-related groups
Federal funding for public hospitals includes a base level of funding, with growth funding set at 45 percent of the “efficient price of services” of activities, determined by the Independent Hospital Pricing Authority (IHPA).

States are required to cover the remaining cost of services, providing an incentive to keep costs at the efficient price or lower. Small rural hospitals are funded through block grants (IHPA, 2015).
Divided Responsibilities

- **Commonwealth (National) Government**
  - Responsible for PHC mostly through private gp
    - Divisions of General Practice (117) - 20 years
    - Medicare Locals (61) – 3 years
    - Primary Health Networks (30) – From July 2015
  - Also responsible for Aged Care, Veterans, Disability and increasingly Mental Health
  - Medicare, Health Insurance, Pharmaceuticals and Technology
- **State and Territory (Provinces) Governments**
  - Responsible for acute care, hospitals but also community health, public health through
  - Independent Hospitals with community Boards – Up to 1980s
  - Large Area Health Services -
  - Local Health Districts – 136 (123 regions, 13 State-wide) 15 in NSW
- **Local Government**
  - Sanitation, waste, water supplies, buildings, community services
Who Governs the Australian Health System

• State and Federal health ministers referred to as Standing Council on Health

• Established and responsible for the Australian Health Ministers Advisory Council (AHMAC). Part of the Australian Council of Australian Governments (COAG)
  • Includes Minister for Veteran Affairs and NZ Minister for Health and is meant to improve:
    – Seamless care across sectors of the health system
    – Quality of care through high performance standards, transparency and engagement of local clinicians
    – Secure funding base for health and hospitals into the future
    – Ensure the development of public health policy and comprehensive health services across the system

• Exercised through Australian Health Care Agreements
Commonwealth and State Health Bodies

- Commonwealth
- Australian Commission on Safety and Quality in Health Care (ACSQHC)
- Australian Institute of Health and Welfare (AIHW)
  - *Australian National Preventive Health Agency (ANPHA)
- Cancer Australia (CA)
- Food Standards Australia New Zealand (FSANZ)
  - *General Practice Education and Training Limited (GPET)
  - *Health Workforce Australia (HWA)
- National Blood Authority (NBA)
- National Health and Medical Research Council (NHMRC)
- National Health Funding Body (NHFB)
- Private Health Insurance Administration Council (PHIAC)
- Private Health Insurance Ombudsman (PHIO) - Statutory Office Holder and Agency
  - Professional Services Review (PSR)
  - *Independent Hospital Pricing Authority (IHPA)
  - *National Health Performance Authority (NHPA)
  - National Mental Health Commission (NMHC)
  - NSW
  - Ministry
  - Agency for Clinical Innovation
  - Bureau of Health Information
  - Clinical Excellence Commission
  - Health Education & Training Institute
Organisation of Health Care – Slowly taking control

- Variable across the States
- Separate Hospital/ Health Departments/ Health Commissions with Regions/ back to departments to Ministry
- Stand alone hospitals with community boards
- Pilot Area Health Services late 1970s small in scale
- Health Districts in rural areas 1990s then AHS
- Increase size and scale of AHS in late 1990s
- Removed Boards, AHS directly controlled by Health Departments
- Importance of Boards of governance - engagement
Area Health Services – NSW and QLD examples

- Pilot Area Health Services in NSW late 1970s typically 5 hospitals and health centres small geographically defined with CE and community board – high decentralisation

- 17 AHS in late 1990s with Board of Directors and CE appointed by government

- Reduced to 8 AHS. No Board controlled by Department – High centralisation

- Qld highly centralised 1990s then 3 large regions with 21 districts, then 38 districts controlled centrally
Rural Districts and Urban AHS

17 Area Health Services
Area Health Services

- Judicial Inquiry into acute Health Care in NSW (Garling) 2008
- Special Commission of Inquiry into Public Hospitals in Qld 2005
- National Health and Hospitals Reform Commission
- Widespread failure of large scale AHS that disengaged with clinicians and communities
- Centrally managed and controlled
- Led to creation of smaller scale Local district health services with Boards for acute care and Medicare Locals
Local Health Districts NSW (Hospitals)
Divisions of General Practice and their GPs

- In 1989 General Practice was recognised as distinct medical discipline
- In the early 1990’s two main issues were identified as problems for GPs: an increasing sense of isolation felt by GPs and an increasing exclusion of general practice from the overall health care system
- "The Future of General Practice: a strategy for the nineties and beyond". (1992)
- 1992/93 Federal budget the Divisions and Projects Grants Program was established
- 110 Divisions of General Practice cover all of Australia

What Divisions Do

- Programs
  - Immunisation
  - eHealth
  - Chronic Disease Mgt
  - Medicines Programs
  - Workforce Support
  - Education and Training
  - Mental Health
  - Allied Health Services

- Medical Specialists
- Quality Improvement
- Accreditation
- General Practice Nursing
- Indigenous Health
- Aged care initiatives
- Refugee Health
- Health Promotion
Divisions of General Practice

NSW- Divisions of General Practice
PHC - Medicare Locals

ML Objectives

- Improving the patient journey through developing integrated and coordinated care
- Provide support to clinicians and service Providers to improve patient care
- Identify health needs of local areas and develop responsive services – assessment, identify gaps and implementing strategies
- Facilitate implementation of PHC initiatives and programs
- Efficient, accountable, strong governance, effective management.
Primary Health Networks (PHNs)

- Established June 2015
- 30 across Australia, funded by Commonwealth government
- Similar role to MLs but not to deliver services
- To purchase, contract and commission services and support PHC professions
Primary Health Networks (PHNs) (Cont’d)

- Only deliver services where there is market failure
- Patient outcomes can be improved by an organisation that reduces fragmentation of care
- The role of general practice is paramount
- Increasing leverage as facilitators and purchasers
- Improving financial performance
What do we do

HNECC PHN supports GPs and other health professionals, and delivers a range of programs.

Supporting health care professionals with:
- Health Pathways - an online portal of localised clinical pathways
- Continuing professional development
- Electronic referrals and eHealth records
- Accreditation and quality standards
- Chronic disease management and care coordination
What do we do (Cont’d)

We also fund, innovate, research, design, plan healthcare and support services and programs for people in the community and populations including:

- Closing the Gap Aboriginal Health programs
- After Hours GP care
- Primary Mental Health Services
- Primary Allied Health Services
- Health screening and immunisation
• Over 1.2 million people
  Significant Geographical Area
  133,812 km²
• 27 Local Government Areas (16
  with significant socio-
  economic disadvantage)
• 18.3% aged 65 years and over
  (14.4% nationally)
• The largest Aboriginal Population
  of any NSW PHN (4.2%
  identifying as ATSI vs 2.5%
  nationally)
• Only 4.2% of the ATSI population
  is aged 65 years or older
Key Facts – Access to Care

- 1322 General Practitioners across 401 practices (81% of HNECC population saw a GP in the past 12 months, 17 LGAs have lower than average GPs per 100,000 residents)
- 31 Public Hospitals (top 3 potentially preventable hospitalisations are cellulitis, COPD and dental conditions)
- 183 aged care facilities (10 LGAs have significantly lower places per 1000 people aged 70 years and over)
Moving our Mountain

- Managing downward fiscal pressure and increasing capacity and demand for services
  - Not letting health spending continue to increase faster than GDP or allowing service providers to exploit their powerful positions.
  - Define the National principles of Medicare and the health system, and the underlying values of a pluralistic society
  - Accept that we are dealing with a moral hazard where consumers and providers do not need to pay for services and where the market has limited influence
    - Obamacare – Affordable Care Act. Remember there is always a cost to healthcare delivery
Ensuring we deliver the right mix of care for the chronically ill and frail aged, allocating resources optimally requires a more integrated system with a stronger primary healthcare infrastructure supporting the new primary health networks as they develop partnerships on the ground with regional hospital networks.
Moving our Mountain (Cont’d)

- Improve the effectiveness of care.
  - Understanding and analysing ‘big data’
  - Implementing shared clinical pathways, evidence based medicine, new models of care, ‘hospital in the home’
  - Population health – identifying at risk and disadvantaged groups and identifying new approaches to addressing disadvantage (Podger, 2016)
  - Measuring performance and outcomes

- Greater investment to address the social determinants of health

- Harmonising or a refocus of health insurance systems – consumer choice
Local approaches to how services are delivered through regional funding without too much prescription, innovative frameworks of innovation, research, service design, population health and planning (HNECCPHN)

Using social media to engage and network across organisations with expert groups and communities to innovate how to deliver services in newer more cost effective ways, redesign approaches that are not effective, develop distributed networks of research and practice
How they can implement knowledge-based health development successfully is the crucial issue.

The passive ill-health-oriented system needs to be reformed to a good-health-oriented system.

Research should lead to development and development lead to more research relevant to development needs.

1. Creation of relevant Knowledge
2. Social movement
3. Political Involvement

Source: Professor Prawase Wasi (2000)
pay more attention in finding and developing *health policy leaders* who can mobilize resources for health development

- Creation of Relevant Knowledge - Social Movement - Political Involvement

*Source: Professor Prawase Wasi (2000)*
From a Leadership and management perspective

1. Health service structures should reflect the diversity of need and differences in geographic location of populations, culture and healthcare needs.
2. Health services at the service delivery level need to have the capacity to achieve inter-sectoral collaboration.
3. Governance should take into account how adequate levels of accountability, trust and stewardship can be restored to the health system

APJ HM DS Briggs 2008;3 (2)11-13
4. Debate about the degree of centralisation and decentralisation should consider the issue of how far those responsible for delivering care should be situated from those who receive care; and that to be effective, managers need to be able to manage out and down to staff and communities and other stakeholders as well as up to central authorities.

5. The relationship between providers and recipients of care requires that health service managers need to be accessible to multi-disciplinary clinical teams and be capable of developing environments, cultures and systems to support the delivery of safe, quality care. The SHAPE Declaration 2008
Health Leadership – Essential requirements for good public policy and management of health services

- Priority in resourcing and policy implementation should be given to developing leadership, management and governance as the means to strengthen health systems development;
- Successful management of health services requires leadership and teamwork from managers who have positive personal and professional values and self perceptions and are empowered to engage with individuals and communities and to respond to the needs of the poor and to marginalised groups;
- Leadership for health systems, public health and PHC requires that managers have access to high quality education, training and experiential health context and knowledge that equips them to operate effectively in health systems;
- A research culture is required that networks and engages in collaborative research to develop health management capacity and evidence as a basis for decisions, to guide policy development and that both challenges and aligns researchers and operational health systems professionals, citizens and communities;
- Outcomes identified from this conference for leadership and health management education training and research be conveyed to health organisations, professional bodies, local government, Ministry(s) of Health and Education and research funding bodies.

Health Leaders and managers need to be supported in their roles by:

1. Being trained and experienced to lead and manage in a range of differing health system and organisational arrangements.

2. Possessing a deep contextual understanding of health systems, public policy, professional cultures and politics.

3. Having competency in organisational sensemaking as negotiators of meaning, active participants, constructors, organisers and persuaders within health systems.

4. Being drawn from a range of backgrounds including those with clinical and non-clinical experience and qualifications who can demonstrate broad contextual health knowledge that demonstrates more than one logic.

5. Understanding how clinical work should be structured and managed and work actively with clinicians and others to deliver coherent, well-managed health services.


