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Designing a Health System for Equity

The key discussions about the relationship between health and equity have understandably concerned the causal relationship between various social, economic, cultural and environmental determinants of health and the health status of populations by socio-economic status, class or other divisions that may be used to illustrate health inequalities. (Acheson (1998); "Bringing Britain together" (1998); Kawachi et al (1997); Canada (1997); Dixon (1999); Marmot (1998); Wilkinson (1996); RACP (1999); WHO (1998), Cochrane/Campbell (2000))

Similarly, there has been key discussion about the nature of organizations and their ability to affect and/or respond to change. We know quite a deal about organizations and their structures. And we now have (as we be shown below) an understanding from both practice and theory of the changes needed for organizations to evolve successfully.

If we are to examine health systems in the light of these two sets of knowledge there are key questions that must be considered:

1. What is the role of the health system in contributing to health outcomes and health status?
2. Do specific sub-systems of the health system affect health outcomes and health status more positively than others? and
3. Does primary health as a specific leading sub-system offer better health outcomes than acute care?

Part 1
The Context of Organisational Reform

What do we know about organizations and how they organise? Mintzberg (1993) makes a number of observations about them, in particular about the environments in which organizations operate and the goals and functions of specific organizations. He notes that the older, larger and more diverse an organization the more likely it is to be organised around a matrix if it is to be successful especially in a dynamic and complex environment:

- The more dynamic the environment, the more organic the structure. (p 270)
- The more complex the environment, the more decentralised the structure. (p 273)

At the same time bureaucracies tend toward standardisation and centralisation especially when faced with a hostile or unstable environment that drives them to centralise. (p 287)

Mintzberg suggests there are five key types of organization. He identified a range of
characteristics that have been simplified below to address the issues raised in this discussion:

### Table 1: Organisational Types

<table>
<thead>
<tr>
<th>Type of Organization</th>
<th>Prime Coordinating Mechanism</th>
<th>Key Part of Organization</th>
<th>Role of Key Part</th>
</tr>
</thead>
<tbody>
<tr>
<td>The Single Structure</td>
<td>Direct supervision</td>
<td>Strategic apex</td>
<td>All administrative work</td>
</tr>
<tr>
<td>The Machine Bureaucracy</td>
<td>Standardisation of work processes</td>
<td>Technostructure</td>
<td>Elaborated to formalize work</td>
</tr>
<tr>
<td>The Professional Bureaucracy</td>
<td>Standardisation of skills</td>
<td>Operating core</td>
<td>Skilled standardized work with much individual autonomy</td>
</tr>
<tr>
<td>The Divisionalized Form</td>
<td>Standardisation of outputs</td>
<td>Middle line</td>
<td>Formulation of divisional strategy, managing operations</td>
</tr>
<tr>
<td>The Adhocracy</td>
<td>Mutual adjustment</td>
<td>Support staff</td>
<td>Highly elaborated but blurred within middle in project work</td>
</tr>
</tbody>
</table>

Mintzberg, *The Structuring of Organizations* (Table 221-1, p 466-7)

According to Morgan (1997) organizations are (among other characteristics) systems of governance with organisational politics, conflict, divergent interests and power bases. Organisational culture can be characterised in four ways:

- “We'll do it this way.” – autocratic
- “We should do it this way.” – bureaucratic
- “It’s best to do it this way.” – technocratic
- “How should we do it?” - democratic

Morgan, (1997, pp 155-161)

Health Departments from the mid twentieth century, along with most public sector agencies, fall into one of the middle three of Mintzberg’s classification and within the first three of Morgan’s if not a combination of them. They are rarely “adhocracies” or democratic as they have strongly hierarchical chains of command with restricted devolution of decision-making despite popular rhetoric to the contrary. This is becoming more so as politicians and the media promote “accountability” as a key factor in public sector and government, and Ministers move to exert control as the embodiment of the democratic will of the electorate.
Yet it may be that this often covert retreat away from attempted overtly decentralised management is precisely why public sector agencies remain unresponsive to change and increasingly bureaucratic. At a time when we know that local decision making, community and consumer participation, and social connectedness promote equity, could it be that health agency structures are reducing our ability to tackle health inequalities and achieve the best health outcomes?

Wheatley (1994, p 119) has suggested that “Order itself is not rigid, but a dynamic energy swirling around us.” In drawing analogies with the chaos theory of nature, she argues that the best organizations are “fractal”, that is are made up of many seemingly different but complimentary parts that work together to form the whole. Organizations with strong guiding values or principles exhibit trust in these differences and by maintaining focus rather than a need for hands-on control, create flexibility and responsiveness through concepts rather than rigid bureaucratic structures. (pp 132-3)

Wheatley is describing the processes that have underpinned the various attempts at intersectoral collaboration in the public sector that have come to dominance throughout the developed and developing world. The UK Government's Third Way, many of the Australian experiments in place management¹ and intersectoral action, and the emerging trend in the developing world to apply development principles of community capacity building, community development and sustainability to previously rigidly controlled government functions can be seen in this light.

The challenge for public sector agencies and their leaders – Government Ministers and Directors-General – is to exercise leadership through these principles rather than through a bureaucratic reliance on the chain of command and inflexible systems of control. This means a new way of looking at accountability, of looking at government as facilitating change and of recognising the legitimacy of divergent thinking in reaching common goals.

Kotter (1996, p 172) argues that the structure of the successful organization of the 21st Century will be less bureaucratic, have fewer levels of command, have an expectation that senior management will lead while lower levels will self-manage and have limited rules and regulations aimed at the level of interdependence needed to maintain consumer satisfaction.

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¹ Place management refers to Government identification of “hot spots” of locational disadvantage where efforts are made by concentrating resources, both funds and meta-planning, in an attempt to break through a perceived cycle of disadvantage.

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Performance information systems, widely distributed performance data, strong management training and support systems will support it across the organization. It will have a culture that is externally oriented, be empowering, rapid in decision-making, be open, honest and transparent, and be risk tolerant.

Pollitt and Bouckaert (2000, pp25-35) have identified a number of influences that drive public sector reform:

- Globalisation and the subsequent economic pressures to make economies more efficient and competitive. This has led to downsizing and efficiency driving in those industrialised countries where there has been a strong welfare state.
- Socio-demographic changes especially the ageing of the population, immigration and employment levels that have exerted pressures on governments with perceptions of unsustainable welfare cost burdens.
- Political and ideological demands with the introduction of new theories of management, demands for an interrelationship between the public and private sectors. Pollitt and Bourckaert call this the “play of ideas” (p 31) that includes TQM, Management by Objective, benchmarking, various micro-economic theories, public choice theory, agency theory and transaction cost economics. They also include party political ideas about how to govern.
- Pressures from citizens for better consumer services that reflect increasing customer awareness in the private sector and rising levels of public discontent with low levels of service quality in public agencies. This may also stem from party political ideas where for ideological reasons, public servants are characterised as lazy or corrupt and growing public demands for reform emerge.
- Individual natural or man-made disasters, scandals, accidents and unpredictable events and tragedies may focus attention on issues such as accountability or the lack of public investment.

They note that these influences do not have an even or free play over a smooth surface but are mediated by constitutions, conventions, existing administrative arrangements, counterposing and contradictory demands, and the cost of reform.

In fact they raise some significant issues with regard to public sector accountability for the management of public assets beyond merely getting the most efficient return on financial investment. Hart, the Australian Auditor-General identified these as “client satisfaction, the public interest, fair play, honesty, justice and equity”(Hart, 2000, p 58). He suggests that the pressures of reform on the public sector that lead to privatisation and commercialisation
“does not obviate the need for proper accountability for the stewardship of public resources, as it is accountability that is fundamental to a democratic system” (Hart, 2000, p 68).

Warner (2000) and Hyde (1997) also identified similar factors specific for health. Warner identifies a number of drivers for change in health including:

- globalisation that drives Western economies in health competitive efficiencies, shifting the costs of health and social services to consumers to keep taxation rates at low levels;
- demographic change including the ageing of the population and falling birth rates;
- epidemiological challenges that have identified a range of new burdens of disease (in particular in mental health) and the need for prevention, cross sectoral responses and integration of treatment and rehabilitation;
- technological challenges, such as genomics that may change or even abolish treatment regimes in favour of prevention and that will certainly change investment patterns and structural responses to health;
- the demand for information that will lead both individuals and communities (through consumer organizations) to demand better health information and which may change the organizations and locations of care.

Elsewhere I have noted similar significant pressures on the health system (Hyde, 1997). These encompass the influences already noted by Pollitt and Bouckaert in the broader area of public sector reform. They can be characterised as follows:

- demographic and social trends such as increasing urbanisation, changing family structures, growing socio-economic disadvantage among some members of society; and changing ethnic blends;
- growing concern to redress social inequities and meet the needs of diverse communities, in particular, indigenous people;
- increasing community and individual demands to have a full range of services available the opportunity for participation in health service planning, delivery and evaluation, and a related expectation by health administrators of such participation;
- increasing consumer expectations for information about health;
- changing technology which impacts on clinical practice, new and emerging models of care, changing treatments regimes, shorter hospital stays and increased use of non hospital-based interventions;
- the power of communities in identifying and managing emerging health problems (re HIV/AIDS);
expectations by the community and health administrators that services will be coordinated and integrated even where there are a range of settings and providers and where conventional boundaries exist between them – both physical and professional; increasing community recognition of the strength of health promotion and prevention – that is, healthy public policy – to impact on population health.

Warner suggests that the new health agenda will require a reorientation of the meaning of need, efficiency gained through evidence based substitution of services and resources, technology assessment, recognition of new levels of public perception, the development of new approaches to care pathways and performance management, and new training approaches for public health workforce and clinicians.

Warner’s solution lies in the virtual reorganisation by design of health services that recognise human rights as a core factor in health (seriously challenging professional standards and autonomy), new communications systems may lead to fragmentation and inefficiency if not harnessed and used constructively, and new technologies (such as genomics) is driving change in prevention and treatments. He says of Europe (but in a statement that could apply across the industrialised and developing world “health services can be identified as one key policy element, a stabilising force in the quest for a more civic society.” (p 12)

What are we addressing?
If we were to design a generic Health Department that identified equity as a key goal, exhibited flexibility and expertise to both manage a complex health system and take a continuing interest in emerging health issues across the sectors what would it look like?

At this point we shall return to the three questions initially advanced:

1. What is the role of the health system in contributing to health outcomes and health status?
2. Do specific sub-systems of the health system affect health outcomes and health status more positively than others? and
3. Does primary health as a specific leading sub-system offer better health outcomes than acute care?

What do we know about health systems? Modern health systems are a complex set of interests, both competing and complimentary, ranging from the acute care of illness, disease and disability, through the treatment and maintenance of regimes for chronic illnesses,
conditions and disabilities, to health education, information, promotion and prevention services and programs. The complexity has increased at all stages in the continuum with technologies in health care equipment, pharmaceuticals and treatments, and in knowledge of community capacity building developing at a steady rate. This is not a new analysis as Sax (1999) suggested that primary care led systems are more equitable, more efficient and more effective in addition they have better acceptability among the general public who report higher satisfaction rates with all levels of the system and better self.

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- Acute (Tertiary) Care = clinical services in illness and care through specialist care.
- Secondary Care = clinical services in chronic illness management, ambulatory and post-acute care, rehabilitation, aged care and disability management and part of General Practice, and in hospitals.
- Primary Health = general Primary Care clinical services in Community Health.
- General Practice = population health services in Education, Health Promotion, Health Maintenance, Prevention, community capacity building and community/organisational development.

Public health ranges across the three but is mostly concentrated in Primary and Secondary Care.

The role of a modern health system is differentiated. While it has the major role to play with regard to acute and curative medical services and clinical treatments, the health inequalities show clearly that the social determinants of health are outside the scope of what has been traditionally the major focus of health systems. This is not to argue that health systems have no role to play in health outcomes and health status, but to argue that health systems have no role to play in health outcomes and health status.

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Sax, (1999) Research shows that primary care led systems are more equitable, more efficient and more effective in addition they have better acceptability among the general public who report higher satisfaction rates with all levels of the system and better self.
However, Starfield’s research result is a fundamental point that affects the way in which solutions can be approached. While acute care led systems - which dominate much of the developed world and which are also emerging under the pressure of demand from growing middle classes in the developing world - are not in themselves invalid, a concentration on acute clinical and medical services limits responses to specific operational and disease or condition focussed recommendations and solutions. While these may be necessary, timely and desirable, they provide only part of the solution.²

Primary health led systems may provide a way in which to tackle the demands for efficiency, the demands of human rights and patient information, and the changes that rapidly developing technologies are driving. Primary health can encompass primary care in intersectoral or cross sectoral settings, address the relationship with acute care and the population health aspects of public health, and through community strengthening bring health public policy to the for in creating a more equitable, just and civic society.

Why is this a good time to be involved in Primary Health?

There is sufficient evidence to show that primary care led systems have better outcomes. At the same time there have been significant developments that may enable primary health to provide the necessary leadership that was envisioned in the Alma Ata Declaration and its successors. Some of these are:

- The evidence about health and equity, the effects of social exclusion and the development of new tools to promote, enhance and measure community and organisational capacity;
- New found confidence of general practice. In Australia this is evident from the activities of the Divisions of General Practice in leading practice reform and emerging as participants with other health service providers in collaborative programs (Hyde, 2001);
- The escalating costs of acute care that have called into question the appropriateness and acceptability of maintaining and acute care focussed health system;
- Emergence of social health as an influential voice with collaboration between clinicians, public health workers and the community.

² The Cochrane /Campbell collaboration (2000) illustrates very clearly the range of determinants on health many of which are unable to be addressed by the acute care system.

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The determinants of health

What is health? The World Health Organization has adopted an inclusive definition incorporating both illness and the absence of illness:

*Health is not simply the absence of disease: it is something positive, a joyful attitude toward life, and a cheerful acceptance of the responsibilities that life puts upon the individual.* (Sitergist 1941 in Warner 2000, p 9)

What is equity in a health context?

*Equity in health implies that ideally everyone should have a fair opportunity to attain their full health potential and, more pragmatically, that no one should be disadvantaged from achieving this potential if it can be avoided.* (Whitehead, 1990)

Thus policies for health and equity will aim to reduce or eliminate factors that lead to health inequality not eliminate all health differences. They must recognise that

*The wider values and power structures of society will influence major action that needs to be taken to address health inequity such as income redistribution, provision of affordable housing and employment opportunities. Our challenge is to decide what are feasible and achievable aspirations for the health care system in the current context.* (Bowen et al, 2001, p 4)

Many if not most opportunities for equity in health are outside the health system and require more than health services to address.

Therefore, the wider determinants of health must be addressed if fundamental reforms are to be achieved and sustained. These come under seven broad groups:

- Biological
- Genetic
- Behavioural
- Environmental
- Cultural
- Economic
- Social

As health public policy moves more into the realm of civil society health system development needs to be applicable to an Area structured system, a centralised system with regions, and for the developing world as well. (Hyde, 1999b; Warner, 2000)

Performance of Health Care Systems

The evidence shows that the overall health of people in both the industrialised countries and the developing world has improved significantly on a global and population health scale.
High quality medical and clinical services, better public health measures and increased recognition of the links between health outcomes and other factors such as access to employment, housing and transport have all contributed.

However, there are some significant problems in improving health status for both individuals and communities. In the industrialised countries there is growing evidence of health inequalities that shows that gains have not been spread equitably across communities. In fact, a recent study in Britain has shown that there is a direct link between growing wealth inequalities and preventable deaths among communities at the lowest end of the wealth continuum (Mitchell and Dorling, 2000). Similarly, in many developing countries, the cost of high technology and advanced pharmaceuticals, and a mistrust of community capacity building have meant that many preventable illnesses and deaths will not be checked because of lack of investment, both financial and human, in health education and prevention.

Claims that the acute health care system alone is responsible for falling mortality rates should be made with care. Recent European figures show an increase in mortality rates that appear to be linked with long-term unemployment and social breakdown. In addition, increases in life expectancy and reductions in mortality appear to be socio-economic dependent with many advances made unevenly across the socio-economic spectrum. Similar figures suggest the same in Australia among the Aboriginal community where those States with the best land rights regimes are heading the table for health improvement and those where land rights are not as comprehensive or more difficult to obtain have a falling life expectancy.

Further, the assertion that an ageing population is increasing pressure on the health system is not supported by the most recent research in Australia or overseas. (Galambos and Rosen, 2000; Mulley, 2000) Indeed there are many other factors as we have seen, such as the health of indigenous people, child health where the early years are seen to be of vital importance to both individual and community health into the future, and the effects of the various determinants of health.

As we are now aware, significant research has illustrated the issue of health inequalities and the strong links between health and equity especially if we are to reorient them toward primary health. But what does this mean when addressing the future nature of health systems? There are a number of specific issues that exercise the day-to-day concerns of health administrators in both industrialised countries and the developing world that have a
direct affect on the ability of health decision makers and administrators to shift resources because they are at the interface between primary health and the rest of the health system.

These issues will need to be tackled regardless of whether health systems are fundamentally reformed or not. In fact, each has been addressed in the existing systems, sometimes innovatively but with varying degrees of short-term success. The fact that permanent solutions have not been able to be developed - irrespective of the financial investment in solutions - suggests that something else is occurring within the broader system that is manifesting itself as a failure of organisational culture at this point. This does not mean a failure of individuals as managers of specific services. Rather it illustrates the bigger problems in health systems such as inflexible interest groups and confused cultural norms (and that merely doing more of the same better may not necessarily lead to more preferred outcomes).

The aim of reform is to improve health systems in total, gain improved health outcomes and promote equity. Successfully addressing these issues – generally structural – has the potential to free up substantial resources for reform and development of both the primary health and acute care sectors. Some of these (though by no means an exhaustive list of examples) are:

**Access Block**
Inappropriate hospital admissions (that is social admissions, aged care services that would be more appropriately provided through ambulatory care or community base care, and various respite care services) are a clear cause of access block to hospitals and also absorb a high level of resources that could be made available to develop and maintain a primary health led system, including reinvestment in those parts of acute care that are under pressure. This is the case in the industrialised world and increasingly a case in the developing world where the demands for hospital development put undue strain on existing inadequate primary health care resources. Savings from reductions in inappropriate admissions should be channelled to a number of other services – eg community health/primary care, health promotion, ageing services – but a significant proportion should remain available to the hospital system as a positive incentive to achieve reform and improvement.³
Emergency Departments/Primary Health Care Interface

Reforms to triage in emergency departments will require significant reform in the relationship between primary health care including general practice and the public health system. This raises questions of:

- Inter-government relations between central, state/provincial and local government
- Changes in work practices in emergency departments, general practice and primary care
- Reform of general practice and primary care funding, in particular, the existing perverse financial incentives to treat illness rather than to maintain health.

Without addressing these issues there are limits on the outcomes that can be achieved. In particular;

Central government agreement is needed to institute some of the necessary reforms that cannot be introduced on a hospital-by-hospital basis (where powerful medical interests may block reform regardless of government policy without strong and active central leadership).

Where Emergency Departments are part of hospitals they will remain the principal after hours service provider for many people where adequate 24-hour coverage by general practice is not provided. There are many reasons for this such as security and limited coverage by GPs. Where they are not, they must have adequate professional cover to enable them to identify, treat and refer, and the must be supported by adequate transport links to major acute care centres.

- In some countries moving from a fee-for-service only to a mixed funding model including capitation, practice payments, block funding and increased incentives for reform and collaboration with other health service providers may address some barriers.4

Funding Primary Health Care

As suggested in the previous issue, the reform of primary health care funding arrangements is central to most reforms of health systems; either to guarantee that basic primary health care services are maintained or that they can be redeveloped. While the interface between emergency departments and primary care, in particular, general practice, is an important issue, more sustainable reform will be gained by reforming the overall funding systems for primary health to tackle the range of areas with which it interacts.

One of these areas is the interface between individual general practice services and population health services. This is an important area for enhancing equity because the
access issues it raises are significant. The reality is in most systems that at least some of
the providers are in the private or non-government sector and an equitable funding system
needs to be established to ensure both equitable access to services and equitable returns to
health service providers.  

What could be improved?
While reforms of this nature will improve health systems, there is also a philosophical shift
that is required. The various determinants of health, in particular those that are not
biological or genetic, suggest that continuing social reforms are required to improve the
development of health systems. This calls into question the role of organizations and
sectors in society that are not necessarily recognised as having health outcomes such as
employment, the education and transport sectors. It also raises issues about a revised role
for the private sector within health systems, from the provision of services, in policymaking
and consultancy, and in supporting health services through health insurance.

This is recognised across the political spectrum. Many commentators have suggested that
subsidising the private sector in health actually promotes inefficiencies in the market.
According to them the private sector in health should be unimpeded by government
intervention other than for quality and safety regulations. In this way governments are free
from having to subsidise the market as well which results in less need for government
assistance to individuals and therefore more resources to provide a universal basic safety
net in health.

Private sector commentators (Lewis, 2000) also recognise the economic benefits of a strong
health care sector, noting that a good, robust health sector will always be labour intensive
and therefore create jobs and economic wealth while contributing to the alleviation of poverty
and the building of economically viable communities with political stability and a strong civil
society. Lewis (2000, p 40) suggests:

To the extent the private health sector finances health insurance for a segment of the
population that then no longer requires public subsidies, governmental resources are
made available to pay for population-based, community-wide health measures.

Dickson (1999, p 6) notes “a large body of literature that suggests profit maximising firms do
not, by any means, satisfactorily address efficiency or equity concerns”. He cites a number
of studies that show costs in private hospitals are generally four to eight percent above those

A proposal is included in Attachment 2

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in public or not-for-profit hospitals and suggests that the evidence does not support arguments that the private health sector will minimise costs to maximise profits and thus contribute to allocative efficiency.

Former Australian Labor Health Minister, Neal Blewett (2000, p 16), suggests that:

_Governments should, where possible, assist the private health sector to be more efficient and cost effective, but not provide taxpayer subsidies, particularly as the few conditions attached to such subsidies have nearly all been resisted by the vested interests involved._

This philosophical shift would allow a more logical discussion to flow regarding specific interventions or systems improvements for people with chronic illness for instance, or people with disabilities who while a small proportion of the population are a significant proportion of health consumers. But it requires as New (1999, p 58) suggests: an explicit statement from government of public health values "coupled with an explicit acceptance of the trade-off values against each other"; the development of consumer participation and inclusive decision-making processes; and changes in medical and clinical education to reflect universal values rather than sectional interests.

But there are significant issues that require addressing other than the provision of services or health insurance, for example, community engagement, consumer participation and community strengthening. Within this field of issues there are some serious questions including:

- the role of social capital development in health outcomes;
- the measurement of intangibles in health development, maintenance and outcomes;
- the definition of community capacity and the link between a "strong" community and health outcomes;
- the effects of private sector decisions on community health outcomes and how should this be addressed;
- the level of responsibility private sector for the health outcomes of its decisions (apart from the occupational health and public safety responsibilities it already has under legislation or common law); and
- does the private sector have a legitimate role in the promotion of equity and the lessening of health inequalities.

A proposal is included in Attachment 3

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Similar issues are raised by the concept of interagency collaboration where the social determinants of health suggest strongly that many government and non-government agencies have a role to play in developing healthy populations, communities and better health outcomes. Both concepts challenge existing power structures within health systems, in particular notions of accountability, professional autonomy and confidentiality, and also the scope of the outcomes that health systems can achieve without external partnerships and interventions.

Part 2

Designing a Primary Health focussed system

While Governments have accepted the wisdom of a primary health led system at least since the Alma Ata Declaration in 1976, the practical ability of most to move toward it has presented significant difficulties. The demands already noted have increased dramatically over the past thirty years with major advances in technology and pharmaceutical developments that have put a great deal of emphasis on supposed “quick fix” investments in high tech solutions. However, these “solutions” have become too expensive, even for the developed world to sustain.

Alma Ata talked of three major facets of health system development:

- accountability
- acceptability
- accessibility

Developments following Alma Ata took into account first accessibility with many governments moving to introduce universality at least for basic services, either through taxpayer funded medicare schemes or a mix of public/private services. As investment increased accountability took on a new importance especially in economic terms. More recently the meaning of accountability has broadened, at least in developed countries, as consumer and patients rights movements have forced a re-evaluation of health from a human rights perspective.

Acceptability is the last of the three major facets to begin to gain new meaning. Communities are now demanding a wider range of services that more appropriately meet their immediate needs. Governments are responding with services that cross-sectoral boundaries and address issues such as community and organisational capacity. The consumer movement has made acceptability a key issue in the debates on consumer and community participation. The evidence about the causes of health inequalities has focused this debate.
Yet with increasing globalisation and continuing pressure from medical and technology interests the re-orientation of health systems is proving to be very difficult. In the developed world evidence is emerging as the health inequalities debate broadens and deepens, of unacceptable disparities in advances in health status.

In fact in some places, life expectancy has fallen among sections of the population – for instance in Australia, indigenous health status has actually declined in some States from already disastrous levels while the health status of the community overall has improved. And in the developing world, emerging and preventable disease such as HIV/AIDS, ebola, resurgent malaria and tuberculosis, coupled with inadequate investments in basic public sanitation, housing, food and water, have meant that millions of people are without even basic health care services.

Governments in both the developed and developing world can no longer ignore the issues of globalisation or the evidence about health inequality. Too often governments in the developed world accept only the advantages globalisation brings to them - increased recognition of the standards of their health care systems, the development of new export markets in health, training export opportunities to name a few. But globalisation also has its downsides. Lee (1999) has noted that the global pattern of disease has changed, as has global trade in tobacco and other harmful substances, blood products and arms. In addition, the richest fifth of the world’s population receive 83% of total world income, and the poorest fifth receive 1.4%.

These factors have a significant impact on health at a local level. Health systems that concentrate on immediate local responses will not be able to recognise or respond to the global issues that directly affect them. Parsons and Atkinson (1999) point out that in London, adolescents have a wide range of knowledge from a global perspective on a range of very complex social and health issues but little local knowledge of services. Refugee populations bring new illnesses and conditions and different perspectives to treatments. Poverty, dislocation and health inequalities are manifested locally while being caused by global forces.

The difference between an acute care led and a primary health led system is recognition in the latter of the relationship between health, illness and medicine. Acute care even while performing at a high quality remains the delivery of a series of clinical services directed to very specific clinical outcomes. This is not a criticism because quality in acute health care is...
a necessary component of an effective health system. However, it is not a sufficient condition given the strength of the evidence available.

**What are the characteristics of Primary Health?**

There are five significant characteristics of primary health\(^6\). They are:

- Point of first contact and subsequent early intervention
- Health promotion, health education and/or prevention focus
- Aim to enable citizens to maintain their independence in the community
- Community participation and consumer involvement
- Planning as a core function

Designing a health system with these characteristics at its core - instead of at its periphery - will be a challenge. And with the evidence available, even existing primary care systems will need to be developed to addressing a more comprehensive and holistic approach to health if an effective health system is to be primary health led. This will require an investment in primary health beyond that now existing in most systems, explicit recognition of the leadership role of primary health and specific strategies for the development of capacity and leadership that includes input from across the health system including acute care.

**Figure 1** illustrates the range of activities in a primary health approach. Column two includes the range of specific primary clinical services in general practice, community health and public health. In this figure it is specific to the health system. Column two includes the areas where effective partnerships must be developed with other agencies. Column three recognises the important and central role of communities in health and the need for them to have the capacity to both initiate and respond to major health issues.\(^7\)

From this model it is then possible to build an outline of a health system with core functions to address the major issues in health:

- the delivery of high quality, appropriate, accessible and accountable services in primary health care, public health, acute care, chronic illness and disabilities;
- health inequalities and equity;
- the devolution of decision-making and the strengthening of communities to participate;

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\(^6\) These were reinforced during a recent study I undertook looking at opportunities for collaboration in primary health between the Australian Federal and State governments. Such a model can be applied to partner agencies to illustrate their role in health outcomes. Column two is the central focus for the agency involved listing the range of its primary care services and activities. In other cases, primary health care services would move to column one.
• the continued development of a system based on access and equity with the ability to meet emerging challenges as they occur; and
• collaboration and partnership with other agencies to achieve key health outcomes.

**Figure 1**

<table>
<thead>
<tr>
<th>Determinants of Health</th>
<th>Working with partners to address</th>
<th>The focus of activities is</th>
<th>Working with communities to Strengthen Communities</th>
</tr>
</thead>
<tbody>
<tr>
<td>Safe, cohesive communities</td>
<td></td>
<td>Community Health Services</td>
<td>Community resilience</td>
</tr>
<tr>
<td>Environmental integrity</td>
<td></td>
<td>General Practice</td>
<td>. governance</td>
</tr>
<tr>
<td>Adequate housing</td>
<td></td>
<td>Specialist Practice</td>
<td>. participation</td>
</tr>
<tr>
<td>Access to education</td>
<td></td>
<td>Allied Health</td>
<td>. development</td>
</tr>
<tr>
<td>Employment capacity</td>
<td></td>
<td>Public Health</td>
<td>. facilitation</td>
</tr>
<tr>
<td>Transport services</td>
<td></td>
<td>Families &amp; Carers</td>
<td></td>
</tr>
<tr>
<td>Cultural participation</td>
<td></td>
<td>Individual self-management</td>
<td></td>
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<tr>
<td>(Medical and clinical services)</td>
<td></td>
<td>NGOs</td>
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<tr>
<td></td>
<td></td>
<td>Community agencies</td>
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<td></td>
<td></td>
<td>Self-help groups</td>
<td></td>
</tr>
</tbody>
</table>

**Building a model for equity**

Mintzberg (1993) noted that the environment in which an organization operates will determine to some extent the type of structure that develops. According to him “Extreme hostility in its environment drives any organization to centralize its structure temporarily. (p 287) He also notes that “the power needs of the members tend to generate structures that are excessively decentralized” (p 291). Yet he also demonstrates that for professionally based organizations – such as health systems – a decentralized or “adhocracy” model is preferable, a finding consistent with Morgan’s (1997) “democratic” model.

There is no doubt that health systems operated in a very dynamic and sometimes hostile environment. Most theories of organization are consistent in arguing that contingency planning to take account of environmental turbulence is necessary. In fact in **figure 2** Mintzberg (p 286) suggests that it is possible to map where an organizational structure best fits.

**Figure 2:**
It can be argued that health systems operate in a complex and dynamic environment and contingency planning must account for variable turbulence, the rapid development of technologies (physical, planning and theoretical) and the demands of a more involved community. This environment is shown in the shaded section of Figure 2.

Figure 3 provides a possible model to achieve an organic health system that meets the demands of its environment. It is a matrix with a combination of operational Divisions and “pulsating” policy and operational units that operate cross Divisionally.\(^8\) It allows a devolved operational system to be guided by a central policy-making department with expertise in the major operational areas of health and with the capacity to monitor and respond to emerging issues and developments. At the centre is a Director-General (responsible directly to the Minister for Health) who is a flexible and innovative leader with strong policy and operational skills. The model makes provision for maintaining strong leadership in policy development and futures thinking through flexible think tanks attached directly to the Director-General.

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\(^8\) see Hyde 1999b for a discussion of the notion of pulsating organizations or units.
Health Policy Think Tank reports directly to the Director-General:

Health Financing Think Tank reports directly to the Director-General:

Globalisation & Equity Think Tank reports directly to the Director-General:

Information Management Unit reports directly to the Director-General:

Chronic Illness Unit reports to the Deputy Director-General:

Acute Care Division reports to the Deputy Director-General.

Public Health Division reports to the Deputy Director-General.

Primary Health Division reports to the Deputy Director-General.

Devolved to Local Health Services: some Finance, Commercial and Information Management activities.

Shared with Local Health Services: some planning and development functions.

*Primary Health focused* includes a small staff and works with the General Managers of each of the three Divisions and the Directors, Policy and Financing to ensure that the chronic illness strategy is well managed.

*Primary Health focused* includes a small staff with budget to buy in expertise from Divisions or externally.

*Primary Health focused* includes small staff (from Primary Health, Indigenous Health, Mental Health, Health Promotion and Inter-Government Relations) with budget to buy in other expertise from Divisions or externally.
It also provides a strong operational focus for acute care, public health and primary health care with a chronic illness unit that operates across the operational Divisions that in turn link to the work of the Area or regional health services. The operational Divisions report directly to a Deputy Director-General (or Chief Operating Officer) who has a strong operational focus, exemplary leadership qualities and an excellent understanding of the relationship between new policy development and operations. The internal operational functions of the Department also report to the Deputy Director-General.

The model also envisages strong partnerships with local health authorities that operate autonomously but under the leadership of the Director-General and the central department. The local services would have multi-faceted and multi-level links with communities and other services. Their structure may mirror the model or may be significantly different depending on local service mix and priorities. Strong links also exist between the community, and other government, non-government and professional agencies.

What this model provides is a move toward recognition that policy making must include the dynamics of a complex environment where the participants are not individuals but groups of interests, such as communities, professionals, and political parties. It takes as its base the notion of community, that is, the notion of community of interest on which politics and public policy are founded. As Stone (1988) notes:

*Because politics and policy can happen only in communities, community must be the starting point of our polis. Public policy is about communities trying to achieve something as communities.* (p 14)

She notes that the public interest – the common good – is not static but dynamic and that good public policy making is about ideas and legitimacy.

In the development of a public service agency, the dynamic of ideas must be encouraged and fostered if the outcomes of good public policy are to be achieved.

**Conclusion**

This paper has reviewed the relationship between organisational development, public sector reform, health and equity. It draws on a number of sources to suggest that organizational structure is a key though not sufficient condition in tackling issues around equity and health inequalities.
In doing so I have illustrated the debate with some key examples that show how the proposed model could be operationalised. However, philosophical change is as important as structural change. The latter cannot succeed without clear leadership. The former can be impeded by inflexible bureaucratic structures that protect existing power bases rather than address health outcomes.

The paper is not intended to present model in significant detail. That is best left to local government and health leaders, administrators and practitioners who know local conditions. Instead, it offers a framework that, with the implementation of a primary health philosophy as the leading values and principles in health, will enable health systems to be flexible, proactive and relevant.
Bibliography


Contributors to the Cochrane Collaboration and the Campbell Collaboration (Cochrane/Campbell 2000), Evidence from systematic reviews or research relevant to implementing the “wider public health” agenda. NHS Centre for Reviews and Dissemination, http://www.york.ac.uk/inst/crd/wph.htm, August 2000


For richer, for poorer, in sickness and in health... (1999), Royal Australasian College of Physicians, Sydney

Hyde, Jim (1997), "Achieving a Sustainable Health System: Extending Integrated Care", *Proceedings of the Hong Kong Hospital Association Convention*, (Hong Kong Hospital Association, Hong Kong, May 1997)

Hyde, Jim (1999a), "Social Capital and Public Service: Knowledge Based Management and Sustainability", in *Inequalities in Health*, a series of seminars held by the Health Education Authority, (eds) Seta Waller, Adam Crosier and Dominic McVey (Health Education Authority, London)


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Morgan, Gareth (1997), Images of Organization, (Sage, Thousand Oaks)


Pollitt, Christopher and Bouckaert, Geert (2000), Public Management Reform, (Oxford University Press, Oxford)

Stone, Deborah A (1988), Policy Paradox and Political Reason, (Harper Collins)


Whitehead, M, (1990), *The Concepts And Principles Of Equity And Health*, (World Health Organization Regional Office for Europe, Copenhagen)
Attachment 1

Under this proposal, the local health authorities would take responsibility for the re-allocation of resources. The central government would support the process by suspending the strict requirement for activity level “measure and share” at the same time working with the local government authorities (State/Provincial) to develop appropriate measurements in areas of new or re-allocated investment.

The model assumes that:
1. not all the identified “inappropriate hospital utilisation” will be able to be re-allocated;
2. acute care system/hospital managers and administrators will best be able to identify the target areas during the life of the re-allocation process; and
3. savings identified during the pre-allocation will be retained within the health system and not be absorbed by Central, State/Provincial or Territory Treasuries.

It outlines a series of specific actions and nominates responsibility for each stage.

This proposal provides a series of incentives to the acute care and primary health systems to make the relevant re-allocations, investments and building of services. It also promotes collaboration between the acute care and primary health systems in a way that will strengthen each.

The model has the following components:
- identify and quantify by system (not individual hospital) an agreed level of “inappropriate hospital utilisation” (say $100m);
- target 50 per cent over ten years for re-allocation to appropriate health service utilisation ($50m);
- hospital managers identify 10 per cent for each two years of the ten year target period ($10m);
- create a retained funding pool by reducing the hospital system allocation by the nominated 10 per cent ($10m) - hospitals will not be permitted to refuse admission unless no other more appropriate services are available;
- allocate 50 per cent of the retained funding pool to the hospital system for unspecified expenditure ($5m) – hospitals will target and support, expand and/or development of more appropriate health system services to which they will be able to refer. Any savings retained by the hospital system;
- allocate 25 per cent ($2.5m) to primary health for hospital substitution services directly related to the 10 per cent “inappropriate hospital utilisations” identified by the hospital...
system. Primary health services will have discretion on the type of service to be established but must work with the hospitals to identify and develop them. Any savings retained by the primary care system;
savings made from the joint investment of the hospital 50 per cent and the primary care 25 per cent that cannot be identified will be retained on the same 2:1 proportion as the investment;
allocate 25 per cent ($2.5m) to the primary health system for innovative and flexible services that do not have to relate directly to hospital substitution;
the central and State/Provincial governments, and local health authorities establish processes to identify relevant measures over the full ten-year life of the re-allocation to evaluate the changes - these may not be activity measurements for the primary care innovative service development.