SUBMISSION TO THE HOUSE OF REPRESENTATIVES

INQUIRY INTO HEALTH FUNDING

July 2006

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That an initiative be established to develop international benchmarking to support measurement of the performance of the Australian health system, particularly with regard to financing and funding.

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That the designing of health funding systems and performance measurement take into account health system complexities including culture, health professionals' roles and needs, and community expectations.

Recommendation 3:
That Federal and State governments should foster research that will provide relevant information on which future restructuring of public health services may be based to ensure that the improvements will bring benefits to the Australian population rather than just part of the health system or individual stakeholders.

Recommendation 4:
That the need for greater research into the impact that the new organizational structures have on the capacity of communities to influence decision making in local and regional health services be recognised.

Recommendation 5:
That the need for greater research into the impact that high turnover of managers has on the quality of health services particularly in rural areas be recognised.

Recommendation 6:
That, in the public interest independent ongoing and post-implementation evaluative research is promoted to assess whether changes in management structures have been based on relevant diagnosis and that changes have led to improved services and additional equity in access and financial burden, efficiency and quality of care. (Of particular concern are the conditions in rural areas of Australia).

Recommendation 7:
That research be undertaken to assess how the structure and role of parallel organizations focusing on quality in health care impact on the overall quality of health care and how to best to align safety and quality efforts and initiatives.

Recommendation 8:
That there is a need for a greater focus on health workforce planning, particularly in the context of emerging models of health care that focus on integrated service delivery and a multidisciplinary team approach to health care delivery.

Recommendation 9:
That there is a need to consider how the health workforce is educated and trained to assist health professionals to work in an environment of increased accountability for effectiveness and efficiency of health services.

Summary of Recommendations (cont')

Recommendation 10:
That health management workforce research is conducted to guide the future development of health services particularly with regard to changes in management structures and practice (including impact on health management turnover).

Recommendation 11:
That there is a need for a greater focus on the workforce planning of health service managers and consideration given to the education and training of future health service managers.

1.0 Introduction

1.1 About the College

The Australian College of Health Service Executives was established in 1945 (then known as the Australian Institute of Hospital Administrators) in order to represent the interests of health service managers and to develop their expertise and professionalism. The College is now in its 60th year.

Today, the College is the professional organization representing health service managers across the full range of health care delivery systems in Australia, New Zealand and the Asia Pacific with members from both public and private sector organizations. Its membership is multidisciplinary with membership covering non-clinical managers, doctors, nurses, allied health professionals. Our members recognise the value of College membership in supporting their roles within the health industry, often holding multi-professional memberships and actively engaging in collegiate professional development activities.

ACHSE operates under a Memorandum of Articles of Association adopted July 1995. The College structure is a non profit company limited by guarantee with limited Australian Tax Office recognition as a Charity. ACHSE Federal Council is the Board carrying all the responsibilities covered by Corporations Law.

The College has some 2800 members on the registry, and a financial turnover of some $2.15 million per annum. There is a well established network of Branch and National organizational arrangements. The College offers a wide range of member services at National and Branch levels. Memoranda of Understanding link ACHSE to similar organizations in New Zealand and Hong Kong and create reciprocal membership and ACHSE Branches in these locations. A Memorandum of Understanding with the Thai Ministry for Health and Naresuan University has recently been signed for ACHSE to assist the formation of a Thai Health Management professional body. The creation of an Asia Pacific entity of health management professional organizations is a policy objective of the College.

1.2 Shared Values and Commitment

The ACHSE shares and is committed to the basic values that underpin the Inquiry that is the "...improving efficiency and effective delivery of highest-quality health care to all Australians". The ACHSE is also committed to the implied equity of access and financial burden for all Australians. Members of the ACHSE are in a unique position to promote such values in the management of health services through their every day work, and the use of coal-face insights into the challenges that face the health care system in the pursuit of effectiveness, efficiency and equity.

1.3 Evidence-based Improvement

The ACHSE understands that changing demographic, social and economic characteristics, as well as changes in technological knowledge and its efficient application in the health system, requires reassessment and possible changes in the scale of operation and the organization of services. In turn, approaches to health

service organization, health services management design, service delivery arrangements and health workforce planning and development should be adapted to follow and possibly be changed to make the health system more effective, efficient and equitable, in the provision of quality health services to the Australian population. To be effective changes need to be based on evidence that they represent improvements and bring benefits to the Australian population, rather than just to a part of the system or individual stakeholders.

2.0 The Inquiry Into Health Funding

The Inquiry is a welcome and timely opportunity to examine the complex features of the delivery of health services in Australia. The delivery system has considerable strengths but some of its attributes need to be addressed to better serve the community.[1] [2] The Australian College of Health Services Executives (ACHSE) is taking advantage of this opportunity, in accordance with the terms of reference of the Inquiry, to put forward some insights into some particular aspects of health services organization, health services management and delivery and health workforce that are not always fully considered when considering overall health system issues and challenges.

There are five parts to this Submission which are of general relevance to the Inquiry's Terms of Reference but especially (a) and (c).

- Accountability and Performance Measurement
- Structure of Health Services Organization and its Management
- Management and Quality
- Emerging Models of Care and Health Workforce
- Health Management Workforce

3.0 Accountability and Performance Measurement

It must be recognised that the health industry is an important component of the overall economy, comprising over 9% of Australia's GDP. Whilst this is significant, what is even more startling is the growth in this share of GDP over the last 30 years. This growth is attributed to the ageing of the population, new technology, including new pharmaceuticals and greater quality of care. It is considered that there is a consensus view by health commentators that these trends will continue and may even hasten into the next 30 years.

Even a cursory review of other similar countries to Australia indicates, that this country's health expenditures compare favourably. This is especially so given that health outcomes are considered to be some of the highest in the world. Consideration

[1] Jo. M. Martins. 2006. Health challenges in Australia. *Asia Pacific Journal of Health Management.* 2006; 1: 1:17-23.
[2] Jeff R. J. Richardson. 2005. Priorities of health policy: cost shifting or population health. *Australia and New Zealand Health Policy.* 2005, 2: 1: 1-31.

to future health funding arrangements including the level of funding provided for the expected outputs should encompass international benchmarking. This approach would contribute to a broader evidence base and assessment of what is realistic funding levels relating to output and performance targets.

The pursuit of health reform initiatives (such as the improved integration and coordination of health services), improving access to and quality of services, and finding suitable health system and organizational structures within constrained funding environments is complex. These complexities include the expectations of governance and management models and the way in which health professionals within the system respond and work with shifting directions, priorities and expectations.[3] [4] The need to carefully consider such issues as health organization culture, health professionals' needs and patient care responsibilities, and community expectations in designing health funding systems and setting funding levels can not be over emphasised.

Recommendation 1:
That an initiative be established to develop international benchmarking to support measurement of the performance of the Australian health system, particularly with regard to financing and funding.

Recommendation 2:
That the designing of health funding systems and performance measurement take into account health system complexities including culture, health professionals' roles and needs, and community expectations.

4.0 Structure of Health Services Organization and Its Management

It is a well known precept, other things being equal, that form should follow function.[5] Similarly, management structures should follow effective and efficient organization of quality services that takes into consideration equity in access and financial burden.

In the last few decades, most states have evolved regional or area administrations to manage the delivery of public health services, including hospitals. In general, this evolution brought a wide range of services within given areas under the same management structure. In most cases, these local administrations were headed by boards representing communities within them. In effect the size and scale of responsibilities of these new regional structures and resources mean that these structures could be considered a form of local health government within state government framework. For this reason we believe that these regional structures should be considered within the terms of reference of this review.

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[3] Ian Powell, 2005. Providing quality healthcare under funding constraints. *The New Zealand Medical Journal*. 2005. Vol 118, No 1215.
[4] Rod Perkins, Pauline Barnett and Michael Powell. 2000. Corporate governance of public health services: Lessons from New Zealand for the State sector. *Australian Health Review*, 2000, Vol 23, No 1.
[5] Jacqueline S. Zinn and Vincent Mor. 1998. Organizational structure and the delivery of primary care to older Americans. *Health Services Research*. 33:2 (June 1998) Part II: 354-379.

However, these administrations do not include the management of private health services, and those administrated by the Federal government. This has meant that a large proportion of complementary or substitute services, such as private primary and specialist medical care, and other services provided by the private sector are not part of the management structures set up by the States.

A major issue is whether the boundaries and features of these regional or area administrative structures were based on sound evidence-based practices or on ad hoc administrative decisions that failed to meet criteria aimed at enhancing the role of management of health services, in the pursuit of improved efficiency, quality of care and equity.

Recommendation 3:
That Federal and State governments should foster research that will provide relevant information on which future restructuring of public health services may be based to ensure that the improvements will bring benefits to the Australian population rather than just part of the health system or individual stakeholders.

4.1 Management Restructuring and Real Costs

Restructuring of the management of health services has to be paid for in terms of the opportunity cost of the time dedicated to it and human and other resources involved.[6] This needs to be taken into consideration in the measurement of costs and benefits arising from change.

Another cost not often taken into consideration is the stress that it entails with its deleterious effect on morale, commitment to the organization and productivity.[7] This is one more reason for management restructuring to be undertaken when there is clear evidence that there will be overall benefits to the community. It requires adequate research and ongoing including post-implementation evaluation. Therefore, it is important that any future restructuring of the management of health services is based on evidence that it will contribute to the effectiveness, efficiency and equity of the whole system. This evidence should include a realistic, independent assessment of all the costs associated with the restructure and not just the perceived reduced costs of operation once the restructure is in place. Major restructures, such as those taking place in NSW and Queensland can take more than two year to implement with substantial costs during that time that may or may not be justified by the gain. The perceived benefits to either Federal and or State governments alone are not sufficient to justify further restructuring.

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[6] Andrew D. Oxman, David L. Sackett, Iain Chalmers and Trine E. Prescott. 2005. A surrealistic mega-analysis of redisorganisation theories. *Journal of the Royal Society of Medicine*. Vol. 98, December 2005: 563-568.

[7] Kent V. Rondeau and Terry H. Wagar. 2004. Implementing CQI while reducing the workforce: how does it influence hospital performance? *Health Care Management Forum*. Vol 17(2): 22-29.

4.2 Restructuring Experience

The management of health care in Australia has been subjected to repeated restructuring, especially at the state level.[8] These restructuring are often justified through perceived but not measured economies of scale of service delivery. A consequence of these restructures has been a tendency towards greater centralisation of management of health services[9] provided by the public sector. Often, the restructured governance and management arrangements relegate the participation of community members to a more peripheral role and in some cases removing their participation in the governance of health services leaving the community representatives with only advisory roles.[10]

The top-down "command and control" practice of centralised structures often leads to the imposing of general rather than targeted constraints and defensive behaviour within the system. This tends to be followed by perceived need for intervention and "micro-management" [11] that usually addresses perceived short-term objectives rather than sustained benefits. The Geoffrey Davies inquiry provides evidence of this management practice against the public interest. [12]

The frequent restructuring has led to a high turnover of managerial staff, especially in NSW rural areas during the four year period to 2000,[13] and a degree of job insecurity. Although most of the information available relates to Chief Executive Officers (CEOs), it is important to note that by management the College means a whole range of managers at the apex of these structures, as well as the managers of the many service points within a given area administrative structure. The gradual removal of local community participation in management structures has been accompanied by a rising tide of micro management of local health facilities by the apex that has been facilitated by the greater centralisation of management decision making.

Recommendation 4:
That the need for greater research into the impact that the new organizational structures have on the capacity of communities to influence decision making in local and regional health services be recognised.

Recommendation 5:
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[8] Judith M. Dwyer. 2004. Australian health system restructuring – what problem is being solved? *Australia and New Zealand Health Policy*. November 2004. 1:6.
[9] Jeffrey Braithwaite, Johanna Westbrook and Rick Iedema. 2005. Restructuring as gratification. *Journal of the Royal Society of Medicine*. Vol. 98, December 2005: 542-544.
[10] Judith M. Dwyer. 2004. Australian health system restructuring – what problem is being solved? *Australia and New Zealand Health Policy*. November 2004. 1:6.
[11] Independent Pricing and Regulatory Tribunal of New South Wales. 2003. NSW Health – Focusing on patient care. Sydney: 87. Among others, the IPART found that there was a perception of tendency to 'micro management' by the New South Wales Department of Health.
[12] Geoffrey Davies. 2005. *Queensland Public Hospitals Commission of Inquiry Report*. Queensland Health.
[13] S. McAlpin (Senior Lecturer, Charles Sturt University and PhD Candidate). Personal communication based on the analysis of reports of NSW Health 1990-2000 relating to PhD research.

4.3 Restructuring and Evaluation of Benefits

Many reasons have been given for the continuing restructuring of the management of health services in Australia.[14] However, there is no evidence available to the public that restructuring has led to greater effectiveness, efficiency[15] or equity in the provision of health services.

The continuing restructuring has not been based on independent and scientific evaluation of existing management structures or the structures they were replaced with.[16] The Productivity Commission has asserted "...Though it is an entrenched part of clinical medicine, an evaluation culture appears to be much less developed in relation to the management of health services and the efficacy of the associated regulatory and institutional arrangements."[17] No wonder that the symptoms that the many restructures were supposed to address continue to be within the system.

Recommendation 6:
That, in the public interest independent ongoing and post-implementation evaluative research is promoted to assess whether changes in management structures have been based on relevant diagnosis and that changes have led to improved services and additional equity in access and financial burden, efficiency and quality of care. (Of particular concern are the conditions in rural areas of Australia).

5.0 Management and Quality

People involved in the provision of care, including clinicians and managers at various levels, share a concern for the quality of care. An earlier manifestation of this concern was the licensing by the States of health professionals and private health facilities. Another, manifestation of this concern for quality is the activities of clinical colleges that aim to promote skill and quality of practice. In the last three decades, the concern for quality has resulted in the growth of organizations such as the Australian Council of Healthcare Standards and the Australian Commission of Safety and Quality in Healthcare that aim to improve the quality of care of health service facilities. We have also seen the appearance of medical complaints commissions and other similar organizations as creatures of state governments to deal with public complaints about health care practice.

Industry and other experience indicate that quality improvement is most effective when it is integrated into every day working and management practices and is dealt with at the coal face.[18] Consequently, the continuing pursuit of quality of care by the growing plethora of parallel organizations should be evaluated in the context of the

[14] Judith M. Dwyer. 2004. Australian health system restructuring – what problem is being solved? *Australia and New Zealand Health Policy*. November 2004. 1: 6.
[15] Jeffrey Braithwaite, Mary T. Westbrook, Donald Hindle, Rick A. Iedema and Deborah A. Black. 2006. Does restructuring hospitals result in greater efficiency? – an empirical test using diachronic data. *Health Services Management Research*. Vol. 19:1-12.
[16] Judith M. Dwyer. 2004. Australian health system restructuring – what problem is being solved? *Australia and New Zealand Health Policy*. November 2004. 1:6.
[17] Productivity Commission. 2005. The health workforce. Issues Paper, May 2005: 32.
[18] National Institute of Clinical Studies. 2003. Factors supporting high performance in health care organizations. Melbourne: La Trobe University.

overall effective management of quality of care at the point of delivery. Although the quality at point of delivery is essential, continuity of care is another important factor in the provision of quality care, especially to people with disabilities or chronic conditions. Therefore, the management of interfaces in the continuous path involving different providers, and often different sources of funding, is a strategic area in the management of quality care.

Recommendation 7:
That research be undertaken to assess how the structure and role of parallel organizations focusing on quality in health care impact on the overall quality of health care and how to best to align safety and quality efforts and initiatives.

6.0 Emerging Models of Care and Health Workforce

The health reform agenda across Australia is focussing on improved integration and coordination of services, patient/client centred care, and provision of services within the community where appropriate.

There is a greater focus on developing health care partnerships and collaborations to support integrated models of care and achievement of greater effectiveness and efficiency.

The introduction of output based funding systems such as casemix funding has increased the ability to measure performance/delivery of outputs against funding grants. This in turn has led to a greater emphasis on the use of care plans and clinical pathways and evidence-based practice. A multidisciplinary approach is also developing across the health sector to support the delivery of integrated planned care.[19]

All of the above developments point to the need to carefully consider and develop the health workforce to meet changing health service delivery modes. Issues such as career pathways development, professional role substitution (eg nurse practitioners, health care technicians eg anaesthesia) and the overall supply of health professionals (particularly in the context of multidisciplinary care delivery) must be put into the equation when considering health funding models and health service outcomes. The fact that 60-70% of total operating costs of hospitals and health services are for salaries and wages underlines the importance of effective health workforce planning.

The constant and significant rate of change in health services, often driven by funding approaches to achieve improved efficiency has placed significant pressure of health professionals and managers.[20] The education, training and professional development of health professionals should prepare them for these changing roles and expectations.

[19] S.J Duckett, 2000. The Australian Healthcare System, 2000. Oxford University Press
[20] Gray Southon, 1996. Health service structures, management and professional practice: Beyond Clinical Management. *Australian Health Review*, 1996 Vol 19. No 1.

Recommendation 8:
That there is a need for a greater focus on health workforce planning, particularly in the context of emerging models of health care that focus on integrated service delivery and a multidisciplinary team approach to health care delivery.

Recommendation 9:
That there is a need to consider how the health workforce is educated and trained to assist health professionals to work in an environment of increased accountability for effectiveness and efficiency of health services.

7.0 Health Management Workforce

Like many other workforces, the health care management workforce is ageing. Furthermore, the health system, as discussed previously is rapidly changing in terms of models of care, financial management, information technology and approaches to human resource management. Hence, managers require expanded information and new skills.

The health care management workforce is currently diffuse, lacking any registration-requirements or formal educational preparation. Beyond membership in ACHSE, on-going professional development is not mandatory in many settings. ACHSE considers that this state of affairs should be addressed given the health care managers' pivotal role in the cost-effective organization and delivery of health care to the Australian population. These managers are to be found in many spheres and levels in public and private sector organizations and non-government and not-for-profit organizations, in health departments, acute care settings, community-care agencies, residential aged care settings and many more locations.

Workforce studies and strategies have and are being developed for a range of clinical workforces, through the work of the Australian Health Workforce Officials Committee, the Australian Medical Workforce Advisory Committee, and the Australian Health Workforce Advisory Committee. The implementation of most of the recommendations arising from these reviews will be dependent to a large degree on the efforts of health service managers. It is therefore important that these managers are appropriately trained and skilled in the management of these valuable clinical workforces.

To date, most work done in development of workforce strategies leaves health managers out of the loop. The Australian Health Ministers' Conference (AHMC) strategic framework recognised that"... Leadership, strategic thinking and management ability will be key skills required of all stakeholders." [21] However, no strategies of direct relevance were evolved to foster this recognised essential capacity and practice.[22] [23] [24] This might be the result of assumptions that the management of

[21] Australian Health Ministers' Conference. 2004. *National health workforce strategic framework.* North Sydney: April 2004: 12.
[22] Australian Health Ministers' Conference. 2004. *National health workforce strategic framework.* North Sydney: April 200
[23] Health Workforce Australia. *National health workforce action plan.* July 2004.

health care is like the management of any other industry, a proposition that ACHSE would not support.

Research into the health service management workforce is urgently required and ACHSE would be pleased to offer whatever support deemed appropriate to support workforce research.

The critical concern of ACHSE is to see health services management in Australia provided at a level that will help ensure appropriate, effective and high quality health services are provided to our community by committed and engaged health professionals.

Lack of insight into the vocational nature of health care personnel and the complex interfaces involved in health care can lead to inadequate management practices. Therefore, it is essential that future consideration of the health workforce strategies takes a serious view of the need to train and sustain managers that are capable of providing leadership and services both at central and service delivery points.

Management structures in the health system that are appropriate to the scale and scope of health service organization can enhance management practice and outcomes in the form of more equitable, efficient and quality services. However as emphasised in this Submission, the human dimension and leadership provided by health managers is necessary to make these structures work.

Managers at different levels in the delivery of health services need to have relevant skills, capacity and time to learn and adapt from experience in new or changing environments. The turnover of health managers over recent years is of concern. ACHSE is particularly aware of this turnover factor through membership of the College. A significant number of managers have either changed employment within the health sector of left the health sector over relatively recent years, often relating to restructuring of health services at an organization or state level.

ACHSE would argue that this turnover of managers and the possibility of relatively short periods of time in positions has the potential to negatively impact on a manager's opportunity to have time for a period of stability during which they have an opportunity to learn, develop relationships with co-workers and clients that enhance the pursuit of identified objectives, and also sufficient time to produce a yield for time invested in that process. It might also lead to short and broken engagement with co-workers and clients that have an effect on the development of a stable and yielding management environment. Consequently, it is important that the cost of this turnover of managerial staff is the subject of review to assess its impact on the efficiency and quality of care provided.

It would appear that often, an implicit assumption in restructuring (reinforced by explicit statements to the effect) is that there are too many health managers and that efficiency will improve with less of them. This assumptions and statements are made in the absence of evidence arising from evaluative research.

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[24] Australian Health Workforce Advisory Committee. *Technology and health workforce planning.* Health Workforce Issues Paper 2. March 2005.

Recommendation 10:
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Asia Pacific Journal of Health Management

Invitation to Write to the Editor

By now you should have received your first issue of the new ACHSE peer-reviewed journal, the Asia Pacific Journal of Health Management. The editorial team would like to hear the views of College members on the first issue of the journal. Perhaps you would like to comment on the policies proposed by the author of our first 'Special feature article' or the findings reported in one of the 'Research articles' or the views expressed by an author of a 'Viewpoint' or 'Management practice' article. If so, please write a letter to the Editor with your comments.

Themes for Future Issues of the Journal

The Editorial team would like to hear from College members about possible future themes for the journal. If you have some ideas, please write to the Editor expressing your ideas.

Call for Papers

The second issue of the journal is expected to be published in September.

ACHSE is now calling for papers for the third issue of the journal. The deadline for receipt of papers is October 15, 2006.

Authors are invited to submit original papers that address important and topical issues, such as, health system and workforce reform in countries throughout the Asia Pacific region and/or management of aged care services or mental health services or Aboriginal health services or rural health services. We are also looking for papers from the private sector as well as the public sector.

Submitted articles can take various forms, examples of which appear in the first issue of the journal:

- **Viewpoint** – a practitioner oriented commentary about a topical and/or controversial health management issue with a view to encouraging discussion and debate among readers.
- **Management practice** - a practitioner oriented report of lessons learnt from current management practice
- **Research** – an article reporting original empirical (quantitative or qualitative) and/or theoretical research relevant to the advancement of the management of health care organisations.
- **Research note** – such an article may report the findings of a pilot study or the first stage of a large complex study or address a theoretical or methodological issue etc.
- **Review** – a careful analysis of a management policy issue of current interest to health care managers.