

## 2004 Chief Health Officer Seminar Series

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#### Abstract:

#### *Recent history of health stewardship in the ACT: From contract control to collegial culture*

The Health and Community Care Services (Repeal and Consequential Amendments) Act 2002 ended the split purchaser/provider arrangements for public health care in the ACT and ushered in the current ACT Health regime.

The purchaser provider arrangements were designed to overcome the tendencies of health care providers to respond at best to immediate presenting demand and at worst to their own self interests. The idea was that well specified health service purchasing contracts would counter these tendencies and effect good government of health services.

At a superficial level, the new arrangements appear to replace the contractual relationships of the purchaser provider split with the traditional hierarchical relationships found in most Canberra government departments. At a deeper level the new structures provide governance through a series of well organised and robust collegial interactions that bring out trust in a common mission, respect for special knowledge, and a willingness to be professionally accountable.

The new management culture has its roots in and is sympathetic to the culture of clinical work and research. Clinical governance is core business along with financial accountability and responsive service planning. Acceleration of teaching and research with the advent of the ANU Medical School is strengthening the shift toward a collegial culture.

#### Transcript:

#### Imagining how to manage

This paper is about what's been happening in ACT Health over the last two years, specifically the shift from a purchaser and provider system to a new approach, which looks to many people like a traditional Canberra departmental structure but which I will characterize as a collegial culture. The paper analyses the old and the new approach in terms of the mentality of governing that pervades the department, what we, following Foucault, can call the 'governmentality' of ACT Health. In a sense this is a lecture on the governmentality of the ACT health system in recent times.

The key shift is away from a mentality of thinking that self-interest pervades what happens in the system; away from a system that imagines the virtues of competition and toward one where a higher level of cooperation is expected. This shift was at one level toward a more traditional structure, but at a deeper level I am going to characterise the new structure as being very much underpinned by ideas of collegiality.

In talking about the mentality of government, there's a simple idea here that there's a lot of group think in the department – everyone thinks the same and everything just flows from that. But to be a bit more analytical, in terms of governing the health system, what are we doing? One way to answer that is we're trying to conduct the conduct of the people who are in the health system; trying establish the settings within which professionals act.

The most efficient way of doing this is inculcating the notion self-government so that the actors follow their own desires, their own motivations. Then they will conduct themselves in the desired way. If you have an appreciation of those desires and motivations and design the system for them to bring about the desired consequences, that's efficient government, efficient design of the system.

When working it out, we imagine that the actors in the system have certain tendencies and then we design the structures and the administrative mechanisms around those tendencies. But we have to understand that what people in the system imagine is subject to fashion, subject to research and certainly subject to change. We develop common ideas about imaginary tendencies that people have and then develop the administrative mechanisms that match those - a style, a mentality of government. One governmentality is elaborated around the imaginary tendency towards self-interest. We have to think 'how are we going to control that?' Through contracts, line management or performance agreements? Ultimately this builds to a whole series of administrative mechanisms concerned with controlling the self-interest within the system.

Another approach is to imagine that the system is full of good people doing what they think is best. Yet we don't know if they have the expertise to do this. We imagine the expertise is distributed among them and then try to invent the kinds of mechanisms they will flourish under, so that expertise is deployed through proper self-government. Proper self-government means recognising their expertise and giving them autonomy of action where managers say 'you decide, I can't tell you because I don't know the situation and I don't know the field'.

### **The mentality of Government in a split purchaser – provider system**

I've outlined to different rationalities of government and I think we've had a shift from one to the other. The contracts of a split purchase/provider system are designed to harness self-interest. A well-written contract is one that provides a win-win for the actors on both sides of the contract and where both of them, acting out of self-interest, will maximise the benefit to themselves of the opportunities created within the contract.

But ultimately the belief is that the providers can't trust the purchasers, and the purchasers can't trust the providers, so everything needs to be specified in contracts. People who have worked on specifying such contracts over the last few years understand there's a pressure towards ever-increasing detail of specification. There's always a sense that the providers are wandering off and trying to provide something different that is driven at best by the immediate needs they confront every day and at worst by their own professional or pecuniary interests.

A serious issue that emerges from creating a model of self-interest and then harnessing it through contracts is that it relies on competition. Competition can be a great driver and creates value in many spheres of life, but it does produce a reduction in cooperation, an ethos against cooperation between agencies. This occurs not necessarily at the individual level, but at the agency level or the level at which the contract is drawn. The Reid Report identified that there was very much less cooperation between agencies in the ACT to maximise the potential of the health system in serving its community than might have been expected.

## **Imagining Colleagues**

Set against this is another imaginary situation, one that supposes people want to learn, want to contribute to the community. This is a pervasive idea in the government of colleges, such as the College of Physicians or the College of Medical Administrators, or within university colleges where there are self-governing faculties. They recognise the expertise of the individuals within them and accept that nobody can really make up anyone else's mind for them because nobody else knows what they know; nobody else has the same opportunity for judgement in their specific circumstances.

This might sound surprising to those people who lived through and watched the transition of the Reid Report from the purchaser provider split to the new system. Some people might think the 'new system' is just a very traditional departmental structure, the same as any other bureaucracy in Canberra. You have a line from the minister to the chief executive, and the chief executive has a top level team and they all have line responsibilities. It's very traditional and that is true at a superficial level.

But my contention is that the traditional structure is really just a convenient way of putting some of the accountability relationships on paper. There are many different forms of government and different administrative mechanisms that suit an imagination of a collegial system of experts. On this view the new structure works primarily through a hierarchy of collegial forums. These collegial forums are enormously respectful of the expertise that comes around the table and the debate in those forums is not what you would expect from a line hierarchy where the boss has assembled everybody and tells them what to do and off they go and do it. There's a little bit of that. But they are enormously respectful of the expertise around the table and the debate is quite robust – even passionate.

Again the self-interest that was imagined in the purchase provider split system is disappearing very rapidly toward a passionate commitment to what our agencies should be about, that is, how they can best serve the community and how they can best discharge their mission. There's a lot of expertise around the tables, a lot of far sighted people and a lot of knowledge of what is happening around the world.

## **Distributed Accountability**

A principal difference that this hierarchy of collegial forums has to a traditional line hierarchy is that there is distributed responsibility. If you are running a hospital or if you are running the Department of Surgery or the population health service, you can't offload your responsibility. The administrative mechanism within many traditionally structured Commonwealth government agencies allows people to say 'well if that's what they want, we'll just cover our backs, put it in a memo and get somebody else to sign off and take responsibility for it'. But they couldn't get away with that in a health system where we're actively providing services. The responsibility needs to be distributed appropriately to all different levels.

The idea is to design the system so responsibility is distributed appropriately. Such a design influences the style of conversation. Instead of getting a management direction coming from the top down, many of the conversations would be along the lines of: 'Can you live with that? You're going to be responsible for it, can you take this decision and run with it?' If the answer is: 'No, I don't think I can,' then the parties will rethink the issue. It's a different style of interaction within the organisation than in many more traditional line departments.

I think the other thing with distributed responsibility is that you get distributed accountability. The accountability burden of health care occurs as an hour by hour reality for many people. But while there is accountability through management lines there's also accountability to your profession and to your colleagues within their specialist colleges, within the nursing fraternity, within the allied health professions and between the professions. Then there's the inter-disciplinary accountability of our clinical review forums and there's also a lot of accountability to patients. Often that's enforced through the courts.

Consider the complexity of care involved for patients who undergo 100-step processes when they're receiving care from maybe 20 different health care professionals. In such cases the responsibility to give an account of what you're doing for the patient within that broad stream of care becomes absolutely critical to securing their cooperation, without which you cannot efficiently deliver the health care.

### **Governing Professionals**

A further thing that underlies the difference between a collegial culture and a traditional hierarchical culture is that we're dealing with professionals in the health system. Professionalism is the basis for getting the work done in the health system and provides the discipline to allow us to hold people to account.

So, to consider some aspects of professionalism further. There's expert knowledge and a requirement for training, there's a culture of enquiry that the profession is on a journey in learning about the world, working out what it can do within its discipline to make life better for the community. That culture of enquiry is a responsibility of every member of the profession to, if not participate actively, then at least to be aware of, the requirement for continuing education about the core knowledge base of the discipline. That includes understanding the way it works to do good within the community and the ways it is evolving.

Related to that is the requirement within professional collegiality for peer review and for support for each other within our own and like minded professions. As a corollary, there's an ethos among professionals that they must contribute to their profession, that everybody should take their turn serving on the committees or doing the teaching or organising the conferences, and also that professionals should be making a contribution to the community.

Surveys of public respect for professions usually rate the health professions pretty high in terms of whether they are self-interested or whether are they trying to serve the community. There's an enormous amount of trust developed by the community for a culture of professionalism. So how do we deal with this? If that's what we're governing, how do we conduct the conduct of professionals? Line management has really got to be kept in perspective.

Meta-regulation and an expectation of self-regulation are the keys to it. There are many statutes set by the Legislative Assembly that relate to professional conduct. There are boards for most of the health professions that have statutory regulation. But if you look at the statutes, the practical reality is that the profession regulates itself, which is why board members are predominantly from the profession, plus some additional people. Much of the real work done to ensure that dangerous practices are recognised, and that good value is delivered to the community, occurs when the statutes and the activities of the profession interact.

To achieve self-regulation, or to facilitate self-regulation, communication is enormously important. Communication between health professionals is a significant driver of our information technology strategy. Communication between the profession and the public is one driver of the overall

expansion of the health sector. People want to know more about what's going on, they want more care and more services and the whole sector is growing as part of the national economy.

### **Reform directions in a collegial culture**

So where does this leave us? If we can see past the superficial structure of a line management department towards an ACT Health that is managed by recognising collegiality, and a culture of professional collegiality, there are some things that fall into place.

I think this partly explains the consolidation of quality and safety as a bottom line within the large health care organisation that is ACT Health. Clinical governance is now joining financial governance and planning as one of the central activities of the department. Because they're quite different spheres, they have quite different pressures. But if we value learning and innovation, both within the professions themselves and with respect to what professionals do on the shop floor, and if we try and be innovative in our care systems, that's where we get a synergistic interaction between quality, finances and planning.

How does this occur in practice? One of the key objectives of our quality and safety approach is to recognise the financial benefits and efficiencies that high quality and safe health care services provide. Just think about it in terms of readmission. If somebody doesn't get any unexpected complications, they don't get readmitted and the system can serve somebody else in that bed.

Similarly, much of our planning now concerns new pathways of care rather than just announcing 'we need to build an additional ward here' or 'we need to buy some new technology there'. It's about redesigning systems of care. Stroke care is a good example that's under redesign at the moment. In five years time we will be caring for people with stroke within an integrated service. The current system, where patients travel through different facilities to different parts of the system as they move from the acute stage of a stroke through to their reintegration into the community, will become a thing of the past.

But it's hard to introduce such changes because to a system of care because they require considerable imagination. There has to be good communication between the management and planning functions on one hand and the care providers and professionals on the shop floor on the other. Collegial interactions value such imagination.

Essentially, a collegial culture within management very snugly fits with ACT health's mission of providing health care to our community.

Teaching and research are a part of that and our mission in the ACT is a key driver for the improvements that we need to make. Consider this - teaching and research are forms of accountability. There's nothing like having a bunch of students asking you questions about why certain things are as they are to make you try and explain in simple straightforward terms 'well, this is what we are suggesting you do, it's evidence based and will make a difference that's positive'. Research is the same. You must give accounts of your findings to the research community through the literature. So I believe the development of teaching research within ACT Health is a great system for increasing accountability to professions on the one hand and to the research world on the other.

In conclusion, management through collegial culture suits the mission of a regional health system. The system might be disguised as a traditional organisational one but it takes on many aspects of the professional culture of self-responsibility, of innovation, of teaching and research and a broad accountability to the community.