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Generalism and advocacy: physicians as street level bureaucrats in the NT

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ABSTRACT

The Northern Territory faces distinctive health challenges, particularly in the areas of Aboriginal health, and rural and remote health. Health practitioners with generalist skills are still very much needed. Those same skills are needed to develop healthy public policy - this talk reflects the personal perspective of a general physician working in a health bureaucracy. Rather than perpetuating an 'us clinicians – them managers' culture, collective leadership is needed in health systems, with good clinical and corporate governance reinforcing each other. Physicians could usefully see part of their role as 'street level bureaucrats', but when they advocate there are some simple rules to follow. The health workforce has been a critical area for advocacy in recent times – can we move from plugging gaps to increasing supply and retention, and modifying demand? Post ATSIIC, it is also a watershed time for Aboriginal health across Australia. A recent economic study done at Wadeye in the NT demonstrates clearly the opportunity costs of doing 'more of the same', and the necessity of doing things differently.

TALK NOTES

Thanks

- Thank you to Arrente - traditional owners of this beautiful land that we are on
- Thank you to Stephen Brady and IMSANZ organising committee for asking me to speak

Introduction

Personal account of a clinician working in management, and as a general physician. I'm going to reflect on the need for generalist skills in both medicine and management. And try to tell you why I enjoy the job I currently do. Diane Howard once paid me the back handed compliment of saying I was a good general physician who was wasting his life in bureaucracy – that's quite a compliment from Diane – and today gives me a chance to present an explanation for that choice.

Start with a personal reflection.

I'm a physician, because when I was a student, I aspired to be like the medical registrars I saw. Medical registrars in particular were glamorous – first to an emergency, in charge of the hospital at night, quick with a clever diagnosis on ward rounds, damning about us students' miserable clinical skills. We probably failed to realise they had failed their own postgraduate exams a number of times, struggled to balance home and work, and were desperately looking up books prior to ward rounds. That realisation came later.

And to be a *general* physician – that was the real challenge. A descendant of Renaissance Man, able to give an opinion on all organ systems, all combinations of signs and symptoms, holding the key to the whole therapeutic armamentarium.

I trained at Royal Perth Hospital, which was a real bastion of general medicine. Sir Charles Gairdner Hospital had gone over to the dark side of sub-specialisation, but we saw that as catering to the upper middle classes in the comfortable suburbs, while we at RPH prided ourselves on the business of our emergency department, emergency surgical lists and intensive care units, as well as the general wards.

I was also lucky enough to be a student in Perth in the halcyon days of clinical epidemiology. Bruce Armstrong and D'Arcy Holman inspired a number of us into first epidemiology and then public health. Starting as a medical student working with D'Arcy on melanoma research, I laboriously worked through medical records, and examined microfiched records till my eyes hurt. In that way, I learnt the value of clinical audit early on, and the necessary contribution of clinical practice and research to population health.

Coming to Darwin to do epidemiological research at the Menzies School of Health Research, and to work in Aboriginal health in the early 1990s seemed somewhat like going off to PNG in the 1960s. When I arrived in the NT in 1991, stepping into Darwin airport was like stepping into a pre-modern shed with rusty overhead fans and a rickety rickety carousel. The health system was also different - there was no nephrologist, no cardiologist, let alone remote dialysis and angiography. There was no Clinical School and great difficulty recruiting Australian trained junior doctors, compared to competing clinical schools and competition for intern places today. There was no organised approach to chronic disease, far less outreach, there were still patients admitted with refractory seizures after sniffing leaded petrol, no Aboriginal Liaison Officers in hospitals, certainly no Aboriginal interpreter service, no Aboriginal Medical Service in Darwin, no Indigenous members of Parliament, and no Aboriginal doctors in the NT.

PART 1. HOW POLICY WORKS

This description of change leads us to the 'glass half full – glass half empty' issue. It's paradoxical – people complain that nothing is changing, when some things are changing amazingly quickly all around us. To say that things have changed does not imply that you think everything now is OK. But to deny change is to deny the collective efforts of many people over time. Managers tend to be in the 'glass half full' school, and clinicians in the 'glass half empty'.

NT Facts

This talk is not going to present you with a whole lot of statistics, but let me give you a few to start

- 1.5 million square kilometres – NT is a big place
- 200,000 people – with not many people
- 30% Aboriginal – by far the highest in the country, and making Aboriginal health a mainstream rather than a minority issue
- 2/3 of whom live in rural and remote areas
- 40% of Aboriginal population are children –
- Aboriginal people are sick - they occupy at least 50% of hospital bed days, and
- 60% of total NT health expenditure is provided to Aboriginal people

Ways of viewing policy

- Policy as contested politics. World is messy, and policy formulation is inherently political and most often contested. However, note that our best current representation of community values is in the political process.
- Policy as rational decision making: goals, strategies, objectives, evidence, cost benefit
- Policy as incrementalism – marginal adjustments, not dramatic – don't scare the horses, but effective often (tobacco control can be seen as a continuous series of small changes over a 30 year period)
- Policy streams – separate streams of problems, policies and politics running through an organisation – key to understanding policy change is their coupling. Timing is crucial in this model, alertness to the environment everything, and readiness to act
- Advocacy coalition framework – coalitions form on a common set of policy beliefs, between governments, NGOs, consumer and professional organisations. Connections with people inside bureaucracies is often vital. In the last 10 years in the NT, we have seen such coalitions form between NT Government and Aboriginal Community Controlled health sector, often to lobby for changes to Federal government programs, such as Medicare and PBS.

Health departments are different

Health systems are different to most businesses and organisational hierarchies. Highly skilled and well paid specialist clinicians sit close to the coal face, at the 'bottom of the traditional organisational tree', with direct experience of patient needs. They can be as powerful in an organisational sense as the CEO, and hence most health organisations are pluralistic and less amenable to top-down direction. Their sense of professional allegiance often outweighs their allegiance to either institution or employer. We will return to this issue later.

Health departments are similar to all government departments, and operate under constraints, particularly legal requirements re appropriation. The CEO, as the responsible officer, cannot knowingly overspend his or her departmental budget. Role of any government department is twofold: to implement government policy and to advise government on policy options. But under our Westminster system, it is elected politicians, through the Cabinet process, who decide upon policy, the size of overall government spending, and the distribution of that spending across the various portfolios, all of which have social good attached to them whether it be education, health or heritage. It is not the bureaucracy.

Health departments deal with hard, complex messy issues

4 levels of deep seated problems (Braithwaite *et al.*, 2002).

Contestation comes in at four levels – political, institutional level (hospital-community, Federal-State), clinical service unit (clinical hierarchies and professional groupings), and then individual level, where professionals interact with patients (communication, access issues).

Solutions can be grouped into 4: power and self interest; economic reasoning – motivated through incentives; scientific or biomedical thinking; business oriented – generic MBA manager. All this leads to is fragmentation.

What we really need is a staged, inclusive process, where people learn together, define the systems, establish some rules, put people at the centre, and work iteratively. Buzz word these days: Collaboratives.

The way that I'd summarise the job of the bureaucracy is to convert ideas and resources into implementable plans and change on the ground. But who is the bureaucracy? My answer is - we all are.

Street level bureaucrats (SLB)

This was a term coined by Lipsky in 1980 to capture the discretion and relative autonomy of professionals in re-construing and applying policy at the local level. SLB work in complex situations, and have discretion to respond to the human dimension of situations. They provide services, grant access to programs (eg patient travel schemes), interpret policy, have credibility greater than their managers, are powerful (eg doctors waiting rooms), and socialise citizens to expectations of govt services.

Their individual actions add up to a large part of perceived agency behaviour.

Lipsky wrote 'the decisions of street level bureaucrats, the routines they establish, and the devices they invent to cope with uncertainty and work pressures, effectively become the public policies they carry out'

4 factors are described as to whether SLB adopt policy direction

- clarity of guidance
- does it coincide with professional values?
- local practices and policies, inc available resources and competing priorities
- own personal vision

So even when policy is clear, it can be interpreted and applied inconsistently.

Clinicians in particular

Clinicians often make bad followers, do not necessarily make good managers, can break the budget with their pens, and show prime loyalty to their professional group rather than their employer. Some managers see these attributes as a problem. What such managers do not appreciate is the strong sense of professionalism in clinicians means that motivation for performance and quality is not an issue (unlike in traditional hierarchical large organisations, where managers spend their lives dreaming up ways to motivate front line workers) and clinicians are action oriented.

So the real question is: how do we harness the ideas and knowledge of clinicians to enhance the organisation?

Answer: strengthen partnerships between clinicians and managers, give them support and information, and find ways to get their feedback on policy as they see it applied on the ground in day to day work. Pick this thread up again when we talk about clinical and corporate governance.

Clinicians as advocates

Given their position, street level bureaucrats *should* advocate, but need to do so effectively. I get to see a lot of advocacy efforts, and some are better than others, and some very simple rules get broken by very intelligent people.

1. Do what you can within your own management structure. If you work for an organisation, you have a responsibility to use normal management processes to resolve issues in the first place

2. If you do choose to advocate through a professional college or other organisation, clearly distinguish your roles – the hat you are wearing
3. Don't rush at advocacy as if you are going to change the world in a couple of months
4. Try to define precisely what you are aiming to achieve through advocacy
5. Identify who your potential allies are (and there are likely to be some inside the bureaucracy) and form a coalition if possible
6. Even if your ideas are so good that you consider their worth self evident, try and articulate them clearly and consider how they might be translated into actual change on the ground. The basic task of bureaucracy is to translate resources into change on the ground, so worthy ideas in themselves do not usually get up against other priorities
7. Prepare your case carefully – an evidence base is useful.
8. Media is a component of advocacy, it is not the only strategy, and is usually a last resort, not a first resort
9. Don't spit the dummy if you don't get what you want – there are many good ideas put to government, all with worth. You don't have to impute bad motives to people who don't agree with you that proposal X is a priority. Regroup, see where you went wrong, involve other people, fashion another strategy. Consider keeping your proposal in the bottom drawer until circumstances are in your favour. As I said before, Timing is crucial.

PART 2. CLINICAL AND CORPORATE GOVERNANCE

As you might have gathered, my job description tells me I have to be unpopular with both clinicians and managers. To clinicians, I present a management perspective; to managers, I present a clinical perspective. So let me continue in that vein.

Not all clinicians are perfect, not all managers are evil. There are good and bad clinicians, good and bad managers. Most, of both, are trying to do a good job. I spent three months sabbatical in 2003 trying to work out what was meant by the term clinical governance. Clinical governance has many definitions: it can be seen as a framework, a philosophy or a process. My conclusion then, which I still hold to, is that the essence of clinical governance is a partnership between clinicians and managers working together to get the best outcomes for patients with the available resources.

A partnership between a good manager and a good clinician sustained over time can achieve a lot, and there are many good role models for this, including I am sure many people in this room. Such partnerships also are the best opportunity for continuing progress, not just sporadic one off changes, that leave everyone exhausted by the end.

People tend to talk about clinical and corporate governance as if they are separate entities– I don't believe they are distinct in a health organisation. Corporate governance is impossible without clinical governance. I've found the following definition of corporate governance helpful in that it describes processes that we recognise on a day to day basis delivering health services, especially the delegation and limitation of risk (eg procedural work).

“Corporate governance encompasses the arrangements by which the power of those in control of the strategy and direction of an entity is both *delegated* and *limited* to enhance prospects for the entities long term success, taking into account *risk* and the *environment* in which it is operating” Commonwealth of Australia, 2003.

There are a number of key underlying cost pressures that affect health systems – health inflation, new technology, staffing costs, patient expectations, improving access, and higher safety and quality standards. Hard choices do have to be made in health. Strategies need to both improve outcomes and control costs. If managers and clinicians are consistently pulling in different directions, everyone loses. What’s happening in Queensland is a good example.

Managers and clinicians need to work towards a shared understanding of priorities, agree that some things are not a priority at this point in time, and make some savings in non-essential areas, in order to do the really important things well. Blowing your budget year after year will cost managers their jobs – sure, but it does nothing for clinical services either, as health gets a reputation as being poor economic managers, and central agencies, such as Treasury, don’t generally favour throwing good money after bad.

Health workforce

One of the key drivers of health costs is staff – health is a human service, and needs to be delivered by people. You can’t open a journal or college publication these days without reading a number of articles about workforce.

However, we plan on what has been, rather than what is needed – it’s like using a sliding scale for writing up insulin, applied to workforce. And any thinking ahead has been very limited by current professional role delineations. We need to de-emphasise a focus on single disciplines in workforce planning and promote the idea of health care as team based care. It will be interesting to hear what the Productivity Commission says about the health workforce.

Part of the problem is how we phrase the question on workforce. It’s usually stated something like ‘Do we have the right people in the right numbers with the right skills to do the right jobs?’

I’m not sure that’s the right formulation – in health departments, we try to plan health services around patient needs, then work backwards.

Let’s take one recent example – the debate on nurse practitioners.

AMA media release of a week ago is titled ‘AMA rejects independent nurse practitioners as medical workforce solution’. It says in part ‘Nurses are no substitute for doctors’. But that’s a rhetorical answer to the wrong question. The AMA goes on to infer that nurses must always work under the guidance of a doctor, and closes its eyes to what is going on elsewhere in the world – physician assistants in the US, nurse endoscopists in the UK, and nurse practitioners in EDs in Australia. The AMA categorically states nurses should not diagnose, nor refer patients to specialists, nor order pathology independently, nor prescribe medications – obviously the national AMA isn’t fully aware of standard clinical practice NT in the last couple of decades, where remote area nurses do all of the above, and Aboriginal health workers some of it.

In contrast, I recently saw a very balanced letter from the Chair of the Medical Advisory Committee at RDH, which supported the concept of nurse practitioners in the NT, but raised concerns about an open prescribing approach. The letter went on to offer practical help with reviewing and keeping a formulary for nurse practitioners up to date.

Generalism in medicine and management

I'm not going to give you my views on how to stimulate general medicine in Australia – there are much better people to do that in this room. And the RACP Restoring the Balance document will be released later today.

But simply point out that wherever you have program silos, there is a need for cross-cutting generalism – and this need is as evident in management as in medicine. In an increasingly subspecialised medical world, it is the strength of general medicine that determines the effectiveness of medicine as a whole. And in a program based health organisation, it is the strength of the horizontal links that determine overall performance.

I'm very glad of the generalist skills I have developed as a physician. They are useful in management.

- Attention to detail and concern for facts is the starting point of any decision making process – it's like taking a good history, and doing a thorough examination
- financing is not so different from epidemiology– you need to care about numbers, ask questions about numbers, construct a story about and around the numbers, and use numbers to plan. Planning – it's of course more than just the numbers – it's about choices and options.
- Judgement is the key generalist skill - sorting wheat from chaff, dealing with uncertainty, being able to construct a management plan, a way forward even in the midst of uncertainty
- Actively reviewing decisions after a period of time – like retaking the history, re-examining patients – is a key strategy in both management and medicine.

PART 3. CASE STUDY IN ABORIGINAL HEALTH

In policy terms, Aboriginal health is a “wicked” problem. It is not easily defined with straightforward answers. It is difficult to describe, difficult to conceptualise, difficult to break down into bits. Multiple, complex approaches are needed. We generally make one of a number of mistakes. We think it's too hard, and throw up our hands. Or we overlook the complexity and offer simplistic solutions.

This is a time of great uncertainty in Aboriginal health, but could be a positive turning point.

Noel Pearson's contribution was to point to the basic Marxist proposition 'It's the economy, stupid'. And he asked: How had we forgotten that? Whether you agree or disagree, it allowed other questions to be asked, other verities to be challenged.

I am reminded of the clinical phenomenon of 'anchoring' (Sutherland, 2002), where an initial faulty triggering of an inappropriate hypothesis is followed by a premature closure, excluding the search for further data that might be relevant to the diagnostic process. Pappworth, whose primer of internal medicine was my unofficial textbook as a student, talked about the crime of Procrustes or ignoring pieces of information that do not fit the hypothesis, in order to maintain the hypothesis. (Procrustes was a bandit who stretched travellers' limbs until they fitted the iron bedstead to which he strapped them).

Post ATSI, familiar anchors have been pulled up, we are drifting in strong currents, there might be a storm coming, but we don't know whether to set sail away from the storm or cast the anchor in a different place.

All the talk now is about mutual obligation and shared responsibility agreements. But what are these going to look like in practical terms? The answer is ‘we don’t know yet’.

Mutual obligation

But what do I think of the underlying philosophy of mutual obligation? I think it’s fine with certain caveats. Mutual obligation is a type of incentive that can be both empowering as a process, and lead to positive outcomes for Indigenous communities, as long as it is consensual, mutual and does not infringe fundamental human rights that should not be negotiated away.

Mutual obligation is at the heart of what we understand by society. It’s one of its founding principles. Any society, every society involves individuals giving up certain things in return for other things – in a classic political philosophy sense, accepting constraints on individual behaviour in return for such things as safety from attack, and various entitlements to basic services. We are literally ‘bound together’ in society by a set of mutual expectations and obligations.

It’s also at the heart of what we understand as ethical behaviour. Mutual obligation is linked to ideas of sharing and reciprocity, and implies a genuine understanding of the other party’s needs. As argued by Pat Dodson and Noel Pearson, it is also an essential practical test of kinship relationships in Aboriginal culture.

So we need to apply certain tests:

1. Truly consensual, not coercive. That is parties must enter into the agreement freely, and be able to withdraw freely.
2. Core services should not be traded – primary care services, child welfare and family support services, obviously statutory services (eg child protection)
3. The agreement must include obligations on both parties – it cannot be one sided. It can serve to hold governments to account.
4. There should be some way to test whether both sides have complied with the agreement – otherwise it is not an agreement, rather a vague aspiration.

If a mutual obligation agreement can meet those tests, fine.

Example: ‘no school, no pool’ policy in certain Aboriginal communities is widely accepted as providing a positive incentive for children to attend school. It is really an agreement between the various families that live in a community, as mediated through their local council, that

- a) kids going to school is a good thing
- b) not enough kids go to school
- c) motivation is a problem and
- d) if some other motivation was provided, such as pool access, school attendance might improve.

The policy could be rephrased from ‘no school, no pool’ to ‘If school, then pool’ to stress the incentive rather than the punitive aspect.

Really, what is the alternative to a new approach? Status quo is not an option, for reasons I will argue now.

Wadeye case study

Wadeye is the largest Indigenous town in the NT with 2200 people. The population will double in 20 years time and it will be bigger than Nhulunbuy. It also is part of a wider demographic feature, namely that across the NT in 10 years time, a large cohort of Indigenous people will have entered the working age, and 66% of Indigenous people will be in that age range, compounding the employment issues currently faced.

In 2002, the Council of Australian Governments agreed to trial whole of government approach to working with Indigenous communities, and Wadeye was chosen as a pilot site. A shared responsibility agreement was signed between Commonwealth, NT Government and Wadeye residents with agreed key priority areas of women and families, youth and construction and housing. I will not talk about the results of that pilot, but instead highlight the importance of a document (Taylor & Stanley, 2005) prepared for the pilot.

This document attempted to answer the question: if we conduct business as usual, what are the costs?

It compared government investment in Wadeye to a benchmark of investment across the NT generally. It found the following

- a) remedial costs – Govt spend in two areas to address community issues
 - a. negative – police, corrections, income support through Centrelink (82% of all income from welfare). Extra 3.7 M
 - b. positive – health (0.6M over NT benchmark). But deficits in Education and Community Development. Overall deficit 10.2M
 - c. Overall underinvestment of \$6.5M
- b) Largest shortfalls in the education area, only about a third of that spent elsewhere. Only one regional school. No funding for secondary school kids. Only half eligible kids enrolled at school, and half of these attended. It's as if expenditure had been adjusted for non-attendance, as our expectations slipped year by year, and non-attendance became normative. \$4M deficit in Education.
- c) Also relatively small CDEP program at Wadeye (20% adults employed, most in CDEP, only 65 Aboriginal people in non-CDEP jobs), therefore ATSSIS funding only half that of elsewhere. \$4M deficit.
- d) production foregone – amount of income not generated due to unemployment – estimated for Wadeye alone to be \$44M

There is clearly then a need to invest positively in education and employment, a point which the NT Branch of the AMA has advocated consistently in the last 5 years or more to their credit.

I've searched for the convincing closing sentence that brings this talk to a conclusion, but have failed to find one. Generalists are needed, and good advocacy is important. My views of the physician role have changed since I was a student – thankfully – less of an emphasis on the flashy diagnostician and more on the skills needed to be a street level bureaucrat.

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