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SWIMMING IN A BOG: THE GULF BETWEEN PLANNING AND IMPLEMENTATION

Introduction

You might think this is a bit of a pessimistic take on health policy, planning and service development after some of the inspiring presentations we have heard this morning. However, I would contend that most of us sitting here today are very aware of, and frustrated by the gulf that appears to exist between policy and planning, and what we see happening on the ground.

Given the considerable work that has been undertaken in North West Qld and in fact all over rural and remote Queensland over the last couple of years, in the development of Regional Strategic Health Plans, I think it is very important that we identify and understand the challenges and barriers to implementation. Because until these barriers are understood and acted upon, we in the health arena are going to continue to waste resources on policy development and planning, and communities are likely to see very little improvement in their primary health care and health status.

We need to articulate these challenges to implementation in order to:

- Develop realistic and do-able plans but still lift the bar in terms of health service delivery and health status
- Develop strategies within the planning process, or change the planning process to develop a platform for implementation
- We will not see health service reform unless we can implement new solutions
- Tell the funders what these barriers are because in some ways they contribute to the lack of implementation

Understand challenges to implementation in order to:

- Develop ***realistic and do-able plans*** but still lift the bar in terms of health service delivery and health status
- Develop strategies within the planning process, ***change planning*** processes to develop platform for implementation
- ***Achieve reform*** – won't happen if we can't implement new solutions
- ***Tell the funders*** so don't keep making the same mistakes (because in many cases they contribute to the lack of implementation

1. **No more needs assessments until we have some change**

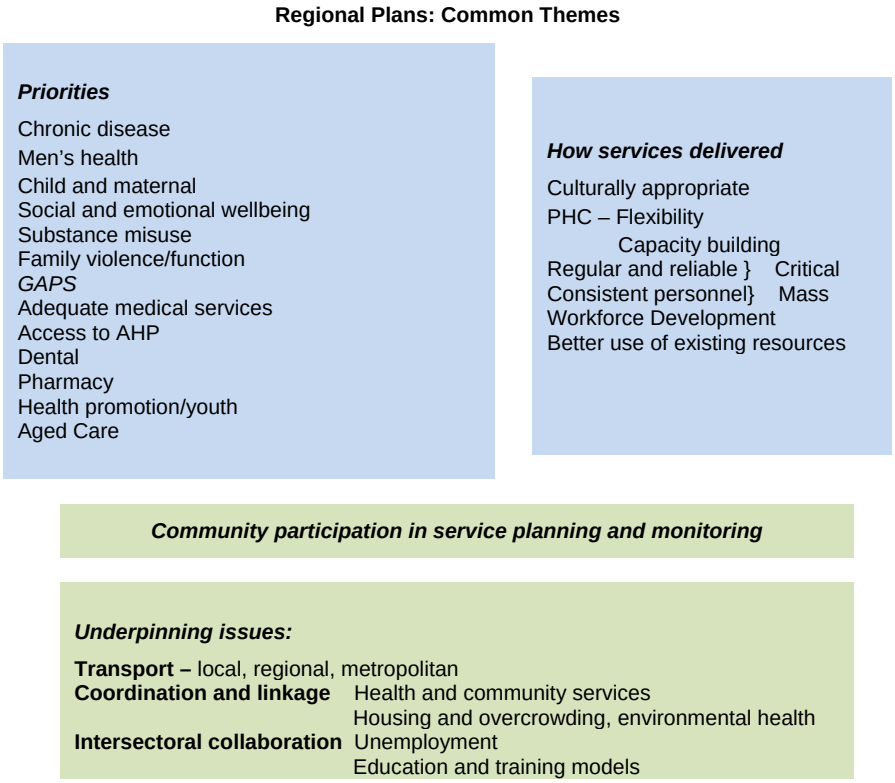
First of all, I would like to put forward that we don't need any more needs assessments in rural and remote Queensland until we start to see some change, or response to the ones that have already done. We have a pretty good idea of the health priorities and service gaps that exist in rural and remote Queensland.

Insert Slide:
Map of Qld coloured by Districts/COI where KBC involved in planning

I base this statement on planning work that has been undertaken in rural and remote Queensland over the last five years under various strategies including Regional Health Service Strategy, Primary Health Care Access Program (PHCAP), and the Qld Partnerships Regional Planning.

I have had a look at the common themes that have emerged from this planning and needs assessment work.

Insert Slide: Common Themes



There are some very clear messages coming from these community-based plans with respect to:

- Priority health issues
- Gaps in health service providers
- How communities want services to be delivered
- The need for community participation in service planning and monitoring

In addition there are underpinning issues that need to be addressed to achieve improved health status in rural and remote communities rather than just applying a band-aid as we appear to be doing now. These are

- Transport to access health services
- Coordination and linkage across health agencies as well as with community services
- Intersectoral collaboration to improve a multitude of environmental health problems; unemployment; and better and more flexible education and training models for Indigenous people and non-Indigenous people residing in rural and remote Australia

Myriad of planning processes, undertaken by a multitude of agencies, for plethora of purposes

Plans relating to Identified Priority Health Issues and Service Gaps (not comprehensive)

1989	National Aboriginal Health Strategy
1992	Qld Health. Some good long talks. About birthing for Aboriginal women in remote Queensland
1994	National Aboriginal Health Strategy (Mark II)
1994	Qld Health. Indigenous Health Policy
1995	Qld Health. Aboriginal birthing on homelands
1996	Aboriginal and Torres Strait islander Framework Agreements
1996	ACIL. The Birthing Service program. Review of services funded under Commonwealth Alternative Birthing Service program related to Qld
1996	Qld Health. 10 year Mental Health strategy
1996	Qld Health. Maternity Services in Aboriginal communities. Clinical needs analysis of five communities and framework for services
1998	Qld Health. Mothers and Babies: Evidence based synthesis of QH endorsed documents to guide development of public sector services for mothers and babies
1999	Health Horizons: A framework for improving the health of rural, regional and remote Australians
2000/01	DoHA. Regional Health Strategy
2000	Qld Health. Director General's Allied Health Recruitment and Retention Taskforce report
2000	Review of Cape York Health Services
2001	Cape York Justice Study
2001	Enhanced model of primary health care and NQ Chronic Disease Strategy
2001	Meeting Challenges making Choices
2001	DATSIP. Towards a Qld government and Aboriginal and Torres Strait Islander 10 year Partnership
2002	Aboriginal and Torres Strait Islander Health workforce Strategic Framework
2003	National Strategic Framework for Aboriginal and Torres Strait Islander Health
2004	Healthy Mouths Healthy Lives: Australian National Oral Health Plan 2004-2013
2005	Re-Birthing. Report of the Review of maternity Services in Qld

2. There has been a Myriad of planning processes undertaken by a multitude of agencies for a plethora of purposes over recent years, all with the purpose of addressing those specific issues identified in rural and remote Queensland.

This Slide is a List of policies and plans released over last 15 years (not comprehensive) that should be addressing priorities and gaps identified in regional plans.

However, I would contend that we seen only limited implementation of many of these state and national plans.

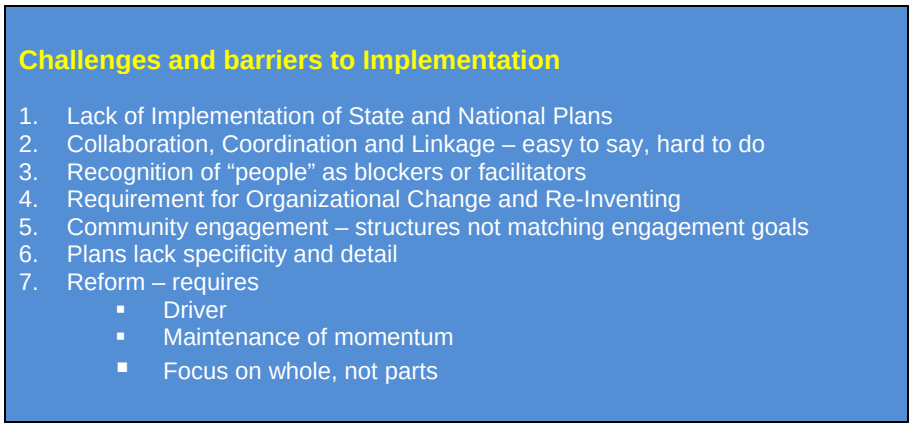
3. What are the challenges and barriers to addressing the core issues identified in the community plans?

I have been thinking about this over recent months and developed this list from my experience, and I am sure that there are others that you could add.

Challenges and Barriers

Challenges and barriers to Implementation of Regional Health Plans

- Lack of Implementation of State and National Plans – particularly impacts on health priorities and workforce
- We need to understand why Collaboration, Coordination and Linkage is easy to say but hard to do
- Lack of recognition of the fundamental importance of "people" and relationships as blockers or facilitators to change
- If we want to see services delivered differently it will require Organizational Change and Re-inventing by providers
- Community engagement – Where on the continuum are we operating and do the structures and processes support engagement
- Plans high level, and lack specificity and detail for implementation
- Reform – requires driver, development and maintenance of momentum by funders, organizations and people on the ground, and reform requires a focus on the whole not parts



4. Discussion of barriers and challenges to implementation

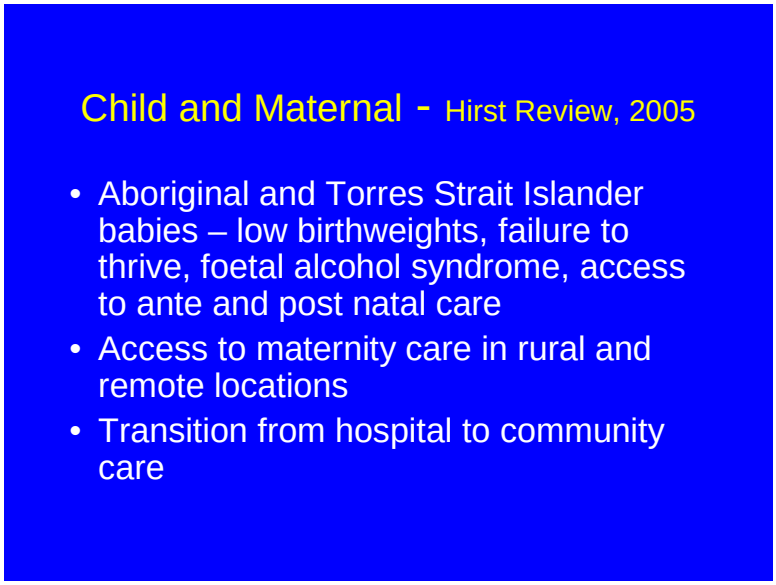
So now what I would like to do is discuss each of these barriers and demonstrate the relationship between them.

4.1 Lack of Implementation of State and National Plans
Many of the local priorities identified in Regional Plans require a state or national response in order to support change at a local level.

4.1.1 Child and Maternal Health

Maternity services in Queensland have been in the spotlight over recent months as a result of the further closure of several rural obstetric units, and the release of Cheryl Hirst's review of maternity services. The community plans and the Hirst Review have identified the key issues around child and maternal services.

But this is not new information. In the period 1992 to 2004 the Hirst Review identified 18 reviews and reports relating to maternity services in Queensland that provided recommendations relevant to these key issues. But yet we have had another Review and in this case, the fast tracked development of an implementation strategy (over a period of several weeks) that fits with the political process, and one would question the effectiveness of this in bringing about structural change.



4.1.2 Development of the Aboriginal and Torres Strait Islander Health Workforce

In May of 2002 the Australian Health Ministers' Advisory Council released the Aboriginal and Torres Strait Islander Health Workforce National Strategic Framework. This framework has 5 very clear objectives with strategies.

Objectives 1 to 4 have been identified as areas for action in the community plans in Cape York, the Near South West COI (around Roma and St George) and in Central West and North West Queensland. But when you try to find out where we are at with respect to implementation – particularly around development of a registration process for Health Workers to support role delineation and recognition with other health professionals, I'm told "we are developing the implementation strategy". That's 3 years down the track after the release of this framework.

Aboriginal and Torres Strait Islander Workforce, 2002

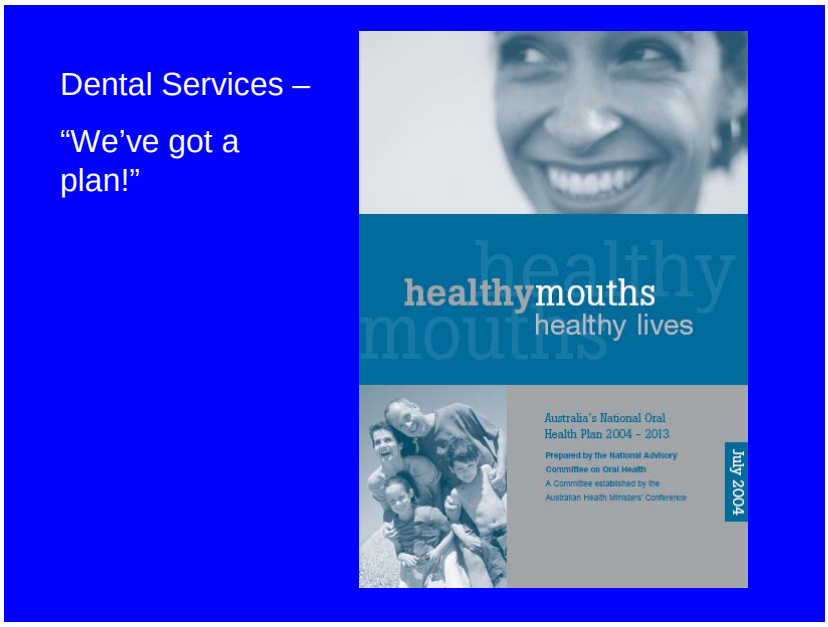
1. Increase number working in health professions
2. Clarity of roles, regulation and recognition of Health Workers
3. Role and development needs of other health professionals
4. Improve training, recruitment and retention of staff working in Aboriginal health services
5. Accountability for govt programs to achieve objectives

Developing Implementation Strategy 3 years down the track!

4.1.3 Dental Services

Access to dental services has been identified in every piece of planning work undertaken in rural and remote Queensland. Whilst we have been able to source Commonwealth funding for a range of allied health, mental health and medical services, dental services have been a no go area, with a history of argy-bargy between the state and Commonwealth around who's responsibility it is to provide dental services. Whilst there continues to be a fight – rural people are missing out on access to regular and reliable oral health services.

Again, this was raised at a meeting of bureaucrats in Canberra a couple of months ago, and the response was "we've got a plan". Well we have, and it is a very comprehensive plan but there still has not been any improvement in access to dental services across rural and remote Queensland.



4.1.4 National Aboriginal Health Strategy, 1989

The National Aboriginal Health Strategy, released in 1989, remains the most comprehensive articulation of the health aspirations of Aboriginal and Torres Strait Islander peoples. However, the 1994 evaluation of the strategy stated that it was never effectively implemented" and the reasons cited for this were:

- Underfunding by governments of initiatives in rural and remote areas
- Lack of political will and commitment from Commonwealth, state and territory ministers and ATSIC
- Lack of accountability for implementation
- Absence of meaningful partnerships between the mainstream health system and Aboriginal and Torres Strait Islander people
- The fact that other portfolios such as housing, essential services, education and local government were not party to the strategy

This evaluation has identified a few more barriers or challenges to implementation that we need to add to out list.

4.2 Why are Coordination, Collaboration and Linkage such a challenge?

There are a multitude of players in the health arena at a regional level. These include:

- Queensland Health – with influences from Corporate, Zone, District and local levels
- Aboriginal Community Controlled Health Services (and sometimes more than one in a region or Community of Interest)
- Division of General Practice
- Individual GPs
- Royal Flying Doctor Service
- Private allied health
- Domiciliary nursing service
- Qld Ambulance Service
- HACC
- ACAT
- Residential aged care
- Regional Health Services under various auspices

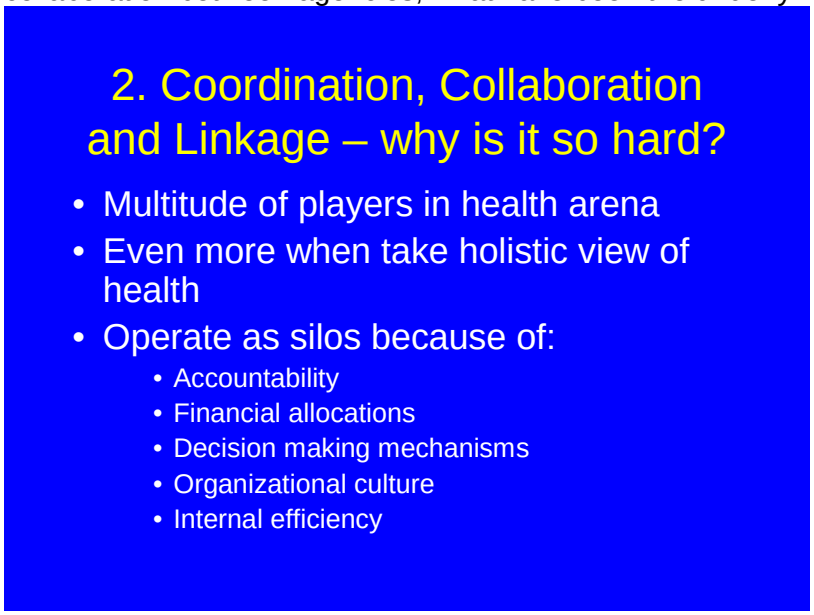
And then if we take the holistic view of health we include:

- Education Qld
- Dept of Communities
- Non-government organizations such as Anglicare
- Housing Corporations
- Employment

We need to understand that it is very hard to bring about coordination and collaboration when these organizations have always operated as silos. Of course there are very good reasons for this that relate to:

- Accountability
- Financial allocations
- Decision making mechanisms
- Organizational culture
- Efficiency

When we think about where we have seen some good and effective coordination and collaboration between agencies, what have been the underlying facilitators to that?



Where have you seen coordination and collaboration between agencies?

What have been the underlying facilitators to that?

4.3 People and relationships

So much of the time when we develop plans that encompass a number of agencies we identify focus on the organizations rather than the people that are managing the organization or operating within it.

We can have a very nice plan that with all the right words around partnership, collaboration, coordination, linkage, but if the people within the organizations at a management and operational level aren't walking the talk – it doesn't happen.

Therefore if we are seeking some form of collaboration between agencies we have to look at the key players in each of these and ask questions around their:

- Perception of the issue, do they see it as part of their problem or is it someone else's
- Objective for collaboration, how will they or their organization benefit
- Willingness to commit
- Resources available to them

If there isn't some congruency between the "people" within organizations, particularly around the first three, it is likely that there will be little change or progress around that part of the plan.

3. "People" and Relationships

Dependent on:

- Perception of the Issue
- Objective for collaboration
- Willingness to commit
- Resources

How can organizations bring about coordination and collaboration?

A very good example of a bottom up approach in North West Queensland is Speech Pathology Services.

Three agencies provide speech pathology services to 10 communities in North West Queensland.

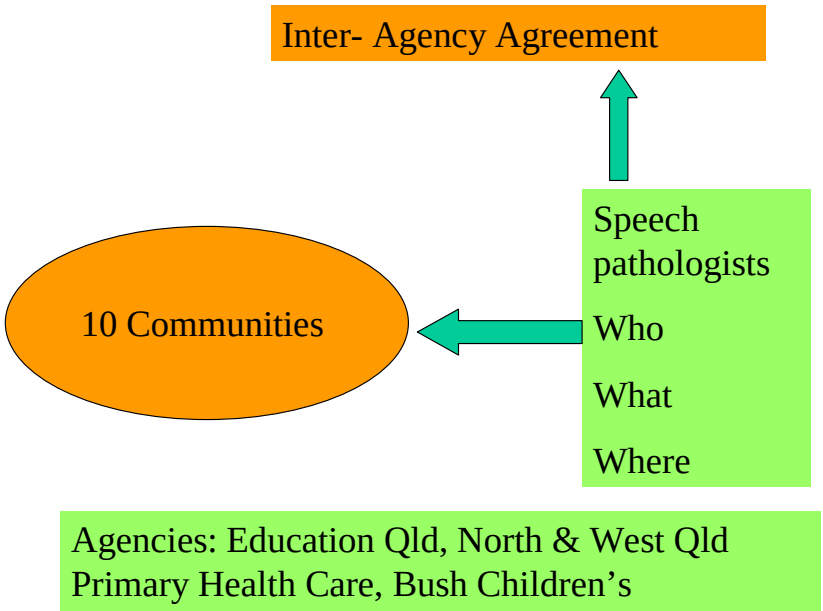
Education Queensland and Bush Children's have a mandate to provide services to children of moderate to high level need, but have some capacity issues. NWQPHC visit all of the target communities on a 6 weekly basis, and operate across all age groups.

The speech pathologists from the 3 agencies got together and sorted out a protocol for service delivery that meets the accountability requirements of the Ed Qld and Bush Children's, using the availability of the speechies from NWQPHC to undertake follow up when required, and service children with low to moderate needs, as well as adults across the 10 communities.

The protocol for coordination was developed by the Speech Pathologists (the operational people) and it has been ratified by the managers of the agencies.

And the key thing about this is that it wasn't developed as part of a formal planning process as such, but rather as a sensible way of organizing their business to make the most of available resources to meet the needs of the communities.

Example: Speech Pathology NW Qld

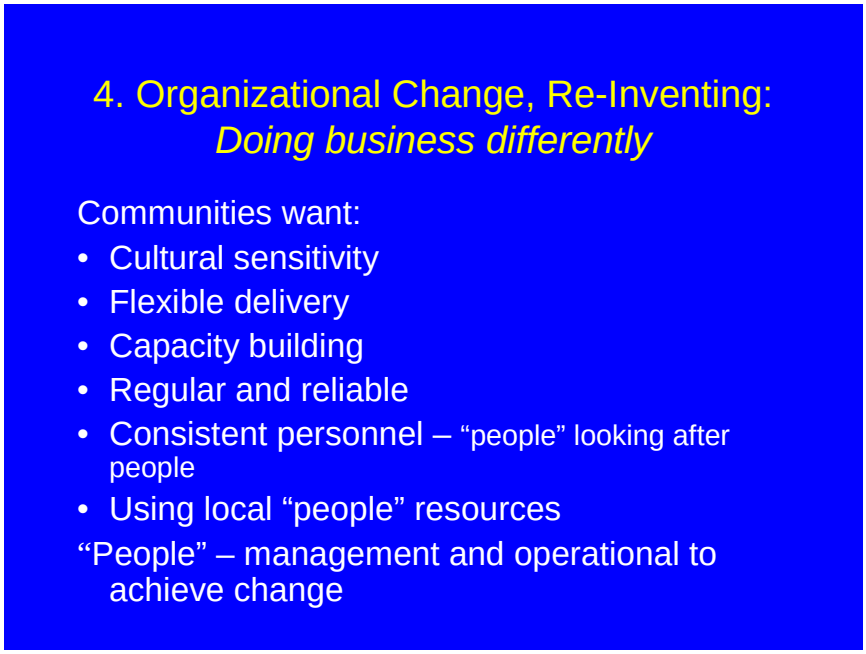


Requirement for Organizational Change and Re-inventing by providers – Doing business differently

There are very clear messages that communities want to see services delivered differently in rural and remote areas.

- Cultural sensitivity: Culturally sensitive service delivery is more than staff turning up at a one day workshop, although this is lost on some
- Flexibility about where services are provided
- Capacity building/skills development in communities – requires providers working from alternative locations within communities (other than hospitals and clinics), and operational people need to be supported by their managers to do this. It requires additional time to show and do with local people, and perhaps change the emphasis of their role to incorporate not only clinical service delivery (occasions of service – the things that get counted), but community based activities as well.
- Regular and reliable services might require a financial commitment – but it might not, it might just require a commitment to "Do It"
- Consistent personnel, and this requires recruiting people with aptitude for rural and remote, and cross cultural practice (rather than just taking who will come), and it requires looking after people by the "people" within the organization, because an amorphous organization can't do that!
- Communities want to see service providers making better use of the "people" resources that already live in a community – this can be local people that have local knowledge and links into the community, and it can also be health personnel already there such as ambos, hospital nurses, health workers. To make this happen requires providers (particularly visiting providers) and their managers, recognizing the local skill base and using and developing it, as well as breaking down professional boundaries that may be real but may also be imagined.

In many ways this should be the easiest part of the regional plans, because often it may not require additional resources, but in fact it is likely to be the hardest, because it has that "people" element at a management level and operational level.



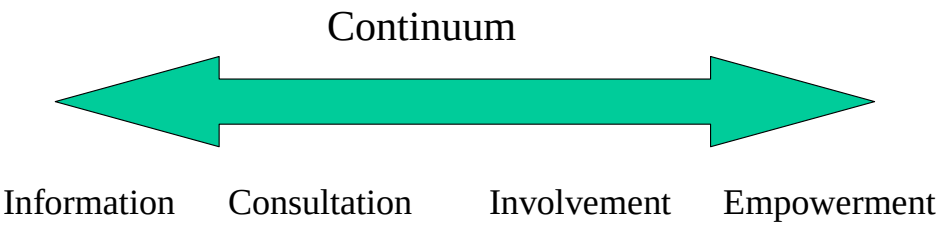
4.5 Community Participation

Rural and remote communities want a legitimate and meaningful role in health service planning, development and monitoring of the roll out of services, and this should contribute to utilization of health services across all groups in a community.

However, we as health service planners and providers have a lot of trouble achieving this because:

- We may not be clear about where on the continuum of community engagement we are operating, and does it match the community's expectation?
- The processes and structures that are in place may not fit with the community, and may not be robust enough to engage with and capture the views of disempowered groups, who are the people less likely to access health services

5. Community Engagement



Where on the continuum are we operating?

Does the structure and/or process match the engagement goals? If not high risk of disengagement

Structures for engagement not "safe" for less empowered groups

4.6 Plans lacking Specificity and Detail

Another factor contributing to the poor or limited implementation of plans - whether at a national, state or regional level is the lack of specificity of these plans. Maybe they shouldn't even be called plans because in reality what they are doing is setting directions – so maybe they should be called Directions Statements.

This diagram helps me understand why we can't get the level of specificity that we need at a regional level, and it shows the inter-relationships between the key factors required for implementation of regional plans.

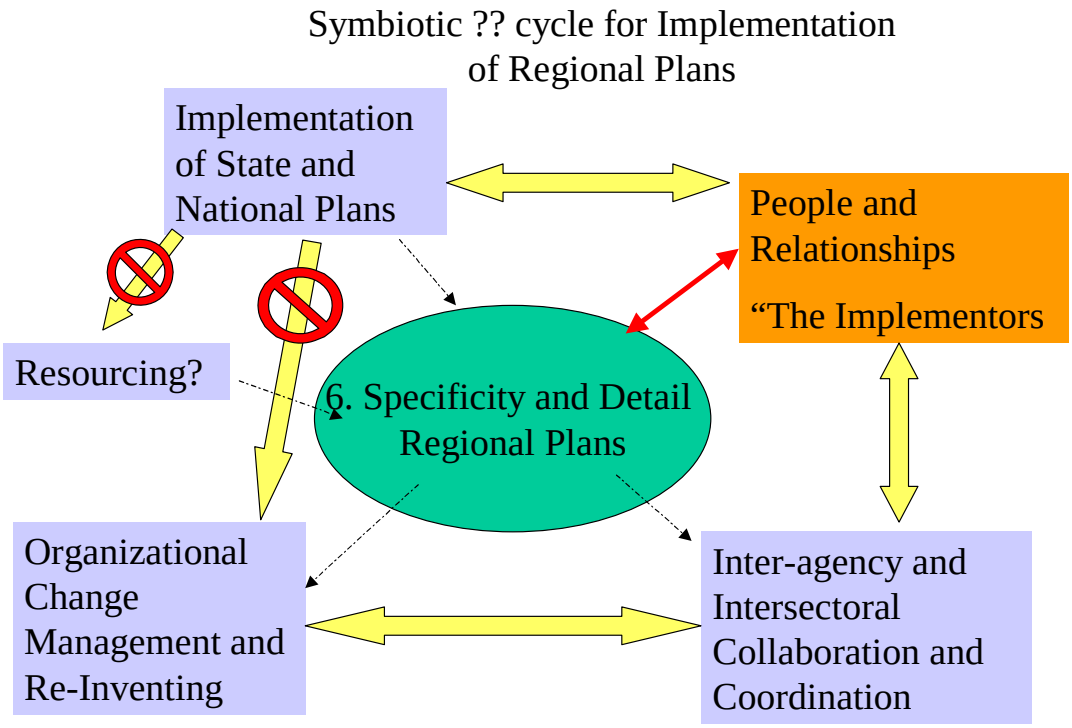
Explain Diagram

State and National Plans - If being implemented can support specificity and detail, and know resources available

Support organizational change – flow on to collaboration, coordination across services

Impacts on the people/managers – what they can and can't do

People and relationships developed and bring specificity because decide on who they will and won't work with and to what extent



4.7 Reform – Driver, Momentum, Focus on the whole not parts

One of the three objectives of Regional Health Service Planning under the Partnership Framework is to reform the local health system to better meet the needs of Aboriginal and Torres Strait Islander people.

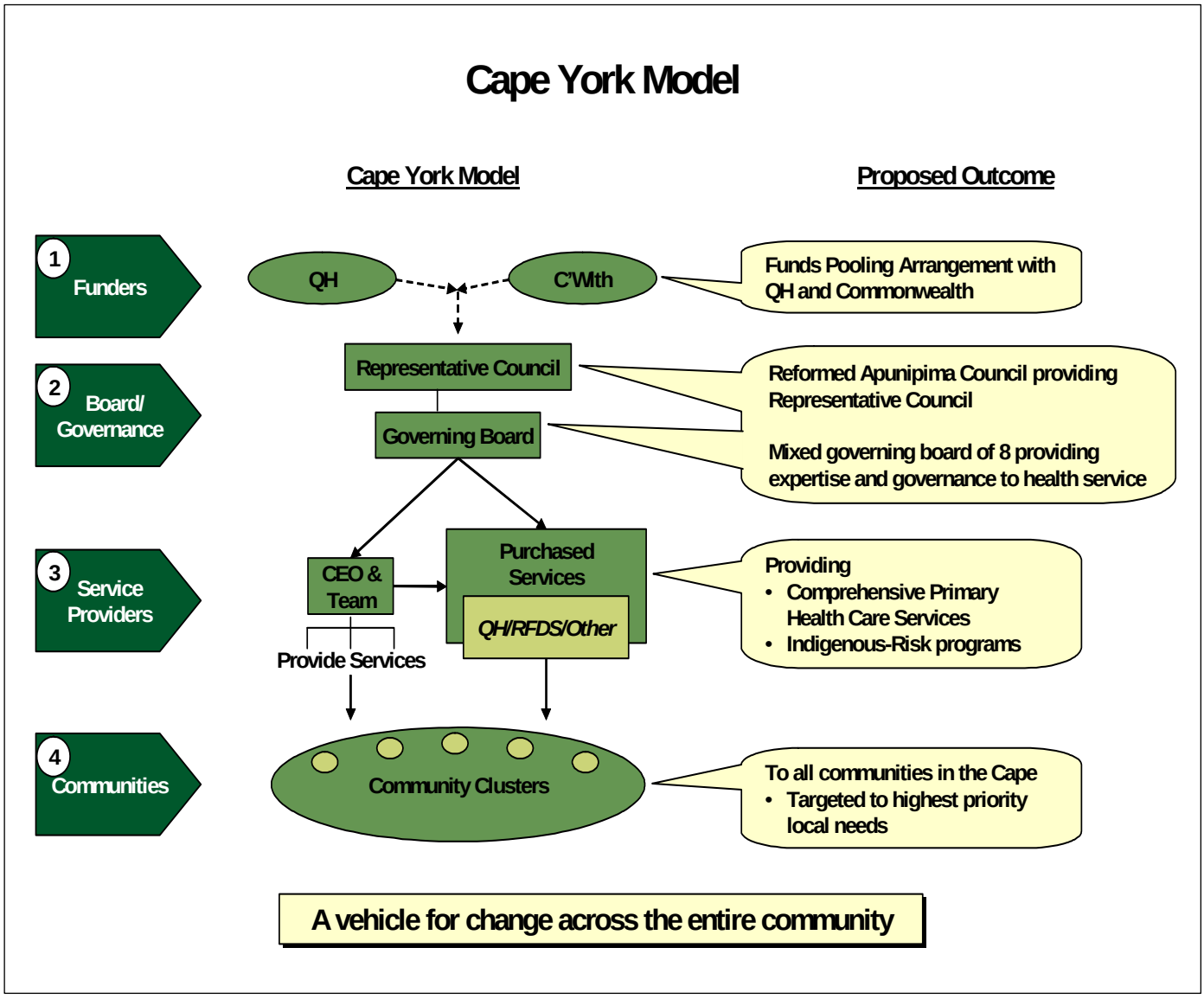
I'd like to present a specific case study to demonstrate the challenges of implementing REAL reform.

Cape York Health Reform Project

In the early part of this year, the Cape York Institute for Policy and Leadership lead a project team to design a health service model for Cape York encompassing funding, governance, service delivery models together with an implementation plan with the aim of enabling the Indigenous Cape York people to reach equivalent health outcomes as non-indigenous Australians.

The key components of the Cape York Model include:

- Funds pooling of state and commonwealth money
- Moving to community control as a staged process
- Increasing the range of primary health care services and how they are delivered in the Cape
- Transition of employment of current Queensland Health positions to the Cape York Health Board.



Are we going to see implementation of this model? It's high risk with respect to implementation because it requires:

- Substantial additional funding – in recognition of the significantly higher costs to deliver services in remote areas
- Funds pooling so ongoing political commitment from both levels of government to continue to work in partnership – both organizational commitment, as well as personal, and this is further challenged when there is turnover of the bureaucrats in these positions
- Requires significant change to how resident and visiting services are delivered – ***reinventing service provision***

- Requires transition of employment of nursing and health worker positions from QH to the Cape York Health Board – ***organizational change and change management***
- Requires significant resources put to community capacity building to support community governance and control – ***building local capacity***
- Requires partnerships between the mainstream secondary health services and CYHB to enable care across the continuum – ***coordination and collaboration across the health system***

There is the risk that the State and Commonwealth will get scared by the magnitude of the reform, and the resources required, and may only support "bits" of the model, and then we won't have reform at all, but rather just a few more disjointed services.

Low Level Reform – still a challenge eg Mental health services in Roma

5. Implementation Success Factors

Finally, I would like to present a case study that demonstrates the successful implementation of a plan, and identify the key factors to success.

This plan addresses allied health services, one of the key gaps in health services across rural and remote Qld.

North West Queensland Primary Health Care was funded to develop a regional health plan and model of allied health service delivery under the Commonwealth Regional Health Strategy. It was then funded to implement the new primary health care model. Today I want to identify the key factors that have contributed to the successful implementation of this plan.

Key factors contributing to success:

Greenfield site

- New model of service delivery developed in response to community priorities with evidenced based strategies for recruitment and retention of staff
- Relatively new and small agency as service provider able to select staff with attributes for working in a primary health care paradigm in a cross cultural environment – with respect to both Indigenous culture and remote culture
- Establishing a new service from scratch doesn't require "re-inventing" or change managing an organizational culture that might not be delivering the optimal service, and allows recruitment of personnel that fit with the culture of the service you are trying to establish
- Opportunity to offer flexible employment packages to support recruitment and retention rather than having to confirm to fixed award structures, as well as recognizing the professional needs in terms of ongoing professional development and mentoring as well as personal factors

Detailed and specific plan because it was a funding submission, but in hindsight the implementation strategy still needed to be more robust than it was

Adequately funded

Enabled NWQPHC to meet its objectives of providing a regular and reliable outreach service and retain personnel

Model focused on the whole, and the Commonwealth funded the whole

Clear accountability for implementation – buck stops with NWQPHC

Development of relationships within the service region, at a management level, service provider level and community level, although acknowledge that more work needs to be done

Engagement with other portfolios particularly education, local government and aged care in the planning phase continuing in the operational phase and extending to child care, private industry

Seeking to engage with the communities both informally and formally, and using this as part of its monitoring and evaluation process

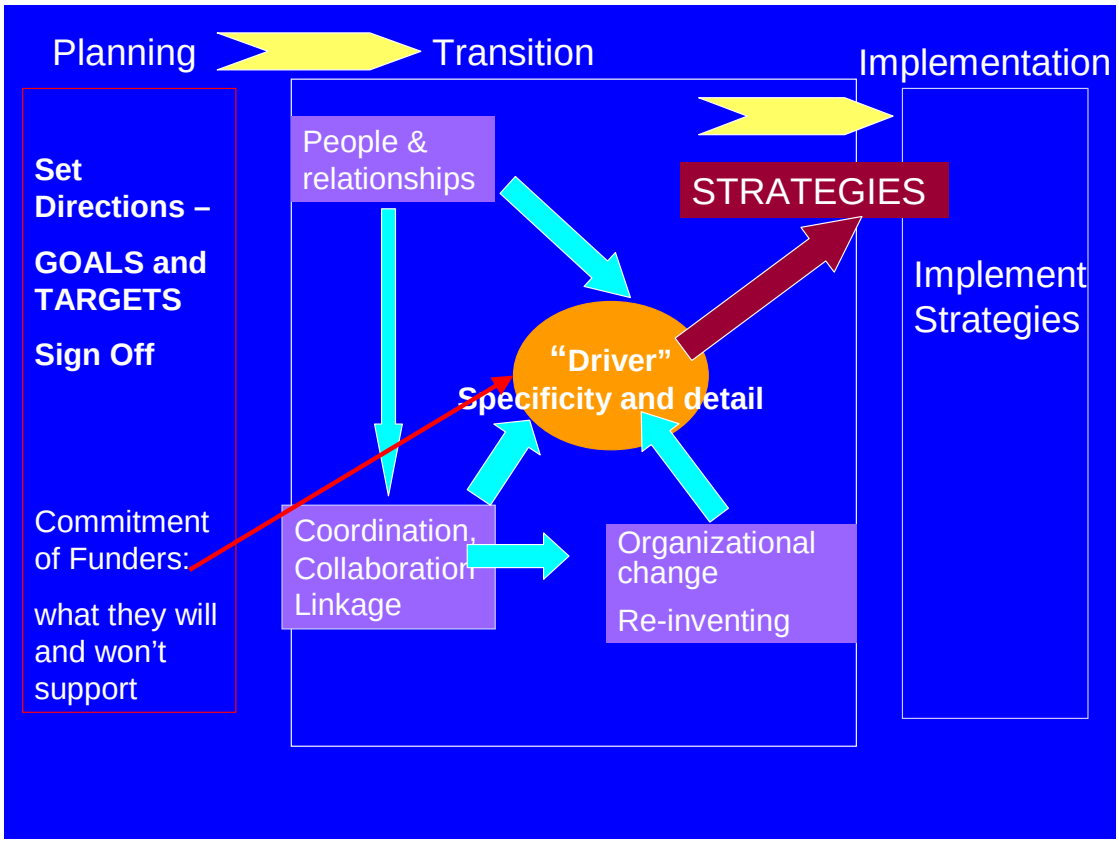
BUT IT WAS and CONTINUES TO BE HARD WORK – because implementation doesn't stop.

6. Conclusion

What do we need to do differently?

Remind ourselves and the funders that planning doesn't stop when they get a document. The Plan is not the endpoint it is just the beginning.

Reduce the turnover of the State and Commonwealth bureaucrats, because often we have the case of a new person in the seat and time is lost while they are "getting across it", and also they don't have the history and context that is implicit in the planning process



But fundamentally, we need to change the way we think and do planning. As I said earlier there is a real gulf between planning and implementation. I think we need to give that gulf a name and call it the transition stage. I propose that there is a need to change the way we try to plan and implement – particularly at the local and regional level.

Under this approach, plans are developed that **set direction** with clear goals and targets. Some of these goals will require resourcing, others won't. For those that need resourcing we need to find out at this stage what the funders will support and to what extent. However, a lot can be achieved by collaboration and value adding across services. This is where we need to put much of our effort "on the ground" to enable the building or strengthening of the interorganizational relationships by focusing on the people, to support coordination and collaboration, change in the way business is done, and give specificity to the strategies. This enables the development of very clear strategies to move forward, providing the platform for implementation.

How does this differ to what currently happens?
Currently, we put a lot of effort into the goal setting and targets, we do a bit of the work that fits into the transition stage and then we hand it over as a plan to the funders. We wait for them to tell us what they will and won't support and to what extent. But this can take up to 12 months. In that time organizations keep going about their normal business – probably still in silos, and then when they get a response the whole process has to be fired up again. Given the turnover of people in organizations, and the myriad of other things that happen at a local level, there is the risk that we are nearly starting over, further delaying that elusive thing called implementation.