Journal of Public Health and Development
Vol.18 No.1 January-April 2020

REVIEW ARTICLE

Health development and health reform: Where to from here?

DS Briggs

University of New England, Armidale, New South Wales, Australia

Corresponding Author: *David Briggs* ***Email:*** *dsbriggs007@gmail.com*

Received: 19 March 2020
Revised: 24 March 2020
Accepted: 29 March 2020
Available online: April 2020

ABSTRACT

Health Development has been a part of the health system lexicon for a considerable period and had currency particularly in the aid context to those countries attempting to improve the health status of their populations. The language had changed to 'health reform' in the first decade where in the period to 2010 the focus of government was often on constraining activity as a means of controlling costs with an emphasis on managing waiting lists and times, rather than developing the health outcomes of populations. The emphasis of health reform was on consolidation of organisations into larger and distant geographic concentrations.

Reform has been less about the detailed design of specific interventions than about the management of institution building in a context of complexity and rapid change. Existing definitions minimises the role of the human capacity to cope autonomously with life's ever changing physical, emotional, and social challenges and to function with fulfilment and a feeling of wellbeing with a chronic disease or disability. This movement in health development towards societal contexts is increased when we use the language of holistic care philosophy which acknowledges the close relationship between body, mind and soul (spirit) with a focus on individualism, emphasizing that every dimension of a human is distinctive and unique as well as being connected to each other.

An institutional based contemporary health system should consider health development and health reform within a framework that encompasses a wider societal context that is based on trusting relationships within a wider community and organisational settings that place valuing health above healthcare and that have a wholistic, patient centred focus.

Keywords: health development, health reform, health policy, societal contexts

INTRODUCTION

Health Development has been a part of the health system lexicon for a considerable period and had currency particularly in the aid context to those countries attempting to improve the health status of their populations. However, any review of the literature, at least in the last decade sees little use of the term globally. The language had changed to 'health reform' in the first decade where in the period to 2010 the focus of government was often on constraining activity as a means of controlling costs with an emphasis on managing waiting lists and times, rather than developing the health outcomes of populations. The emphasis of health reform was on consolidation of organisations into larger and distant geographic concent-rations the consequences of which proved to be ineffective, at least in the Australian context.[1,2]

The intensity of the use of the term 'health reform' also seems to be in decline with the main language in the literature, being focussed on safety and improved quality of care. This emphasis has seemed to reach a stable state suggesting that health development or reform has again moved its focus.

This brings us to the oft quoted statement that reform is set in 'a paradoxical pattern of policy development' that is describe as 'reform without change and change without reform'.[3] This author suggests that in highly centralised governance, health reform is difficult and that in more decentralised political structures 'rapid or decisive structural policy change has proved far more elusive. This in particular describes the Australian experience where a federation of state and territories makes progress in health reform difficult, requiring government agencies where state and territories first health ministers meet and engage with their Commonwealth or national counterpart, the Minister for Health to negotiate funding and service delivery with continued divided responsibilities in both cases.[4] In contrast the Thai health system with a central national government has promoted decentralised local district health systems quite successfully.[5]

In the China experience, as an example, it is suggested that reform has been less 'about the detailed design of specific interventions than about the management of institution building in a context of complexity and rapid change'.[6] The authors suggest that 'an effective health sector relies on trust-based relationships between users, providers and funders of health services' and that the institutions are where those relationships might be embedded.[6]

At the same time, Huber and colleagues[7] suggest that the original WHO[8] definition of health development as developed in 1948, was based on a 'state of complete physical, mental and social wellbeing…' is no longer appropriate and in fact is counterproductive.

Huber and colleagues go on to suggest that the existing definition 'minimises the role of the human capacity to cope autonomously with life's ever changing physical, emotional, and social challenges and to function with fulfilment and a feeling of wellbeing with a chronic disease or disability'.[7] They go on to suggest that the diseases of the modern world are impacted by ageing and chronic disease. Even in developing countries where they may still address communicable diseases, they are also having to respond to ageing and chronic disease and that in all cases a complete absence of disease is unrealistic and unattainable. The current emphasis on Coronavirus (COVID-19) reinforces the fact that a complete absence of disease and not having to deal with communicable diseases are both unrealistic and unattainable.

This article describes the contemporary meaning of health development or health reform in terms of contemporary institutional arrangements in the context of health, health care and health system provision.

The societal context of health and healthcare

Huber and colleagues[7] suggest that initiatives like the Ottawa Charter [9] has attributes that emphasises social and personal resources as well as physical capacity. They suggest that 'health gain in survival years may be less relevant than societal participation, and an increase in coping capacity may be more relevant and realistic than complete recovery'. Since these observations, the concept of what may be health development has moved on. We have pursued the achievement of the UN Millennium Development Goals (MDGs) and more recently have turned our attention to the Sustainable Development Goals (SDGs). We talk of health reform accepting that it is a constant within our meaning of health development and our world view or global perspective is about health being delivered within complex adaptive health systems.

This movement in health development towards societal contexts is increased when we use the language of holistic care philosophy which acknowledges the 'close relationship between body, mind and soul(spirit) with a focus on individualism, emphasizing that every dimension of a human is distinctive and unique as well as being connected to each other'.[10] It is suggested that medicine has become distracted from its duty to care, comfort and console and is focussing on its duty to ameliorate, attenuate and cure. This 'de-coupling' of 'medicines humanistic character from its scientific knowledge is exerting negative effects on the patients experience of illness and the capacity of clinicians to attend well to it'.[11]

In recognition of these societal constructs we talk in terms of patient centred care and in the wider primary healthcare we adopt the vision of an organisation as 'healthy people and communities'.[12] This suggests that we need to value health above healthcare.[13,14] Health professionals and their organisations need to engage with people and communities in planning and decision-making about their health and how they might access the care required. This will require innovative across sector approaches [15] and this will require an understanding of the principles of localism, subsidiarity and the concept of distributed networks of practice (DNOP) as a means to engage and provide care.[16] Localism is 'a form of governance that proposes a shift of power from the centre to local communities to provide devolved models of care'.[16]

The principles of subsidiarity states that 'government should only fulfil a subsidiary function for those tasks that cannot adequately be dealt with by lower tiers.[17] This suggest actions around lifting the burden of bureaucracy; empowering communities to do things their way; increasing local control of public finance; diversifying the supply of public services; opening the government to public scrutiny and; strengthening accountability to local people.[18]

Innovation and networks of practice

To give meaning and effect to the broader societal view of health development and health reform we need to emphasis innovative approaches to service delivery and care outcomes because traditional approaches have failed to 'close the gap' or improve existing poor health outcomes. It is also clear that this approach requires us to cross organisational boundaries to work with others which increasingly means we will be working within distributed networks of practice (DNoPs). Learning will increasingly be

derived from practice and through communities of practice (CoPs). the potential for diffusion of innovation[15] through networks needs to be a major consideration for managers.[19] Managers need to understand how to 'indirectly' manage networks [20] and to understand that innovation increasingly needs to occur at the interstices of collaborating groups and organisations.[21]

Innovation is both a process and an outcome and social innovation can be described as 'a new combination or configuration of practice' and as a means to an end described as process orientated social innovation.[15]

Frameworks and Declarations

Frameworks and Declarations also have currency in the movement of the language which we use to describe the societal consideration of healthcare with the SHAPE Declaration[22] asserting that public policy should focus on improving health outcomes and not be prescriptive but provide frameworks of responsibility and cooperation at the program delivery level. Reform should focus on the needs of communities and populations and structural arrangements should be determined in the light of that focus. If government and public policy focus on principles and guidance, then providers should be structured to meet the diversity of need and demonstrate good governance and management through proper engagement of structural interests. Effective models of community engagement need to be incorporated into public policy and the governance of health services. Health managers should be appropriately qualified, skilled and adept in managing complex health service organisations.[22]

In 2009, in Phitsanulok, Thailand at the 1st International Conference on Health Service Delivery Management, with 450 delegates concluded the conference with a Declaration, that comes after thirty years of the Alma Alta Declaration with a focus on the importance of capacity building, leadership and health management. This declaration states that:

1. Priority in resourcing and policy implementation should be given to developing leadership. management and governance as the means to strengthen health systems development
2. Successful management of health services requires leadership and teamwork from managers who have positive personal and professional values and self-perceptions and are empowered to engage with individuals and communities and to respond to the needs of the poor and to marginalised groups
3. Leadership for health systems, public health and PHC requires that managers have access to high quality education, training and experiential health context and knowledge that equips them to operate effectively in health systems
4. A research culture is required that networks and engages in collaborative research to develop health management capacity and evidence as a basis for decisions, to guide policy development and that both challenges and aligns researchers and operational health system professionals, citizens and communities
5. Outcomes identified from this conference for leadership and health management education training and research be conveyed to health organisations, professional bodies, local government, Ministry(s) of Health and Education and research funding bodies.[23]

DISCUSSION

For health professionals and health managers these contemporary elements of health development and health reform go beyond traditional skills of planning, organising, leadership and control to concepts that include sensemaking – making sense of complex contexts for others, demonstrating empathy through

engagement, being a boundary spanner, collaborating across boundaries in networks of practice, consistently strategizing as normal practice and by leading by example.[24]

An institutional based contemporary health system should consider health development and health reform within a framework that encompasses a wider societal context that is based on trusting relationships within a wider community and organisational settings that place valuing health above healthcare and that have a wholistic, patient centred focus.

CONCLUSION

How can we implement these approaches in our practice, our professions and our organisations? First, we need to ask the question-is public policy supportive? If not, can you work away quietly at the local level with colleagues and other organisations to influence innovation. Secondly, Is your organisation fit for purpose? Does the culture of your organisation adequately align? Are your staff predisposed? In addition, is your management of staff holistic, humane and integrated? Are you and your organisation 'fit for purpose' and speaking the language of reform-transformational not hierarchical, evidenced based and innovative, collaborative, multidisciplinary, providing stepped care or appropriate care? Are we as researchers and academics educating and training health professionals that advances health professionals to engage in this future?

Finally, and as Professor Wasi[25] challenged us that to implement knowledge-based health development successfully we need to do so in the context of the creation of relevant knowledge, the force of social movement and with political involvement.

REFERENCES

1. Davies G. Public hospital commission of Inquiry report. Queensland Health: Brisbane. 2005.
2. Forster P. Queensland health system review. Independent Review Brisbane.2005.
3. Hacker JS. Review Article: Dismantling the Health Care State? Political Institutions, Public Policies and the Comparative Politics of Health Reform. British Journal of Political Science. 2004; 34:693–724, doi:10.1017/S0007123404000250.
4. Briggs DS. Challenges for health systems: Australian perspectives. PAAP. 2007; 20.1:06-17.
5. Tejativaddhana, P. Briggs, DS. Singhadej, O and Hinoguin, R. Developing primary health care in Thailand innovation in the use of socio-economic determinants, sustainable development goals and the district health strategy. Public Administration and Policy. 2008; 21(1):36-49, doi: 10.1108/PAP-06-2018-005.
6. Bloom G. Building institutions for an effective health system: Lessons from China's experience with rural health reform. Social Science & Medicine. 2011; 72(8): 1302-1309, doi:10.1016/j.socscimed.2011.02.017.
7. Huber M, Knottnerus JA, Green L, van der Horst H, Jadad AR. How should we define health?. BMJ. 2011;343: d4163,doi:10.1136/bmj.
8. World Health Organization. Constitution of the World Health Organization, 2006. [Cited 2020 March 1]. http://www.who.int/governance/eb/who_constitution_en.pdf.
9. Ottawa Charter for Health Promotion, 1986. [Cited 2020 March 1]. http://www.who.int/hpr/NPH/docs/ottawa_charter_hp.pdf.1986

10. Demirsoy N. Holistic care philosophy for patient-centered approaches and spirituality, patient centered medicine. IntechOpen, 2014, doi: 10.5772/66165.
11. Miles A. The European society for person centered healthcare. The European Journal for Person Centered Healthcare. 2013;1(1):4-40.
12. Briggs DS, Nankervis, R. Australian Primary Health Networks: Innovation in Improving Patient Care. National Conference on District Health Systems Management Development towards SDGs Achievement. Phitsanulok Thailand, 2018.
13. Robert Wood Johnston Foundation. Building a culture of health. Accessed 2019 at https://www.rwjf.org/en/how-we-work/building-a-culture-of-health.html.
14. Briggs DS. Building a Culture of Health. Asia Pacific Journal of Health Management. 2017; 12:1,doi:10.24083/apjhm.v12i1.85
15. Briggs, DS. Nankervis, R. Baillie, J. Turner, C. et al. Innovation to improve patient care in Australian Primary Health Network: an insider's perspective. Public Administration and Policy. 2019; 22(2):111-124, doi: 10.1108/PAP-09-2019-0017.
16. Briggs DS. Localism: A way forward? Asia Pacific Journal of Health Management. 2014; 9:1.
17. Hartwich O. A global perspective on localism. Occasional Paper. Wellington: The New Zealand Initiative and Local Government New Zealand; 2013. [Cited 2020 March 1]. http://nzinitiative.org.nz/site/nzinitiative/files/publications/Global%20Perspective%20on% 20Localism.pdf.
18. Institute of Local Government Studies. The world will be your oyster? Reflections on the Localism Act of 2011. Raine J, Staite C. Edgbaston: School of Government and Society, University of Birmingham; 2012.
19. Greenhalgh T, Robert G, McFarlane F, Bate P, Kyriakidou O. Diffusion of innovation in service organisations: systematic review and recommendations. Milbank Q. 2004; 82(4):581-629, doi:10.1111/j.0887-378X.2004.00325.x.
20. Lewis JM. The future of network governance research: strength in diversity and synthesis. Public Administration. 2011;89(4):1221-1234, doi: 10.1111/j.1467-9299.2010.01876.x.
21. Van den Hooff B, van Weenen F, Soekijad FM, Huysman M. The value of online networks of practice: the role of embeddedness and media use. Journal of Information Technology. 2010;25(2):205-215, doi:10.1057/jit.2010.11.
22. Briggs DS. Shape Declaration on the Organisation and Management of Health Services: a call for informed public debate. Asia Pacific Journal of Health Management. 2008; 3:2.
23. Briggs DS, Tetjativaddhana P, Cruickshank M, Fraser J, Campbell. The Thai-Australian health alliance: Developing health management capacity and sustainability for primary health care services. Education for Health. 2011; 23(3): 1-9.
24. Briggs, DS. Smyth, A. Anderson JA. In search of capable health managers: what is distinctive about health management and why does it matter?. Asia Pacific Journal of Health Management. 2012:7:2.
25. Wasi, P. Triangle that moves the mountain and health systems reform movement in Thailand. Human Resources for Health Development Journal. 2000; 4(2):106-110,