The Discursive Dynamics of Changing Health Policy
- An insider perspective

Siobhan Harpur – CEO Public Health and Associate Professor of Health, UTAS
The Tasmania Health Plan
2005 – 2010

- Getting primary health on to the agenda
- Managing complexity
“For fundamental change to occur, we have somehow become convinced that we need to tackle everything at once – we don’t”

Malcolm Gladwell, in the Tipping Point
Dr Thomas McKeown

Faced with the challenges of chronic disease - each had a seminal way forward ...

A social model of health?
Or:
the RCT to determine best investment?

Dr Archie Cochrane
Fundamental change is critical

Why?

- Health policy is conflated with healthcare
- We had a “burning platform” in the 1970s, and now....
- Healthcare costs are rising exponentially with and 85% of disease burden is chronic
- “Wicked” issues are creating a tyranny of complexity and worsening outcomes for people and communities

Current projections demand new approaches to governance and leadership
Getting onto the agenda

• “service locations are historical…. [Outside of] nationally accepted benchmarks… risk of serious quality and safety adverse incidents …. Critical workforce shortages”  *In-coming Minister Briefing April 2006*

• “…the Tasmanian primary health care system [is] historically based, and overly complex, funding arrangements which consolidate the bulk of resources into clinical/hospital settings”  *Local Service Advisory Committee, Campbelltown May 2006*

• “Primary health is a critical part of the health care system and getting it right is essential if we are to improve individual health and relieve pressure on acute care services”  *Health Minister press release Sept 2006*
Multiple actors and institutions and their discourses
Multiple actors and institutions and their discourses..an example

<table>
<thead>
<tr>
<th>Institution/actor group</th>
<th>Relevance and level of engagement</th>
<th>Challenges to legitimacy and implementation</th>
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<td>Primary Health Services</td>
<td>Involved with ideas development and fit with new structure, strengthen primary and community health policy and broaden health policy to a more social model</td>
<td>Making structure changes, recruiting, not bedded down. Implementing multiple new changes and managing communications. The complexity and resourcing requirements, and the time frames for practice change are not realistic.</td>
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Managing complexity

- Deliberate change activity included:
  - Layering conversations
  - Using the respective language of groups or professions
  - Describing new service delivery features
  - Celebrating progress
  - Inviting possibilities of different futures
  - Sharing examples of primary health in practice from other places – organizing visits to and from Tasmania

The key actors were actively engaged in the process of reflection and adaptation
Why a fundamental policy change requires adaptive thinking

- Competing rationalities
- Multiple perspectives, discourses and interests
- There is an atheoretical and episodic nature to contemporary public service
- Public knowledge is disjointed with gap between rhetoric and reality
- Complex and contestable soup – problems and solutions
- “contemporary disillusionment” - health policy reform is institutional and structural change
Discursive Institutionalism lens

• (Schmidt) There is no objective explanation for the dynamics of change and the circumstances for which it is able to occur.

• The agents themselves may be largely responsible for framing the narrative and legitimising the discourse.

• This is consistent with the alignment of Kingdon’s streams, and the window of opportunity.
Analysis

• The discourse for health policy change is most active within and between policy elites, and key actor groups within governments
• Getting traction for change requires continuous processes of engagement across multiple interests inside and between health organisations and health decision makers within governments
• Changes occur through the framing and re-framing of narrative through discussion and written documents
• “diremption” (Habermas) is applied to the genesis or creation of intuitions reflecting reality occurring at more than one moment – fluid – more “cinema” than snapshot
• Discursive debate assists in making sense of competing frames and values, including different casual factors and alternate solutions
Implications for health policy?

– **Policies should be large scale visions** with built in learning for continual evaluation and adaptation from multiple safe to fail experiments

– **Relationships are a key feature** and decision-making, needs time and resource allocation.

– **Public service leadership** in partnership with research is critical, because fundamental change is incremental

“I pin my hopes on small circles in which vital and transforming events can take place” Rufus Jones