AUSTRALIAN PRIMARY HEALTH CARE
RESEARCH INSTITUTE

GREATER GREEN TRIANGLE UNIVERSITY DEPARTMENT OF RURAL HEALTH,
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MANAGING CHANGE IN PRIMARY CARE: THE CONTRIBUTION OF A CLINICAL LEADERSHIP PROGRAM

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POLICY CONTEXT

A third of health expenditure is wasted. Patients with chronic diseases receive half the care they should. As health expenditure continues to take a higher proportion of GDP, the challenge is to get better performance out of the system.

Health care expenditure is committed by the GPs through prescriptions, referral letters, and requests for investigation. The only way to improve that output is to engage GPs themselves in the pursuit of better clinical outcomes which generally reduces costs.

A comprehensive review of health policy by the Rudd government has resulted in two reports relevant to the introduction of clinical leadership for primary care. These reports are the National Health and Hospital Reform Commission which called for clinical leadership training, and the National Primary Care Strategy.

New primary care policy may mean changes for divisions of general practice as they transform into primary care organisations and it is likely that many who have been leaders in the divisional network will continue to lead for some years to come.

THE IMPORTANCE OF CLINICAL LEADERSHIP

High-performing healthcare organisations and systems consistently demonstrate high levels of effective clinical leadership. Efforts to change clinical practice by influencing individuals have proved ineffective unless the organisation in which they work is ready to change. It is clear that performance in healthcare organisations is inextricably linked to leadership. which will optimise the delivery of chronic disease management across organisational boundaries. There is evidence that clinical leaders can improve teamwork, communication, integration and coordination, especially through the building of clinical networks.

What convinces senior health managers about the value of clinical leadership courses is that without active engagement of clinicians and clinical leadership, improved services for patients will not come about. Conversely, managers have seen large, expensive quality improvement programs flounder because they were not led by clinicians.

KEY FINDINGS

For the Government's reform agenda to succeed, it requires clinical leaders who understand and can interpret the new policies for their peers. Also, clinical leaders need to understand how to bring about change. It follows that the large body of knowledge on how to be an effective clinical leader needs to be at their disposal along with peer support and mentoring. Training and support alone will not be enough.

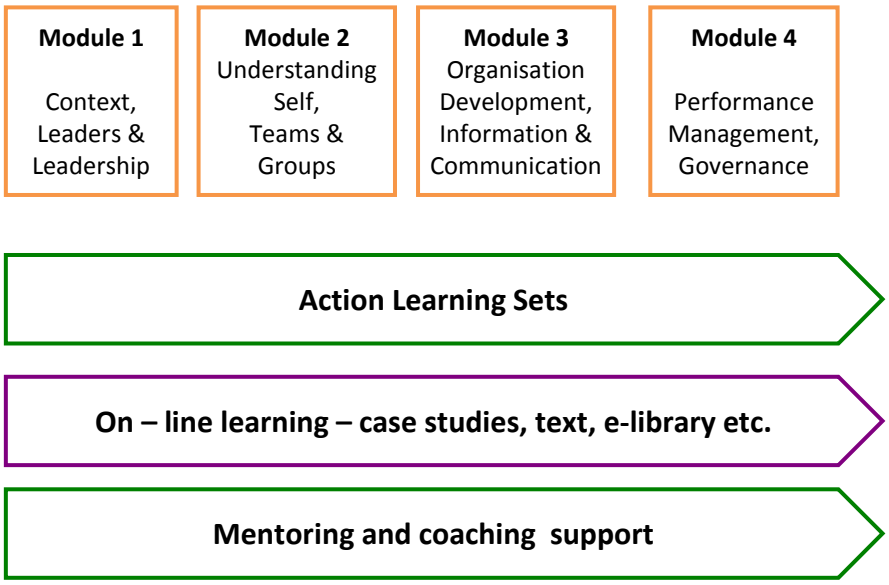
POLICY OPTIONS

The widely held view is that there is no systematic support for change and the approach is *ad hoc* and fragmented.

General practitioners appear to recognise the importance of organisations and teams in improving clinical outcomes. They have also recognised what good leadership can do when properly funded and supported. e.g. Australian Primary Care Collaboratives. The ground is well prepared for a clinical leadership program.

The features of a successful program

- There is a strong desire to use real problems and case histories for much of the learning with the theory taught subsequently to provide framework explanation.
- A stepwise course progressing from a Grad Cert to a Masters program is thought to be the best option. An important outcome is that peer support lasts beyond the course.
- Interviewees favour the blended approach of both face-to-face training and the use of distance learning. A combination of two days face-to-face four times a year with web based and tele/video conference activities between them comprises the blend.



The core program will be designed to run over a 12 month period, with four residential modules of 2/3 days at quarterly intervals, interspersed with at least 2 action learning set discussions between each residential module. Learning sets will be established at the first residential module, linking people on an issue rather than geographic basis and offering the opportunity to opt for either e-enabled or video conference based learning set sessions.

The program will be made up of 8 learning modules, the core of which will be delivered through the residential elements with the expectation that participants will then supplement the core input with reading, reflection and application supported by a resource of on-line materials that combines articles, research text, case studies, abstracts etc.

This individual learning will be tailored around the practice challenges each individual is working with, and will be supported through the action learning sets and on-line/telephone coaching.

RECOMMENDATIONS

Based on the results of our review of existing programs, interviews and inquiry into international practice, we would recommend:

1. The establishment of a national primary care clinical leadership development program tied to the achievement of service change and improvement. It is expected that there would be 60 to 80 participants per year for five years.
2. Clinical leadership be clearly identified as a fully resourced initiative within the primary care strategy for there to be any belief that there will be effective implementation of the strategy.
3. That APHCRI which enjoys wide support from the professional stakeholder group put this course together.
4. That clinical leadership should be open for the whole sector not simply for superclinics or comprehensive primary care centres.
5. Participants should neither pay for nor be paid for completion of the program. The Department of Health and Ageing is expected to cover the cost of university fees, travel, locums, and accommodation.

METHODS

Synthesis of a systematic review of the literature using narrative meta analysis with key informant interviews in Australia, UK and USA.

For more details, please go to the full report

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