Local Solutions for Local Problems - is it really that simple?

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Devolution?

- The decentralization of public policy decision-making and budgetary responsibility to the 'local' level
- Started in late 1990s, usually enabling different models (e.g. NHS in the UK) making it hard to generalise about this approach
- Can involve various spheres of government responsibility, but healthcare of special interest perhaps due to burgeoning health budgets in affluent countries with ageing populations.
- Ensuring public (population-focused) health is maintained has been of particular concern..

The Australian context

- Public health has been the responsibility of central government, whereas hospital-based services are relegated to the state, regional or district level; primary health care is funded on a fee-for-service basis via a national health insurance system (Medicare)

  Have had triennial Australian National AIDS, Aboriginal BBV & STIs, Hepatitis and Drug Strategies since late1980s
- State-Commonwealth matched funding approach, which requires each state to match the national investment.
- Funding comes with the obligation to monitor and achieve nationally set KPIs for each Strategy.
- Now moving to longer term strategies e.g. current National Drugs Strategy: 2017 – 2026)…

Important questions…

- What are the states' resource allocation based on?
  - The size of the state's population - is the population's demographic profile factored in e.g. age and indigenous status; are economies of scale factored in?
  - The needs of the state's population – its current and future disease profile?
  - The state's current health activity (outputs) or health outcomes-based? Which outcomes are measured and how: e.g. are surgical waiting list times as important as the incidence of HIV among vulnerable populations? And how does non-achievement of outcomes affect future funding?
  - Or is it just historically-based?
- How is the appropriate balance is between disease prevention, health promotion and acute (short term) and chronic (longer term) treatment and care decided?

Advantages (disadvantages) of ‘localism’

- More responsive to ‘local’ issues: local stakeholders with the greatest understanding of local conditions able to proceed to apply locally appropriate solutions to local problems, unhindered by those less acquainted with their situation (risk of parochialism?)
- Less top down; encourages grass roots initiatives; greater local autonomy (risk of going ‘rogue’?)

Advantages (disadvantages) of ‘localism’ cont.

- More ‘democratic’; responsive to the ‘voice of the people’ (Does this favour populist views? Is the loudest voice at the local level always the majority voice? Is the majority voice always right?)
- What of the role of ‘professional ‘expert v’s those with ‘lived experience’ v’s local community stakeholders?
- Who has the final say?

Advantages (disadvantages) of 'localism'

- Can encourage 'healthy' competition ("constructive discomfort"!) especially if combined with purchaser/provider arrangements (e.g. England, NSW and VIC) (risk of reduced collaboration and partnership approaches at the local level?).
- May also engender greater collaboration and partnership approaches, and enhance inter-sectoral and horizontal service integration at the local level
- Need to identify exactly where the final responsibility lies for public health imperatives; performance and funding agreements need to be clear re accountabilities for expected outcomes, but also flexible to meet different and changing local needs

Advantages (disadvantages) of ‘localism’ cont.

- May encourage the development of scientific/technical expertise and leadership at the local level - but in countries with remote areas, the expertise at central level is not necessarily able to be relocated to the local level
- Risk of hollowing out of technical expertise at central level, and the re-emergence of the ‘career bureaucrat’ with limited personal commitment: health this week, sport and the arts the next …

Advantages (disadvantages) of 'localism' cont.

- Unless quarantined, public health funding may be exposed to local budgetary constraints, forcing it to compete with more immediate needs e.g. acute care services
- The 'Cinderella' health fields with stigmatised, often 'hidden' populations e.g. the homeless, sex workers, alcohol and drug dependent, those living with HIV, TB, hepatitis, mental health issues, prisoners, those with disabilities, are most at risk

Advantages (disadvantages) of 'localism' cont.

- Assumes all geographical areas, and disease and population advocates are born equal, whereas the richer, best resourced areas usually attract the greatest expertise and vice versa, perpetuating inequalities in health service funding and provision
- Poorer areas are more likely to have higher health needs, but may also be more reactionary/less politically progressive in approach to addressing such needs

To achieve the right balance…

- Nurture political leadership at national, state and local levels to support resource allocation according to need
- Develop methods to measure health outcomes and establish systems to monitor these
- Develop and communicate approaches that are knowledge, science and evidence informed
- Support structures that encourage effective advocacy for such approaches by the affected communities and other expert voices, at all levels
- Educate the broader community about the societal value of achieving the right balance between prevention, treatment and care, and short and longer term health needs

to ensure ‘health for all’!


Health for All