

Asia Pacific Journal of Health Management

Volume 4 Issue 1– 2009

The Journal of the Australian College of Health Service Executives



Health Reform

Innovation, improvement
and productivity

Health management research

Knowledge management

The health workforce and research

Health system responsiveness

... and more

THIS ISSUE PROUDLY SPONSORED BY:

Blake Dawson

CONTENTS

EDITORIAL	
Health Reform: deconstruct, reconstruct or transform	4
David Briggs	
In this Issue	7
Letters to the Editor	9
Editor's Response	11
SPECIAL FEATURE	12
Supporting productivity in the NHS in England	
Bernard Crump	
VIEWPOINT	23
Developing a Collaborative Approach to Health Management Research	
Gary Day and Liz Fulop	
REVIEW ARTICLE	27
Knowledge Management in Healthcare Settings	
Bruce Perrott and Rick Iedema	
RESEARCH ARTICLE	34
Exploring Administrative Staff Views on Planning for Hospital Relocation: the experience of the Mercy Hospital for Women	
Katrina O'Sullivan and Sandra Leggat	
RESEARCH ARTICLE	41
Challenge and Excitement – Part One: loving and hating rural medical practice	
Gil-Soo Han, Janice Chesters and Harry Ballis	
RESEARCH ARTICLE	47
Facility Turnover and Vacancy Rates of Registered Nurses: do they predict how nurses are recruited?	
Kent Rondeau and Terry Wagar	
RESEARCH ARTICLE	57
After Hours Palliative Care Provision in Rural and Urban Victoria, Australia	
Lisa Ciechowski, Heather Tan, Margaret O'Connor, Gail Miles, Britt Klein and Peter Schattner	
REVIEW ARTICLE	64
Health System Responsiveness in Preventive Healthcare in Indonesia: implications for policy and practice	
Ketut Aryastami, Nunik Kusumawardani and Selma Siahaan	
Q & As	71
Can you describe the major approaches adopted in your country/region or more local health services in relation to health systems reform in the past decade or so, and the lessons that you think can be drawn for countries/regions or more localised health services in the Asia Pacific?	
In this issue, our selected participants address the question above.	
IN PROFILE	77
Prawit Taytiwat	
BOOK REVIEW	80
Lean Hospitals: Improving Quality, Patient Safety and Employee Satisfaction	
Reviewed by Brenda Ainsworth and Sheryl Harrison	
LIBRARY BULLETIN	82
GUIDELINES FOR CONTRIBUTORS	87

Cover: Picture of the Royal Barge Suphannahong courtesy of the photographic section, Tourism Authority of Thailand. Built in 1911 and resembling a mythical swan, the craft measures 46 metres. The King and his Royal Family are housed in the golden pavilion. The barges once served a military function but are used today for State ceremonies and celebrations.

PUBLISHER

Australian College of Health Service Executives

EDITOR

David Briggs BHA(NSW), MHM(Hons), PhD(UNE), FCHSE, CHE, FHKCHSE

Co-ordinator Health Management and Gerontology Programs,
University of New England, New South Wales, Australia

EDITORIAL ADVISORY BOARD

Jeffrey Braithwaite BA, DipLR, MIR(Hons), MBA, PhD, FAIM, FCHSE, CHE
Professor, Director, Centre for Clinical Governance Research in Health,
Faculty of Medicine, University of New South Wales, Australia

David Briggs BHA(NSW), MHM(Hons), PhD(UNE), FCHSE, CHE, FHKCHSE

Co-ordinator Health Management and Gerontology Programs,
University of New England, New South Wales, Australia

Gwenda Freeman BA, Grad DipBusMgt, MBA, FCHSE, CHE
Service Manager, Australian Red Cross,
Queensland, Australia

Godfrey Isouard BSc MHA PhD AFCHSE CHE AFAIM
Associate Professor, Head, School of Biomedical and Health
Sciences, University of Western Sydney, New South Wales, Australia

Man Yung Cheng MBBS(HK), M Sc(Birm), FHKCCM(HK), FHKCHSE(HK),
FCHSE(Australia), FRACMA(Australia)

President, Hong Kong College of Health Service Executives,
Senior Advisor, SureCare Medical & Health Network, Board Member
and Chairman, Hong Kong University Family Institute

Judith Meppem PSM, RN, RM, BHA, COTM, FCN, MACORN, FINE,
MNSWMA(Hon), MNUMS(Hon), FCHSE(Hon)
Former New South Wales Chief Nursing Officer; Consultant, Nursing,
Midwifery and Health Care

Rod Perkins BDS, MHA, PhD, FCHSE, CHE
Senior Lecturer in Health Management, Health Systems Group
and Associate, Centre for Health Services Research & Policy, School
of Population Health, The University of Auckland, New Zealand

Mavis Smith BHA, MHA, FCHSE, CHE, FHKCHSE, FAICD
Chief Executive Officer, Mayfield Education, Victoria, Australia

Dianne Ball PhD, MBA, BHA, Grad Cert Change Mgt, RN, AICD,
FCHSE, CHE
Chief Executive Officer ACHSE

EDITORIAL OFFICE

Dianne Ball PhD, MBA, BHA, Grad Cert Change Mgt, RN, AICD,
FCHSE, CHE
Chief Executive Officer ACHSE

Carolyn Marsh BHA, AFCHSE, CHE
Executive Officer ACHSE
Production Manager

Rose Ellis PhD, BA(Hons)

Director, Workforce Education and Training
New South Wales Rural Doctors Network
Sub-Editor

Angela Magarry RN, BHA, MPS, FCHSE, CHE
Executive Director, Policy and Analysis,
Australian Vice Chancellors Committee, Canberra, Australia
Book Editor

Sue Brockway BA, ALIA
Health Planning and Management Librarian, ACHSE

EDITORIAL COMMITTEE

Jim Birch BHA, FCHSE, CHE
Lead Partner, Health and Human Services,
Ernst and Young

David Briggs BHA(NSW), MHM(Hons), PhD(UNE), FCHSE, CHE,
FHKCHSE
Co-ordinator Health Management and Gerontology Programs,
University of New England, New South Wales, Australia

Robert Cusack BHSM, FNIA, AFCHSE, CHE
Executive Director, St Vincent's Private and Mater Hospitals,
New South Wales, Australia

Janice Lewis BSc, MBus, DBA, FCHSE, CHE
Program Coordinator, Health Policy and Management, School
of Public Health, Curtin University, Western Australia, Australia

Nicola North PhD, MA, FCNA
Director of Post Graduate Studies, School of Nursing, Faculty of Medical
and Health Sciences, The University of Auckland, New Zealand

Terry O'Bryan MAdmin, BBus(Actg), FCHSE, CHE, FCPA
Chief Executive Officer, ISIS Primary Care, Victoria, Australia

John Rasa BA, MHP, FCHSE, CHE, FAIM, MAICD, FAHRI
Associate Professor, Director, Australian Centre for Leadership
Development, Victoria, Australia

Stephanie Short DipPhy, BA(Hons), MSc, PhD, FCHSE, CHE
Adjunct Professor, Law and Justice Research Centre, Faculty of Law,
Queensland University of Technology, Australia

Sally Torr RN, CM, BA, MHP, PhD, FCHSE CHE
Patient Care and Services Manager, Greater Western Area Health
Service, Bourke, New South Wales, Australia

Peter Yuen PhD, BA, MBA, FCHSE(Hon), CHE
Professor, Department of Management and Marketing, the Hong
Kong Polytechnic University, Kowloon, Hong Kong

Australian College of Health Service Executives

PO Box 341 North Ryde NSW 1670 Australia
Telephone: +61 2 9878 5088; Facsimile: +61 2 9878 2272;
Email: journal@achse.org.au.
ISSN: 1833-3818 (Print)

SUBMISSION OF ARTICLES

Contributions, including letters to the Editor, should be submitted to the Editor, ACHSE APJHM journal@achse.org.au and should comply with the Guidelines for Contributors. These guidelines appear at the end of the Journal and are available in electronic form from www.achse.org.au or a hard copy can be obtained from the National Office by phoning +61 2 9878 5088 or emailing the Editor APJHM at journal@achse.org.au.

MISSION STATEMENT

The mission of the Asia Pacific Journal of Health Management is to advance understanding of the management of health and aged care service organisations within the Asia Pacific region through the publication of empirical research, theoretical and conceptual developments and analysis and discussion of current management practices.

The objective of the Asia Pacific Journal of Health Management is to promote the discipline of health management throughout the region by:

- stimulating discussion and debate among practising managers, researchers and educators;
- facilitating transfer of knowledge among readers by widening the evidence base for management practice;
- contributing to the professional development of health and aged care managers; and
- promoting ACHSE and the discipline to the wider community.

MANAGEMENT PRACTICE ARTICLES

Management practice papers are practitioner oriented with a view to reporting lessons from current management practice.

RESEARCH ARTICLES

An article reporting original quantitative or qualitative research relevant to the advancement of the management of health and aged care service organisations.

RESEARCH NOTES

Shorter than a research article, a research note may report the outcomes of a pilot study or the first stages of a large complex study or address a theoretical or methodological issue etc. In all instances it is expected to make a substantive contribution to health management knowledge.

REVIEWS

A careful analysis of a management or policy issue of current interest to managers of health and aged care service organisations.

PEER REVIEW

The Journal publishes original articles and has a policy of blind review for all contributions. This means that authors and reviewers are not disclosed to each other during the review and publishing process.

VIEWPOINTS

A practitioner oriented viewpoint/commentary about a topical and/or controversial health management issue with a view to encouraging discussion and debate among readers.

LETTERS TO THE EDITOR

A positive or critical comment about the Journal or a particular article or perhaps some suggestions for future Journal themes or suggestions for improving reader interest in the Journal.

SUBSCRIPTIONS

The cost of subscription to the Journal is included in the membership dues for ACHSE members. For non-ACHSE members the subscription cost is \$80 plus GST.

ADVERTISING

All booking and enquiries concerning advertising in the Journal should be directed to the Production Manager (Editorial Office) or email achse@achse.org.au

COPYRIGHT

© Australian College of Health Service Executives 2006.

This publication is copyright. Subject to the *Copyright Act 1968* (Cth), no part of this Journal may be reproduced by any process, without the written permission of the Australian College of Health Service Executives.

ARTICLE REPRINTS AND PERMISSIONS

Reprints are available in hard copy or as electronic downloads with permission to print. Reprint prices are as follows:

1 – 9 copies	\$6.00 each
10 – 49	\$5.50
50 – 79	\$5.00
80 – 99	\$4.50
100 – 499	\$4.00

(Minimum order \$10.00)

For an article reprint please email library@achsensw.org.au
All costs are in AUD.

FOR INFORMATION OR TO ORDER:

Health Planning and Management Library
PO Box 341
NORTH RYDE NSW 1670
Phone: 61 2 9805-0125
Fax: 61 2 9889 3099
Email: library@achsensw.org.au

DISCLAIMER

All articles published in this Journal including editorials are the opinions and views of the authors and do not necessarily reflect those of the Australian College of Health Service Executives unless otherwise specified.

Health Reform: deconstruct, reconstruct or transform

It was interesting to sit, listen and reflect on the presentations at the recent ACHSE New South Wales (NSW) State Conference held in Sydney where the theme was 'Deconstruct or Reconstruct'. [1] Most speakers prefaced introductions to their papers with a cautionary comment to the effect that in implementing change we should recognise that the Australian Healthcare System is a comparatively good system with a number of strengths. The caution was, that in implementing reform, we need to ensure that these strengths are protected. The concern was that requirements to respond quickly to inquiries and reform proposals might unintentionally weaken those strengths. This is perhaps a vote for reconstruction over deconstruction?

The second, common response in the presentations was that of the influence of organisational and professional subcultures, which were seen as both major impediments to and important considerations in successful reform. There was a degree of incredulity from some speakers that health professionals of different disciplines and health managers of all disciplines appeared to still find it difficult to value and respect what the different professions bring to the practice of healthcare. The differing professional subcultures were identified as limiting effective teamwork and the implementation of innovative service delivery models. There are of course, volumes of research and publications about the impact of these influences on the Australian, New Zealand and United Kingdom health systems. [2] Another example, perhaps, of well-documented research largely ignored. While it is good that these influences might receive greater consideration, it is important to remember that professional behaviour is mostly enacted within organisational cultures and often in response to how the different professions are managed. This engagement of the professions and clinicians will not occur without well-qualified health managers being placed at the service delivery level [3, 4] with the skills and competency to engage clinicians and to manage down and out. [5]

The reflection that this conference participant gained from the presentations around Garling [6] and the response of the government [7] as published by NSW Health, is that many of the supported recommendations for implementation are (and were) basic to good management of hospitals. Recommendations are supported that require attention to infection control, good cleaning and catering standards and clerical support to hard working ward nursing staff. Other recommendations about being respectful to and of patients, other staff, volunteers and visitors were, in past decades, seen as examples of good leadership and governance at the hospital level! The impact of systemic, integrated health systems, such as NSW Health, are known for their complexity and bureaucratic nature with often insensitive, standardised approaches that lead to the demoralisation of both health professionals and managers and failed attempts at reform. [8]

It is encouraging that there is a supported recommendation to examine the role and the place of hospitals in the health-care system and Garling [6] does talk about strengthening management at that level. It would be good to see an outcome that recognises the central importance of well-qualified health managers engaging with clinicians at the service delivery level. [3, 4] Perhaps the skill of managing by 'walking and talking' at the facility level could be re-introduced in much the same way that the existing recommendation for the re-introduction of ward rounds has been supported?

There is significant criticism of NSW Health in the submissions to and in the responses and recommendations of the Inquiry headed by Garling. [6] The response from the government and the Department has been swift and comprehensive and there has been demonstrated leadership at the Ministerial and Departmental level to engage with clinicians about reform. However, that leadership, given the scale and complexity of the State health system,

needs to be seen in symbolic terms and will at some stage also come to depend on how well managers are skilled and given authority and accountability for engaging with clinicians again, at the service delivery level.

We all have different perspectives around how to gauge the likely success of health reform. The recommendations of the Special Inquiry [6] and the response of NSW Health and the Government [7] fall short of the Principles and Parameters of the Shape Declaration on the Organisation and Management of Health Services. [3] This is particularly the case in respect to the level and type of community engagement and the placement of effective management at the service delivery level as discussed above. Importantly there is a lack of attention to meaningful governance, not just clinical governance, within the system.

This balanced concern within the Declaration [3] does not represent a single voice of concern. There are more strident and forthright views and Richardson [9] describes the failure of monopolies particularly at being dynamic and innovative. Richardson suggests that the health system has much to learn from published literature about why monopolies, often characterised as bureaucracies, fail. Recommendations from Richardson include the depoliticising of health, a more independent reform process and distinctions between funding and service delivery. Caspar is even more critical about current governance arrangements and calls for 'independent, self responsible boards' to govern public hospitals. [10, p. 9] So there is some degree of deconstruction as an approach in these views.

Whilst these last two perspectives come from an economist's lens they are supported by others. The Business Council of Australia also proposes greater accountability and leadership with some independence to the reform process, a focus on governance at the service delivery level, with local boards and fewer layers of management. [11] Importantly, Andrew Podger with extensive senior level management and policy experience in the healthcare sector, responding to an issue about governance and ownership of a health facility in the Australian Capital Territory (ACT) asks the question, 'which arrangement is most likely to deliver high quality and efficient hospital services to patients?'. [12, p.1] The by line to this article and the tenor of his response suggests independently managed hospitals are likely to be the more effective delivery vehicle. In the same article he also reports on a recent round table conducted by the Institute

of Public Administration Australia on health governance with the participation of invited experts. While there were differing views about a preferred national health system model, there was said to be strong support for among other things, purchaser provider separation and 'a degree of independence for providers'. [12, p.1] This independence includes 'hospitals having their own expert boards and taking responsibility for safety and quality'. [12, p.1]

Podger goes on to describe the debate about the potential reform models/options and makes the case that the purchaser-provider separation is consistent with the 'short term reform agenda' and 'longer term governance options' of the proposed national health reforms. [12, p.1] He argues that case-mixed based purchasing/funding will allow clarification of responsibilities and 'limit the sort of politicisation seen in NSW'. He suggests that this will allow a move towards 'expert hospital governance, with well-qualified boards ensuring good management, including strong clinical leadership and governance'. [12, p.1] To the detractors and opponents of this approach, he suggests that both an internal view of the relatively successful Victorian model and an external view of developments in Britain and more recent reform in Singapore, Germany and the Netherlands as evidence of support for this strategic direction.

The question remains, 'do we deconstruct or reconstruct?'. Perhaps the answer is in the adoption of sensible principles of reform. Principles that allow the patient to be placed at the centre of our concerns. Reforms that enable health professionals to effectively engage in organisations that are focussed on healthcare delivery. Health services that have clarity of responsibility and that are responsive to both community needs and national health goals. Perhaps this approach might provide an opportunity to transform the health system, a better option than deconstructing or reconstructing.

David S Briggs BHA, MHM(Hons), PhD, FCHSE, CHE, FHKCHSE
Editor

References

1. ACHSE NSW State Conference. Deconstruct or Reconstruct 2009. 2009 May 1; Sydney.
2. Briggs DS. The lived experience of health service managers [Dissertation]. Armidale: University of New England. 2008.
3. Briggs DS. The 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):10-13.
4. Sorenson R, Iedema R. Managing clinical processes in health services. Sydney: Elsevier; 2008.
5. Mintzberg, H. Towards healthier hospitals. *Health Care Manage Rev*. 1997;22(4): 9-18.
6. NSW Department of Health. Caring Together. The Health Action Plan for NSW. New South Wales: NSW Government; 2009 [Accessed 2009 May 8]. Available from: http://healthactionplan.nsw.gov.au/files/CaringTogether_Complete_ReportV13.pdf
7. Final Report of the Special Commission of Inquiry: Acute Care in NSW Public Hospitals, State of NSW. NSW Government; 2008 [Accessed 2009 May 8]. Available from: [http://www.lawlink.nsw.gov.au/lawlink/Special_Projects/Il_splprojects.nsf/vwFiles/E_Volume1.pdf/\\$file/E_Volume1.pdf](http://www.lawlink.nsw.gov.au/lawlink/Special_Projects/Il_splprojects.nsf/vwFiles/E_Volume1.pdf/$file/E_Volume1.pdf)
8. Denis JL, Lamothe L, Langley A, Valette A. The struggle to redefine boundaries in health care systems. In: Brock DM, Powell MJ, Hinings CR, editors. *Restructuring the professional organisation: accounting, health care and law*. London and New York: Routledge; 1999. p.105-130.
9. Richardson J. Steering without navigation equipment. The lamentable state of Australian health policy reform. Melbourne: Centre for Health Economics. Monash University; 2009 [Accessed 2009 May 8]. Available from: <http://www.buseco.monash.edu.au/centres/che/steering-without-navig-equip.pdf>
10. Kaspar W. Radical surgery: the only cure for NSW hospitals. *Papers in health and ageing (7) CIS Policy Monograph 91*. Sydney: The Centre for Independent Studies; 2009.
11. Business Council of Australia. Fit for the job. Adapting to Australia's new healthcare challenges. Melbourne: Business Council of Australia; 2009 [Accessed 2009 May 8]. Available from: <http://www.bca.com.au/Content/101545.aspx>
12. Podger A. Is public ownership the right medicine for Calvary Hospital's patients? *Canberra Times*. 2009 May 5; p. 4. Available from: <http://www.mediamonitors.com.au/Default.aspx>



1ST INTERNATIONAL CONFERENCE ON

Health Services Delivery Management



University of New England
AUSTRALIA

**International perspectives on the management of Primary Health Care
and the delivery of district health services**

**Topland Hotel
Phitsanulok THAILAND
14-16 OCTOBER 2009**

They are a number of keynote speakers from Australia attending the Conference
which also has the support of the World Health Organization.

PROUDLY SUPPORTED BY:



The photograph on the cover is a typical scene of Thailand. It was selected for the cover of this issue because ACHSE has signed a memorandum of understanding with colleagues in Thailand to assist them to develop the profession of health management in that country with a longer term objective of establishing a similar organisation to that of the College in Thailand. Importantly, ACHSE is a major partner, along with the World Health Organization South East Asia Region Office (WHO SEARO) and others in the forthcoming '1st International Conference in Health Service Delivery Management' at Naresuan University in Phitsanulok, 14th-16th October 2009. Details are in this issue.

Health reform is a constant in most countries and even more so in Australia at the moment. The next issue will provide some substantial contributions about the national reforms. The editorial in this issue provides some reflection on the immediacy of some elements of reform and the implications of current State-based reform in that context.

The Journal has received international attention thanks to an article on open office planning by Oommen, Knowles and Zhao in the last issue and further details of that interest are included in this issue. That article has also prompted a letter to the Editor from Sally Torr about office accommodation needs of community health workers. This provides another perspective about inadequacy in accommodation and emphasises the need for a common area for workers to meet, communicate and debrief after a days work on the road. Warren Westcott commends the SHAPE Declaration paper also from the previous issue and challenges SHAPE and ACHSE to respond to some of the opportunities this paper suggests are required. The interest generated by the letters to the Editor is appreciated.

Appropriately the feature article in this issue is provided by Professor Bernard Crump, Chief Executive of the NHS Institute for Innovation and Improvement. The article he has contributed is about improving productivity in the NHS. At a time, when many health systems are grappling with reform agendas, this article provides useful insights into approaches adopted in the United Kingdom health system.

The article by Day and Fulop is also timely and relevant to reform agendas. In this article they propose a national approach to put health management research on the National agenda as an important approach to provide a sound evidence base for practice. This proposal already adopted by SHAPE and participating academic organisations, calls for major collaborative research initiatives by researchers, initially across Australia and New Zealand, and invites practitioner participation. This is an opportunity for SHAPE, the College, and others to again demonstrate leadership in advancing professional practice in health management and progressing understanding about the organisation and delivery of healthcare. The next article by Perrott and Ledema provides us with an introduction to knowledge management in healthcare. This is an important area for health managers given that healthcare organisations are information rich and that the translation of knowledge into practice remains one of the great challenges we face.

The Journal has been presented with increased numbers of research-based articles for publication and this is appreciated, both in respect to the support the Journal is receiving and because it reinforces the call by the College and SHAPE and personified in the Day and Fulop article for greater collaborative research. Three of the research articles focus on aspects of practice that affect different occupational and professional groups in healthcare. The first, by O'Sullivan and Leggat, explores the views of the administrative staff of a large hospital in Victoria, Australia, subject to relocation. The next article by Han, Chesters and Ballis, explores the influences on doctors' decision-making about the location of their practice and the positive experiences of a cohort of doctors in rural practice. Important perspectives for those involved in managing rural workforces and services.

The next article is provided by Canadian colleagues Rondeau and Wagar and focuses on research examining nurse recruitment in the context of labour shortages and high turnover rates and how recruitment is influenced in these contexts. This paper arises from the participation of the authors in the Biennial Conference of the International

Scholars in Organisational Behaviour in Healthcare (OBHC) conducted in Sydney by the Society for the Study of Organising for Healthcare (SHOC) in March 2008.

The next article by Ciechomski, Tan, O'Connor and colleagues brings the perspectives of differing health professions together with those of carers and terminally ill people to explore the provision of after hours palliative care services in three regions of Victoria, Australia. The article describes differing perceptions about the services, identifies gaps and associated factors. Important reading for those involved with policy service planning and delivering after hours services.

Finally, in our group of research articles we present our first contribution from research colleagues in Indonesia. Aryastami, Kusumawardani and Siahaan, all from the National Institute of Health Research and Development, Jakarta, present research they have conducted into the responsiveness of the Indonesian preventative health system towards mothers and their children in the important areas of nutrition and immunisation. The authors examine seven domains of health service responsiveness to mothers of children at the district health service level to examine implications for policy and service delivery.

Our question and answers section returns to the question of health reform and invites contributions from Australia, the United Kingdom, Hong Kong, Thailand and New Zealand. We value the contributions from differing health systems and would encourage readers from other health systems to indicate to us their willingness to contribute. The 'In Profile' contribution this month features Dr Prawit Taytiwat from Thailand. He is a College member, passionate about health management development in his own country and has engaged the College to assist in that objective. He is responsible for organising the '1st International Conference on Health Services Delivery Management' referred to earlier.

The book review this month is provided by Brenda Ainsworth and Sheryl Harrison. The Book is '*Lean hospitals: improving quality, patient safety, and employee satisfaction*' by Graban. Again contributions about books for review and willing reviewers are always welcome. Contact the Editor or the book review editor Angela Magarry. Our thanks also to ACHSE Librarian Sue Brockway, for the provision of a quality library bulletin for our readers.



For those who are involved in health management at all levels, this is your best career move

The Australian College of Health Service Executives was established in 1945 to represent the interests of health service managers and to develop their expertise and professionalism. Today the College is the professional organisation representing health service managers across the full range of health care delivery systems in Australia, New Zealand and the Asia Pacific from both public, private and aged care sector organisations.

Enjoy access to a comprehensive Health Planning and Management Library, participate in formal professional development programs, receive regular information on contemporary health issues as well as the peer reviewed *Journal Asia Pacific Journal of Health Management*. Meet other health professionals through College functions. Mentoring, networking and peer support are all available to you as a College member.

Join Australia's largest leadership and learning network today.

Go to www.achse.org.au for more information



The Australian College of Health Service Executives

Phone: 61 2 9878 5088 Fax: 61 2 9878 2272 Email: achse@achse.org.au

The SHAPE Declaration,

I think the SHAPE Declaration outlined in the last issue of *Asia Pacific Journal of Health Management*, is the most sensible proposal I have read on health management for a long time. As someone who has worked for 40 years in health management and in the health management education area, I would strongly support the statement that 'Health managers should be appropriately qualified, skilled and adept in managing complex health service organisations'. It never ceases to amaze me that many health managers undertake undergraduate or Masters qualifications and then don't do anything to keep themselves up-to-date for the rest of their career apart from whatever their employer might send them to. If it is good enough for accountants to have a continuing professional development requirement, so should health service managers.

If health services in Australia are to cope with the challenges of the future, they need well trained managers and leaders. Relying on clinical qualifications or out-of-date tertiary qualifications is not good enough. However, there must be a commitment from health service organisations to invest in the education of managers and leaders. This isn't a luxury item; it should be an up-front commitment.

It also seems that management skills/qualifications are undervalued in the health system. I marvel at some positions which are 'Business Manager' type positions being occupied by people from clinical backgrounds with no business management qualifications. And of course there has long been the situation of senior clinical staff occupying management positions with no management qualifications, although I think this is changing.

The other issue that needs addressing is the lack of no career path for health managers. It is so difficult to describe to young management trainees starting their careers, what course to steer so they can progress to senior positions. There is a lot of luck needed to be in the right place at the right time to achieve progression. Mentoring of these young staff is so important these days to give them some support. Yet there are so few formal mentoring programs available.

I think the College is in a unique position to give these issues some focus - at least in the area of careers and competencies. The College conducts two Management Training Programs - in NSW and Victoria and Mentoring Programs in four States. I think the College could use these programs to look at the competencies that health managers should be achieving and then use this as a basis for Mentoring and Management Training Programs. If these fundamentals can be addressed, there may be a basis for building a career structure for health managers in Australia.

Maybe this is a starting point for a joint SHAPE/ACHSE focus?

Yours sincerely

Warren Westcott FCHSE, CHE
Management Development Consultant

To the Editor,

I refer to the article entitled 'Should Health Service Managers Embrace Open Plan Work Environments?' (APJHM. 3;2:37-42).

One needs to give close attention to workplace design solutions, especially to the housing of primary and community health teams. The majority of their work is conducted in the place of residence of clients or outside a health facility.

In Australia community health teams are often accommodated in semi-derelict houses or old run down nurses' homes with a lack of car parking space and no place for health homecare or health promotion equipment.

No thought is given to community health workers' work environment or how they work. It appears that they should be grateful they have a desk and a chair.

A majority of staff working in these teams is out on the road alone for most of the day. When they come back to their base they usually want to let off steam: talk about clients, car issues, traffic and parking issues, administrative problems, have a cup of tea, and/or chat with their colleagues, before they put in an hour of report writing and phoning.

Health services should provide more drive through services/ warehouses for staff and patient relatives. Services where they drive their car in to dump dirty linen or used equipment, obtain petrol and collect new supplies, medication and IV supplies, food supplements, equipment etc. This type of service is widely seen in the United States and in a couple of sites in South Australia.

I fully agree with the conclusion reached by the authors. There is a need for workplace design solutions, especially in health, to become more dynamic.

Dr Sally Torr

Health Service Manager
Bourke Health Service

Open plan offices and APJHM reaches for the stars

Readers will be interested to know that the article 'Should Health Service Managers Embrace Open Plan Work Environments? A Review' by Dr Vinesh Oommen and Isabella Zhao, both of the Institute of Health and Biomedical Innovation, Queensland University of Technology, and Mike Knowles, Executive Officer ACHSE Queensland Branch, has created worldwide interest in the media, business and academia.

The article published in the last issue (3;2:37-42) created so much interest that by January 13 2009, the Media Monitor reports and articles extended to 17 pages of closely clipped listings and extracts. Interest came from, but was not restricted to Australia, the United Kingdom, Belgium, Germany, Switzerland, and the United States. Requests for copies of the article also came from radio, television and the print media. Industry, academia, trade unions and diverse groups such as the West Yorkshire Constabulary, a department of the Australian Tax Office, FoxNews and even that rather famous organisation interested in things galactic, NASA, requested copies.

It is obvious that the question of the work environment is of considerable interest to diverse groups and our authors are to be congratulated on researching and reporting in an area of some importance and relevance.

A review of the headlines from the reporting also suggests a lot of congruence with the authors' themes and also some contested views about work environments, in a common concern about their importance. This presents a challenge to the Journal and those who might be considering publishing to perhaps respond to this obvious interest. We would of course be interested in receiving any contrary views to those already published.

College members should be pleased that in all this diverse and extensive reporting, the College's Journal was duly noted and highlighted adding to the rapidly increasing interest in the Journal that College members can rightly claim as their own and as a defining descriptor of what is an essential element of a credible professional College.

Dr David S Briggs BHA, MHM(Hons), PhD, FCHSE, CHE,
FHKCHSE
Editor

Supporting productivity in the NHS in England

B Crump

Abstract

With the implications of the international recession for public spending becoming visible, productivity and optimal use of resources are back on the agenda for the National Health Service (NHS) in England. The purpose of this article is to share the experiences and learning that have unfolded from the NHS Institute for Innovation and Improvement's 'Delivering Quality and Value' program. It is based on the philosophy that helping clinicians and managers to deliver high-quality care to patients, that is 'right-first-time', is the most likely way to achieve sustainable improvements in productivity. The range of approaches, tools and ideas developed and implemented as part of this program are resulting in profound and rapid change.

The article will describe how, by balancing both external motivators (eg, published performance data)

and more intrinsic levers for change (eg giving control back to frontline staff), you can introduce practitioners to well-framed and culturally-acceptable programs that they will use and adapt to transform the quality, and therefore the value, of local healthcare.

Abbreviations: AHT – Acute Health Trust; BCBVI – Better Care Better Value Indicators; CEO – Chief Executive Officer; DRG – Diagnosis Related Group; GDP – Gross Domestic Product; HRG – Healthcare Resource Group; IHI – Institute for Health Improvement; NHS – National Health Service; NHSI – NHS Institute for Innovation and Improvement; PCT – Primary Care Trusts; PDSA – Plan Do Study Act.

Key words: Productivity; quality; value; benchmarking; improvement; innovation.

Professor Bernard Crump

Chief Executive Officer
NHS Institute for Innovation and Improvement
Coventry, United Kingdom

Correspondence:
bernard.crump@institute.nhs.uk

Introduction

The National Health Service (NHS) in England has seen an unprecedented period of growth in resources in the last few years. The seminal report commissioned by the Government from Sir Derek Wanless (a former banker) and published in 2002, has been used to guide the allocation of these resources in the health sector. [1] His report clearly indicated that additional resources needed to be matched with real reforms in practice. Indeed, his report proposed three scenarios for healthcare and outlined the potential costs of each to the public purse by 2022 – the timeframe he

was asked to address. Table 1 shows the key characteristics of the 'fully engaged' scenario, in which public engagement in health is high; the nation's health status is dramatically improved; and the service itself is fully engaged in change and innovation. The 'fully engaged' scenario is substantially less costly than the 'slow uptake' scenario (around £30 billion less by 2022/23) yet delivers significantly better health outcomes.

Notwithstanding the availability of additional resources, some NHS organisations have had to take major steps recently to balance their books. [2] Reports suggest that the system has not yet (more than six years after the Wanless publication) hit the trajectory necessary to achieve a 'fully engaged' outcome. [3] The costs of treatments and increased demand due to changing demographics, are leading to resource-related headlines that will be familiar to readers from any continent. [4] And now the implications of the international recession for public spending are becoming

Table 1: Wanless Report 2002

	2002-3	2007-8	2012-13	2017-18	2022-23
Total health as % of GDP					
Solid progress	7.7	9.4	10.5	10.9	11.1
Fully engaged	7.7	9.4	10.3	10.6	10.6
Slow uptake	7.7	9.5	11.0	11.9	12.5
NHS spend					
Solid progress	68	96	121	141	161
Fully engaged	68	96	119	137	154
Slow uptake	68	97	127	156	184
Average annual growth					
Solid progress	6.8	7.1	4.7	3.1	2.7
Fully engaged	6.8	7.1	4.4	2.8	2.4
Slow uptake	6.8	7.3	5.6	4.0	3.5

visible. Ensuring the optimal use of resources is back at the top of the agenda in England.

The NHS Institute for Innovation and Improvement

The NHS Institute for Innovation and Improvement (NHSI) was formed in July 2005. We are a national body (a Special Health Authority¹), funded by the Department of Health and responsible for: 'supporting the NHS to transform healthcare for patients and the public by rapidly developing and spreading new ways of working, new technology and world class leadership'.

The organisation is active in many arenas, including leadership development; supporting innovation and innovators; advancing learning for improvement; and promoting innovation in safety and quality.

Given the importance of the productivity agenda, the NHS Institute has, from the outset, been active in this field. The purpose of this article is to share our experience of three complementary programs that have been developed by the NHS Institute and are helping NHS organisations make strides forward in improving local productivity and quality of care.

1. Special Health Authorities operate nationally on behalf of the NHS in England, rather than serving a specific geographical area.

Delivering quality and value

The philosophy that underpins these programs is this: work that helps clinicians and managers to deliver high-quality care to patients and that is 'right first time', will be the work most likely to lead to sustainable improvements in productivity. The senior leaders of the NHS Institute share many years' experience of working in the NHS and in other sectors. Discussions with executive directors of NHS organisations and with international partners have helped distil the common traits that have characterised previous attempts to improve productivity. These tended to focus more on the peripheral aspects of healthcare delivery (eg, back office and administrative functions; cleaning and laundry services; procurement of support services; utilities and supplies). A crude approach to 'sharing the pain' was not uncommon, with a percentage reduction in costs being 'salami sliced' across all budget lines. This caricature also sees limited clinical engagement, despite many initiatives to give clinicians greater involvement in resource management, and despite the fact that clinical care has often been 'off limits' for cost-cutting considerations.

While this picture is exaggerated to make a point, nonetheless the instinct of many clinicians has been that improvements in quality inevitably lead to an increase in costs, and that the inverse is also true. Such a relationship between cost and quality in healthcare is very different to the experience of other sectors of the economy where

improving quality reduces costs. But recently, there have been many reports and case studies showing that quality improvements can lead to cost reduction in the healthcare sector too. [5]

Three complementary approaches

As part of the NHS Institute's 'Quality and Value' program, we have taken three complementary approaches to support the NHS in these areas.

Approach one: the 'Better Care, Better Value Indicators'

Benchmarking has been in use in the NHS in England for around a decade. [6] However, much of this benchmarking had not focused on clinical activity, or had done so at a highly-aggregated level. The time lag between data collection and publication of benchmarks was often significant, leading to the frequent response from outliers that 'everything has changed since then'.

Benchmarks had not been easily accessible by the public, and had not been commonly used by NHS Boards in planning

their strategies. There had also been no explicit attempts to assess the impact on resource use that would result from a change in performance.

Following consultation with NHS organisations, in October 2006 the NHS Institute published the 'Better Care Better Value Indicators' (BCBVIs). We chose 15 indicators which are shown in Table 2. Four of the indicators were based on the performance of hospitals, with another four focused on the performance of Primary Care Trusts.² The remaining seven applied to both types of organisation.

The indicators were derived from routinely-collected data; principally Hospital Episode Statistics (which are submitted after every admission and outpatient attendance) and from workforce and prescribing data.

2. Primary Care Trusts, now 152 in number, receive resources with which they deliver primary and community services and commission secondary and tertiary services.

Table 2: 'Better Care, Better Value Indicators'

Reduced variation in length of stay (bed days saved)	AHT	
Day case rate for Audit Commission basket for 25 procedures	AHT	
Reduction in wasted bed days as a result of admission prior to operation	AHT	
Admission rates for selected procedures where thresholds for surgery vary		PCT
Reduction of avoidable emergency admissions against 19 recognised diagnoses		PCT
Referral rate standardised - first outpatient appointment		PCT
Income and expenditure – percentage variation in I&E position	AHT	PCT
Cash – variation in cash position	AHT	PCT
Monthly run rate – surplus or deficit for previous month	AHT	PCT
Staff turnover	AHT	PCT
Sickness absence	AHT	PCT
Agency costs	AHT	PCT
Finished consultant episodes per consultant	AHT	
Uptake of nationally negotiated procurement contracts	AHT	PCT
Proportion of statin prescriptions that are low cost		PCT

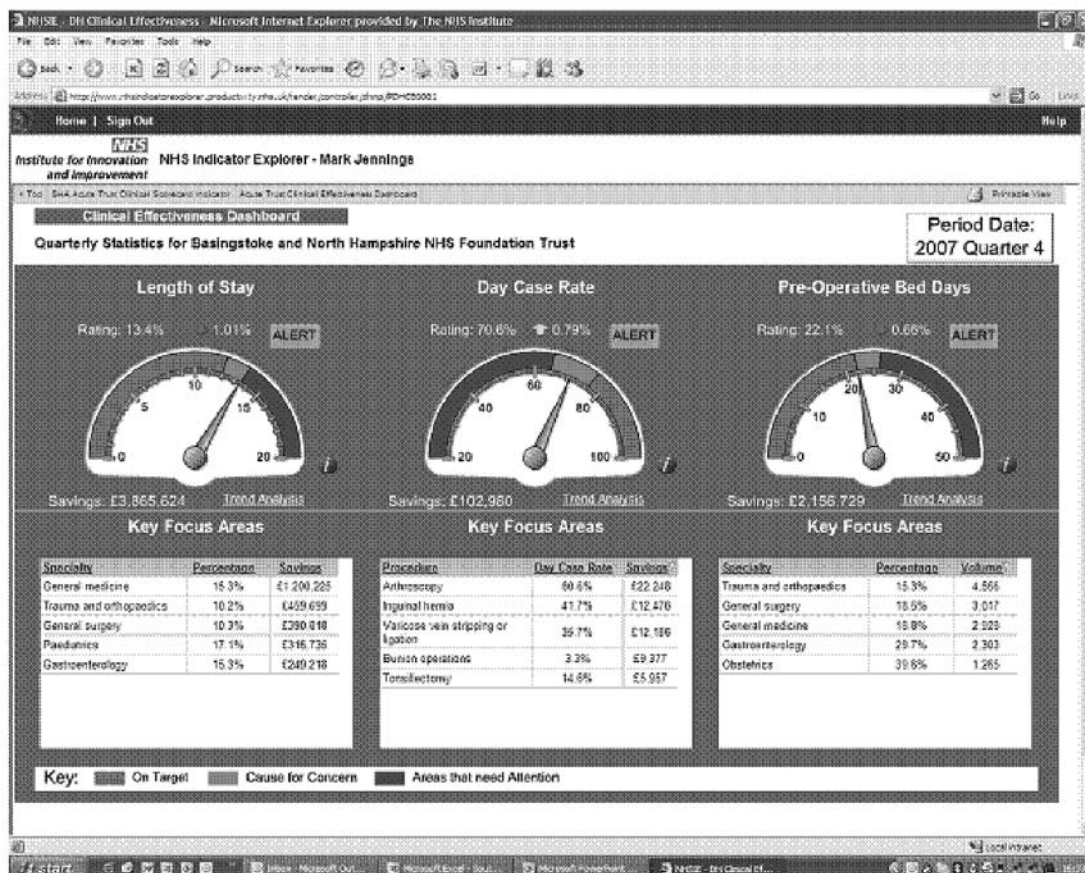
Working with a contracted partner, we implemented a process where the data were typically published within three months of the quarter to which they related. Each NHS organisation received a scorecard showing their performance against each relevant indicator; their past performance; their rank for that indicator compared to other NHS organisations of the same type; and, for each indicator, the distance between their performance and that of the best quartile of organisations. For those organisations with a level of performance below that of the best quartile, their 'distance' was also translated into a 'Productivity Opportunity' – a financial value that we believed would be helpful for organisations, their commissioners and the public in understanding the scale of the different opportunities to release resources for reinvestment. The scorecards also pointed to helpful resources, publications and tools. These were developed by the NHS Institute and others to share the steps that highly-performing organisations had taken to improve their own performance.

The overall performance of all NHS organisations is published on a publicly-available website (www.productivity.nhs.uk) together with tables that show all of the data for NHS organisations in each Strategic Health Authority.³

In addition, we have developed and published a web-based tool – the NHS Indicator Explorer (Figure 1) – which allows each organisation to accredit members of staff who, through a secure website, can interrogate the data that contribute to their organisation's performance. So, for example, an organisation with a low level of performance on an indicator such as the 'proportion of patients admitted for an elective procedure on the day of surgery' can use this tool to look at the comparative performance of individual surgical teams; information that is not available publicly. Users can also use the tool to identify their own comparator set of organisations, as well as generating compelling reports for their Board.

3. There are ten Strategic Health Authorities in England, each one responsible for the strategic supervision of all the NHS trusts in its area.

Figure 1: The NHS indicator explorer



Experience with the 'Better Care, Better Value Indicators'

Several aspects of this approach to benchmarking were novel for the NHS in England – and somewhat controversial. When they were first published, the total value (across all indicators and all organisations) of Productivity Opportunities was around £2.5 billion (or 4% of total system expenditure). This was based on the value of resources that could be released for reinvestment if organisations were to adopt the levels of performance that were being delivered by organisations at the best quartile level for each indicator.

From the outset, however, the NHS Institute made it clear that there was no 'expected' level of performance for any indicator. For example, the proportion of patients being admitted on the day of surgery would be higher in a hospital delivering a more complex case mix than one serving a more rural and dispersed population.

Nonetheless, the visibility of comparative performance, together with reasonably up-to-date data, offered Boards and executive teams a good basis for dialogue with their clinical staff. Commissioners could also question the

comparative performance of their provider organisations and also their General Practices on issues such as utilisation of relatively low-value procedures, and value for money on their choice of drugs such as statins, where national guidance was available.

After the first year of publication, performance on several of the indicators had markedly improved: the overall productivity opportunity consequently showed an initial reduction of £400 million. During this period, many NHS organisations were taking steps to recover from a deficit position and they, and their performance managers, were able to use the 'Better Care, Better Value Indicators' to help target their strategies.

Following consultation, it was agreed that the indicator set should be expanded overall, while some of the initial data set was dropped where it was felt to be less helpful, or where the data were unreliable. The current version of the indicators is shown in Table 3. The expansion of the indicator set, and the significant increase in activity delivered by the NHS since the launch of the benchmarks, mean that the total value of the Productivity Opportunities across all organisations and all indicators is now £3.4 billion.

Table 3: Current version of 'Better Care, Better Value Indicators'

Reduced variation in length of stay (bed days saved)	AHT	
Day case rate for Audit Commission basket for 25 procedures	AHT	
Reduction in wasted bed days as a result of admission prior to operation	AHT	
Admission rates for selected procedures where thresholds for surgery vary		PCT
Reduction of avoidable emergency admissions against 19 recognised diagnoses		PCT
Referral rate standardised - first outpatient appointment		PCT
Outpatient – did not attend percentage	AHT	
Outpatient – new to follow up appointment ration	AHT	
Unplanned admission percentage at 14 days	AHT	
Staff turnover	AHT	PCT
Sickness absence	AHT	PCT
Agency costs	AHT	PCT
Proportion of statin prescriptions that are low cost		PCT

Approach two: 'High Volume Care'

While developing the 'Better Care, Better Value Indicators', we were also engaged in a more detailed program of work called 'High Volume Care'.

A new system of payment for secondary care was introduced into the NHS in 2002. Known as 'Payment by Results' the system uses a national tariff for inpatient care. The data collected after each inpatient episode are analysed using a software tool which classifies each case into one of 620 Healthcare Resource Groups (HRGs). The HRGs have been developed for the NHS in England, but are similar to Diagnosis Related Groups (DRGs) used in the United States and in some states in Australia.

Fifty HRGs account for 50% of admissions and bed days occupied in England. We wanted to investigate the specific practices of high-performing organisations in their care of patients with these 'High Volume' conditions, and to understand how these differed from practices in less well-performing organisations.

From the list of 50 HRGs, we used the available data to identify eight diagnoses for common conditions in which practice seemed variable. This entailed examining data on utilisation and on length of stay in particular. The initial diagnoses which we studied are shown in Table 4, along with a further eight diagnoses which we studied in a second phase of our work.

We then recruited clinically-led teams to visit hospitals at both extremes of the performance spectrum for each diagnosis. Each team was led by a consultant in the relevant specialty, supported by a general manager, an improvement expert and an analyst. They carried out structured visits to a representative group of sites; not uncommonly the same hospital was a high performer for one diagnosis, and a poor performer for another.

Using the experience from the visits; relevant guidance; visits to high-performing units in other countries; and dialogue with specialist after associations; a report was compiled for each diagnosis. [7] This included an analysis of the key drivers of high performance for that diagnosis; a 'high-performance care pathway' for the typical patient; and a variety of tools to help those delivering such services.

In addition, the NHS Institute is now supporting organisations that are seeking to deliver improvements using these materials through a number of collaborative projects. Each project involves a hospital from each of the ten Strategic Health Authority areas.

We have also been advocating for change in the current payment approach. At present, the designated tariff for each HRG represents an average value, drawn from all England's hospitals, for the delivery of care for a specific combination of diagnosis and procedure. We believe our work, and the care pathways developed as part of it, form a firmer basis for the introduction of a 'normative tariff'; in essence a tariff which provides sufficient resource for an organisation to deliver high-quality yet efficient care for their patients. This principle has been accepted and included in the White Paper, 'High Quality Care for All' as part of the published proposals to introduce a 'Best Practice' tariff. [8]

The work has also played a major part in another NHS Institute program in which we supported 12 NHS Chief Executive Officers (CEOs), each committed to delivering their organisation's bottom-line objectives through an improvement philosophy.

The 18-month support program, 'Delivering Through Improvement', had two phases. For the first nine months the CEOs were supported by the NHS Institute (as well as by their peers and management consultancy partners) to

Table 4: Diagnoses for common conditions with variable practice

PHASE 1	PHASE 2
Ambulatory emergency care for adults	Cataracts
Acute admissions in adult mental health	MRI and low back pain
Acute stroke	Children and young people emergency and urgent care
Caesarean section	Heart failure
Cholecystectomy	Inpatient care for people with diabetes
Fractured neck of femur	Preparing for end stage renal disease
Frail older people	Psychiatric intensive care units
Primary hip and knee replacement	Emergency admissions for suspected cancer

develop a transformational vision for their organisation. This was underpinned by a transformational plan and translated into a series of powerful narratives that enabled each CEO to communicate their vision clearly and compellingly to internal and external stakeholders in their area.

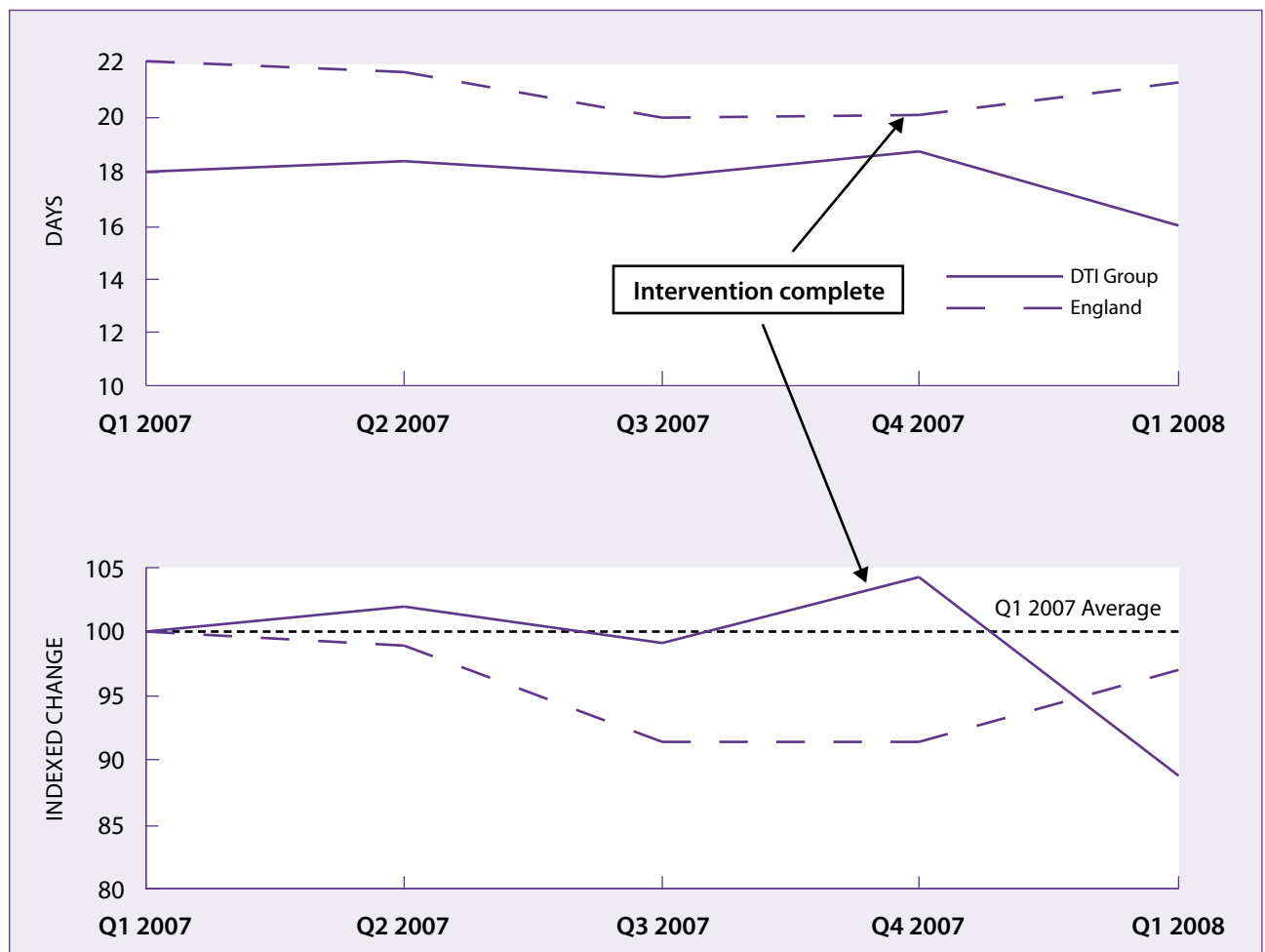
With this groundwork in place, the CEOs reviewed the 'High Volume Care' pathways alongside their own organisation's performance. They chose to work together on delivering improvement in two pathways; stroke and fractured neck of femur. Over the next nine months, the CEOs, supported by leads for each pathway and working collaboratively with their peers, set out to implement the recommendations in our 'High Volume Care' reports for these conditions. The results have been impressive, with major improvements in mortality and greater use of recommended clinical processes, such as early imaging in stroke, and optimal surgical management in fractured neck of femur. Graphs A and B show the performance of this group of Trusts compared with all other hospitals in England.

Approach three: the 'Productive series'

Our third approach is based on the philosophy that if we can put the right improvement skills, tools and motivation into the hands of those delivering care at the front line, major benefits will follow. The approach was developed from pilot work we carried out in the earliest days of the NHS Institute, exploring the use of 'Lean Thinking' in healthcare.

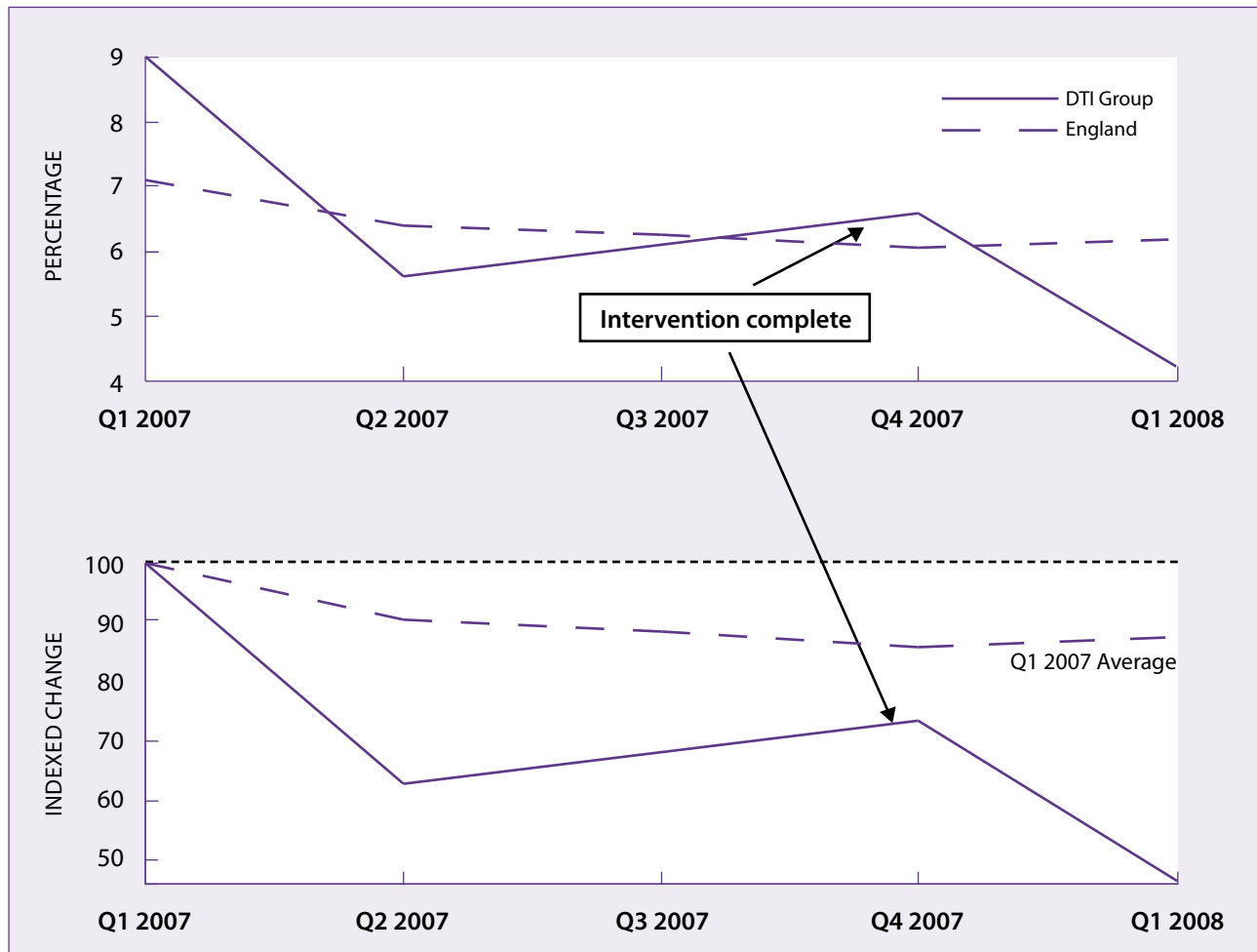
Lean has its origin in engineering, particularly in automotive engineering, and particularly in Japan. [9] A number of hospitals in England are experimenting successfully with the use of these approaches as an overall organisational philosophy. [10] However, in the 'Productive series' our ambitions are more modest. Firstly, we wanted to work with frontline staff to develop simple, comprehensible ways of using some of the tools from Lean and Six Sigma and assessing their impact. (Lean helps eliminate waste, while Six Sigma helps users understand and reduce variation.) Secondly, we wanted to find ways of disseminating the findings from these pilots in a compelling way that would

Graph A: Evolution of stroke average length of stay (by quarter)



Source: Dr Fosters Intelligence Ltd

Graph B: Evolution of fractured neck of femur percentage mortality rate at 30 days (by quarter)



Source: Dr Fosters Intelligence Ltd

also create 'pull' from the professions for involvement in the programs.

Our first program focused on ward-based care in acute hospitals. Hospital wards are busier than ever before. There is a strong sense that the levels of activity and occupancy contribute to the prevalence of hospital-associated infection, as well as to problems of patient safety and compromised patient experience. However, both our pilot work and the literature suggested that there was considerable scope to release more of ward staff's time for direct patient care, if a systematic approach was taken.

We initially recruited four hospitals to pilot the work that we called 'The Productive Ward'. Supported by the NHS Institute, and working with specialist consultancy support, ward staff in these hospitals implemented some small but key changes to the routine work of their wards. They used a range of approaches, borrowed from Lean and Six Sigma,

implementing and testing the changes using the Model for Improvement. The latter was developed by the United States-based Institute for Healthcare Improvement (IHI) and is a tool we promote widely in our programs and our own work processes. [11]

Early on it became clear the term 'productivity' was not popular with nurses in England. As our principal impact measure for the work was the proportion of a nurse's time that she or he spends in direct patient care, we reframed the program under a new title, 'Releasing Time to Care'.

Baseline measures in our four pilot hospitals showed that typically only 25-30% of ward staff's time on duty was being spent on direct patient care. By focusing on recurring events (such as meal times, drug rounds, handovers and ward rounds) and by looking at factors such as ward organisation and management of supplies, ward staff were able to make changes that moved this number significantly; typically spending closer to 50% of time on direct care activities.

The improvement was delivered entirely as a bottom-up initiative, with the changes being designed, implemented and tested by the staff themselves. Importantly, healthcare assistants as well as domestic and administrative staff played an extremely valuable role in designing the changes.

Working with the initial sites, we developed a modular program which we felt could be used by any ward to begin the process and tackle the commoner issues. [12] We recruited a further ten hospitals to act as 'learning partners', testing and improving the modules and, together with the initial four pilot sites, offering advice and support to other hospitals in their area.

We also began to share the early results of this work through professional channels, particularly with the nursing community. Using presentations and video, and collaborative social media such as WebEx (where people join a discussion from their workplace using the internet) the pilot sites shared their experience and an exciting story began to unfold. The pilot sites reported more time available for priority clinical issues; a strong sense of ownership and self-efficacy as staff regained control of the work environment; and evidence of secondary improvements in numbers of complaints, length of stay and complications – including infections and pressure area problems.

Working with our learning partners, we developed and published materials to support hospitals in using, 'Releasing Time to Care: the Productive Ward'. This modular program has foundation elements that are recommended for any user, and optional modules that focus on specific aspects of the ward routine (eg, drug rounds, handovers, mealtimes) from which a ward can design their own improvement program. The modules also give users a clear indication of the internal support and time needed from senior leaders within the organisation and from ward-level leaders in order to ensure a successful implementation. Two of our learning partners have committed to implement the program on every ward; both are major teaching hospitals and have planned a three-year program to achieve this.

Some hospitals have also said they would welcome hands-on support to get the process started. Two 'extended service' programs have been designed to meet this need, and many hospitals have decided to buy extra support through these channels. The modular materials, meanwhile, are available without charge to all NHS hospitals in England.

As of December 2008, 12 months after the launch of the program, 123 hospitals, representing over 68% of the acute

hospital base, were known to be using 'Releasing Time to Care: the Productive Ward'. The program has also attracted international interest and is being used in six countries. Through our networks, we also identified at an early stage that the approach could be adapted to specialist areas. Modular programs have now been developed for mental health and maternity wards.

The generic principles of the Productive series are also being incorporated into new programs. The 'Productive Community Hospital' was launched in September 2008. It was developed in partnership with four smaller hospitals and focuses on the specific challenges that these organisations face. 'Productive Community Services' will be available this summer and applies the Productive principles to the delivery of services in home and community settings. The 'Productive Operating Theatre' will also be available in 2009 and aims to improve the safety and efficiency of care in the operating room.

A common reaction when talking to senior leaders about this work was that, however compelling, they could not find the time to engage with quality improvement. As part of our response, we recruited four executive teams and worked with them to apply the principles of the Productive series to their own work. Together we developed a modular program in which they and their executive assistants, who were vital to this effort, redesigned their approach to individual and group routines – such as meetings, email handling and supervision. On average, each team freed up one day a week per each executive team member, and six hours a week per assistant. A modular program based on this approach was launched in October 2008 and is being widely used in healthcare. Now others in the public sector want to explore its potential for their organisations.

Discussion

I have described here three complementary approaches developed by a national improvement organisation to support the NHS in improving quality of care, and hence value. So what have we learned from this program?

Since the establishment of the NHS Institute, we have been strategic partners with the IHI in Boston - widely acknowledged to be a global leader in healthcare improvement. In drawing out the learning from our work on Quality and Value, I will borrow a framework commonly used by IHI to characterise successful programs: Will, Ideas and Execution. [14]

Will

Our complementary approaches use a range of different tools to help develop the will to change among both organisational leaders and frontline staff. In the 'Better Care, Better Value Indicators' work, publicly-available information about comparative performance stimulated interest; be that from the organisation itself, its commissioners and performance managers, or from the press and the public. This is a 'push' strategy with bodies outside the organisation initiating action. Inevitably such strategies can provoke a negative reaction. A common response pattern often started with: 'the data must be wrong'; then moved on to: 'our organisation is different'; followed by: 'we have already changed since then'. We encountered all of these reactions, some valid and leading to improvement in the data by the organisation itself, or leading to an agreement to exclude some highly-specialised providers from one or two indicators. In general, however, the 'Better, Care Better Value Indicators' are regarded as valuable in that they are more comprehensive and more relevant than those used in previous benchmarking attempts, and they are linked to advice on how to respond to an outlying performance.

In our work on 'High Volume Care', we have tried to balance 'push and pull' strategies. Particularly when a normative or best practice tariff is introduced for the care pathways we have studied, there will be a significant external stimulus for providers to examine their performance in comparison to high-performing organisations. However, we have also disseminated this work through professional channels, working with specialist organisations and capitalising on the need for doctors in training to engage in continuous professional development. In some instances, we have tried to create the 'pull' among patients themselves – seeing them as another important route for raising local awareness of what can be achieved through these pathways.

In our 'Delivering Through Improvement' program, push and pull were expressly combined. Having developed their transformational plans and narratives, CEOs were shown performance data for eight pathways in their own organisations and the rest of the country. They chose two pathways to be their focus and, taking control with their clinical pathway leads, they pulled the help and support they needed from the NHS Institute and our expert partners (as well as from one another). The result was rapid and profound improvement.

In the Productive series, we set out from the beginning to adopt a pull strategy to motivate people to discover and use this work. In parallel with this program, our senior

NHS Institute leaders have been exploring how social movements and campaign methods can stimulate change. [15] We have actively sought to discourage the Department of Health and performance managers from seeking to mandate the use of the Productive series. (Remember, we reframed the title of the program to 'Releasing Time to Care' when our fieldwork confirmed that many nurses in England see negative connotations in the term 'productive'.) On every occasion, nurses or clinical professionals (in person or through extensive use of video) described their experiences to their peers. And crucially, they set the 'targets' for their own program.

The scale and pace of the uptake of the Productive series, and of the measured improvements in 'Delivering Through Improvement', make us confirmed advocates of a pull approach. Gratifyingly, and after observing these programs, the Department of Health itself is rethinking its own approach to change. The Department will design an approach based on clinical engagement; alignment; subsidiarity (decision-making taken as locally as possible); and co-production (interventions designed hand-in-glove with frontline practitioners). [16]

One challenge we face in building will is the fact that these complex interventions don't lend themselves to the forms of evaluation most valued by clinicians. But improvements in the evaluation methods that are applied to programs like these also need to be combined with efforts to broaden understanding about the role of more generative methods of evaluation. [17]

Ideas

The ideas behind these programs are not novel in themselves, but the use of these tools has allowed frontline staff to apply their own ideas to the improvement of their work. This is part of a broader NHS objective to empower staff to take control of their work and use their creativity to improve services. Many of the most successful ideas are very simple, sometimes eliciting an understandable suspicion that their impact can be so significant, or encouraging others to ask why these things were not already routine. Working with design experts, we have learned to use skills and techniques that, while simple, are new to many participants. These include the value of observation, particularly when people have been introduced to different ways of observing. Reviewing a common process by watching it on video, rather than being part of it, often results in a very vocal realisation of the ways it can be improved. Prototyping, developing simple home-made models and doing small-scale testing through the Model for Improvement's Plan,

Do, Study, Act (PDSA) cycles, can create change at pace. A culture of measurement is also central; it is still a surprise that a sector which relies on measurement and observation for direct care is commonly unused to using these tools in service design and improvement.

Execution

Nothing will happen without some disciplined elements of execution. The modules in the Productive series, and many of the tools developed to support 'Delivering Through Improvement', were essentially ways of introducing execution discipline without relying on a burdensome or overly-bureaucratic project management system. Almost all of the projects in this program were led by clinical leaders who had not learned formal project management and were highly-suspicious of any use of managerial jargon. But they were, when the will had been established, extremely quick to adopt and adapt the modules. They were also extremely willing to share their experiences within and beyond their organisation.

A frequently-voiced concern about the recent direction of NHS reform has been that, in a more competitive environment, teams and organisations will not share their good practice. Many of the organisations involved in these programs are Foundation Trusts,⁴ yet there has been no hesitation in working together. On the contrary, leading clinicians have willingly visited hospitals where clinicians had reservations over a new practice, helping local managers implement change.

Conclusion

Improving the quality and, thus, the value of healthcare is more relevant than ever and there are a range of approaches that support a service such as the NHS in England with this agenda. A balanced program, using both external motivators and more intrinsic levers can prove acceptable to healthcare workers and can produce profound and rapid change. In particular, where professional channels can be used to introduce practitioners to well-framed and culturally-acceptable programs, transformation can result.

Competing interests

The author declares that he has no competing interests.

References

1. Wanless D. Securing our future health: taking a long-term view. London: HM Treasury; 2002.
2. Audit Commission. Review of the NHS financial year 2006/07. London: Audit Commission; 2007.
3. Wanless D, Appleby J, Harrison A, Patel D. Our future health secured? A review of NHS funding and performance. London: King's Fund; 2007.
4. BBC. NHS top-up care ban under review. BBC News. 2008. Available: <http://www.news.bbc.co.uk/1/hi/health/7459461.stm> (Accessed 26/01/09)
5. Premier Inc. Centers for Medicare & Medicaid Services (CMS)/ Premier Hospital Quality Incentive Demonstration (HQID) project: Findings from year two. Premier Inc. 2006. Available: <http://www.premierinc.com/quality-safety/tools-services/p4p/hqi/resources/hqi-whitepaper-year2.pdf> (Accessed 26/01/09)
6. NHS Benchmarking Network. Benchmarking: finding and implementing best practice. NHS Benchmarking Network. 2007. Available: <http://www.nhsbenchmarking.nhs.uk/benchmarking.asp> (Accessed 26/01/09)
7. NHS Institute for Innovation and Improvement (NHSI). Focus on: high volume care. Series 1 and 2. NHSI. 2007. Available: http://www.institute.nhs.uk/quality_and_value/high_volume_care/focus_on%3a_high_volume_care.html (Accessed 26/01/09)
8. Darzi A. High quality care for all: NHS next stage review. London: Department of Health; 2008.
9. Womack JP, Jones DT, Roos D. The machine that changed the world: the story of Lean production. New York: Free Press; 2007.
10. Fillingham D. Lean healthcare: improving the patient's experience. Chichester: Kingsham Press; 2008.
11. Langley GJ, Nolan KM, Nolan TW, Norman CL, Provost LP. The improvement guide: a practical approach to enhancing organizational improvement. San Francisco: Jossey-Bass; 1996.
12. The NHS Institute for Innovation and Improvement (NHSI). Releasing time to care: the productive ward. NHSI. 2008. Available: http://www.institute.nhs.uk/quality_and_value/productivity_series/productive_ward.html (Accessed 26/01/09)
13. Nolan TW. Execution of strategic improvement initiatives to produce system-level results. IHI Innovation Series white paper. Cambridge, MA: Institute for Healthcare Improvement; 2007. Available: www.IHI.org (Accessed 26/01/09)
14. Bate P, Bevan H, Bibby J, Carter E, Robert, G. The power of one, the power of many. NHS Institute for Innovation and Improvement. 2009. (Forthcoming)
15. Department of Health (DH). The NHS in England: The operating framework for 2008/9. London: DH; 2007.
16. Crump B. Should we use large scale healthcare interventions without clear evidence that benefits outweigh costs and harms? Yes. Br Med J. 2008;336:1276.

4 NHS Foundation Trusts are NHS organisations that have gained a new status as independent, not-for-profit, public benefit corporations, and are accountable to their local communities rather than Central Government.

Developing a Collaborative Approach to Health Management Research

G Day and L Fulop

Abstract

Purpose: This article explores approaches to health management research in Australia. This paper points to a collaborative approach that brings researchers, industry and professional bodies together around common research interests rather than fixed institutions. In contrast to organisation-based research institutes or collectives, this article suggests an alternative model of collaboration based on a distributed leadership framework. While understanding the value of institution-based research collectives, this paper points to a model that can operate along side organisation-based research structures.

Originality/Value: This paper reframes the current thinking on how health management research is organised and undertaken, particularly in organisations where there is not a critical mass of researchers in a given specialisation.

Abbreviations: HMRA – Health Management Research Alliance; OECD – Organisation for Economic Co-Operation and Development; SHAPE – Society for Health Administration Programs in Education.

Key words: health management, research, distributed leadership

Dr Gary Day DHSM, MHM, BNurs, DipAppSc (Nursing Mgt), RN, EM, FCHSE, CHE
School of Public Health
Co-leader Health Management Research Alliance
Griffith University, Logan campus, Queensland, Australia.

Professor Liz Fulop BA (Hons), PhD
Department of Management
Co-leader Health Management Research Alliance
Griffith Business School
Griffith University, Gold Coast campus, Queensland, Australia.

Correspondence:
g.day@griffith.edu.au

Introduction

Establishing a critical mass of researchers around common themes has largely been the domain of university-based research centres or institutes. These models have supported researchers from the host organisation developing medium and large research teams and subsequently attracting large grants and the associated kudos and prestige. But what happens when your area of specialisation is small, the research projects are more aimed at applied research and

consultancies and other researchers with similar interests are scattered across Australia or located internationally? These traditional approaches to organisation-based research teams have reduced cross-institutional networking and research collaboration opportunities. In these cases, researchers have not been able to develop a critical mass of expertise in one organisation and have often had to work alone on small projects. This can lead to frustration and pockets of similar research being done across the country, when bringing like-minded academics together may produce richer, co-ordinated research outcomes. Health service management research in Australia has often had these problems.

An alternative model may be considered in terms of a collaborative cross-institutional approach that brings researchers together on a project basis rather than on an organisational basis. A potential solution to these issues was the development of a Health Management Research Alliance (HMRA) that brings together health management researchers from a range of universities and outside agencies across Australia and New Zealand. Finding a suitable framework to underpin the HMRA is considered important to its success.

The framework had to be one that encompassed the qualities of sharing, collaboration, dispersion, being distributed and democratic. [1] The framework that best suited this fluid, multi-site, project-based alliance was one of a distributed leadership model.

Bolden [2] describes distributed leadership as 'a less formalised model of leadership (where leadership responsibility is dissociated from the organisational hierarchy) ... individuals at all levels in the organisation and in all roles (not simply those with an overt management dimension) can exert leadership influence over their colleagues and thus influence the overall direction of the organisation.' The benefit of using this approach for the HMRA is that distributed leadership models emphasise 'not in the individual agency of one, but the collaborative efforts of many.' [3] The HMRA is utilising a set of principles that implies a social distribution of leadership where the leadership function is stretched over the work of a number of individuals and where the leadership task is accomplished through the interaction of multiple leaders. [4] The literature supports this approach by suggesting that a distributed leadership model promotes multiple groups of individuals; social distribution of the leadership function, and interdependency and shared responsibility. [5] The concept of distributed leadership has merit in the development of collaborative research groups because of the complex social and situational contexts that undertaking research projects often encounter. Distributed leadership promotes inquiry-oriented practice through collegial relationships [5] and dynamic interdependence between individuals and groups. [6]

Over the last two decades, the Society for Health Administration Programs in Education (SHAPE) has established a clear role in bringing together Australian and New Zealand health management academics around the pedagogy of health management, systems and education. Up until this time, SHAPE has struggled to find a unifying approach to engage these same academics in collaborative research. The challenge SHAPE faced in developing a useful research framework was twofold. Firstly, the model must allow members to be part of organisation-based research groups as well as a SHAPE-promoted research collective. Secondly, the group has to add to and not detract from groups currently engaged in health services management research.

In 2008, SHAPE endorsed a framework that encourages health management research between member organisations across Australia and New Zealand. This inclusive

framework was driven by the vision to engage in research that improves health management and health systems practice and pedagogy through collaborative, multi-disciplinary, multi-sectoral, multi-organisational research.

Direction and Purpose

It could be argued that there are currently a number of research centres in Australia that have an emphasis on health management or health system research. While this is the case, the HMRA has been developed to provide a mechanism by which researchers can still participate in research at an organisational level while at the same time increase collaboration with others outside of the usual university research bodies, especially on projects that have national or international significance. In this way the HMRA breaks down institutional boundaries by promoting cross-institutional research collaboration and creates a critical mass of researchers around recognised priority areas. While hosted by one organisation on a biennial rotational basis, projects will be led across Australia depending on where the expertise is generated. In essence, there will be multiple leaders on multiple sites across Australia working under the HMRA 'banner'. In this way, no one organisation or group can lay claim to the HMRA. This approach should provide the necessary impetus to increase the amount of research funds directed to health management and health systems research in Australia and New Zealand.

The distributed model of leadership and engagement has been used to encourage a flexible and dynamic approach to research and will be central to building research partnerships with a range of external health service practitioners and agencies. Additionally, the HMRA will provide an overarching 'brand' to promote health management and health systems research in Australia and New Zealand.

Aims and Goals

The key aim of the HMRA is to enhance the reputation and influence of health management and health system researchers through a collaborative model of research engagement. This key aim will be accomplished by:

- Developing research projects that are informed by the needs of health sector stakeholders and end-users;
- Identifying and widely disseminating research findings of members of the HMRA on health management and health systems improvements;
- Building strong and sustainable cross-institutional partnerships;

- Attracting diverse research funding through the HMRA; and
- Growing a strong cohort of Research Higher Degree (RHD) students researching in the areas of health management and health systems improvements.

Priority Areas

Following discussions amongst the fifteen member organisations of SHAPE, the HMRA has set itself four initial research priority areas over the next two years. These areas include:

(1) Safety, risk and voice in health organisations

This area of research encapsulates issues covered by the generic term 'relational governance' and focuses on how health organisations deal with dissent, whistle-blowing, adverse event reporting, voicing strategies and other processes that lead to changes in the culture of these organisations and systems and how risks can be better managed to ensure in the safety and well-being of all involved in such organisations. Additionally, this priority area will examine inter-professional relations, professional identity, role identity, organisational culture and climate and sub-culture formations.

(2) Health leadership

This area of research will focus on leadership development in relation to processes that encourage health services (eg, hospitals, clinical units and community-based services) to adapt to their changing environments in innovative and creative ways so that they can lift their performance and deliver better health outcomes. This priority area encompasses research from the leadership development of the individual health manager to the development of departments or groups in leading change in clinical practice and improved client outcomes. Research in this area will also explore the leadership of integrated health service provision in the community setting.

(3) Skills retention and replacement

This priority area will explore workforce issues that underlie the major factors in the provision of quality health services that are safe, affordable and accessible to the general public. Both areas reflect a major concern across the broader health sector, especially in terms of the ageing population, an ageing workforce and access in remote areas. Both areas are also a priority for State and Federal Governments as well as governments in other Organisation for Economic Co-operation and Development (OECD) countries. There are many levels at which the issues of skills retention and replacement can be researched.

Skills retention has three key areas of interest for the HMRA:

- The first stream of research will focus on high performance human resource management practices and their effect on skill retention in health services;
- A second one focuses on issues of well-being in areas relating to nurse retention;
- A third will look at safety issues in the workplace as a retention issue.

Skills replacement has two key areas of interest in the HMRA:

- Irrespective of labour retention strategies, the projected short-fall in professional health workers in Australia has also shifted attention to skills replacement through various 'Skill Escalator' programs and other forms of lean thinking practices within health services. However, another major way to address skill replacement is to shift demand for services into non-institutional contexts and to lower cost delivery systems. The need to shift care from an institutional context to the home and community care sector is a critical part of addressing both skills retention and replacement;
- The shift to community and de-institutionalised healthcare has created opportunities for the virtual organisation of healthcare in remote areas. This research would focus on the tele-health environment and novel ways to deliver health services to practitioners and patients in the low cost home and community care settings.

(4) Collaboratives and clinical networks

The final research priority areas reflects a major shift in health management through the creation of collaboratives and clinical networks and these have emerged as either organic, mandated or hybrid structures. A major issue in the future management of these networks will be to establish what constitutes collaborative efficacy at both the collaborative and network levels.

The HMRA aims to provide a much-needed framework for health management researchers to work more collaboratively around important research areas in a network that shares the leadership and the successes across a wider base. Due to the important role SHAPE plays in networking, sharing and advancing the pedagogy of health management, the HMRA provides a natural conduit for research findings to feed back into and inform teaching across Australia and New Zealand.

If you would like more information about the HMRA or would like to be involved in one of the priority areas outlined in this paper, please contact the authors.

Competing interests

The authors declare that they have no competing interests.

References

1. Odura GKT. Distributed leadership in schools: what English headteachers say about 'pull' and 'push' factors. British Educational Research Association Annual Conference. 2004 September 16-18; University of Manchester.
2. Bolden R. What is leadership? Leadership South West Research Report 2004: p.12. Available: www.leadershipsouthwest.com
3. Johnson SM. The misguided search for heroic leadership: a brief article. School Administrator [serial on the Internet]. 1997; (February): 2. Available: http://findarticles.com/p/articles/mi_m0JSD/is_2_54/ai_77382130.
4. Spillane J. Distributed leadership. San Francisco: Jossey-Bass; 2006.
5. Harris A. Teacher leadership as distributed leadership: heresy, fantasy or possibility? School Leadership and Management. 2003;23(3):245- 63.
6. Greenfield T. Theory about organisation: new perspective and its implications for schools. In: Greenfield T, Ribbins, P, editors. Greenfield on education administration: towards a human science: Routledge; 1993.

**BUILDING OUR HEALTHCARE SYSTEM
AROUND PEOPLE AND THEIR NEEDS**

ACHSE
NATIONAL CONGRESS 4-7 AUGUST 2009

In partnership with
CENTRE FOR HEALTH ASSETS AUSTRALASIA
Faculty of the Built Environment, UNSW

chaa

Don't miss out . . .

... visit the ACHSE website
**www.achse.org.au for sponsorship,
exhibition and general information**

*Discounted Rates
Still Available
Register NOW on-line*

Small images at the bottom: a beach, a roller coaster, a lighthouse on a cliff, a night scene with a sign, and a forest with a tree.

Knowledge Management in Healthcare Settings

B E Perrott and R Iedema

Abstract

Strong forces of competition and globalisation have created awareness and an urgency to focus on how an organisation controls and nurtures its intellectual capital. The knowledge concept and its management have gained currency and momentum as technology has enabled thoughts and ideas to be more easily generated and distributed. The knowledge management debate has relevance for all stakeholders involved in healthcare. As a contribution to this debate, this paper describes various knowledge domains at the different levels of healthcare organisations. The paper uses Polanyi's knowledge framework to identify issues that need to be considered to ensure knowledge can be progressively applied to the continuous improvement of health services whilst safeguarding the rights of individuals.

Knowledge management has received the attention of academics and managers over the years with varying

degrees of intensity and enthusiasm. This paper will first provide a brief background on the subject. This background will provide a basis on which to examine knowledge management from a health perspective. A framework suggesting knowledge domains will be introduced to enable discussion on the issues that healthcare managers face in gaining a better understanding of the dynamics of knowledge flows in the health environment. The purpose of the paper is to provide a conceptual basis that will stimulate future research and discussion on how knowledge is managed in a healthcare setting.

Keywords: knowledge exchange; knowledge management; tacit and explicit knowledge; intellectual assets; healthcare knowledge.

Dr Bruce E Perrott BCom, MBA, PhD
Senior Lecturer
School of Marketing, University of Technology Sydney,
New South Wales, Australia

Professor Rick Iedema BA, MA, PhD
Professor of Communication and Associate Dean (Research)
Faculty of Humanities and Social Sciences
University of Technology Sydney,
New South Wales, Australia

Correspondence:
bruce.perrott@uts.edu.au

The knowledge management evolution

In the 1990s senior managers discussed knowledge management as they began to realise that the foundations of modern economies had shifted from natural resources to intellectual assets. Networked computers provided the capability to address how knowledge may be codified, stored and shared, practically and economically. [1] One

estimate from this period suggested that three-quarters of the Fortune 100's total market capitalisation was represented by intangible assets such as patents, copyrights and trademarks. These intangibles make up the intellectual knowledge of organisations. Hence the responsibility of managing these important company assets must be the priority concern of senior managers as well as the corporate legal staff. [2]

A renewed interest in knowledge management is seen to be a logical extension to three basic business trends: [3]

- a) An increasing amount of digitised information data that is available all the time;
- b) Globalisation of business such that production can occur anywhere in the world as it is knowledge that is the true source of competitive advantage; and
- c) Growing complexity of business requires new business processes that will deliver 'the right information at the right time' so as to ensure accountability and reduce the risk of mistakes.

Some academics have suggested that between 1995 and 2005 new concepts in knowledge management were emerging, including knowledge economy, knowledge alliance, knowledge culture, knowledge organisation, knowledge infrastructure and knowledge equity. [4]

When exploring the subject of knowledge in an organisational context, it is useful to make a distinction between various gradations of terminology discussed in the literature. Data are often described as the base platform in the knowledge hierarchy and are defined as facts and statistics either historical or derived from experimentation or calculation. [5] Information is the next step in terms of value and has been considered as, 'systematically organised data'. [6] Knowledge has been seen as 'actionable information' thus more effectively assisting in the decision-making processes within the organisation. Wisdom is often seen as the highest dimension on the knowledge tree where it is possible to act appropriately in a given situation with a strong element of ethical judgement. [7]

What is knowledge management?

A new focus of interest emerged in post-industrial times known as the 'knowledge economy'. [8] The management of knowledge has gained interest from both academics and practitioners with the realisation that knowledge holds the key to organisational growth and development. Research and publications have emerged from different disciplines reflecting the wide impact of this interest area on numerous functions and at different levels of the business. Some have conveniently attempted to organise contributions into those that have an information based approach, while others have looked more at the human side of knowledge creation, sharing and management.

It has been suggested that knowledge management as a field of study will gain considerable momentum through dialogue and debate with multiple disciplines. Some say that this field of study will yield rich rewards as it moves into a new paradigm of work. [7]

The literature contains many definitions of knowledge management. A few are listed here in order to observe differences in perceptions of scope and emphasis:

'... any processes or practice of creating, acquiring, capturing, sharing and using knowledge, wherever it resides, to enhance learning and performance in organisations.' [9]

'... all methods, instruments and tools that in a holistic approach contribute to the promotion of core knowledge processes.' [10]

'Knowledge management is the identification, storage, protection of knowledge for future operational and strategic benefit of the organisation - this may be implicit or explicit.' [11]

The latter definition is used to guide this discussion as it contains a number of elements considered essential in helping the reader to conceptualise the scope and dimensions of knowledge management in organisations. [12] Firstly, it distinguishes between operational and strategic knowledge. Strategic knowledge is knowledge which is essential to major decisions an organisation must make to capitalise on priority opportunities and successfully overcome major threats. Operational knowledge is concerned with the day-to-day running of the business. Secondly, it recognises that knowledge contained in an organisation may be implicit (that is remaining in the domain of the individual), or explicit (knowledge that is available for use throughout the organisation). The third benefit of this definition is that it recognises knowledge management as process rather than an occasional or ad hoc event.

Healthcare organisations are seen to be information-rich and have an implicit capacity to create or access knowledge necessary for the successful delivery of their services. However, they have been slow to embrace the concepts of knowledge management or demonstrate visible knowledge assets. More recently others recommend that a sound knowledge management infrastructure is a critical consideration as the health industry attempts to come to terms with current challenges. [13] Healthcare stakeholders face increasing risk to assets and operations as there are mounting pressures in areas such as cost reduction, quality improvement, customer service, disease management and professional liability. Hence the realisation that there is a need for a focused attempt to effectively manage knowledge in healthcare organisations.

Knowledge dimensions

There is considerable debate in the literature about the various types and dimensions of knowledge. Here the distinction between tacit and explicit knowledge receives considerable attention. Tacit knowledge is that held in the minds of individuals while explicit knowledge is that externalised and shared with others. The discussion on when and how knowledge should be shared is a critical one in contemporary healthcare organisations. Individuals may have an opinion of what knowledge should be kept to safeguard personal worth and differentiation. This may not always align with managers' opinions on the type of

knowledge that needs to be shared for the broader benefit of the organisation and its stakeholders.

Hence a framework will be introduced that helps to explain the various dimensions and flow paths of tacit and explicit knowledge. One such framework suggests that there are four modes of interaction between these two forms of knowledge: [14]

- From tacit knowledge to tacit knowledge: the process of 'socialisation' through shared experience and interaction;
- From explicit knowledge to explicit knowledge: the process of 'combination' through reconfiguring existing knowledge such as sorting, adding, recategorising and reconceptualising explicit knowledge can lead to new knowledge;
- From tacit knowledge to explicit knowledge: the process of 'externalisation' using metaphors and figurative language'; and
- From explicit knowledge to tacit knowledge: the process of internalisation through the learning process.

Other authors [15] describe the knowledge management process as necessarily loose and collaborative because the human qualities of knowledge such as experience, intuition and beliefs are not only the most valuable, but also the most difficult to manage and maximise. Hence the knowledge management process integrates theories from at least four distinct fields; theories about organisational culture, organisational structures, organisational behaviour and knowledge-based systems leading to theories about knowledge support infrastructures. [4]

Other research emphasises the importance of context in the knowledge conversion process [16] suggesting that knowledge should be seen as a cultural process situated in and inextricably linked to the material and social circumstances in which it is produced and consumed. [17] A balanced environment of power, control and trust is seen as an essential condition for a successful, knowledge-oriented culture. Allee [18] suggests that if people do not trust each other, they do not exchange knowledge and ideas. Here trust helps build and sustain valuable networks and rewarding relationships while a lack of trust erodes knowledge leadership, creation and transfer.

The knowledge management process is seen to begin with the formulation and implementation of strategies for the construction, embodiment, distribution and use of

organisational knowledge. Other strategies include those for the basic management functions to monitor and measure the knowledge assets and processes. [19]

Organisation context is critical to effective knowledge management. The ideal structure has been described as 'N-form' rather than the traditional 'M-form'. M-form is a hierarchical structure where communication is primarily vertical with top management as the critical layer and the competitive scope is based on economies of scale and diversification. By contrast in the N-form, communication is lateral where middle management is the critical layer and competitive scope focuses on specialisation.

Knowledge management in health

As early as 1997, knowledge management was forecast to become a hot topic in healthcare. [20] However, progress in this area has been slow. By 2001 another author [21] observed that knowledge management was not a well known discipline in the healthcare industry. In the United Kingdom, the National Health Service has embarked on a wide-ranging program of change and reform to address pressing issues on health service delivery with mixed results. Here it has been suggested that knowledge management concepts and practices could positively contribute to more effective reforms in that health system. [22]

More recently another academic has recommended that a sound knowledge management infrastructure is a critical consideration as the health industry attempts to come to terms with the current challenges of escalating costs and the shift to disease management. From the human perspective, it has been noted the exit of knowledge workers is causing a major problem for Canada's healthcare organisations as they have been impacted with corporate memory loss from senior executives. [23] This observation highlights the need for more focused discussion on how healthcare knowledge is collected, managed, stored and disseminated.

Healthcare organisations are seen to be information rich and have an implicit capacity to create and access knowledge necessary for the successful delivery of their services. However, they have been seen to be slow to embrace the concepts of knowledge management or demonstrate visible knowledge assets. To stimulate discussion of the issues surrounding knowledge flows in a healthcare setting, a general schema of knowledge domains is attempted in Figure A.

Figure A: Healthcare knowledge domains

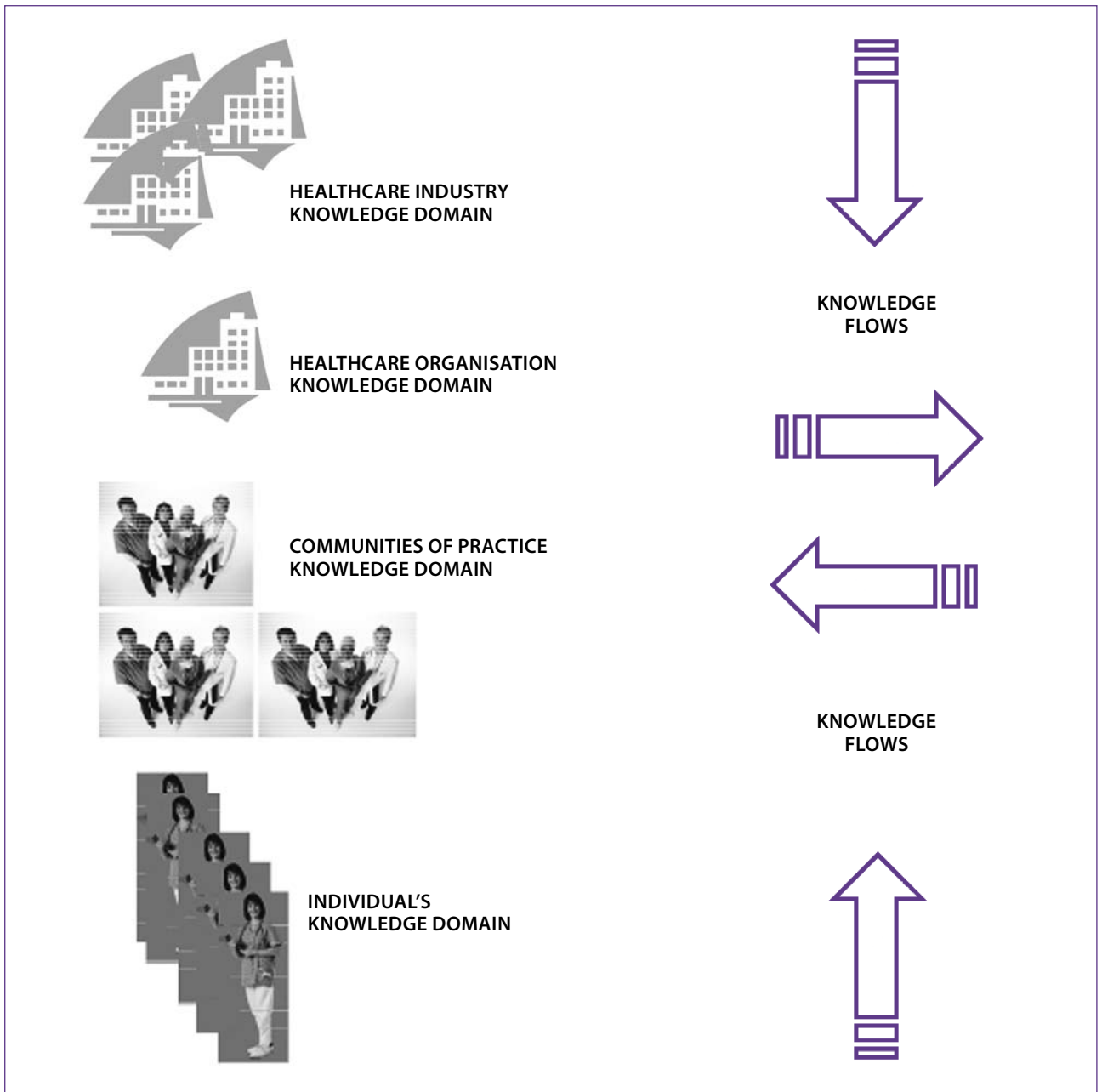


Figure A proposes a hierarchy of knowledge domains with individual healthcare workers fundamentally responsible for the tacit knowledge they hold, build and share. This layer of knowledge is shown as the 'Individual's Knowledge Domain' at the base of Figure A.

The next level of knowledge hierarchy is the 'Communities of Practice Domain'. Communities of practice are groups of individuals working together in a common cause and with a particular charter within the healthcare organisation. Emergency, spinal care, oncology, psychiatry and obstetrics are possible examples of community domains. There is

synergy in knowledge sharing here as individuals contribute knowledge so that the objectives of a particular community can be achieved.

Collectively, communities of practice make up the healthcare organisation which will be responsible to stakeholders for achieving agreed objectives. This is shown in Figure A as the 'Healthcare Organisation Knowledge Domain'. Effective tacit and explicit knowledge flows will be critical if the organisation is to be judged as being successful in maintaining its charter.

Taken collectively, organisations will make up an industry. This is shown as the 'Healthcare Industry Domain' in Figure A. The degree of cooperation in knowledge transfer at the industry level will vary greatly. For example an industry association may have the support of its members to share specific knowledge across the industry as well as groups external to the industry such as the press, suppliers, government units and other specified organisations.

Two case study investigations of healthcare providing organisations are summarised here to demonstrate the possible wide variation in knowledge perspectives within healthcare settings. Two cases were researched, one in Canada, the other in Australia. [24] Both cases were seen to have similar macro operating environmental challenges in health service delivery. However, the Australian palliative care organisation operated in a care environment and hence knowledge was flexibly and implicitly managed through people. By contrast, the Canadian spinal case operated in a cure environment, which was heavily reliant on technology using explicit and clearly communicated directions for knowledge processing procedures.

These two cases demonstrate widely differing knowledge management strategies according to the demands of the different healthcare operations and type of risks that need to be managed. Authors Wickramasinghe and Davidson [24] propose the use of a knowledge management infrastructure made up of a number of components, namely; organisational memory, human resource infrastructure, knowledge transfer network, business intelligence infrastructure and infrastructure for collaboration. The authors point out the usefulness of this infrastructure model in making decisions about resourcing, possible difficulties and risks to be incurred, and timelines necessary in evolving explicit knowledge management capability in healthcare organisations.

Future strategies for healthcare knowledge

Polanyi's four modes of knowledge interaction cited above [14] provide a useful basis for a summary discussion of some of the knowledge issues to be resolved in healthcare organisations. Figure B shows, diagrammatically, issues to be considered in planning knowledge management strategies for healthcare settings. This framework is intended to stimulate discussion on the subjects of research, possible strategies and future directions of knowledge management in healthcare organisations.

A healthcare enterprise memory has been proposed which has the functionality to acquire, share and operationalise the various modalities of healthcare knowledge. [25]

This proposal includes an architectural specification which would enable more effective use and leverage of knowledge to improve healthcare delivery. Figure B provides a basis for further discussion on such an interim specification.

From tacit knowledge to tacit knowledge: This is the process of sharing an individual's healthcare knowledge with others. For an individual there may be conflict regarding which knowledge to share and which should be retained for personal use and differentiation. Management in healthcare organisations needs to decide which policy on strategies it should use to encourage the sharing of important healthcare knowledge among individuals.

Knowledge sharing between healthcare workers:

Location 1 in Figure B

Issues to be considered:

- What knowledge is currently shared?
- What knowledge should be shared in the future?
- What are the desirable strategies to encourage knowledge sharing?

From explicit knowledge to explicit knowledge:

This is the process of looking to add value to stores of knowledge existing in various parts of an organisation. Synergies can be found by filtering, sorting and analysing existing explicit healthcare knowledge which can lead to the creation of new knowledge to then be used to the advantage of key stakeholders. Healthcare organisations are heavily focused on dealing in the day-to-day knowledge dimension. Planning for synergies under this knowledge domain would require a special focus and resource dedication over and above everyday operational knowledge demands.

Building healthcare knowledge value:

Location 2 in Figure B

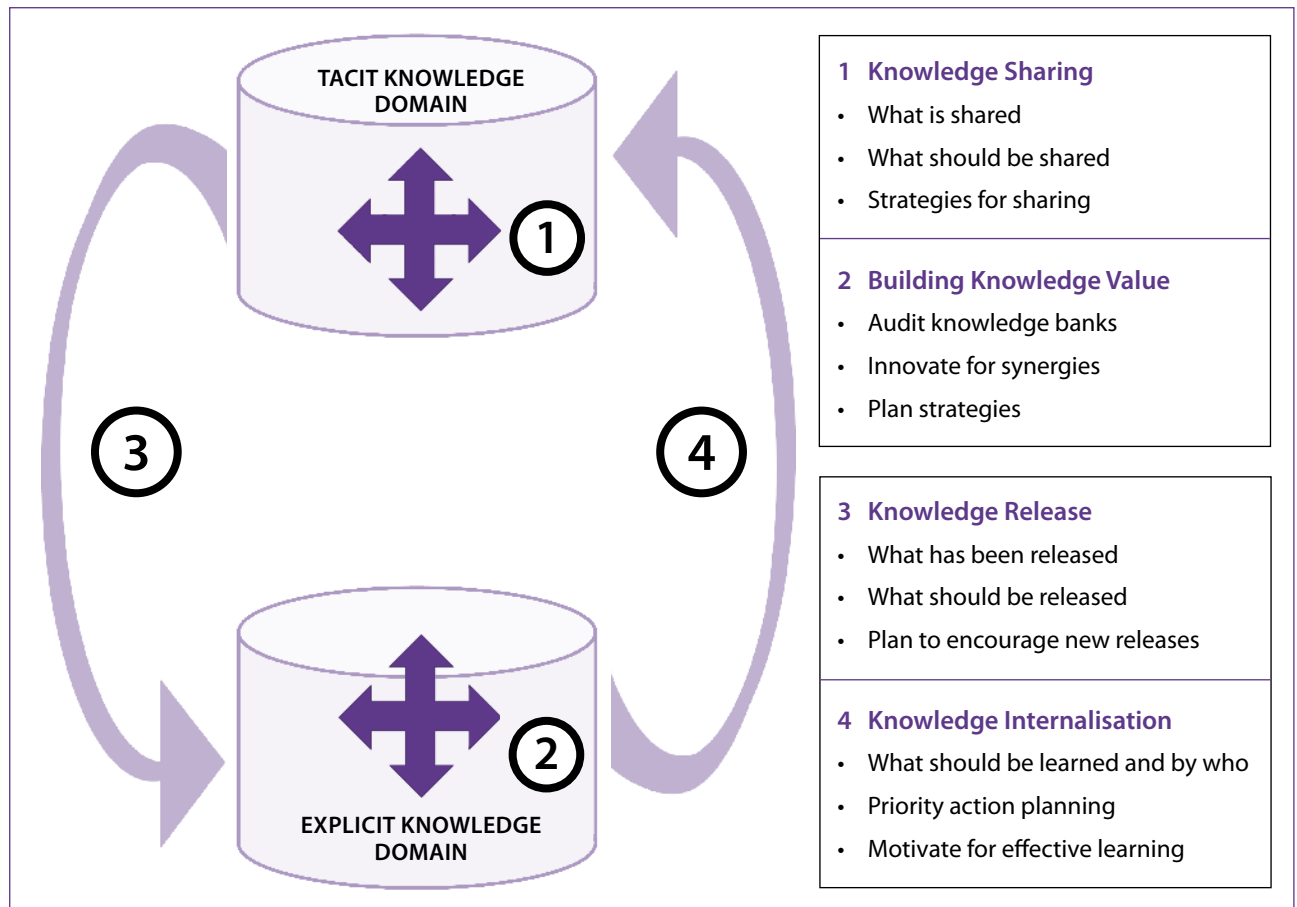
Issues to be considered:

- Understand and audit existing organisational knowledge banks;
- Look to where value can be added – innovate for synergies; and
- Plan and action knowledge value adding projects.

From tacit knowledge to explicit knowledge:

This is the process of releasing personal knowledge for use in other parts of a healthcare organisation. From the organisation's perspective, there are decisions to be made regarding personal knowledge that is needed for use beyond individual concerns and priorities. An organisation will consider knowledge from a broader perspective for strategic and operational advantage. This domain can be the most controversial in terms of which knowledge should remain in personal possession, and which should be made available for organisational use.

Figure B: Knowledge issues in healthcare settings



Knowledge release to healthcare workers:

Location 3 in Figure B

Issues to be considered:

- What knowledge has been released?
- What knowledge should be released in the future?
- What are the desirable strategies to encourage knowledge release in the future?

From explicit knowledge to tacit knowledge:

This is the process of knowledge internalisation through the learning process. One important dimension to this domain is that the process of internalisation gives way to the generation of new tacit knowledge created using the characteristics of each individual healthcare worker with their unique backgrounds, experience and healthcare insights. The question for the healthcare organisation is how this new and regenerated knowledge should be harvested and made available for broader use.

Healthcare knowledge internalisation:

Location 4 in Figure B

Issues to be considered:

- What knowledge should be learned and by who?
- Develop strategies for learning to individuals and communities of practice?
- Motivate healthcare knowledge workers for effective learning?

Conclusion

The effective management of intellectual assets in the form of knowledge will be an important aspect of building the capability to deliver continuous improvements in health service delivery. For this to be achieved, healthcare managers need to better understand where critical knowledge is generated, stored and circulated through the various organisational levels.

Effective proactive knowledge management will involve a sensitivity to the rights of individuals who are the owners of tacit knowledge and the organisation's need to create and share explicit knowledge, for the benefit of the organisation and other stakeholders.

Perhaps the time has come for organisations to include knowledge management in their strategic thinking and planning. This seems reasonable considering the role and importance of intangible assets on the balance sheets of healthcare organisations. The challenge for senior management is to decide how and when the knowledge that generally resides in the heads of healthcare workers in tacit form, should be made explicit using an effective mix of technologies and management strategies such as leadership and rewards.

Competing interests

The authors declare that they have no competing interests.

References

- Hansen MT, Nohria N, Tierney T. What's your strategy for managing knowledge? *Harv Bus Rev.* 1999; March-April:106-116.
- Reitzig M. Strategic management of intellectual property. *Sloan Manage Rev.* 2004;45 (3):25-40.
- Guptill J. Knowledge management in healthcare. *J Health Care Finance.* 2005;31(3):10-15.
- Baskerville R, Dulipovici A. The theoretical foundations of knowledge management. *Knowledge Management Research and Practice.* 2006;4:83-105.
- Gedes, Grosset. *English Dictionary.* New Lanark: David Dale House; 1999.
- Meadows J. *Understanding information.* Munchen: K G Saur; 2001.
- Jashapara A. *Knowledge management: an integrated approach.* Harlow: Pearson Education; 2004.
- Drucker P. The new society of organizations. *Harv Bus Rev.* 1992; September-October:95-105.
- Swan J, Scarborough H, Preston J. Knowledge management - the next fad to forget people? *Proceedings of the 7th European Conference on Information Systems.* 1999; Copenhagen.
- Mertins K, Heisig P, Vorbeck J. *Knowledge management: best practices in Europe.* New York: Springer-Verlag; 2000.
- Perrott B E. Knowledge management in health: an evolution? *Proceedings of the Knowledge Management: the Key to Innovative Health Programs Conference;* 2002 March 8-9; Sydney.
- Perrott B E. A strategic risk approach to knowledge management. *Bus Horiz.* 2007; 50 (6):523-533
- Desouza K C. Knowledge management in hospitals: a process oriented and staged look at managerial issues. *International Journal of Healthcare Technology and Management.* 2002; 4(6): 478-497.
- Polanyi M. *The tacit dimension.* New York: Doubleday; 1967.
- Davenport TH, Prusack L. *Working knowledge: how organisations manage what they know.* Boston: Harvard Business School Press; 1998.
- Ancori B, Bureth A, Cohendet P. The economics of knowledge: the debate about codification and tacit knowledge. *Ind Corp Change.* 2000; 9(2): 255-287.
- Hassard J, Kelemen M. Production and consumption in organisational knowledge: the case of the 'paradigms debate'. *Organisation.* 2002; 9(2):331-355.
- Allee V. Evolving business forms for the knowledge economy. In Holsapple CW, editor. *Handbook on knowledge management Vol 2.* Berlin: Knowledge Directions; 2003. p. 605-622.
- Quintas P, Lefrere P, Jones G. Knowledge management: a strategic agenda. *Long Range Plann.* 1997;30(3):385-391.
- Johnson D E L. Making knowledge management a priority. *Health Care Strateg Manage.* 1997;15(4): 2-4.
- Malone S M. Knowledge management: white knight or white elephant? *Top Health Inf Manag.* 2001; 21(3):33-44.
- Bate S P, Robert G. Knowledge management and communities of practice in the private sector: lessons for modernizing the National Health Service in England and Wales. *Public Administration.* 2002;80(4): 643-663.
- Lahaie D. The impact of corporate memory loss: what happens when a senior executive leaves? *Int J Health Care Qual Assur.* 2005;18(4/5):35-48.
- Wickramasinghe N, Davison G. Making explicit the implicit knowledge assets in healthcare: the case of multidisciplinary teams in care and cure environments. *Health Care Manag Sci.* 2004;7:185-195.
- Abidi S. Knowledge management in healthcare: towards 'knowledge-driven' decision support services. *Int J Med Infor.* 63;1-2:5-18.

Invitation to submit an article or write to the Editor

The *Asia Pacific Journal of Health Management* invites researchers, policy makers and managers to submit original articles that increase understanding of issues confronting health leaders in countries throughout the region and strategies being used to address these issues. Articles from the private sector will be welcomed along with those addressing public sector issues.

Readers of the Journal are also invited to express their views by writing a letter to the Editor about possible themes for future issues or about articles that have appeared in the Journal.

ACHSE is now calling for papers for the eighth issue of the Journal. The deadline for receipt of papers is 3 August 2009.

Exploring Administrative Staff Views on Planning for Hospital Relocation: the experience of the Mercy Hospital for Women

K O'Sullivan and S G Leggat

Abstract

After 30 years at the same inner-city site in Melbourne Australia, the Mercy Hospital for Women (MHW), relocated to Heidelberg, a suburb north-east of the city, Australia. Prior to the move the Hospital established a formal system of capturing, evaluating and learning from the relocation experience that MHW was about to undergo. As part of this initiative a study was conducted in order to learn more about the impact of relocation on the administrative staff.

A questionnaire was distributed to 115 administrative staff and the 47% response rate enabled some conclusions to be drawn about the involvement of administrative staff in the planning for relocation and the subsequent impact on their enthusiasm for their work at the Hospital. The results confirmed that organisational change processes in healthcare organisations that do not consider and appropriately

involve administrative staff are at risk of loss of motivation of these staff. Those administrative staff that did not perceive that their opinion and involvement in the planning for relocation were valued, were significantly less positive about their preparation for the move to the new hospital and reported less motivation and enjoyment of their work. While this finding is consistent with previous general research into the positive aspects of work place participation, this is the first study to explore this participation among hospital administrative staff in association with a major change initiative.

Abbreviations: HR – Human Resource; MHW – Mercy Hospital for Women.

Key Words: organisational change; hospital administration; human resource management.

Katrina O'Sullivan BBus (Admin Mgt), PGDip (HSM)
Personal Assistant to Chief Financial Officer
St Vincent's Hospital, Victoria, Australia

Sandra G Leggat BHSc (Physical Therapy), MHSc, MBA, PhD,
FCHSE, CHE
Professor, Health Services Management
School of Public Health
La Trobe University, Victoria, Australia

Correspondence:
s.leggat@latrobe.edu.au

Introduction

In May 2005 the Mercy Hospital for Women (MHW), which had been located for over 30 years on the edge of the Central Business District at East Melbourne, Australia, relocated to Heidelberg, a north-eastern suburb in the same city. The relocation was endorsed in the *Metropolitan Healthcare Services Plan* in 1996 after being proposed 15 years earlier. [1] Prior to the move the Hospital developed a formal system of capturing information to be able to evaluate and learn from the relocation experience. While clinical and management staff are typically involved in planning hospital relocations, there has been less emphasis on the involvement of administrative staff. This study explored the contribution of the administrative staff to the success of the relocation.

Although governed by the Board of Mercy Health and Aged Care, a company of the Sisters of Mercy, the MHW provides public hospital care. In Victoria the design of a new public hospital is the ultimate decision of the Department of Human Services and hospital management, curtailed by government budgetary restrictions. However it was standard practice throughout the planning stages to involve Hospital staff in discussions and encourage them to provide feedback. At MHW the Relocation Project Team initially set up 14 user groups which met monthly to provide advice and assistance on the building design and facilities. [2] The Project Team also consulted regularly with the medical and nursing clinical directors, who were expected to liaise with their staff throughout the planning and design process. As a result the type, amount and effectiveness of staff input to the development of the new hospital varied by service and department, depending on the approach taken by the individual clinical directors.

In 1999 the MHW engaged Best Practice Australia to conduct an initial climate survey among all employees. This climate survey showed that at the time, the organisation was considered to have a culture of blame. [3] Further climate surveys were held in 2001 and 2004, and by 2004 MHW had moved to a culture of ambition. [4] Significantly, in the two years leading up to the relocation, staff were continually reminded that this was relocation, not a redundancy exercise – there would be jobs for everyone. [2]

MHW aspired to be the Employer-of-First-Choice. This was seen to be dependent on initiatives to:

- Communicate and listen to staff issues;
- Provide excellent working conditions;
- Promote mutual respect;
- Involve staff in suggestions; and
- Develop individual areas of expertise. [5]

Based on the research related to high performance work settings that links employee involvement with a variety of performance outcomes, [6, 7] including service quality, [8] these would be considered to be appropriate aspirations for an organisation. It has been stressed that healthcare organisations need to adopt the high involvement work practices that have been found to be associated with better performance in other industries, [9] and at the time of the relocation MHW espoused this high employee involvement approach. In particular, the evidence is clear that organisational change requires the involvement of those most affected by the change in the processes of planning, implementing, and redesigning change. [9]

However, in comparison with the number of health professionals, there is a relatively small number of administrative staff working within the healthcare system. As a result, these staff may not be provided with opportunities to have a voice and involvement. In particular, consultation on system initiatives and change programs often is focused primarily on healthcare professionals. For example, while administrative and clerical staff accounted for 12% of expenditure on salaries and wages in public acute and psychiatric hospitals in 2000/01, it was noted that there is little written about their participation and influence in future planning in the health system. [10]

The broad objective of this study was to ascertain whether the promise to communicate and listen, to provide excellent working conditions, to provide mutual respect, staff involvement and staff development was upheld among the administrative staff in relation to the move to the new hospital. The study was designed to measure administrative staff perception of their involvement in the planning for the new hospital, and to explore the implications for their future work at MHW.

Method

The study comprised administration of a questionnaire to capture the views of the target staff on their involvement in the relocation. *The Relocation: Exploring Administrative Staff Views* written questionnaire included questions on demographics, satisfaction and opinions about the relocation. The questionnaire comprised yes/no, four point Likert scale (for example, *is your current work environment adequate to enable you to carry out your work role? Rarely – Sometimes – Most of the time – All of the time*) and qualitative open-ended questions.

We defined administrative staff as those staff employed under the Health and Allied Services (Public Sector) Victoria Consolidated Award (1996) and The Health, Community Services and Ambulance – Management and Administrative Staff (Public Sector – Victoria) Award (2003), and at the time of the MHW relocation this comprised around nine percent of the total staff complement. Generally the administrative staff included personal assistants, administrative assistants, ward clerks and clerks from Oncology, Medical Imaging, Medical Records, Parent Education, Admissions, Physiotherapy, Outpatients, Engineering, Supply, Emergency, Environmental Services, Administration/Executive and Social Work departments and the Neonatal Intensive Care, Post Natal and Gynaecology wards. The only administrative staff excluded from completing the survey were four members of the engineering staff, one staff from

executive management and one member of the building project team for the new Heidelberg site. It was felt that these staff would have knowledge and involvement that were not representative of the other administrative staff. Administrative staff associated with satellite programs that did not relocate to Heidelberg were also not included in the survey.

Five months after relocation, in August 2005, the questionnaire was sent through the internal mail to 115 administrative staff members. An addressed envelope was enclosed for return of the questionnaire to the surveyor and respondents could choose to identify themselves or remain anonymous.

To ensure questions could not be misinterpreted and to limit potential bias from the surveyor, who is a member of the administration staff at the Hospital, the questionnaire

was read and edited by the MHW Human Resource (HR) Manager. The involvement of the HR Manager was essential to ensure none of the questions would cause disquiet or concern to any staff member or manager. The survey was pilot tested by another non-administration staff member to ensure clarity and completion in a reasonable time.

Results

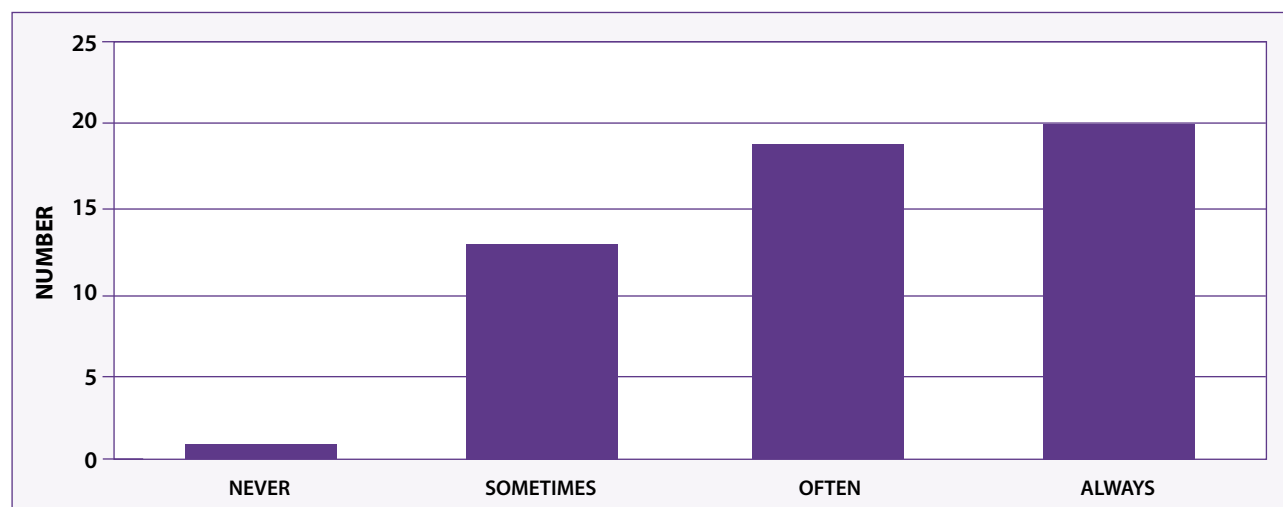
Demographics of the respondents

Fifty-four completed questionnaires were returned for a response rate of 47%. Table 1 outlines the demographics, indicating the majority of the respondents were female and 63% worked in a non-clinical area. Only 7% had started their career at MHW and the majority of the respondents had worked in this organisation for one to nine years. The reported demographics of the survey respondents were consistent with the demographics of the MHW administrative staff, suggesting a relatively representative sample.

Table 1: Demographics of survey respondents

	MALE		FEMALE	
	No's	%	No's	%
Clinical area	0	0	9	20.9
Non-clinical area	6	100	27	62.8
Both clinical/non-clinical	0	0	7	16.3
Total	6	100	43	100
Started career at MHW	0	0	4	9.3
Always worked in healthcare	2	33	16	37
Less than 1 year	0	0	5	11.6
1-4 years	2	33.3	19	44.1
5-9 years	1	16.7	10	23.4
More than 10 years	3	50	9	20.9
Total	6	100	43	100

Figure 1: Respondent responses to 'Do you enjoy your work at MHW?'



The majority of the respondents (81%) indicated they worked in a location where they were with other administration staff. It was pleasing to see that most enjoyed working at the Hospital; 74% indicated they often or always enjoyed their work at MHW (Figure 1).

The hospital relocation and its impact

Sixty-two percent of the respondents reported that their work role had changed since the Hospital relocated to Heidelberg. Of those respondents whose work had changed 59% (32 of 54) chose to report whether they were pleased with the change. Of these 32 respondents 38% said they were pleased; 28% said they were not pleased; and 34% were both pleased and not pleased with the change in work role.

The questionnaire included the yes/no question 'Were you involved in planning for the new facility at Heidelberg?' Despite the Hospital's pledge to communicate and listen to staff issues and to involve staff in suggestions, 70% of the respondents reported that they were not involved in the planning for the new facility. An even larger number of 83% of respondents, reported that they had not had input into the size and design of their own work area. Of the 17% who reported that they had input into the planning of their new work area, 69% said their involvement comprised providing an opinion about their unit/department building requirements. Forty-two percent indicated that they felt their opinion/involvement in the relocation process was valued, while 58% indicated they felt their opinion had not been valued.

The qualitative comments were consistent. Respondents made comments such as:

Absolutely no consultations whatsoever.

[I had] basically had no input at all. When I tried to make a point I was told that I was being negative...

Input was limited – it was fait accompli.

I feel let down by decision makers of our department. I feel that we are working in noisy cramped areas causing a low morale among my co-workers.

We were most interested in the relationship between the perceptions of involvement of these administrative staff and their reported satisfaction with their job and working environment. To explore this relationship we compared the responses to the questions about job satisfaction among those who indicated they were involved in the planning for relocation with those respondents who indicated they were not involved in the planning for relocation. We completed t-tests with this variable which we called involvement in planning for relocation as the grouping variable. Table 2 outlines the analysis. As illustrated the only significant difference was found in the respondents' reported motivation at work. Those staff that indicated they were not involved in the planning for the new facilities were significantly less positive about their feelings of motivation since the relocation. There were no significant differences found in the answers provided by the respondents for other workplace factors.

Table 2: Reported impact of level of involvement in planning for the new facility with workplace outcomes

	T	DF	ST ERROR DIFF	SIG
Is your work environment adequate?	-1.683	52	0.270	0.098
Has your role changed since the move?	-0.894	50	0.149	0.376
Are you pleased with the change in role?	1.153	32	0.299	0.258
Did you feel prepared for the role change?	-0.728	37	0.169	0.471
Did you feel prepared for the move?	-0.690	49	0.128	0.494
Following relocation do you feel motivated?	2.075	50	0.275	0.043
Do you enjoy your work?	0.951	50	0.235	0.346

Similarly, we completed t-test analysis with the respondents' perceptions of whether their opinion/involvement in the relocation was valued as the grouping variable. This was a yes/no question – *do you feel your opinion/involvement in the relocation process was valued?* Table 3 outlines this analysis, with significant differences found in a number of important areas. Those staff who did not feel that their opinion/involvement in the relocation planning was valued were more likely to indicate that their work environment was inadequate and that they were unprepared for their change in role and unprepared for the move in general. In addition, those respondents that did not feel that their opinion/involvement was valued were also more likely to indicate they were less motivated and did not enjoy their work to the same extent as those staff that indicated they perceived their opinion/involvement was valued.

Discussion

Impact of the respondents' perceived involvement in planning for relocation

As we were most interested in the relationship between the perceptions of involvement in the planning for relocation of these administrative staff and their ultimate satisfaction with their job and working environment, the discussion focuses on the differences among those respondents that reported they had been involved in the planning for relocation and those that reported they had not been involved. We did not measure the extent to which these staff had been involved, but asked their perceptions as to their level of involvement and their perceptions as to the value the organisation placed on their involvement.

The first finding was that the analysis suggested a relationship between involvement in the planning for relocation and reported motivation at work. Those staff that indicated they were not involved in the planning for relocation were significantly less positive about their feelings of motivation since the relocation. These findings do not suggest a measurable decline in motivation, but indicate that the administrative staff who reported that they had not been involved in the planning for relocation also indicated that following relocation they did not feel motivated in their work role. There were no significant differences found in the answers provided by the respondents for other workplace factors.

The finding of a negative relationship between those administrative staff that did not perceive that they were involved in the planning for the relocation and their reported motivation following the move is consistent with other studies conducted in healthcare settings throughout the world. Case studies from the United Kingdom and United States consistently found that staff involvement, when implemented effectively, was associated with evidence of organisational commitment, individual innovation, low patient complaints and higher external ratings. [11,12,13]

Impact of the respondents' perceptions of whether their involvement was valued

Similarly, the respondents' perceptions of whether their opinion/involvement in the relocation was valued was related to significant differences in a number of important areas. Those staff who did not feel that their opinion/involvement in the relocation planning was valued were more likely to indicate that their work environment was inadequate and that they were unprepared for their change

Table 3: Reported impact of perceptions that the respondent's opinion/involvement in planning for the new facility was valued with workplace outcomes

	T	DF	ST ERROR DIFF	SIG
Is your work environment adequate?	-3.205	47	0.251	0.002
Has your role changed since the move?	-0.539	46	0.146	0.593
Are you pleased with the change in role?	-1.199	31	0.298	0.239
Did you feel prepared for the role change?	-3.227	34	0.153	0.003
Did you feel prepared for the move?	-2.876	46	0.119	0.006
Following relocation do you feel motivated?	3.758	46	0.249	0.000
Do you enjoy your work?	3.190	45	0.232	0.003

in role and unprepared for the move in general. In addition, those respondents that did not feel that their opinion/involvement in planning for relocation was valued were also more likely to indicate they were less motivated and did not enjoy their work to the same extent as those staff that indicated they perceived their opinion/involvement was valued. Again, these measures were based on the respondents' perceptions.

These results are important for health services managers. It is clear that those administrative staff that did not perceive that they had made a valuable contribution to the relocation planning were significantly less positive about their working environment and their work in general. These are not unexpected results, as there is a strong body of literature that has identified the negative impact of lack of participation and involvement in organisational decision processes on organisational performance outcomes. [14,15,16,17] Lawler, Ledford and Mohrman were specific that not involving staff in decision processes is a frustration for the staff and often results in a loss of potential within an organisation. [18]

As noted previously, there are fewer administrative staff than there are healthcare professionals in the healthcare sector, and therefore the administrative staff are likely to have fewer opportunities to influence changes in healthcare practice. As well, the lack of studies that report on the impact of organisational change on health service administrative staff suggests that administrative staff in healthcare may not be considered to be important stakeholders to organisational change. Locke has suggested that involving staff in decisions about organisational goals can increase motivation, [19] with

others suggesting that the needs of different organisational groups must be considered in order to achieve effective and successful organisational change. [20] Although a relatively small group of employees in healthcare, our study suggests the need to ensure administrative staff perceive that they have made a valued contribution to the planning for significant organisational change, such as hospital relocation.

Limitations of the study

We recognise that there are many factors that can impact on staff member satisfaction following a major change process, such as this hospital move. The move could spawn many additional aspects, such as changes in key management staff, changes in staff roles, models of care, workload, geographical distance from home and convenience to name a few. To minimise confounding factors from others associated with the move, we designed a focused questionnaire that explored these other aspects, enquiring about change in work role, change in workload, and physical location. We did not find that any of these other factors had an impact on the satisfaction measures. We found that only one administrative staff member left the hospital as a direct result of the move to Heidelberg, and while the remaining administrative staff may not have been generally happy with the move and the new facility, it appeared from our results that the level of acceptance was related to their participation in the planning for the relocation.

Conclusions

This study illustrates that organisational change processes in healthcare organisations that do not consider and appropriately involve administrative staff are at risk of loss

of motivation of these staff. Those administrative staff that did not perceive that their opinion and involvement in the relocation planning was valued by the organisation were significantly less positive about their preparation for the move to the new hospital and reported less motivation and less enjoyment of their work. It is essential that administrative staff, many of whom perform important roles linking the health service to consumers and community, are appropriately involved in organisation change processes.

Competing interests

The authors declare that they have no competing interests.

References

1. DHS Steering Committee. Mercy Women's Hospital Heidelberg Steering Committee Report. 2000.
2. Aho Z. Relocation Review Mercy Hospital for Women. Melbourne: 2005.
3. Parle G. From blame to success – a longitudinal study into organisational culture. Brisbane: Best Practice Australia; 2001.
4. Parle G. Mercy Hospital for Women Survey Results. Brisbane: Best Practice Australia; 2004.
5. Mercy Hospital for Women. Strategic Directions 2002-2005. Melbourne: Mercy Hospital for Women.
6. Delaney JT, Huselid MA. The impact of human resource management practices on perceptions of organizational performance. *Acad Manage J*. 1996; 39 (4): 949-969.
7. Huselid MA. The impact of human resource management practices on turnover, productivity and corporate financial performance. *Acad of Manage J*. 1995; 38:635-72.
8. Terziovski M, Dean A. Best predictors of quality performance in Australian service organisations. *Managing Service Quality*. 1998; 8(5):359-366.
9. Ramanujam R, Rousseau D M. The challenges are organizational not just clinical. *Journal of Organizational Behavior*. 2006;27:811-827.
10. Harris M, Gavel P, Conn, W. Planning Australia's hospital workforce. *Aust Health Rev*. 2002;25(5):61-77.
11. Parkes C, Scully J, West M, Dawson J. High commitment strategies. It ain't what you do; it's the way that you do it. *Employee Relations*. 2007;29(3):306-318.
12. Ziari M, Jarra, YF. Measuring organizational effectiveness in the NHS: management style and structure best practices. *Total Quality Management*. 2001; December: 882-890.
13. Edmondson AC, Bohmer R et al. Disrupted routines: team learning and new technology implementation in hospitals. *Adm Sci Q*. 2001;46:685-716.
14. Cotton JL. Employee involvement. In Cooper CL, Robertson IT, editors. *International review of industrial and organizational psychology*. Chichester: John Wiley; 1996.
15. Heller FA, Pusic E, Strauss G, Wilpert B. *Organizational participation: myth and reality*. Oxford: Oxford University Press; 1998.
16. West MA, Guthrie JP, Dawson JF, Borrill CS, Cater, M. Reducing patient mortality in hospitals: the role of human resource management. *Journal of Organizational Behaviour*. 2006;27:983-1002.
17. Bartram T, Stanton P, Leggat S, Casimir G, Fraser B. Lost in translation: exploring the link between HRM and performance in healthcare. *Hum Resour Manage Journal*. 2007;17(1):21-41.
18. Lawler EE, Ledford G, Mohrman S. *Employee involvement and total quality*. San Francisco: Jossey Bass; 1992.
19. Locke EA. Toward a theory of task motivation and incentives. *Organizational Behavior and Human Performance*. 1968;3:157-189.
20. Jones L, Watson B, Hobman E, Bordia P, Gallois C, Callan VJ. Employee perceptions of organizational change: Impact of hierarchical level. *Leadership and Organization Development Journal*. 2008; (29)4:294-316.

Challenge and Excitement – Part One: loving and hating rural medical practice

G S Han, J Chesters and H Ballis

Abstract

Aims: This is the first of two papers that explore influences on doctors' decision-making about the location of their practice. Part one focuses on the positive experiences of rural medical practice as expressed by a cohort of rural general practitioners. Part two focuses on the concerns that the doctors have about rural medical practice.

Methods: We have purposefully selected and interviewed 12 rural doctors in rural/regional Gippsland, Victoria, Australia, exploring their general childhood experiences, why they chose medicine as their career and what they like and dislike about rural practice and life in general.

Results: The doctors said that their rural upbringing and exposure to rural experiences during their postgraduate training led them into rural practice. However, the influence of partners, and unexpected opportunities and life experience also impacted on the location of

their practice. Many said that they eagerly embraced the excitement, challenge and anxiety of rural practice and complex medical tasks, for example, dealing with emergencies.

Conclusions: Recruiting and retaining rural doctors is a health policy priority. Understanding why and how people practice in rural communities makes a vital contribution to health policy. These doctors form a key group of experienced Australian trained general practitioners. It is this cohort who will be relied upon to supervise and train medical students, registrars and overseas trained doctors.

Abbreviations: GP – General Practitioner; RRMA – Rural Remote Metropolitan Area.

Key Words: rural general practice; rural medical workforce; career decision-making; recruitment; retention.

Associate Professor Gil-Soo Han PhD
Communications and Media Studies
School of English, Communications and Performance
Studies
Monash University, Melbourne, Australia.

Associate Professor Janice Chesters PhD
Acting Director
Department of Rural and Indigenous Health
Faculty of Medicine, Nursing and Health Sciences
Monash University, Victoria, Australia.

Associate Professor Harry Ballis PhD
Deputy Pro Vice Chancellor
Office of the Pro Vice Chancellor (Gippsland)
Monash University, Victoria, Australia.

Correspondence:
Gil-Soo.Han@arts.monash.edu.au

Introduction

A shortage of doctors in rural Australia is an on-going problem of long standing. In 2000, there were 307 medical practitioners per 100,000 persons in 'capital cities', whereas there were only 94 in 'other rural centres'. [1,2] Although these figures improved to 335 in major cities per 100,000 population; 181 in inner regional areas; 153 in outer regional areas; and 147 in remote/very remote areas, they nevertheless maintained the urban versus rural discrepancy. [3]

The Rural Remote Metropolitan Area (RRMA) classification system classifies the areas of medical practice within Australia. RRMA 1 and 2 refer to metropolitan cities and centres; RRMA 3 refers to large rural centres with populations 25,000–99,000; RRMA 4-7 refer to small rural and remote centres with population <5,000–24,999. RRMA 3-7, the locations discussed in this paper, represent a very diverse range of climates, industries, cultures and population density.

Research informs us that a rural upbringing and positive exposure to rural practice during undergraduate and postgraduate training are the two most important reasons health professionals return to work and remain in country towns.¹ [4, 5, 6, 7-12] Other studies did not totally agree. [13] The ways in which these two factors influence recruitment and retention have been the subject of extensive research by workforce organisations such as Rural Health Workforce Australia (formerly Australian Rural and Remote Workforce Agencies Group), [14] academics and medical practitioners. [15] However, most of this research involves the collection of workforce or survey data. We suggest that analysing the results of open-ended interviews with rural doctors can add to and enhance the value of the existing research in this area.

Comprehensive research that contributes to the implementation of effective recruitment and retention strategies is lacking and desperately needs to be undertaken. [16] There is a need to uncover the complexity of personal and professional issues in rural practice. This study was designed to explore the subjective understandings of rural doctors in the context of societal change and to illuminate practitioners' perspectives on resolving recruitment and retention issues. The study will not only improve and expand the knowledge base in this area, but will have implications for training, recruiting and retaining doctors in rural and regional Victoria and Australia. The study is also an attempt to understand the extent to which study participants represent 'instances' of social and historical process, which will enable us to illustrate how individuals make decisions reflecting given structural relations. In other words, we wish to explain the links between 'personal strategies' and 'contextual strategies'. [17]

The study was conducted in Gippsland. This region is located in the south-eastern part of Victoria, Australia and has a population of 227,748. [18] Major industries are agriculture, dairy farming, fishing, forestry and power generation. Major towns are Traralgon, Morwell, Moe, Sale, Bairnsdale and Lakes Entrance. The distance from Melbourne ranges from 100-400 km.

Methods

The research team discussed potential respondents, taking into account their medical experience, gender, geographical location and practice characteristics. We selected 12 established rural general practitioners (GPs) all vocationally

trained in Australia or the United Kingdom and not principally based at a hospital.

A letter was sent to the selected doctors, inviting them to participate in the research, which was followed-up by phone. All 12 doctors agreed to participate. The doctors were aged between thirty and sixty with the majority in their mid-forties. We conducted 60-90 minute individual, semi-structured, face-to-face interviews with the six male and six female general practitioners at a time and place of their choosing.

The interviews explored the doctors' childhood experiences and the moments when career decisions were made. Other topic areas included:

- Higher education experiences and how they influenced their future plans to be health professionals;
- Why they considered rural practice;
- Rural practice experience and why they stayed in rural communities;
- Their roles in their rural community; and
- What they like (Part One) or dislike (Part Two) about rural practice.

The qualitative interview data was transcribed and systematically coded (open coding, axial coding and selective coding) and analysed using techniques derived from grounded theory [19,20] and phenomenological analysis. [21] Open coding was undertaken and themes identified with the support of NVivo (a qualitative data analysis tool) software. Two researchers (GSH and JC) undertook the interviews and data analysis separately, and compared their findings for the purpose of data validation. The researchers were satisfied that sufficient data saturation was achieved. [22]

Ethics approval was obtained for this research project from Monash University Standing Committee on Ethics in Research Involving Humans (Approval number B3/2000).

Findings and discussion

Childhood, school days, family backgrounds, parents' support

Of the 12 interviewees, half were born in rural/regional areas and half in urban areas. The occupational backgrounds of the interviewees' parents included farmer, motor mechanic, factory worker, electric engineer, ship captain, nurse, teacher, manager, professor and doctor. These occupational backgrounds may indicate that the interviewees come from a relatively broader range of socio-economic backgrounds than those of recent medical students. Although the

¹ This is known as the hypothesis of the homecoming salmon.

participants come from relatively 'modest' socio-economic backgrounds, the parental support for the interviewees during their school days, is particularly notable. Further, university education was perhaps more affordable for academically capable students irrespective of their socio-economic backgrounds a few decades ago when this cohort undertook their medical training.

When the interviewees entered medical school, the competition was apparently not as intense as it is today. Some of the interviewees admitted that their entrance scores would not gain them admission to medical school these days. However, all the interviewees were high academic performers. As may be expected, the interviewees commenced their medical training with little understanding of what 'doctoring' entailed. They were well aware of a range of opportunities available for medical graduates, such as helping out the sick, researching human physiology, doctoring as a popular and portable job, and more implicitly, a well-rewarded profession.

University and GP training and settling with rural practice

Of the 12 interviewees, 10 trained for their vocational/postgraduate qualifications in rural/regional areas, for example, Warrnambool and Toowoomba. Their experiences of training and living in rural/regional areas appeared to be positive and memorable. As past studies have indicated, exposure to rural lifestyles and positive experiences seem to be significant factors that lead newly-trained doctors to practice in rural communities. [23-25]

Why the participants chose rural practice – Choosing a rural town as a place to undertake their vocational training or to begin their careers has resulted from their upbringing, their awareness of medical practices in different places, and their personal preferences. Their choice of medical practice location has made a significant impact upon their lives. An important reason the interviewees chose the country as their place for vocational training was in part because of what they did not like about the nature of medicine and general lifestyles in the city, such as rigid hierarchy, less friendly or impersonalised relations between teachers and trainees, traffic congestion, noise and pollution. The positive reasons they chose to settle included: friendly working environment and opportunities to practice a broad range of clinical skills such as minor surgery and obstetrics. In their medical careers, these factors have developed as vital parts of their professional life and practice in rural towns. These are also the factors that encourage them to stay in rural towns.

Negotiation with their partner – Of many factors that led the doctors to settle in rural towns, negotiation with one's partner appears to have significantly facilitated the process.

You have to have a wife that wants to go to the country, end of story. (Dr G)

Partners are actually one of the things that make people leave. I mean they'll say, 'no, we've had enough, we'll have to go.' It's the partner that calls the shots. (Dr I)

Doctors' partners were more comfortable about being in the country if their upbringing was in rural areas or they wished to live in rural areas. One of the relevant factors was employment opportunities for both a doctor and their partner.

Despite the common notion of 'doctoring as a portable job', the choice of place where junior doctors can start their early careers largely depends upon the availability of the positions at the time of applications. Once they have a few years' experience as qualified doctors, their doctoring skills become much more portable.

Why they love living and working in a rural community: 'challenge and excitement'

Personal and family life/preferences – Although a comparison between the interviewees and their city counterparts is not possible in this study, the interview results indicate that the interviewees tend to pursue a variety of activities outside their medical practices. The kinds of activities and organisations they engage in include Rotary, soccer refereeing, RSPCA, drama, music, opera, volley-ball, water polo, water skiing, theology and health politics, the Lions Club, school council, school camp and local wine club.

I'd find it very dull to have medicine as the only interest in life ... I've never been able to devote myself entirely just to one thing. (Dr G)

The interviewees have chosen to live in the country because their preferred lifestyles were more easily available for them and their family members than in the city. Those opportunities and benefits include horse riding, sailing, open space and hobby farming. [8] Also, there seems to be a notion that country lifestyles have much to offer families:

You do have a good quality of life with your family up here and all there is to offer in the area. (Dr E)

I got pregnant and we'd definitely decided that ... we were going to bring up our children in a rural area. (Dr F)

As the interviewees placed a high value on family life, the doctors at times had prioritised their family over professional advancement.

Because in those days ... you seemed to have to move around, like you may do three months here and six months there and so on, and being married to a farmer I didn't want to do that. (Dr C)

I decided I needed to have something that would move around so I could be with [my partner] because he was obviously going to go into specialist surgical training ... I made the decision ... that I wouldn't try and make a specialist career myself ... I actually wanted to have a marriage that worked. (Dr D)

Work related – The interview data indicate that the interviewees' everyday activity is centred on their medical practice. The study participants note that doctoring in the country is much more interesting and challenging than working in the city and this is a most important reason they have settled in rural/regional parts of Australia.

I like the challenge of ... having to deal with whatever comes in the door. (Dr C)

It was a challenge and it was interesting and it was getting skills that were worthwhile and interesting and I did things there that you just can't do anywhere. (Dr H)

You do a wider variety of things, so it's far more enjoyable, it's more challenging. (Dr I)

What has led them to pursue a challenging work environment is beyond the scope of this study. Crucial components of 'challenging' and 'interesting' medical practice include emergency medicine and opportunities to practice a variety of medical practices. These opportunities were available in metropolitan areas till the 1980s and some participants for this study were satisfied with the availability of such work opportunities. Had metropolitan-based practices continued to offer them those opportunities they might have stayed there. Other participants discovered the characteristics of medical practices in the city and the country during their vocational training period, and therefore pursued opportunities to practice in the country.

So the nature of general practice changed enormously over the 10-12 years combined with change in the hospital [leading me] to leave the city and come to rural Gippsland ... I certainly haven't regretted moving from urban to rural practice. In rural practice the role is quite different, it's more like the sort of role that I had as a GP before all the changes happened. (Dr J)

The study participants seem to have developed their interest in emergency medicine as early as in their second year of medical school. Although most medical students would

have expressed such interest, the study participants may be some of those who continually pursued it.

It was good the emergency department was run by second year students. ... I thought I want to try and find a place with that sort of medicine. (Dr I)

Their consequent exposure to courses such as the Emergency Management of Severe Trauma, experiences working for a remote or Aboriginal community with few health services or the Royal Flying Doctor Service have provided further enthusiasm for working in rural communities. A vital aspect of critical medical care that interests them is a significant level of control over their work. This may in part have been made possible by solo practice or being one of the practice principals.

Working by myself in this place is good because I can set it up and do it my own way. (Dr B)

The rural practice environment offers medical students, GP registrars and GPs opportunities to learn or practice an extensive range of procedural skills and medical services, which often leads trainees to choose rural communities for their clinical training.

I went to Launceston General Hospital because you could get a wide variety of hands-on experience very early. You could do tonsillectomies and bunions and appendixes and ear, nose and throat clinics and gynaecology clinics and casualty, all of it. Because hands-on experience in Melbourne or Sydney – you have to stand in line and wait before you can get near it. I went to where I could get all this hands-on experience to get because there was no College of General Practice then either. (Dr B)

Two and a half years in Wyndham and about 12 months in Broome, this was just a great experience. After doing just about everything there, operating, major traumas and all that sort of stuff there is no way you could easily go back to working in a city environment where you have to pass everything on. (Dr H)

It is important to note that such diverse skills are also required in a rural or remote setting. The shortage of medical specialists in rural Australia means that there is a relatively low degree of specialisation or division of labour in medical services in rural Australia. This rural condition suits GPs with diverse skills.

So I had the qualifications to be a useful rural doctor. So I did a lot of anaesthetics, obstetrics and a little bit of general surgery. (Dr G)

It is interesting to note that it is not only rural general practice but also general practice itself rather than specialist practice that allowed a notable degree of independence and control over their work.

To become a specialist meant playing to someone else's tune. (Dr L)

When I left the Flying Doctor Service I went to Fremantle Hospital to try and see whether I could cope with a city lifestyle. But we just found the whole concept, the hierarchy of the hospitals. [sic] I wasn't going to follow instructions just because someone else said that they'd like to have this particular test done ... Someone who came in and definitely had an appendix and ... the registrar wanted them to have blood tests and kidney tests and X-rays and all that sort of stuff when it was just totally unnecessary. But I'm the boss, this is the way I want it done. So there's a little bit of independence. (Dr H)

The control over work and the independent nature of solo practice or practice leadership have led a few participants to explore less conventional practices such as acupuncture, counselling, herbal therapy, methadone treatment and hypnotherapy. Two participants of the study were focusing on these modalities as much as on biomedicine.

Other aspects that contribute to satisfaction with rural practice are the friendly or close human relationships they developed with their own colleagues or other health professionals in the region in which they practice. [8] There are also opportunities to contribute to the increasingly important local Division of General Practice through their involvement in continuing their medical education, rural health politics, teaching medical students and community health initiatives. Local Divisions of General Practice also offer them professional, political and social interactions.

Involvement in the community – Apart from the satisfaction they enjoy from their work-related activities, their involvement in the community is conspicuous, as detailed above. The doctors commented that their close involvement in people's birth, marriage and death fosters a special relationship between them and the members of the community, which also adds to a high level of satisfaction. As the interviewees have eloquently expressed, country doctors are involved in people's lives. They are often at the birth of a child, provide advice for a vaccination, and at the time of sexually maturing, developing relationships and at the funerals of the child's family (Dr L). They regard their health services as not only what they provide for the community, but also as part of their everyday activities. The

doctors reflect what they encounter as medical practitioners on their personal life and vice versa.

... they have a genuine concern for you and seem to value the service they get, which I gather isn't always the case in the city. So that's a very positive thing. (Dr C)

I guess that you get some wonderful opportunities of getting to know someone and share in their good times and their bad times and just by being good friends to people if they have their deaths ... (Dr G)

Being part of the community, [I enjoy] all the positive contacts... To be touching people at such significant times you really get a very moving insight into how people live and what it is to be a human being, besides [sic] from myself. I really value that ... It also has integrity between; I think that it is healthy to have integrity between my work persona and my social persona. Who I am at work is also who I am socially and I think that's ... a healthy way to be. (Dr L)

A deep involvement in many people's lives can cause distress. However, most interviewees for this study tend to see the positive side of such involvement although others noted its downsides and ambivalent effects.

There's the personal reward of knowing your patients so well and taking them through everything ... not necessarily always elderly, but people with cancer wanting to die in their homes and that's both sad and rewarding. (Dr E)

The doctors with young children are often involved in local sports clubs and school councils, which may benefit their children and others in the community. They generously give time to other local organisations. These activities help them expand their personal interests and hobbies and contribute to the broader community. Indeed, rural doctors make a significant contribution to social capital in rural communities. In addition to medical services they provide to their communities, they are dealing with many other non-medical aspects of people's lives in the country. This cannot be underestimated. They are rightly aware that being a medical practitioner is not simply about medicine per se, but entails what is not particularly 'medical'. They went as far as to suggest what might lead a person to be a good doctor.

Academic component is only a small part of what you do in your career. (Dr A)

How much medicine is scientific? (Dr B)

Occasionally, people with very high marks are not going to make good doctors. (Dr G)

You don't need to get 95 or higher marks, you just need an average intelligence and a lot of common sense. (Dr J)

Concluding remarks

The delivery of medical services in rural towns is constantly undergoing change. Given many of the doctors' preference for procedural medicine and practice autonomy, there needs to be careful consideration of what medical practice opportunities are provided to rural GPs. However, more positively, these doctors are likely to be attracted to the challenges associated with teaching and research which are increasingly available in regional clinical schools and regional medical schools. The training and support of the rural medical workforce of the future will depend on retaining the interest and rural commitment of these key Australian trained practitioners.

Acknowledgement

This research project was funded by Monash Rural Australia Project. We are grateful to the study participants for their time despite their busy schedule.

Competing interests

The authors declare that they have no competing interests.

References

1. AIHW. Medical labour force, 2000. Canberra: Australian Institute of Health and Welfare; 2003.
2. Trickett P, Titulaer I, Bhatia K. Rural, remote and metropolitan area health differentials: a summary of preliminary findings. *Aust Health Rev.* 1997; 20(4):128-37.
3. AIHW. Medical labour force, 2005. Canberra: Australian Institute of Health and Welfare; 2008.
4. Cooper JK, Heald K, Samuels M. The decision for rural practice. *J Medical Educ.* 1972; December(47):939-44.
5. Fromm B, Konen JC, Boska RB, Wolff LT. Exposures leading to the selection of family medicine and rural practice. *Fam Prac Res J.* 1985; 5(2):127-36.
6. Humphreys JS, Rolley F. A modified framework for rural general practice: the importance of recruitment and retention. *Social Science and Medicine.* 1998; 46:939-45.
7. Strasser R. How can we attract more doctors to the country? *Aust J Rural Health.* 1992; 1(1):39-44.
8. Ernst RL, Yett DE. Physicians background characteristics and their career choices: a review of the literature. *Med Care Rev.* 1984; 41:1-36.
9. Stratton TD, Geller JM, Ludtke RL, Fickenscher KM. Effect of an expanded medical curriculum on the number of graduates practising in a rural state. *Academic Medicine.* 1991; 66: 101-5.
10. Magnus JH, Tollan A. Rural doctor recruitment: does medical education in rural districts recruit doctors to rural areas? *Med Educ.* 1993; 27:250-3.
11. Chesters J, Han G-S, Strasser S, Ballis H. An anatomy of doctoring rural towns. In: Dibden J, Fletcher M and Cocklin C, editors. *All change! Gippsland perspectives on regional Australia.* Melbourne: Monash Regional Australia Project, Monash University; 2001.
12. Ranmuthugala G, Humphreys J, Solarsh B, Walters L, Worley P, Wakerman J, Dunbar JA, Solarsh G. Where is the evidence that rural exposure increases uptake of rural medical practice? *Aust J Rural Health.* 2007; 15(5):285-8.
13. Sesney JW, Kreher NE, Potts MJ. Graduates' reflections on their rural medical education: the upper peninsula campus experience. *Journal of Rural Health.* 1994; 10(4):279-85.
14. Health Workforce Queensland and New South Wales Rural Doctors Network. *Medical practice in rural remote Australia: national minimum data set report as at 30th November 2007.* Brisbane: HWQ; 2008.
15. Somers G, Young AE, Strasser R. Rural career choice issues as reported by first year medical students and rural general practitioners. *Aust J Rural Health.* 2001; 9 Supplement 1:S6-S13.
16. Hoyal FMD. Retention of rural doctors. *Aust J Rural Health.* 1995; 3:2-9.
17. Watson I. Life history meets economic history: the experiences of three working class women in the local labor market. *Work, Employment & Society.* 1993; 7(3):411-35.
18. ABCTV. *New program to help depressed doctors,* 12 June: Australian Broadcasting Corporation; 2001.
19. Strauss AL. *Qualitative analysis for social scientists,* Cambridge: Cambridge University Press; 1987.
20. Strauss AL, Corbin J. *Basics of qualitative research: grounded theory procedures and techniques,* Thousand Oaks: Sage Publications; 1990.
21. Colaizzi P. Psychological research as the phenomenologist views it. In: Valle R and King M, editors. *Existential-phenomenological alternatives for psychologists.* New York: Oxford University Press; 1978:48-71.
22. Miles MB, Huberman AM. *Qualitative data analysis: an expanded sourcebook.* 2nd ed, Thousand Oaks: Sage Publications; 1994.
23. Wilkinson D, Laven G, Pratt G, Beilby J. Impact of undergraduate and postgraduate rural training, and medical school entry criteria on rural practice among Australian general practitioners: national study of 2414 doctors. *Med Educ.* 2003; 37:809-14.
24. Blue AV, Chessman AW, Geesey ME, Garr DR, Kern DH, White AW. Medical students' perceptions of rural practice following a rural clerkship. *Fam Med.* 2004; 36:336-40.
25. Hayes RB. Guiding principles for successful innovation in regional medical education development. *Rural Remote Health.* 2006; 6:516.

Facility Turnover and Vacancy Rates of Registered Nurses: do they predict how nurses are recruited?

K V Rondeau and T H Wagar

Abstract

Objectives: Healthcare organisations in Western industrialised countries are experiencing nursing labour markets characterised by extreme staff shortages and high levels of turnover and vacancy for Registered Nurses (RNs). The effective recruitment and retention of nursing personnel are considered an essential management function if healthcare organisations wish to survive and prosper in these difficult times. The objective of this study is to examine the relationship between healthcare establishment turnover and vacancy rates of RNs and the means these establishments use to recruit nursing personnel. It is predicted that in the face of higher turnover and vacancy rates for registered nurses, healthcare organisations will utilise more active (employer-initiated) and fewer passive (employee-initiated) recruitment channels.

Method: Data for this study were collected from over 700 hospital and nursing homes in Canada. Directors of Nursing at these establishments were asked about the use of various recruitment channels to attract nursing personnel.

Results: Bi- and multi-variate analyses were performed to characterise the relationships between establishment RN turnover and vacancy rates with respect to the selection of recruitment channel utilised. Ordinary Least Square regression analysis showed that perceived

vacancy rate, and to a lesser degree turnover of RNs, were strong predictors of the use of more active recruitment channels. Healthcare organisations with a local labour market characterised by a greater supply of employable RNs, were more likely to use more passive channels, even in the face of higher RN turnover and vacancy. Healthcare organisations which were perceived as being stronger 'employers-of-choice,' were also more likely to use more passive recruitment channels, even in the face of higher vacancies for RNs.

Conclusion: Results from this study suggest that when labour markets have a larger surplus of RNs for potential employment, establishments are less than proactive in their attempts to vigorously recruit. During these times, having a perception of being a strong employer-of-choice, enables healthcare organisations to maintain full employment without having to launch aggressive recruitment initiatives.

Keywords: Registered Nurse turnover; Registered Nurse vacancy rate; modes of recruitment; employer-of-choice.

Abbreviations: LTC – Long-Term Care; OECD – Organisation for Economic Co-operation and Development; OLS – Ordinary Least Square; RN – Registered Nurse; USD – United States Dollar.

Dr Kent V Rondeau PhD
School of Public Health
University of Alberta, Edmonton, Alberta, Canada

Dr Terry H Wagar PhD, LLB
Department of Management
St Mary's University, Halifax, Nova Scotia, Canada

Correspondence:
kent.rondeau@ualberta.ca

Acknowledgement:

The paper in this Journal was selected for publication from papers presented at the Biennial Conference of the International Scholars in Organisational Behaviour in Healthcare (OBHC) conducted in Sydney by the Society for the Study of Organising for Healthcare (SHOC) in March 2008. OBHC was chaired by Professor Jeffrey Braithwaite at the University of New South Wales and had as its theme *Culture and climate: cracking the code*.

Introduction

Healthcare organisations in Australia, New Zealand, Canada and other Organisation for Economic Co-operation and Development (OECD) countries are having great difficulty in retaining a sufficient number of registered nurses. [1] Many are suffering under a dual burden of excessive turnover while experiencing a high vacancy rate for registered nurses. Some are attempting to redress their nursing shortfalls by vigorously pursuing foreign graduates, [2,3] by making greater provisions for working overtime, [4] or by hiring temporary or contingent staff. [5] None of these approaches is considered an effective strategy for dealing with entrenched recruitment and retention problems. [6]

High rates of organisational turnover and vacancy for nurses have adverse impacts on healthcare costs and can undermine quality of care. [7] The economic burden associated with replacing departing nurses varies from United States Dollar (USD) \$10,100 in Canada, USD \$16,600 in Australia, to USD \$33,000 in the United States per registered nurse (RN), while 'the savings to a 500-bed hospital of reducing nurse turnover from 13% to 10% can amount to USD \$800,000'. [8] The indirect costs of turnover and vacancy are significant and reflect the loss of efficiencies with new employees and the diminution of staff morale and group productivity. When vacancy positions remain unfilled, there is emerging evidence that patient outcomes may be compromised as nurses are required to manage a fixed workload with fewer colleagues. [9,10,11,12]

Although employee turnover can help facilitate the adoption of new practices and innovations and promote better 'person-job' or 'person-organisation' fit, [13] it has been associated with a number of adverse consequences. [14] Staw [15] suggests that turnover can lead to higher and higher job vacancies as otherwise satisfied persons now consider leaving in response to the increased work stresses and strains that result as a consequence of departing employees. In a recent review on nursing turnover, Hayes and colleagues [16] suggest that turnover is a product of diminished job satisfaction, and is driven by a number of factors including experienced workload, work schedules, perceived stress and burnout, leadership and management style, degree of workplace empowerment, promotional opportunities, as well as other economic factors. Of course, voluntary turnover is not always a sign of an organisation under bad management, as people may leave a well-managed employer for better pay and promotion opportunities elsewhere, career pursuits, return to school, or change in health status.

Healthcare organisations must not counter the rate at which nurses voluntarily leave, but must ably fill vacancies created by departing staff. Although these two factors are often interrelated, in as much as a higher turnover necessitates that more positions be filled, few nursing studies have examined their combined effect.

Effectively managing organisational recruitment and retention is based upon sound human resource planning. Recruitment is the process 'of informing, searching for and attracting applicants with the necessary abilities, attitudes and motivation, in order to offset shortages identified in human resource planning'. [17] In order to fill job openings, organisations must be aware of recruitment sources (where qualified individuals can be found) as well as recruitment methods or modes (how a pool of the most qualified can be found at the lowest possible cost). [18] The process of employee recruitment usually begins by assessing the pool of internal candidates (ie, internal job postings, replacement charts, succession planning systems, etc), and continues through to an evaluation of external candidates (ie, job advertisements, recruitment campaigns, employee referrals, walk-in candidates, employment agencies, resident placements from education institutions, internet/world wide web, etc). Each method has a number of advantages and disadvantages and necessitates that organisations evaluate the effectiveness of their recruitment activities. [19] Incurred cost remains only one of a number of criteria that can be used to evaluate recruitment effectiveness. [20]

Organisations can fill existing or potential job vacancies through employer-sponsored as well as employee-sponsored means. Employer-sponsored recruitment is directed by the employer, usually to fill an existing job vacancy or a job position which will become vacant in the future. As such it is an 'active' form of recruitment because it represents an organised and concentrated effort by the employer to manage the recruitment process. On the other hand, employee-sponsored recruitment is a form of 'passive' recruitment whereby direct applicants for a position are solicited without prompting from the organisation. One advantage of passive recruitment is that direct applicants are usually already aware of the benefits and drawbacks associated with working with that organisation and so their entry process into it becomes much smoother. [21] This 'self-selection' effect can improve the likelihood of a good 'person-organisation' fit. An important form of self-selection recruitment can come about through employee-referrals. The use of local 'social networks' not only helps the job seeker, but can also simplify the recruitment process

for employers. [22,23] This form of recruitment has the potential to build a more unified organisational culture. It may be most appropriate when job vacancies remain low and manageable or when costs to mount formal recruitment drives are prohibitive. A testable research hypothesis follows:

H1: Healthcare organisations which have low levels of nursing job vacancies will make greater use of passive recruitment channels.

Some organisations play on their reputation in the community to generate a continuous stream of self-referrals. Often described as 'employers-of-choice', these organisations are able to foster high levels of employee attachment and commitment. The business press has characterised those organisations, which have created strong employer-of-choice reputations as having done so through the development and promulgation of an effective employee retention culture. [24,25] Existing and potential employees are keenly aware of the benefits that these organisations provide to their staff and see these establishments as great places to work that afford social prestige to those fortunate enough to work there.

The employer-of-choice concept is loosely related to the magnet hospital movement. [26] In magnet hospitals, positive perception of managerial practices and environmental characteristics improves the job satisfaction of nurses and increases their commitment to the organisation. [27] Nurses in magnet hospitals are more likely to report an intention to stay than nurses in non-magnet hospitals. [28] Magnet healthcare organisations are seen as having a positive workplace climate, cohesive and supportive staff, professional norms and standards, egalitarian culture, a high quality of nursing leadership, and manageable workloads. [29] These factors and others have been found to be associated with greater job satisfaction and lower organisational turnover. [30]

Providing a superior quality of work life, magnet healthcare organisations show lower levels of turnover and as a consequence should experience fewer job vacancies. Because of their strong retention cultures, it seems likely that these organisations will rely more on employee-sponsored or passive channels of recruitment to fill the few available vacancies. If true, passive selective hiring practices such as employee referrals or word-of-mouth approaches would characterise the primary recruitment strategies used by these establishments. A second testable research hypothesis follows:

H2: Healthcare organisations which are perceived as being strong employers-of-choice by their existing or potential employees will use more passive channels of recruitment.

The choice of recruitment mode may also depend on the general conditions in the local labour market. Staffing levels are affected by the general supply of labour that is available for employment. [31] When the local labour market is tight, there are fewer nurses available for employment and vacancy rates for nurses remain high, even in the face of low levels of turnover. Healthcare organisations may choose to lower their staffing levels in response to shortfalls in the local supply of labour, often by changing their staffing mix through labour substitutions. Recently, Blegen, Vaughn and Vojir [32] found evidence for this effect in both intensive care and non-intensive care units, where a decrease in staffing levels occurred as the supply of RNs in the surrounding geographic area decreased. When the local supply of labour is tight, healthcare organisations may be forced to become more aggressive in their pursuit of nursing staff, consider staffing mix changes (ie, substituting nurse auxiliaries for registered nurses), or be prepared to run their operations under-staffed. Under conditions of a tight local labour market, they will be less likely to use passive approaches in their search for additional recruits. A third testable research hypothesis follows:

H3: Healthcare organisations which are in labour markets characterised by a lower supply of registered nurses will experience higher vacancy rates and accordingly, will use fewer passive channels of recruitment.

Most studies examining recruitment or retention factors assess either the level of voluntary turnover or the vacancy rate, but rarely both. The choice of recruitment mode is dependent not only on the velocity of turnover as a measure of employee retention but is also shaped by the magnitude of the vacancy rate for registered nurses. It is unknown which (if either) of these two factors determines the choice of recruitment strategy used. Does the level of turnover (ie, the establishment's retention rate) predict the choice of recruitment mode used, or is the choice determined more so by level of job vacancy? In organisations that have good employee retention (ie, low turnover), which mode of recruitment is preferred when vacancy rates increase in response to a constricted local supply of registered nurses? Does excessive turnover trigger more active recruitment efforts, or does the organisation wait until realising a higher vacancy rate, regardless of rate of turnover, before initiating a more aggressive (active) recruitment process? This study is an attempt to assess the independent and combined effect

of turnover and vacancy rates on the choice of recruitment mode utilised. To test the independent and combined effect of turnover and vacancy, two additional research hypotheses can be examined:

H4: *Healthcare organisations which have low levels of establishment turnover (high retention rates), and low levels of establishment vacancy of registered nurses will be more likely to use passive channels of recruitment.*

H5: *Healthcare organisations which have high levels of establishment turnover (low retention rates), and high levels of establishment vacancy of registered nurses will be less likely to use passive channels of recruitment.*

Methods

Data for this study were collected by a survey questionnaire that was sent to 2,208 hospitals and Long-Term Care (LTC) organisations in late 2005. The study population included all relevant organisations operating in all ten provinces and three territories of Canada with more than 25 licensed beds. Site information was provided to the study researchers by the Canadian Healthcare Association. [33] The study received ethics approval from the Health Research Ethics Board at the University of Alberta. A six page survey questionnaire was sent to the site administrator who was asked to forward it to the individual responsible for the management of the nursing function at that establishment. Six weeks after the initial mailing, the questionnaire was resent to those facilities that did not respond to the earlier request for participation. A total of 713 useable questionnaires were returned. After subtracting those returns that were identified as undeliverable or refused ($n=33$), an overall response rate of 32.3% was attained. The final sample included 232 hospitals (acute, chronic, or rehabilitative) and 473 LTC establishments. Response bias was evaluated by examining differences in establishment size and location between earlier and later respondents. Results do not show response bias with respect to establishment size or location.

We are interested in examining how establishment turnover and vacancy rates for registered nurses shape the choice of recruitment strategy. The decision whether to use passive (employee-initiated) or active (employer-initiated) channels is based on two somewhat complementary phenomena. First, how quickly employees are voluntarily leaving the organisation (measured as the establishment turnover rate). Being perceived as a great place to work (ie, having a strong employer-of-choice culture) has the potential to mitigate high establishment RN turnover. Second, does the organisation have the ability to fill positions that are created

by departing employees (measured as the establishment vacancy rate)? Having a local labour market characterised by an ample supply of available labour can mitigate high establishment RN vacancy as well as affecting the means by which healthcare organisations fill these vacancies.

The choice of which recruitment channel to emphasise depends on both on the rate of establishment turnover and vacancy. Four categories of healthcare establishments were created on the basis of their combined RN turnover rate and RN vacancy rate. High RN turnover (low retention) establishments were identified as having RN turnover rates greater than ten percent, while high RN vacancy establishments were identified as having a RN vacancy rate greater than five percent. It must be recognised that these categories were arbitrarily created and reflect estimates for comparative purposes only. In this fashion, all establishments in the sample can be characterised as belonging to one of four categories: a) low turnover and low vacancy (511 establishments); b) low turnover and high vacancy (44 establishments); c) high turnover and low vacancy (55 establishments); and d) high turnover and high vacancy (59 establishments). Establishments categorised in this fashion provide a means to examine the independent and the combined effect of turnover and vacancy for registered nursing personnel on the choice of recruitment mode utilised. This is an important distinction as most research studies have examined employee turnover or vacancy rate separately, but rarely the combined effect.

Respondents were asked to identify the percentage of their RN workforce that has been recruited using a variety of employee-initiated and employer-initiated channels (see Table 1). As an example, the index assessing the relative use of employee-initiated (passive) recruitment channels was constructed by adding the percentage of the RN workforce that are recruited by means of a 'walk-in application', by 'direct mail solicitation', or through a 'referral from existing staff'

Employer-of-choice strength was measured using a five-item scale developed by Rondeau and Wagar. [34] The scale demonstrates strong internal reliability with a Cronbach alpha of .91. To obtain an estimate of the overall supply of RN labour, respondents were asked to assess the market for RNs in their local geographic area using a seven-point scale. Four establishment-level control variables were also used: establishment size (assessed as the natural log of the number of beds), establishment location (five-point scale from rural area to urban metropolitan location), establishment type (coded as 1=hospital and 2=LTC establishment), and

whether the establishment had a formal human resources management department (coded as 1=yes and 0=no). Market and establishment variables have the potential to impact the choice of recruitment mode utilised, and thus need to be controlled in the analysis.

Analysis

The authors were interested in examining how the decision to pursue passive recruitment channels for registered nurses is associated with existing establishment turnover and vacancy rates. Using categories combining RN turnover

and vacancy rate, four separate Ordinary Least Square (OLS) regressions were conducted. Two regressions were run for low turnover (high retention) establishments, adjusting for vacancy (low vacancy versus high RN vacancy establishments), (see Table 3). Two additional regressions were run where we examined the impact in high turnover (low retention) establishments, again adjusting for vacancy (low vacancy versus high RN vacancy establishments), (see Table 4). Each of the four turnover/vacancy categories was run separately with each combination in turn serving as our dependent variable.

Table 1: Healthcare establishment characteristics

	HOSPITAL MEAN VALUE	LTC FACILITY MEAN VALUE
Registered nursing workforce characteristics		
Number of RNs employed	412.3	17.4
Number of auxiliary (non-RN) staff employed	84.5	29.7
RN to auxiliary nursing staff ratio	4.88	0.59
Establishment RN vacancy rate (as valid percentage)		
No RN job vacancies	21.7	58.3
Few RN job vacancies (1-5%)	54.0	32.0
Several RN job vacancies (6-15%)	19.1	8.5
Many RN job vacancies (> 15%)	5.2	1.3
Establishment annual RN turnover rate (as valid percentage)		
Little or no RN turnover (0-2%)	18.1	53.0
Light RN turnover (3-10%)	63.7	31.1
Moderate RN turnover (11-25%)	14.2	10.8
Heavy RN turnover (>25%)	4.0	5.1
Local labour market RN supply score	3.05	2.71
RN employer-of-choice score	5.02	5.27
RN recruitment channels (as percentage of total RN workforce recruited to establishment)		
Schools of nursing	29.6	6.8
Walk-in applicants	21.8	32.1
Advertisement in news/trade media	18.3	33.1
Referrals from existing staff	13.5	19.1
Recruitment fairs	7.3	2.4
Professional recruiters	3.0	0.9
World-wide-web inquiry	3.3	1.3
Direct mail solicitation	1.0	2.1
Other	2.2	2.3
Establishment Characteristics		
Number of establishments	232	473
Establishment size (#beds)	219.3	111.0
Formal Human Resources Department	0.92	.50
Establishment location (as valid percentage)		
Rural (<1000 residents)	3.9	13.0
Town (1,000 to 10,000 residents)	35.7	29.0
Small city (10,000 to 100,000 residents)	28.3	24.8
Large city (100,000 to 500,000 residents)	13.0	18.1
Metropolitan (>500,000 residents)	19.1	15.1

Two sets of control variables were run in our regressions: market control variables (includes the measure of employer-of-choice score and RN local labour market supply) and establishment control variables (includes establishment size, location, type, and presence of an organised human resources function).

Results

Establishment participant profile

An overview of the general operating characteristics of the hospitals and LTC establishments in this study can be found in Table 1.

Table 2 is the correlation matrix for our study variables. Establishments reporting higher RN vacancy rates are more likely to be larger in size and to be a hospital ($p<.001$), much more likely to report higher turnover ($p<.001$) and much less likely to be perceived as being a strong employer-of-choice ($p<.001$).

Healthcare establishments in our sample which use passive recruitment channels are more likely to report higher employer-of-choice scores ($p<.001$), and report lower vacancy and turnover rates for registered nurses ($p<.001$). Not surprisingly, establishments reporting a more favourable local labour market for RNs are more likely to be found in more urban locations ($p<.001$) where larger pools of specialised labour reside.

Results for high RN retention establishments

The authors were interested in examining differences in the choice of recruitment mode for those healthcare establishments experiencing low RN turnover, which were labelled as high retention establishments, an arbitrary assignment for the purpose of the data analysis. For healthcare establishments with good retention rates (ie, low turnover), we can examine establishment factors associated with good recruitment effectiveness (low RN vacancy rates),

Table 2: Correlation matrix

VARIABLES	MEAN	SD	1	2	3	4	5	6	7	8	9
1. Establishment RN turnover score	1.80	.83	1.00	.50**	-.19**	-.29**	-.10*	.05	.02	-.21**	.13*
2. Establishment RN vacancy score	1.71	.78		1.00	-.25**	-.28**	-.21**	.16**	.04	-.33**	.18**
3. Uses passive recruitment channels	15.90	10.99			1.00	.16**	-.04	-.12*	-.03	.24**	-.25**
4. Employer-of-choice score	5.19	1.01				1.00	.18**	.06	.09	.12*	-.12*
5. Local RN labour supply	2.83	1.53					1.00	.23**	.29**	-.10	.05
6. Establishment size (in beds)	4.55	.86						1.00	.58**	-.13*	.19**
7. Establishment location ^a	2.97	1.24							1.00	-.05	.10*
8. Establishment type ^b	1.68	.48								1.00	-.40**
9. Formal Human Resources Dept	.64	.49									1.00

* $p<.01$; ** $p<.001$

^acoded as 1=rural to 5=urban

^bcoded as 1=hospital; 2=LTC facility

Table 3: OLS Regression results for high RN retention establishments

	LOW VACANCY (511 ESTABLISHMENTS)	HIGH VACANCY (44 ESTABLISHMENTS)
Recruitment channels		
Passive recruitment channels	.004 ** (.002)	-.002 * (.001)
Market factor controls		
Employer-of-choice (magnet) score	.058 *** (.012)	-.003 (.009)
Local area RN labour supply	.038 ** (.012)	-.022 *** (.006)
Establishment Factor Controls		
Establishment size (in beds)	-.041 (.025)	.057 *** (.013)
Location	-.008 (.017)	.001 (.001)
Establishment type	.036 (.040)	-.078 *** (.021)
Formal human resources department	-.052 (.038)	-.018 (.020)
Constant	.387 ** (.148)	.036 (.078)
Adjusted R-square	.088	.084
F statistic	8.916	8.599

* p<.05; ** p<.01; *** p<.001

as well as those with poor recruitment effectiveness (high RN vacancy rates). Table 3 includes OLS regression results for low turnover healthcare establishments.

Low RN turnover-low vacancy establishments: These healthcare establishments have little organisational exit and report little difficulty in filling any openings for registered nurses. Our OLS regression results show that healthcare organisations reporting a low RN turnover and vacancy rate are more likely to use passive recruitment channels (p<.01). These organisations report having a greater supply of RNs in their local labour market (p<.01), and are much more likely to report that they consider themselves to be strong employers-of-choice in their communities (p<.001).

Low RN turnover-low vacancy establishments: These healthcare establishments have a low level of RN turnover, nevertheless report some difficulty in filling the few openings for registered nurses that do occur. Our results show that healthcare organisations reporting low turnover and

high RN vacancy rates are more likely to be larger (p<.001), to be a hospital (p<.001) as opposed to a nursing home, and given the need to fill a larger number of vacancies for registered nurses are less likely to use passive recruitment channels (p<.05). These establishments are also much more likely to characterise their local supply of registered nurses as inadequate (p<.001).

Results for low RN retention establishments

The authors were interested in examining differences in the choice of recruitment mode for those healthcare establishments experiencing high RN turnover. For healthcare establishments with poor retention rates (ie, high RN turnover), we can examine establishment factors associated with good recruitment effectiveness (low RN vacancy rates), as well as those with poor recruitment effectiveness (high RN vacancy rates). Table 4 includes OLS regression results for high turnover healthcare establishments.

Table 4: OLS Regression results for low RN retention establishments

	LOW VACANCY (55 ESTABLISHMENTS)	HIGH VACANCY (59 ESTABLISHMENTS)
Recruitment channels		
Passive recruitment channels	.001 (.001)	.001 (.001)
Market factor controls		
Employer-of-choice (magnet) score	-.027 * (.012)	-.053 *** (.011)
Local area RN labour supply	.003 (.008)	-.015 (.008)
Establishment factor controls		
Establishment size (in beds)	-.012 (.017)	-.007 (.017)
Location	-.011 (.011)	.018 (.011)
Establishment type	.070 * (.027)	-.045 (.027)
Formal human resources department	.070 ** (.026)	-.019 (.025)
Constant	.160 (.101)	.483 *** (.100)
Adjusted R-square	.023	.049
F statistic	2.946	5.226

* p<.05; ** p<.01; *** p<.001

High RN turnover-low vacancy establishments: These health-care organisations have significant RN turnover, yet report little difficulty in filling any openings that occur. They are slightly more likely to be LTC establishments (p<.05), and to have an organised human resources function (p<.01). They are slightly less likely to be an employer-of-choice (p<.05). These organisations could not be differentiated on the basis of their mode of recruitment. That is to say, they are no more, nor no less likely, to use passive recruitment channels to fill existing vacancies for registered nurses.

High RN turnover-low vacancy establishments: These health-care establishments have both high levels of organisational exit and also report significant difficulty in finding replacements for departing nurses. We are unable to distinguish these organisations on the basis of most of our study variables, including the use of passive recruitment strategies, nor on the basis of the RN local labour market supply. Nevertheless, these healthcare organisations appear

ineffective at RN recruitment and retention efforts and are much less likely to be considered to be employers-of-choice (p<.001).

Discussion

The results of this study show some important differences in the way that healthcare establishments recruit registered nurses. The use of employee-initiated (passive) approaches to recruit nursing personnel achieves statistical significance in our model, but only for those establishments that experience high overall retention rates for their nurses. For high retention establishments with low vacancy rates, the results suggest that these organisations rely heavily on passive approaches (ie, walk-in applications, write-in applications, employee referrals, etc) to fill the few available RN jobs that are available. Establishments in this category are also more likely to report that there exist sufficient nurses in the local market to address their labour needs.

For high retention establishments with high vacancy rates, employee-initiated passive channels are much less likely to be used. Although the study is unable to say definitively if active recruitment approaches are favoured by this group of organisations, the results suggest that high retention healthcare organisations that experience higher vacancy rates do not rely on 'employee-initiated' means for filling their job vacancies. A shortage of qualified nurses in the local labour market is seen by these establishments as a major contributor to their high RN vacancy problem.

In summary, for high retention establishments, the use of passive recruitment channels is heavily influenced by its existing vacancy rate: that is to say, passive channels are more likely to be used in establishments with low vacancy rates and less likely to be used in high retention establishments with high vacancy rates. The local supply of registered nurses in the local labour market is also an important factor in these high retention establishments: the local labour market is more likely to be considered adequate in establishments with low vacancy rates and more likely to be considered inadequate in establishments with high vacancy rates. Thus, for high retention establishments, it seems that a low RN vacancy rate and a favourable local labour market are important factors associated with the use of more passive recruitment channels. For low retention (high RN turnover) establishments, our results are less clear. We are unable to distinguish these establishments on the basis of their choice of recruitment mode.

There are some important limitations in the design of this study that need to be identified. First, the data collected reflect the subjective opinions of nurse managers. As the data are drawn from a single source, common method variance has the potential to confound results. Second, the measures of recruitment channels are quite crude and reflect the relative percentage of registered nurses which have been recruited through each channel. It does not sufficiently capture the use of those recruitment channels that have not resulted in the recruitment of new nurses. It also does not adequately account for the organisational and employee costs associated with the use of each recruitment mode. Third, the conceptualisation and measurement of organisational turnover is problematic. One confounding factor is that respondents were not asked to differentiate between voluntary and involuntary turnover in their establishments. This is an important oversight as some turnover that was measured may be involuntary (eg, such as employee terminations and layoffs). Finally, the design of our study is retrospective and reflects merely a snapshot

in time and does not establish causality between the variables of interest. That is to say, the authors are unable to say that experienced turnover and vacancy rates 'causes' healthcare establishments to adopt (or not to adopt) passive recruitment strategies, but merely the choice of recruitment mode appears to be associated with level of turnover and RN vacancy in the establishment.

In conclusion, there is some support for the first four hypotheses: H1, H2, H3 and H4, however H5 is not supported. Consistent with expectations, the use of passive recruitment strategies dominates in healthcare organisations perceived as being 'employers-of-choice'. Passive strategies are consistent with attracting individuals who share similar values with existing staff, thus building a stronger corporate culture. These organisations use their reputations to successfully retain staff as well as the ability to quickly fill any (of the few) vacancies that appear. If passive recruitment strategies are less expensive to conduct than active ones, this has a real and enduring economic advantage to the organisation.

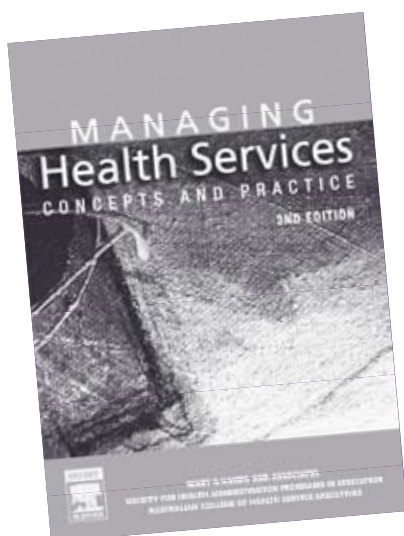
Competing interests

The authors declare that they have no competing interests.

References

1. Organisation for Economic Co-operation and Development (OECD). The looming crisis in the health workforce: how can OECD countries respond? OECD Health Policy Studies; 2008.
2. Kingma M. Nurses on the move: a global overview. *Health Serv Res*. 2007; 42(3 pt 2):1281-1298.
3. Oulton JA. The global nursing shortage: an overview of issues and actions. *Policy Polit Nurs Pract*. 2006; 7(3Supp): 345-39S.
4. Berney B, Needleman J, Kovner C. Factors influencing the use of registered nurse overtime in hospitals, 1995-2000. *Image J Nurs Sch*. 2005; 38(1):165-172.
5. Aiken LH, Xue Clarke SP, Sloane DM. Supplemental nurse staffing in hospitals and quality of care. *J Nurs Adm*. 2007; 37(7-8): 335-342.
6. Brownson K, Harriman RL. Recruiting and retaining staff in the twenty-first century. *Hospital Material Management Quarterly*. 2000; 22(2): 34-44.
7. Waldman JD, Kelly F, Arora S, Smith HL. The shocking cost of turnover in healthcare. *Health Care Manage Rev*. 2004; 29(1): 2-7.
8. O'Brien-Pallas L, Griffin P, Shamian J, Buchan J, Duffield C, Hughes F, et al. The impact of nurse turnover on patient, nurse, and system outcomes: a pilot study and focus for a multicenter international study. *Policy Polit Nurs Pract*. 2006;7(3):169-179.
9. Aiken LH, Clarke SP, Sloan DM, Solchalski J, Silber JH. Hospital nurse staffing and patient mortality, nurse burnout, and job satisfaction. *JAMA*. 2002; 288(16): 1987-1993.
10. Lankshear AJ, Sheldon TA, Maynard A. Nurse staffing and healthcare outcomes: a systematic review of the international research evidence. *ANS Adv Nurs Sci*. 2005; 28(2): 163-174.
11. Sasichay-Akkadechanunt T, Scalzi CC, Jawad AF. The relationship between nurse staffing and patient outcomes. *J Nurs Adm*. 2003;33(9):478-485.

12. Van den Heede K, Clarke SP, Sermeus W, Vleugels W, Aiken LH. International experts' perspectives on the state of the nurse staffing and patient outcomes literature. *Image J Nurs Sch.* 2007; 39(4): 290-297.
13. Abelson MA. Optimal and dysfunctional turnover: toward an organisational model. *Acad Manage Rev.* 1984; 9(2): 331-341.
14. Price JL. The consequences of turnover. Ames, IW: Iowa State University Press; 1977.
15. Staw BM. The consequences of turnover. *Journal of Occupational Behavior.* 1980; 1: 253-274.
16. Hayes LJ, O'Brien-Pallas L, Duffield C, Shamian J, Buchan J, Hughes F, et al. Nurse turnover: a literature review. *Int J Nurs Stud.* 2006; 43(2): 237-263.
17. Wright PC, Mondy RW, Noe RM. Human resource management. Canadian Edition, Scarborough, ONT: Prentice-Hall Canada; 1996: 110.
18. Catano VM, Cronshaw SF, Wiesner WH, Hackett RD, Methot LL. Recruitment and Selection in Canada. Toronto, ONT: ITP Nelson; 1997.
19. Rynes SL. Recruitment, job choice, and post-hire consequences. In: Dunnette MD, Hough LM. Handbook of industrial and organisational psychology. Volume 2. Palo Alto, CA: Consulting Psychologists Press; 1991.
20. Wanous JP, Colella A. Organisational entry research: current status and future directions. In: Rowland KM, Ferris GR. Research in personnel and human resource management. Volume 7. Greenwich, CT: JAI Press; 1989.
21. Wanous JP. Organisational Entry. 2nd Edition, Reading, MA: Addison-Wesley; 1992.
22. Russell J. Social networking: applications for healthcare recruitment. *Nurs Econ.* 2007; 25(5): 299-301.
23. Wanberg CR, Kanfer R, Banas JT. Predictors and outcomes of networking intensity among job seekers. *J Appl Psych.* 2000; 85(4): 491-503.
24. Ashby FC, Pell AR. Embracing excellence: becoming an employer of choice to attract and keep the best talent. Upper Saddle River, NJ: Prentice-Hall; 2001.
25. Herman RE, Gioia JE. How to become an employer of choice. Winchester, VA: Oakhill Press; 2000.
26. Kramer M. The magnet hospitals: excellence revisited. *J Nurs Adm.* 1990; 20(9): 35-44.
27. Upenieks VV. Assessing differences in job satisfaction of nurses in magnet and nonmagnet hospitals. *J Nurs Adm.* 2002; 32(11): 564-576.
28. Lacey SR, Cox KS, Lorfing KC, Teasley SL, Carroll CA, Sexton K. Nursing support, workload, and intent to stay in magnet, magnet-aspiring, and non-magnet hospitals. *J Nurs Adm.* 2007; 37(4): 199-205.
29. Smith H, Tallman R, Kelly K. Magnet hospital characteristics and northern Canadian nurses' job satisfaction. *Can J Nurs Leadersh.* 2006; 19(3): 73-86.
30. Stordeur S, D'Hoore W. Organisational configuration of hospitals succeeding in attracting and retaining nurses. *Journal of Advanced Nursing.* 2006; 57(1): 45-58.
31. Rondeau KV, Williams ES, Wagar TH. Turnover and vacancy rates for registered nurses: do local labor market factors matter? *Health Care Manage Rev.* 2008; 33(1): 69-78.
32. Blegen MA, Vaughn T, Vojir CP. Nurse staffing levels: impact of organisational characteristics and registered nurse supply. *Health Serv Res.* 2008; 43(1 pt 1): 154-173.
33. Canadian Healthcare Association (CHA). Guide to Canadian healthcare facilities. Ottawa, ONT: Canadian Healthcare Association Press; 2001.
34. Rondeau KV, Wagar TH. Nurse and resident satisfaction in magnet long-term care organisations: do high involvement approaches matter? *J Nurs Manag.* 2006; 14(3): 244-250.



Managing Health Services: Concepts and Practice – 2ND EDITION

To order your copy of this book please contact:

Elsevier Australia Customer Service

- Phone 1800 263 951
- Fax 02 9517 8950
- Email: customerserviceau@elsevier.com
- Quote the following code number and receive 10% discount and free delivery within Australia and New Zealand
- Code Number: HPHMG1005W

Pub Sept 2005 • ISBN 0729537595 • PB • 496pp • Mosby A\$79.95 • NZ\$94.50

Mosby is an imprint of Elsevier Australia

After Hours Palliative Care Provision in Rural and Urban Victoria, Australia

L Ciechomski, H Tan, M O'Connor, G Miles, B Klein and P Schattner

Abstract

Objective: This paper reports the preliminary findings of a project exploring after hours palliative care service provision in three regions of Victoria, Australia. The outcomes of this phase will inform the subsequent quantitative survey in the next phase.

Design: Qualitative: thematic analysis of transcribed semi-structured interviews.

Setting: Of the three participating regions, one is classed as urban (highly accessible), one both urban and rural areas (45% highly accessible, 65% accessible), while the third is entirely rural (19% accessible, 65% moderately accessible, 16% not classified).

Participants: Thirty-eight interviews were completed with general practitioners (12), nurses (12), managers (5), terminally ill people and their carers interviewed together (9). Participants were recruited from across the three participating regions through the relevant Divisions of General Practice and the participating palliative care services.

Result: Some examples of satisfaction with services were indicated, however, gaps in the provision of after hours palliative care services, such as training, remuneration and availability of general practitioners, care planning that includes after hours care, interdisciplinary team communication issues, staff safety and after hours telephone support and information for families, were all identified by stakeholders. These results will be used to inform the development of a quantitative study to explore these issues with a larger number of participants.

Conclusion: Further research is needed to explore these gaps and to test alternative or modified models of after hours care. Awareness of these problems can be used to inform policy development for after hours service arrangements.

Abbreviations: GP – General Practitioner; AHTSS – After Hours Telephone Support Service; EPC – Enhanced Primary Care; PEPA - Program of Experience in the Palliative Care Approach.

Key Words: palliative care, after hours, qualitative, dying, home care.

Dr Lisa Ciechomski PhD, BPsych
e-Therapy Unit
Faculty of Life and Social Sciences
Swinburne University of Technology
Hawthorn, Victoria, Australia
(Note: was at School of Nursing and Midwifery
Monash University, Victoria, Australia at the time of the study)

Dr Heather Tan PhD, M Gr&PCC, BSc, Grad Dip Ed
Research Fellow
School of Nursing and Midwifery
Monash University, Victoria, Australia

Professor Margaret O'Connor DN, MN, BTheol, RN,
FRCNA, AIMM
Vivian Bullwinkel Chair of Nursing (Palliative Care)
School of Nursing and Midwifery
Monash University, Victoria, Australia

Dr Gail Miles DN, MPubH, BAppSci, RN
Royal District Nursing Service
St Kilda, Victoria, Australia

Associate Professor Britt Klein DPsych, BA
Co-Director, e-Therapy Unit
Faculty of Life and Social Sciences
Swinburne University of Technology
Hawthorn, Victoria, Australia

Associate Professor Peter Schattner MD, MMed,
FRACGP
Department of General Practice
Monash University, Notting Hill, Victoria, Australia

Correspondence:
Heather.Tan@med.monash.edu.au

Introduction

Palliative care in Australia has developed in response to local need. In recent years dependence on primary healthcare providers has become the dominant model of palliative care provision. [1] Published literature, describing after hours palliative care service provision in Australia, has highlighted gaps in service delivery such as access in rural areas to specialist palliative care staff, strategies to facilitate communication between service providers and regular clinical up-skilling. [2] Low numbers of people receiving palliative care in any one area, General Practitioner (GP) shortage, and the different needs of Indigenous patients, have also been cited as challenges in rural areas. [3]

Studies have consistently shown that most people with a life limiting illness prefer to die at home. [4, 5] Indigenous people living in rural and remote settings have a clear preference for dying at home. [6] In some regional areas only 19% of Australians receiving palliative care achieve this goal. [7] While the provision of community nurse support has been shown to enhance home care, [8] some problems remain including: poor communications between services providing care, [9] increasing complexity of symptoms, difficulty accessing medications [10] and unwillingness of carers to contact available after hours services. [11]

In some regions in Australia, after hours home nursing services are not available and specialist after hours telephone support has only become available in recent years.

An After Hours Telephone Support Service (AHTSS) for people requiring palliative care and their family, implemented in rural New South Wales, has led to positive outcomes. [8] Registered clinical nurses providing AHTSS reported that most callers needed reassurance in relation to specific care issues. There was evidence that an AHTSS reduced hospital admissions.

In 2000 the Enhanced Primary Care (EPC) items of the Australian National Health System (Medicare) were extended to cover chronic diseases to support the work of GPs. Incentives were provided for the development of management plans and team care arrangements for patients receiving care for chronic and complex illnesses including palliative care. [12]

Research aimed at increasing palliative care in primary healthcare services in rural and remote Australian communities demonstrated that GPs and other healthcare providers who participated in workshops that included participant nominated topics, small group case management discussion and psychosocial and counselling issues, had significantly greater confidence in managing symptoms such as pain, following the training. [13] The opportunity for regular training is now available to Australian GPs through initiatives such as the Program of Experience in the Palliative Care Approach (PEPA). [14]

Table 1: Characteristics of participating Divisions.

Area	A	B	C
Description	Inner urban	Semi-urban, retirement area	Small and medium towns, some areas quite isolated
Area Covered (Square Kilometres)	69	851	27,778
Population (2001 census)	137,986	266,469	74,266
ARIA¹ – score range	0	0 – 1.3740	1.7997 – 5.8798
– average score	0	0.4099	3.3584
– accessibility	All areas HA ²	14 areas HA 17 areas A ³	6 areas A 21 areas MA ⁴ 5 areas no classification available

1 Accessibility/Remoteness Index of Australia. [15]

2 Highly Accessible – relatively unrestricted accessibility to a wide range of goods and services and opportunities for social interaction.

3 Accessible – some restrictions to accessibility of some goods, services and opportunities for social interaction.

4 Moderately Accessible – significantly restricted accessibility of goods and services and opportunities for social interaction.

Method

The project was approved by the ethics committee of Monash University and those committees relevant to participating hospitals and community services. Three Divisions of General Practice also consented to be involved. These Divisions are characterised in Table 1. GPs were recruited through the participating Divisions (A, B and C), utilising advertisements in their internal email bulletins and newsletters as well as flyers provided to practices. Nurses were similarly recruited through participating nursing services. Letters were also sent to service managers. People receiving palliative care and their carers were recruited through the community service nurses, who provided those interested with explanatory

material. All participants gave informed consent prior to being interviewed.

Semi-structured interviews were conducted by two experienced qualitative researchers with nurses (n=12), managers (n=5), GPs (n=12), people receiving palliative care and their carers interviewed together (n=9). The percentage of the total interviews carried out within the service areas of the three participating Divisions were as follows: Division A 41%, Division B 25% and Division C 34%. A list of prompt questions was developed for health professionals and other participants (Tables 2 and 3). The interview process was exploratory and open-ended. All interviews were audio-recorded and transcribed verbatim.

Table 2: Questions for doctors, nurses and managers

Please describe the 'after hours' service that you provide for your patients receiving palliative care:

- What form of service do you provide eg, telephone calls, home visits, hospital visits?
- How do you record after hours services?
- How do patients know who to contact?
- What sort of distances are you travelling to make the visits?
- Can you describe some of the main problems that you deal with when you provide palliative care services?
- Which ones are more common?
- Which ones are more difficult to manage and why?
- Are there any other problems that patients might have in receiving 'after hours' care, not necessarily from you?
- Do you see any gaps in the service?
- If so, how can these be redressed?

Table 3: Questions for patients and carers

Please describe the 'after hours' service that you receive for your palliative care needs:

- On average, how frequently do you receive this service?
- What form of service have you received eg, telephone calls, home visits, hospital visit?
- Who has been making the after hours visit/s? Nurse/GP/other
- How do you know who to contact?

Describe some of the main health problems you have had when you needed 'after hours' palliative care services.

- Which ones are more common?
- Which ones were not resolved and why?

The language texts were entered into the Qualitative Solutions Research (QSR) NVivo (7.0) computer program and thematically analysed. All participants' comments were coded into nodes (a collection of references about a specific theme) and the emergent themes identified. In order to maintain confidentiality, no identifying information has been included in the reporting of findings.

Results

The identified themes emerging from the data fell broadly into two categories: good practices experienced or observed relating to after hours palliative care services and challenges faced in the provision of after hours services.

(1) Good practices observed in after hours palliative care service provision

All categories of stakeholder provided examples of good practices contributing to the quality of after hours services. These are summarised in Table 4.

Education was a key theme and situations in which current education programs have proved successful were identified. Nurses and managers spoke of the importance of educating families early, in relation to symptom management and the administration of medication. This importance is emphasised by this statement from a carer:

Mum used to get bowel obstructions and she would start vomiting a lot with that and have a lot of pain and just occasionally the pain relief I was giving her wasn't working so I would call them and they would check it all out and give me permission to give her more or whatever I could do for her. *Carer.*

Both GPs and nurses considered that good communication amongst team members was very important and reported relevant examples. They commented on the benefits of the training offered to GPs by one of the participating Divisions:

They've actually got a program that runs through hospice where the doctors come out on the road to see what we actually do, and this helps because they can see where we're coming from and why we do the things that we do, and then they feel more confident in us as a team to prescribe medications knowing how we work. *Nurse.*

The case manager (nurse) is very informative about all these community services. They are much better than us, they know exactly who to call and they can pull strings we can't. If you get a good case manager you have it made. They organise everything and can get a bed. *GP.*

All participating services provided some level of after hours telephone service and managers spoke specifically about the benefit of triaging calls after hours:

That means that people are not getting a huge number of calls. People aren't getting woken up at three o'clock in the morning because someone rings and remembers that they're going shopping tomorrow and they're cancelling their visit. *Manager.*

Table 4: Good practice observed in after hours palliative care service provision

- Education of families in good symptom management is a key for patients being cared for at home. This reduces panic responses by carers and increases the likelihood of timely application of appropriate medication after hours.
- Regular fortnightly meetings between nurses and GPs greatly improves communication and helps to ensure that those staff involved in after hours care have all the relevant information needed to provide best care after hours.
- Hospital palliative care coordinators triaging calls determine whether phone advice or a home visit is needed. At times all that is needed is reassurance that support after hours is available including a visit if needed.

(2) Challenges in after hours palliative care service provision

The professionals, carers and terminally ill participants all reported a number of challenges in after hours palliative care service. These are summarised in Table 5 and illustrated below.

Despite the availability of an after hours service in all three participating Divisions, it was evident that some families are reluctant to call this service, sometimes resulting in patients deteriorating or spending unnecessary time in emergency departments:

Sometimes families do tend to ring the ambulance, even though they know about the on call service. They don't ring (the on-call service) because they don't want to disturb us, or they think it's an emergency. *Manager.*

Access to GPs or locums after hours was reported as problematic and variable by both urban and rural nurses. Filling prescriptions and obtaining emergency medication after hours can be difficult. One nurse reported that she had been refused medications by GPs for people who had then subsequently deteriorated quickly over the weekend:

Some GPs don't see the purpose of it (emergency medication), or don't think the patient really needs it. *Nurse.*

Another implication of lack of access to GPs was the issue of certification of death, nurses not being legally able to do this:

I had one the other day and the local doctor refused to come out and the relative insisted because they'd promised the mum that unless a doctor came to certify they wouldn't let her go out the house so there's an issue around certification of death. *Manager.*

Problems with current education programs were evident, one example being that some GPs were unaware that the use of EPC items on the Medicare schedule included care planning and team meetings for people requiring palliative care. Another example was a lack of palliative care trained staff for after hours work that was identified by GPs and nurse managers, with one GP indicating that 'many people that are working after hours are trained in acute, curative medicine rather than palliative medicine, so they are inappropriate providers after hours'.

Carers were also aware of problems in providing after hours care:

Well I really can't see how they can improve... they're (the nurses) probably overworked. *Carer.*

Table 5: Challenges in after hours palliative care service provision

Need for uniformity in after hours care

- Nurse safety is an issue in rural areas

Note: many of the issues listed below, such as access to GPs, availability of locums and after hours call services are also relevant to this section.

Training, access to and remuneration of GPs

- Access to GPs after hours is a problem in some areas.
- Some GPs will not supply emergency medication in the patient's home.
- Certification of death can be problematic after hours.
- Some carers do not access formal respite services even when this service is available.

Support for people receiving palliative care and their carers

- In crisis situations, some people receiving palliative care are still spending several hours in emergency departments.
- Some people do not call the after hours palliative care service.
- Terminally ill people and their carers want access to experienced palliative care nurses for after hours telephone advice and visits.
- People do not call the locum service because of the long wait for a doctor. They prefer to wait for the nurse to visit in the morning, and symptoms may worsen overnight.

Even when available, staff safety was an issue especially in rural areas due to lack of mobile phone coverage, poor roads and long distances to travel:

‘Driving there it isn’t safe, in that the kangaroos are just ... one person did drive there and said it was seventy kangaroos they counted on their way, a huge number’.
Nurse.

Discussion

The findings of phase one of this study indicate that although some aspects of after hours palliative care service provision are working well, all stakeholders still face challenges in providing or accessing these care services. The main issues identified are discussed below.

(1) The need for uniformity in after hours palliative care services

After hours palliative care services vary in the three participating regions, especially in relation to availability and level of after hours telephone services, availability of GPs and palliative care beds, and access to after hours support for health professionals. Generally, the more rural the area the more disadvantaged it is. These outcomes are consistent with other studies. [2, 3, 6] A more equitable and adequate provision of community after hours palliative care support, delivered at a consistent level across all areas, would probably improve the percentage of terminally ill people able to meet their desired outcome of dying at home. [7] This is certainly the vision of current State Government policy. [16]

(2) Training, access to and remuneration for GPs

The findings of this study indicating reduced access to medical advice, lack of after hours access to medication and the changing role of GPs, evident in all areas although particularly apparent in rural areas, are not unique. They have also been reported in other rural areas of Australia [2, 3] and in relation to after hours palliative care services in the United Kingdom. [10]

Continuing education of GPs about EPC items for palliative care services such as care planning, which should include after hours needs, similar to the changes reported in the United Kingdom [16] may improve GP remuneration and encourage their focus on the provision of after hours palliative care. Further investigation is required into the most appropriate way to accommodate the needs of busy professionals and the unique problems of rural areas. These issues are being pursued in later phases of this study.

The results of this study suggest that many GPs are no longer conducting home visits and refer their patients to a locum service, particularly at night. However there is also

evidence that GPs would like access to specialist palliative care training and additional back-up by specialists. This outcome is consistent with the work of other researchers. [3, 13] It was also evident that nurses require greater access to after hours advice from GPs and specialists, especially in relation to emergency medications. The most effective ways of providing training and access to after hours assistance for professionals will be the subject of further investigation in this study.

(3) Support for people receiving palliative care and their carers

Some after hours telephone support was available in the three participating service areas in this study. Earlier studies have shown that terminally ill people and their carers benefit from access to such services. [8] Preliminary results of the study suggest that carers may be reluctant to contact after hours services, a finding consistent with the literature. [11] These findings highlight a need for ongoing provision of information for families about access to after hours palliative care services and suggest that they need to be regularly encouraged to use this type of service when needed. Ways of providing this information will be investigated in later stages of this study.

Some themes common to both GP and nurse responses, especially in relation to how after hours services could be improved, did emerge. Some examples are the need for improved communication between GPs and palliative services, improving availability of scripts for after hours emergency medication, staffing levels; especially for after hours staff and issues of distance and safety for after hours staff. These issues were further explored in the quantitative study conducted in phase two of this project.

Conclusion

While there will always be unpredictable crises, regardless of the model of care adopted, [10] the preliminary findings of this study indicate that there are currently several challenges in after hours palliative care provision. These include: the remuneration and training of GPs in palliative care provision, after hours telephone support for professionals, people receiving palliative care and their carers, and more information for families about the availability and utilisation of after hours services. These matters require further investigation and the development of strategies to improve after hours service.

Competing interests

The authors declare that they have no competing interests.

References

1. Zappart S, Kenny P, Hall J, Servis B. Home-based palliative care in Sydney Australia: the carer's perspective on the provision of informal care. *Health Soc Care Community*. 2007;15(2):97-107.
2. Phillips J, Davidson P, Jackson D, Kristjanson L, Bennett M, Daly J. Enhancing palliative care delivery in a regional community in Australia. *Aust Health Rev*. 2006;30(3):370-9.
3. Pereira G. Palliative care in the hinterlands: a description of existing services and doctors' attitudes. *Aust J Rural Health*. 2005;13:343-7.
4. Higginson IJ, Sen-Gupta GJA. Place of Care in Advanced Cancer: a qualitative systematic literature review of patient preferences. *J Palliat Care*. 2000;3(3):287-300.
5. Tang ST. When death is imminent: where terminally ill patients with cancer prefer to die and why. *Cancer Nurs*. 2003;26(3):245-51.
6. McGrath P. 'I don't want to be in that big city; this is my country here': research findings on Aboriginal peoples' preference to die at home. *Aust J Rural Health*. 2007;15:264-8.
7. Howat A, Veitch C, Cairns W. A retrospective review of place of death of palliative care patients in regional north Queensland. *Palliat Med*. 2007;21:41-7.
8. Wilkes L, Mohan S, White K, Smith H. Evaluation of an after hours telephone support service for rural palliative care patients and their families: a pilot study. *Aust J Rural Health*. 2004;12:95-8.
9. Jo S, Brazil K, Lohfeld L, Willison K. Caregiving at the end of life: perspectives from spousal caregivers and care recipients. *Palliat Support Care*. 2007;5:11-7.
10. Thomas K. Out-of-hours palliative care - bridging the gap. *European Journal of Palliative Care*. 2000;7(1):22-5.
11. Worth A, Boyd K, Kendall M, Heaney D, Macleod U, Cormie P, Hockley J, and Murray S. Out of hours palliative care: a qualitative study of cancer patients, carers and professionals. *Br J Gen Pract*. 2006 January;56(522):6-13.
12. Australian Department of Health and Ageing. Enhanced Primary Care Medicare Items: Note A30. 2000. Available from: www9.health.gov.au/mbs
13. Reymond L, Charles M, Israel F, Read T, Treston P. A strategy to increase palliative care capacity of rural primary healthcare providers. *Aust J Rural Health*. 2005;13:156-61.
14. National Palliative Care Program. PEPA - Program of Experience in the Palliative Care Approach. 2005 [cited 2008]; Available from: <http://www.pepaeducation.com>
15. Australian Department of Health and Ageing. Accessibility/ Remoteness Index of Australia (ARIA): Search Facility. [cited 2008 8th May]; Available from: <http://www9.health.gov.au/aria/ariaintp.cfm>
16. Victorian Government Department of Human Services. 2004. Strengthening Palliative Care: a policy of health and community care providers 2004-09. Available from: <http://www.dhs.vic.au/ahs/concare.htm>.

Caring for the super of over 600,000 of us
While we're busy taking care of others, HESTA is busy taking care of us.






H.E.S.T.A. Australia Limited ABN 44 004 818 495 AFSL 215 249 HESTA Super Fund ABN 44 871 749221
 Consider our Product Disclosure Statement before making a decision about HESTA
 +61 800 813 127 or visit www.hesta.com.au for a copy

www.hesta.com.au

Health System Responsiveness in Preventive Healthcare in Indonesia: implications for policy and practice

N K Aryastami, N Kusumawardani and S Siahaan

Abstract

The responsiveness of the Indonesian preventative health service towards children's nutritional and immunisation status has been analysed utilising the 2004 National Household Health Survey data. The objective is to understand the health system's responsiveness from the mother's perspective, against seven domains of health system responsiveness and assess the implications for policy and practice. The survey included the youngest children, aged 12-59 months, of mothers who are included in this survey. Nutritional status was described in terms of weight and age indicators. The data were processed by SPSS 10.1 version.

The prevalence of under-nourished children is 27.9% of the 1400 children included in this analysis. This percentage has increased compared to the previous study. [1] There was no association between completeness of immunisation and nutritional status ($p=0.16$; $OR=0.75$, $CI=0.51-1.09$). Furthermore, there was no significant difference on nutritional status if children

were regularly weighed or not, except for vitamin A supplementation ($p=0.04$). In addition, there was no significant difference between mothers' satisfaction and completeness of immunisation or the availability of public transportation.

There was no significant difference in responsiveness of the health system and nutritional status or completeness of immunisation. However, there was a difference with these measures in respect to seeking to use health services in relation to responsiveness (aspect of friendliness of health personnel) ($P=0.05$).

Keywords: Health system responsiveness; preventive healthcare.

Abbreviations: BCG – Bacillus Galmette-Guerin; DPT – Dyptheria; IDHS- Indonesia Demography and Health Survey; HHS: Household Health Survey; KMS: Child Health Card; NSS: National Socio-Economic Survey; WHO – World Health Organization.

Ketut Aryastami MCommNut, MHLthSerRes
Centre for Health System and Policy Research
National Institute of Health Research and Development
Ministry of Health, Indonesia

Nunik Kusumawardani MSc(PubHlth)
Centre for Biomedical Research and Pharmacy
National Institute of Health Research and Development
Ministry of Health, Indonesia

Selma Siahaan MHA
Centre for Health System and Policy Research
National Institute of Health Research and Development
Ministry of Health, Indonesia

Correspondence:
aryastami@litbang.depkes.go.id

Introduction

Health system responsiveness is a method of measuring performance related to the quality of services provided by healthcare facilities or the health system. It is based on the perception and information given by the community according to their experience of visiting healthcare facilities. The World Health Organization (WHO) operationalised the concept of health system responsiveness in eight domains: 1) respect for the dignity of persons; 2) autonomy to part-icipate in health-related decisions; 3) confidentiality; 4) prompt attention; 5) adequate quality of care; 6) communication; 7) access to social support networks; and 8) choice of healthcare providers. [3]

This analysis includes seven domains adapted from the WHO concept that have been adjusted to the local situation: 1) spending time waiting for the health services; 2) confidentiality; 3) health worker friendliness; 4) communication and clear information given by health providers; 5) choice of healthcare providers; 6) autonomy to participate in health-related decisions; and 7) facility cleanliness.

Public health is the responsibility of the government as well as the community. The government's responsibility is to improve community health status in affordable ways, with fairness and equity. Health problems are closely related to many other factors, not only the availability of healthcare facilities, but also the socio-cultural perspective of the community, as well as access in affordability and infrastructure. Previous studies have shown that morbidity and mortality tend to be higher in communities with lower socio-economic status. [1] In addition, inefficient health services can reduce the ability of the community to gain access to healthcare facilities. [2, 3]

The analysis of the Indonesia Demography and Health Survey (IDHS) 1997, showed that there was a gap in access to childhood immunisation among the under-five age group because of socio-economic status. [4] The issue of health system responsiveness was supposed to be able to address this condition so that these dimensions could be understood and used in problem-solving in the future.

The objective of this analysis is to study health system responsiveness related to the childhood nutrition and immunisation status from the community perspective. In Indonesia, various programs have been developed to improve the community's health status. These include health promotion, prevention, curative and rehabilitation programs. For example, children in the under-five years age group have been provided immunisation freely by the government, including Bacillus Calmette-Guérin (BCG), Diphtheria (DPT), Polio, Measles and Hepatitis B. [5] Immunisation is compulsory for the under-five age group and is ideally completed before the children are 12 months of age. However, it is commonly observed that children are not completely immunised within that time frame.

Nutritional program implementation for the under-five age group included anthropometry measurement and vitamin A supplementation. Anthropometry measurement refers to comparing the child's age and body weight, which are plotted into the child's health card called 'KMS'. The measurement is completed every month at the integrated health

post called 'posyandu'. The KMS card describes in chart form the pattern of body weight of a healthy child. The use of the KMS card is very efficient in monitoring the health and nutritional status until five years of age.

A massive dose (200,000 IU) of vitamin A supplementation is implemented every six months. The purpose of this program is to prevent blindness prevalence as well as reduce morbidity in children under five years of age. Indonesia has been declared free of Xerophthalmia as the prevalence is 0.33%. [6]

Access to health services is one of the intermediate variables towards children's health status in spite of health behaviour and environmental health. Access is determined by many attributable factors, such as socio-economic status (it assumed that those who have money and education tend to seek healthcare when they get sick as being financially affordable), the availability of healthcare facilities, time, distance and quality of health services etc. However, some people may not visit the healthcare facilities for their sick children for many reasons. In terms of facilities, posyandu describes a community developed owned and maintained facility from which government health programs are delivered. On the other hand, health centres represent the primary access and delivery point for government health services and are part of the sub-district structure of a district health service.

Methodology

The setting of the study is an integrated National Socio-economic Survey (NSS) (VSEN2004.K; MPK) and Household Health Survey (HHS) 2004 covering 10,000 households. There were 3,104 children in the under-five age group covered in the data, but only 1,400 children matched the analysis criteria; that is, the youngest child in the household aged 12-59 months during the survey.

The design of the study is a cross-sectional study. For this particular analysis the study population was limited to ages 12-59 months in the year 2004. Samples are the youngest children of the households covered in this survey. The sampling strategy implemented for the HHS was according to the NSS; that is three stages of Linear Systematic Sampling: 1) population census; 2) listing for the census block; and 3) random system for 16 households as a sub-block census.

Data collection was by structured interviews, body and health measurements as well as specimen (blood) collection. For this particular analysis, interview data became our major

source of information, supplemented by data available from the NSS and HHS surveys. Data on immunisation were collected subjectively based on mother or child attendants' interviews. Immunisation status was measured by the completeness of immunisation which is compulsory for the under-five age group. The immunisation completeness was defined when children have had all types of vaccines, that is BCG 1x, DPT 3x, Polio 4x, Measles 1x, B-Hepatitis 3x.

Data on health system responsiveness were taken from the variables of HHS 2004, questions Block VII (JA 06-12) including seven domains on health responsiveness: 1) spending time waiting for health services; 2) confidentiality; 3) health worker friendliness; 4) communication and clear information given by health providers; 5) choice of healthcare providers; 6) autonomy to participate in health-related decisions; and 7) facility cleanliness.

Data were analysed utilising the SPSS 10.1 version, and presented in frequency distribution and cross tabulation. The chi-square test was employed to test the statistically significant relations between health system responsiveness and children's nutritional and immunisation status. The primary null hypothesis was that the access to preventive health services such as immunisation and nutrition was not affected by the responsiveness of the health system.

Results

There were 3,104 children covered in the 2004-HHS. Of the total, there were 1,400 children who matched the criteria to be analysed in this study; ie, the youngest child, aged 12-59 months, of every household. The objective of this analysis was to correlate community access to healthcare facilities based upon community perception of health

services provision. Nutritional status of children was used as a dependent variable.

1. Access and community's satisfaction towards preventive care

Access in preventive care, described in Figure 1, was measured by the attendance of children under-five in the weighing program of the previous month, immunisation status, as well as vitamin A supplementation during the last year. Half (53.8%) of the children attended and were weighed in the previous month and only 11.4% were immunized completely and precisely at the right ages for all types of immunisation, suggesting that access to preventive care was still very low. Vitamin A supplementation was given to 75% of the children.

Access to the healthcare facilities described in Figure 2 was also measured by the availability of the public transportation and time in distance. More than 80% of mothers having children in the under-five age group said that public transportation is available, and only 46% said that the distance to the public health facilities is relatively close (less than one kilometre).

Patients' (mothers') experience of health service satisfaction while seeking care for children (coughing/fever/diarrhoea) during the last year is described in Figure 3. Of the 1400 respondents, only 697 children were sick and required outpatient treatment. 637 responded to the interview question related to satisfaction with services.

Furthermore, all of those variables were further analysed employing the chi-square test to estimate the risk factor (odd ratio) as can be seen in Table 1.

Figure 1: Frequency distribution of preventive health services indicators of children in the under-five years age group

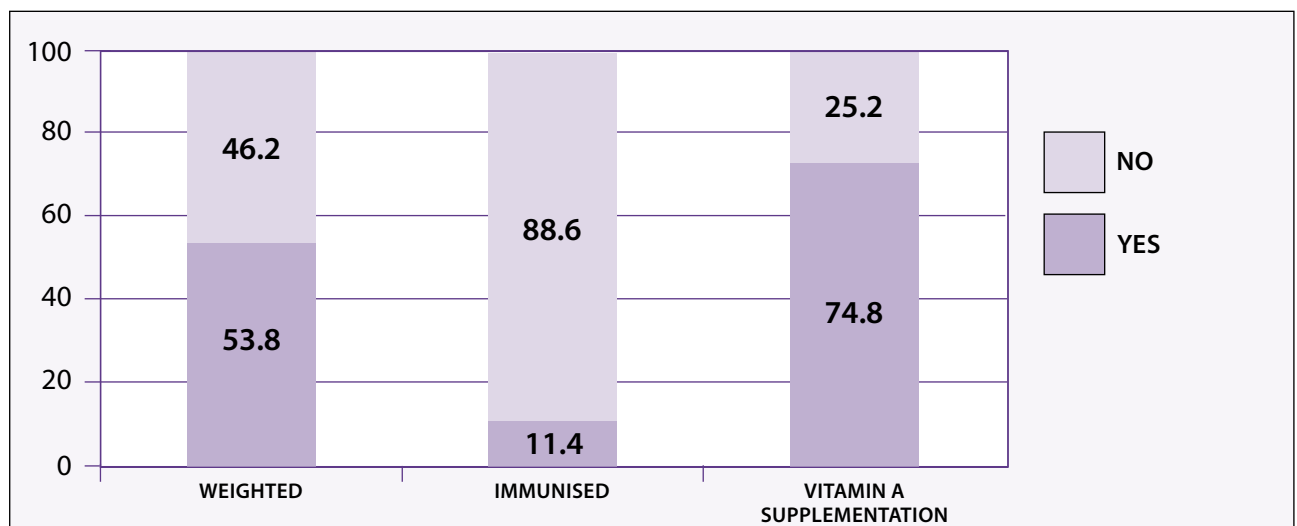


Figure 2: Frequency distribution of access indicators to healthcare facilities

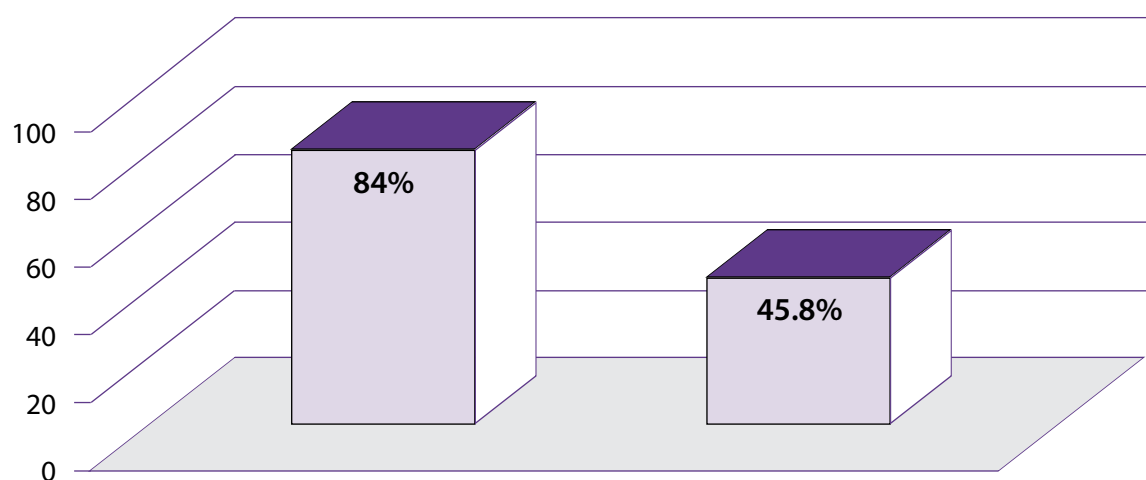


Figure 3: Frequency distribution of mothers' satisfaction with outpatients (n=637)

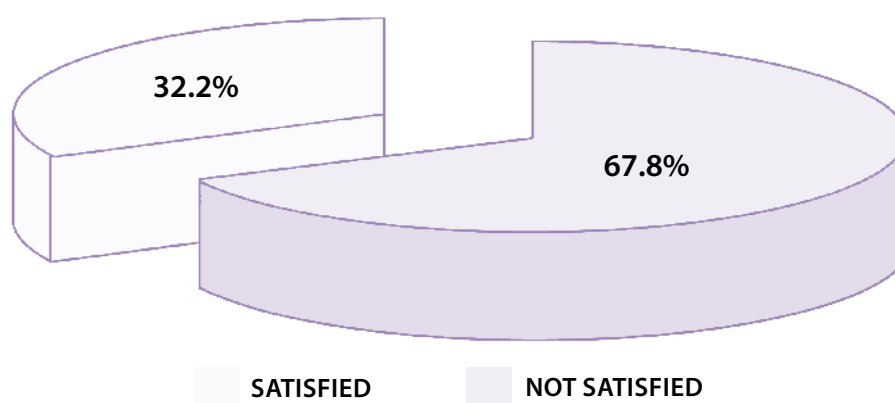


Table 1: The correlation of access and patient's satisfaction with completeness of immunisation

INDICATORS	COMPLETE IMMUNISATION	N TOTAL	P	OR	CI
Public transportation					
Available	12.3	1400	0.06	0.61	0.37-1.01
Not available	7.9				
Distance to h-facility					
Far (> 1 km)	14.0	1400	0.00	0.55	0.39-0.79
Close (<=1 km)	8.3				
Patient's satisfaction					
Satisfied	13.4	637	0.24	0.71	0.41-1.20
Not satisfied	9.8				

There was a gap between the transportation availability and the completeness of immunisation status. Significant difference was shown between the completeness of immunisation and distance to healthcare facilities such as health centres/polyclinics ($p=0.00$); however, the risk of completeness of immunisation seems better for the respondents further away (> 1 km) than those at a closer distance ($OR=0.55$, $CI=0.39-0.79$). In other words, people who live at a distance of one kilometre or further tend to have immunisation completeness more than twice that of those who live closer. Mothers' satisfaction of health services was examined in respect to the completeness of immunisation. Mothers who were less satisfied with the services had a higher risk of not coming to immunise their children, though the result was not significantly different ($p=0.24$; $OR=0.71$; $CI 0.41-1.20$).

2. Community perception of health system responsiveness in delivering services

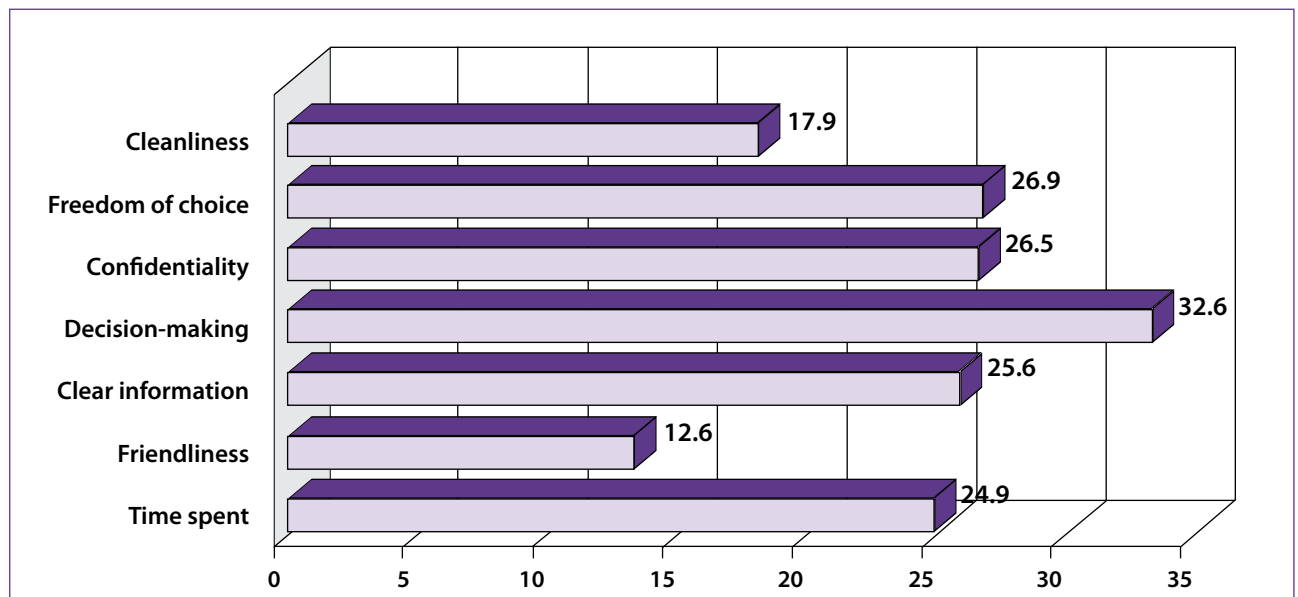
Responsiveness in this analysis was assessed based on respondents' perception of health performance and quality of services provided by the Indonesian government. Although some of the responsiveness domains were theoretically not relevant to relate to immunisation and nutrition status, they were still undertaken to accommodate the purpose of the analysis. In addition, information related to health system responsiveness is rarely available from the Indonesian health statistics. Aspects of health system responsiveness will become more relevant when an examination of hospitalised patients occurs.

Mothers' perception of responsiveness was gained from some 801 of those interviewed as described in Figure 4. Criterion 'less' was classified when the responses to the questions were mediocre, bad and worse in the five criteria stated. In other words, health service friendliness was the best of the criteria served by the health providers (12.6%), followed by cleanliness (17.9%) of the health facilities. Further, autonomy of the respondents to participate in health-related decisions was the worst placed. The other four aspects such as spending time waiting for health services, communication and clear information given by the health providers, confidentiality, as well as choice of healthcare providers were equally distributed.

The analysis results showed none of the responsiveness aspects correlate to the children's nutritional status. Mothers' perception was equally distributed either for 'good' or 'less' nutritional status of children. There was a presumption prior to this analysis that health worker friendliness, spending time waiting and cleanliness of the healthcare facilities would affect the mothers' interest in seeking services, but this examination proved that the hypothesis has to be rejected.

The distribution of the responsiveness aspect and completeness of immunisation seemed reversed. It is hard to explain this situation. Fortunately, statistical examination showed the difference was not significant, even though the p-value of the communication and clear information given by the health providers aspect is nearly significant ($p=0.06$).

Figure 4: Health system responsiveness proportion for the criteria of 'less' among respondents (n=801)



Responsiveness was also analysed from the mothers' perception and experience of seeking out-patient care for their children during the last year. Distribution of health system responsiveness of mothers' experience in outpatient services seemed homogenous. Positive and negative responses were equally distributed ($\pm 60\%$) with approximately neutral odd-ratio. It can be concluded that there was no statistical difference between those two variables.

Discussion

The results showed that only half of the children who attended the posyandu were weighed. This conclusion was very obvious as the national report mentioned that the number and activities of posyandu have declined during this period. This situation is of concern, with the reduction of the number of children who came to the posyandu meaning that children's nutritional status would be more difficult to monitor. In addition, the communication gaps between mother and health provider are getting wider. As a result, efforts to improve the nutrition and health status of the community as part of the country's idealism and health vision are getting harder. [8]

Completeness of immunisation status of children is still low (11.4%). The fact that the nutrition status of children is not yet optimal (undernutrition of 27.9%), increases the need to speed up immunisation coverage to improve morbidity status and to reduce disease incidence in children. Health service systems are said to be run successfully when healthcare is widely available, financially accessible, continually provided, qualified and assured for the client's satisfaction. [9] When all of these indicators can be achieved, the gaps between clients (community) and providers (governments) can be narrowed. In addition, it would influence the community to utilise more of the healthcare facilities so that community health status can be optimally achieved.

Distance and public transportation seemed not to be obstacles in accessing health services. More than 80% of respondents have no problem relating to public transportation and 45.8% have no problems with distance. Nonetheless, distance and availability of public transportation provide no guarantee that the community will actively seek healthcare facilities unless they have knowledge and awareness of the importance of immunisation for children.

Public transportation availability and mothers' satisfaction with health services has no direct correlation to the completeness of immunisation. But the odd ratios indicate

that the immunisation completeness is better when public transportation is available and mothers are satisfied with the services provided by the government. On the other hand, distance to the healthcare facilities (health centres/polyclinics) makes a significant difference to immunisation completeness. Complete immunisation status is higher in children who live farther from the healthcare facilities (14% versus 8.3%). This was possibly due to the situation that the immunisation activity was no longer conducted in the health centres, but at the posyandu in the neighbourhood. Although the community lives close to the health centre, it doesn't mean that the children have completed their immunisation status. Child health promotion activities towards specific vertical programs such as immunised and growth monitoring need to be strengthened as it obviously has capacity in helping to prevent children from experiencing unexpected diseases. [10] Other factors may influence this situation such as knowledge and awareness of the family related to child health.

Although immunisation is delivered freely, other intangible causes and obstacles are always possible, such as allocation of the mother's time to bring her children to the healthcare facilities, or availability of money to pay for the transportation. For those reasons, the health system needs to be re-adjusted. Either cadres or nurses need to pick up or visit the children or, a sanction provided to mothers who did not bring the child to be immunised. As a consequence, the acceleration of health service improvement can be achieved and the performance of the health providers can be optimised. [11] When the mothers feel satisfied with the service, it is expected that they will come again and again for immunisation and other services.

Mothers' satisfaction with health services has a positive impact on immunisation status. WHO stated that public health optimisation can be achieved when there is no more gaps between need and supply 'goodness', and equality 'fairness'. [12] Basically many factors contribute to people's satisfaction with health services such as the eight domains mentioned earlier, but other factors such as culture and environment may still have influence.

This study provides a national perspective on the issues studied. However, it did not address the impact of socio-economic status of households or of educational levels attained by the mothers involved in the study. It also did not attempt to discern any differences between urban and rural populations. Further studies addressing these perspectives would contribute knowledge to policy development in the improvement of services important to the health of children.

Conclusion

Results show that only 11.4% of the children were immunised completely (BCG and Measles 1x, DPT and B-Hepatitis 3x, Polio 4x), having the right sequence of time immunised. Compared to the 2001-HHS results, it seems that only one fifth of the children were immunised in 2004. The possible reasons that can explain this situation were the different categories and frequency of immunisation implemented in the analysis. The examination of a correlation between completed immunisation rates and the nutritional status of children in this analysis was not statistically significant.

Only half of the children attended in the posyandu activity in the last month. This result was not surprising as the national status of posyandu survival is declining. Distance and public transportation availability are not becoming an obstacle. More than 80% of public transportation is available and relatively close to the healthcare facility. Posyandus revitalisation is important to be re-activated in order to bring the services closer to the community and to make mothers more active in bringing the children to get health prevention services.

The examination of distance, time spent and child immunisation status was not statistically significant. There is no correlation between distance and immunisation completeness in this analysis. In addition there is no correlation between children either or not completely immunised and mothers' satisfaction.

The seven aspects or domains of responsiveness starting from the best category showed: 1) friendliness of the health provider; 2) cleanliness of the health facilities; 3) clear information given by the providers; 4) time spent to get the services; 5) choice of healthcare providers; 6) confidentiality; and 7) autonomy to participate in health-related decisions. Not all of the responsiveness aspects of WHO's domain are applicable for the 2004_HHS; especially towards the preventive care and outpatient services. In addition, none of the responsiveness aspect was significantly different related to nutritional status, immunisation completeness as well as outpatient services.

Acknowledgement

Our deep appreciation and thanks to the team of the Household Health Survey 2004, and NIHRD-MoHRI for the opportunity given in analysing the data sets. Our thanks also to the Head of the Centre for Health System and Policy Research for the time permitted to undertake this analysis. Last, but not least, our thanks to the team who undertook this analysis; unless we do it patiently, this result will never be presented.

Competing interests

The authors declare that they have no competing interests.

References

1. Illsley R. Health inequities in Europe. Comparative review of sources, methodology and knowledge. *Soc Sci Med.* 1990;31(3):229-36.
2. Mackenbach JP, Stronks K, Kunst AE. The contribution of medieval care to inequities in health: differences between socioeconomic groups in decline of mortality from condition amenable to medical intervention. *SocSciMed.* 1989;29:369-376.
3. Sundari TK. The untold story: how the healthcare systems in developing countries contribute to maternal mortality. *Int J Health Serv.* 1992; 22(3):513-28.
4. Aryastami K. Inequity and inequality in healthcare utilisation in Indonesia 1997: Analysis of Indonesia's Demographic and Health Survey 1997. Erasmus University: 2001.
5. Ministry of Health Republic of Indonesia. Minister's statement No. 1611/Menkes/SK/XI/2005: Immunisation program guideline. Jakarta: 2005.
6. Community Nutrition Directorate. Nutrition in Number until 2002. Ministry of Health, Directorate General of Community Health: 2003.
7. Gostin L, Hodge JG, Valentin N, Nygren-Krug H. The domains of health responsiveness – A human right analysis. Health and Human Rights Working Paper Series No. 2. WHO: 2003. Available from: http://www.who.int/hhr/information/en/Series_2%20Domains%20of%20health%20responsiveness.pdf (Accessed: May 14, 2007).
8. Ministry of Health Republic of Indonesia. National Health System. Jakarta: 2004.
9. World Health Organization. The world health report. Health system: improving performance. Geneva; World Health Organization: 2000.
10. Ehiri JE, Prowse JM. Child health promotion in developing countries: the case for integration of environmental and social intervention? Review article. *Health Policy Plan;*14(1):1-10.
11. Kusumawardani N. An analysis of seven elements of health responsiveness for outpatients in 14 districts of Intensified Communicable Disease Control (ICDC) project areas in Indonesia [Thesis, MScPH]. Griffith University; 2002.
12. Blendon RJ. The public versus the World Health Organization on health system performance. 2001. *Health Aff.* 2001;20;3.

Can you describe the major approaches adopted in your country/region or more local health services in relation to health systems reform in the past decade or so, and the lessons that you think can be drawn for countries/regions or more localised health services in the Asia Pacific?

In each issue of the *Asia Pacific Journal of Health Management* we ask experienced health managers throughout the Asia Pacific region to reflect on an aspect of health management practice. In this issue of the Journal, our selected participants address the question above.

1 The Australian healthcare system reform has generally been built on the foundation of Medicare, which was introduced in 1984 to provide all Australians with universal healthcare coverage. Medicare has provided a fair and equitable system of access to basic medical and hospital care which can always be improved. Combined with the Pharmaceutical Benefits Scheme that heavily subsidises prescription medications, Medicare has enabled Australians to have one of the best healthcare delivery systems in the world, with the life expectancy of Australians placing us among the top five nations in the world. So most health system reforms generally worked to either improve equity of access, raise quality of care, or increase efficiency, but since 1983 successive governments have realised that the Australian people want universal healthcare coverage retained.

One area of health system reform has been funding. Historical funding, a constant frustration to health service managers in the 1970s and 80s, was seen as an inappropriate way of allocating resources. Allocative efficiency was certainly improved when the health system started moving away from historical to casemix funding in 1993, led by Victoria. This enabled hospitals to make more informed decisions on the most appropriate use of their resources. Casemix funding acted to decrease the cost of healthcare by reducing unnecessary bed days in acute hospitals and improve the overall efficiency of care delivered by the acute sector.

The vigorous use of casemix funding for Weighted Inlier Equivalent Separations payments in Victoria, has not only resulted in the lowest public hospital bed numbers per 1000 of population, but also in very high bed utilisation and regrettably often difficult patient access. Nevertheless, casemix has often resulted in structural reform in hospitals, enhancing the ability of the clinician manager to function

within devolved decision-making structures but with increased accountability. The question remains as to whether the reaching of higher output targets through increased efficiency has led to greater effectiveness or appropriateness in the use of limited healthcare dollars. I suspect not. That is why better coordination of care delivery for people suffering chronic disease and prevention of disease, will need to be given higher priority by decision-makers over the next decade.

Also in the mid-nineties, private health insurance membership was seriously falling, putting significant additional pressure on public hospital waiting lists, while private hospitals were increasingly underutilised. The thirty percent rebate on private health insurance was introduced by the Howard government in 1999 as a reform to encourage more Australians to take out private health cover. Under this policy, the Federal Government returns 30 per cent of the cost of health insurance to the 9.65 million Australians who have private cover and has acted to prevent unsustainable demand on the public hospital system. Australia has a reasonable track record of making good use of both public and private health resources and one would hope that this continues in the current economic downturn. If an ageing population does not see a benefit from retaining costly private health insurance and no incentive exists, there is a serious question as to whether the public hospital system could absorb the resulting significant demand. The subsequent demand would most likely undermine the capacity of the public hospital system to continue to deliver a quality health service.

At about the same time there was a reform to quality and safety in healthcare. The introduction of 'customer focus' strategy in New South Wales (NSW) in 1993 and the rise of the continuous quality improvement movement in the 90s resulted in an increased focus being given

to the process of safety in hospitals beyond the Australian Council on Accreditation Standards accreditation process. Adverse events in 15% of all overnight hospital stays and poor continuity of care helped raise safety and quality as a policy issue, resulting in the Commonwealth establishing the Australian Council on Safety and Quality in Healthcare in 1995.

As a consequence, significant leadership challenges resulted from attempts to change the culture of health facilities to one embracing transparency and open disclosure, measurement, analysis, audit and review, consumer satisfaction, training and multidisciplinary teamwork. A number of public failures of quality in hospitals around most states in Australia raised serious questions as to whether this reform had gone far enough and whether it needed more teeth. The Australian Commission on Safety and Quality was formed on January 1 2006 to ensure that the safety of patients can be assured and that care delivery can be demonstrated to be improving. A greater focus was placed on developing more effective measurement systems and elevated discussion of the role of clinical information systems. The need for a nationally coordinated system reform on health information led to the establishment of the National E-Health Transition Authority, which was long overdue and holds great promise. Furthermore, the work done on leadership development in Queensland clearly demonstrated that health leadership, both clinical and non-clinical, needs to be nurtured and actively supported by governments if safety and quality reforms are going to be made to work. Similar investments can also be seen to be now occurring in Western Australia.

Health system reform in Australia has generally produced a positive effect on the health of the Australian nation. However, there will always be a healthy tension between cost and quality, set in the context of varying funding approaches. Successive State and Commonwealth governments need to keep these management tensions in fine balance along with the weighty expectations of key stakeholders and consumers. This makes the work of the National Health and Hospitals Reform Commission (NHHRC) all the more important to clarify the responsibilities and accountabilities of the Commonwealth and State Governments. The NHHRC needs to ensure that the positive gains made to Australian health system reform in the last three decades are not threatened, but that better healthcare coordination results and that the remaining inequities such as those confronting indigenous and rural communities, are addressed in a substantial manner.

Associate Professor John P Rasa BA, MHP, FCHSE, CHE, FAIM, MAICD, FAHRI

Director

Australian Centre for Leadership Development

2 Where do I begin! The National Health Service (NHS) in the United Kingdom has had a long love affair with organisational reforms over the past decade. Since devolution of government to each of the home countries, organisational arrangements and policy priorities have diverged. However, whereas the reform focus had hitherto been on structural change with the aim of achieving improvements in efficiency, there is now a strong political, professional and societal movement to drive improvements in health and the quality and safety of care.

The NHS celebrated its sixtieth birthday last year. The guiding principles of equal access for all based on need, and free at the point of delivery, remain strong and strongly cherished by the community. Nevertheless, until a few years ago, England was a poor relation of most European countries in terms of access and clinical outcomes around cancer and heart disease survival rates.

Ten years ago, it was not unusual for patients to wait over a year for an out-patient appointment and longer periods for in-patient treatment. Somewhat belatedly, health system reforms are now based very much around quality and safety. Patients in the NHS in England can now expect to wait less than a maximum of 18 weeks from the time of referral to treatment. In addition, a minimum of 98% of patients attending an Accident and Emergency Department will either be discharged or admitted to a ward within four hours. *High Quality Care For All: NHS Next Stage Review Final Report* (DoH, England, 2008) offers some powerful advice to any government or system contemplating reform.

The NHS must respond by improving the quality of care it provides. This is because the evidence shows that, in general, higher quality care works out better for patients and the taxpayer. For instance, day surgery for cataracts delivers the highest quality of care with no admission to hospital. High quality care is safe, meaning no avoidable healthcare associated infections. This is obviously better for patients and also reduces the need for costly post-infection recovery in hospital. Finally, high quality care involves giving the patient more control over their care, including information to make healthy choices, which will reduce their chances of poor health and dependency on the NHS. The answer is therefore to focus on improving the quality of care it provides. (Para 2.29)

The lesson is strikingly clear. The *raison d'être* of any health system is to improve the health of the population and to deliver high quality personalised care. Any reforms *must* focus on these key aspirations. This requires health leaders at all levels to share this vision and to have the ability to inspire and lead their teams in this more challenging, but rewarding, world. It is not therefore about new financing and organisational models but around leading service and quality improvements. If the leadership capacity or capability is not there, improvements will not happen by chance. The NHS, like a number of other health systems including Western Australia Health, has recognised this and made significant investment in leadership development and leadership succession planning to ensure that those charged with leading quality and service improvements have the required vision and capability.

Mr John Clark MSocSc, BSc, AHSM

Director of Medical Leadership and International Relations
NHS Institute for Innovation and Improvement, England and
Director of the Institute for Healthy Leadership, WA Health

3 Hong Kong has often been admired for having a healthcare system that provides access to reasonably high quality care to all of its residents at an affordable price. It has excellent general health status indicators. Spending on health is still low compared to countries in the West. There is no compulsory health insurance or medical savings contributions. Public hospital services are financed almost entirely through government general revenue, despite the fact that tax rates in Hong Kong are amongst the lowest in the world. The income of healthcare providers is high by international standards. Despite all of the above, the dissatisfaction level appears to be higher than ever before for both healthcare providers and consumers in Hong Kong.

There are rising staff shortages, frequently reported medical blunders, unacceptably long and worsening waiting times in the public sector. Serious, perverse incentives exist in the public sector as a result of the historically-based resource allocation system. The private sector has limited hospital capacity and can be easily affected by changes in the dominant and highly subsidised public sector. There is insufficient emphasis on prevention and personal health. Primary care services tend to be episodic and treatment-oriented, lacking in continuity and sparse in prevention. Many highly desirable prevention and early detection services are not provided by the public sector or covered by private health insurance.

While many countries in the Far East implemented substantive reforms in their healthcare financing systems in the 1980s and 1990s, Hong Kong did not. In Hong Kong, the major healthcare system reform initiative in the 1980s to 1990s was the formation of the Hospital Authority in 1990. The Hospital Authority exercise was not a healthcare financing reform measure. It restructured public hospitals under a corporate management framework to modernise care but did not implement any substantive change in the way hospital services are financed. The financing of hospital services remains primarily tax-based. There were no attempts to introduce competition to or within the massive public hospital system either.

With the sustainability of the system being questioned, attempts to reform the healthcare financing system resulted in the publication of four consultation documents within a ten year period: *Improving Hong Kong's Healthcare System: Why and For Whom (1998)*; *Lifelong Investment in Health (2000)*; *Building a Healthy Tomorrow (2005)*; and *Your Health Your Life (2008)*. Government presented six possible financing proposals in the latest consultation exercise: social insurance, increased user fees, mandatory savings, voluntary private health insurance, mandatory private health insurance, and a compulsory savings plus insurance scheme. As with the previous consultations, Government once again concluded that 'the community had rather diverse views on each of the six proposals', and there was no consensus on how to reform the current financing arrangements.

Public reaction to the proposals of the previous consultation papers unmistakably suggest that preserving and improving on the present tax-based financing system as the major source of healthcare financing is the only option. Energy should not be further diverted at finding a replacement for the existing system. Instead, efforts should be directed at improving it. Recent plans by the Hospital Authority to adopt a case-mix and performance-based resource allocation system for public hospitals represent a step in the right direction.

Professor Peter Yuen PhD, BA, MBA, FCHSE(Hon), CHE
Professor, Department of Management and Marketing
Hong Kong Polytechnic University, Kowloon, Hong Kong
and

Dr Man Yung Cheng MBBS(HK), MSc(Birm), FHKCCM(HK),
FHKCHSE, FCHSE, CHE, FRACMA
President, Hong Kong College of Health Service Executives
Senior Advisor, Sure Care Medical and Health Network
Board Member and Chairman, Hong Kong University Family
Institute

4 Thailand has continually improved accessibility to effective healthcare for its citizens. Major approaches to Thailand's healthcare reform in the past decade are as follows:

1. Health financing reform

Thailand changed its health budget from a supply-side allocation to a demand-side allocation. Before 2001, the health budget was allocated by the size of hospitals and on an historical basis. In 2001, the government launched the Universal Health Coverage (UHC) policy, which encourages the reallocation of the health budget to reflect the health needs of the community especially where those communities are located in rural and remote areas on a per capita basis.

At the first launch, the government provided small per capita funding compared to that required for a core package of healthcare. The experience was that this funding was inadequate. The government has continually increased the budget for healthcare each year.

2. Health services delivery reform

The emphasis in Thailand is on reforming health services from curative, hospital-based care to health promotion, disease prevention and primary care-based health services.

Lessons for other countries:

These two approaches were implemented through the UHC policy as 'Big Bang' reform. The key success factor is the leadership of the government and its political commitment. There was some resistance to this reform by medical specialists, but due to the support from the community, as they benefit the most, the resistance couldn't impede its implementation. However, as Thailand has a severe shortage of health professionals, especially doctors and nurses at the primary care level, our challenge in rural areas is how to continue and sustain the quality improvement of primary care services and to improve equitable access to quality primary care.

Honorary Professor Paichit Pawabutr MD, FCHSE (Hon)
Former Dean
Faculty of Public Health, Naresuan University, Thailand

5 New Zealand's health system has undergone many structural changes in the past 20 years in relation to 'health system reform'. The table below outlines the basic re-structuring approaches and timeframes.

APPROACH TO RE-STRUCTURING	TIMEFRAMES
Hospital Boards – each city/town.	70s-80s
Area Health Boards (community elected boards) (AHBs) (14) – hospital and aligned community services – Primary Care and NGOs funded through Department of Health subsidies and contracts but predominantly private providers.	Mid-latter 80s
Purchaser-Provider Split – Regional Health Authorities (RHAs)(4) purchaser and Crown Health Enterprises (CHEs) (hospitals); Primary Care reorganises around Independent Practitioner Associations (IPAs).	1993-1997
Purchaser-Provider Split – Health Funding Authority (1) purchaser and Hospital and Health Services (HHSs) (providers).	1997-2000
District Health Boards (DHBs) (21) along with Primary Health Organisations (PHOs).	2001-present

While a great deal of 'sector' restructuring occurred over the last 20 years, it is interesting that the key principles, objectives and 'perceived problems' that generated each of the Government reforms were very similar. The key principles and objectives included:

- Services that are responsive to individual and community needs and take account of different cultural perspectives;
- All healthcare providers encouraged to develop their expertise and contribute fully to an effective and efficient health system;
- Access and allocation of public funds requires providers to be accountable for, and efficient in, the use of those resources;
- Provision for efficient management of all hospital and related services;
- Provision of an effective balance between health promotion, protection and the provision of care and curative services;

- Public health systems will never be able to provide all of the services demanded and needed by the population – prioritisation is essential;
- Equality of outcomes in health status across all population groups in the population is the goal so that everyone enjoys the best possible health.

The 'perceived problems' for almost all of the different reforms included:

- **Equity**
Equity of outcomes;
Equity of access and in particular waiting lists/waiting times;
Inability to set priorities;
Inconsistency/incompatibility of central and local policies;
Impact of the Accident Compensation Corporation (ACC) as a separate funder with different access policies and the ability to separately fund 'private' access;
Poor system responsiveness.
- **Efficiency**
Significant variation around the country;
Comparison to international health systems difficult;
Slow to move to alternatives to in-patient care;
Primary Care links.
- **Workforce Morale**
New Zealand salaries less than international counterparts;
Medical control over 'high-cost' allocative decision-making;
General Practitioners private Fee-for-Service providers with Government subsidies.
- **Management Practices**
Lack of 'management' information;
Lack of 'costing' information;
Lack of 'productivity' monitoring.
- **Boards of directors (whether appointed or elected) having little strategic input;**
- **Department of Health/Ministry of Health/Public Health Commission taking a 'Centre' control perspective;**
- **Funding of health services not transparent.**

One could surmise from the above that much of the restructuring did not achieve the gains expected and probably led Governments to further reform through more structural change.

Admittedly over the past 20 years some important 'changes/ approaches' have resulted:

1. New Zealand moved from 'institutionalisation' to deinstitutionalisation with more care for long-term patients in the community many through home-based services delivery;
2. Average Length of Stay (ALOS) of inpatients has reduced considerably and fewer repeat outpatient visits have occurred than in previous years;
3. More 'day stay' interventions are being performed;
4. General Practitioners are now part of not-for-profit PHOs through mixed capitated and fee-for-services funding systems with 'enrolled populations';
5. Management information is more available and benchmarking is occurring;
6. Hospitals are moving to collective procurement models;
7. A national services framework is used and continuously updated;
8. A national 'electives' system has moved towards improving equity of access for people who are assessed as needing services;
9. The national Pharmaceutical Management Agency (PHARMAC) has been highly successful in ensuring access for all New Zealanders to a range of pharmaceuticals as well as managing to keep cost escalation from being a major concern.

There has been a great deal of rhetoric around 'market-orientation' versus 'public good/population health' as key objectives for the reforms at various stages. In carefully analysing the background and implementation of each of the reforms this does not appear to be the case. What is obvious is that each of the reforms cited many of the same problems as previous ones, blaming lack of impact on the underlying 'philosophy' of the reforms. What is apparent when one reads through the considerable paperwork involved is that the policy development around the key issues lagged considerably behind the introduction of the changes. Additionally, as implementation proceeded, ad hoc changes were made that did not align to the original proposed reform model. Also, elements of many of the new structures were repackaged through a series of unplanned incremental changes. Finally, the necessary changes in 'process' and 'culture' amongst the highly skilled medical, nursing and allied health professionals (clinicians) never eventuated. In fact, the singular constant through all of the reforms was a continuation by clinicians of what had always been done.

While clinicians did respond to some of the 'efficiency' pressures and were generally cognisant of equity and quality of care requirements, they failed to appreciate and recognise the importance of effective management practices to their daily work. Managers were thrust into the system in the latter 80s and have continued to struggle with acceptance of their role through subsequent reforms.

Only in the last reform with the introduction of DHBs under the *New Zealand Public Health and Disability Act (2000)*, have any of the 'reform' changes been underpinned by a legislated purpose and clear strategy around policy. Fundamental to this has been the method of funding the system through the Population Based Funding Formula (PBFF). The PBFF uses historic utilisation, cost data, gender, ethnicity and deprivation statistics to determine each DHB's fair share for health services. PBFF divides funding between DHBs (including funding for mental health) according to the relative needs of their population and the cost of providing health services to meet those needs. For mental health there is an agreed 'ring fence'. The mental health 'ring fence' is an important mechanism which ensures the funding allocated for mental health is spent on mental health. In seeking Blueprint funding from Government, the 'ring fence' has been essential to provide assurance to Government that any additional funding approved above PBFF will be spent on developing mental health services.

However, there continues to exist fundamental 'failure of clinical leadership' in the alignment of resource allocation decisions with clinical decisions. This is the 'process' and 'culture' change necessary if any future structural reform is to become embedded as 'custom and practice' and succeed where other reforms have not.

The 'two cultures' divide between management and clinicians must cease if Government is to deliver affordable publicly-funded health services now and into the future. What is needed is agreement by clinicians working within the system in New Zealand to demonstrate considerable leadership in partnership with their manager counterparts in achieving a fair, equitable, efficient and affordable health system.

To do this, clinical leaders need to recognise that they operate under two guiding principles. The first involves the principle of fidelity as embodied in the Hippocratic Oath; ie '*I will follow that system of regimen which according to my ability and judgement, I will consider for the benefit of my patients, and abstain from whatever is deleterious and mischievous.*'

The second involves the principle of stewardship which is taking personal responsibility over use/allocation of the finite resources within the local/national health system; ie, something they do not personally own but for which they are accountable. It is arguable that of the two principles, stewardship takes precedence because the 'system' must continue to be sustainable to enable clinicians to provide the care their individual patients require and will benefit from.

For New Zealand into the future, new moves to reform/restructure should follow a carefully planned and charted course.

To do this, Government leaders, health sector officials, and managers and, in particular, clinical leaders should:

1. Clarify the requisite goals and values all of us and New Zealanders wish any future reforms to achieve;
2. Look carefully at the past and diagnose the root causes to the underlying 'problems' honestly using the 'five whys';
3. Aim to build a responsive, high-quality, efficient, 'health system' that has as its foundation the goal of achieving improved population health outcomes across all modalities of care interventions within the available funding;
4. Ensure that any future reforms are based on, and within, the unique cultural norms of New Zealanders and, particularly our Maori partners;
5. Rely on and require clinical and management leadership collaboration to navigate the 'health sector' ship through to a sustainable berth;
6. Work together 'to do it'; continue to refine, and continue to improve processes as new challenges emerge;
7. Invest in 'continuous system's improvement' through strong local, regional and national networks;
8. Measure the gains, ensure that the 'system' remains on course and take corrective action incrementally.

Dr Sharon Kletchko MD, FRCPC, FRACP, FACEM, AFCHSE, CHE, CNZID

General Manager Planning & Funding

Nelson Marlborough District Health Board
New Zealand

Prawit Taytiwat

Prawit is an Associate Fellow of the College and is the Dean of the Faculty of Public Health, Naresuan University (FPH NU), Phitsanulok, Thailand. He has recently been appointed as an Executive Board member of the Network of the World Health Organisation (WHO) Collaborating Centres and Centres of Expertise in Thailand (NEW-CCET). Prawit's experience and appointments have included Advisor to the Minister of Public Health.

Previously, Prawit practised as a General Practitioner (GP) and was also an executive of two private hospitals in Bangkok. In 1997 he then became a medical lecturer at the Faculty of Medicine, Naresuan University (NU). He was appointed Director of the Health Sciences Research Institute (HSRI), which later became the Naresuan University Hospital. At the HSRI, he initiated the first Heart Centre in the Lower-Northern region of Thailand. At NU he was involved in a project to increase rural GP training to improve the shortage of doctors in rural areas and was also engaged with the community to research and develop models of primary care services for urban and rural poor.

Prawit graduated as a Doctor of Health Services Management (DHSM) from the University of New England (UNE), Australia in 2008 through a scholarship funded by the Royal Thai government. He has a very strong passion for developing professionalism in health management for Thai health managers and at the same time improving primary care services quality, especially for the rural poor. In 2005 he became an Associate Fellow of ACHSE and facilitated collaboration between NU, UNE and ACHSE as well as the Thai Ministry of Public Health. These passions have become the objectives of the collaboration.

From this collaboration, Prawit initiated the Centre of Expertise on Hospital and Health Services Management in Thailand, which is attached to the FPH at NU. With the support from UNE, this Centre is now becoming the WHO CC for Health Services Management. The centre will be the focal point for Thailand and member states of the WHO South East Asia Region Office (SEARO) in improving health management and leadership skills for health managers in order to assist their health services to achieve the UN Millennium Development Goals (MDGs). Prawit would also like to see the development of a professional college in Thailand with links to ACHSE.



Prawit Taytiwat

What made you venture into health management?

My career started with my medical training at the Faculty of Medicine, Ramathibodi Hospital, Mahidol University, in Bangkok. After I graduated in 1993, I started my work as a GP at the medical services department, Supreme Command, Bangkok and was appointed as the Acting Head of that department as another doctor, who was the Head and more senior, resigned from his position. At that point, I started to learn health services management by doing. I was very frustrated by the lack of management experience both at individual and organisational levels.

I subsequently worked at private hospitals in Bangkok in dual roles as GP and manager. In the private sector, I enjoyed practising my management and leadership skills, which was quite different from when I worked in the public sector as it emphasised more cost-effective and informal approaches. I developed my networking skills from working there. I was promoted to be an assistant to the Managing Director before

I resigned and moved to work in the rural area of Phitsanulok where the Naresuan University (NU) is located. It is the only comprehensive public university near my hometown, about 350 kilometres north of Bangkok.

While working in the private sector, I tried to find an appropriate health services management program to improve my management and leadership skills. Unfortunately at that time there was no formal training program specifically for health services management in Thailand. The health managers I knew usually learnt health management by doing. This meant that too much time was spent on trial and error. This is why I have developed a passion for health services management as a profession. I believe that anyone, not only the doctor, can work as an effective health manager with health management education.

I rejoined the public sector at the Faculty of Medicine NU with the idea that I could teach medical students my experience in both the public and private sectors of health services management. In the 2000 period there was a severe financial crisis but we still were able to develop the HSRI, which actually provided infrastructure in research as a teaching hospital. We started the first Heart Centre in our region and coronary arterial bypass surgery was performed from 2003. While enjoying this experience, the government launched the Universal Health Coverage (UHC) policy which intends to improve accessibility to quality care for all citizens by ensuring quality first contact care.

I was aware of the importance of that policy and realised that primary care services would be the prime priority. I had a strong belief that improving the management and leadership skills of health managers would assist them in turning their mindset from hospital care to primary care and that the UHC policy could be successfully implemented and achieve its goals.

Therefore, I moved to help Honorary Professor Paichit Pawabutr to found the Faculty of Public Health (FPH) with the intention of improving training for primary care health professionals and developing the health management program. Following this I went to study the Doctor of Health Services Management (DHSM) at UNE in Australia. I learnt that Australia is one of the best countries in the world and its population has great health with strong primary care and professional health management. After I graduated my DHSM and returned to NU, the NU Council appointed me to be the Dean of the Faculty of Public Health. During this time I had a good opportunity to be involved in national health policy when I was appointed to be the Advisor to the Minister of Public Health in 2008.

What is the most rewarding and enjoyable aspect of your position?

I have enjoyed every role and the challenges and opportunities to learn and improve my own skills and spirit even when feeling pressured. I enjoyed working with my staff and colleagues, politicians and community. I and my team helped raise funds to run free heart operations for the rural poor and we gained big support from the media and the community. We were both proud and honoured when Her Royal Highness Princess Sirindhon, who is revered and beloved by Thai citizens, also supported this project.

At present, as the Dean of the FPH, the challenge is to work to improve the health of our community from another perspective. I am now working with academics and practitioners to improve their qualifications and career paths by quality teaching and research. I am enjoying helping people in Lower-Northern communities to access tertiary education in public health and health management so that they can have knowledge, skills and good attitudes in providing quality healthcare to rural poor.

What is the greatest challenge facing health managers in Thailand?

The greatest challenge facing health managers in Thailand is how they can adapt themselves to meet the complexity of health, political and socioeconomic situations while they have to ensure the coverage of and access to care for their community. Thai health managers are facing a triple burden of diseases; communicable, chronic and global. The political unrest in Thailand is creating deep separation and conflict amongst our fellow Thais. The society is changing and there is now more pluralism to which health managers must adapt their mindset of working independently, to that of networking and adopting multidisciplinary approaches. The world financial crisis, which has hit Thailand very hard, will make health sector resources inadequate. Meeting this challenge requires strategies at individual, organisational and structural levels.

At the individual level, health managers need to improve their primary care and management knowledge and skills. Health management at the professional level is now required more than ever. At the organisational level, networking and partnerships with other related organisations to ensure access to effective and efficient health care are needed. Finally, at the structural level, the supportive systems and working environment for effective professional managers must be developed.

What is the one thing you would like to see changed?

What I would like to see changed is that health management professionalism should be developed. One should be appointed as a health manager because of either management experience or training, not through seniority or by chance. All health managers should be trained in health services management. The government should build an appropriate working environment, such as clarity of role and responsibility for health managers with financial rewards for great performance. Moreover, the allocation of workload for health managers who are both doctors and managers should be clarified. I would like to see the position of manager or executive not limited to only doctors or any specific health professionals and that anyone can have an equal chance to be recruited as a health manager if they can prove that they are capable to do so. Another thing that I would like the government to support is health management training and networking of health managers in the same way that ACHSE attempts to do this in Australia.

Who or what has been the biggest influence on your career?

There have been many persons who influenced my career. First, my Dad and Mum influenced me to become a doctor from a young age, as they had their own belief that when I grew up I would. Being a doctor in Thai society is quite prestigious and of high social value. However, the norm in my family is that we believe that helping other people will make us happy and will have a good return for our future even in our next lives. This norm also influenced what I did and continues to do for the sake of improving healthcare for people, especially ones who are needy and underprivileged. My family runs a private business in the local area and I think that I assimilated management skills from my Dad, especially networking and communication skills. Second, my medical professor, Professor Boonchob Pongpanich, former Dean of the Faculty of Medicine at Ramathibodi Hospital, Mahidol University, is another influence. He always works for his patients and their families, who are very poor, without any financial self-interest. He is very revered by his colleagues and staff as well as his patients and their families. Also, he was a very successful Dean in managing his Faculty. He is my good role model and I want to be like him.

Finally, David Briggs, my advisor and friend, is another influence who encourages my work at an international level. He always shows a positive mind and supports younger colleagues like myself. His commitment to developing health management as a profession is what I want to contemplate and follow.

Where do you see health management heading in Thailand in ten years time?

I think that health services will be more primary care-oriented and that networking between hospitals and primary care will be more prominent. People will be more educated and that will help improve equality of status. Health management will be upgraded as a profession and health management training will be a necessity. I predict that health management as a subject will be included in health sciences curricula. Also, health management training at the postgraduate level will be more influential. More and more health management research will be required. Health services management in ten years time will be more evidence-based. Health managers must be more accountable for their performance and the effectiveness of their care delivery.

What word of advice would you give to emerging health leaders?

They need to understand the complexity of the challenges they will face in the future. Therefore, to keep learning both from experience and formal education is very important. Networking with colleagues is another key success factor for them. In the real world, managers cannot work by themselves. Our success comes from the support of others.

I would also like to encourage them to have a common vision of developing health management as a profession, as this will help us strengthen our health system and ensure access to effective and efficient healthcare for people. Strengthening health management today will mean more effective health managers in the next generation.

Lean Hospitals: Improving Quality, Patient Safety and Employee Satisfaction

Reviewed by **B Ainsworth** and **S Harrison**

Bibliographic details:

Graban M

Lean Hospitals: Improving Quality, Patient Safety and Employee Satisfaction

New York: Productivity Press, Taylor and Francis Group; 2009. ISBN 978-4200-8380-4

Lean Hospitals is a book written for people working in healthcare who understand their organisation's problems and are looking to overcome them through the implementation of quality systems and approaches.

The book's author, Mark Graban, is an engineer and consultant and has many years experience working in the field of process improvement and in the implementation of Lean in United States manufacturing and healthcare. He is the founder of a Lean website and an author of numerous publications.

This book is not a 'how to' manual for applying Lean in a healthcare setting but rather, it is an explanation of Lean concepts, principles, tools and systems using hospital-based examples. *Lean Hospitals* sets out to answer the question 'What is Lean?' for a healthcare audience and does this well. Those seeking detailed guidance on implementing Lean should perhaps look elsewhere.

Lean Hospitals consists of twelve chapters in total with the first two providing background, context and the more generalised descriptions of the Lean methodology. The next eight chapters are dedicated to explaining the various

elements of Lean. Chapter 11 provides a starting point for implementation of Lean and the final chapter outlines the vision for a fully Lean hospital.

The book begins by outlining the case for adoption of Lean principles and methodologies in health settings and highlights the need for workers to find solutions to their own problems. This is followed by a good summary of the various definitions of Lean and their sources and an outline of the various tools and elements. The importance of adopting the entire Lean approach and not just some tools or elements is emphasised. The important contribution of leadership and management is also stressed.

The next section of the book begins the reader's journey through Lean with a chapter on identifying value and waste (fundamental Lean concepts) using healthcare examples. The identification of value-added and nonvalue-added activities is explained well, in particular how nonvalue-added activities can be broken down to identify 'required waste' and 'pure waste'. 'Required waste' is nonvalue-added from the perspective of the patient but nonetheless required for the health system to function. The objective for healthcare providers must firstly be the elimination of 'pure waste'.

The fourth chapter explains identifying and mapping of 'value streams'. This is essential to Lean processes and requires personal observation of activities and processes. This chapter provides many examples of the ways in which activities can be observed, tracked and documented. Chapter five introduces the 'foundations' and 'pillars' forming the Lean structure and this provides the context for the next five chapters that explain Lean in practice. The concepts of standardised work, Lean tools, root cause problem-solving, preventing errors, improving flow and engaging and leading employees are appropriately explained in the chapters devoted to each element.

The final chapters examine how and where to begin the implementation of Lean. Examples are given of what has motivated healthcare providers to commence their Lean journey and the questions that leaders have asked to

Ms Brenda Ainsworth RN, BHIthSc(Nur), MMgt
Executive Director
Health Performance, Improvement, Innovation and
ReDesign, ACT Health; and

Ms Sheryl Harrison RN, BHIthSc(MenHIthNur),
GradCertMgt(Pub Sec), DipProjMgt
Program Manager Innovation & ReDesign-Access
Improvement Program, ACT Health.

Correspondence:
brenda.ainsworth@act.gov.au

guide the prioritisation of Lean efforts. The importance of leadership, management and change management methodologies is emphasised and examples given of utilising Lean principles and processes to inform hospital design and re-building. *Lean Hospitals* concludes with the author's vision for the Lean hospital including patient and employee experiences and the implications of building a Lean culture.

The book follows a familiar but effective pattern. A concept is presented, an explanation offered and a host of examples follow cementing the concept through practical applications. The concepts are presented effectively and should be easily understood by those working in a hospital setting. The explanations are all hospital-based, drawing largely from the author's personal experiences in applying Lean in hospital settings.

Lean Hospitals provides a sound orientation to the Lean methodology and its relevance to healthcare providers. The use of illustrations, diagrams, tables and dot points is effective and the chapter structure includes separate sections for conclusions, lessons learned and important points

to reinforce the important elements of the chapter. The author acknowledges the focus of the book as providing only a foundation for understanding and that further resources will be required by those contemplating commencing the Lean journey.

Lean Hospitals effectively outlines the tools, techniques, systems and management elements of the Lean methodology and is a good introduction for those seeking to familiarise themselves with Lean in a manner directly relevant to the healthcare setting.

CALL FOR BOOK REVIEWS

The Journal appreciates the opportunity to provide relevant book reviews. Readers, publishers and authors are encouraged to nominate appropriate books. The Journal would also like to hear from readers interested in reviewing books in future issues. Contact can be made direct for future issues about that interest, mailto: journal@achse.org.au



STRATEGY SOLUTIONS
PROFESSIONAL RECRUITMENT CONSULTANCY

Healthy Choice

Health Care. Life Style. Life Choice.
Strategy Solutions – a leader in Healthcare recruitment.

Our focus on the recruitment of healthcare professionals has provided many healthcare professionals with new career opportunities. We are regarded as one of the leading recruitment providers in healthcare Informatics and business and are proud to have serviced clients in the Australian, New Zealand, North American, Asian and UK markets as an industry expert.

We have placed people within the Healthcare industry who have had a variety of experience including: Executive, Management, Consulting, Government, Information Technology, Operations, Sales & Marketing, and Office Services. Our Recruitment for Health division combines the best of a full-service recruitment agency with an exclusive focus on the Healthcare industry.

We understand the need for exceptional talent for the betterment of human health.

Contact us to discuss the next phase in your Healthcare career.

Tel 61 2 9460 0733 Fax 61 2 9460 0933
Level 12, 157 Walker Street, North Sydney NSW 2060.
www.strategysolutions.com.au

This Library Bulletin is part of a service offered by the Health Management and Planning Library of ACHSE. The Library provides information on topics such as health services management, organisational change, corporate culture, human resources and leadership. The Bulletin highlights some of the most up to date articles, books, features and literature on health management from both Australia and internationally. Copies of these articles are available at a small charge. The first article costs \$10.00 then \$5.00 for each additional article. All prices are inclusive of GST.

To obtain copies of articles, please contact Sue Brockway, Librarian, by phone (02) 9805 0125 or fax (02) 9889 3099, by mail PO Box 341 North Ryde NSW 1670 or email to: library@achsensw.org.au

CLINICAL HANDOVER

OSSIE Guide to Clinical Handover Improvement: For Clinician-Leaders and Managers. Consultation Edition

Australian Commission on Safety and Quality in Health Care, March 2009

http://www.safetyandquality.gov.au/internet/safety/publishing.nsf/content/PriorityProgram-05_OssieGuide

COMMUNITY PARTNERSHIPS

Using the Balanced Scorecard in the Development of Community Partnerships

Tsasis, Peter and Owen, Susan M
Health Services Management Research
Vol 22(1) February 2009 pp 33-38

CREDENTIALLING

Clinical Privileging: Don't Just Tell Me - Show Me!

Monagle, John, Shearer, Bill and Kelly, Cate
Asia Pacific Journal of Health Management
Vol 3(2) 2008 pp 14-18

To develop a framework for individual credentialing and privileging that acknowledges individual training and competence and organisational needs and 'fit'.

DECISION MAKING

Why Good Leaders Make Bad Decisions

Campbell, Andrew, Whitehead, Jo and Finkelstein, Sydney
Harvard Business Review

Vol 87(2) February 2009 pp 60, 62- 66

Neuroscience confirms what some have long suspected: we cannot reliably recognise or safeguard against our own errors of judgment. But there is a systematic way to spot and counteract our biases so they don't cloud important decisions.

FALLS

Documentation of In-hospital Falls on Incident Reports: Qualitative Investigation of an Imperfect Process

Haines, Terry P and others
BMC Health Services Research

11 December 2008

Incident reporting is the basis for gathering data on accidental falls in hospitals for both research and quality assurance purposes, but it is of questionable quality as staff time pressures, perception of blame and other factors are thought to contribute to under-reporting.

<http://www.biomedcentral.com/1472-6963/8/254/abstract>

Hospitalisations Due to Falls by Older People, Australia 2005-06

Australian Institute of Health & Welfare, March 2009
<http://www.aihw.gov.au/publications/index.cfm/title/10683>

HEALTH CARE

Bringing Health Care Back to the Local Community

Woodruff, Tim and others
Centre for Policy Development, November 2008
<http://cpd.org.au/article/bringing-health-care-back-local-communities>

Fit for the Job: Adapting to Australia's New Healthcare Challenges

Business Council of Australia, March 2009
The BCA says we need a new independent health body that can break the current impasse and seamlessly provide for patient needs, boost efficiency and drive the reforms required to meet the needs of the future.
<http://www.bca.com.au/DisplayFile.aspx?FileID=527>

Fixing Health Care: The Professionals' Perspective

Economist Intelligence Unit, March 2009

The EIU conducted a global survey of healthcare professionals in four key economies – the US, UK, Germany and India – about the issues they see as most urgent for their healthcare systems, and what they see as the best way forward for those systems.

http://www.eiu.com/site_info.asp?info_name=fixing_healthcare&page=noads&rf=0

Making Integrated Healthcare Delivery Happen – A Framework for Success

Jackson, Claire and Nicholson, Caroline

Asia Pacific Journal of Health Care Management

Vol 3(2) 2008 pp 19-24

Organisational Structures for Addressing the Attributes of the Ideal Healthcare Delivery System

Cowen, Mark E and others

Journal of Healthcare Management

Vol 53(6) 2008 pp 407-418

Planning for Scale: A Guide for Designing Large-scale Improvement Initiatives

Institute for Healthcare Improvement, 2008

This white paper aims to support those who are planning to take effective health care practices from one setting or isolated environment and to make them ubiquitous across a health care system, region, state, or nation.

<http://www.ihl.org/IHI/Results/WhitePapers/PlanningforScaleWhitePaper.htm>

HEALTH FACILITIES PLANNING AND DESIGN**Adapting Australian Health Facilities to Cope with Climate-related Extreme Weather Conditions**

Carthey, Jane, Chandra, Venny and Loosemore, Martin

Journal of Facilities Management

Vol 7(1) 2009

http://www.fbe.unsw.edu.au/chaa/4.1_publishedworks.asp

Ambulatory Care: A Decade of Evolution

Welch, Lesley

Health Estate Journal

Vol 63(1) January 2009 pp 50-53

New generation, well-equipped ambulatory and emergency care centres, a relatively new development in the UK, are offering local day care patients a holistic healthcare service in a high quality setting, while reducing pressure on general hospitals and cutting waiting times.

Capitalising in the Long Term

Rechel, Bernd and others

Health Estate Journal

Vol 63(2) February 2009 pp 33-37

Report on an international study on improving the effectiveness of health capital investment which analyses innovative European capital projects and examines the key issues that arise. The study suggests that hospital design that takes into account facility management costs results in significant efficiency gains.

Designs for the Delicate: A Look at Evolving NICU Design Standards

Harrell, James W and Moon, Gregg R

Health Facilities Management

Vol 21(12) December 2008 pp 45-48

Retrospective Evaluation of the Impact of the Planetree Patient-Centered Model of Care on Inpatient Quality Outcomes

Stone, Susan

HERD Health Environments Research and Design Journal

Vol 1(4) Summer 2008 pp 55-69

A Review of the Research Literature on Evidence-based Healthcare Design

Ulrich, Roger S and others

HERD Health Environments Research & Design

Vol 1(3) Spring 2008 pp 61-125

Should Health Service Managers Embrace Open Plan Work Environments? A Review

Oommen, Vinesh, Knowles, Mike and Zhao, Isabella

Asia Pacific Journal of Health Management

Vol 3(2) 2008 pp 37 - 44

HEALTH MANAGERS**Common Competencies for all Healthcare Managers: The Healthcare Leadership Alliance Model**

Stefl, Mary E

Journal of Healthcare Management

Vol 53(6) November/December 2008 pp 360-373

The HLA, a consortium of 6 major professional membership organisations, used the research from and experience with their individual credentialing processes to posit 5 competency domains common among all practicing healthcare managers.

The Twenty-first Century Face of Senior Health Executives

Liang, Zhanming and Brown, Claire

Asia Pacific Journal of Health Management

Vol 3(2) 2008 pp 30-36

The demography, roles and responsibilities of senior health executives within the NSW public health system, post-1990s.

HEALTH POLICY

Evaluating Health Policy: Learning from International and Australian Experience

Gleeson, Deborah H, Legge, David G and O'Neill, Deirdre
Australia & New Zealand Health Policy

26 February 2009

<http://www.anzhealthpolicy.com/content/6/1/3/abstract>

Steering without Navigation Equipment: The Lamentable State of Australian Health Policy Reform

Richardson, Jeff

Centre for Health Economics, Monash University

March 2009

<http://www.buseco.monash.edu.au/centres/che/steering-without-navig-equip.pdf>

HEALTH SERVICES

Report on Government Services 2009 Part E (Health)

Productivity Commission, January 2009

The Report primarily concentrates on the performance of public hospitals, primary and community health services (including general practice) and management issues: mental health and breast cancer.

<http://www.pc.gov.au/gsp/reports/rogs/2009>

Options for Reforming Australia's Health System

Boxall, Anne-Marie and Buckmaster, Luke

Background Note, Australian Parliamentary Library

February 2009

This Background Note is intended as a guide to some of the main recent proposals for health reform. The Note focuses on the main features of each model and seeks to explain what problems they are intended to address and how they differ from one another. The Note also highlights some of the main criticisms of each model.

<http://www.aph.gov.au/library/pubs/bn/2008-09/HealthReform.htm>

Radical Surgery: The Only Cure for New South Wales Hospitals

Kasper, Wolfgang

Centre for Independent Studies, 2009

Argues that systemic failures of public hospitals in NSW are caused by their excessive bureaucratisation.

http://www.cis.org.au/policy_monographs/pm91.pdf

HEALTH SERVICES RESEARCH

Risky Research

Dahlen, Hannah and Tracy, Sally

Inside Story

March 2009s

Private hospitals are safer than public hospitals for mothers and newborn babies, according to a recent study. But there was less coverage when clinicians and other researchers began to express concerns about the research methodology.

<http://inside.org.au/risky-research/>

HEALTH TECHNOLOGY

Health Technology Assessment and Health Policy-making in Europe: Current Status, Challenges and Potential

Garrido, Marcial Velasco and others

European Observatory on Health Systems and Policies, 2008

[http://www.euro.who.int/observatory/](http://www.euro.who.int/observatory/Publications/2007/20081107_1)

[Publications/2007/20081107_1](http://www.euro.who.int/observatory/Publications/2007/20081107_1)

INDIGENOUS HEALTH SERVICES

Aboriginal and Torres Strait Islander Health Performance Framework 2008 Report: Detailed Analyses

Australian Institute of Health and Welfare, 2009

<http://www.aihw.gov.au/publications/index.cfm/title/10664>

Building Capacity towards Health Leadership in Remote Indigenous Communities in Cape York

Laverack, Glenn and Hill, Kristy

Australian Indigenous Health Bulletin

Vol 19(1) March 2009 pp 1-11

This paper describes an established approach for building capacity used for the first time with Health Action Teams in 3 remote indigenous communities in Cape York. A key purpose was to determine if the approach was an appropriate and practicable 'tool' in an Aboriginal context.

http://healthbulletin.org.au/wp-content/uploads/2009/01/bulletin_original_articles_laverack.pdf

Challenges of Change Management in Aboriginal Community-controlled Health Organisations: Are There Learnings for Cape York Health Reform?

Coombe, Leanne L

Australian Health Review

Vol 32(4) November 2008 pp 639-647

Health Research Policy: A Case Study of Policy Change in Aboriginal and Torres Strait Islander Health Research

Leon de la Barra and others

Australia & New Zealand Health Policy

February 2009

<http://www.anzhealthpolicy.com/content/6/1/2/abstract>

Pathways into the Health Workforce for Aboriginal and Torres Strait Islander People

Australian Indigenous Doctors Association, 2008

<http://www.aida.org.au/pathways.asp>

INQUIRIES

Improving Maternity Services in Australia – The Report of the Maternity Services Review

Australian Government Department of Health and Ageing, February 2009

The report focuses on the need to improve the choices available to pregnant women, access to high quality maternity services, and support for the maternity services workforce.

<http://www.health.gov.au/internet/main/publishing.nsf/Content/maternityservicesreview-report>

Report of the Special Commission of Inquiry into Child Protection Services in NSW

The Wood report, November 2008
<http://www.lawlink.nsw.gov.au/cpsinquiry>

LEADERSHIP

Core Competencies of the Entrepreneurial Leader in Health Care Organisations

Guo, Kristina L
The Health Care Manager
 Vol 28(1) 2009 pp 19-29

Developing NHS Leadership – The Role of the Trust Medical Director

The NHS Confederation, Future of Leadership Paper No 2, April 2009
 Based on seminars and interviews with current medical directors, this paper argues for clearer expectations of the role, increased support and more structured development opportunities.
<http://www.nhsconfed.org/Publications/leadership/Pages/Developing-NHS-leadership.aspx>

Development of an Interprofessional Competency Model for Healthcare Leadership

Calhoun, Judith G and others
Journal of Healthcare Management
 Vol 53(6) November/December 2008 pp 375-389
 The Health Leadership Competency Model is an evidence-based and behaviourally focused approach for evaluating leadership skills across the professions, including health management, medicine and nursing, and across career stages.

Picking the Right Transition Strategy

Watkins, Michael D
Harvard Business Review
 Vol 87(1) January 2009 pp 47-53
 When moving into a new leadership role, the skills and strategies that worked in the past may not work in the new environment.

The Quick Wins Paradox

Van Buren, Mark E and Safferstone, Todd
Harvard Business Review
 Vol 87(1) January 2009 pp 55-61
 Leaders in new roles may need a quick win to prove themselves but focusing on individual success can produce toxic results. They should engage their team members in collective 'quick wins' instead.

Reforming Leadership Development... Again!

NHS Confederation, Future of Leadership paper 1 March 2009
 It is based on interviews health leaders, and explores two important questions: what are the real issues with NHS leadership and what solutions can best be provided by central or regional action?
<http://www.nhsconfed.org/Publications/leadership/Pages/Future-of-leadership.aspx>

What it Takes to be an Authentic and Transparent Leader: Living the Organisation's Mission, Vision and Values

Buell, John M
Healthcare Executive
 Vol 23(6) November/December 2008 pp 20-24

Women and the Vision Thing

Ibarra, Herminia and Obodaru, O
Harvard Business Review
 Vol 87(1) January 2009 pp 62, 64-70
 Women outshine men in evaluations of leadership ability except in envisioning - the ability to recognise new opportunities and trends in the environment and develop a new strategic direction for an enterprise. However, this is a capability that can be learned.

LEARNING ORGANISATION

Evidence in the Learning Organisation

Crites, Gerald E and others
Health Research Policy and Systems
 Vol 7, March 2009
 How do you ensure that organisational members are adopting work innovations in a timely fashion? Organisational leaders in healthcare have attempted to resolve this dilemma by offering specific solutions, such as Evidence-based Medicine, but organisations are still not systematically adopting evidence-based practice innovations as rapidly as expected by policy-makers (the knowing-doing gap problem).
<http://www.health-policy-systems.com/content/7/1/4>

MENTORING

What Can Coaches Do For You?

Coutu, Diane and Kauffman, Carol
Harvard Business Review
 Vol 87(1) January 2009 pp 91, 93-97
 The coaching field is filled with contradictions. Coaches themselves disagree over why they're hired, what they do and how to measure success.

PRIMARY CARE

Care that Puts People First: Responding to the Health Challenges of Today, Preparing for Those of Tomorrow

The Australian General Practice Network, Primary Health Care Position Statement 2009
 A paradigm shift towards an enhanced primary health care system is required to improve the way health care is delivered, funded, organised and governed, and to best meet the current and future needs of Australians.
http://www.agpn.com.au/client_images/263972.pdf

Integrated Models or Mayhem? Lessons Learnt from Three Integrated Primary Health Care Entities in Regional New South Wales

May, Jenny and others
Australian Health Review
 Vol 32(4) November 2008 pp 595-604

Primary Health Care Delivery Models in Rural and Remote Australia – A Systematic Review

Wakerman, John and others
BMC Health Services Research
Vol 8, 2008
<http://www.biomedcentral.com/1472-6963/8/276/abstract>

WORKFORCE PLANNING

Managing the Multigenerational Nursing Workforce: Managerial and Policy Implications

Manion, Jo, International Centre for Human Resources in Nursing, 2009
http://www.ichrn.com/publications/policyresearch/Multigen_Nsg_Wkforce-EN.pdf

Medical Training Board: The Future of the Medical Workforce: First Annual Report Nov 2007 – Dec 2008

Wellington, NZ Medical Training Board, March 2009
The Report discusses the influences on demand for health services (demography, epidemiology, standards of care and provider productivity), and proposes a model for forecasting future medical workforce needs.
<http://www.moh.govt.nz/moh.nsf/indexmh/medical-training-board-annual-report-nov07-dec08>

Rural Allied Health Workforce Study: Background, Rationale and Questionnaire Development

Keane, Sheila and others
Rural and Remote Health
Vol 8, 2008
<http://www.rrh.org.au/articles/showarticlenew.asp?ArticleID=1132>

Rural and Remote Health Workforce Capacity – The Contribution made by Programs Administered by the Department of Health and Ageing

Australian National Audit Office, 2009
Over the last decade, Australia has experienced workforce shortages in a number of health professions, particularly in rural and remote regions. This report finds that the Department of Health and Ageing has not yet developed a cohesive approach to inform its strategies to deal with these shortages and to report on its contribution to health workforce outcomes in rural and remote areas of Australia.
http://www.anao.gov.au/download.cfm?item_id=1C259BCF1560A6E8AAAA3D66CDF9A9C5D&binary_id=1CEE267E1560A6E8AA56720216A29128

Why do Medical Graduates Choose Rural Careers?

Henry, John A and others
Rural and Remote Health
Vol 9, February 2009
Current medical student selection processes and medical course training experiences have failed to deliver sufficient medical practitioners with a commitment to rural medical practice. This study looked at those selection processes and within-training experiences deemed to promote the likelihood that, on graduation, medical students would pursue a medical career in rural communities.
<http://www.rrh.org.au/articles/subviewnew.asp?ArticleID=1083>

Will More Medical Places Result in More Rural GPS? A Discussion Paper

Leveratt, Mandy
Rural Health Workforce Australia, October 2008
http://www.rhwa.org.au/client_images/762459.pdf

READING LISTS

The Health Planning Library has put together Reading Lists on the following topics:

- Cancer Services
- Competencies
- Health Service Managers
- Hospitals
- Leadership
- Multipurpose Services
- Nursing Workforce
- Organisational Change
- Organisational Culture
- Post-occupancy Evaluation
- Resource Allocation

Please contact the Library on library@achsensw.org.au if you would like a copy of a Reading List.

Manuscript Preparation and Submission

General Requirements

Language and format

Manuscripts must be typed in English, on one side of the paper, in Arial 11 font, double spaced, with reasonably wide margins using Microsoft Word.

All pages should be numbered consecutively at the centre bottom of the page starting with the Title Page, followed by the Abstract, Abbreviations and Key Words Page, the body of the text, and the References Page(s).

Title page and word count

The title page should contain:

1. **Title.** This should be short (maximum of 15 words) but informative and include information that will facilitate electronic retrieval of the article.
2. **Word count.** A word count of both the abstract and the body of the manuscript should be provided. The latter should include the text only (ie, exclude title page, abstract, tables, figures and illustrations, and references). For information about word limits see *Types of Manuscript: some general guidelines* below.

Information about authorship should not appear on the title page. It should appear in the covering letter.

Abstract, key words and abbreviations page

1. **Abstract** – this may vary in length and format (ie structured or unstructured) according to the type of manuscript being submitted. For example, for a research or review article a structured abstract of not more than 300 words is requested, while for a management analysis a shorter (200 word) abstract is requested. (For further details, see below - Types of Manuscript – some general guidelines.)
2. **Key words** – three to seven key words should be provided that capture the main topics of the article.
3. **Abbreviations** – these should be kept to a minimum and any essential abbreviations should be defined (eg PHO – Primary Health Organisation).

Main manuscript

The structure of the body of the manuscript will vary according to the type of manuscript (eg a research article or note would typically be expected to contain Introduction, Methods, Results and Discussion – IMRAD, while a commentary on current management practice may use a less structured approach). In all instances consideration should be given to assisting the reader to quickly grasp the flow and content of the article.

For further details about the expected structure of the body of the manuscript, see below - Types of Manuscript – some general guidelines.

Major and secondary headings

Major and secondary headings should be left justified in lower case and in bold.

Figures, tables and illustrations

Figures, tables and illustrations should be:

- of high quality;
- meet the 'stand-alone' test;
- inserted in the preferred location;
- numbered consecutively; and
- appropriately titled.

Copyright

For any figures, tables, illustrations that are subject to copyright, a letter of permission from the copyright holder for use of the image needs to be supplied by the author when submitting the manuscript.

Ethical approval

All submitted articles reporting studies involving human/or animal subjects should indicate in the text whether the procedures covered were in accordance with National Health and Medical Research Council ethical standards or other appropriate institutional or national ethics committee. Where approval has been obtained from a relevant research ethics committee, the name of the ethics committee must be stated in the Methods section. Participant anonymity must be preserved and any identifying information should not be published. If, for example, an author wishes to publish a photograph, a signed statement from the participant(s) giving his/her/their approval for publication should be provided.

References

References should be typed on a separate page and be accurate and complete.

The Vancouver style of referencing is the style recommended for publication in the APJHM. References should be numbered within the text sequentially using Arabic numbers in square brackets. [1] These numbers should appear after the punctuation and correspond with the number given to a respective reference in your list of references at the end of your article.

Journal titles should be abbreviated according to the abbreviations used by PubMed. These can be found at: <http://www.ncbi.nih.gov/entrez/query.fcgi>. Once you have accessed this site, click on 'Journals database' and then enter the full journal title to view its abbreviation (eg the abbreviation for the 'Australian Health Review' is 'Aust Health Rev'). Examples of how to list your references are provided below:

Books and Monographs

1. Australia Institute of Health and Welfare (AIHW). Australia's health 2004. Canberra: AIHW; 2004.
2. New B, Le Grand J. Rationing in the NHS. London: King's Fund; 1996.

Chapters published in books

3. Mickan SM, Boyce RA. Organisational change and adaptation in health care. In: Harris MG and Associates. Managing health services: concepts and practice. Sydney: Elsevier; 2006.

Journal articles

4. North N. Reforming New Zealand's health care system. Intl J Public Admin. 1999; 22:525-558.
5. Turrell G, Mathers C. Socioeconomic inequalities in all-cause and specific-cause mortality in Australia: 1985-1987 and 1995-1997. Int J Epidemiol. 2001;30(2):231-239.

References from the World Wide Web

6. Perneger TV, Hudelson PM. Writing a research article: advice to beginners. Int Journal for Quality in Health Care. 2004;191-192. Available: <<http://intqhc.oxfordjournals.org/cgi/content/full/16/3/191>>(Accessed 1/03/06)

Further information about the Vancouver referencing style can be found at <http://www.bma.org.uk/ap.nsf/content/LIBReferenceStyles#Vancouver>

Types of Manuscript - some general guidelines

1. Analysis of management practice (eg, case study)

Content

Management practice papers are practitioner oriented with a view to reporting lessons from current management practice.

Abstract

Structured appropriately and include aim, approach, context, main findings, conclusions.

Word count: 200 words.

Main text

Structured appropriately. A suitable structure would include:

- Introduction (statement of problem/issue);
- Approach to analysing problem/issue;
- Management interventions/approaches to address problem/issue;
- Discussion of outcomes including implications for management practice and strengths and weaknesses of the findings; and
- Conclusions.

Word count: general guide - 2,000 words.

References: maximum 25.

2. Research article (empirical and/or theoretical)

Content

An article reporting original quantitative or qualitative research relevant to the advancement of the management of health and aged care services organisations.

Abstract

Structured (Objective, Design, Setting, Main Outcome Measures, Results, Conclusions).

Word count: maximum of 300 words.

Main text

Structured (Introduction, Methods, Results, Discussion and Conclusions).

The discussion section should address the issues listed below:

- Statement of principal findings;
- Strengths and weaknesses of the study in relation to other studies, discussing particularly any differences in findings;
- Meaning of the study (eg implications for health and aged care services managers or policy makers); and
- Unanswered questions and future research.

Two experienced reviewers of research papers (viz, Doherty and Smith 1999) proposed the above structure for the discussion section of research articles. [2]

Word count: general guide 3,000 words.

References: maximum of 30.

NB: Authors of research articles submitted to the APJHM are advised to consult 'Writing a research article: advice to beginners' by Perneger and Hudelson (2004) and available at: <<http://intqhc.oxfordjournals.org/cgi/content/full/16/3/191>> This article contains two very useful tables: 1) 'Typical structure of a research paper' and 2) 'Common mistakes seen in manuscripts submitted to this journal'. [3]

3. Research note

Content

Shorter than a research article, a research note may report the outcomes of a pilot study or the first stages of a large complex study or address a theoretical or methodological issue etc. In all instances it is expected to make a substantive contribution to health management knowledge.

Abstract

Structured (Objective, Design, Setting, Main Outcome Measures, Results, Conclusions).

Word count: maximum 200 words.

Main text

Structured (Introduction, Methods, Findings, Discussion and Conclusions).

Word count: general guide 2,000 words.

As with a longer research article the discussion section should address:

- A brief statement of principal findings;
- Strengths and weaknesses of the study in relation to other studies, discussing particularly any differences in findings;
- Meaning of the study (eg implications for health and aged care services managers or policy makers); and
- Unanswered questions and future research.

References: maximum of 25.

NB: Authors of research notes submitted to the APJHM are advised to consult 'Writing a research article: advice to beginners' by Perneger and Hudelson (2004) and available at: <<http://intqhc.oxfordjournals.org/cgi/content/full/16/3/191>> This article contains two very useful tables: 1) 'Typical structure of a research paper' and 2) 'Common mistakes seen in manuscripts submitted to this journal'. [3]

4. Review article (eg policy review, trends, meta-analysis of management research)

Content

A careful analysis of a management or policy issue of current interest to managers of health and aged care service organisations.

Abstract

Structured appropriately.

Word count: maximum of 300 words.

Main text

Structured appropriately and include information about data sources, inclusion criteria, and data synthesis.

Word count: general guide 3,000 words.

References: maximum of 50

5. Viewpoints, interviews, commentaries

Content

A practitioner oriented viewpoint/commentary about a topical and/or controversial health management issue with a view to encouraging discussion and debate among readers.

Abstract

Structured appropriately.

Word count: maximum of 200 words.

Main text

Structured appropriately.

Word count: general guide 2,000 words.

References: maximum of 20.

6. Book review

Book reviews are organised by the Book Review editors. Please send books for review to: Book Review Editors, APJHM, ACHSE, PO Box 341, NORTH RYDE, NSW 1670. Australia.

Covering Letter and Declarations

The following documents should be submitted separately from your main manuscript:

Covering letter

All submitted manuscripts should have a covering letter with the following information:

- Author/s information, Name(s), Title(s), full contact details and institutional affiliation(s) of each author;
- Reasons for choosing to publish your manuscript in the APJHM;
- Confirmation that the content of the manuscript is original. That is, it has not been published elsewhere or submitted concurrently to another/other journal(s).

Declarations

1. Authorship responsibility statement

Authors are asked to sign an 'Authorship responsibility statement'. This document will be forwarded to the corresponding author by ACHSE on acceptance of the manuscript for publication in the APJHM. This document should be completed and signed by all listed authors and then faxed to: The Editor, APJHM, ACHSE (02 9878 2272).

Criteria for authorship include substantial participation in the conception, design and execution of the work, the contribution of methodological expertise and the analysis and interpretation of the data. All listed authors should approve the final version of the paper, including the order in which multiple authors' names will appear. [4]

2. Acknowledgements

Acknowledgements should be brief (ie not more than 70 words) and include funding sources and individuals who have made a valuable contribution to the project but who do not meet the criteria for authorship as outlined above. The principal author is responsible for obtaining permission to acknowledge individuals.

Acknowledgement should be made if an article has been posted on a Website (eg, author's Website) prior to submission to the Asia Pacific Journal of Health Management.

3. Conflicts of interest

Contributing authors to the APJHM (of all types of manuscripts) are responsible for disclosing any financial or personal relationships that might have biased their work. The corresponding author of an accepted manuscript is requested to sign a 'Conflict of interest disclosure statement'. This document will be forwarded to the corresponding author by ACHSE on acceptance of the manuscript for publication in the APJHM. This document should be completed and signed and then faxed to: The Editor, APJHM, ACHSE (02 9878 2272).

The International Committee of Medical Journal Editors (2006) maintains that the credibility of a journal and its peer review process may be seriously damaged unless 'conflict of interest' is managed well during writing, peer review and editorial decision making. This committee also states:

'A conflict of interest exists when an author (or author's institution), reviewer, or editor has a financial or personal relationships that inappropriately influence (bias) his or her actions (such relationships are also known as dual commitments, competing interests, or competing loyalties).

... The potential for conflict of interest can exist whether or not an individual believes that the relationship affects his or scientific judgment.

Financial relationships (such as employment, consultancies, stock ownership, honoraria, paid expenses and testimony) are the most easily identifiable conflicts of interest and those most likely to undermine the credibility of the journal, authors, and science itself...' [4]

Criteria for Acceptance of Manuscript

The APJHM invites the submission of research and conceptual manuscripts that are consistent with the mission of the APJHM and that facilitate communication and discussion of topical issues among practicing managers, academics and policy makers.

Of particular interest are research and review papers that are rigorous in design, and provide new data to contribute to the health manager's understanding of an issue or management problem. Practice papers that aim to enhance the conceptual and/or coalface skills of managers will also be preferred.

Only original contributions are accepted (ie the manuscript has not been simultaneously submitted or accepted for publication by another peer reviewed journal – including an E-journal).

Decisions on publishing or otherwise rest with the Editor following the APJHM peer review process. The Editor is supported by an Editorial Advisory Board and an Editorial Committee.

Peer Review Process

All submitted research articles and notes, review articles, viewpoints and analysis of management practice articles go through the standard APJHM peer review process.

The process involves:

1. Manuscript received and read by Editor APJHM;
2. Editor with the assistance of the Editorial Committee assigns at least two reviewers. All submitted articles are blind reviewed (ie the review process is independent). Reviewers are requested by the Editor to provide quick, specific and constructive feedback that identifies strengths and weaknesses of the article;
3. Upon receipt of reports from the reviewers, the Editor provides feedback to the author(s) indicating the reviewers' recommendations as to whether it should be published in the Journal and any suggested changes to improve its quality.

For further information about the peer review process see Guidelines for Reviewers available from the ACHSE website at www.achse.org.au.

Submission Process

All contributions should include a covering letter (see above for details) addressed to the Editor APJHM and be submitted either:

(Preferred approach)

1) Email soft copy (Microsoft word compatible) to journal@achse.org.au

Or

2) in hard copy with an electronic version (Microsoft Word compatible) enclosed and addressed to: The Editor, ACHSE APJHM, PO Box 341, North Ryde NSW 1670;

All submitted manuscripts are acknowledged by email.

NB

All contributors are requested to comply with the above guidelines. Manuscripts that do not meet the APJHM guidelines for manuscript preparation (eg word limit, structure of abstract and main body of the article) and require extensive editorial work will be returned for modification.

References

1. Hayles, J. Citing references: medicine and dentistry, 2003;3-4. Available: <<http://www.library.qmul.ac.uk/leaflets/june/citmed.doc>> (Accessed 28/02/06)
2. Doherty M, Smith R. The case for structuring the discussion of scientific papers. *BMJ*. 1999;318:1224-1225.
3. Perneger TV, Hudelson PM. Writing a research article: advice to beginners. *Int Journal for Quality in Health Care*. 2004;191-192. Available: <<http://intqhc.oxfordjournals.org/cgi/content/full/16/3/191>> (Accessed 1/03/06)

4. International Committee of Medical Journal Editors. Uniform requirements for manuscripts submitted to biomedical journals. *ICMJE*. 2006. Available: <<http://www.icmje.org/>> (Accessed 28/02/06).

Other references consulted in preparing these Guidelines
Evans MG. Information for contributors. *Acad Manage J*. Available: <http://aom.pace.edu/amjnew/contributor_information.html> (Accessed 28/02/06)

Health Administration Press. Journal of Health care Management submission guidelines. Available: <<http://www.ache.org/pubs/submisjo.cfm>> (Accessed 28/02/06)

International Journal for Quality in Health Care. Instructions to authors, 2005. Available: <http://www.oxfordjournals.org/intqhc/for_authors/general.html> (Accessed 28/02/06)

The Medical Journal of Australia. Advice to authors submitting manuscripts. Available: <<http://www.mja.com.au/public/information.instruc.html>> (Accessed 28/02/06)

Further information about the Asia Pacific Journal of Health Management can be accessed at: www.achse.org.au.