Asia Pacific Journal *of* Health Management

Volume 4 Issue 2 – 2009

The Journal of the Australian College of Health Service Executives

Feature
Assessing policy in health reform

Reviews
Private health insurance and hospital services
Engaging doctors in leadership:
the NHS experience
HIV/AIDS in South Africa

Research
Monitoring sentinel events
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ASIA PACIFIC JOURNAL OF HEALTH MANAGEMENT

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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.

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

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

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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.

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

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

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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.

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ISSN: 1833-3818 (Print)

Learning is the keystone for the College: developing members, informing health management policy and practice

Recent reflection by the author on the reasons why the Australian College of Health Services has been so successful and grown, and perhaps matured as a 'professional society', unearthed a College Federal Council planning document from 1998 [1] that canvassed the issues around what type of organisation the College purported to be. The discussion was about the relative differences between 'Association', 'Institute' and 'College'. The first was defined as 'Interests and welfare of members are primary concerns, and implies representation and political and industrial action'. The term 'Institute' had usage in the name of this organisation as it gave greater connotation of being established around a body of knowledge and being profession-based. The currently accepted term 'College' was defined as:

> A body of knowledge with formal entry requirements and examination procedures, a professional, educational role, setting standards, a focus on continuing professional development, expression of policy viewpoints but not essentially industrial or political in activity and, overall, a concern with the advancement of the profession and the development of members.

The early founders of the College were of course the prominent hospital chief executives of the time, who mostly worked independently of health departments for hospitals with Boards of Directors. They actively promoted the importance of a profession-based college and ultimately the teaching of the body of knowledge in tertiary institutions and they were, at the same time, active in industry and industrial organisations and leaders in their own communities. This created concern at the time as there was little surety about 'which hat' they might wear at a particular time. They were also predominantly male; and mostly, but not all, from a 'generalist health management' background with accounting and business qualifications and a wealth of knowledge of health and hospital-based management. Therefore, the early College development addressed commonly accepted labels of what constitutes a profession by developing ownership of the delivery of certain services, the development and teaching of a body of knowledge and, in those times, they had a relative degree of autonomy and authority. [2] However, the College and its leadership have not sought to set boundaries around the profession and to demark boundaries, characteristic of that used to describe many of the professions that seek both control and ownership of territory. [3-4] In fact, the College has been responsive and innovative in its strategic approach to changing circumstances in health systems.

Today the College is multidisciplinary in the range of health professional disciplines within the membership, has a reasonable gender balance and has representation from most health industry sectors including public and private, acute, aged care, divisions of general practice, community and primary healthcare and health management academics. The participation of these diverse groups is, in fact, impressive. The challenge from this multi-disciplinary, multi-sector membership left unanswered at this stage, is do the governance arrangements and appointments/election to office and the development of future strategy of and for the College, adequately reflect that diversity?

The evolution of the College has addressed most of the identified challenges professional workforces have had to face. [2] These challenges include an increased recognition that all health professionals have multiple roles, including that of manager as well as care provider, educator and researcher and, [5] that they increasingly work within inter-professional teams and have had some exposure to inter-professional education. [6] Remarkably, the College and its membership have met the challenges of intra-professional conflict in a remarkable way in the context that it represents multiple interest groups [7] and that the membership includes those with the wide range of clinically-based and discipline-based backgrounds at various levels of transition to management-based roles and the often internalised tensions between the roles, at least in transition. [8]

Therefore the prevailing strengths of the College have been the ability to change and shape its agenda to that of constant health system reform, to present a diverse and multi-disciplined, multi-health sector membership base and to have resisted any incursions into sectoral industry or industrial-based issues of structural interests, so admirably described as a 'strife of interests.' [9] Furthermore, the College has foreseen the globalised nature of the health workforce and the increasing delivery of care in both advanced and developing countries to citizens seeking care or being recipients of care delivered internationally and across national boundaries. Early collaborations with colleagues in New Zealand, Hong Kong, Papua New Guinea and more recently in Singapore and Thailand, demonstrate that these colleagues value what the College might bring to their profession. The value of the College was powerfully demonstrated in front of 470 delegates from 17 countries at the recent First International Health Services Delivery Management Conference in Thailand. [10]

So besides getting the structure right and ensuring that these long held values are reinforced in the governance of the College, what else must occur to ensure that a professional society – a College – remains relevant and vibrant? While some recognition must be given to corporate governance and member services where should the focus of governance be? The experience of the clinical colleges may reinforce the current direction of the College and provide lessons on which the College can build on its core business. What is the core business? Well 'Professional societies are central to the provision of learning activities'. [11 p.1170] They accomplish this role together with a range of providers, academic units and training organisations and, in the Australian context, with government, that dominates health funding, policy and provision. The College provides this learning in the context of continuing professional development and education opportunities in diverse settings increasingly available on line and often in partnership with academic health management units and recognised training organisations with the exemplar being the quality of the national conference held annually.

Consistent with these approaches is a highly successful Fellowship process and examination that is as valued by our international colleagues and members as it is by those resident in Australia and demonstrated in this issue by respondents to the Q&As section. The College, in association with the Society of Health Administration Programs in Education (SHAPE), accredits tertiary health management programs and there is usually participation of operationally experienced health manager College members together with health management academics engaged in this process on an ongoing basis. Engagement of College members in these contexts is also a valued opportunity for continuing professional development. In some state branches, health management training programs are longstanding contributions to would-be health managers obtaining a contextualised, work-based experience and a graduate education. Unfortunately, these types of opportunities from providers are not as extensive as they should be and the College could well seek further investment from providers in these schemes that will also provide increased opportunity for international health management experience. Again the value of much of these approaches to learning requires the engagement of College members in their successful delivery. Member participation and engagement is then central to the values that have bolstered and sustained the College.

Again the clinical colleges suggest that in continuing professional development there needs to be a move away from counting credits 'Towards a process of self accreditation and reflection, recording learning that has occurred and applying it to practice'. [12 p.393] In the College, member engagement is not only a value of membership but an opportunity to learn by doing and contributing. Our medical colleagues also suggest that 'Practising medicine without reading is unthinkable'. [13 p.394] The College places high value on reading in that it has invested in a health management library that is a useful resource to the membership in their research, professional development and education as professional health managers who must also 'Know and be able to use the literature, must derive practical and effective results that create or improve learning systems'. [11 p.1169]

In a relatively short time frame of four years this Journal, established by the College to give clear priority to health management research and practice, powerfully defines the role of the College, a learning society and the values developed over sixty years of contribution by many far sighted College members. The Journal is unique in many ways because it covers pure research, scholarly domains to management practice, views, commentaries and current issues. It has enjoyed early and great success. There are more than 30 members, both practising health managers and senior health management academics, involved in the governance and production of issues of the Journal.

Some 60 peer reviewers, mostly College members, willingly contribute to the peer review process with more than 80 articles published by multiple authors, some College members, some not, but exposed, possibly for the first time to the College and its ethos. From a start that required invited articles, the majority are now voluntarily submitted for publication with a number of repeat submissions from those already published. Increasingly, the contributions have become international and we have encouraged many first time authors as well as welcoming publication from senior academics and practitioners. The Journal is mandatory reading for the Fellowship process and so has become an integral component of the learning framework skilfully constructed over time by the College leadership and membership.

The challenge for the Journal team is responding in a timely and effective manner to the volume of contributions now received, given our policy of a limited number of issues per year. We also need to build on access to the Journal now that it has an established record and there is clear commitment for this to occur.

The challenge for the College is to build a strategic framework around the strong values described in this editorial as underpinning 60 years or more of success and ensuring that the values and the elements of learning implicit in College activities are brought to the forefront of its governance and strategic direction at state, national and international levels.

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

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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 tenth issue of the Journal. The deadline for receipt of papers is 26 February 2010.

IN THIS ISSUE

The photograph on the cover exemplifies in many ways the central role of the College as a learning society and demonstrates the value of the process of Fellowship to that learning. We are indebted to Dr Alison Dwyer for providing us with the idea of featuring the College Fellowship. Her enthusiasm in submitting a paper about her experience of that process led us to the selection for the cover and also provided us with our Q&As section and some inspiration for the Editorial.

We also introduce some of our Honorary Assistant Editors in this issue who will assist in giving us better geographic representation and participation. We are examining similar Australian- based roles to help the Journal meet the challenge of increasing numbers of articles being submitted for publication. An excellent way for members to participate, contribute and learn.

The Editorial explores the successes of the College over time and places education, learning and professional development at the centre of what should be the focus of our governance at state and federal levels of the College. Our achievements have been many and it is important to remember what the central role of the College is as we move forward and strategically focus at the governance level as to 'where to from here'?

Health reform continues to be central to our concerns in managing within the health system and we are fortunate to have as our feature article the contribution by Leeder, Beaton and Lewis, which provides criteria for assessing policy documents around health reform. Given the extensive health reform reports and government focus on how to move forward proposed reforms, this article should provide useful assistance to those of us in the health system considering the likely impact of this latest reform agenda.

The article by our colleague Jo Martins on private health and hospital insurance, provides useful data and insights to the long standing interest of readers on the likely impact of health insurance reforms over time on both our public and private hospital sectors in the Australian context. Armit and Roberts provide details of the United Kingdom NHS initiatives in medical leadership education and why that focus has been taken. Again a useful contribution to be considered in the various approaches differing health systems might take in engaging doctors and looking for their participation in effective reform.

Ansari concludes our review articles in this issue by providing a descriptive overview of a significant risk to health for the population of South Africa and the need for multi-dimensional approaches to addressing the risk factor. While Australia has been relatively successful in addressing this challenge, it remains a significant priority for many of our neighbouring countries' health systems.

Our research articles commence with the contribution from Jackson and colleagues about monitoring sentinel events using routine inpatient data. This research is important in terms of the current focus on safety and quality in the health system and adds to our knowledge about the relative usefulness of approaches in identifying and addressing significant events that impact on that care. Likewise Georgiou and Hancock provide some insights into varying perspectives on the dimensions of quality-of-life indicators and assessment in the adult day care context. Han, Chesters and Ballis conclude our research articles with their second part of their paper about rural general practice.

We thank our entertaining Q&As contributors for their insights into the College Fellowship process and Swan and Price for the two book reviews of the same book and to Sue Brockway for yet another excellent library contribution.

HONORARY ASSISTANT EDITORS

The Board of Directors of ACHSE has made appointments to newly created Honorary Assistant Editor roles for the *Asia Pacific Journal of Health Management*. The appointments were made in consultation with our College's international colleagues and their local College/Institute and from the advice of College colleagues in national health organisations where a formal branch or organisation is yet to be established. The first appointments made are to positions that reflect the international focus of the Journal. Interest in an Australian- based Honorary Assistant Editor have also been received and will be advanced before the next issue of the Journal.

These roles have eventuated due to the success of the Journal and the rapidly increasing volume of papers being received for review and publication. The roles also reflect a commitment of the College and the Journal to utilise this publication to increase member engagement in professional development and continuing education activities. The appointments also reflect the increased importance our colleagues from the Asia Pacific place on the important contribution of the Journal and the value they place on College membership and developing international networks.

The Honorary Assistant Editors will generally assist the Editor and become familiar with the processing of submitted papers through the review and submission process. They will provide coverage to the Editor during periods of leave and absence and will assist new and emerging authors with the development of papers. They will also assist with developing special issues, themed issues and contributions from specific health industry sectors and from geographic sectors within the Asia Pacific.

Congratulations to our new appointees Dr Geoffrey Lieu from Hong Kong, Dr Phudit Tejativaddhana from Thailand (formerly known as Dr Prawit Taytiwat) and Mr Stuart Francis from New Zealand.

A brief biography on each Honorary Assistant Editor follows.

Dr Geoffrey Lieu

Dr Geoffrey Lieu is currently Chairman of the Hong Kong Healthcare Corporation Limited, a private healthcare investment and development firm which develops and operates hospitals and clinics in Asia. He has worked as a hospital chief executive and senior corporate executive for nearly 20 years in the United States before returning to Hong Kong in 1991 to head up the reforms of public hospitals under the newly established Hospital Authority.

In 1996, he founded the Institute for Health Policy and Systems Research (IHPSR), the first private not-for-profit healthcare think-tank in Hong Kong and a founding member of several international health policy and economics networks. The organisation has completed a number of widely recognised studies on Hong Kong's healthcare system and policy development.

Dr Lieu is Adjunct Associate Professor of the University of Minnesota School of Public Health, Visiting Fellow and Director of the MSc in Health Services Management Program at the Hong Kong Polytechnic University, in addition to serving as visiting faculty in a number of local and overseas universities.

Dr Lieu is Life Fellow of the American College of Healthcare Executives, Fellow of the Australian College of Health Service Executives and Advisor and Fellow of the Hong Kong College of Health Service Executives. He serves as non-executive director on a number of hospital, NGO and corporate boards. He is also an internationally active speaker on subjects on healthcare reform, financing, organisational performance and leadership development.

Dr Phudit Tejativaddhana (formerly known as Dr Prawit Taytiwat)

The recent change in name represents an honour bestowed by the King of Thailand, His Majesty King Bhumipol. Dr Phudit Tejativaddhana is a Fellow of the College and Dean of the Faculty of Public Health, Naresuan University (FPH NU), Phitsanulok, Thailand. Dr Phudit is also an Adjunct Associate Professor of the Schools of Health and Rural Medicine, University of New England (UNE), Australia. Additionally, he is an Executive Board member of the Network of the World Health Organization (WHO) Collaborating Centres and Centres of Expertise in Thailand (NEW-CCET) and the Chair of the Regional Health Security Board for Region 3 which covers five provinces. Dr Phudit has also served as an Advisor to the Minister of Public Health.

Previously, Dr Phudit was a General Practitioner (GP) and an executive of two private hospitals in Bangkok. In 1997 he became a 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. During this time he became involved with a project to increase rural GP training to reduce the shortage of doctors in these areas. Dr Phudit also engaged in community research and development of models of primary care services for urban and rural poor. He was awarded a scholarship by the Royal Thai Government and earned his degree as a Doctor of Health Services Management (DHSM) from UNE.

Dr Phudit is passionate about developing professionalism in health management in Thailand and improving 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 and the National Health Security Office, Thailand. These collaborations and their subsequent activities have arisen out of his fervent desire to represent under-served populations.

Dr Phudit initiated the Centre of Expertise on Hospital and Health Services Management in Thailand, as part of the FPH at NU. This has now become the Centre of Expertise on Leadership in Health Management (CELHM). With support from UNE, this centre is now working to be designated as a WHO Collaborating Centre. The goal is to become a 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. Advancement in these areas will contribute to the achievement of the UN Millennium Development Goals (MDGs). He also hopes to develop a professional college in Thailand with links to ACHSE.

Mr Stuart Francis

Stuart Francis is a senior management and healthcare consultant specialising in the government and health sector and is the Managing Director of the Francis Group. He works at senior levels within the public sector in New Zealand and the United Kingdom, particularly facilitating multi-agency initiatives and national programs. He is on the National Council of the New Zealand Institute of Health Management, is a Fellow of the Australian College of Health Service Executives and a member of the New Zealand Institute of Directors. Recent roles have included leading a surgical service improvement and organisational development program for a large tertiary District Health Board in New Zealand; an organisational review of outpatient services for one of the largest NHS Foundation Trusts in the United Kingdom and as a director of combined change on the executive of the Tertiary Education Commission, overseeing the reform program for the tertiary education sector, the restructure of the Commission itself and some 20 associated IT projects. Before establishing the Francis Group in 2002, Stuart was a Director in the Public Sector group of Cap Gemini Ernst & Young, responsible for their government and health practice in Victoria, Australia.

Criteria for Assessing Policy Discussion Documents Containing Proposals for Health Reform

S Leeder, A Beaton and S Lewis

Abstract

This paper presents a guide for healthcare professionals and policymakers contributing to and assessing discussion documents and reports relevant to health policy. Our purposes are to: (1) help develop a more systematic approach to making written submissions and participating in deliberations; (2) provide criteria for constructively critiquing published discussion documents and reports and reaching an informed opinion on them; and more generally, (3) suggest an approach for participating in the policy development and review process. With this in mind, we propose a set of fundamental questions to pose in critically assessing a document or set of recommendations and framing submissions to deliberative or consultative bodies seeking responses to prominent reports. To illustrate, we have applied these questions to one of the structural options around Commonwealth responsibility for healthcare funding, policy and regulation, as discussed in the Final Report of the National Health and Hospitals Reform Commission, *A Healthier Future for All Australians.*

Abbreviations: NHHRC – National Health and Hospitals Reform Commission; NSW – New South Wales; PHC – Primary Health Care.

Key Words: health policy; health reform; assessment tool; NHHRC.

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Several policy discussion papers have been published recently pertaining to healthcare and disease prevention in Australia, including the final reports of the National Health and Hospitals Reform Commission (NHHRC) *(A Healthier Future for All Australians)*, [1] the National Preventative Task Force *(Australia: The Healthiest Country by 2020)*, [2] the National Primary Health Care Strategy External Reference Group *(Primary Health Care Reform in Australia)*, [3] the *Special Commission of Inquiry into Acute Care Services in New South Wales Public Hospitals* (also known as the Garling Report), [4] and that of the Standing Committee on Health and Ageing on the inquiry into obesity in Australia *(Weighing it up: Obesity in Australia)*. [5]

It is sometimes difficult to distinguish policy-oriented documents explicitly based on high quality research and analysis from those that are essentially collations of informed opinion or interesting ideas. The point is not that only the former are worth taking seriously; but rather it is to understand the difference, and to recognise the importance of understanding where empirical evidence has significantly informed the recommended directions.

This paper presents a guide for healthcare professionals and policymakers contributing to and assessing discussion documents and reports relevant to health policy. Our purposes are to: (1) help develop a more systematic approach to making written submissions and participating in deliberations; and (2) provide criteria for constructively critiquing published discussion documents and reports and reaching an informed opinion on them; and more generally, (3) suggest an approach for participating in the policy development and review process.

With this in mind, the basis on which one might form a critical judgement of a document may be based on the following questions, which were developed by one of the authors (Lewis):

1. What major goals are advanced in the report and are they internally consistent? What problems are proposed options designed to solve?
2. Are the main structures and recommendations likely to achieve the intended results?
3. Where are the gaps in the proposals? Which need to be elaborated more fully?
4. Which proposals carry the greatest risk of producing unintended consequences and how might these be mitigated?
5. How have other countries experienced and dealt with similar (reform) challenges and how might the lessons learned be applied?
6. What historical and contextual features appear to have influenced the proposals, and to what extent do they affect the likelihood of attaining the report's ambitious goals?

To illustrate how this might work, we have applied these questions to one of the structural options around Commonwealth responsibility for healthcare funding, policy and regulation, as discussed in the NHHRC Final Report, *A Healthier Future for All Australians*.

Cultural, historical and other contextual factors

There is no shortage of calls for sweeping health reform in Australia and other countries. The typical fate of these proposals is fairly broad intellectual agreement among academics and disinterested policy analysts; mixed responses among practitioners; reluctance by government to push controversial reform items; and bewilderment on the part of the public. This leads, typically, to cherry-picking of certain recommendations and ignoring others, and a series of negotiations at multiple levels that in the end, tinker incrementally with the status quo. We state this as an empirical reality rather than as a criticism. There is a large and respected body of political theory that rejects sweeping change as dangerously disruptive and likely to fail to meet stated objectives. [6, 7, 8] Grand social engineering acquired a deservedly spotty reputation given the managerial excesses of the last century. Social scientists have developed the theory of path dependency, which essentially holds that future possibilities are constrained by historical and institutional traditions. These insights argue in favour of gradual, incremental change, and aligning ambition with the practicalities of making it happen.

However, history is not linear, and there are defining moments and windows of opportunity to change things dramatically for the better. Kuhn's famous paradigm shifts do occur. The Iron Curtain did not erode gradually; it tumbled, somewhat unpredictably, in a few months. The elements and forces for large-scale change may assemble gradually and even invisibly, but eventually they gather strength and manifest with unusual speed and scope. This tends to occur when the status quo is revealed as non-viable, whether it is a heliocentric view of the world or the compatibility of totalitarianism with human aspirations. Put another way, the evidence that favours change overwhelms the defence of the status quo.

The first question, then, is whether the healthcare system's status quo is fundamentally unsustainable, and if so, on what grounds. The NHHRC report's perspective is that the system needs a major overhaul. We concur – there is sufficient evidence of its failure to deliver quality, value for money, accessibility, and equity to warrant a transformation. Again, this is not unique to Australia: there is remarkable consensus internationally that this is the case (for example, the Health Council of Canada report, *Value for Money: Making Canadian Health Care Stronger*; and the Institute of Medicine report, *To Err is Human*). [9, 10] The need for reform is a necessary but not sufficient condition for its achievement. Australia is a federal country where healthcare responsibilities are unusually fragmented and interest groups are (not so unusually) powerful. In such arrangements one cannot discuss health reform in isolation from Constitutional law, Commonwealth-state relations, taxation power, political sensitivities, administrative structures, practice cultures and a whole host of related variables.

Practically speaking, it is to be hoped that major substantive change is possible without major structural change. But practically speaking, that may not be possible. In this case, these understandings should underlie any response or critical appraisal of the NHHRC report document.

Reforming governance and reconfiguring funding responsibilities

The Commission makes two main recommendations on reforming the governance of our health system. The first calls on First Ministers[1] to agree to a new 'Healthy Australia Accord' that clearly articulates the roles and responsibilities of all governments. The Commonwealth would: (1) be responsible for all funding, policy and regulation for primary healthcare, basic dental and aged care; (2) pay 40 per cent of the efficient cost of every public patient admission to a hospital, sub-acute or mental healthcare facility and every attendance at a public hospital emergency department; and (3) pay 100 per cent of the efficient costs of delivery of hospital outpatient services with an agreed, capped activity-based budget.

Using the criteria to assess this proposal

1. International recognition of the importance of integrated approaches to care (both vertically and horizontally), has led to an interest in developing structures that promote or at the very least permit a more seamless, systemic approach to care, both upstream (health promotion, prevention, primary healthcare) and downstream (acute and sub-acute care, long-term residential care, specialised services). There should be incentives at all levels, from individual through to organisational, to minimise the need for expensive care and to deliver care efficiently and fairly.

2. The historical legacy that divides responsibility for related sectors and activities between two levels of government is a challenge. It is quite clear that the assignment of responsibility for some parts of the care continuum to the states and others to the Commonwealth, creates tensions, inconsistencies, and misalignments. The NHHRC report gamely tries to make a virtue out of the perceived need to retain historical and Constitutional arrangements; it is conceivable that it has made the right call in accepting that which cannot be changed. However, it is important to establish mechanisms and transparent criteria by which the two levels of government can negotiate significant changes in these arrangements based on mutual interests and guided by a focus on serving people better.

3. While beyond the mandate of the Commission, the issue of fiscal capacity and imbalance will have to be addressed if sound and durable solutions are to be achieved. Responsibility and taxation power must be aligned. It is vital to remove perennial sources of intergovernmental tension and the temptation to offload and game[2] the system. More importantly, intergovernmental rivalries and sources of friction should be invisible at the local delivery level, where coordination and integration are essential.

4. The model proposes full Commonwealth responsibility for Primary Health Care (PHC) and outpatient care. Combined responsibility for these services makes sense: if the expansion of PHC is successful there should be less need for specialty care, and the authority to invest, where it makes most sense along the continuum, should be consolidated. Whether this responsibility should lie at the state or Commonwealth level is a key question. Historically, the state has been more closely involved in the provision as well as the funding of services. One of the declared Commission goals of the reforms is to retain the more intimate state relationship with its citizenry. PHC is an obvious point of connection since virtually everyone uses PHC annually while relatively few use hospitals, and then for typically short periods of time. The report touts the advantages of Commonwealth responsibility to include consistency of approach and improved health human resources planning. However, there is no proven ideal model for PHC and some natural experimentation is inherently desirable. Health human resources planning can be done cooperatively through intergovernmental councils, but perhaps more to the point, states may have legitimately different views on needs, priorities, and how to address them, which suggests some degree of autonomy over the education and distribution of personnel.

5. The cost-sharing model for hospital inpatient care has the virtue of creating a common interest in controlling costs and overall system planning. Judging from experiences elsewhere, the Commonwealth may perceive itself to be at risk because its share is entirely dependent on the actions of the states.[3] For the Commonwealth, the incentive is to minimise hospitalisation to keep its costs down; its main levers of influence are effective PHC and outpatient care, which in this model it would fund exclusively. For

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[1] 'First Minister' is a term used for the Prime Minister, State Premiers, Territory Chief Ministers and the President of the Australian Local Government Association in the Council of Australian Governments, the peak intergovernmental forum in Australia.

[2] 'Gaming' is behaviour designed to exploit certain features of existing rules to maximise benefits. An example would be a primary care doctor referring time-consuming cases to specialists to avoid income loss, or one level of government limiting capacity in a sector for which it is financially responsible so that people in need seek care in facilities paid for by another level of government.

[2] That is what caused the Canadian federal government to shift from essentially a 50-50 funding arrangement with the provinces, to a formula that tied its future cost increases to the rate of inflation, and ultimately to the transfer of tax points to the provinces to replace most of the cash contributions.

the states, there is at least a partial incentive to maximise hospitalisations because a) access and wait times are usually hot political buttons; b) giving providers more capacity to perform more procedures is often politically attractive; and c) 60 cents of additional spending automatically triggers 40 cents from the Commonwealth.

In conclusion, this recommendation requires a very information-rich environment to calculate efficient costs and understand the relationship between inputs and outcomes. Logically, authority should be commensurate with responsibility; having one government pay a fraction of costs of programs over which it has little or no influence is an obligation unlikely to be warmly embraced. If hospital services are to be cost shared, it would therefore seem prudent – from the Commonwealth perspective – to secure a substantive role in determining the nature and size of the hospital envelope, and in setting overall direction for the sector. Finally, if the goal is to definitively improve coordination and align incentives and responsibilities with intended results, this option addresses only part of the problem. Its practicality is also its defect: it is minimally disruptive structurally but also unlikely to remove the barriers that impede seamless delivery of care and shared accountability.

This brief analysis and discussion is designed to provide an indication of the utility of pre-defined questions in interrogating policy discussion documents and the recommendations and proposals they describe. We hope this will provide those healthcare professionals not already actively engaged in health policy development and review the wherewithal to become involved.

In summary, we have applied the six questions to the NHHRC's structural recommendations to conclude the following:

1. The report is quite clear in its goals – a more integrated, efficient system that improves the health of Australians.
2. It is unclear whether the main structures and recommendations would achieve the intended results; we are sceptical because the fundamental problems involve much more than structure.
3. There are significant gaps in the proposals; the report is largely silent on issues such as practice cultures and multi-level (not just Commonwealth-state) incentives.
4. The structural recommendations in their current form are at risk of producing unintended consequences such as gaming and diminishing the state presence in (and therefore commitment to) primary healthcare, which should be the foundation of a health-oriented system. The proposed funding split loads risks disproportionately on the Commonwealth Government.
5. Other federal nations have dealt with these issues; Canada's historical experience merits some elaboration in this context. Australia does appear to have a unique division of responsibilities. Based on international experience, structural reforms are not sufficient to bring about major improvements in quality and efficiency; the question is whether they are necessary.
6. Important historical and contextual conditions certainly influenced the NHHRC deliberations and proposals. Nonetheless, the proposed structural reforms are quite dramatic, entailing major realignment of responsibilities and new funding arrangements. Yet they do not eliminate the tensions and disincentives that accompany fragmented authority.

For those interested in participating more meaningfully and influentially in future policy development efforts, a number of possible strategies emerge from this exercise. Perhaps paramount is the importance of an empathetic understanding of the task and circumstances faced by those charged with producing a report. One way or another, they have to answer the questions posed in their terms of reference and take note of the political, cultural, economic, and historical factors that both explain things as they are and constrain the options for making things better. Those who make submissions to commissions and their equivalents are often effective advocates for their particular interests. The challenge is to connect the advocacy to the broader issues and choices facing the commissioners. In other words, participants are more likely to influence the final outcome if they are able to imagine themselves to be commissioners responding to their submission in the course of producing it.

Finally, we do not suggest that our list of questions is either definitive or comprehensive. The important thing is to have a list of questions relevant to the policy issues under consideration. This both disciplines and makes more transparent the production of submissions and interactions, and provides the foundation for a thoughtful critique of what is ultimately produced. It also enhances the likelihood that people will engage in useful conversation with each other.

Competing interests

The authors declare that they have no competing interests.

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REVIEW ARTICLE

Private Health Insurance and Hospital Services in Australia

JM Martins

Abstract

Public subsidy of private hospital services, either directly or through private health insurance, is a controversial policy issue. The Romanow's review of Canadian medical and hospital services rejected suggestions that the use of for-profit private hospitals would help to improve the efficiency of Canadian services. He cited studies of health services in the United States that raised doubts about the benefits of the use of for-profit hospitals in the neighbour country. In view of the similarity of the public funding of medical and hospital care in Australia and Canada and the Canadian stance, it is useful to examine the various impacts of policy thrusts in Australia that promoted the expansion of private health insurance for private hospital use. This paper adds to the findings of a number of analysts concerned with efficiency and equity questions, through the examination of trends in the capacity and use of hospital services in Australia in the ten year period 1997-2007. Further, it provides an analysis of the relative specialisation of public and private hospital services, to assess whether the set of policy measures has been associated with the expansion of the range of services in private hospitals that might substitute for those provided by the public sector.

Abbreviations: **ICD – International Classification of Diseases; PHI – Private Health Insurance; PHIIS – Private Health Insurance Incentives Scheme; RESPIND – Relative Specialisation Indices.**

Key Words: **private health insurance; subsidy of private hospitals; hospital services; hospital specialisation.**

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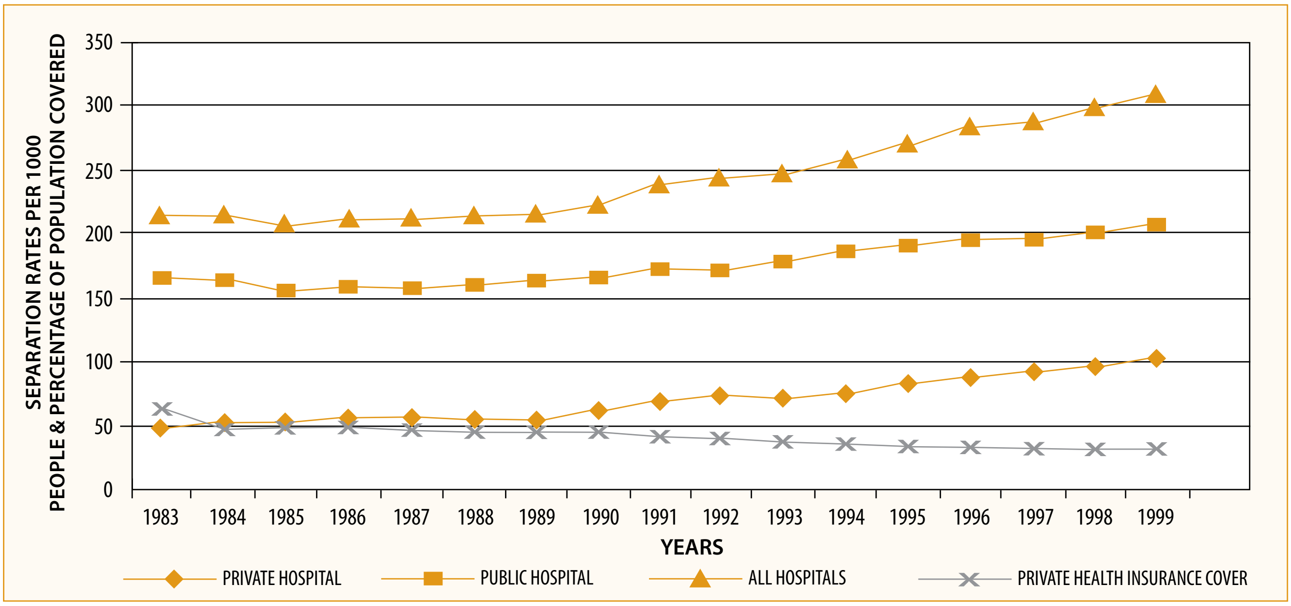
**A version of this paper was presented at the meeting of the International Health Policy and Management Institute, Bucharest, Romania in September 2008.*

Introduction

In many regards, Medicare in Australia is similar to the public financing of medical and hospital services in Canada. In one aspect, they differ substantially: Medicare in Canada does not support inpatient care in private for-profit hospitals. The Romanow's review of the Canadian healthcare system revisited this issue. Although Romanow acknowledged that there were advocates of the use of for-profit private hospitals in Canada, he rejected that pathway. Romanow referred to a number of studies in the United States that raised questions of quality of care, as well as 'creaming' of easily provided services by for-profit establishments that left the public sector with more difficult cases. [1] In spite of some recent changes in legislation, the Federal Government in Australia continues to support private health insurance for private hospitals in contrast with the Canadian stance. In this context, it is useful to examine the more recent evolution of hospital use in Australia after policy thrusts to make private health insurance (PHI) for private hospital use more compelling in the late 1990s and early 2000s. This paper provides a brief examination of trends in PHI coverage and hospital use in Australia in the 1980s and 1990s, before major fiscal incentives and subsidies were introduced to bolster PHI for private hospitals. It considers the stated purposes of the new policy thrusts (1997-2000) and reviews policy issues concerned with effectiveness, efficiency and equity. It then adds analyses of the growth in hospital capacity and use in Australia in the period 1997-2007, and provides evidence whether or not the policy stimulus was

Figure 1: Hospital separations and private insurance cover Australia 1983 – 1999



Sources: prepared by author from various sources [2,3,4,5,6,7,8,9,10,11]

accompanied by changes in private hospitals case-mix that made them more like public hospitals to provide relief to the public sector.

The decline in private health insurance and rise in private hospital usage

After the reintroduction of universal coverage of most health services in the early 1980s, Australian residents regained free access to public hospital services. During the 1980s and 1990s voluntary PHI that provided coverage for private hospital services declined from about 62 percent of the population in 1983 to about 31 percent in 1999. However, admissions per head of population to private as well as public hospitals continued to rise (Figure 1).

Public subsidy of private health insurance for private hospitals

A change of government in the late 1990s was accompanied by new policy initiatives on PHI related to the use of private hospitals. According to the then Minister of Health, the aim was to:

- give a financial reward for PHI membership;
- reduce the premium paid to PHI funds by members;
- make PHI more affordable and attract new members;
- help people to avoid public hospital waiting lists; and
- allow choice of own doctor and hospital, stop the decline of PHI cover that had placed pressure on Medicare and state health systems and contributed to longer waiting lists for elective surgery in public hospitals. [12]

These policies went through a phased evolution over 1997-2000. Three policy thrust are identifiable:

- The first was the Private Health Insurance Incentives Scheme (PHIIS) that became effective in 1997. It is known as the *carrots and sticks* package. Boundaries were drawn for individuals and families in the lowest third taxable income, the middle and the highest third. Those in the lower third (individual's taxable income \$0 – 35,000 and familie's \$0 – 70,000[1]) became eligible to receive a subsidy for their private health insurance premiums (it had to include private hospital coverage). People in the highest third (individuals above \$50,000 and families above \$100,000) were to be penalised if they did not obtain PHI with coverage of private hospital services (Medicare surcharge). And people in the second band (individuals \$35,000 – 50,000 and families \$70,000 – 100,000) received no subsidy and were not penalised for their absence from private health insurance. The subsidy could be received in three ways, either as an income tax rebate, a direct payment or a reduction in the premium. [13]
- The second became effective in 1999. It replaced the PHIIS fixed amount subsidy by an ad valorem subsidy of 30 percent of the premium and all Medicare covered people became eligible for the subsidy regardless of taxable income. This resulted in individuals and families under the middle and top band of taxable income under PHIIS to be eligible for the subsidy and pay no tax surcharge if they took PHI with private hospital coverage. [13]

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[1] All amounts are in Australian dollars

- The third changed statutory regulations that imposed community rating in private health insurance in Australia, regardless of age or risk, on what became known as *lifetime community rating*. This change allowed the setting of PHI premiums in accordance with age at the time of joining and with rising premiums with penalties up to 70 percent of the base premium for people aged 65 years and over. [13]

Implications of the change: effectiveness, efficiency and equity

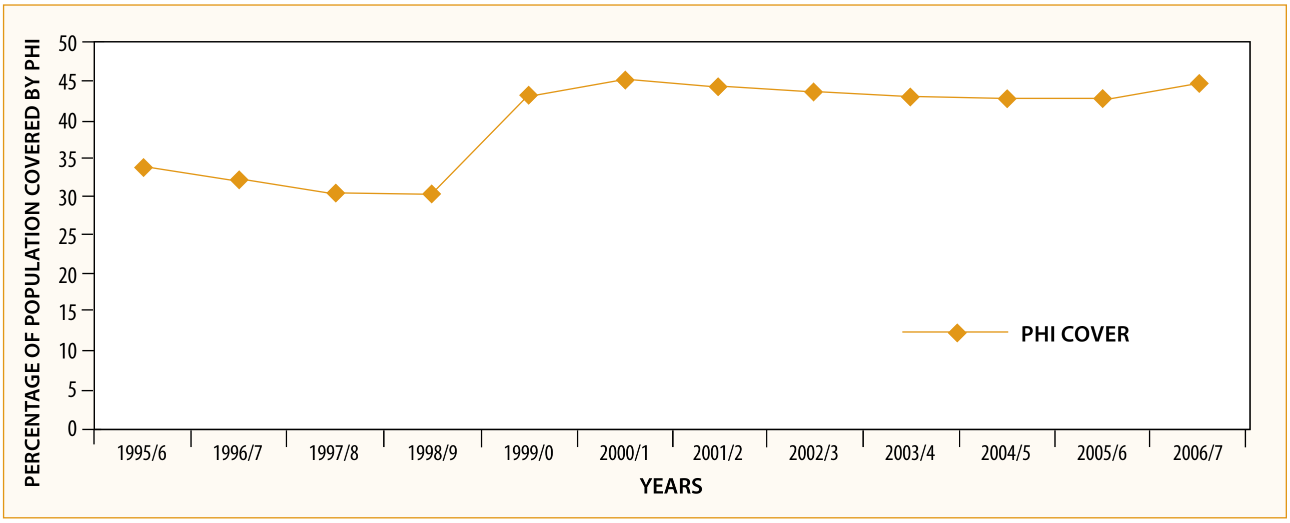
These policy initiatives have been the subject of considerable debate on the effectiveness of their thrusts and on their efficiency and equity effects. It has been claimed that the first policy thrust was not effective in raising PHI coverage: possibly because it subsidised people in low incomes who were the least likely to be able to afford PHI and penalised those most likely to have PHI. There were indications that the second version of *carrots and sticks* might have had some effect in increasing PHI coverage, and it has been asserted that the lifetime community rating had the most effect in raising PHI coverage of the Australian population. [13] However, this analysis was carried out over a short period of time and might not have allowed for time-lags that should be expected in the take up of PHI following each of the three changes. [14]

PHI coverage: It is apparent that regardless of other effects, these policy measures were successful in raising PHI cover from about 32 percent of the population in 1996/7 to about 45 percent in 2006/7 (Figure 2). Contrary to some scenarios from modelling earlier in the decade, [15] PHI coverage in Australia has remained stable in the band of 42-45 percent since 2000 (Figure 2). However, the raising of the taxable income threshold of the Medicare surcharge by a new government in 2008 might affect this stable situation. It is too early to assess its full impact.

Funding efficiency: The increase in PHI coverage was achieved at the cost of a substantial subsidy by the Federal Government that rose from $407 million in 1997/8 to $3,177 million in 2005/6. It represented the equivalent of a large proportion of the contribution of PHI to the funding of health expenditure in Australia in 2005/6. [16]

The proportion of PHI funding of the total expenditure on public and private hospitals in Australia was reduced from about 18 percent in 1996/7 to about 11 percent in 2005/6. And that of private hospitals declined from about 70 percent in 1996/7 to 46 percent in 2005/6. [16,17] Richardson and Segal [14] estimated that possibly only about 26 percent of the public PHI subsidy was spent on hospitals in the period 1998-2001. Total expenditure on private hospitals as a proportion of expenditure on all hospitals was about the same 22 percent in 1996/7 and 2005/6. A major difference in the source of funding of private hospitals was the growth in the Federal Government's share from about ten to about 28 percent over the same period, through the premium rebate. It is relevant to note that the Federal Government provides other substantial subsidies through Medicare for medical and surgical, pathology and imaging services provided by private medical practitioners in private hospitals and pharmaceuticals through the Pharmaceutical Benefits Scheme. Out-of-pocket funding of private hospitals fell substantially from about 8 to 4 percent. [16,17] Thus, there

Figure 2: Private health insurance coverage Australia 1995/96 – 2006/07



Source: prepared by the author from various sources. [11]

was a considerable substitution in the funding of private hospitals: Federal Government outlays took up a substantial share of private hospital funding that compensated a decline in funding from PHI and out-of-pocket.

Waiting times: A stated objective of the set of policies was to reduce waiting times for elective surgery in public hospitals. A study carried out on waiting lists in public hospitals in the State of Victoria indicated that the higher PHI cover in that state might have reduced the expected level of waiting lists for surgical services in Victorian public hospitals in the period to 2001/2. [18] This perspective was challenged on a number of grounds including methodology. [19] A major issue is that most surgeons in Australia work both in public and private hospitals. Studies cited by Duckett [20] carried out in Canada and the United Kingdom indicate that where surgeons perform work both in the public and private surgeries, the waiting times in the public sector tend to be higher than when surgeons work almost exclusively in the public sector. [21,22] A review of Australian data by Duckett fits with the hypothesis that the greater the proportions of cases in the private sector, the greater the waiting time in the public sector. This association raises questions as to whether rising access to private hospitals through larger PHI coverage diminishes pressure on public hospital waiting lists. [20]

Although there were substantial increments in the number of procedures performed both in public and private hospitals such as cholecystectomy, coronary angioplasty, hip replacement, lense insertion and prostatectomy, [23] the waiting for total knee and hip replacements (a private hospital specialisation) continued to rise. [24] In general terms, the median waiting time in public hospitals climbed from 28 days in 2002/3 to 32 in 2006/7. However, there was an improvement in waiting times over 365 days from four percent in 2002/3 to three in 2006/7. [23] Nevertheless, caution is needed in interpreting these findings, as the quality of the data collected continues to be an issue.

Equity: The set of policies to promote PHI has also been criticised on equity grounds in view of the relationship between income levels and affordability of households to buy PHI coverage. After the PHI policy thrusts of the late 1990s, in 2004/5, 23 percent of people in the lowest income quintile held PHI while 76 percent in the highest income quintile had PHI (after adjusting for age differences). [25] Prior to the implementation of these policies a similar situation prevailed in 1992. [26] In both surveys, the majority of people gave affordability as the reason for not having PHI coverage. [25,26] The argument is made that most of the Federal subsidy for PHI went to people in higher incomes who already had PHI policies and did not help those in lower incomes who could not afford PHI coverage [27] and remained without access to private hospital services now more heavily subsidised by public funds.

PHI and consumer decisions: A more recent study was concerned with factors that influence the (i) decision to seek inpatient hospital services, and once that is made (ii) the decision to use public or private hospitals. The study used data from the Australian National Health Survey and information usually at state level on waiting times, bed and medical staff numbers in public hospitals and co-payments made by insured consumers. Findings confirmed well established relationships that the use of hospital services (asymmetric U-shaped curve) and PHI cover rises with age. Married people, usually with children, tend to have more PHI cover than single people. Household PHI cover rises with household income. PHI cover is associated with higher use of private hospital services.

Less healthy people are more likely to use more hospital services, however, less healthy people or people at-risk because of their life styles tend to have lower PHI coverage. Average waiting times were not a factor in seeking PHI cover but delays of more than one year were. Quality of care proxies of the number of beds and medical staff proved not to be significant in relation to hospital care use or PHI cover. The authors recognised that the quality and relevance of the data used was an issue. In relation to the two major decisions that the study set out to address, the study concluded that seeking hospitalisation was slightly greater among those with PHI than those without (less than two percent difference) but the use of private hospitals was about ten times higher among those with PHI than those with no cover. About 21 percent of individuals got insured because of the gain in the government benefit or to avoid the Medicare surcharge. The authors concluded that *medical need is an important determinant of hospital utilisation but not the choice between public and private care* [28 p. 23] and that *a significant proportion of privately insured opt for public treatment in hospitals*. [28 p. 27]

Public and private hospital capacity

A number of questions remain. Among them are changes that have occurred in public and private hospital capacity and utilisation associated with the PHI policy thrusts during the last decade.

Table 1: Hospitals and hospital beds Australia 1997-2007

	1997			2007		
HOSPITAL TYPE	HOSPITALS	BEDS	BEDS/1,000 PEOPLE	HOSPITALS	BEDS	BEDS/1,000 PEOPLE
	%	%	%	%	%	%
Acute	59.2	66.3	2.9	56.8	64.8	2.6
Psychiatric	1.9	4.2	0.2	1.5	2.8	0.1
Public	61.1	70.5	3.1	58.3	67.6	2.7
Free-stand – day facilities	11.8	1.3	0.1	20.3	2.4	0.1
Other	27.1	28.2	1.2	21.4	30.0	1.2
Private	38.9	29.5	1.3	41.7	32.4	1.3
Number of all hospitals	**1,190**	**80,640**	**4.4**	**1,301**	**82,663**	**4.0**

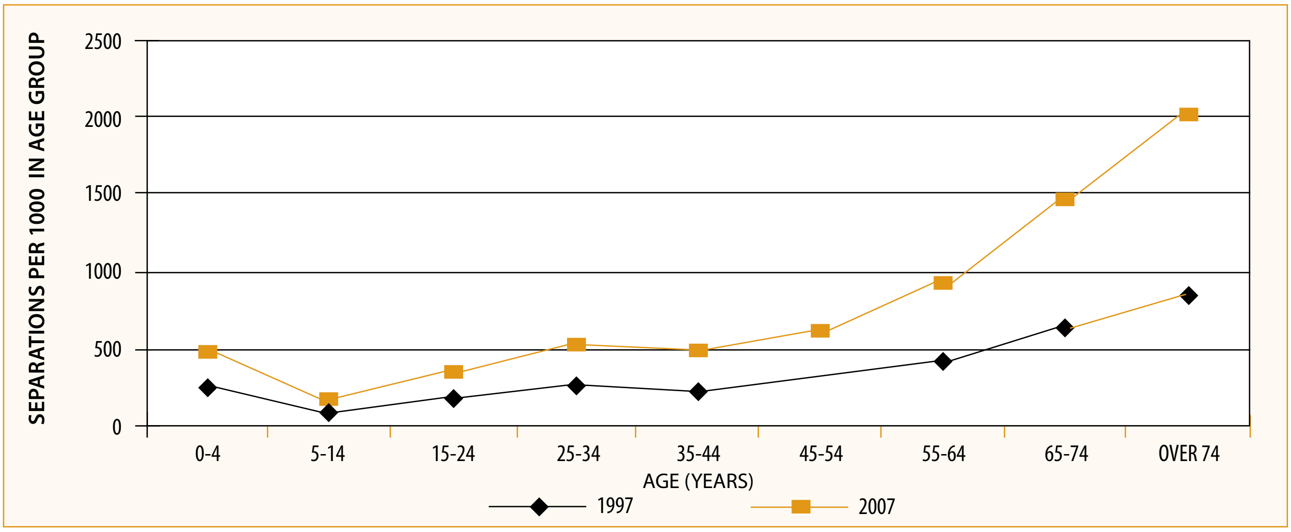
Sources: prepared by the author from a number of sources. [5,23,29]

The major feature of the change in capacity was the substantial rise in free-standing day facilities in the private sector that grew from 140 in 1997 to 265 in 2007. This reflects the continuing shift in surgery and some diagnostic services to day-only services. There was a considerable decline in the number of beds in public psychiatric facilities as the result of the closure of some institutions. This follows the continuing practice of closing public psychiatric hospitals and the policy of providing mental healthcare either in general hospitals or in the community. Yet another change was the closure of some private hospitals or their conversion to day-only facilities, but an increase in the number of private hospital beds from about 27 to 30 percent of the total hospital bed complement in the 10-year period. In contrast, the number of beds in public hospitals remained about the same and consequently their proportion of the total fell slightly from 66 to 65 percent. These trends indicate that hospital services capacity continued to shift towards day-only services that require less hospital beds for overnight stays and that the increases in capacity took place in the private sector during the 10-year period. The overall number of hospital beds increased by about 2,000 but the number of hospital beds per head of population fell from about 4.4 to 4.0 per thousand people (Table 1).

Hospital utilisation: public and private hospitals

Over the period 1997-2007, the use of hospital services in Australia in terms of separations (discharges, transfers and deaths) grew by about 43 percent (it had risen 55 percent in the previous 10 years: 1987-1997). Some of this increase

Figure 3: Age-specific rates of separations hospitals Australia 1997-2007



Sources: prepared by the author from a number of sources. [5,23,30,31] Note: for reasons beyond the author's control, MS software has inversed the use rates of 0-4 and 5-14 that are lower in 2007 than 1997.

Table 2: Separations from public and private hospitals Australia 1997-2007

	NUMBER OF HOSPITAL SEPARATIONS (000s)			GROWTH 1997-2007	PERCENTAGE OF 1997-2007 GROWTH
	PUBLIC HOSPITAL	PRIVATE HOSPITAL	ALL HOSPITALS		
1997	**3,642**	**1,685**	**5,327**	**100**	
Increase 1997 population rates	541	250	791	15	35
Increase 1997 age rates	182	127	308	6	14
1997-2007 Increase population and age	723	377	1,099	21	48
1997-2007 Other increase	297	880	1,176	22	52
1997-2007 Addition	1,019	1,257	2,276	43	100
2007	**4,661**	**2,942**	**7,603**	**143**	
1997 Separations percent. total	68	32	100		
2007 Separations percent. total	61	39	100		
Percentage of total increase	**45**	**55**	**100**		

Sources: prepared by the author from a number of sources. [5,23,30,31] Note: the increases between 1997 and 2007 were decomposed applying 1997 population and age-specific age rates in 1997 to the 2007 population.

could be attributed to the substantial growth in the Australian population and an ageing population that requires more services per head of population. Using 1997 population and age-specific rates of hospital separations, it is estimated that about half (48 percent) of the rise could be attributed to population growth and the ageing of the population stock (Table 2). This implies most of the growth in hospital use (52 percent) arises from the more intensive use of hospital services.

In the ten year period about 45 percent of the rise in use took place in public hospitals, in spite of their unchanged inpatient capacity and 55 percent in private hospitals. Although most hospital services continued to be rendered in public hospitals, their share of the total separations declined from 68 to 61 percent while private hospitals increased their proportion from 32 to 39 percent (Table 2).

The substantial growth in hospitalisation in Australia from 291 separations per thousand people in 1997 to 360 in 2007 was characterised by a stable use of overnight stays and a growth of 53 percent in same-day separations per head of population. The trend in the rising proportion of same-day separations precedes the PHI policy thrusts and was also observed in a study of the period 1997-2001. [32]

While same-day separations per head of population rose by about 31 percent in public hospitals, the growth in private hospitals was of the order of 91 percent, reflecting the substantial growth on the use of free-standing day facilities. However, the growth in the private sector was also aided by a 12 percent rise in overnight admissions, while public hospitals with a larger proportion of overnight and same-day admissions in 1997 reduced substantially their proportion of overnight stays and increased their same-day use (Table 3).

More of the same or sharing of the burden?

One of the issues the PHI policy thrust, was to address concerns over the transfer of the burden of growing hospital services use from public to private hospitals. Therefore, it is relevant to review the changes that have taken place, not just in volume but also the types of conditions seen at public and private hospitals in 1997 and 2007.

A major pressure on public hospitals is their role of providing emergency services. [33] A potential source of information on how private hospitals share the burden of providing emergency services is the data on separations related to external causes. Unfortunately the relevant classification of separations changed from 1997 to 2007 and comparisons are not clear cut. Nevertheless, the data available are unambiguous that public hospitals provided the bulk of services related to external causes concerned with accidents, violence and poisoning before and after the PHI policy thrusts of the late 1990s and early 2000s (Table 4).

Table 3: Same-day and overnight hospital separations Australia 1997-2007

	1997 HOSPITAL SEPARATIONS PER 1000 PEOPLE			2007 HOSPITAL SEPARATIONS PER 1000 PEOPLE		
HOSPITAL TYPE	ALL	SAME DAY	OVER NIGHT	ALL	SAME DAY	OVER NIGHT
Acute	197.8	83.0	114.8	218.0	109.4	108.6
Psychiatric	1.1	0.1	1.9	0.7	0.1	0.6
Public	198.9	83.1	115.8	218.7	109.5	109.2
Free-standing – day facilities	12.1	12.0	0.1	27.9	26.7	1.2
Other	80.0	34.9	45.1	113.5	62.9	50.6
Private	92.0	46.9	45.1	141.4	89.6	51.8
All hospitals	**290.9**	**130.0**	**160.9**	**360.1**	**199.0**	**161.1**
Percentage of total	**100.0**	**44.7**	**55.3**	**100**	**55.3**	**44.7**

Sources: prepared by author from a number of sources. [5,23,30,31]

Table 4: Hospital separations related to external causes Australia 1997 and 2007

	HOSPITAL SEPARATIONS PER 1000 PEOPLE		
	PUBLIC HOSPITAL	PRIVATE HOSPITAL	ALL HOSPITALS
1997 (ICD9)	17.1	3.8	41.8
2007 (ICD10)	32.6	9.2	20.1

Sources: compiled by the author from a number of sources. [5,23,30,31]

The International Classification of Diseases (ICD) used in Australian hospital statistics changed in the period 1997 and 2007. However, it is possible to re-arrange the data to close equivalences of the major ICD diagnostic groups in ICD10. The following analysis involves the estimation of Relative Specialisation Indices (RESPINDs) for public and private hospitals in 1997 and 2007, to review how public and private hospitals might have changed their case-load specialisation in the period 1997 to 2007, and see whether private hospitals moved closer to sharing the case-load of public hospitals.

The analysis shows that public hospitals specialised over a broader range of major diagnostic groups than private hospitals both in 1997 and 2007 (Tables 5 and 6). However, private hospitals increased their specialisation indices over the range of diagnostic groups that involve same-day admissions in the case of mental and behaviour disorders, and overnight stays in the cases of endocrine, nutritional and metabolic diseases, diseases of the nervous system, and factors influencing health status and contact with health services (Table 6). The indices of specialisation of public hospitals declined in same-day separations for mental and behavioural disorders and in the case of overnight stays for endocrine, nutritional and metabolic diseases and diseases of the nervous system (Table 5). This indicates that the PHI thrusts were accompanied by some expansion of private hospital services not only in the areas they specialised in 1997 but that they added to some of the hospital services that they share with public hospitals.

Table 5: Relative specialisation indices of public hospitals Australia – major diagnostic groups with index more than one: 1997 and 2007

	RELATIVE SPECIALISATION INDICES					
	1997			2007		
ICD10 MAJOR DIAGNOSTIC GROUP	ALL	SAME DAY	OVER NIGHT	ALL	SAME DAY	OVER NIGHT
Infectious & parasitic dx	1.27	1.32	1.21	1.42	1.57	1.26
Dx blood & bld-form org & some im mech	1.15	1.25	1.07	1.13	1.21	1.08
Endocrine, nutritional & metabolic dx	1.15	1.29	1.07	1.05	1.08	0.99
Mental & behaviour disorders	1.04	0,82	1.12	0.94	0.55	1.16
Dx nervous system	1.03	1.02	1.02	0.96	1.19	0.80
Dx circulatory system	1.08	1.09	1.03	1.08	1.04	1.01
Dx respiratory system	1.15	1.24	1.09	1.24	1.37	1.10
Dx skin & subcutaneous tissue	1.01	0.92	1.07	1.11	0.97	1.16
Pregnancy, childbirth and the puerperium	1.11	1.06	1.09	1.14	1.09	1.06
Certain cond originating in perinatal period	1.21	1.33	1.15	1.31	1.70	1.13
Congen malform., deform & chrom anomalies	1.07	1.07	1.06	1.13	1.19	1.06
Symptoms, signs & ill-defined conditions	1.05	1.02	1.06	1.13	1.09	1.13
Injury, poison & cert other cons ext causes	1.16	1.31	1.08	1.34	1.54	1.17
Fact infl health stat & contact w health serv	1.33	1.22	1.05	1.05	1.17	0.94
All	**1.00**	**1.00**	**1.00**	**1.00**	**1.00**	**1.00**

Sources: compiled by the author from various sources. [5,23] Note: The Relative Specialisation Indices were estimated using the following equation RESPIND= $\{C_{ip}/(C_{ip}+C_{it})\} / \{ \Sigma C_{ip} /(\Sigma C_{ip} +C_{it})\}$ where C_{ip} = number of cases in i ICD10 diagnostic group in public hospitals and C_{it} = number of cases in i ICD10 diagnostic group in private hospitals in the given year. This was applied to each of all separations, same-day and overnight separations.

Table 6: Relative specialisation indices of private hospitals Australia – major diagnostic groups with index more than one: 1997 and 2007

	RELATIVE SPECIALISATION INDICES					
	1997			2007		
ICD10 MAJOR DIAGNOSTIC GROUP	ALL	SAME DAY	OVER NIGHT	ALL	SAME DAY	OVER NIGHT
Neoplasms	1.28	1.32	1.26	1.33	1.31	1.39
Endocrine, nutritional & metabolic dx	0.67	0.49	0.82	0.92	0.91	1.03
Mental & behaviour disorders	0.92	1.31	0.70	1.09	1.54	0.63
Dx nervous system	0.94	0.96	0.94	1.06	0.77	1.46
Dx of eye and adnexa	1.89	1.71	2.04	1.79	1.58	1.68
Dx ear and mastoid process	1.36	1.36	1.10	1.19	1.16	1.12
Dx digestive system	1.48	1.58	1.20	1.37	1.47	1.04
Dx skin & subcutaneous tissue	0.98	1.15	0.83	0.83	1.03	0.64
Dx musculoskeletal syst & connective tissue	1.72	1.51	1.94	1.54	1.35	1.93
Dx genitourinary system	1.18	1.13	1.21	1.13	1.08	1.25
Fact infl health stat & contact w health serv	0.72	0.62	0.88	0.91	0.79	1.14
All	**1.00**	**1.00**	**1.00**	**1.00**	**1.00**	**1.00**

Sources: compiled by the author from various sources. [5,23] Note: the Relative Specialisation Indices were estimated using the following equation RESPIND= $\{C_{it}/(C_{ip}+ C_{it})\}/\{\Sigma C_{it}/(\Sigma C_{ip} + C_{it})\}$ where C_{ip} = number of cases in i ICD10 diagnostic group in public hospitals and C_{it} = number of cases in i ICD10 diagnostic group in private hospitals in the given year. This was applied to each of all separations, same-day and overnight separations.

Conclusions

Faced with a decline in PHI during the 1980s and 1990s, a new government sought to induce (or financially coerce) Australian residents to take PHI cover. The stated aims were clear. It used *carrots and sticks* incentives by providing subsidies for the purchase of PHI and taxing those unwilling to do so. The government aimed to stop the decline in PHI cover and swell the membership of PHI funds in Australia.

The stimulus worked to a point and PHI cover rose from about 32 to 45 percent of the population from 1997 to 2007, but not to the higher level of the early 1980s. The government also aimed to provide a financial reward for PHI membership and make it more affordable. This also seems to have been achieved through the reimbursement of 30 percent of the premium to policy holders. The proportion of out-pocket as a source of funds for hospital services has fallen substantially making it less costly in those terms. However, this reward and affordability might have been diminished somewhat by the continuing rise in PHI premiums regulated by the same government.

The government aimed to reduce public hospital waiting lists mostly for elective surgery. Although there has been a substantial rise in the number of procedures performed both in public and private hospitals, the average recorded waiting time for elective surgery continued to increase. In general terms, the median waiting time in public hospitals climbed but there was a slight improvement in waiting times over 365 days. This issue continues to be difficult to assess because of the quality of the data collected.

The government thrusts were accompanied by the expansion of free-standing day facilities and larger overnight capacity in private hospitals. However, this trend was apparent before the PHI policy initiatives. There is some evidence that in addition to the traditional specialisation in surgical procedures and day-only services, the private sector expanded the range of services offered, but did not make a substantial contribution to emergency services, under pressure, traditionally provided by public hospitals.

Although the government was most effective in raising PHI coverage, it was done at a considerable cost to the public purse. It resulted in a reduction of the contribution of PHI to fund the expenditure of private and public hospitals and in a considerable rise in the Federal Government's share of the funding of private hospitals. In view of other subsidies provided through Medicare for medical fees related to private physician and surgeon fees, pathology and imaging services provided by the private sector and pharmaceuticals funded by the Pharmaceutical Benefits Scheme, the expansion of private hospital facilities raises funding efficiency questions.

The subsidies provided for PHI policies have also been criticised on the grounds of equity, as those who benefit mostly from them are people with higher incomes who can afford private health insurance and do not improve the lot of people in lower incomes who cannot afford private health insurance and private hospital services.

The PHI policy initiatives of the late 1990s and early 2000s were accompanied by the continuing transformation of the traditional hospital system. These initiatives achieved most of their goals in promoting coverage of PHI but bring up a number of important questions regarding efficiency and equity.

Competing interests

The author declares that he has no competing interests.

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REVIEW ARTICLE

Engaging Doctors: the NHS needs the very best leaders

K Armit and H Roberts

Abstract

There has been increasing acknowledgement by the medical profession and policy-makers that doctors need to be competent managers and leaders in their practitioner roles at all stages of their careers. This view is being endorsed not only in the United Kingdom but also internationally, as increasing evidence becomes available of the relationship between medical engagement and organisational performance.

This paper provides an overview of an ambitious project being jointly led by the Academy of Medical Royal Colleges and the NHS Institute for Innovation and Improvement in the United Kingdom. The project aims to create organisational cultures where doctors seek to be more engaged in the management and leadership of health services, and non-medical leaders genuinely seek their involvement to improve services for patients. A unique Medical Leadership Competency Framework has been developed to describe the management and leadership competences that will be required by all doctors in the United Kingdom.

The paper also shares learning about medical engagement and organisational performance, including how Chief Executives might involve doctors more effectively in the management, leadership and transformation of services.

It is hoped that learning from this project will inspire and inform similar initiatives in the Asia Pacific region.

Abbreviations: AoMRC – The Academy of Medical Royal Colleges; GMC – General Medical Council; MLCF – Medical Leadership Competency Framework; NHS – National Health Service; NHS Institute – NHS Institute for Innovation and Improvement; UK – United Kingdom.

Key Words: medical; education; management; leadership; competency; engagement.

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Introduction

Medical training has traditionally focused on the clinical skills necessary to be a safe and competent clinician. However, with the growing trend to more team-based practice and integrated care approaches, it is important that doctors are not only competent practitioners but also have the skills to enable them to function efficiently and effectively within complex health systems.

In the United Kingdom (UK), the impetus for this emphasis on doctors, rather than other clinical professions, has been an increasing acknowledgement by the medical profession and policy-makers that all doctors need to be competent managers and leaders at every stage of their careers. In part, this is due to their direct and far-reaching impact on patient experience and outcomes and their broad legal duty which means they have an intrinsic leadership role within healthcare services. It is also about the recognition that without doctors actively involved in the management, leadership and transformation of health services, initiatives to improve the patient experience are unlikely to succeed.

Changing role of the doctor

The work of the doctor is changing dramatically, in ways that challenge many of the assumptions on which the medical profession has based its practice for more than 150 years. [1]

Dowton, [2] writing from an Australian perspective, recalls the traditional role of the medical profession being defined through 'Longstanding legislative canons coupled with the status accorded to individual doctors by society and societal contact, and deeply entrenched cultural systems'. Dowton identifies a number of external influences that have now altered doctors' autonomy and the hierarchies within which they practice. These include greater demand for accountability for the safety of patients, quality and efficacy of healthcare and public access to medical information. He concludes that despite the leadership roles being critical, inadequate attention has been paid to developing individual leaders and new models of leadership within the medical profession.

The Royal College of Physicians of London report, *Doctors in Society: Medical Professionalism in a Changing World*, [3] was an important contribution to the debate about the changing nature of the medical profession. The report states that:

> The complementary skills of leadership and 'followership' need to be incorporated into a doctor's training to support professionalism. These skills argue strongly for managerial competence among doctors. (p. 27)

It would be fair to say that the medical profession is now subject to new ways of leading, a shift from the formal leader to a shared leadership model. With shared leadership, leadership occurs at every level and is not the sole responsibility of individuals at the top of their organisation. There is a shared sense of responsibility for the success of the organisation and its services. Importantly, shared leadership also recognises the importance of 'followership' which means, in a team setting, knowing when and how to lead and when to follow. [3]

The experience of engaging doctors

The National Health Service (NHS) has attempted on various occasions to engage doctors in the leadership and transformation of health systems and organisations. This has included the establishment of Directorates and appointing Medical and Clinical Directors in hospitals, Professional Executive Committees and more recently practice-based commissioning in primary care, and the appointment of National Clinical Directors within the Department of Health. However until recently, training in management and leadership including service improvement methodologies for doctors, has, at best, been scant and ad hoc and certainly not part of any formal competency framework until perhaps reaching senior medical leadership roles. In other words, it has generally been left to individual doctors to voluntarily seek management and leadership training and development.

It is now widely recognised that improving the health of the population and the delivery and effectiveness of health and social care is very dependent on the support and active engagement of all doctors, not only in their practitioner activities but also in their management and leadership roles. As recognition that the role of a doctor is changing, UK policy-makers have started to emphasise the importance of involving doctors in management and leadership.

In a recent review of *Modernising Medical Careers*, [4] Sir John Tooke highlighted that the 'Doctor's frequent role as head of the healthcare team and commander of considerable clinical resource requires that greater attention is paid to managerial and leadership skills irrespective of specialism.' (p 17)

Lord Darzi, [5] in his recent review of the NHS, has also stressed the importance of medical leadership:

> The essence of clinical leadership is to motivate, to inspire, to promote the values of the NHS, to empower and to create a consistent focus on the needs of the patients being served. Leadership is necessary not just to maintain high standards of care but to transform services to achieve even higher levels of excellence. (p 49)

Importantly, medical engagement is not just about the appointment of a small group of leaders to roles such as Medical or Clinical Director. It is recognition that leadership is a social function and not just defined by hierarchical reporting lines. Enhanced medical engagement should work towards a model of shared leadership, where influence is exercised across relationships, system and culture. It should apply to all rather than just a few.

Looking elsewhere, Australia is now taking a national approach to supporting and harnessing clinical leadership within hospitals and broader health settings and across professional disciplines. This extends to setting up state-wide clinical networks to increase the level of clinician involvement in the planning and delivery coordination of health services and using clinical senates as a forum for clinical leaders to share their knowledge and expertise. Their reform agenda recognises that clinical leadership translates to better planning and delivery of health services and that strong clinical leadership is needed to hasten implementation of evidence-based practice. [6]

Enhancing engagement in medical leadership

Enhancing medical engagement is a priority throughout the NHS. Since 2006, the Academy of Medical Royal Colleges[1] (AoMRC) and NHS Institute for Innovation and Improvement[2] (NHS Institute) have been leading an ambitious project, entitled 'Enhancing Engagement in Medical Leadership'. This UK-wide initiative aims to generate a culture change by strengthening the contribution of doctors in management and leadership of health services to improve services for patients. The project is strongly supported by the key medical professional, educational and regulatory bodies and NHS organisations.

The Enhancing Engagement in Medical Leadership project has involved several strands of work, including:

- A review of the research on the impact of medical engagement and the experience of the NHS in involving doctors in leadership;
- A review of international experience and evidence around engaging doctors in leadership;
- Research into the link between medical engagement and organisational performance; and,
- The development of a Medical Leadership Competency Framework (MLCF). [7]

Management and leadership competences for all doctors

While not always recognised, all doctors are required to fulfil some managerial function from an early stage in their careers. The Enhancing Engagement in Medical Leadership project aims to embed management and leadership competence as a standard of practice that must be upheld and maintained throughout a medical career.

There are a number of frameworks currently used in both the UK and in other countries. Many, including the UK's *Leadership Qualities Framework* [8] and the Health Care Leaders Association of British Columbia's *Health Leadership Capabilities Framework for Senior Executive Leaders*, [9] are intended for individuals, including doctors, already in formal leadership roles and aiming for executive level positions. Those that exist for doctors such as British Association of Medical Manager's *A Syllabus for Doctors in Management and Leadership Positions in Healthcare*, [10] are also focused on doctors currently in or moving into positional leadership roles.

The MLCF [7] has been designed for application at all stages of a doctor's training and career and is based on the concept of shared leadership. It describes the leadership competences doctors need to become more actively involved in planning, delivery and transformation of health services. Also important is the highly inclusive process by which the MLCF has been developed, and the resulting buy-in and ownership from the medical profession. The integration of the MLCF means that eventually all doctors, regardless of specialty, will develop a minimum set of management and leadership skills to be able to fulfil their practitioner roles more effectively.

Development of the MLCF was informed by a review of literature and key publications; comparative analysis of local and international leadership competency frameworks; analysis of existing medical curricula in the UK; consultation with members of the medical and wider NHS community; and input from the project steering, reference and focus groups as well as patient and user groups. Testing the MLCF in a range of medical education and health service communities across the UK has helped position the leadership competences within the reality of working in healthcare today.

The competency framework is set around five domains: demonstrating personal qualities; working with others; managing services; improving services; and setting direction. To deliver appropriate, safe and effective services, it is essential that every doctor is competent in each domain. The MLCF applies to all medical students and doctors. The manner in which the doctor demonstrates competence and ability will vary according to the career path chosen and the level of experience and training.

In March 2008, the project steering group and AoMRC approved the MLCF. This has led to several activities aimed at embedding the competences into curricula and NHS organisations.

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[1] Academy of Medical Royal Colleges (www.aomrc.org.uk) promotes, supports and facilitates the work of the Medical Royal Colleges and their Faculties for the benefit of patients and healthcare professionals.

[2] NHS Institute for Innovation and Improvement (www.institute.nhs.uk) supports 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.

Figure 1: Medical Leadership Competency Framework [7]

www.institute.nhs.uk/mlcf

Embedding management and leadership in curricula and training

To incorporate the MLCF into curricula at undergraduate and postgraduate levels, the team has taken separate approaches due to two different regulatory organisations overseeing medical curricula in the UK. The General Medical Council's[3] (GMC) document, *Tomorrow's Doctors*, [11] describes the standards for undergraduate medical education. This has recently been reviewed and now incorporates the competences from the MLCF, although in a language appropriate to the publication. As such, each medical school will now be required to review their existing curriculum (including assessment) to ensure that it meets the standards and learning outcomes set by the GMC. The project team is working with a consortium of medical schools to develop some general guidelines that will assist medical schools integrate the medical leadership competences into undergraduate curricula and assessment. Development of e-learning materials to help deliver the knowledge component of the competences is also being considered.

To satisfy postgraduate competence, a medical leadership curriculum was developed (based on the MLCF) and scrutinised by the Postgraduate Medical Education and Training Board[4] (PMETB). As a result, all Medical Royal Colleges are expected to incorporate the medical leadership curriculum within the revisions of their specialty curriculum to be submitted to PMETB throughout 2009-2010. The project team is providing support and advice for integration and developing e-learning materials to help with the delivery of the knowledge component of the curriculum.

The NHS Institute is also working with NHS organisations, GMC, PMETB and the AoMRC to ensure the MLCF is embedded in the service, ideally to inform recruitment, appraisal and professional development of doctors at all levels. This particularly applies to revalidation, which 'Is the process by which doctors will, in future, demonstrate to the GMC on a regular basis that they remain up-to-date and fit to practise'. [12]

Despite this focus on doctors, it is widely accepted by healthcare professions and policy-makers that all clinicians are in a unique position to understand and listen to the concerns of patients and the public, and contribute to the management of healthcare organisations and development of health policy. In order to do this they need the relevant skills, knowledge and behaviours. The Department of Health has articulated a clear vision for all clinicians to develop leadership competence from their undergraduate education through to postgraduate training: [5]

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[3] General Medical Council (www.gmc-uk.org/) The General Medical Council (GMC) registers doctors to practise medicine in the UK. Their purpose is to protect, promote and maintain the health and safety of the public by ensuring proper standards in the practice of medicine.

[4] Postgraduate Medical Education and Training Board (PMETB) (www.pmetb.org.uk/) PMETB is the independent regulatory body responsible for postgraduate medical education and training.

> It is unrealistic to expect NHS staff to take on leadership without action to make it integral to training and development. So we will explore ways to ensure that the undergraduate curricula for all medical and nursing students reflect the skills and demands of leadership and working in the NHS. We will also ensure that leadership development is an integral part of modernising careers programmes for other healthcare professions. (p. 66)

Widespread recognition and support of the MLCF has meant that consideration is being given to using the medical leadership competences as the basis for other clinical professions, with of course variations to allow for different training structures and clinical experience.

Medical engagement and organisational performance

A number of studies [2, 13-19] have highlighted the positive link between effective clinical leadership and improved patient care. Ham's review [13] suggests that doctors have the most influence when it comes to implementing operational changes that can lead to improved performance. Failures in care have often been attributed to inadequate medical leadership, poor communication, disempowerment of staff and patients and a disconnection between doctors and managers. Without doctors, attempts at radical large-scale change are doomed to fail.

The relationship between medical engagement and organisational performance has been explored via interviews conducted with Chief Executives and Medical Directors across England in 15 high and seven low-performing organisations.* [19] The interviews revealed that high performing organisations consistently identified high levels of engagement whereas poor performing organisations reported lower levels. There was a tendency for most organisations to refer specifically to the top 20 or so medical leaders represented in formal positions. This underlines the need to reinforce the message about engaging all doctors, not just doctors in positional roles, eg, Medical Director.

All Chief Executives interviewed wanted to get to know their doctors better and a few had strategies in place to address this. No single or simple approach was identified but clues emerged as to how engagement might be promoted. Several of these actions were identified through a Medical Engagement Scale as being associated with higher levels of engagement:

- The participation of the Chief Executive and/or other executives in doctors' induction programs;
- Regular formal meetings between doctors and the Chief Executive and/or other executives to discuss quality, safety and performance; and
- Regular informal opportunities to meet with the Chief Executive and/or other executives.

Importantly this highlights that the appointment of doctors in leadership or management roles alone will not necessarily translate to greater medical engagement and health service improvement.

The Medical Engagement Scale is currently being strengthened through further data collection to establish an empirical link to performance, as well as developing norms across the NHS. At the time of writing, further analysis of the link between medical engagement and organisational performance is being explored. Preliminary findings indicate a high association in terms of standardised mortality rates, key patient safety indicators, better patient experience, and existing national targets. [20]

Discussion

Enhancing medical engagement is a priority throughout the NHS. The emerging data from the Medical Engagement Scale indicates that if doctors are engaged in management and leadership of health services, it is likely that organisational performance and particularly patient experience will improve. To achieve this, non-clinical executives need to genuinely encourage greater engagement. The attainment of leadership competences for all doctors in their practitioner roles should not only enhance their effectiveness in the future but also hopefully stimulate more to take on positional leadership roles in service improvement and at executive level.

Other countries with similar histories of low medical engagement in planning, delivery and transformation are also recognising that the improvements to the health system sought are unlikely to be realised without creating organisational cultures that encourage doctors to want to be involved.

While writing from a UK perspective, it is hoped that the findings and methodology used in the Enhancing Engagement in Medical Leadership project will offer some important insights for colleagues in health systems in Asia Pacific countries. If anything, success of the project has weighed heavily on taking a highly consultative approach involving the key medical, professional, regulatory,

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* According to the Health Care Commission ratings 2006

education and service bodies and this would be our strongest recommendation. In addition, the project team has endeavoured to:

- Recognise and use learning drawn from existing good medical leadership practice and research evidence;
- Widely consult through a variety of approaches including reference groups representing all levels and specialties;
- Ensure an awareness of similar activities happening elsewhere both internally (NHS) and externally (other sectors and internationally);
- Engage with patient/lay groups;
- Ensure a focus on diversity and equality;
- Remain clearly focused on key deliverables;
- Have a project team of mixed experience and expertise eg, combining medical education and service advice with leadership development background; and
- Recognise that attainment of leadership competence will span across 15 years of doctors training and that leadership competences developed for doctors are likely to be relevant to other clinical professionals.

In the UK, the integration of the MLCF, developed by and for the medical profession, into curricula at all stages of a doctor's education and training and into health service will have a long-term impact on the culture of medical engagement and influence the next generation of doctors to view engagement and leadership as part of their working lives.

An online version of the MLCF is available at www.institute.nhs.uk/mlcf. Information on other project activities is available at institute.nhs.uk/medicalleadership.

Competing interests

The authors declare that they have no competing interests.

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The Spread of HIV/AIDS: a priority risk factor in South Africa

R M Ansari

Abstract

Objective: South Africa is a transitional country where action to combat one of the most significant priority risk factors, HIV/AIDS, is required. The South African Government has launched a comprehensive operational plan to combat the HIV/AIDS epidemic, aimed at providing all South Africans with AIDS antiretroviral treatment by 2009. This paper reviews current strategies on HIV/AIDS in South Africa and makes recommendations to speed up the treatment for HIV/AIDS-infected people. Other recommendations include the support and enhancement of the government's HIV/AIDS operational plan by addressing risk factors at the community level, incorporating complex interactions between the individual, family, community and society to overcome the epidemic.

Background: South Africa is facing significant challenges in addressing the severe impact of the HIV/AIDS epidemic. An estimated 5.5 million people are HIV-positive and 1000 new infections take place every day. Young women have been particularly affected by HIV/AIDS. During the 1997-2004 period, the death rate for women aged 20-39 more than tripled and for men 30-44, it more than doubled. The major risk factors for HIV/AIDS in South Africa include wide income disparities, a history of colonialism, political and economic disenfranchisement and gender inequality. The stigma around HIV/AIDS populations remains strong in South Africa and is a factor likely to influence personal decision-making with regard to HIV testing and disclosure.

Funding Implications: The funding implications of implementing a comprehensive HIV/AIDS program and enhancing the 2005 HIV/AIDS operational plan are significant. The total cost of providing antiretroviral to everyone who needs it would be between United States (US) $1 billion and US $1.09 billion. It is estimated that 1.7 million lives could be saved by 2010 if antiretroviral were provided to all of those who need it.

Conclusion: A comprehensive HIV/AIDS program to address the needs of the wider population and enhance the South African HIV/AIDS Strategic Plan (2000-2005) requires an effective response based on four balanced foci (learning, preventing, understanding and responding to the pandemic) by educators, education policy-makers and planners, and their partners in other sectors.

Abbreviations: HEARD – Health and Economics and HIV/AIDS Research Division; TSF – Technical Support Facility; US – United States; USAID – United States Agency for International Development; WHO – World Health Organization.

Key Words: HIV/AIDS; South Africa; risk factor; funding; health priority.

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Introduction

The first case of HIV infection in South Africa was reported in 1982 and this started the first wave of the HIV epidemic, which was limited to the homosexual community and blood transfusion recipients. [1] The level of HIV infection in the general heterosexual population remained relatively low till 1987 [1] and was also found to be low in voluntary blood donors [2] and in stored specimens from community-based surveys. [3] In 1990, the prevalence in women attending public antenatal clinics was close to one percent with an estimated doubling time, based on mathematical models, of 14 months. [4] The spread of HIV in South Africa is best described as explosive because of the rapid rise in HIV prevalence. National HIV prevalence rates, based on annual anonymous antenatal surveys, [5] rose from 0.76 percent in 1990 to 10.44 percent in 1995 and 22.4 percent in 2000.

South Africa is a middle-income country with a variety of living conditions ranging from wealthy and middle-income suburbs to undeveloped rural areas. South Africa's population is 47.4 million with 51 percent women, 79.5 percent black South African, 9.2 percent white South African, 8.9 percent coloured South Africans and 2.5 percent Indian/Asian South Africans. [6,7] The life expectancy in South Africa is 50.7 years (men 49 years and women 53 years). As a result of the relatively high level of injuries and HIV/AIDS, the burden of disease in South Africa has been described as a 'quadruple burden' of conditions connected to underdevelopment, emerging chronic diseases related to unhealthy lifestyles, HIV/AIDS and injuries. [6]

South Africa's demographic and epidemiological data systems have limitations, and sources of complete and reliable vital statistics remain difficult to achieve. [6] The country's rapidly growing AIDS epidemic has affected many demographic and epidemiological trends in atypical ways that would challenge data systems under even optimal circumstances. An estimated 320,000 people died of AIDS in South Africa in 2005 [7] resulting in 900 deaths every day. The HIV-prevalence rate for adults (aged 15-49) is 18.2 percent. An estimated 5.5 million people are HIV-positive and 1000 new infections take place every day. Young women have been particularly affected by HIV/AIDS and between 1997 and 2004, the death rate for women aged 20-39 more than tripled, while for men aged 30-44 it has more than doubled. These rates are in line with the United Nations' estimate that women make up 58 percent of South Africa's HIV-positive adult population. [7] This has led to a recent acknowledgement that among the most important determinants influencing HIV transmission prevention are the 'risk environments' in which risk is produced. [8, 9] HIV infection is a behavioural disease subject to environmental influences. Therefore, effective HIV prevention not only comprises targeted interventions fostering changes in individual behaviour, but also interventions creating local environments conducive to, and supportive of, individual and community-level behaviour change. This requires a focus in bringing about changes in the physical, social, economic, legal and policy environments influencing HIV risk and HIV prevention. [8, 10] These approaches have been variously termed as an 'enabling environment' approach to prevention [11] and 'structural HIV prevention'. [12]

Burden of disease (HIV/AIDS)

The initial burden of disease study of 2000 [6] provides the first set of estimates of the causes of mortality experienced in South Africa. Figure 1(a) and Figure 1(b) show the age distribution of the estimated number of deaths in 2000 by broad cause group. The distinct age pattern of AIDS deaths among children and young adults is clear. Communicable diseases occur across all ages, while injuries particularly

Figure 1(a): Male deaths by age and cause, 2000 [1, 6]

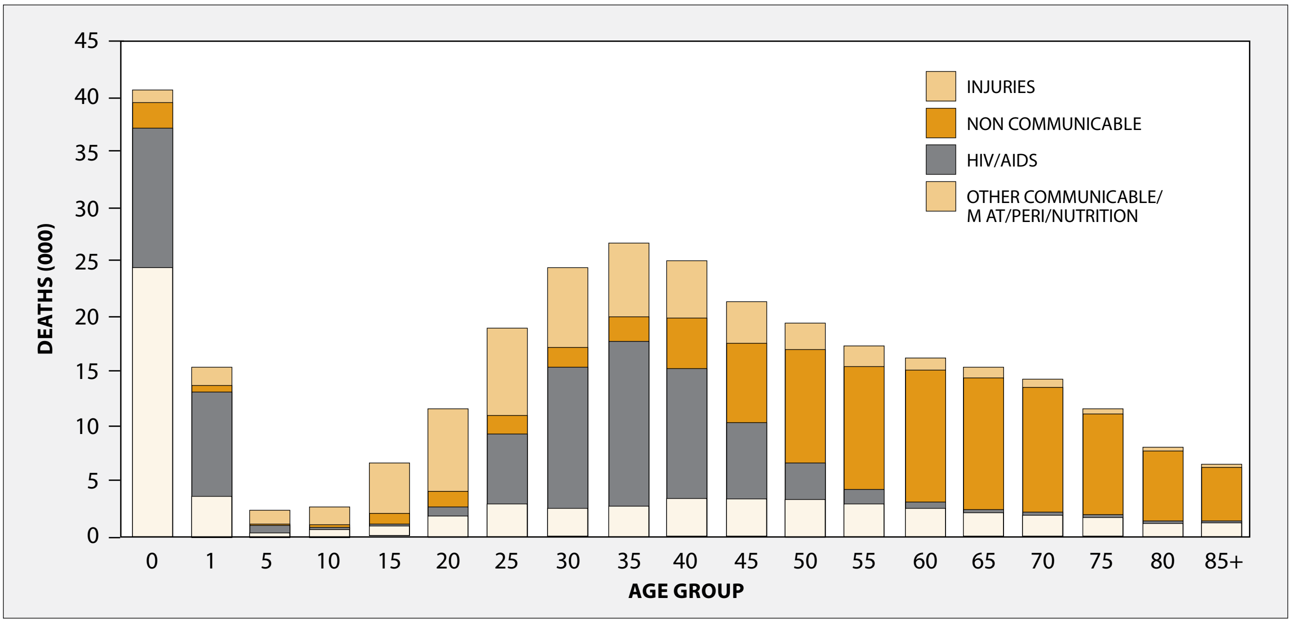
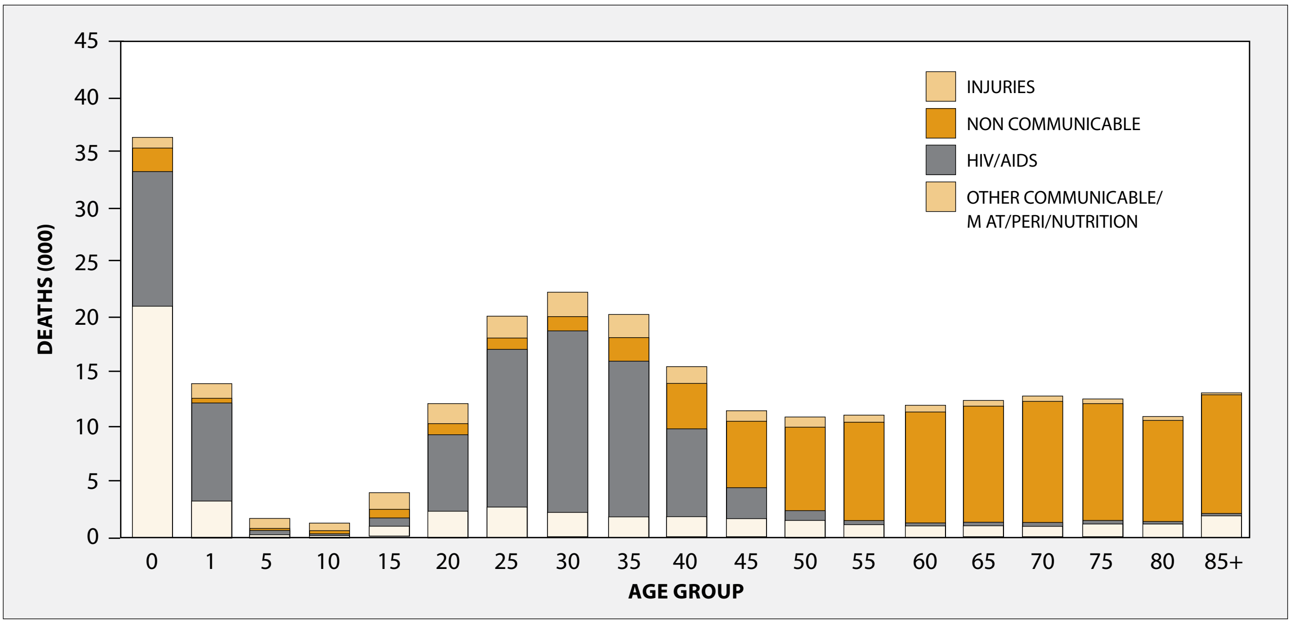


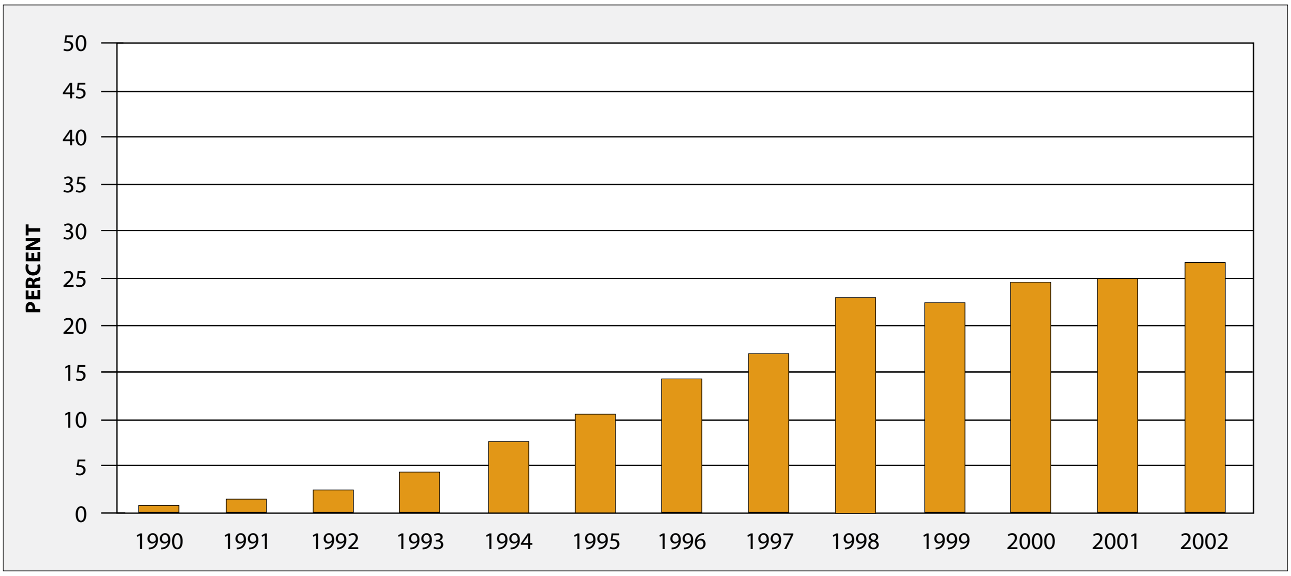
Figure 1(b): Female deaths by age and cause, 2000 [1, 6]



affect young adult men. The South African national burden of disease study estimated that in 2000 non-communicable disease accounted for 37 percent of deaths, followed by HIV/AIDS, which accounted for 30 percent. Non-communicable disease accounted for 40 percent of female and 36 percent of male deaths.

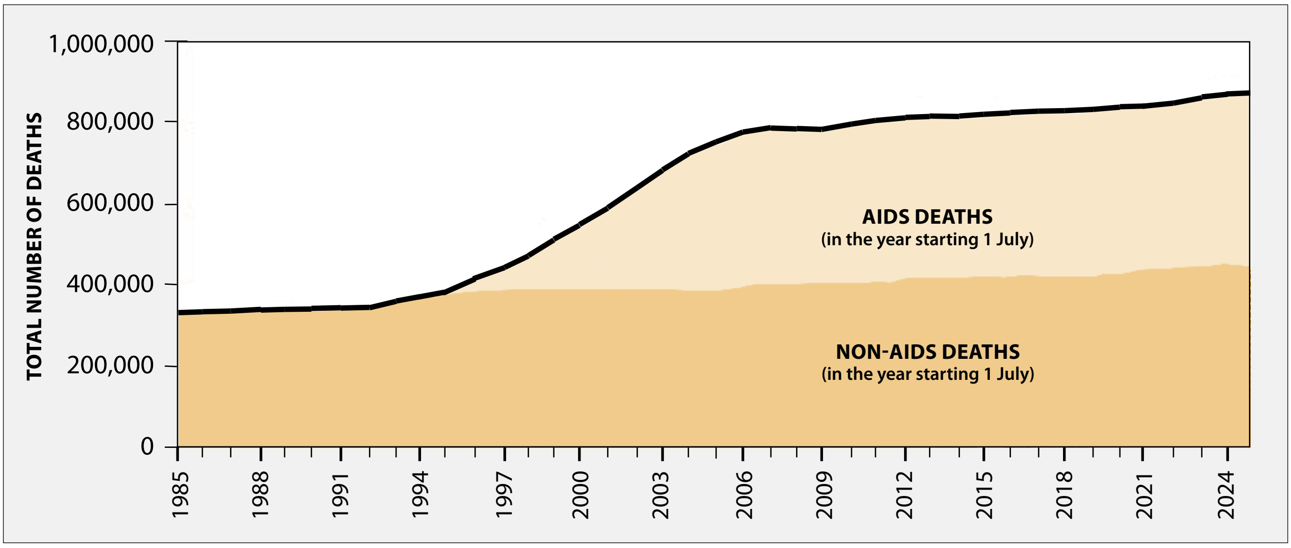
The prevalence of HIV among pregnant women attending public sector clinics has been surveyed annually to monitor trends. The surveys show that prevalence has increased from 0.8 percent in 1990 to 27.9 percent in 2003, reflecting a remarkable spread of the epidemic within a decade (Figure 2). It is estimated that by 2000 HIV/AIDS had become the biggest single cause of death in South Africa [7] and by 2004, about 12 percent of the total population was infected with the virus. [7] In 2004, the government adopted a five-year treatment plan to roll out anti-retroviral therapy in the public sector with the aim of meeting at least 80 percent of need. The ASSA2002 model [7] shows that in 2004 approximately five million people were HIV-positive, and 500,000 were AIDS-sick. Allowing for the impact of treatment intervention, the number of infected people is projected to peak in 2013 and then decrease slowly, while the number of AIDS-sick people increases gradually.

Figure 2: Prevalence of HIV as determined by antenatal surveys (1990 to 2002)



Source: Health Systems Trust, 2004

Figure 3: Projected annual numbers of AIDS and non-AIDS deaths (1985 to 2025)



Source: The model estimation (ASSA, 2004). www.assa.org.za

Figure 3 shows that the projected total number of deaths increased as a result of the gradual increase in non-AIDS deaths and the rapid increase in AIDS deaths during the late 1990s. In 2004, the model estimates 389,000 non-AIDS deaths and 311,000 AIDS deaths. The total deaths in 2004 were 701,000, ie, about 44 percent of total deaths were AIDS deaths. The proportion of AIDS deaths to total deaths is also fairly constant over the time span depicted in Figure 3.

Major risk factors (HIV/AIDS)

The major risk factors for HIV/AIDS in South Africa include wide income disparities, a history of colonialism, political and economic disenfranchisement and gender inequality. [13] The relationship between HIV prevalence and socioeconomic status is highly complex and is very much related to individual behaviour and socioeconomic characteristics as well as to the socioeconomic profile of the community in which one is situated. [14]

Race is also a significant determinant of HIV risk even when it is adjusted for socioeconomic factors. [13] HIV risk is highest among black South Africans, substantially lower among Asian South Africans, and lowest among white South Africans. The prevalence of AIDS is relatively low in the Western Cape and Northern Cape provinces [14,15] mainly because the population of black South Africans is relatively low. In addition, rates of AIDS orphanhood are likely to be highest among black South Africans and among poorer socioeconomic groups. [16]

HIV prevalence among those who are unemployed is often 30 to 50 percent higher than among the employed, in part reflecting the large share of unemployed young people. These data suggest that unemployed women are particularly vulnerable to HIV infection. [17] The high mobility of the population among urban, rural, mining and port areas, within South Africa as well as within the southern Africa sub-region, dominated by men, [14,18] separates men from their families, exposes them to 'high-risk' sexual networks, and may lead to women's reliance on sex to supplement their incomes while their male partners are away for long periods. [13,14]

The important risk factor for HIV/AIDS is the stigma around the infected population which remains strong in South Africa [19] and is likely to influence personal decision-making regarding HIV testing and disclosure. In 2002, the Health Systems Trust noted that only 0.5 percent of South Africans believed that there was someone infected with HIV in their families. [13] Up to 92 percent of persons who tested positive for HIV were not able to tell their partners. [20] The grief, depression and stress that result from HIV/AIDS morbidity and mortality can also lead to reduced productivity and risk-taking behaviour. [13,21]

Health priorities and current strategies in South Africa

HIV/AIDS is one of the priority areas of South Africa's health department. [22] In 1997, the department focused on numerous aspects of HIV/AIDS, the social security system and social marginalisation. It underscored the need for programs to address its impact on vulnerable persons and for further analysis of the impact of HIV/AIDS on social welfare and demand for social assistance. [23] One goal of the department's strategic plan during 2000 to 2005 [24] was to mitigate the socioeconomic impact of HIV/AIDS on poor households and children by means of a rapid expansion of home and community-based care and support. [22] In May 2002, the South African Council of Churches launched a campaign to reduce the stigma associated with HIV/AIDS, issued guidelines for planning and adopted a strategic plan for 2003-06. [13]

The South African Government launched a comprehensive operational plan in 2003 to combat the HIV/AIDS epidemic. The plan was aimed at HIV/AIDS care, management and treatment for South Africa. The main objective of this program was to provide all South Africans with AIDS antiretroviral treatment by 2009. [25] This program also included prevention, counselling, good nutrition and healthy lifestyle, treatment of infections and traditional medicine. [26] The health department is geared up to monitor the implementation of the plan with a mid-term review scheduled for 2009. The objective of the plan is to reduce the HIV infection rate among children under the age of five by expanding the mother-to-child transmission prevention program and providing antiretroviral therapy to pregnant women. The aim is to increase the reach of the country's antiretroviral treatment program from the current estimated one-quarter to at least 80 percent of people living with HIV/AIDS as well as their families. [27]

Health cost of HIV/AIDS to South Africa

The health cost of HIV/AIDS is very alarming and has already forced the public health sector to incur significant expenditure. [13] The combined national and provincial expenditure on HIV/AIDS in 2001-2002 was around US $45 billion, representing 15 percent of total public health expenditure. In 2000, there were an estimated 628,000 admissions to public hospitals for AIDS-related illnesses, accounting for 24 percent of all public hospital admissions. In 2001-2002, the cost of hospitalising AIDS patients in public facilities was at least US $34 billion or 12.5 percent of the total public health budget. [28] If current levels of acute in-and outpatient HIV/AIDS care remain constant, the costs of such care will more than double in the public sector. [13]

In 2003 the United States of America, recognising the global HIV/AIDS pandemic as one of the greatest challenges of all time, announced the emergency plan aimed at implementing the effective strategies for combating HIV/AIDS and ensuring the efficient use of all the resources. South Africa being one of the 15 focus countries of that plan, representing approximately 50 percent of HIV infections worldwide, received substantial help from various organisations. Under the emergency plan, South Africa received nearly US $89.3 million in 2004 and nearly US $148.2 million in 2005 to support a comprehensive HIV/AIDS prevention, treatment and care program. In 2006, the United States provided approximately US $221.5 million to support South Africa's efforts to combat HIV/AIDS. [28]

Discussion and analysis

Implementation of the comprehensive HIV/AIDS program

The implementation of a comprehensive HIV/AIDS program addressing the needs of the wider population, women and girls, children and orphans, young people, migrants and highly stigmatised populations such as sex workers, injecting drug users and prisoners, is of vital importance to South Africa.

Despite the commitment of the government to address the spread of HIV/AIDS, the scale and magnitude of its efforts have not been sufficient to deflect the pandemic. Karim and Karim [29] suggested that the 1994 plan implementation has been impeded principally by problems of process, context, structure and organisation, rather than by its technical content. They identify complicating factors, including the fact that while government plans may be coherent, implementation has been deeply flawed. There was a lack of vision, political commitment, and management capacity at all levels, and an inability to work effectively with local partners that continued to inhibit performance. [29] Many of the policies and laws in the 1994 plan, have been inadequately implemented and have not had significant impact on the ground. Poverty, stigma, and poor access to legal resources deter many South Africans from seeking redress for human rights violations. Women's low socioeconomic status, coupled with lack of support services and shelters, often prevented them from taking steps to protect themselves from HIV.

Enhancing the HIV/AIDS operational program of 2004-2005

The South African HIV/AIDS Strategic Plan (2000-2005), concentrates principally on biomedical problems. It is essential now to recognise that HIV/AIDS is not just a set of health issues. The pandemic inevitably brings with it social, economic, management and planning consequences for education in South Africa. This advice is based on practical experience and evidence in the region suggests that an effective response to HIV/AIDS requires four balanced foci (learning, preventing, understanding and responding to the pandemic) by educators, education policy-makers and planners, and their partners in other sectors. [29]

Mitigating the impact of HIV/AIDS on communities, societies and culture

The four balanced foci require us to understand how the virus is affecting our communities and institutions, to learn to live with the virus which we are failing to contain, and to mitigate its impact as much as possible. The education sector (learning) needs information about conditions which encourage the spread of HIV/AIDS and how best to educate those at risk. New and more robust evidence must inform HIV/AIDS teaching and learning, particularly in life skills programs. [30] Children, their parents and communities need comprehensive health education aimed at preventing and controlling the spread of the disease among young people in and out of school. The national policy on HIV/AIDS for educators must protect the constitutional rights of all educators and learners and there should be no compulsory disclosure of HIV/AIDS status. The educators need more knowledge of, and skills to deal with HIV/AIDS and should be trained to give guidance and be able to respond to the need to reduce, manage and control the impact of the pandemic. [31]

Funding implications

There are funding implications in implementing the comprehensive HIV/AIDS program and enhancing the 2005 HIV/AIDS operational plan. In 2002, the government stated that it had allocated overall amounts to HIV/AIDS, mainly through the departments of health, social development, and education. In May 2003, the South African health minister announced that the government planned to spend an additional US$87 million on HIV/AIDS. [32] Recently, South Africa committed US$1 billion over the next three years to speed up the operational plan for comprehensive HIV/AIDS care and antiretroviral treatment. [25]

The South African Government found that the total cost of providing antiretroviral to everyone in need of it would be between US$1 billion and US$1.09 billion in 2005. [33] It was estimated that 1.7 million lives could be saved by 2010 if antiretroviral were provided to all in need of it. In the absence of antiretroviral treatment it was projected that 1.8 million more children would be orphaned by 2010. This number would be reduced by 860,000 with 100 percent antiretroviral coverage, and by 350,000 with 50 percent antiretroviral coverage. [33]

Consultation

The panel of experts consulted and literature cited during this review paper include scientists and the regional director from the World Health Organization (WHO) responsible for HIV/AIDS in African countries and WHO publications, the HIV/AIDS research group from the Nelson Mandela School of Medicine, South Africa and other HIV/AIDS related organisations such as the Technical Support Facility (TSF), the Health and Economics and HIV/AIDS Research Division (HEARD – South Africa) and the United States Agency for International Development (USAID) of South Africa.

Recommendations by the author

Increase the knowledge of HIV/AIDS and intensify HIV prevention

Prevention and treatment efforts for HIV/AIDS need to be increased for the affected population as well as for the surrounding host population. The government should establish an integrated epidemiological surveillance, monitoring and evaluation system to collect strategic information and to develop and refine the existing national HIV/AIDS operational plan. [26] The future of HIV prevention largely depends upon the extent to which environmental change interventions are promoted. Parkhurst and Lush [34] compared the macro-political environment of HIV in South Africa with that of Uganda and addressed the degree to which policy environments could impede or expedite the effective implementation of AIDS prevention programs. On the other hand, at the micro-social level, Green [35] launched an initiative to engage local traditional healers in Mozambique in HIV prevention through education and outreach. That attempt to integrate traditional knowledge became an inspirational innovation with important implications for similar programs in other parts of the world. The HIV/AIDS pandemic is intertwined with complex social, political and cultural environments and covers a wide range of knowledge and theory concerned with understanding and influencing human behaviours and the context in which they occur.

Enhancing the HIV/AIDS operational program

The South African national HIV/AIDS program as described in the South African HIV/AIDS Strategic Plan (2000-2005), is essentially a health promotion scheme. The program should address the economic, social and other consequences of the pandemic to make it effective. Provincial departments of education should be encouraged to promote program targets at a local level. The HIV/AIDS program should reflect both health and social concerns.

Understanding the impact of HIV/AIDS on the education and training system

There is a great need for plans and strategies to respond to the impact of HIV/AIDS on the sustainability of the education and training system, and the human resource requirements of the education and training system for learners and educators affected by HIV/AIDS.

Conclusion

This paper has discussed the spread of HIV/AIDS in South Africa as a major health challenge in the context of different culture and social settings. Prevention and intervention initiatives require sustained and coordinated global strategies, sufficiently flexible to take account of local understandings of AIDS and associated risk behaviours and policy environments conducive to effective implementation.

In order to address the needs of the wider population and to enhance the South African HIV/AIDS Strategic Plan (2000-2005), an effective and comprehensive HIV/AIDS program is required. This program should be based on four balanced foci (learning, preventing, understanding and responding to the pandemic) by educators, education policy-makers and planners, and their partners in other sectors, addressing the economic, social and other consequences of the pandemic.

Competing interests

The author declares that he has no competing interests.

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RESEARCH ARTICLE

Monitoring Sentinel Events Using Routine Inpatient Data

T Jackson, C Moje, J Shepheard and A McMillan

Abstract

Objective: To explore the extent to which routine inpatient diagnosis data correspond to the Australian nationally-mandated Sentinel Events (SE) data collection and Victoria's additional serious reportable events.

Background: Since 2005, state health authorities across Australia have required public hospitals to report on any instance of the eight nationally-agreed 'sentinel events'. The adoption of this list for national monitoring of 'events in which death or serious harm to a patient has occurred' was sponsored by the former Australian Council for Safety and Quality in Health Care. The State of Victoria has policies that support high quality coding of diagnoses in routine hospital data, but it is unclear whether this data source could be used by hospitals to validate voluntary reports and inform ongoing quality improvement efforts.

Methods: Code lists were developed by two Health Information Managers to identify ICD-10-AM codes that could be used to define each of the eight national indicators, and an additional 14 subcategories of 'other catastrophic events' reported only in Victoria in 2005. These were translated into computerised algorithms to select cases from the Victorian Admitted Episodes Database (VAED) or 2005/06 which matched the code sets for each of the 22 indicators. We used the 'C-prefix' (now incorporated into the national 'condition onset' flag) in Victorian data to identify hospital-acquired diagnoses, combining these with information on separation mode (specifically, death in hospital), and on admission type (maternity cases) to define some indicators.

Results: Seven indicators (one national and seven of the Victoria-specific SEs) could not be replicated using data available in the VAED, and several others could be replicated only partially. 'Serious harm' could not be identified other than by limiting analysis to deaths associated with (but not necessarily caused by) a SE. Coded records apparently under-reported cases of wrong patient/wrong surgery, suicide by an inpatient and maternal deaths, when compared with voluntary reports. Routine data, however, identified more incidents of retained instruments, gas embolism and medication errors.

Discussion and Conclusions: While Australian clinical coding standards are among the best in the world, routine patient abstract data may not be reliable for identifying all types of SEs. Voluntary reporting of adverse events is vulnerable to a different set of human and organisational factors that also impede full reporting. The code sets reported here identify some 'events' that may be less serious than those hospital staff are encouraged to report. This has the advantage of identifying 'near miss' events, but some may be false positives and would not warrant full root cause analysis. Hospital leadership may value the timeliness and low cost of using the routine data and this suggests its use as a second source of information on serious patient safety breaches.

Abbreviations: QAHCS – Quality in Australian Health Care Study; RCA – Root Cause Analysis; SE – Sentinel Events; US – United States; VAED – Victorian Admitted Episodes Database; VSE – Victorian Sentinel Events.

Key Words: sentinel events; patient safety; adverse events; administrative data.

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Introduction

Health systems around the world wrestle with improving hospital performance on key patient safety issues. Collecting and publishing incident and adverse event information is a key strategy used in improving patient safety. The purpose of this paper is to investigate the role of routinely-coded hospital discharge data to assist in this effort. One way of using information on compromised patient safety is to require that incidents be internally investigated and their root causes reported. One such reporting system is that of the United States (US) Joint Commission. [1] Building on the US work, the Department of Human Services (now Department of Health) in Victoria introduced a clinical risk management strategy in 2001 and was the first jurisdiction to include a similar collection of Sentinel Events (SEs) for its public hospital system. [2] In 2005, all Australian states agreed to a common collection, with the first national report published in 2007. [3]

The Joint Commission defines a SE as 'An unexpected occurrence involving death or serious physical or psychological injury, or the risk thereof . . . Such events are called 'sentinel' because they signal the need for immediate investigation and response.' [4] Australian authorities use a quite similar definition ('Events in which death or serious harm to a patient has occurred'). [5] Reports to both systems result in a mandated 'Root Cause Analysis' (RCA). RCAs are 'a systematic process whereby the factors that contributed to an incident are identified'. [6] They are designed to assist the hospital involved to learn from the incident, and publication of summary causal factors is intended to help reduce risks in the system as a whole and contribute to system learning.

The collection relies on voluntary reporting of safety breaches by healthcare workers. This has a number of advantages: it engages the altruism of clinicians to improve patient outcomes, and evidences 'Collaboration between the government, health services, clinicians and consumers striving to continually improve care delivery for patients'. [7]

But voluntary reporting also has a number of drawbacks, particularly for monitoring events at the hospital level, and the system as a whole. Workers involved in such events may feel reluctant to report because of the associated stigma, [8-11] resulting in under-reporting. [12] Perversely, safety-aware health workers and hospitals appear to perform worse than individuals and hospitals that choose not to report to the system. More subtly, by focusing on single, relatively rare events, such reporting may skew system attention toward dramatic and single-cause events, and away from the more mundane and multi-causal. [13]

A second approach to data collection is exemplified by the Quality in Australian Health Care Study (QAHCS). [14] This landmark study used multi-reviewer auditing of medical records to identify adverse (including 'sentinel') events in hospital care, and became a catalyst for much of the recent interest in patient safety. While the methods of the QAHCS study have strong validity for identifying adverse events, the cost and time delay entailed in the review process makes it impractical for routine monitoring of hospital performance.

Australia has a well-supported system of abstracting patient information from the hospital record. Trained medical record coders (along with varying proportions of qualified health information managers) assign ICD-10-AM codes by reviewing each record on discharge. Coders have access to clinicians who treated the patient and to 3 or 4-year university qualified health information managers for advice where notes are ambiguous or difficult to interpret. A number of states use these data as the basis for hospital payment, and Victoria has instituted an independent data audit. The current study thus set out to compare rates of voluntary reporting of SEs with identification of these from the routinely-reported hospital data in Victoria to evaluate the strengths and weaknesses of the two data systems.

Methods

The eight Australian national SE categories were 'translated' into sets of diagnosis codes in ICD-10-AM. [15] The State of Victoria has supplemented the national list with 14 additional 'Other catastrophic event' categories to broaden the scope of the collection and resulting RCAs. These were also translated into ICD-10-AM codes and are denoted here as Victorian Sentinel Events (VSEs). All event types are shown in Table 1. A health information manager on the

Table 1: Australian national sentinel event categories and Victorian additions

SE 1	Procedures involving the wrong patient or body part
SE 2	Suicide in an inpatient unit
SE 3	Retained instruments or other material after surgery requiring re-operation* or further surgical procedure
SE 4	Intravascular gas embolism resulting in death* or neurological damage*
SE 5	Haemolytic blood transfusion reaction* resulting from ABO incompatibility
SE 6	Medication error leading to the death of patient* reasonably believed* to be due to incorrect administration of drugs
SE 7	Maternal death associated with labour or delivery
SE 8	Infant discharged to the wrong family
VSE 9.1	Complications of emergency management (resuscitation)*
VSE 9.2	Complications of anaesthetic management
VSE 9.3	Complication of surgical management
VSE 9.4	Foetal complication of delivery
VSE 9.5	Complication of inpatient fall (associated with death)
VSE 9.6	Complication of inpatient fall (injury not death)
VSE 9.7	Patient absconding from inpatient unit with adverse outcome*
VSE 9.8	Infection control breach*
VSE 9.9	Hospital process issue*
VSE 9.10	Medication error (not resulting in death)
VSE 9.11	Misdiagnosis and subsequent management*
VSE 9.12	Communication of test results*
VSE 9.13	Other - mental health management
VSE 9.14	Other – unspecified*

*Concepts not able to be fully captured in analysis of routine hospital data

team (CM) nominated code sets for each of the event types. These were independently reviewed by a second health information manager (JS) and a patient safety researcher (TJ), with revisions agreed amongst the reviewers. These revised code sets were then reviewed by the Director of the Victorian Department of Health Statewide Quality Branch (AMcM), and a second round of revisions agreed.

Some event categories required information about whether the patient died in hospital or whether the patient was a surgical or maternity patient; both variables derived from non-diagnosis fields on the patient extract. The full set of these codes is available from the authors. Limitations in using the morbidity data to replicate definitions that attribute causation; that create overlapping categories; that require linkage of more than one episode; and/or that include particular types of consequent morbidity are considered later in the Discussion.

Data for analysis was the Victorian Admitted Episodes Database (VAED) [16] comprising all public and private separations for the State of Victoria from 1 July 2005 to 30 June 2006 (*n*=2,031,666). Up to 40 fields are available to record clinical details of an inpatient episode. Diagnosis data are recorded by trained professional coders or health information managers. Data are routinely edited by the Victorian Department of Health, against published standards for plausible code combinations, and the Department conducts audits of patient records from every public hospital, with financial penalties for hospitals with exceptional rates of coding error. [17]

Coding standards require that all diagnoses recorded in the data abstract be documented as actively evaluated or treated during the admission, and/or extended the patient's length of stay. [15] The routine data in Victoria has included information on the timing of diagnoses since at least 1980. [18] For application of the 'C' prefix (indicating a 'complication') the coder must ascertain that there was no evidence of the condition existing prior to admission – that is, the C-prefix is used only for a diagnosis arising after admission. This distinguishes incident diagnoses (arising as a consequence of SEs) from those treated in a subsequent episode. [19] Analysis was undertaken on C-prefixed diagnoses to avoid double-counting arising from readmissions to hospital.

Comparison totals for Australia (using 2004/05 data) and for the State of Victoria (using 2005/06 data) were available from published reports. [3,20] These collections are anonymous (both patient and clinician) and thus could not be linked to the routine data for comparison.

Results

Overall, the routine data identified more of some event categories, but fewer of others. They flagged significantly more cases of the Victoria-specific events than did voluntary reporting. Useable ICD-10-AM codes could not be found for one of the national SE categories and for six of the Victoria-specific *Other Catastrophic Events* shown in Table 1. *Infant discharged to the wrong family* (SE 8) has no coded equivalent, and has never been reported in either the Victorian or the national data collections. Although the Victorian category *Complication of emergency resuscitation management* (VSE 9.1) could be identified with the diagnosis codes T88.4 *Failed or difficult intubation*, and similar codes in the obstetrics chapter (for intubation problems during pregnancy, labour, delivery and the puerperium), it was judged impossible to distinguish emergency from other intubation using the routine data, leading to the exclusion of this event from the analysis. The Victorian events *Patient absconding from inpatient unit with adverse outcome* (VSE 9.7), *Hospital process issue* (VSE 9.9), *Misdiagnosis and subsequent management* (VSE 9.11), *Communication of test results* (VSE 9.12), and *Other - unspecified* (VSE 9.14) do not have ICD-10 equivalents and are not further considered here.

The codes available for identifying wrong patient/wrong operation/wrong site cases were only tangentially related to the concept of the sentinel event collection. With the exception of Y65.5 *Performance of inappropriate operation*, there was probably little overlap between the cases identified by the two methods. Variations from the definitions used for other SEs are considered in the Discussion.

Table 2 presents comparative counts for the national SE categories that could be identified using diagnosis coding, with Victorian totals for the same year, and national totals for the preceding year. Victorian coded records showed half the number of cases of *Wrong patient/wrong surgery* (SE 1; 13 vs 25), and *Inpatient suicide* (SE 2; 3 vs 7). Two separate definitions of *Maternal deaths* (SE 6) were trialled, but no cases were found in computerised records, compared with two in the year identified by the voluntary reporting system. This may be attributable to coding standards that discouraged C-prefixing of obstetric diagnosis codes at the time of the study, limiting our ability to identify obstetrics-related SEs.

The routine data, however, identified nearly ten times the number of incidents of *Medication errors* associated with death (SE 5; 20 vs 2) and *Retained instruments or other surgical materials* (SE 3; 53 vs 6). Six deaths associated with *Intravascular gas embolism* (SE 4) were identifiable through the routine data, where none was voluntarily reported. No transfusion reactions were reported in either system; the rarity of this event reflected in the fact that the national collection identified only one in the preceding year. In total, the data algorithm identified 95 national SEs, compared with 42 voluntarily reported to the VSEs collection.

Results for the Victoria-specific 'Other Catastrophic events' are shown in Table 3. These events were subject to larger disparities between the two data sources, with the routine data again identifying more events (4,280 compared with 33 voluntary reports). Over 2,800 injuries were identified in the routine data as attributable to *Inpatient falls* (VSE 9.6), while voluntary reporting resulted in only one such case being identified. Nearly 400 non-fatal *Medication errors* appeared in the routine data compared with only seven voluntary reports.

Table 2: Frequency of national SE types: coded data vs voluntary reports

	VOLUNTARY SE REPORTING		
	THIS STUDY 05/06	VICTORIA 05/06	NATIONAL 04/05
SE1 Wrong patient or body part	13	25	53
SE2 Suicide in an inpatient unit	3	7	25
SE3 Retained instruments /material	53	6	27
SE4 Intravascular gas embolism	6	0	1
SE5 Transfusion reaction	0	0	1
SE6 Medication error	20	2	7
SE7(1) Maternal death (O95, O96, O97)	0	2	16
SE7(2) Any maternal death	0	–	–
Total	**95**	**42**	**130**

Table 3: Victoria-specific Sentinel Events (VSEs)

	THIS STUDY 05/06	VICTORIA 05/06
VSE 9.2 Complications of anaesthestic management	39*	0
VSE 9.3 Complication of surgical management	543*	5
VSE 9.4 Foetal complication of delivery	9*	2
VSE 9.5 Complication of inpatient fall§	309*	4
VSE 9.6 Complication of inpatient fall (other injury)	2837	1
VSE 9.8 Infection control breach	4	3
VSE 9.10 Medication error (not resulting in death)	397	7
VSE 9.13 Other - mental health management	142*	3
Total	4,280	33

* measured in this study as a complication associated with (not 'causing') death in hospital
§ defined as 'death or serious morbidity'

The problem of causation is apparent in VSEs 9.2-9.5, and VSE 9.13 where the routine data algorithm uses in-hospital death as the marker of harm. This may overestimate the consequences of the SE (where death resulted from the patient's underlying condition and the complication was a minor one), in contrast to the more nuanced judgments, which can be made in the voluntary reports.

Discussion

Our findings show that the routine data are capable of identifying a range of serious adverse events in hospital care, but it is clear that these data have a number of shortcomings for providing SEs information for public reporting. Codes do not exist for some event categories (eg, *Infant discharged to wrong family, Wrong patient or body part*). The Wrong patient event is interesting in that the three very specific codes available do not match the national definition well. A more general code Y65.8 *Other specified misadventures during surgical and medical care* undoubtedly captured some of the 'wrong patient/wrong body part/wrong operation' cases (n=722), but was judged to be too broad to attribute to the National SE definition. Further development of the Australian Modification of the ICD-10 classification system to take account of patient safety uses for the data could substantially improve the usefulness of coded hospital data.

Establishing causation is particularly problematic. National SE 6 calls for causal links to be made between a medication error and the patient's death, as well as a 'reasonable belief' that 'incorrect administration' was the source of the error. We used death in hospital to proxy for 'catastrophic' outcomes, but the routine data cannot establish that the death was a direct result of these events. Age and procedure type are among the risk factors for hospital-acquired adverse events. [21] Older patients may also be sicker patients, and sicker patients are more vulnerable to hospital-acquired illness and injury because of more intensive treatments and longer stays. They are also at greater risk of death while in hospital. Thus we support Kable and Gibberd's more general warning that in-hospital death can only be considered to be 'associated with' an adverse event in most forms of patient safety research.

Divergences in definition between the voluntary reporting system and the routine data, such as using 'associated with death in hospital' as a surrogate for 'catastrophic events', may explain the higher rates found, especially for the broader Victoria-specific events. It may be the case, however, that 'near misses' are included in the routine coding. For example, VSE 9.10 *Medication Errors (not resulting in death)*, recorded nearly 400 coded events, where the voluntary reporting system identified only seven. Healthcare professionals may not have seen a need for reporting medication errors that did not result in patient harm, but these 'near misses' may give a better picture of the full range of medication-related risks.

We found some SE categories created the potential for overlap. In writing the algorithm for the routine data, we had to resolve whether drug-related *Complications of anaesthetic management* (VSE 9.2) should be assigned as *Medication errors*, and similarly, whether obstetric deaths related to anaesthetics should be counted as *Maternal deaths*. Here, root cause analysis could have prioritised the factors involved to give the best account of the event. For this study, we assigned all complications of anaesthesia to that SE category, and as noted, there were no recorded maternal deaths.

Some of the descriptors of the events required sequenced information, as in *Retained instruments …requiring re-operation*. The routine abstracts include information about all procedures performed, but do not allow for particular procedures to be linked to particular diagnoses. Further, without episode linkage, it is not possible to know whether a re-operation occurred when a patient was transferred to another hospital, or in a subsequent admission to the same hospital.

Finally, some of the national definitions require information on morbidity associated with the event. SE 4 *Intravascular gas embolism* seeks to identify 'neurological damage' as well as in-hospital death caused by this outcome. It may be possible to identify specific ICD-10-AM codes that define 'neurological damage' but as routine records are currently structured, neither causation nor sequencing could be unequivocally linked to the SE.

Conclusion

The routine hospital data is a vastly under-used resource in Australia, particularly given the high quality of coding. The extensive documentation, support and training for coders in Australia means that definitions can be consistently applied, and periodic data audits strengthen the motivation of coders to be accurate and thorough. Scanning routine data for particular forms of patient harm has a very low marginal cost, and could be applied in a timely way (typically monthly) at the hospital level in support of clinical governance.

It was our hypothesis that coders, being further from the bedside, were more likely to record adverse events in patient care (when evidence of these appears in the medical record), providing a useful way of estimating reporting rates. Routine coding can identify 'near miss' events where the level of harm would not be sufficient to motivate clinicians to make a voluntary report. All of these features make the coded data a valuable tool for health service managers to monitor events recorded in their hospital.

Voluntary reporting also has some clear advantages: it provides an inbuilt feedback loop through RCA that can motivate staff involved and demonstrate system learning from SEs. The small numbers of voluntary reports make it feasible to undertake RCA, where the number of coded events might overload such a system. Our work demonstrates that for most event categories, the routine coding identifies a larger number. Publication of rates from the routine data might have the undesirable effect of discouraging recording and/or abstracting of these into the patient record. Clinicians may feel able to make an anonymous SE report even when recording the same event in the patient's record would be compromising; events that are not recorded cannot be coded. Finally, reports from the front line of healthcare (eg, RCAs) can capture the complex causal links between events and harms that coded data cannot. Analysing the routine hospital data may be a useful way of exploring trends in unintended outcomes, so that patient safety programs can prioritise their efforts to minimise harm.

Given the history of ascribing individual blame for untoward patient outcomes, any data on a healthcare system's performance on safety and quality measures will be controversial. In July 2007, Australia's first national report on SEs in hospital care [3] was greeted with the headline 'Hospital bungles are killing scores'. [22] Routine data can help answer important questions in the healthcare system, and provide a useful way of monitoring the extent to which voluntary reports of SEs are representative of the range of patient harms. Increased use of these data at the facility level would both improve patient safety and the quality of the data itself.

Acknowledgements

The authors are grateful to the Victorian Department of Health (formerly Human Services) for access to the Victorian Admitted Episodes Database, and to participants in the National Centre for Classification in Health (NCCH) 2007 'Coding Matters' conference for comments on an earlier draft of the paper. The Australian National Health and Medical Research Council provided support for Dr Jackson's participation. All views expressed are those of the authors, and do not represent the policy of the Victorian Department of Health.

Conflict of Interest

The authors declare that they have no conflicts of interest in this research. The algorithm to identify sentinel events reported here is not copyright and will be available from the authors.

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RESEARCH ARTICLE

Assessing and Improving Quality of Life Indicators and Assessments: a case study of an adult day care centre

J Georgiou and P Hancock

Abstract

Objectives: This paper presents the findings of a post graduate research degree study in the School of Psychology and Social Science (SPSS) at Edith Cowan University (ECU). [1] The primary purpose of this study was to collaboratively explore the ways in which a group of aged clients and service providers perceived the concept of Quality of Life (QOL) amongst older people. Moreover, another aim of the research was to ultimately use this information to expand and reform the existing QOL indicator, currently being utilised by Community Vision (CVI) – the Referral and Assessment Form. [2] CVI is a large aged care non-government organisation, operating in the northern suburbs of Perth, Western Australia (WA). The third facet of the study was to evaluate the global phenomenon of an ageing society and the implications it would have for maintaining the QOL of aged clients in the future. These objectives and the outcome of the research are important to the management and delivery of services to older populations and to related public policy.

Design and Setting: The research was purely qualitative, comprised of an extensive literature review, a series of face-to-face, semi-structured interviews and survey interviews conducted by e-mail. The same question guides were utilised in both interview types. The sample group included a small cohort of older people, as well as members of staff and managers from CVI's adult day centre and administrative offices. Key informants from three peak WA aged service providers were also included in the study. Informal participant observation was conducted at the adult day centre prior to the actual research taking place.

Results: New objective and subjective QOL indicators were identified in the literature review and interviews. Both tangible and personal measures of QOL were discussed by the participants. Based on an analysis of the primary and secondary data, it was determined that the objective indicators used in the CVI referral and assessment form were universally significant to the measurement of QOL amongst older people. Additionally, subjective dimensions of QOL were described as being equally important to the evaluation of QOL. However, such individualised measures appeared to be lacking in the CVI QOL indicator. The research further suggested that the QOL of older people may be negatively impacted upon by the effects of an ageing society and that minimal government funding and poor recruitment rates in human services would severely limit the quality of aged care, and minimise the QOL of aged clients.

Conclusions: Overall, QOL frameworks and assessment instruments were deemed inadequate if they failed to individualise older people and when aged care agencies were themselves non-consultative about their use. In both the primary and secondary data, subjective and objective QOL indicators were found to be intrinsically linked to each other. Despite this, it appeared that many existing assessment tools remain focused on quantifying the QOL of aged clients and it is recommended that future assessments need to focus on qualitative or individualistic instruments as well. Ultimately, the wellness approach and the technique known as 'reminiscence' were presented as avenues that would promote the individuation of care and foster egalitarian relationships between aged clients and

their service providers. The Honours thesis identified new and more appropriate ways to analyse and refer the aged (referred by aged care service agencies), using individualised QOL frameworks. New ideas relating to QOL measurement, service provision and an ageing population were highlighted as pertinent areas for future research and policy discussion in Australia.

Abbreviations: **CVI – Community Vision; ECU – Edith Cowan University; HSW – Human Service Worker; NHMRC – National Health and Medical Research Council; QOC – Quality of Care; QOL – Quality of Life; SPSS – School of Psychology and Social Science; WA – Western Australia.**

Key words: **Quality of life indicators; subjective ageing; objective ageing; qualitative inquiry into ageing; reminiscence; referral and assessment; ageing society.**

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Introduction

The research evaluated how a small group of aged clients and service providers understood the concept of Quality of Life (QOL) amongst older people. [1] It also analysed the appropriateness of Central Vision's (CVI) Referral and Assessment Form (this form being a standardised instrument adopted from the Western Australian Department of Health pro formas). [2] This was accomplished by summarising and evaluating information obtained through primary and secondary data collation and analysis. In addition to this, the concept of an ageing society was also explored, especially in relation to: the phenomenon's impact on the Australian aged care industry; the future QOL of older people; and the five fundamental research questions used to shape this study, which are listed in Table 1.

Table 1: Research questions and recommendations

1) How does a small cohort of aged clients, staff members and managers from CVI and key informants representing peak WA aged services, perceive QOL amongst older people? • That the concept of QOL amongst older people be viewed as a multi-dimensional construct composed of both Objective and Subjective indicators. • That the existing interrelationship between Objective and Subjective dimensions be recognised by academics, service providers and policy-makers when evaluating the QOL of aged clients, aged care services and facilities and older people in Australia. • That older people in Australia be viewed as a heterogeneous population with individual needs and QOL requirements. • That older people in Australia be viewed as cognisant individuals and active participants in decisions relating to aged care interventions.
2) To what extent is the current QOL indicator used by CVI, the Referral and Assessment Form, applicable to the group being studied? • That the Referral and Assessment Form retains part of its original thematic structure and therefore ensure that the Objective indicators of QOL are applied to the aged client group under study. • That it be recognised the Referral and Assessment Form is missing a crucial Subjective dimension to its composition and therefore not fully applicable to the aged client group under study.

Table 1: Research questions and recommendations ***continued***

3) ***Does the QOL indicator used by CVI need to be refined and further developed to incorporate additional QOL indicators?***
   - Refine and further develop the Referral and Assessment Form to include further Subjective and Objective QOL indicators that provide a holistic view of QOL. Refer to previous page for discussion about these additional QOL indicators. This would be necessary for assessors to accommodate the level of individuality amongst older people in Australia.
   - Refine and further develop the Referral and Assessment Form to include open-ended questions, thereby allow aged clients to describe issues significant to their QOL or discuss interrelationships between Objective and Subjective indicators of QOL.
   - In light of the strong Objective-Subjective relationship that exists within the concept of QOL, refine and further develop the Referral and Assessment Form to include dimensions from individualised QOL Frameworks, the Wellness Approach and the Subjective concept of reminiscence.

4) ***How can the results of this project be used to better inform policy-makers and service delivery practices related to aged care?***
   - That older people, academics, aged service providers and policy-makers work collaboratively to produce new approaches to practice in order to meet the demands of an ageing society and provide individualised interventions.
   - To consider implementing the Wellness Approach which would help to ensure the independence of aged clients and provide care, based on an ongoing assessment of older people's level of need.
   - To implement reminiscence wherever possible which would help to account for aged clients' physical and social histories during the assessment phase; thereby allowing assessors to have a full account of aged clients' individual needs and indicating that the assessors have an interest in their clients. This in turn could potentially maximise the feelings of worth amongst older people.

5) ***In light of Australia's rapidly 'ageing society', will older people require greater input from policy-makers and service providers to ensure their QOL is considered, debated and maintained?***
   - Increased input from Australian policy-makers and service providers to ensure the QOL of older people is considered debated and maintained in an ageing society.
   - Greater government funding to policy-makers and service providers in order to attract more human service workers, thus ensuring that the level of QOC is maintained in Australian service delivery.
   - An increase in the future services available to older people in order to cope with an increase in demand as part of an ageing society in Australia; centre-based care and in home care were identified as strong predictors of a positive QOL amongst older people.

Source: Georgiou (2008) Research questions and recommendations

The QOL indicators and their interrelationships are described in Table 2. Overall, there appeared to be considerable overlap between the objective (tangible phenomena) and subjective (personal beliefs) QOL indicators identified in this study. The four main themes identified in the CVI Referral and Assessment Form were predominantly objective; 'physical', 'intellectual', 'sensory' and 'social' indicators of QOL. [2] However, we found that an individual's interpretation of a situation significantly influenced their QOL, and these interpretations were commonly subjective. As will be discussed further, new and alternative QOL indicators were identified and it was subsequently recommended that they be added to the CVI's assessment model. The literature review that formed part of the original research study, argued that there was strong momentum in the QOL debate for the individuation of QOL frameworks. As was reported in many studies, respondents were being encouraged to identify themes they perceived to be personally significant to the measurement of QOL. [3, 4, 5, 6] However, as will be seen, this debate has not led to a greater consultative approach being utilised by aged care agencies when measuring their clients' QOL.

Table 2: Main QOL indicators and their sub-themes

OBJECTIVE QOL INDICATORS (MAIN)	INTERCONNECTED SUB-THEMES OF QOL
Physical wellbeing	Mobility (Objective) Daily tasks (Objective) Personal hygiene (Objective) Intrinsic importance (Subjective) Autonomy of choice (Subjective) Attitude (Subjective) Contextual situation (Subjective)
Sensory	Hearing (Objective) Vision (Objective) Intrinsic importance (Subjective)
Intellectual	Cognitive functioning (Objective) Attitude (Subjective)
Technological aids and human support	Resistance (Subjective) Adaptability (Subjective)
Service delivery	Care and support (Objective) Medical (Objective) Autonomy of choice (Subjective) Adaptability (Subjective) Intrinsic beliefs (Subjective) Resistance (Subjective) Feelings of loss (Subjective)
Residential	Private residences (Objective) Villages (Objective) In-home care (Objective) Age friendly cities (Objective) Perception (Subjective) Autonomy of choice (Subjective)
Financial	Government pension rates (Objective) Third party assistance (Objective) Attitude (Subjective) Autonomy of choice (Subjective)
Social	Contact (Objective) Service delivery (Objective) The ability to communicate (Objective) Isolation (Objective) Depression (Subjective) Autonomy of choice (Subjective) Access to transport (Objective) Age friendly cities (Objective) Value and worth (Subjective) Intrinsic importance (Subjective) Personality (Subjective)
Geographical location and climate	

Table 2: Main QOL indicators and their sub-themes *continued*

OBJECTIVE QOL INDICATORS (MAIN)	INTERCONNECTED SUB-THEMES OF QOL
Anxiety	Bereavement (Subjective) Feelings of loss (Subjective)
Reminiscence	Growing older (Objective) Life review (Subjective)
Autonomy of choice	(See above)
Attitude	(See above)
Resistance	(See above)
Adaptability	(See above)
Depression	(See above)
Bereavement	(See above)
Feelings of loss	(See above)
Resilience	
Wisdom	

Source: Georgiou (2008) Semi structured and survey interview data

QOL frameworks

QOL frameworks have generally been constructed with either a narrow focus or based on a broader understanding of an individual's wellbeing. [6] Models based on health-related QOL fall into the first category [6] and therefore QOL has often been regarded as synonymous with one's 'physical functioning'. [7] Opponents of such a view have argued that individuals with physical debility may be limited in their mobility, however this does not necessarily demonstrate that they have a poorer QOL than a physically healthy individual. [7]

It has been suggested that such a 'narrow' correlation discriminates against older people with disabilities and those with long-term diseases. In order to maximise one's life status, it has been argued that the societal, monetary and cultural dimensions of wellbeing need to be addressed in conjunction with a person's physical state. [7] As such, health-related QOL frameworks were not applied in this study and it was surmised that QOL should not be evaluated purely on the individual's health. [7]

Conventional QOL measurement devices have been 'ad hoc', with no uniform structure. [3] However, data obtained from the literature review suggested that QOL could be broadly categorised as being objective or subjective in nature. Objective indicators of QOL identified in the literature, included 'tangible' dimensions such as finances, employment, place of residence (home ownership), education levels and one's social or physical environment. [3] Subjective indicators of QOL included one's contextual understanding of QOL based on their personal history, future prospects, attitude, as well as their emotional and physical wellbeing. [3] An evaluation of subjective wellbeing involves a comparison between one's current life status and prior experiences. [8] The primary data also provided new and alternative indicators of QOL that expanded on these existing themes and suggested innovative ways in which to conceptualise and assess QOL among aged people. These dimensions will be discussed in greater detail.

Method

A brief proposal outlining the purpose and ethical considerations of this study was submitted to CVI's Board of Executives in May 2008. National Health and Medical Research Council (NHMRC) ethics approval was obtained from Edith Cowan University (ECU) in June 2008 and CVI subsequently approved the research. Information Letters and Ethics Consent Forms based on ECU and NHMRC guidelines were then presented to all prospective participants. Presented in hard copy and digital formats (depending on the individual), some documents had to be read to aged participants with visual impairments.

The research design was made up of a series of semi-structured interviews and survey interviews, as well as 200 hours of informal participant observation at the adult day care centre. The same question guides were utilised for both interview types. The semi-structured interviews were conducted face-to-face; whereas the survey interviews were completed electronically and sent as e-mails. The total number of interview participants was 16. Eleven participants (six clients and five members of staff) were chosen from the CVI adult day centre. Two managerial staff members were also selected from the CVI administrative offices. In addition to this, three key informants from separate peak WA aged service delivery organisations were also recruited. Participants selected their own pseudonyms to protect their anonymity and secured confidentiality. By including them in part of the decision-making process it also ensured that the research design was collaborative.

Initially, respondents were asked probing questions relating to their subjective and conceptual understanding of QOL. The second phase of the interview was based on the four fundamental themes identified in CVI's referral and assessment form; 'physical', 'intellectual', 'sensory' and 'social' QOL indicators. Other pertinent information was gathered regarding the QOL of older people in an ageing society and how Australian aged care services could evolve in order to meet the demands of an ageing society. All interviews closed with an open-ended question that allowed respondents to discuss matters personally significant to them.

The majority of questions relating to the four main themes were asked of all participants and these universal questions were modified to suit the separate sample groups and individuals therein. [9] However, some questions were relevant only to clients, staff, managers or key informants; they were specific to these respondent groups' subjective opinions or expertise and are described in Table 3. Overall, the questions were not prescriptive and conversations were flexible. Even in the survey interviews, respondents were encouraged to provide in-depth accounts of their personal experiences, allowing the researcher to establish the meaning behind their responses. [10]

As part of the analytical process, the researcher put field notes and survey interview data into the qualitative data analysis program *NVivo 7*, which was used to develop substantive codes and nodes. From this it was determined what initial themes appeared to be emerging from the primary data relating to old age and QOL indicators. Using these substantive codes as a foundation, further data analysis involved the categorisation of full interview and survey content by constructing themed tables. These themes and quotes described in Table 2 were then used as part of the thesis findings and used to explore and discuss any new or alternative QOL indicators.

Results: the subjective/objective interface

QOL is both subjective and objective. There are things 'out there' such as housing, getting food, the weather, all sorts of quite objective things, which of course, affect how I feel, but how I choose to respond is up to me.
(Eddie, key informant from a peak WA aged service delivery organisation.)

Respondents interpreted the concept of QOL using similar objective-subjective parameters identified in the literature review briefly outlined above. Certain tangible indicators were identified to be universally important in predicting whether an older person's QOL was adequate. However, it was widely posited that the intrinsic nature of older people (or being aged) also influenced an individual's level of QOL. In addition to this, objective and subjective indicators were found to be intrinsically linked as the following examples illustrate.

The objective indicator 'physical wellbeing' was further subdivided into one's ability to carry out 'daily tasks and routines' as well as maintaining their 'personal hygiene'. The objective indicator 'sensory' referred to 'hearing' and 'sight'. Participants measured older people's 'intellectual' QOL in terms of their 'cognitive functioning' and the subjective measure of one's mental 'attitude'. Although largely objective in nature, 'technological aids and human support' were highly influenced by the subjective QOL indicators of 'resistance' and 'adaptability'. That is, learning how to cope with an age-related impairment and thereby changing their lifestyle accordingly.

Table 3: Interview questions for staff (FIELD NOTES)

SECTION A: PRELIMINARY

- What do you feel are the most significant issues that affect older people in Australia today?
- What are the advantages of being an older person in Australia today?
- Australia has been described as a rapidly ageing population. What implications do you believe an ageing society will have on older people's QOL in the future?
- Do you believe older people's QOL will change as a result of a rapidly ageing population?

SECTION B: PHYSICAL INDICATORS OF QOL

- How is type of residence an indicator of an older person's QOL (private residence, hostel, retirement village)?
- In what specific circumstances does an older person require a care or support worker and what does this indicate about an older person's QOL?
- What does reliance upon a medical professional or medication indicate about an older person's QOL?
- How would physical issues (mobility) affect an older person's ability to complete daily tasks or routines (housework or catching public transport)? Would this impact on a person's QOL?
- How would physical issues (mobility) affect an older person's ability to care for themselves? (personal hygiene)
- Would this impact on a person's QOL?

SECTION C: INTELLECTUAL / SENSORY INDICATORS OF QOL

- What impact does getting older have on older people's mental abilities and subsequent QOL?
- How important is vision and hearing to an older person's QOL? In what way?
- If an older person requires technological aids or human assistance to perform tasks (routine or otherwise), how would this impact on their QOL?
- Is the ability to communicate well with others an indication of an older person's QOL? In what way?
- Would outside control of finances affect an older person's QOL (bank, lawyer, family)?

SECTION D: SOCIAL INDICATORS OF QOL

- How important is social contact in terms of an older person's QOL?
- Can isolation or feelings of depression have an impact on an older person's QOL? In what way?

SECTION E: QUESTIONS RELATED TO SERVICE DELIVERY

- What can be inferred about an older person's QOL if they are a recipient of services provided by a community service agency or Government body?
- In light of Australia's ageing population, how do you believe your role as a human service worker (HSW) will change, particularly in terms of ensuring that QOL issues for the elderly are met?

SECTION F: FINAL

- Is there anything further you would like to add or discuss (old age, growing older, an ageing society or QOL amongst older people)?

Source: Georgiou (2008) Semi structured and survey interview question guide

The objective QOL measure, 'service delivery' was subdivided into 'care and support services', as well as 'medical services'. 'Residential' indicators of QOL were subdivided into 'place', 'in-home care' and 'age-friendly cities' (all primarily objective in nature). Participants measured the objective indicator 'financial' QOL, in terms of 'government pension' and how they perceived 'third party assistance'. That is, whether they were willing to give up their financial independence or if this constituted a decline in their QOL. The broad area of 'social' was related to the areas of 'service delivery', one's objective ability to 'communicate' and how this impacted on them personally. 'Social' was further subdivided into feelings of 'isolation', 'depression' and 'one's autonomy of choice' and how this influenced their QOL. The subjective indicator 'anxiety' was strongly related to experiences of 'bereavement' and feelings of 'loss'. Similarly, the subjective theme of 'reminiscence' was also related to participants' feelings of 'loss', particularly when comparing one's past accomplishments or position in society to their current lifestyle.

Discussion

Complexity among QOL indicators

The responses concerning what constitutes QOL amongst older people varied significantly. However, upon analysis of the primary data, there appeared to be some main themes throughout all interview groups. Objective indicators were deemed central to an individual's QOL and encompassed areas such as physical and mental wellbeing, access to adequate financial resources, physical security (place of residence) and the weather (Perth's good climate was a common theme). In addition to this, was one's status in society and the maintenance of social contacts. More specifically, it was found that in old age, QOL meant having access to emotional support and services delivered by centre-based care organisations where social participation was facilitated (Jane Davies).

There appeared to be a strong correlation between how these objective indicators of QOL personally impacted on the individual, further indicating the existence of a subjective dimension to QOL. For example, it was suggested by several respondents and supported in the secondary data, that it was not enough to just have social contact, but that older people needed to value that contact in order for it to benefit one's QOL. [6] The key informants stipulated that individuals evaluated their lives along a continuum that consisted of positive, negative, objective and subjective dimensions.

Social contact was nominated as a significant indicator of one's QOL amongst the client, staff and managerial cohorts. There was a strong objective-subjective relationship in respect to social wellbeing. Overall, it was believed that social contact gave many older people's lives subjective meaning (Dorothy). Anne felt that older people needed *to feel connected and needed within the community* in order to experience a positive QOL in terms of physical health and mental wellbeing. One's contextual situation was thought to impact on older people's social wellbeing. Staff members Dorothy and Margo argued that older people needed to be engaged in society after losing a spouse. It was believed that in such situations, social contact was essential to maintaining a widowed older person's physical health and longevity. This view was mirrored by client Ben who expressed great sadness at the loss of his wife. Several other clients suggested that having a partner, or other family and friends was an important indicator of their QOL. Matilda stipulated – *I'm lucky that I still have my husband. For company you know… 24-7 company*.

Discussion about social indicators of QOL appeared to be synonymous with talk about personal contact with friends, family and the CVI Day Centre – *Just having company and people that you relate to… and having a meeting place like this, meeting up with people like you* (Drew). Centre-based care was viewed as a source of social activity and new opportunities – *they're getting out, they're doing something they probably wouldn't be able to do… it definitely improves their QOL… particularly the social aspect* (Joan). Members of the staff population believed that centre-based care was not only a source of social stimulation and intrinsic satisfaction, but a panacea for ill health – *with company comes contact… they feel better about themselves and they don't get as sick as often*. (Margo).

Members of the client, staff and managerial sample groups suggested that poor health and isolation were two of the major objective factors that impacted on older people's QOL. Social interaction was correlated with a decrease in feelings of loneliness and isolation, as well as many intrinsic and physical gains. If older people *have an involvement in something, there is more motivation, their mind is stimulated, friendships are formed; which all result in a more positive attitude which brings health benefits and can also mean reduced need for medications.* (Anne). Experiences of isolation and the subjective indicator of depression caused a *downward spiral* where losses in physical health and mental acuity could be fatal (Andy; Regina).

> *People who have difficulties in communicating are sometimes overlooked, people make choices for them, instead of finding out what they want.* (Fay, Manager from CVI Administrative Offices).

One key informant stipulated that if older people didn't have access to transport *then often they can't participate* in society (Nirva). Although access to 'transport' appeared to be a strong indicator of a good QOL, its effectiveness was greatly influenced by one's physical wellbeing. The client Matilda commented on the trials of public transport as a result of her physical limitations – *I can hobble down to the bus, if I have to… but it's when I'm coming home, I'm just about pooped!*.. This highlighted the subjective nature of 'transport' and its potential to impact on QOL positively or negatively.

There was a strong objective-subjective link in respect to the value placed on social constructs that may be used to measure QOL. Despite isolation (loneliness) and depression being conveyed as universally detrimental to the QOL of older people, there was no agreed upon solution either in the literature or the primary data in regard to reversing these negative affective states. Although it was agreed that action must be taken when individuals experience isolation or depression, care or interventions would need to be highly individualised; what might benefit one person, could prove to be ineffective for another.

Key informants suggested that the subjective notions of a sense of worth, being valued and feeling respected were as essential to older people's QOL as having their objective needs met. It was collectively argued throughout the primary data, that older people were undervalued in society. Staff member Dorothy suggested that older people experienced a sense of loss, in terms of their economic value to society:

> *You become a lesser person. You're no longer needed for your work… you start to become a burden on your family… or they'll sort of take this high horse attitude, they'll say – 'we're more important because we're still working; we're still in the community'.*

Overall, there were clearly opposing views about carers and the impact support services have on older people's QOL. Some respondents viewed care as an opportunity for older people to socialise, whilst others perceived support services as representing a loss in independence. Independence was related to the major subjective indicator, autonomy of choice. [3,11] It would appear that autonomy was a recurring theme throughout the primary and secondary data in discussion pertaining to separate areas of QOL, illustrating the theoretical importance of independence as construct in maintaining one's QOL.

Interview data with participants revealed that the relationship between objectively-based medical services and their impact on QOL was actually deemed highly subjective to the individual – *This will depend upon the individual… Many people need medication to keep them in optimum health – it does not necessarily mean that they need assistance in other ways* (Fay). Members of the manager and key informant population suggested that an older person's medical experience was affected by whether the consultation process was collaborative – *health care and medication can either be positive or negative, it depends on the delivery of the service and your own involvement, control and being seen as valuable in that process… that then affects your QOL* (Danni). A professional who assesses an older person as being incapable of remaining in their home (based on objective dimensions such as health), may force them to relocate to residential care, resulting in ramifications to one's subjective dimensions of QOL – such as a loss of independence (Anne).

The heterogeneity of older people was discussed by respondents throughout the interviews. It was indeed heterogeneity that caused the researchers to argue the intrinsic relationships between objective and subjective QOL indicators. The contextual situation of older people and their individual personalities were constantly reiterated as important factors in determining what interventions might be suitable for them. A recurrent theme throughout the primary and secondary data was the importance of individuating care and making it possible for older people to maintain control over decision-making for as long as possible.

Although physical wellbeing was primarily an objective indicator of QOL, it was clearly influenced by various subjective dimensions. A poor physical state does not necessarily imply that an older person has a diminished QOL, however it is a strong predictor that an older person may experience limitations related to their autonomy of choice. As such, care services that control multiple facets of an aged client's life, may be seen as a further threat to an older person's already diminished independence. The measurement of QOL appears to be highly dependent on how one perceives their physical wellbeing, based on their attitude, their contextual understanding of the situation and their ability to adapt.

According to CVI staff and managers, good hearing and vision generally indicated that an older person had a high level of physical and social functioning – they were usually healthy and able to engage with others on a personal level. Conversely, poor eyesight and hearing were seen as detrimental to an older person's ability to participate in society or conduct everyday tasks. Low sensory functioning was viewed as a multi-dimensional issue – *Independence would be affected in every aspect of life… driving, preparing meals, shopping, cleaning, personal care, socialising, watching TV or movies, eating, safety and using technology* (Anne).

> *Not to be able to read, not to be able to see, I think it's worse than being in a wheelchair* (Jane Davies).

It was apparent that mental wellbeing was thought to be related to objective indicators of QOL. These included one's physical wellbeing and the nature of their social contact – *Once again, it all depends on how fit they are and mobile… coming here (the CVI Day Centre) is good, it's good therapy for everybody. It gets you out. You mix with people* (Margo). Key informant Eddie agreed that physical activity could negate mental decline and help individuals cope with potential threats to their physical wellbeing. Margo also opined that if an individual had *a good state of mind, then they can cope with everything*. This was further supported by manager Fay, who stated that older people *who remain mentally alert and engaged would tend to retain a better QOL*.

New and alternative QOL indicators

The importance of subjective dimensions of QOL and the interrelationship that exists between objective and subjective QOL indicators was widely discussed above. It appeared however, that the current QOL indicator applied by CVI was restricted to measuring only objective indicators of QOL. The Referral and Assessment Form was a standardised document and the provision for clients to engage with it in the form of open-ended, subjective responses was minimal. Initially, in this study, it was argued that the Form should retain its original objective indicators as these four fundamental categories were identified as important dimensions of QOL in both the primary and secondary data.

However, following an analysis of existing QOL paradigms and QOL indicators it was also determined that the Referral and Assessment Form could be expanded to include new or alternative objective and subjective indicators of QOL, as well as a qualitative component. By incorporating a subjective dimension into the referral and assessment form, the QOL indicator would become more individualised, taking into account the heterogeneity of older people and their QOL requirements. It was suggested the Referral and Assessment Form could adopt methods used in the individualised QOL frameworks, [3] the wellness approach (Danni), and the subjective concept of reminiscence. [12, 1]

Australian policy and services in an ageing society

Based on primary and secondary data collated in this study, it is argued that the world-wide phenomenon of an ageing society is likely to have implications for Australian service delivery and for society in general. The input of policy-makers and service providers was believed to be essential in maintaining the QOL of older people. Most respondents believed that government inaction would adversely affect all sectors of society. It was widely argued that social engagement through services such as centre-based care and community-based activities would remain essential objective dimensions for the QOL of older people. However, a decline in social expenditure, a combination of growing demand and a lack of human service workers was thought to have negative implications for the future QOL of older people. Overall, financial issues and budget constraints were predicted to be potential causes for a decline in the QOL of older people and restrictive of the necessary development of the aged care industry in Australia.

It was widely believed by many particpants, that QOL would diminish as a result of inadequacies in government policy and service delivery. The data indicated that presenting the aged sector as a lucrative industry would counteract poor recruitment rates and therefore ensure that Quality of Care (QOC) would not diminish and QOL amongst older people would be maintained or improved. It was suggested in the data, that due to the rising costs of living in an ageing society, Australians should initiate financial planning in their youth rather than electing to rely on a government aged-pension, insufficient for the future QOL needs of older people.

Conclusion

This study explored the concept of QOL amongst older people from the perspective of a small cohort of Australians. It focused upon three main facets. The first was a review of the seminal and current academic literature surrounding the broad areas of gerontology, sociology and QOL paradigms. Evidence from these sources was used to support primary data collected through further qualitative inquiry. Objective indicators related to tangible phenomena in the physical world, such as one's 'physical wellbeing' or 'financial' status. Subjective indicators were intrinsic constructs and strongly related to an individual's perception of the world; these included feelings of 'loss' or affective states like 'depression'.

The second facet of this study was to ascertain how a sample of respondents perceived the concept of QOL. Both objective and subjective indicators of QOL were equally significant to the aged clients and staff who participated. In many cases an older person's QOL was directly influenced by their subjective interpretation of objective events in their lives, rather than their QOL being determined only by their physical environment. The new or alternative QOL indicators identified in the primary and secondary data were used to inform the further development of the Referral and Assessment Form.

The variation of responses made by clients indicated that older people are a vastly heterogeneous group. It was evident from the primary data, that the contextual situations of older people and their subjective personalities were important factors in determining whether aged care interventions would improve or diminish their QOL. A significant theme throughout the primary and secondary data was the importance of individuating care and providing a facility whereby older people have an active role in decision-making, thereby maintaining their overall QOL.

The third facet of the study was concerned with the global phenomenon of a rapidly ageing population. Based on data from the literature review and qualitative inquiry, it was found that a rapidly ageing society had implications for the future QOL of older Australians. These included various societal changes relating to aged care service delivery practices and social policy development and implementation. As evidenced in the primary and secondary data, it was argued that governments, academics and policy-makers could employ several strategies aimed primarily at reducing the potential and significant implications that will almost certainly accompany Australia's rapidly ageing population. [1]

Acknowledgement

The authors wish to thank the staff and clients from CVI (Community Vision) for their cooperation and honest input and for approving this research.

Competing interests

The authors declare that they have no competing interests.

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RESEARCH ARTICLE

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

GS Han, J Chesters and H Ballis

Abstract

Aims: This is the second of two papers that explore influences on doctor's decision-making about the location of their practice. Part One focused on the positive experiences of rural medical practice as expressed by a cohort of rural general practitioners. This paper, 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, what they like and dislike about rural practice and life.

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, 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 international medical graduates.

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

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

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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] These figures improved to 335 in major cities per 100,000 population; 181 in inner regional areas and 153 in outer regional areas; and 147 in remote/very remote areas, maintaining the urban versus rural discrepancy. [3]

Until recently, the Rural, Remote and Metropolitan Areas (RRMA) system was used to classify the areas of medical practice within Australia. RRMAs 1 and 2 refer to metropolitan cities and centres; RRMA 3 refers to large rural centres with population 25,000–99,000; RRMAs 4-7 refer to small rural and remote centres with population <5,000–24,999. RRMAs 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] [4-12] 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 organisations such as Rural Health Workforce Australia, [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/semi-structured interviews with rural doctors can add to and enhance the value of existing research in this area.

Comprehensive research that contributes to the implementation of an effective recruitment and retention strategy 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. Distances from Melbourne range from 100 to 400 kilometres.

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 30 and 60 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 GPs 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

This paper, Part Two, focuses on the concerns that the doctors have about rural medical practice while the first paper published in issue 4:1 focussed on the positive experiences of rural medical practice as expressed by a cohort of rural general practitioners.

The reasons the doctors do not appreciate working and living in the rural community are centred on two issues; over-work and the lack of resources at their practices and in their communities. Frequent on-call duties and a continuing necessity to over-work due to a shortage of experienced GPs puts them under significant stress. The stress is at times exacerbated by the close personal relationships that occur in many rural contexts. Lack of resources supporting

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

general practice; emergency care; the relative isolation from professional colleagues; and the limited opportunities for continuing medical education afforded by many rural environments, are of concern.

The realities of contemporary general practice involve overseeing practice management, integrating care with other health professionals, gaining accreditation and recruiting fellow doctors and locums. This complex working environment makes the task of establishing and maintaining a rural practice onerous and imposes additional layers of pressure on doctors who were primarily trained to deliver healthcare in the structured setting of a hospital or a fully functioning practice. One doctor explained:

> I'm finding I'm really worn out . . . There are so many things to get done. I'm finding that hard and I'm really tired . . . (Dr E)

The shortage of fully trained, experienced doctors affects the provision of services for patients and puts more pressure on rural GPs. These doctors are frustrated at not being able to offer their patients the care and attention that they believe is optimal:

> It was a very big patient load down at [my past rural practice] and it was quite often, it seemed like seven minutes medicine and that was very frustrating. I didn't get any enjoyment from practising medicine at all while I was there . . . I saw how stressed out they all were and what time at night they got home and I didn't enjoy what I [did there]. (Dr E)

Frequent on-call duty can have a devastating impact on the doctors' professional and personal life. These doctors indicated that the frequent on-call duty is the worst thing in their professional life and it 'puts off rural doctors'. Participants explained that the busy schedules such as one in two roster (on call every second day), nearly 'wreck' their lives and make them 'totally ignore the family':

> Especially if you're doing a one in two roster you're fully booked a week before the date. And then all of the daily ones want to get booked in as well and somebody needs a long consult. You can be really stuffed. (Dr H)

> It's the GPs that have to get out at night and that's what ruins it. (Dr I)

Small rural settings often promote the establishment of close social ties between patients and doctors. While this closeness can have many benefits, it also makes it difficult for the rural doctor to draw a line between their personal and professional life. It is not uncommon, for example, for rural community members to seek to consult their doctors in the supermarket or the street:

> The biggest difficulty…has been the making boundaries about how much responsibility for people's health I'm willing to take because there is constant pressure to see more people. (Dr L)

> Yeh, that gets a real pain . . . It's all a bit much and I'm really weighed down and someone comes and talks to me in the street about something, then that's really hard. I really feel like running away and hiding, so that no one can corner you and talk to you about work when you're having some time off. (Dr E)

> Living in a small community has been both a difficulty and a privilege. All the things that people classically talk about have been an issue for me. There's the sense of privacy. I'm a prominent person in the community, everybody knows who I am and my wife's had to live with that which she doesn't like, she is a fairly private person. I can end up on the golf course and people have always got a smart comment to make about the fact that I am there and sometimes I just don't feel like that. (Dr L)

The doctors in this study enjoyed and appreciated the close relationships or friendships with patients, however by virtue of these close social links the doctors say they also experience emotional distress when their patients suffer serious ill health or die:

> Sometimes in the country, your patients are your friends . . . everyday we agonise when a friend of ours is sick and usually very sick and it hurts us. (Dr G)

The lack of resources or access to a hospital and the sense of professional isolation [23] are a source of distress, particularly when coupled with the pressures of ensuring the practice is financially viable. Their procedural practice, which they said is a key reason for them to stay in the country, is also limited if there is not a hospital in their town. Patients cannot see some specialists for up to three months due to workforce shortages and the lack of hospital support. Additional frustration is generated when rural doctors cannot find emergency accommodation at a nearby hospital and by the lack of services for acute psychiatric emergencies. One participant mentioned that some doctors without a hospital in their town dropped out of obstetrics because of the worry about needing to conduct a caesarean section without a hospital close-by.

Most of the doctors interviewed referred to the socio-economic environment in which they practised as health practitioners as a 'rural downturn' that has had an adverse effect on their provision of services and impacts on their financial viability:

> Both those little towns have suffered by this economic rationalist thing . . . they were in danger of losing their banking services, their milk factory has just closed and fifty jobs have gone. Fifty jobs in a small town is a lot of pay packets. (Dr B)

The lower socio-economic status of rural communities means that a significant number of the patients in rural towns cannot afford to consult their doctors, and this affects the finances of rural practices and their capacity to employ appropriate staff numbers to service the health needs of the community:

> If we didn't bulk-bill most of our patients we couldn't survive here. (Dr G)
>
> Particularly in a poor community like [mine] where many, [the] majority of the patients are bulk billed ... So I think money comes into it to an extent. In my case because I'm married to a farmer . . . we have our other income it wouldn't be as critical as if you were the solo, the sole bread winner for the family and you were relying on your income to do everything. (Dr C)

The interviewees acknowledged that a broad range of health practitioners can better service the health needs of a rural population. However, the reality of the situation is that rural communities often are without or geographically removed from hospital services, mental health nurses, psychiatrists, other specialists and allied health professionals. The study participants also found it difficult to attract GP registrars or locums. Professional isolation or working in isolation with little interaction is a concern for these doctors and a potential barrier to workforce reform.

A critical finding from this study is that the doctors' own health is affected by busy routines and the multiple pressures they have to manage. The study revealed that they simply do not have the time to consult another doctor. Some reported that when they did manage to arrange a time to consult a doctor their condition had become more serious. One doctor explained:

> I had a pretty severe depression last year and the year before, especially after doing the one in two roster [on calls]. I just wasn't coping at all and so I ended up going to see someone. (Dr H)

A television report in 2001 highlighted an alarming number of medical practitioners without their own doctors and noted the potential dangers for the practitioners and their patients. Anecdotal evidence suggests that less than 50 percent of doctors in New South Wales and Victoria had their own doctors. The television report made reference to a country doctor in a sole-person practice who 'Was on call 24-hours a day, and attended his patients while being addicted to narcotics'. [18]

It is an irony that notwithstanding the challenges of a practice and the demands from their patients and the community generally, it is these same elements that attracted the doctors to live and work in rural communities and makes their work worthwhile and rewarding.

The complexity of their jobs entailing medical care and close involvement in the community demands a significant amount of time and personal emotional investment. Not surprisingly one of the consequences for rural doctors is to suffer occupational 'burn out' or to transfer their tension to their own families. [23] A surprising finding of the interviews is that most doctors reported experiencing 'burn out' or feeling that the demands of rural practice were 'soul destroying'. The following excerpt from one of the interviews highlights the tensions experienced by rural doctors:

> Well, the biggest difficulty . . . has been making boundaries about how much responsibility for people's health I'm willing to take because there is constant pressure to see more people. To see them for longer at the expense of myself and my family and so I got to the stage about seven years ago. I got quite burnt out because the emotional burden of the clinical medicine that I was dealing with left me in the evenings not wanting to talk to anybody, not wanting to relate and so I was poor company for my family. That tended to make me depressed and bad tempered. To counter that I have had to say no and often it's no, because when someone comes for a clinical encounter they might come for something for them at that time is seemingly very important, they've got a two years old sick child. That to me is very important. . . . Encountered by say, I'm at the end of a busy day, I've had it and I get asked to do this bit of extra work. If I say yes, then that deals with the clinical issue for that mother and child but it costs me emotionally in terms of how I'm going to be with my family that night. Now it's okay to take that cost occasionally but when it happens all the time, it is destructive. In the end brought me to the point well, if I continue like this I'm not going to continue

> working. It's also, I strongly believe that the biggest place in my life where I make the biggest difference to anybody is for my immediate family for my children and my wife and I think it's a tragedy when professionals' work significantly compromises what they offer to their family. So I have over the last four years made considerable restrictions on my exposure to clinical medicine so that now I only work one session a day. (Dr L)

The challenge for rural doctors is to maintain a healthy work and personal life balance as they try to cope with the constant demands on their professional skills. However, the reality is that for isolated rural doctors, the demands of professional life forces them to slip back to a less balanced life. One of the respondents explained that with the children grown up and not living at home, the work life balance got worse rather than better:

> We don't have children at home any more and we work ridiculous hours now . . . I have to do something about it. Because it's got out of hand. I used to work until 4.00 pm, now I work until 7.00 pm or 8.00 pm it's ridiculous, what am I doing this for? (Dr D)

These rural doctors acknowledge that they carry disproportionate workloads. Most responded to the demands of their work through a process of adapting to their circumstances and have attempted to adjust their programs to make provision for their own lives. They are also aware that the community is becoming sensitised to the problems their doctors face. They acknowledged and welcomed the support they receive from the community. For example, when one doctor's family members fell ill and the doctor could provide only urgent services, the community members were highly supportive of the doctor and her family. Such a response from the community also provides the doctors with a real sense of support and wellbeing:

> They were nothing but supportive . . . That's really nice that 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. (Dr C)

Concluding remarks and policy implications

Admitting students from rural backgrounds to medical school and early exposure to rural medical practice [24] are necessary steps to increase the number of GPs in the country. However, this study notes that the continued erosion of benefits and life facilities in rural areas in favour of the economy of scale or metropolitan settings may reach a point where even those medical practitioners from rural places may choose not to practice in rural communities. While governments have moved to increase medical school places and the number of rural medical schools, the training and support of students will come down to the doctors like the ones who participated in this study. These doctors, burdened as they already are may find the added burden of being responsible for rural medical education too much for them.

It is vitally important to provide rural populations with adequate health services. Rural communities that are able to recruit and retain well-integrated GPs, benefit in many other non-medical areas including finding additional participants for the school council, local sports club, and other community-based organisations.

Doctor isolation is ubiquitous to rural practice. Adequate financial reward is an important factor for recruitment and retaining doctors to rural towns, but is not sufficient. Appropriate continuing education within their rural communities or close-by is strongly recommended. This has become more possible with the Australian Government's initiatives to establish Rural Clinical Schools, University Departments of Rural Health, the Primary Health Care Research, Evaluation and Development Strategy and the changes to rural service payments and referral options. These important rural programs enable doctors, and the other health professionals they are being encouraged to work with, to develop inter-professional practice, research, and evaluation and teaching skills. Doctors are now encouraged to gain teaching qualifications and to consider enrolling in research degrees. However as we have already mentioned, these important extensions to rural general practice may just add to the significant pressures that are already causing concern to many rural doctors. Due to the time-lag between policy change and fully trained GPs setting up practice, it is likely to be another ten years before the pressure on the experienced rural medical workforce is lessened by the arrival of fully qualified Australian trained doctors.

This study indicates that there should be some short term policy changes to support the existing excellent Australian trained rural general GPs. Support and commitment to rural doctors' professional development, health and welfare, can be fruitful for practitioners and their families as well as rural communities. [23] These policies may enable rural GPs to have their own family doctors, develop additional access to effective information technology, such as various conferencing packages and links between general practice and pathology and imaging services. More general practice training opportunities for advanced year medical students and more registrar places would also assist in reducing the workload of the experienced GP. An increase in the number of nurse practitioners and perhaps physician's assistants would also help, as would better support for enhanced inter-professional practice and chronic disease self management programs.

The degree to which rural medicine retains its levels of procedural skills will have both a positive and negative impact on recruitment and retention. The doctors in this study generally wanted to continue to do procedures. However, several of the doctors mentioned that they had noticed that many would-be applicants to work in their practices, were reluctant to enter an environment where procedural and emergency skills were essential. One doctor also mentioned a distinct gender divide with female doctors who were more reluctant to take on procedural posts. If this gender divide is a real pattern then this does not bode well as we move towards a more feminised medical workforce.

Although our findings are based on a relatively small number of rural doctors, we conducted in-depth interviews and were able to explore their experiences and the meanings they attribute to them. This enabled us to gain valuable understandings which will increase knowledge in this important research topic. However, we are unable to generalise our findings to other doctors and practitioners.

The constant struggle for rural doctors is to maintain and run viable medical services both professionally and financially in the context of rural economic downturn. The experiences of rural doctors outlined in this study are not confined to one type of rural community but are typical of many. In this respect the challenge is not limited simply to attracting doctors into rural locations but involves developing strategies to deal with the broader determinants of rural health in an era of climate change, oil shortages and other socio-economic, environmental and other global and regional change. [25]

Acknowledgement

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

Competing interests

The authors declare that they have no competing interests.

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Q & As

Having recently undertaken ACHSE Fellowship, what do you see as the key value of this program? The development and implementation of competency -based credentialing for health managers on competencies secured through education and training and those demonstrated in practice is gaining momentum. What are your views?

We start this section of the Journal with the contribution from Dr Alison Dwyer, who in her enthusiasm for completing the Fellowship process submitted an article prior to a decision being taken on what the Q&As might address in this issue. In fact, this contribution decided that Q&As would focus on the Fellowship process and all recent candidates were invited to contribute.

1 Learning from other health professionals: why medical managers should undertake ACHSE Fellowship.

Abstract

Medical managers within the Australian healthcare system have a dedicated professional college, the Royal Australasian College of Medical Administrators (RACMA), with core requirements for continuing professional development (CPD). Anecdotally, some medical managers may query 'how involved' they should become within the Australian College of Health Service Executives (ACHSE), and 'What is in it for me?' Upon completion of the ACHSE Fellowship examination in 2009, I felt it essential to share some experiences of the process with my medical manager peers, and hence strongly advocate that all medical managers should undertake the thoroughly stimulating and valuable experience that active involvement with ACHSE can bring, including understanding a broader health context, and learning from differing viewpoints of other health professionals in a multi-disciplinary study environment.

Introduction

As an Associate Fellow of the Australian College of Health Service Executives for the last three years, I have experienced and participated in professional development activities with ACHSE to a fairly limited extent. As a dual Fellow with the Royal Australasian College of Medical Administrators, and a Director of Medical Services, I have been encompassed professionally and occupationally in all that is medical management. It has been in this context that I (and a lot of my medical manager peers) have often waxed lyrical regarding how 'involved' should we become with ACHSE, knowing the CPD already required for RACMA and mandatory Medical Practitioners Board recertification as of July 2010.

As such this year I threw down the personal challenge to really try to get to know ACHSE and all that it can offer, and I felt what better way than undertaking the ACHSE Fellowship exam. Upon successful completion in August this year, and on personal reflection, I felt it essential to share some experiences of the process with my medical manager peers, and hence strongly advocate that all medical managers should undertake the thoroughly stimulating and valuable experience that active involvement with ACHSE can bring.

Background to ACHSE Fellowship process

For those medical managers who are not familiar with the ACHSE Fellowship process, the summary below briefly outlines the key eligibility criteria, options for pathways, and core content for the Fellowship process.

The current eligibility requirements prior to consideration for Fellowship include a total score of 30 points, through a range of the following:

- Minimum of three years of membership of ACHSE, earning five points (or minimum one years membership of ACHSE and two years membership of a professional body relevant to health management). Greater than five years ACHSE membership earns ten points.

- Demonstration of CPD within the health industry over the past three years, including at least one year in the ACHSE professional development program (three years, five points; > five years, ten points).
- Completion of an accredited or approved degree, diploma or post-graduation qualification in health services management, such as MBA, MHA, MHSM, earns ten points.
- Currently working in a health management role (> one year five points, > three years, ten points).
- Evidence of contribution to the health sector by publication in relevant journals, ACHS surveyor etc (ten points).

Once eligible, there are two pathways to Fellowship:

- Major oral exam (between one hour and 75 minutes);
- Minor thesis pathway with minor oral exam (30 minutes).

Major oral examination

Most Fellowship candidates undertake the Major oral exam pathway. The examination involves demonstration of the following:

- Broad knowledge of the structure, trends and current issues in the Australian health sector;
- Understanding of leadership and management theories to the health sector and evidence of skillful application of these theories;
- Ability to assess and contrast major national and international health policy and management trends and the relative merits of various approaches to advancing the health of populations;
- Evidence of ethical practices; and
- Capacity to assess complex situations and apply problem-solving techniques.

A recommended reading list is provided by the College, but also includes an understanding of current state and national health policy changes, as well as key developments in contemporary literature. The subject areas expected include:

- Healthcare systems/policy;
- Health services organisation;
- Strategic planning/management/leadership;
- Human Resources and organisational change;
- Financial management;
- Law/ethics;
- Information Management;
- Quality/risk management/corporate governance;
- State, national and international contexts of health policy and outcomes;
- Contemporary major issues;
- Indigenous health management; and
- Research and evaluation.

Minor thesis pathway

The Minor thesis pathway involves submission of a piece of research work (as for a Masters or PhD) or several published papers in relevant journals. The Fellowship committee then assesses the thesis or published papers for relevance, originality and substantial contribution to the profession of health services management. Research papers require appropriate referencing, rigour of research design and methodology and a high standard of analysis and interpretation of findings.

The Minor oral examination has a modified reading list and core requirements, however still expects a demonstration of a broad range of knowledge and relevant application to contemporary health issues. ACHSE has recently reviewed the Minor thesis pathway process for 2010, with a revised reading list and clear guidelines on the process.

Experience of study groups and content for exam

ACHSE Victorian Branch is very proactive in supporting the Fellowship candidates throughout the examination process. Major oral examination candidates are strongly encouraged to participate in a monthly study group, coordinated by a senior ACHSE Fellow. The Minor exam candidates are invited to attend all study groups, and are involved on the email distribution list, however it is not considered essential as for the Major exam candidates.

The Victorian study group was well-structured, commencing monthly meetings in February 2009, with a monthly format of topics to cover by candidates. Each candidate was given a 'task' per month, including allocation of parts of the reading list to summarise and present to the group at the face-to-face tutorials. Closer to the exams, the study group also allocated past exam questions for each member to complete and share amongst the group.

The focus of study was more than just content. It was encouraged that for each 'topic' that the candidate would not only cover the relevant literature content, but would consider the contemporary health policy issues/papers/health department directions relating to the topic, and also bring their own personal experience of the relevant topic.

For example, with chronic disease, it was not only encouraged that candidates articulate the current literature on approaches to managing chronic disease, but also be aware of the national policies/approaches to chronic disease (including the National Health Priority Areas), the Victorian Government strategy for chronic disease (such as the Victorian Hospital Admissions Risk Program for Chronic Disease), and how our own organisation may be tackling programs to support patients with chronic disease. In addition, we were expected to reflect on the literature and current practice, and identify areas that we perceived were successful, identify those that we would improve or change, and demonstrate reasons behind our decisions.

The last 12 months has seen a significant shift in the national approach to the ethos of healthcare, with the changing of a Liberal to a Labor Government and the questioning of the fundamental structure and governance of our health system. Key work by the National Health and Hospitals Reform Commission (NHHRC), with the revolution of the Australian Healthcare Agreements as a result of the Commission's *Beyond the Blame Game* report and the Commission's final report *A Healthier Future for All Australians – June 2009,* were essential Fellowship reading. In addition, key Inquiry findings including the *Final Report of the Special Commission of Inquiry into Acute Care Services in New South Wales Public Hospitals* conducted by Peter Garling, provide health service managers with a wealth of literature on the current challenges and options for the future. Such contemporary issues were essential to grasp for the Fellowship exam.

The exam day

As with every examination, the examination day often arrives more quickly than anticipated. For my Minor oral exam, I was presented to a panel of senior, very experienced health managers who provided an introduction to the exam, themselves and their experience. I was then given the opportunity in five minutes to provide background on my career/contributions to health management to date. In addition, I was also required to articulate the core aims and outcomes of my thesis, and how my work contributed to the overall health management research literature.

The examination was purely oral, with each examiner asking specific, targeted questions on the topics outlined above. Depending on the topic, the examiner might allow you to discuss your response without interruption; however some might interject, questioning further and exploring your statements in depth. Five broad areas were covered over the 45 minutes of the examination process, across a wide spectrum of health topics, challenging my broad understanding, but also targeting specific areas of my knowledge, experience, and my own recommendations on addressing certain issues. At the conclusion, I felt intellectually challenged, exhausted but rejuvenated in the stimulating, sometimes animated discussions I had with my panel members over the key issues facing Australian healthcare.

Reflections on the Fellowship experiences and value for medical managers

On reflection, not only am I personally proud of successfully completing the Fellowship examination, but feel that I have become a better health and medical manager for the experience. I am acutely aware of the broader health contexts that impact on my day-to-day medical management practice, and more confident to bring literature and evidence-base into my practice. Although the RACMA examination provided an equivalent stimulation and growth of my evidence-based medical management practice, the ACHSE Fellowship process has opened my eyes wider to learning from other health professions, not just medicine. The study group brought together medical, allied health, nursing professionals as well as non-clinical health managers, all with differing opinions and views on the same issue. In addition, through reflecting on my own areas of research interest, I can see opportunities for collaboration and synergies with non-medical health research in the future as well.

In summary, I feel that not only have I achieved my goal of Fellowship for ACHSE, completed by CPD requirements for mandatory medical board registration, but also enhanced my own everyday practice in medical management through the experience. And for that, I can't recommend the Fellowship exam, and CPD in general, highly enough to those fellow RACMAs out there; not just because it is mandatory, nor for the specific content that is covered, but for the viewpoints, experiences and learning that arises from being in a truly multi-disciplinary, cross-professional environment with fellow health management peers.

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2 'As we speed along this endless road to the destination called "who we hope to be", I can't help but whine, "Are we there yet?"[1]

There's a sizeable cult of followers who will agree the fictional Carrie Bradshaw's ramblings are entertaining, but every now and again you have to admit that she also offers a poignant observation that you can't help but ponder how it relates to your own journey.

Ah, the *journey*. Health managers love a good journey. Mostly we're seeking, or at least love to talk about, the nirvana that is the patient-centric, patient-journey – if only Don Watson[2] could hear us now. But once in a while you have to consider your own road trip, don't you? Where are we going; in fact, where is the profession of health service management going; and indeed, are we there yet?

One look at my over-zealous, youthful enthusiasm (laced with a generous splash of determination and endurance) will tell you that, personally, I'm far from 'there'. But having chaired the Emerging Health Managers group in Victoria for two years, it's a question I repeatedly found others around me trying to answer; how do you know when you've emerged? Invariably, people seem to conclude that you're always emerging and developing in some way.

Back to the road trip analogy. There we all are – health service managers – sitting on our big, blue Ventura bus with a retro-style destination roll reading: professionalism. On our epic road trip we'll need to stop and pick up some essential odds-n-ends that will equip us to perform at out best. If you're going to the Great Barrier Reef, you'll need a snorkel and some 30+. So if you want to be a health manager, what do you need to acquire along the way? Are there competencies that we must acquire? Or is the 'health management is an art, not a science' argument still relevant today?

In addressing this question, David Briggs suggests that:

> If it is appropriate for health professionals who deliver care to be registered, licensed and required to evidence continuing professional development, then the same circumstance should be applied to those entrusted with the management of those health professionals and the resources consumed by the health system. This suggests minimum standards of health management education, structured health system experience and continuing professional development.[3]

There are many that would jeer at Briggs' intimation that registration is warranted. We could assume the jeering folk are the old 'back in my day' set, and therefore immediately disregard the notion, but perhaps on this one they have a point in suggesting that the idea of registration is self-indulgent twaddle.

The argument of registration aside, I applaud Briggs for suggesting that a minimum standard is required. There's no doubt that to meet the challenges facing health systems of the future, we will need effective, high performing managers leading and embedding the reforms currently in debate.

To conjure up these brilliant managers, Briggs indicates the need for a trilogy: education; experience; and continuous professional development (more applauding). But we must remember that the elements in this trilogy are only vehicles, which enable you to acquire the necessary competencies.

Another vehicle, arguably an essential one, is Fellowship. I'd like to throw down the gauntlet (picture Homer Simpson[4] brandishing a glove) and suggest that all senior managers in the sector should complete the Fellowship. In my mind, it is an essential process that reminds us how we fit into the bigger picture. We're not just managing organisations; we're cultivating parts of a critical system. The Fellowship challenges us to question why we're doing something, or why the health system is working this way.

So, as we merrily continue down the road to 'who we hope to be', surely we need to define the list of things we need to collect on our little treasure hunt? I reckon the list of competencies is a good place to start and it's a tool we should be religiously referring back to.

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[1] 'Carrie Bradshaw', fictional character in the HBO series: *Sex in the City*. Quote taken from Season 4 / Episode *Coulda, Shoulda, Woulda.*

[2] Watson D. *Death Sentence: The Decay of Public Language*. Alfred A Knopf; 2003 and *Watson's Dictionary of Weasal Words, Contemporary Clichés, Cant & Management Jargon*. Random House; 2004.

[3] Briggs, D. *SHAPE Declaration on the Organisation and Management of Health Services: a call for informed public debate*. Asia Pacific Journal of Health Management. Asia Pac J Health Manag. 2008; 3: 2, p. 10-13.

[4] 'Homer Simpson', fictional character in FOX Broadcasting Company's animated sitcom: *The Simpsons*

3 Why did I sit the Fellowship exam, especially given that I failed it 20 years ago (albeit a very different process), have just retired from full-time work and had $200 worth of business cards printed saying that I am an Associate Fellow? It's far too late to pretend that this will help me take further steps up the career ladder and the study requires a lot of reading and effort to remember key facts.

If, for you, retirement means retirement, then have a rest. But, if you think health services management is a profession, then when do you stop being a member of the profession and when do you decide it is time to stop learning?

A good reason for pursuing the Fellowship at any stage of your career is that it provides a reason to catch up on all that professional reading that sits in piles or is moved, unread, from office to home and back. If retirement gives you more time to read and think, you have both the reason and the opportunity. Another is that you might actually enjoy meeting colleagues in your study groups to discuss contemporary issues and management in healthcare. You might be exposed to a lot of important information that your relatively narrow and busy work life does not allow you to explore.

The more senior your role, the more important it is to understand the broad context within which your organisation and your role sit and be able to contribute to the debate about policy, priorities and politics. You will be looked to by your coworkers and others for advice and views about the place of your organisation in the wider healthcare environment and your views are likely to be given great weight. In your senior and busy (pre-retirement) years, that is a powerful reason to explore in some detail the current management and healthcare issues in the Fellowship reading list.

Your ability to give yourself a 'very high' assessment for many of the questions in the ACHSE Management Competency Self-Assessment Questionnaire will be considerably enhanced.

Undertaking the Fellowship late in your career will, in a small way, provide an opportunity for you to give something back to the profession by contributing your experience and historical perspective to the discussion in your study group. (You need to seek independent advice about whether the older candidates droned on and on in 2009.)

Finally, there are some privileges that go with being a Fellow and, if it is important to you to develop your network of contacts while still in a busy role, or after leaving full-time work, the Fellowship is a very effective way of doing so.

And, returning to the ACHSE competencies, should they, or some outcome of an educational program, be a prerequisite to appointment in a senior health services management role? I'm sure we all know of some unsuccessful senior appointments and it is tempting to think that a better match with the requirements of the job could have been achieved if the candidate's competencies had been independently and objectively certified. The temptation should be resisted until a much closer correlation can be demonstrated between measured competencies and performance. As we do with psychometric testing, by all means take them into account but don't make certification a prerequisite. The risk of excluding excellent candidates who do not have the certification outweighs the value it would add to the judgement of a carefully chosen selection panel.

And please, spare me the argument that if mandatory competencies are appropriate for clinicians, there should be a set of mandatory competencies for people who manage the clinicians and other resources. There are several special reasons why clinicians must demonstrate their competencies but principal among them is that the community gives them a very high degree of autonomy – or allows them a low level of daily supervision and accountability – in deciding diagnoses and ordering therapies that are always accompanied by some risks. Managers can make mistakes with far reaching and serious consequences but, with appropriate supervision and accountability, there is little likelihood that their daily activities will lead directly to tragedy.

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Key values: knowledge and friendship

The ACHSE Fellowship program provides candidates with more than sound knowledge and an in-depth appreciation of the healthcare system. The learning set environment coupled with contemporary text books and journal papers sets the scene for lively debate, rich discussion and collegial relationships. In completing various chapter summaries and discussion questions, candidates warmed to the notion of a major oral exam as a result of continued support by their peers and coordinators. Value was derived, not only in the course material, but from the journey traveled in becoming a Fellow.

Competency-based credentialing for a health manager is imperative. For years our clinical colleagues have driven continuous professional development and competency-based practice and as we stand before them it would be arrogant to think that health managers should not have to do the same. Management theory continues to change. A few examples include the movement from transactional leadership to transformational leadership, we lead systems-based thinking and champion change, much of which would have been serendipitous had it not been for continued life-long learning. University education, private study, learning sets, action learning and research supported by an organisational or collegial learning culture are rich methods of personal development. A competency framework assists emerging managers to navigate their way and find purposeful professional and personal development. Continued efforts towards implementing a management competency must persist in order to enhance the skill set of managers within the health system.

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Having just completed the ACHSE Fellowship, it is good to now reflect on the value of the program. The amount of change that continues to happen at the national level, including the release of the National Health and Hospitals Reform Commission report *A Healthier Future for all Australians* the week before the exam, meant the amount of current information available for consideration was challenging. The Fellowship provided an opportunity for considering all the potential changes such as the release of the *National Primary Care Strategy*, and the *National and State Mental Health Strategy* from a conceptual framework gleaned from the reading material. There were opportunities for robust discussions with contemporaries who contributed valuable insights based on their backgrounds through our study group. The looming Fellowship exam provided a focus to do a more in-depth analysis on current issues. Because of the breadth of information required for the exam, the Fellowship also provided the incentive to focus on areas that were normally outside our current areas of expertise or work area. The Fellowship provided the incentive and opportunity to look at the health system as a whole, really considering how it does or could be redeveloped. For Victorians in particular, considering the implications of the national agenda on the Victorian system is a task most health managers have on their to-do list.

In considering the second part of the question regarding the development and implementation of competency-based credentialing for health managers, we need to consider what is happening on a national and state-wide basis.

The purpose of the newly formed National Registration and Accreditation Scheme for Health Professions is to ensure only appropriately qualified people are allowed to practice. Some of the professions have an ongoing requirement for professional development. In Victoria, there is a state-wide policy regarding the credentialing and scope of practice for doctors in rural hospitals where doctors are credentialed to ensure they are still safe to practice. The Victorian Healthcare Association (VHA) is the auspicing body for a Clinical Governance Working Group, which has been working on a range of policies, tools and papers in relation to clinical governance for the community health sector (www.vha.org.au). One of the first items on the work plan was to develop policies and a background paper on credentialing and scope of practice for staff working in community health services. With such a focus on ensuring staff of health services are credentialed and competent to practice, there must be a program in place to ensure that health managers are also credentialed and competent through credentialing activities and or education and training. Undertaking the ACHSE Fellowship program is one way managers can participate in ongoing education and a (future) credentialing activity.

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Nellie Tang

In this issue of the Asia Pacific Journal of Health Management, we bring you an interview with Mrs Nellie Tang, Chief Executive Officer and Chief Academic Officer of the Parkway College of Nursing and Allied Health Pty Ltd in Singapore, which she established in 2008. As CEO and CAO, she is responsible for the operations, management, financial growth and academic quality of the College.

Prior to this appointment, Nellie was the General Manager for nine years of Mount Elizabeth Hospital (MEH) in Singapore, a premier tertiary hospital. In 2007 her position was re-designated as CEO.

Her career in healthcare began as a nurse and she has moved up the ladder to hospital management. Nellie has been at MEH for over 26 years and served as a consultant for Parkway Group Healthcare (PGH) hospitals in the region until 2006. She oversees the Management Corporation Strata Title 1692 (MCST) as managing agent and serves as secretary to MCST for Mount Elizabeth Medical Centre.

Nellie has worked on business strategies and growth to enhance Mount Elizabeth Hospital into a medical hub in line with national interests. Her role involves recruitment of new doctors. She has led MEH to achieve many awards and many firsts in healthcare technology. For example, MEH was the first in Asia to install a fully functional Endo-suite with voice command systems and robotics.

Nellie holds a Master of Science in Healthcare Management from the University of Wales, United Kingdom, a Diploma in Business Efficiency and Productivity as well as Nursing and Specialty certificates from the Singapore General Hospital.

She was Chairman of the Singapore Private Hospital Group for one term, and has also had roles as secretary and member. Projecting visionary perceptions of nursing, Nellie has undertaken an action research method project on nursing services. In 1999 she wrote a PGH Nursing white paper 'Nursing Services 21'.

Nellie Tang

In addition, Nellie has served on the Professional Board and Healthcare Education Advisory Committee. She was a member of the Professional Standards and Accreditation Committee of the Singapore Nurses Association for a two year term from 1998 to 2000. In 2007 she was appointed to the Singapore Workforce Development Agency (WDA) Healthcare Industry Skills and Training Council. She has been a member of the Singapore Nursing Board (SNB) since 1999. She was the first nurse to be appointed as Chairman of the Singapore Nursing Board by the Ministry of Health. (Historically the Chairman of SNB is always the Director of Medical Services.) She also sits on the Healthcare Training Advisory Committee of the Institute of Technical Education and has done so since 1999.

We asked Nellie a few questions about her career in health management and the challenges that such a role brings.

1. What made you venture into health management?

I began my career as a nurse, and during this time, I had the opportunity to experience hospital management and work closely with senior managers, such as CEOs. I was thus inspired to move into management, as I felt that I would be able to contribute more to the organisation in a managerial role. I actively sought to upgrade my skills, and obtained a Masters degree in Healthcare Management. I was appointed General Manager of Mount Elizabeth Hospital in 1999, and was re-designated as CEO of the hospital in 2007.

In 2008, I was appointed CEO of the Parkway College of Nursing and Allied Health. As the head of a premier healthcare educational institution, this role gives me the opportunity to build an educational business from scratch, and provides me with an avenue to pass on operational skills and knowledge in healthcare management to the next generation; healthcare management is an area of healthcare education that has previously been lacking.

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

As the CEO of Parkway College, I am always thrilled when our students, whether they are nurses, allied health professionals or healthcare managers, graduate and enter the healthcare industry as full-fledged professionals. I feel honoured and glad to have been able to play a part in their professional development, and to grow their knowledge and skills. Through our students, I am able to play an active part as an educator in developing a skilled labour force for Singapore's healthcare industry.

3. What are the greatest challenges facing health managers in Singapore?

Currently, healthcare institutions in Singapore are facing a shortage of nurses, healthcare professionals and hospital administrators. The problem will only get worse as the demand for healthcare rises due to the ageing population, and as new hospitals like Jurong General Hospital, Khoo Teck Puat Hospital and Parkway's new hospital at Novena open in the coming years. Hospitals require a great deal of operational and management expertise to be able to run efficiently and I worry that there will be a shortage of trained healthcare professionals in the future. To this end, Parkway College is doing its best to alleviate this problem by producing highly skilled professionals who will be able to contribute to Singapore's healthcare institutions.

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

I would like to see more people in Singapore venture into the field of healthcare management. With all the new healthcare institutions emerging, Singapore will need a pool of skilled healthcare managers to operate them. Perhaps the profile of healthcare management as a discipline can be raised, so that more people are aware of the opportunities that are available in this field.

Also, some people worry that there is little prospect for career advancement in nursing. However, as my personal experience has shown, nurses who work hard and are interested in moving into management roles can have the chance to do so. Once they have more experience, nurses can also choose to branch out into other areas and specialties like teaching, clinical research and administration. So there is always the opportunity to further your career in nursing.

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

Being a qualified nurse by training has been a great influence on my career in healthcare. During my career as a nurse, I had the opportunity to interact with patients, their families and doctors. This allowed me to personally share the experience of the patients during their hospital stays. My career as a nurse allowed me to think from my patients' perspective and not just think about the clinical aspects of their care.

Also, as a director of nursing, I had the opportunity to work with senior managers at the hospitals, who inspired me to upgrade my skills and to contribute more to the organisation. This inspiration led me down the road to being actively involved in hospital management and to eventually becoming CEO of Mount Elizabeth Hospital.

6. Where do you see health management heading in Singapore in ten years time?

With the ageing population in Singapore, geriatric care and palliative care will be key areas that health managers will have to focus on in the future. I think healthcare institutions will start paying more heed to these specialties, and will actively seek to train more healthcare professionals in these fields.

Also, I believe that as the Singapore government establishes our global reputation as a medical hub that provides quality healthcare, more medical tourists from around the world will flock here for treatment. As a result, health managers will have to keep in mind the associated issues, such as balancing local and foreign demands for healthcare, cross-cultural issues like language barriers, and competition with other healthcare institutions in the region.

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

Remember that patients always come first, and that their welfare is of paramount importance. Without patients, we would not be managing hospitals.

Enhancing Patient Care – A Practical Guide to Improving Quality and Safety in Hospitals

Reviewed by C Swan

Bibliographic Details:
Wolff A, Taylor S.
Enhancing Patient Care – A Practical Guide to Improving Quality and Safety in Hospitals.
Sydney: MJA Books; 2009.
ISBN 978 0 9775786 5

The subtitle of *Enhancing Patient Care – A Practical Guide to Improving Quality and Safety in Hospitals* suggests its authors intend it for consumption and application by people closely involved in safety and quality in a hospital setting, but there is a lot to suggest that this book is a text for undergraduate and postgraduate courses in healthcare. However, it is also an authoritative reference for the trained safety and quality worker, and it is written by authors who are among the doyens of the discipline in Australia.

Indeed, this text should be in every hospital in Australia. There is no doubt that any hospital or health service that implemented systems and approaches as set out in this work would be a truly exemplary organisation. The book's great strength is the soundness of the tenets expounded, and the thoroughness of the components and steps in building quality, safety and risk management into an organisation's structure and operations. Its principles are firmly founded in theories widely accepted in Australian healthcare; in its authors' own experience; in reference to the academic literature, and in modern applied safety and quality practice.

Moreover, there is ample explanation of organisational theory to accompany the sections on definitions; quality; safety; risk; adverse events; reporting, and clinical governance in general. The problems before us are put clearly into context.

While the authors suggest structures and processes from their own experience – based on the now somewhat legendary Wimmera Group – their suggested models are sound and universal enough to be adaptable to most settings: rural and urban, public and private.

The book is replete with detail, especially on organisation types, and on risk and adverse event management. Processes for gap analysis, surveillance, committee formation and recruitment of personnel to address clinical governance problems, are set out in a staged and progressive pattern. This allows quality and safety staff to plan and implement their approach in an ordered way and without risk of overlooking vital steps. It is hard to think of any aspect of adverse event management, data collection and interpretation and clinical change management that has not been thoroughly covered and expanded. However, it must be said that the more experienced in the field would find this guide far easier to apply than the newer practitioner.

While the introductory chapters enumerate and explain basic definitions and meanings, the opportunity to put them succinctly has been missed. For example, the perspicacious observations that 'Quality…can be defined as ensuring that the right things happen to patients more often' and 'Patient safety can be simply defined as ensuring that the wrong things happen to patients less frequently' should be boldly displayed, in a coloured box and in large type, and not just buried in the text. The writing is dense, with little highlighting of the cardinal points. The ends of the chapters have lists of 'important points', but the lists are far too long to be useful. Brevity is the soul of wit, but there are checklists and other lists that sometimes run to two to three pages in close-typed small font. Much of this dense information could have been succinctly summarised. Much more could have been made of the highlighted, short, sharp and bold 'take-home message'. And there are no less than 370 references! The book does rather have the look of a university text (and it would make a very good one).

Enhancing Patient Care covers virtually every detail required for effective safety and quality and every step from the second one onwards. The first, though – prerequisite executive

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support – does not receive the attention it demands. The book leaves the reader with the question of what to do in a dysfunctional organisation, or even the average one (which might well be the same thing). The section referring to organisational theory and organisational type makes it clear that management, and especially executive, needs to be ideologically and practically committed to safety. The reader is even shown how to measure this commitment, but very little is offered to solve the all-too-frequent problem of the cash-strapped, hard-nosed, politicised and finance-preoccupied CEO and executive that typify so many state-run organisations. Budget and output remain paramount in too many hospitals, with insufficient leadership in safety and quality. Many area and regional health services still don't even have risk management covered, or enough properly trained staff, and in too many, safety and quality are seen as nice ideals and icing on the cake that we could have, if only we had the money. By comparison, uncompliant clinicians are a push-over.

A lot of unsafe hospitals are so, not because the staff do not know the principles and practice of safety and quality, but because senior executive don't place enough emphasis on this area. Too often, they see safety and quality either as a mere ideal or as an added cost, and not as fundamental. Even without antipathy, their passivity or indifference are enough to block Wolff and Taylor's excellent staged processes at the starting gate.

The weakness of the book is that some of its suggestions are idealistic, and really only applicable in progressive, versatile and enlightened organisations. Many of these actions are simplistic, a few even facile. They assume informed, proactive support from local, regional, area and departmental non-clinical executives. The book fails to properly acknowledge or address the heavy politicisation of state-run health with its preoccupation with budgetary and output compliance, and the reality of innumerable CEOs and directors who focus their response on these imperatives.

Enhancing Patient Care will serve the well-informed safety and quality staff in progressive hospitals very well indeed. It will form an excellent bridge between the drier disciplines covered in health management degrees. And it will form a very good reference for any hospital. But it needs to be complemented by a partner work – perhaps written by these same excellent authors. Such a book would be short, with short lists of tips and succinct principles, and numerous real-life examples. Such a book might come with a title like *How to Elevate Safety and Quality to their Rightful Place in Hospitals*.

Reviewed by K Price

In recent years there has been a plethora of inquiries into health services. In the introduction to this text the reader is called to reflect on the fact that these reports are 'salutary, useful reminders to management and clinicians in any health service about what can go wrong in the delivery of health services without adequate and effective clinical governance procedures'.

Applying both local and international research and experience, the Australian authors of this book provide both a conceptual framework for clinical governance, and a practical guide for the implementation of quality and safety systems.

The soft cover text runs to 242 pages, and consists of 12 chapters and two appendices. The forward is by Bruce Barraclough, AO, President of the International Society for Quality in Health Care. The Preface and Introduction acknowledge the authors' perspective, clearly outlining the fact that the clinical governance framework presented in the book is 'Based on relevant theory, evidence, and 19 years of practical experience', with their program at the Wimmera Health Care Group in Horsham, Victoria.

In undertaking this exercise, this reviewer brings a background in General Practice, and an interest, but little formal experience, in hospital-based safety and quality systems. In attempting to develop a broad understanding of clinical governance in the current training rotation to the Patient Safety Centre, Queensland, the reviewer borrowed three books from the library, but made little progress from those readings. However, the Wolff and Taylor book in contrast, presents concepts that are logical, easy to understand and practical to apply. On the whole, it is informative and easily read and has taken this reviewer a great distance in understanding the concepts presented.

The first chapter provides a general overview of the concept of clinical governance – roles, processes and structures, and components of a program.

The following two chapters address the key aspects of clinical governance: quality improvement and risk management. These chapters outline the individual components of each system, ultimately outlining the Wimmera Quality Improvement and Risk Management model.

The subsequent chapters provide significant details about various methods and strategies. They cover such issues as detecting adverse events and risk, analysis and prioritisation of risk, introducing clinical pathways and strategies for change. The final few chapters present the practical application of this information. Utilising step-by-step processes, practical advice, an illustrative case study and useful tools and checklists, the authors provide sufficient structure to implement a clinical risk management program either in a health service, or within a small hospital.

The authors refer to both Australian and international systems, and, whilst providing a thorough review of the literature, the style is not dry and academic. They seek to provide information about components of the quality and safety systems, with practical rationalisations for choices in various contexts. There is open discussion of the limitations of certain methods, and also the means to address these issues. The authors' health service – Wimmera Health Care Group – is used as the significant example throughout each stage of the book. In line with its 'practical' nature, the term 'bottom line' is used frequently to cut to the chase in an issue.

As a medical practitioner of some years standing in Queensland, the reviewer is aware of the relevance of the issue of credentialing and scope of practice in many of the recent publicised adverse events and subsequent inquiries. There is little mention made of this significant component of clinical governance, other than a brief reference in the Chapter One overview. Consequently, it would seem that the framework provided in this text is predicated on the clinical workforce being competent and capable. A practical framework to address this complicated and difficult area of human resource management is perhaps a work still in progress.

The reviewer appreciated the balance of the literature-based structure and the practical and pragmatic perspective presented. The title of this book states its purpose – it is a 'practical guide'. Despite this, there does not appear to be any loss of academic rigour in the presentation of information and advice provided by the authors.

This book is a must for anyone entering the field of medical administration and will prove valuable to those undergoing training.

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LIBRARY BULLETIN

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.

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AGED CARE SERVICES

Aged Care Packages in the Community 2007-08: A Statistical Overview

Australian Institute of Health & Welfare, October 2009

This report provides information on the availability of packages in Australia, the characteristics of outlets providing these packages, the care recipients at 30 June 2008 and the people who started or ceased receiving help during the year.

http://www.aihw.gov.au/publications/index.cfm/title/10750

Pathways through Aged Care Services: A First Look

Australian Institute of Health & Welfare, October 2009

Analysis of care pathways provides information that is useful to both policy planners and service providers alike.

http://www.aihw.gov.au/publications/index.cfm/title/10781

Real Cost of Quality Care and Support

National Care Forum and Counsel + Care, November 2009

For adult long term care and support services, understanding the cost of care and quality is a crucial issue for government, policymakers, providers and the wider ageing population alike.

http://www.counselandcare.org.uk/assets/library/documents/The_real_cost_of_quality_6.11.09.pdf

AUSTRALIAN HEALTH SYSTEM

An Analysis of the 2009-10 State and Territory Health Budgets

Beaton, Angela and Russell, Lesley, Menzies Centre for Health Policy, 2009

http://www.ahpi.health.usyd.edu.au/publications/healthbudgetsaug09.pdf

Does the Commonwealth have Constitutional Power to take Over the Administration of Public Hospitals?

Scully, Sharon

Parliament of Australia, June 2009

http://www.aph.gov.au/Library/pubs/rp/2008-09/09rp36.htm

Health Expenditure Australia 2007-08

Australian Institute of Health & Welfare, September 2009

Health expenditure in Australia in 2007-08 reached $104 billion. As a percentage of GDP it was 9.1%, the same level as in 2006-07. The report describes funding by the Australian and State governments; private health insurance and individuals; compares health expenditures in the different states and territories; and compares Australia's spending with other countries.

http://www.aihw.gov.au/publications/index.cfm/title/10954

A Healthier Future for All Australians: Final Report of the National Health and Hospitals Reform Commission, June 2009

National Health and Hospitals Reform Commission, July 2009

http://www.nhhrc.org.au/internet/nhhrc/publishing.nsf/Content/nhhrc-report

BULLYING AND DISRUPTIVE BEHAVIOURS

Bullying, Incivility and Disruptive Behaviours in the Healthcare Setting: Identification, Impact and Intervention

Felblinger, Dianne M

Frontiers of Health Services Management

Vol 25(4) Summer 2009 pp 13-23

Every organisation has the responsibility to develop processes for managing threatening and intimidating actions.

Teaching Respect at Maimonides Medical Center

Brier, PS

Frontiers of Health Services Management

Vol 25(4) Summer 2009 pp 25-31

Leadership at all levels must foster the teamwork and respect needed to overcome disruptive behaviour.

COMMUNICATIONS AND INFORMATION TECHNOLOGY

The Impact of Health Information Technology on the Quality of Medical and Health Care: A Systematic Review
Jamal Aziz, McKenzie Kirsten and Clark Michele
Health Information Management Journal
Vol 38(3) 2009 pp 26-37
http://www.himaa.org.au/members/journal/HIMJ_38_3_2009/Jamal_et_al_Impact_of_HI_technology.pdf

Nothing but the Truth? A Discussion Paper
UK Audit Commission, November 2009
This paper asks if citizens, along with frontline staff, managers, politicians, central government and local public service regulators, can have confidence in the data they rely on. And if not, what needs to be done about it?
http://www.audit-commission.gov.uk/SiteCollectionDocuments/Downloads/91105nothingbuthetruth.pdf

Use of Information and Communication Technologies to Support Effective Work Practice Innovation in the Health Sector: A Multi-site Study
Westbrook, Johanna I and others
BMC Health Services Research
Vol 9 November 2009
This Australian-based project will assess the factors that allow health service organisations to harness ICT, and the extent to which such systems drive the creation of new sustainable models of service delivery which increase capacity and provide rapid, safe, effective, affordable and sustainable health care.
http://www.biomedcentral.com/1472-6963/9/201/abstract

COMPETENCIES

Health Care Management Competencies: Identifying the GAPs
Lockhart, Wallace and Backman, Allen
Healthcare Management Forum
Vol 22(2) Summer 2009 pp 30-37
Looks at management competencies that are most important at the frontline, middle and senior management ranks, the current perceived competency levels in each of these areas and where are the greatest gaps that should be addressed.

DISASTER PLANNING

Strained by Katrina, a Hospital Faced Deadly Choices
Fink, Sheri
New York Times
August 30, 2009
Dr Anna Pou argues that informed consent is impossible during disasters and that doctors need to be able to evacuate the sickest or most severely injured patients last – along with those who have Do Not Resuscitate orders – an approach that she and her colleagues used as conditions worsened after Katrina.
http://www.nytimes.com/2009/08/30/magazine/30doctors.html?hp

HEALTH FACILITIES PLANNING AND DESIGN

Capital Investment in Health: Case Studies from Europe
Bernd, Rechel and others
WHO on behalf of the European Observatory on Health Systems and Policies, 2009
This book offers policy-makers, planners, architects, financiers and managers practical illustrations of how health services can be translated into capital assets and aims to expand the evidence base on how to improve the long-term sustainability of capital investment.
http://www.euro.who.int/Document/E92798.pdf

Exploring the Impact of the Physical Environment on Patient Outcomes in Ambulatory Care Settings
Gulwadi, GB, Joseph, Ajali and Keller, Amy Beth
HERD Health Environments Research and Design Journal
Vol 2(2) Winter 2009 pp 21-41

Lessons from Evidence-based Medicine: What Healthcare Designers Can Learn from the Medical Field
Viets, Elizabeth
HERD Health Environments Research and Design Journal
Vol 2(2) 2009 pp 73-87

A Multidimensional Framework for Assessing Patient Room Configurations
Pati, D and others
HERD Health Environments Research and Design Journal
Vol 2(2) Winter 2009 pp 88-111
Looks at the patient room and how a performance-centred approach to evidence-based design could be implemented.

Splendid Isolation: The Pros and Cons of Single Occupancy Rooms for the NHS
Policy Plus
Issue No 17, April 2009
Until the 1960's most patients entering NHS hospitals were cared for in 'Nightingale wards'. Since then new builds have experimented with "racetrack" wards and 4 - 6 bedded bays. More recently the case has been made for more single room accommodation in new hospital designs and some argue for the abolition of all shared accommodation.
http://www.kcl.ac.uk/content/1/c6/05/47/76/PolicyIssue171.pdf

Unit-related Factors that Affect Nursing Time with Patients: Spatial Analysis of the Time and Motion Study
Hendrich, Ann and others
HERD Health Environments Research and Design Journal
Vol 2(2) Winter 2009 pp 5-20
Altering the nurse work environment has the potential to influence nurse workload, satisfaction, burnout and retention, as well as patient safety and overall mortality.

HEALTH INSURANCE

What is Medicare Select?
Boxall, Ann-marie
Parliament of Australia Library, Background Note
August 2009
This paper addresses key questions about the Medicare Select proposal by the National Health and Hospitals Reform Commission in order to help explain what is and how it would change the Australian health system if it were implemented.
http://www.aph.gov.au/library/pubs/bn/2009-10/MedicareSelect.htm

HEALTH SERVICES

The Human Factor: How Transforming Healthcare to Involve the Public can Save Money and Save Lives
Bunt, Laura and Harris, Michael
NESTA Discussion Paper
November 2009
This report examines the challenges faced by the National Health Service in UK. It shows how radical new ways of innovating that give genuine power to frontline staff, patients and the public can reduce spending at the same time as increasing health and wellbeing.
http://www.nesta.org.uk/the-human-factor/

INDIGENOUS HEALTH SERVICES

Aboriginal Health Impact Statement and Guidelines
NSW Health Policy Directive 2009_82, November 2009
http://www.health.nsw.gov.au/policies/pd/2007/PD2007_082.html

Health of Indigenous Males Building Capacity, Securing the Future
Australian Medical Association, Indigenous Health Report Card, November 2009
http://www.ama.com.au/system/files/node/5114/AMA+Indigenous+Health+Report+Card+2009.pdf

The Overburden Report: Contracting for Indigenous Health Services
Dwyer, J and others
Flinders University and Cooperative Research Centre for Aboriginal Health
July 2009
The report points to the need for serious reform of funding to Aboriginal Community Controlled Health Services. There is a need for a 'single bucket' of funding for Aboriginal primary health care services and a greater focus on long-term funding cycles, funding flexibility to meet local needs, and a reduction in administrative and transaction cost.
http://som.flinders.edu.au/FUSA/DHM/overburden%20report.pdf

LEADERSHIP

Cultivating Tomorrow's Leaders: Comprehensive Development Strategies to Ensure Continued Success
Squazzo, Jessica D
Healthcare Executive
Vol 24 (6) 2009 pp 8-10, 12, 14-16, 18, 20

The Health Foundation's Position Statement on Effective Leadership Development Interventions: Research Report
Anderson, Lisa and others
September 2009
http://www.health.org.uk/document.rm?id=1380

The Leader as Coach
Scott, Gail
Healthcare Executive
Vol 24(4) July/August 2009 pp 40, 42-43
Effective coaching is key to patient satisfaction and quality of care.

LEAN THINKING

A Community Hospital's Journey into Lean Six Sigma
Stuenkel, K and Faulkner, T
Frontiers of Health Services Management
Vol 26(1) Fall 2009 pp 5-13
Floyd Medical Center, Rome, GA (USA) has used Lean Six Sigma to change its culture.

The Missing Link: Lean Leadership
Mann, David
Frontiers of Health Services Management
Vol 26(1) Fall 2009 pp 15-26

MANAGEMENT

Death by Information Overload
Hemp, Paul
Harvard Business Review
Vol 87(9) September 2009 pp 83-89
Current research suggests that the surging volume of available information – and its interruption of people's work – can adversely affect not only personal well-being but also decision making, innovation and productivity.

Evidence-based Management in Health Care Organisations: A Cautionary Note
Arndt, Margarete and Bigelow, Barbara
Health Care Management Review
Vol 34(3) July-September 2009 pp 206-213
Commentary pp 214-224

How to be a Good Boss in a Bad Economy
Sutton, Robert I
Harvard Business Review
Vol 87(6) June 2009 pp 42, 44-50

What's Needed Next: A Culture of Candour
O'Toole, James and Bennis, Warren
Harvard Business Review
Vol 87(6) June 2009 pp 54, 55-61
We won't be able to rebuild trust in institutions until leaders learn how to communicate honestly – and create organisations where that's the norm.

MATERIALS AND SUPPLIES MANAGEMENT

International Perspectives on Backsourcing in Health: Is it Just a Merry-go-round?
Macinati, MS and Young, Suzanne
Health Care Management Review
Vol 34(4) 2009 pp 372-382
Outsourcing in health was used in the 1990s as managerialism was adopted across the Italian and Australian public sectors. Many health care organisations are opting to bring some outsourced services back to internal provision – this is defined as backsourcing

Strategic Information Technology Alliances for Effective Health-care Supply Chain Management
Shih, SC and others
Health Services Management Research
Vol 22(3) August 2009 pp 140-150

MENTAL HEALTH SERVICES

Mental Health Services in Australia 2006-07
Australian Institute of Health and Welfare, August 2009
http://www.aihw.gov.au/publications/index.cfm/title/10686

ORGANISATIONAL CHANGE

A Theory of Organisational Readiness for Change
Weiner, Bryan J
Implementation Science
Vol 4, 2009
Change management experts have emphasized the importance of establishing organisational readiness for change and recommended various strategies for creating it. Organisational readiness for change has not been subject to extensive theoretical development or empirical study. The author conceptually defines organisational readiness for change and develops a theory of its determinants and outcomes.
http://www.implementationscience.com/content/4/1/67

PATIENT SAFETY

Improving Patient Safety Incident Reporting Systems by Focusing Upon Feedback – Lessons from English and Welsh Trusts
Wallace, L and others
Health Services Management Research
Vol 22(3) August 2009 pp 129-135

POLICY

Challenges of Evidence-based Policy-making
Australian Public Service Commission, 2009
The Prime Minister has called evidence-based policy-making a key element of the Government's agenda for the public service and wants policy design to be driven by analysis of all the available options, and not by ideology.
http://www.apsc.gov.au/publications09/evidencebasedpolicy.htm

Increasing the Use of Evidence in Health Policy: Practice and Views of Policy Makers and Researchers
Campbell, Danielle M and others
Australia and New Zealand Health Policy
Vol 6, 2009
http://www.anzhealthpolicy.com/content/pdf/1743-8462-6-21.pdf

Policy Implementation through Devolved Government
Australian Public Service Commission, 2009.
For many years, governments have funded non-government 'third-sector' organisations to deliver a range of social, health and education services. This approach, known as devolved government, has grown in its usage and diversity.
http://www.apsc.gov.au/publications09/devolvedgovernment.pdf

PRIMARY CARE

Australia: The Healthiest Country by 2020: National Preventative Health Strategy – Overview
National Preventative Health Taskforce, June 2009
The Strategy's recommendations are directed at primary prevention and will address all relevant arms of policy and all available points of leverage, in both the health and non-health sectors.
http://www.yourhealth.gov.au/internet/yourhealth/publishing.nsf/Content/nphs-report-overview

Australia: The Healthiest Country by 2020: National Preventative Health Strategy – The Roadmap for Action
National Preventative Health Taskforce, June 2009
http://www.yourhealth.gov.au/internet/yourhealth/publishing.nsf/Content/nphs-report-roadmap

Building a 21st Primary Health Care System: A Draft of Australia's First National Primary Health Care System
Australian Government Department of Health and Ageing, August 2009
The Draft Strategy reinforces the messages from the National Health and Hospitals Reform Commission that a strong and efficient primary health care system is critical to the future success and sustainability of our health care system.
http://www.yourhealth.gov.au/internet/yourhealth/publishing.nsf/Content/nphc-draft-report-toc

Primary Health Care Reform in Australia: Report to Support Australia's First National Primary Health Care Strategy
Department of Health and Ageing, 2009
http://www.yourhealth.gov.au/internet/yourhealth/publishing.nsf/Content/nphc-draftreportsupp-toc/$FILE/NPHC-supp.pdf

PUBLIC HEALTH

Public Health Expenditures in Australia, 2007-08
Australian Institute of Health & Welfare, November 2009
Expenditure on public health activities by health departments has grown, in real terms, by a total of 77.7%, at an average annual growth rate of 7.4%. In 2007-08 it represented 2.2% of total recurrent expenditure on health-up from around 1.9% in the previous years.
http://www.aihw.gov.au/publications/index.cfm/title/10952

QUALITY

Does Improving Quality Save Money?
Øvretveit, John R
The Health Foundation
September 2009
http://www.health.org.uk/publications/research_reports/does_quality_save.html

From a Blame Culture to a Just Culture in Health Care
Khatri, N, Brown, GD and Hicks, LL
Health Care Management Review
Vol 34(4) 2009 pp 312-322
A just culture has emerged as an imperative for improving the quality and safety of patient care. However, health care organisations are finding it hard to move from a culture of blame to a just culture.

Towards National Indicators of Safety and Quality in Health Care
Australian Institute of Health & Welfare, September 2009
This report sets out recommendations for a set of 55 national indicators of safety and quality in health care. The report concludes the National Indicators Project, a major project funded by the Australian Commission on Safety and Quality in Health Care and undertaken by the AIHW in close consultation with the Commission and a wide range of clinical and other stakeholders.
http://www.aihw.gov.au/publications/index.cfm/title/10792

RESOURCE ALLOCATION

Identifying Research Priorities for Health Care Priority Setting: A Collaborative Effort between Managers and Researchers
Smith, N and others
BMC Health Services Research
Vol 9, 2009
http://www.biomedcentral.com/1472-6963/9/165

RURAL HEALTH SERVICES

Putting Health in Local Hands: Shifting Governance and Funding to Regional Health Organisations
Armstrong, Fiona and others
Centre for Policy Development
October 2009
http://cpd.org.au/sites/cpd/files/u2/CPD_Putting-Health-in-Local-Hands-Oct09.pdf

Index of Rural Access: An Innovative Integrated Approach for Measuring Primary Care Access
McGrail, Matthew R and Humphreys, John S
BMC Health Services Research
Vol 9, July 2009
The problem of access to health care is of growing concern for rural and remote populations. Many Australian rural health funding programs currently use simplistic rurality or remoteness classifications as proxy measures of access. This paper outlines the development of an alternative method for the measurement of access to primary care, based on combining the three key access elements of spatial accessibility (availability and proximity), population health needs and mobility.
http://www.biomedcentral.com/1472-6963/9/124

WORKFORCE PLANNING

Medical Practitioners in Australia: Education and Training in Australia
Jolly, Rhonda
Parliament of Australia Library, Background paper, July 2009
http://www.aph.gov.au/Library/pubs/BN/2009-10/MedicalPractitioner.htm

READING LISTS

The Health Planning Library has put together Reading Lists on the following topics:

- Competencies
- Community Health Services
- Dental Health Services
- Leadership
- Models of Care
- Organisational Change
- Organisational Culture
- Primary Health Care
- Project Management

Please contact the Library on library@achsensw.org.au if you would like a copy of a Reading List.

GUIDELINES FOR CONTRIBUTORS

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 Orgnaisation).

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.