Asia Pacific Journal of Health Management

Volume 7 Issue 1 – 2012

The Journal of the Australasian College of Health Service Management

ACHSM

Features:

Global workforce issues

Pathology workforce

Health service improvement

Capital works planning

Palliative care research

. . . and much more

CONTENTS

Cover: The cover graphic features the logo for the upcoming ACHSM National Congress 'Surfing the Crest of the Wave' to be held at the Marriott Surfers Paradise Resort and Spa, on the Gold Coast, Queensland, 15-17 August 2012.

ASIA PACIFIC JOURNAL OF HEALTH MANAGEMENT

SUBMISSION OF ARTICLES

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

MISSION STATEMENT

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

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

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

MANAGEMENT PRACTICE ARTICLES

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

RESEARCH ARTICLES

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

RESEARCH NOTES

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

REVIEWS

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

PEER REVIEW

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

VIEWPOINTS

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

LETTERS TO THE EDITOR

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

SUBSCRIPTIONS

The cost of subscription to the Journal is included in the membership dues for ACHSM members. For non-ACHSM members the subscription cost is $120 plus GST.

ADVERTISING

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

COPYRIGHT

ARTICLE REPRINTS AND PERMISSIONS

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

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

(Minimum order $10.00)

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

FOR INFORMATION OR TO ORDER:

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

DISCLAIMER

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

Australasian College of Health Service Management
PO Box 341 North Ryde NSW 1670 Australia
Telephone: +61 2 9878 5088
Facsimile: +61 2 9878 2272
Email: journal@achsm.org.au
ISSN: 1833-3818 (Print)

EDITORIAL

Networks, democracy, innovation, pumpkins and pimples

At a recent seminar held in Sydney and organised by the Australasian College of Health Service Management, eminent practitioners, managers and academics closely involved in primary healthcare reform in Australia, identified the risks, opportunities and challenges surrounding the establishment of Medicare Locals. The reporting of this seminar in the media identifies the range of issues discussed and was replete with and enriched by the metaphors used by presenters to reinforce their views. [1]

In the reporting of that seminar, the comment was made that, 'in a sense, they (Medicare Locals) are being asked to do, locally or regionally, what endless meetings of bureaucrats and politicians haven't achieved nationally'. [1] This raises the question why Government, in implementing national health reforms, settled on governance and an organisational framework that was distinct from that of the State and Territory-led acute care (health district) hierarchical arrangement of direct ownership of services, albeit through ministerial appointed Boards created under state health legislation. Instead, Medicare Locals are being established under Australian company law as standalone entities with governance by a Board appointed by the directors of the company!

This difference in design is likely to be for a range of reasons. It builds on the model of the former Divisions of General Practice and therefore suggests a focus on developing that foundation and not disrupting a model that seemed to work. The 'pragmatists' and the 'realists' [2] amongst us might suggest that the space created by this model of 'direct hands off' leaves all the risk with the companies rather than government for potential failures in this reform process. Some of the metaphors in the reported article [1 p.2] describe the primary healthcare sector as 'a patchwork' where knitting its disparate elements is 'core business… but the knitting needles are slippery and the wool is in pieces'. [1 p.2] Medicare Locals are further regarded as 'a type of super-band aid patching together a fractured health system… roping together the silos within'. [1 p.2] So these metaphors are suggesting that Medicare Locals are required to be the 'glue in the system'. Perhaps all these metaphors suggest that the government chose this approach because it felt that independent companies have the best structure to provide a framework of collaboration in a part of the health sector that mostly 'comprises largely small independent businesses'. [1 p.2]

Perhaps this approach in primary healthcare reform reflects a more global movement by government to 'move to post-bureaucratic institutional arrangements for public governance and management'. [2 p.1253] The intention in this governance movement is to enable public managers to take 'considerable agency (action) in shaping the institutions through which government interacts with citizens, civil society organisations and business'. [2 p.1253] This means that Medicare Locals as networked institutions are better placed to negotiate, interpret and realise public policy in a more open and transparent manner through greater 'interactions with citizens, the public, through the way they format and constitute the composition of their Boards and the structures created to engage both health professionals, communities and special interests'. [2 p.1253] This places Medicare Locals in a context where collaborative and 'public private partnerships, citizen-centred governance and interactive decision making' will be required. [2 p.1253]

This changed context not only needs to be clearly understood by the Medicare Local governors (the company directors), the PHC professional leadership and the managers, it will require different competencies and capabilities to those used by those engaged in the more traditional, hierarchical and bureaucratic structures of the acute care sector. [3] This contemporary government-society interaction is described as horizontal in shape, as opposed to hierarchical forms of governance [4] and will require those engaged to focus more on relationships that encourage participation and flexibility. [5] Community involvement should be essential and this will require 'community ownership, local knowledge, relationship building, careful planning and the development of trust'. [6 p.89] Managers will need to understand how to 'indirectly' manage

networks. [7] Importantly, they will need to understand that 'innovation increasingly needs to occur at the interstices of collaborating groups and organisations'. [8] Therefore, the potential for diffusion of innovation through networks needs to be a major consideration for managers. [9]

Jeffares and Skelcher suggest that little is known about how managers think about democracy but posit that amongst them there may be pragmatists, realists, adaptors, and both progressive optimists and radical optimists. They go on to suggest that adaptors, progressive and/or radical optimists should be selected for these managerial roles in network forms of governance. These preferred characteristics more readily identify 'potential for greater inclusiveness', filling 'the gap between the theory and practice of representative democracy' and, potentially 'enabling direct dialogue'. [2 p.1253]

So viewing Medicare Locals, their governance, leadership and management in the context of 'post-bureaucratic institutional arrangements for public governance and management', [2 p.1253] as networks that extend democracy to greater professional and community engagement may 'shift the focus', enabling Medicare Locals to concentrate on 'innovation rather than managing existing systems'. [1 p.8] Time and commitment may well demonstrate that PHC is more than the 'pimple' on the acute sector 'pumpkin' and is in effect the exemplar of the way healthcare needs to be delivered, which the 'pumpkin' should be emulating. [1]

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

The author is the Chair of the Board of a Medicare Local.

References

1. Sweet M. Medicare goes local in search of 'disruptive innovation'. Canberra Times. 2012; Inside Story, (p.4). ID 13937991. http://readnow.mediamonitors.com.au/Readnow.aspx?1RssQBy24Ks
2. Jeffares S, Skelcher C. Democratic subjectivities in network governance: a Q methodology study of English and Dutch public managers. Public Administration. 2011;89(4):1253-1273 (/doi/10.1111/padm.2011.89.issue-4/issuetoc). Available from: http://onlinelibrary.wiley.com.ezproxy.une.edu.au/doi/10.1111/j.1467
3. Briggs DS, Isouard G, Kershaw G, May J. Governance of Medicare Locals: a distributed network of practice (DNOP) model. Poster presentation at International Primary Health Care Reform Conference; 2012 March; Brisbane, Queensland.
4. Lewis JM. The future of network governance research: strength in diversity and synthesis. Public Administration. 2011;89(4): 1221-1234.
5. Rhodes RAW. Policy network analysis. In Moran M, Rein M, Goodin RE editors. The Oxford Handbook of Public Policy. Oxford: Oxford University Press; 2006.
6. Wakerman J, Humphreys JS, Wells R, Kuipers P, Jones JA, Entwhistle P, Kinsman L. Features of effective primary health care models in rural and remote Australia: a case study analysis. Med J Aust. 2009;191(2): 88-91.
7. Lewis JM. A network approach for researching partnerships in health. Aust New Zealand Health Policy. 2005 [cited 2012 Jan 1]. 2:22.doi:10.1186/1743-8462-2-22. Available from: http://www.anzhealthpolicy.com/content/pdf/1743-8462-2-22.pdf.
8. Van den Hooff B, van Weenen F, Soekijad FM, Huysman M. The value of online networks of practice: the role of embeddedness and media use. Journal of Information Technology. 2010;25(2):205-215.
9. Greenhalgh T, Robert G, McFarlane F, Bate P, Kyriakidou O. Diffusion of innovation in service organisations: systematic review and recommendations. Milbank Q. 2004;82(4):581-629.

IN THIS ISSUE

In this issue we have borrowed from the forthcoming ACHSM National Congress theme of 'Inspiring Concepts in Health Management', for our cover. This theme acknowledges that locally (in Australia) we are in the throes of a 'wave' of change – and globally we are all striving for the same thing – put simply, better health outcomes as a result of better health management. As decision-making becomes increasingly complex, existing workforce profiles are evolving, and as demand to improve the safety of healthcare continues to grow, healthcare managers must do better than to merely keep the status quo.

Global forces are impacting on most national health systems, including Australia. Short and colleagues highlight the global impact on the health workforce in addressing fundamental issues surrounding health professional migration in order to create a win–win situation for both source and receiving countries as well as individual workers, by taking the Philippines as a case study. Isouard draws on the 2011 National Survey of the Pathology Workforce for Australia to highlight pathology workforce issues and suggests that a workforce crisis in pathology is upon us. The paper identifies the four strategies recommended to address future pathology workforce needs in Australia. Continuing a workforce theme, Plummer and colleagues describe a study to evaluate current practice, vision and strategies for Saudi Arabian and expatriate nurse managers in Saudi Arabian hospitals, further highlighting the global nature of the issues that confront us all.

Turning to Hong Kong, Chan provides a description of applying lean management to improve the pre-consultation patient journey in outpatient services using a Hong Kong case study. This analysis of management practice in improving work flow and reducing patient complaints through the use of lean management techniques by a multidisciplinary team, provides a valuable lesson for all of us addressing similar problems. Hunt and colleagues describe the experience of project management in building new hospitals in Brisbane, Queensland and the importance of the operational brief in engaging stakeholders in these important processes of capital works projects in healthcare.

Tan and colleagues explore the experiences and challenges in undertaking independent evaluations of community palliative care services. They provide suggested strategies to facilitate future evaluation processes in this important area of health services provision. In a review article for this issue Corcoran and colleagues pose the question: is transport a barrier to healthcare for older people with chronic disease? Access is an important issue and this review will assist readers in understanding the relationship between transport difficulties and access.

Our In Profile this month describes the inspirational leadership of Dr Torao Tokuda, Chairman of the Tokushukai Medical Corporation, in his response to questions put to him by our assistant editor Phudit Tejativaddhana recently.

REVIEW ARTICLE

'Filipino nurses down under': Filipino nurses in Australia

S Short, L Hawthorne, C Sampford, K Marcus and W Ransome

Abstract

The developed world continues to face a critical shortage of nurses that is yet to become more acute with an ageing population, and as a consequence the chain effect of the brain drain or brain circulation will continue. Brain drain is a thoroughly researched and documented phenomenon where source countries such as the Philippines supply nurses to the world, thereby losing their best qualified nurses to developed countries. This creates losses to the source country that trained them, given many leave soon after gaining qualifications and preliminary experience for more lucrative salaries and better lifestyles in the developed world. The situation is particularly complicated in relation to the Philippines, which has positioned itself as a global supplier of nurses, making human resource export a national government strategy. This paper explores fundamental issues surrounding health professional migration in order to assess ways of creating a win-win situation for both source and receiving countries and individual workers, taking the Philippines as a case study. The purpose of this paper is to provide background information on Filipino nurses in Australia within the context of the Philippines as a global supplier of nurses.

This paper formed the foundation of an Australian Research Council Linkage Grant with Partner Organisations; Queensland Health and the University of Sydney, Griffith University, Queensland University of Technology and The University of Melbourne. Key collaborators also include York University and Queen Margaret University.

Abbreviations: **AHPRA – Australian Health Practitioner Regulation Authority; ANMAC – Australian Nursing and Midwifery Accreditation Council; ASEAN – Association of South East Asian Nations; COAG – Council of Australian Governments; IELTS – International English Language Testing System; NMBA – National Nursing and Midwifery Board of Australia; OET – Occupational English Test; WHO – World Health Organization.**

Key words: **Migration of health workers; brain drain; Filipino nurses; ethical recruitment; international agreements; international workforce.**

Stephanie Short[1], Lesleyanne Hawthorne[2], Charles Sampford[3], Kanchan Marcus[4] and William Ransome[5]

[1] Associate Dean Postgraduate, Faculty of Health Sciences, University of Sydney, New South Wales, Australia.

[2] Professor (International Health Workforce), Faculty of Medicine, Dentistry and Health Sciences, University of Melbourne, Australia.

[3] Director, Institute for Ethics, Governance and Law, Foundation Dean and Professor of Law, Griffith University, Research Professor, QUT.

[4] Research Assistant, Faculty of Health Sciences, University of Sydney, New South Wales, Australia.

[5] Law and Justice Research Centre, Queensland University of Technology and Key Centre for Ethics, Law, Justice and Governance, Griffith University.

Correspondence:
stephanie.short@sydney.edu.au

Introduction

The global shortage and misdistribution of nursing professionals is well documented. [1] Australia, like other English-speaking Western countries, may increasingly depend on recruiting health professionals educated abroad as a consequence of an ageing population, problems with nurse retention, issues of maldistribution and the outflows of local graduates. This is despite the establishment of a national goal of health workforce self-sufficiency by 2025. Concerns about health worker migration are manifold, with two prominent issues related to ethics and sustainability: how to provide mutual benefits to both sending and receiving countries, including individual nurses; and the long-term viability of this process in relation to the Australian health workforce. Bilateral agreements are slowly coming into force between several countries. One of the first countries to take action was the United Kingdom in relation

to the Philippines. In 2010, the execution of the World Health Organization (WHO) *Global Code of Practice on International Recruitment of Health Personnel* was a key milestone that provides guidelines for member states to act ethically and responsibly within a global context.

This paper highlights the foundations that formed the basis of our Australian Research Council Linkage Project with Partner Organisation Queensland Health; *Building an Ethical and Sustainable Model for Health Professional Recruitment to Australia; the Case Study of the Philippines (2010-2012)*. The purpose of this paper is to provide background information on Filipino nurses in Australia within the context of the Philippines as a global supplier of nurses. The ethical implications for Australia and the Philippines will also be considered.

Background

The Philippines is the largest provider of nurses for export in the world. [1] A remarkable 85% of the Philippine's best-qualified nurses work outside the country. [1] In recent decades, Filipino-educated nurses have applied in large numbers for work in the United States, the Middle East and the United Kingdom where shortages have been common for 20-40 years. However the United States ceased recruiting nurses from the Philippines following 9/11 and the United Kingdom also shifted priority to securing nurses from the European Union when shortfalls in domestic supply occurred. While the top rated training institutions (such as the University of the Philippines) and hospitals in the Philippines have high standards and quality training, hundreds of colleges and institutions have entered the demand-market for nurses by offering courses which were of poor teaching and training quality. Standards are thus highly variable, in a context where there are few mandatory quality assurance mechanisms. [2] In order for Filipino nurses to apply for work in Australia, they and other migrant nurses are required to pass a mandatory Occupational English Test (OET) or International English Language Testing System (IELTS) test (with scores of IELTS Band 7 or OET B across all four bands of reading, writing, listening and speaking). [3] They must also pass specific examinations in Australian nursing theory and practice to obtain nurse registration, [4] or complete a registered nurse bridging program. These are based on Australian nursing standards and competency levels for safe practice in Australian hospitals. Cultural sensitivity issues of relevance to healthcare environments may also be different from those in hospitals back home. For instance, Filipinos rely heavily on family members to care for their aged population whereas Australians depend on the hospital system and geriatric care nurses to conduct the same duties.

The Philippines is a major source country for a number of reasons. The country deliberately educates and produces health professionals, particularly nurses, for export. [5] In 2001 alone, 13,500 nurses, equivalent to a quarter of the nurses employed in Philippine hospitals, left the country for foreign jobs. Remittances from those working abroad are a significant source of foreign capital for the economy, but little of that money is invested in the country's health system. [6] However, serious ethical concerns are generated by four compelling statistics: (i) health expenditures in the Philippines declined from 3.5% of GNP in 1997 to 2.0% in 2003; (ii) although the number of nursing schools in the Philippines increased from 170 to 470 between 1999 and 2005, the quality of nursing education is not improving; (iii) because of the shortage of nurses and other health professionals, 200 hospitals in the Philippines have closed and 800 have partially closed; and (iv) ratios of health professionals to the population are declining, with reductions in rates of immunisation and medically attended births. [6]

Global ethical debates on health workforce migration are complex, with the Philippines the prime global example of a source country which facilitates rather than discourages skilled worker departures in this field. The government supports the production of 'excess' professionals in order to expand remittance flows (the key national development strategy). [2] Competing developing countries, such as Indonesia are also following trends from the Philippines, and are also emerging as nurse-export countries. For example Indonesia produced 34,000 nurses and the Philippines produced 60,000 nurses in 2007 [7] and despite the overproduction of nurses, both countries experience a shortfall in nurse employment at subnational levels. [7] While governments may over-produce for export, they may maintain frugal domestic employment strategies, regardless of health sector need.

The impact of the global financial crisis limited the scope for migration opportunities for nurses in the Philippines, which unfortunately exacerbated the scale of nurse volunteerism-for-a-fee (a longstanding practice). [8] The national policy of producing excess nurses for export [2] intertwined with an imbalance in supply and demand, is a major driving force behind high nurse unemployment rates in the Philippines, where the national health system was never intended to support the scale of graduate supply. Developed countries importing nurses from the Philippines have the potential to assist the oversupply situation by maintaining migration pathways. To facilitate this, they need to help generalist nurses secure full registration to practice, a process that research evidence suggests may take years.

Greater incentives would also be needed for the redistribution of Filipino nurses to work in rural areas of their country, including the provision of adequate salaries and conditions. Health Secretary of the Philippines, Enrique Ona, recently advised students to avoid nursing and to take on specialist courses in other fields to prevent an even greater number of unemployed nurses. Enrique Ona stated that 200,000 nurses were unemployed in 2010 and also confirmed the closure of several schools, following a government-mandated review of quality and nursing standards. [9] The migration of nurses and other health professionals occurs as a result of several push-pull incentives, most notably to secure higher wages and salaries in developed countries; better working conditions; to provide financial support to assist family members; to gain permanent residency in a developed country; and to enhance professional skills and experience, just to name a few. [10,11] A WHO Western Pacific Region Press Release affirms that 250,000 families in the Philippines encounter financial hardship as a consequence of healthcare costs. [12]

Without government initiatives such as rebates and assistance to families, poor and lower-middle class groups will continue to encounter ill health and poverty due to lack of healthcare aid. It is simple to understand the attractiveness for Filipino nurses working abroad, which not only assists their families, but has the potential to exchange the poverty cycle for a good quality of life. Furthermore, the universal right to obtain a better standard of living cannot be argued, but the long-term sustainability of healthcare in developing countries could be compromised as experienced nurses, nurse educators and graduates exit the home country, which also impacts the quality of nursing education and training.

Filipino nurses in Australia

More than 1,000 Filipino degree-qualified nurses migrated to Australia from 2001 to 2006. The Philippines is thus the second main source country of international nursing graduates after the United Kingdom/Ireland (2,081 nurses). [13] However the major study of nurse migration to date found they have major barriers to securing employment. Even once registered, they are 840% more likely to be clustered in the geriatric care sector.

Immigration processes into Australia are very rigorous and time consuming when nurses apply for Permanent General Skilled Migration visas, where principal applicants are tested pre-migration for human capital attributes (including English language ability and the likelihood of foreign credential recognition). Large numbers of Filipino applicants do not succeed in this process. For example, they secure exceedingly low pass rates in English language testing, compared to all other migrant groups. [14,15] By contrast, turnaround is swift in terms of applicants for a 457 Long Stay Temporary Work visa, which may be used as a stepping-stone towards permanent migration. [16] Due to Australia's flexibility in meeting supply and demand for nurses, temporary nurse flows have grown rapidly. In 2008-09 around 1,500 permanent nurses arrived per year while 3,850 nurses arrived on a temporary sponsored basis to Australia. [2] These nurses are subjected to preliminary screening, and are the most likely to secure work. Large numbers of Filipino nurses however also arrive as family category migrants, untested in advance for human capital attributes. Within five years of arrival in Australia, 58% of Filipino nurses secure nursing employment (combining all immigration categories). Twenty-one per cent are categorised as 'not in the labour force', typically struggling to secure professional registration. [2] Many of these nurses hold de-skilled positions or are excluded from the nursing workforce for years due to challenges in English testing and qualification recognition.

Pre-migration, the Australian Nursing and Midwifery Accreditation Council (ANMAC) is responsible for screening a prospective migrant nurses' qualifications, including school accreditation. Once foreign trained workers arrive in Australia, several registration processes are involved before a nurse can start employment. The national Nursing and Midwifery Board of Australia (NMBA) is the national body that governs codes of practice and regulates the registration of nurses and midwives before they can work in Australia. Registration with the NMBA is lodged through the Australian Health Practitioner Regulation Authority (AHPRA). The second major hurdle is English language testing in which Filipino nurses do particularly poorly relative to all other groups. [14,15, 17]

Migration of Filipino nurses to Australia is not occurring in high numbers like that from Ireland and United Kingdom due to these serious employment barriers. [18] As Australia continues to attract and employ nurses from source countries like Ireland and United Kingdom, these developed countries then recruit more nurses from developing countries like the Philippines, emphasising the global nature of health worker migration. [13] Supply and demand in the nursing profession in Australia is highly cyclical. It is affected by demographic shift; the economic situation (which influences health budgets); and the impact of economic global downturn which encouraged local nurses back into the workforce. [18] Given this volatility, there is potential for a situation

of undersupply to transform to a glut – with serious consequences for the employment prospects of Filipino nurses. With an average nurse age of 50, Australia however is likely to experience nursing shortages in the future. Many will have been trained in developing countries, with highly variable systems (arriving through all immigration paths). Serious issues exist in this context, including effective communication in Australia's multicultural society and the quality of training. Patient care may be compromised if nurses are unable to effectively communicate with a team of doctors, nurses and patients. Local Australian nurses may also fear job security if a surge of migrant nurses are employed in the country, leading to possible competition and conflict as nurses compete for terms and conditions. The research we aim to conduct will include interviews with nurses, managers and peers in Australia and key informants in the Philippines to explore whether migration, communication, employment opportunities, skills and training are current areas of concern.

The Philippines has a national policy of over-producing professionals, in an environment where worker export and remittance-generation are major development goals. Growing attention is now being paid to Filipino quality assurance, in a context where private sector institutions have rapidly proliferated and few are covered by quality assurance processes (as in the United States). Incentives need to be provided for institutions to commit to national accreditation (a mere 19% currently covered, with 221 higher education institutions now being assessed). [19] The quality of Filipino training remains highly variable, with subjects assessed rather than the quality of institutions and staff. Improved quality assurance in line with global norms appears to be a policy imperative, while the mismatch between education and domestic employment demand will continue to ensure out-migration. [19]

Ethical considerations

Good ethical behaviour – treating other people and the world well – and sustainable practices that pay close attention to overall long-term consequences are fundamental in achieving the ideal of integrity within health workforce recruitment systems. [20] Ethical and sustainable recruitment, however, is complicated on a global scale, with varying legal rules, macro and micro policies, politico-social values, institutions, governments, and varying interpretations of defining ethical goals and values. The formulation and adoption of well-functioning legal and ethical rules is rarely sufficient per se for the achievement of integrity. First, legal rules and ethical norms need to be consistent. Ethical norms unsupported by legal rules to impose consequences on those who fail to live up to those norms are a 'knave's charter'; but legal rules are ineffective unless they are informed by ethical standards which give them meaning, guide their interpretation and help officials understand their duties. Accordingly, ethical standards and legal rules need to be mutually supportive and avoid giving contradictory guidance. Secondly, legal and ethical norms need to be supported by institutional arrangements that keep those norms consistent, give guidance to officials in both the originating and recruiting countries, ensure that the relevant rules are observed and check that the claimed outcomes are achieved and the benefits for both countries are delivered. [20]

The macro and micro aspects of global health professional recruitment are an intricate area with bilateral, multilateral legal-political elements intertwined with government bodies, agencies and institutional stakeholders. Each relevant institutional organisation will declare and hold values and interests distinct from those in other organisations, and moulding those entrenched values to align with a coherent global ethical code is very challenging. [20]

Global integrity systems are needed for the ethical international recruitment of health workers. Recruitment of migrant nurses spans social, economic, cultural, political and ethical dimensions between regional, national, local and individual levels. Potential damage that developed countries can do by exporting their best qualified and highly experienced health professionals is one manifestation of this social, political and economic complexity. Health professionals, particularly nurses, are migrating in larger numbers usually at the expense of the developing countries that pay for their education and training. Further consequences include costs to the home country's domestic health systems, where the best qualified nurses work abroad and other essential health professionals tend to retrain as nurses in order for migration opportunities. A clear example has been that of trained Filipino doctors who retrain as nurses to gain foreign employment, as a result of push-pull incentives. According to the WHO study on health workforce resources, there is now an estimated shortage of 1,164,001 doctors, nurses and midwives in South East Asia, and 817,992 in Africa – eight times higher than in OECD countries. [19] Few experts believe it will be possible to halt this scale of movement and with governments such as the Philippines, supporting the production of 'excess' professionals in order to expand remittance flows, it could be damaging local health services delivery and quality of training. [19]

Recognition of the 'brain circulation' has led to the development of ethical norms and codes to guide the recruitment of health professionals [21] with more recent advances headed by the WHO *Code of Conduct on International Recruitment of Health Personnel*. This Code dictates the need for developed countries to consider sustainable health services planning, training and education in order to reduce reliance on migrant health workers. [22] Unfortunately, these ethical guidelines are generally seen to be abstract, inadequate, unfair and unsustainable [23] and have lacked grounding and support within sustainable governance regimes. In 2007, the British National Health Service signed bilateral agreements with the Philippines to address the ethical migration of nurses [24] while the Japan-Philippines Economic Partnership Agreement was also executed in December 2008, both of which include provisions on health worker migration. Mutual agreements in the United Kingdom, South Africa, Philippines, United Arab Emirates, China and ASEAN Mutual Recognition Agreements have all come into force, which also endeavour to address gaps in ethical health worker migration.

The Australian Government has in place a bilateral agreement with the New Zealand Government, which standardises nursing qualifications, and hence graduates in New Zealand are accepted at the same standard to that in Australia. This eases and speeds the registration process for health workers applying to work from New Zealand. However, 21% of New Zealand's nurses were trained abroad. [11] The indirect route of nurses also increases ethical challenges where a Filipino nurse is likely to work in several developed countries like the United Kingdom, the Middle East or New Zealand before eventually settling in a permanent location. [11] As remaining countries gradually pursue these developments, [25] bilateral trade agreements encourage and facilitate nurse migration, but is this beneficial for developing countries which already experience staff shortages, maldistribution of nurses and heavier workloads for non-migrating nurses? On the other side of the ethical debate, there is the individual right for people to move for better work and lifestyle and more often that involves a move from a country such as the Philippines to a developed one.

Frequent monitoring of international recruitment policies and agreements is needed to ensure adherence to those policies and agreements, to ensure that they reflect the values they are intended to uphold, and to reduce loop holes and corruption vulnerabilities. Strong and stable institutional ethical standards, incorporating the activities of government agencies, corporations and professions, are required on a global scale for reliable ethical standards to be achieved. [20] Such arrangements should guide agencies and officials in the execution of their duties and confirm whether mutual benefits are forthcoming. On this front, e-governance initiatives [26] may provide a potential ethical advantage, encouraging use of technology and web display to ensure transparency and accountability; and remittance income may be reinvested into quality training and the healthcare sector in developing countries. The innovation of technological schemes under a regulating body would be ideal, but initial set up costs for governments in developing countries would be high, which is where developed countries could step in.

Our ARC Linkage study with Queensland Health is projected to begin answering some of these questions. The research team will develop a system of employer support (in this case Queensland Health) for the growing potential of health recruitment from the Philippines, taking into consideration orientation, communication, cultural sensitivity, work arrangements and community engagement. Queensland Health plays a vital role in the conduct of the study, aiming at enhancing its standing as an employer of overseas trained health professionals, and at providing national leadership in this area. Ethical and sustainable nurse recruitment is a fundamental constituent in providing equitable and accessible healthcare services to the public and crucial for workforce planning.

Ethical models will be studied and compared to those in other countries in order to develop an appropriate ethical and sustainable health recruitment model for Australia and the Philippines. Our study will consider if unintended consequences are occurring, such as whether this type of system may encourage Philippine-trained health professionals to migrate to developed countries in greater numbers, whether it will create pressures to lower income and/or standards of practice of existing health professionals, and whether it can be developed to ensure the appropriate distribution of those professionals to areas where they are most needed. Issues such as permanent residency and career goals of migrant Filipino nurses will also be investigated. In seeking to answer those questions, the research team will map out an integrity system for ethical and sustainable nurse recruitment including legal rules, administrative rules and practices, transparency and the potential for watchdogs, auditors or ombudsmen to ensure structures and processes are functioning as intended. The study will also suggest and consider institutional arrangements to ensure that ethical standards for recruitment are maintained and the claimed benefits to Australia and the Philippines delivered.

Our study will make substantive contributions within the field of health workforce management by supporting the development of bilateral agreements with developing countries, in this case the Philippines. Furthermore, the research outputs meet several national and international goals on ethical healthcare migration; the Millennium Development Goals are supported as Australia works in collaboration with the Philippines to assist in governance reform; and the ethical model developed for the Philippines could also be applicable to other jurisdictions of low- and middle-income countries, such as Papua New Guinea and Fiji. Significance of health migration research is also timely with the release of the WHO *Global Code of Practice on International Recruitment of Health Personnel* [27] encouraging all countries to act ethically in the migration of health workers. Another substantiative contribution the project will have is on Australia's National Research Priorities: *Promoting and Maintaining Good Health and Ability to Safeguard Australia*, as it is aims to enhance access to health services in Australia more generally through recruitment. Nursing shortages are a significant barrier to equitable access to healthcare, especially in rural Australia, where low nurse:patient ratio levels stand in the way of good quality care. The ideas and evidence generated by this research will enhance understanding of the policies and practices in nurse migration and education within the Philippines and Australia and assist with recruitment procedures in a manner that is of benefit to both countries.

Conclusion

Health professional migration has led to apparent distortions in healthcare delivery and human resources; experienced nurses depart overseas resulting in a shortage of skilled, specialised and experienced nurses and nurse educators in the Philippines; a proliferation of nursing schools affected the quality of nursing education; and demand-driven factors shifted preferences of doctors to study nursing. As a consequence, the oversupply of nurses in the Philippines resulted in volunteerism-for-a-fee in the temporary situation, yet the developed world faces a critical shortage of nurses that is set to become more acute with the ageing population. Developed countries are unlikely to be able to reach self-sufficiency in nursing in the foreseeable future, and will continue to rely on attracting and retaining international nursing graduates. However, such recruitment drains valuable human capital in which the developing country has invested scarce resources. The global thirst for nurses trained in developing countries needs to be turned from the 'brain drain' into a phenomenon that is mutually beneficial. Central to the sustainability of such an arrangement is a regime that underpins good relationships between health systems – by putting back more than it takes out, the smooth integration of professionals from different cultural and training environments and the continuing attractiveness of employers as a destination for international graduates. The challenge remains in how to recruit overseas-trained nurses in an ethical and sustainable manner, especially as developed countries continue to recruit the most able and mobile; this means they are lost to the healthcare systems in which they trained. Creating a positive-sum game will secure lasting benefit for both health systems in which both recruiting and source countries benefit while ensuring the rights of individual health professionals. Further empirical research is required to address gaps in health worker migration and health workforce integration in both developed and developing countries.

Competing Interests

The authors declare that they have no competing interests.

References

1. Lorenzo FME, et al. Nurse migration from a source country perspective: Philippine country case study. Health Serv Res. 2007;42(3):1406-1418.
2. Hawthorne L. Migration and education: quality assurance and mutual recognition of qualifications - Australia Report. UNESCO, Paris; 2008.
3. AHPRA. English Language Explanatory Note. Melbourne: Nursing and Midwifery Board; 2010.
4. Hawthorne L. The globalisation of the nursing workforce: barriers confronting overseas qualified nurses in Australia. Nurs Inq. 2001;8(4):213-229.
5. Brush BL, Sochalski J. International nurse migration: lessons from the Philippines. Policy Polit Nurs Pract. 2007;8(1):37-46.
6. Racelis R, et al. The national health accounts of the Philippines: continuing development and new findings. Philippine Journal of Development. 2006;33(Pt 1-2):179-210.
7. Kanchanachitra C, et al. Health in Southeast Asia 5. Human resources for health in southeast Asia: shortages, distributional challenges, and international trade in health services. Lancet. 2011; 377(9767):769-781.
8. Jumilla L. Glut of Filipino nurses leads to exploitation. ABS-CBN News: Manila, Philippines. 2011 Nov 1.
9. Cimatu F. Health secretary tells students: avoid nursing. Philippine Daily Inquirer/Asia News Network. 2011 Nov 5.
10. Buchan J, PerfilievaG. Health worker migration in the European region: country case studies and policy implications. Division of Country Support, WHO Regional Office for Europe; 2006.
11. Kingma M. Nurses on the move: a global overview. Health Serv Res. 2007; 42(3 Pt 2):1281-1298.
12. WHO, WPR Office. Press Release: New studies show healthcare is a heavy burden for millions. 2011.
13. Hawthorne L. Competing for skills - migration policies and trends in New Zealand and Australia. Wellington: Australian Department of Immigration and Citizenship and NZ Department of Labour; 2011.

14. To A, Hawthorne L. The impact of English language testing of nurses' migration and registration outcomes. Melbourne: International Health Workforce Unit, Faculty of Medicine, Dentistry and Health Sciences, University of Melbourne; 2011.
15. Hawthorne L, To A. Nurse migration flows, registration and employment outcomes. Melbourne: International Health Workforce Unit, Faculty of Medicine, Dentistry and Health Sciences, University of Melbourne; 2011.
16. Spinks H. Australia's migration program. Canberra: Parliamentary Library; 2010.
17. Hawthorne L. Health workforce migration to Australia – policy trends and outcomes 2004-2010. Adelaide: Health Workforce Australia; 2011.
18. Buchan J. An 'ethical' approach to health workforce sustainabiltiy: Desirable? Achievable? In Healthy Australia Forum. Adelaide: University of South Australia; 2011.
19. Hawthorne L. Migration and education: quality assurance and mutual recognition of qualifications - Australia Report. UNESCO, Paris; 2008.
20. Ransome W, Sampford C. (forthcoming) Building an ethical and sustainable model for health professional recruitment, In Short S, McDonald F, editors. Health workforce governance: improved access, good regulatory practice, safer patients. UK: Ashgate; 2012.
21. Alinsao V, et al. Voluntary code of ethical conduct for the recruitment of foreign-educated nurses to the United States. Academy Health Report; 2008. Supported by the John D. and Catherine T. MacArthur Foundation and conducted in collaboration with the O'Neill Institute for National and Global Health Law at Georgetown University. Available from: http://www.nursingworld.org/MainMenu Categories/ThePracticeofProfessionalNursing/workforce/ForeignNurses/CodeofConductforRecruitmentofForeignEducatedNurses.aspx
22. Zarocostas J. WHO agrees new code on ethical recruitment of international health personnel. Br Med J. 2010;340.
23. Buchan J, McPake B. The impact of the Department of Health, England, Code of Practice on International Recruitment. Report for the Department for International Development. London; 2007.
24. Pagett C, Padarath A. A review of codes and protocols for the migration of health workers. The Regional Network for Equity in Health in East and Southern Africa (EQUINET) with the Health Systems Trust And in co-operation with the East, Central and Southern African Health Community. 2007;50:40.
25. Dhillon I, Clark M, Kapp R. Innovations in cooperation: a guidebook on bilateral agreements to address health worker migration. Washington DC: Realizing Rights/Global Health and Development; 2010.
26. Sudarshan H, Prashanth NS. Good governance in healthcare: the Karnataka experience. Lancet. 2011;377(9768):790-792.
27. Buchan J. Can the WHO code on international recruitment succeed? Br Med J. 2010;340(7750):791.

RESEARCH ARTICLE

The Pathology Workforce Crisis: future solutions

G Isouard

Abstract

Introduction: **A recently released report, the *National Survey of Pathology Workforce 2011*, has painted a bleak future for clinical pathology services in terms of a looming major workforce shortage.**

Approach: **A review is undertaken of the current pathology workforce situation to determine the key contributing issues, future demands, workforce needs and strategic solutions.**

Findings: **A workforce crisis in pathology is upon us, with approximately a third of the total workforce expected to leave within the next five years. This represents a real threat to the future capacity of the workforce to sustain quality services at current levels and the likely growth of demand for pathology testing into the future.**

Conclusion: **Four strategies are recommended to address the future pathology workforce needs in Australia through leadership and workforce development. These are; increasing supply of the workforce; redistributing the workforce from areas of lower to higher demand; improving productivity; and reducing demand for pathology services.**

Abbreviations: **AIMS – Australian Institute of Medical Scientists; NHWT – National Health Workforce Taskforce; RCPA – Royal College of Pathologists of Australasia.**

Key words: **Pathology; workforce; pathologist; career structure; leadership; medical scientists.**

Associate Professor Godfrey Isouard BSc, MHA, PhD, FCHSE, CHE
Faculty of the Professions
School of Health
University of New England, New South Wales, Australia

Correspondence:
gisouard@une.edu.au

Introduction

A recently released report, the *National Survey of Pathology Workforce 2011*, has painted a bleak future for clinical pathology services. [1] The report confirmed a major workforce shortage and projected a significant impact on pathology service quality if urgent strategic action was not taken.

There has been a workforce shortage in the pathology sector for at least a decade, [2,3] and in particular in rural and remote locations of Australia. [4] Internationally it has been a significant problem for years. [5] This clearly presents an enormous threat for the future capacity of the various professions and governments to maintain and support clinical service delivery at current and future levels. [6]

The delivery of clinical pathology services is pivotal to healthcare. A well trained and skilled pathology workforce is critical for the delivery of quality pathology services to the community. In fact, the Royal College of Pathologists of Australasia (RCPA) reports that healthcare would significantly be impacted without the provision of quality pathology services. [3]

Similarly, the Australian Institute of Medical Scientists (AIMS) recognises that a medical scientist workforce crisis is looming, with acute shortages in rural areas being exacerbated by the ageing workforce. [7] Scientists and Senior Scientists are usually medical science graduates with training in a specific specialist discipline of pathology. Senior Scientists often possess additional qualifications at the postgraduate level or professional qualifications attained from the relevant scientific professional body.

Over the past 20-30 years demand for pathology services has escalated significantly with growth much faster than general practitioner and specialist activity. [8] This has raised numerous concerns which include the increased financial burden, the excessive and inappropriate use of services, and the resulting impact on the quality of patient care being delivered. [9-12] Increased service requirements also place enormous strain on pathology service efficiency and the declining workforce associated with it. [13-15]

Reports indicate that approximately 70% of all medical decisions involving diagnosis or treatment are informed by clinical pathology data. [16] Nationally, pathology tests are requested in 36.7% of all general practitioner episodes, with about 50% of the population experiencing one episode or more of pathology testing annually. [8]

As pathology is the clinical discipline concerned with understanding the causes of disease, it is therefore, important in the diagnosis, management and treatment of the patient. Service delivery is provided through a laboratory team comprising largely pathologists, scientists, laboratory technicians and health information professionals.

A significant issue in addressing the workforce shortage has been the lack of any timely and available data to accurately determine the extent and severity of the shortage of staff. For many years the unavailability of basic data such as the numbers, gender, ages, geographical distribution, educational and employment levels, and other relevant information has severely limited any exercise in workforce planning. [7,17,18]

A number of recently published national reports have highlighted the impending crisis in the workforce for pathology. [1,7,8] The recent *National Survey of Pathology Workforce* [1] is timely as it provides a comprehensive account of the current workforce status to support the creation of workforce development strategies. This also provides a means of monitoring, measuring and assessing future pathology workforce needs. It enables a much needed analysis of the Australian pathology workforce in terms of key workforce groupings, demographic characteristics and workplace characteristics.

The problem

The *National Survey of Pathology Workforce* report [1] has identified a number of the most pressing issues facing the pathology workforce. In particular, there is a shortage of qualified pathologists and scientists within an ageing workforce. [19] The acute shortage of pathologists in regional and rural areas and the difficulty of attracting suitably qualified people to work there were also highlighted. [4]

The report identified several important secondary issues, including high staff turnover, training, and the recruitment for blood collecting, administrative and reception staff. Retention and replacement of staff was found particularly difficult and costly in terms of time used and recruitment costs. The groups likely to leave work in the short-term included laboratory assistants (9%), senior scientists (7%), medical/anatomical typists (6%), and blood collecting staff (6%).

Another significant issue was the need for, and the associated costs associated with providing on-the-job training. This was necessary due to the general lack of practical training being present in the curriculum of most university courses, and in particular for medical scientists. The data indicated that many graduates lacked the necessary practical experience when commencing work. [20]

Pathology has also recently been shown to be an unpopular residency choice for medical students. [21] The authors reported that in some countries this has resulted in a critical shortage of pathologists, which has ultimately impacted on the quality of pathology services delivered. Several contributing issues were identified from participating medical students, including a negative perception about pathologists, and perceptions of pathologists being 'non-medical', and of being 'invisible' in practice. The study concluded that as a result of these perceptions the medical students had most likely rejected pathology as a career. These quite negative aspects were viewed as major detractors for selecting pathology as a career.

Another serious difficulty was the recruitment of suitably qualified people to work in remote and rural areas. [4] Research indicates that often there is very little incentive for experienced metropolitan-based people to move to smaller regional communities. Overall, around 25% of the pathology workforce is located outside of the metropolitan areas. In Western Australia and South Australia the incidence is much lower with 11% and 13% respectively. Pathologists (17%) are very much under-represented outside the metropolitan areas.

The recent *National Survey of the Pathology Workforce* also raised the important point that since pathology rarely hits the headlines in terms of media attention, together with its relatively small numbers in terms of being only about 5% of the total health workforce, it can easily be overlooked by Governments and Health Departments in terms of providing resources to address workforce issues. [1]

Graves [3] in 2007 reported significant implications on the healthcare system if pathologist workforce issues were not adequately resolved. These included delays in cancer diagnosis, infectious diseases not being diagnosed, and blood transfusion not able to proceed safely. In addition, Graves predicted eventual bed and emergency department blockages in hospitals due to a decrease in the availability of pathology results. The concern from the RCPA perspective was that if the issue is not rectified then the current quality of pathology services will not remain sustainable.

Future demands and workforce needs

The alarming aspect is that the crisis is expected to reach a peak within the next five years, with approximately a third of the total workforce expected to leave. The survey found that pathologists were likely to seek reduced working hours more than any other discipline group within the pathology workforce, but comparatively less likely to leave the workforce in the short-term. [1,22]

The report identified several key issues contributing to the shortage of scientists. One important one was that there seemed to be limited opportunities available to advance careers as scientists. Opportunities were, however, available from time to time in management and leadership positions of laboratories and departments. This required some type of postgraduate qualifications in business administration. There was, however, an overall lack of interest by many in pursuing such leadership roles. The lack of senior scientist positions to progress and promote staff was seen as a significant issue impacting on the shortage.

Senior scientists were expected to be most vulnerable with 42.5% planning to leave their positions in the short-term. However, it was notable that pathologist trainees were the least likely to leave (5.6%).

The report stressed the immediate need for the introduction of training programs for the various professionals employed in pathology. [1] In particular, there was a need for ongoing development of scientists to enhance laboratory expertise.

In 2003, workforce studies conducted by the Australian Medical Workforce Advisory Committee had indicated that from 61 to 232 new entrants would be necessary each year by 2013 to ensure supply meets workforce requirements for pathologists in pathology. [1] The current review has indicated that only a half of this number were new pathologist recruits in 2009. [1]

Workforce solutions

Workforce shortages are a heath system-wide issue, not just pathology. Nationally, the workforce crisis is such that it is struggling in health and aged care to maintain the numbers, distribution and skill set required for the ageing population. [23] Reports on health workforce issues by the Productivity Commission and by the National Health Workforce Taskforce (NHWT) have painted a gloomy picture for healthcare into the future. [24,25]

Several factors are seen as major drivers to growing demand for health services and, therefore, to increased strain on the workforce. These include population growth, ageing of the population, growing impact of chronic disease, and increased emphasis on prevention. [26]

Essentially, four main strategies have been reported to address the future pathology workforce needs in Australia. These include, increasing the supply of pathology workers, redistributing the workforce from areas of lower to higher demand, improving the productivity of the workforce, and reducing the demand for services: [1,7]

- Increasing the supply of pathology workers through enhancing the opportunities for providing education and training, improving recruitment practices, retaining workers for longer periods, and attracting re-entry of workers who have previously moved on.
- Redistribute the pathology workforce from areas of lower to higher demand, both geographically by region and also by specialty.
- Improve the productivity and efficiency of the workforce through innovative work re-design, accessing new technology, and further gains through consolidation.
- Reduce the demand for services through improving the quality of test requisition, and through use of appropriate clinical guidelines.

The *National Survey of Pathology Workforce* review [1] also found the need to develop more formal career structures for workers so as to provide training opportunities as pathways to self-development and advancement for scientists. This measure requires the creation of more positions and workplace opportunities, and in doing so makes pathology a far more attractive career choice than at present. This is particularly important at the highly skilled levels of pathologist and senior scientist. The aim would be to target new people into a career of pathology through a major shift in internal focus as well as a significant promotion of the positive aspects of the profession. This strategy should also promote rural and remote area pathology placements and careers.

In introducing such key strategies, several important supporting initiatives and enablers were recommended by the employers to allow the implementation process to operate smoothly. [1] These initiatives included:

- Providing effective leadership that allows for succession planning, appropriate workplace training practices, and commitment to aligning organisational goals with workforce issues.
- Fully engaging with tertiary program providers so that graduates in the various pathology disciplines are 'job ready' through structured training directed at the workplace.
- Creation of various new appointments that support both the career structures of scientists and also assist in overcoming the shortage. One suggestion was the provision of trainee positions backed with government-sponsored funding.
- Targeted lobbying for industry best practice on a number of fronts, including universities, medical administrators and government.

There is also another possible approach in strategy which views the potential for a shift in the skill base of the profession to include lesser qualified people as the work-place requirements change to greater automation and less handling in the laboratory. This would have particular significance in discipline areas such as Anatomical Pathology, Cytology and Microbiology. As greater automation is introduced into these areas, there should be a corresponding reduced need for highly qualified pathologists and scientists, and potentially a greater need for lesser qualified staff with a different skill set. [20] A closer examination and understanding of the workforce characteristics, the boundaries between different specialist groups and a detailed review of the current industrial arrangements were seen as possible alternative avenues in addressing the current dilemma with the pathology workforce.

Discussion

This brief review of the workforce issues currently being faced with pathology services has revealed significant problems with declining staff numbers and accompanying skill set shortages in some areas. The just-completed, comprehensive, national survey projects a significant impact on pathology service quality if urgent and immediate action is not undertaken.

The key strategies outlined in this paper have been proposed to address the future pathology workforce needs in Australia. These include, increasing the supply of pathology workers, redistributing the workforce from areas of lower to higher demand, improving the productivity of the workforce, and reducing the demand for services.

The key theme voiced by all major industry stakeholders is the need for strong leadership at the policy and decision-making levels of both government and the professions to increase the overall numbers through investment in the required key areas. Strategies would target new people into a career of clinical pathology through a significant shift in internal focus as well as a major promotion of the positive aspects of the industry. The strategies would also establish new formal career paths and structures for current and future scientists and pathologists, and promote rural and remote area placements and careers.

Competing Interests

The author declares that he has no competing interests.

References

1. Department of Health and Ageing. Final Report. National Survey of Pathology Workforce. Canberra: DoHA; 2011. Available from: http://www.health.gov.au/internet/main/publishing.nsf/Content/3C6E5A7B54517A7ACA2574E50005BF99/$File/Survey%20of%20the%20Pathology%20Workforce.pdf
2. Eccles K. Pathologist shortage causing stressful wait for results. Medical Observer. 2006;10:8-10.
3. Graves D. The impact of the pathology workforce crisis on acute healthcare. Aust Health Rev. 2007;31(1):S28-S30.
4. Hilborne L. The other big workforce shortage. Mod Healthc. 2008;38:23.
5. Cameron H, Dupal P. Rural pathology under the microscope. Aust J Rural Health. 2009;17:222-223.
6. Department of Health and Ageing. Discussion Paper: Career Structures and Pathways for the Scientific Workforce in Medical Pathology Laboratories. Canberra; DoHA. Available from: http://www.health.gov.au/internet/main/publishing.nsf/Content/3C6E5A7B54517A7ACA2574E50005BF99/$File/WKFCE%20Final%20Project%20Report%2024%20Aug.pdf
7. Legg M and Associates. The Australian pathology workforce crisis. Canberra: DoHA; 2008. Available from: http://www.health.gov.au/internet/main/publishing.nsf/Content/3C6E5A7B54517A7ACA2574E50005BF99/$File/Pathologyworkforce08V2.pdf
8. Australian Association of Pathology Practices Inc. An analysis of pathology test use in Australia. Sydney: Beach Program, Family Medicine Research Centre, University of Sydney; 2008. Available from: http://www.aapp.asn.au/images/document/DOD%20paper%20+%20append.pdf
9. Isouard G. A quality management intervention to improve clinical laboratory use in acute myocardial infarction. Med J Aust. 1999; 170(1):11-14.
10. Isouard G. The key elements in the development of a quality management environment for pathology services. J Qual Clin Pract. 1999;19(4):243-248.
11. Isouard G. Uncovering the causes of poor quality pathology laboratory services in acute myocardial infarction. J Qual Clin Pract. 1999;18(4):233-239.

12. Rao GG, Crook M, Tillyer ML. Pathology tests: is the time for demand management ripe at last? J Clin Pathol. 2003;56(4):243-248.
13. Isouard G. Improved turnaround time of laboratory tests using a FOCUS PDCA approach. Australian Journal of Medical Science. 1999;20(1):14-17.
14. Isouard G. A quality management intervention to improve clinical laboratory use in AMI. Med J Aust. 1999;171(4):222-223.
15. Isouard G. Improved emergency department specimen handling time using a CQI approach. Australian Journal of Medical Science. 2000;21(1):10-15.
16. Lord Carter of Coles. Report of the Second Phase of the Independent Review of NHS Pathology Services in England. 2010. Available from: http://www.rcpath.org/resources/pdf/Review_Report_final_proof08.pdf
17. Vance RP. Some thoughts about the past and future of pathology workforce. Human Pathology. 1999;30(2):117-122.
18. Vance RP. Outcomes management- new opportunities in a shrinking pathology market. Arch Pathol Lab Med. 1997;121(11):1183-1186.
19. Blanckaert N. Clinical pathology services: remapping our strategy itinerary. Clin Chem Lab Med. 2010;48(7):919-925.
20. Human Capital Alliance. Career structures and pathways for scientists in medical pathology laboratories. Canberra: DoHA; 2010. RQF 432/0910. Available from: http://www.aims.org.au/c/uploads/file/documents/nat/docs/careers_path_project_dec10.pdf
21. Hung TT. Residency choices by graduating medical students: why not pathology? Hum Pathol. 2011;42(6):802-807
22. The Royal College of Pathologists Australasia. Impact of the workload of Anatomical Pathologists on safety and quality. Sydney: RCPA; 2011. Available from: http://www.health.gov.au/internet/main/publishing.nsf/Content/3C6E5A7B54517A7ACA2574E50005BF99/$File/Impact%20of%20Workload%20of%20Anatomical%20Pathologists%20on%20Quality%20and%20Safety%20-%20Final%20Report.pdf
23. Scott IA. Healthcare workforce crisis in Australia: too few or too disabled? Med J Aust. 2009;190(12):689-692.
24. Productivity Commission. Australia's health workforce, research report. Canberra: Productivity Commission; 2006.
25. Productivity Commission. Caring for older Australians: overview. Report No. 53, Final Inquiry Report. Canberra: Productivity Commission; 2011.
26. Isouard G. Leading and managing the implementation process: the key to successful national health reform. A Pac J Health Manag. 2010; 5(1):11-16.

MANAGEMENT ARTICLE

Nursing Management in Saudi Arabia: evaluating strategies for succession planning

K Al Hosis, V Plummer and M O'Connor

Abstract

Objective: This paper describes a study undertaken to examine the visions of nurse managers and leaders for succession planning and to examine the associated policies and practices for Saudi Arabian and expatriate nurse managers in Saudi Arabian hospitals. The factors that play a direct role in preparing future nurse managers to guide nursing services in the future for that country are explored.

Design: Many definitions of succession planning can be identified in both nursing and business literature and an underlying theme is that good succession planning retains the best people for an organisation. This may seem to be stating the obvious at first glance, but the complexities for the sample and the 'social world' in this setting was such that a mixed methods approach was utilised to gain an in-depth understanding. A sequential explanatory research design was used in two phases. The first phase was a survey, which explored demographics, organisational succession planning, the importance of competencies in the development of nurse managers and the use of open-ended questions to elicit qualitative information. The focus of the second phase was qualitative and explored the themes of management styles and quality, the development of managers, organisational issues and human resource issues. At the participating hospitals, 11 nurse managers/nurse executives took part in semi-structured interviews.

Setting: The study was conducted in seven Saudi Arabian hospitals with a range of approaches to succession planning. Fundamental to the study was the ethical and professional responsibility of the Kingdom of Saudi Arabia (the Kingdom) to provide an Islamic focus in the delivery of quality healthcare and effectively continue to implement the Saudisation policy for nursing.

Outcome: Although effective succession planning is built on the framework of solid organisational vision and policy, this was not reflected in practice in the Saudi Arabian hospitals in this study.

Conclusion: Recruitment and retention of more Saudi nurses is both desirable from a population perspective and required from the government's policy perspective on Saudisation of the workforce. Effective succession planning for nurse managers is one factor which may modify attrition rates and enhance recruitment; however it remains a major challenge for health services.

Abbreviations: KSA - Kingdom of Saudi Arabia.

Key words: Succession planning; nursing management; Saudi Arabia.

Dr Khaled Al Hosis
Dean of Nursing
Qassim University, Saudi Arabia

Dr Virginia Plummer
Senior Lecturer in School of Nursing and Midwifery
Monash University
Victoria, Australia

Professor Margaret O'Connor AM
Vivian Bullwinkel Chair in Palliative Care Nursing
Monash University
Victoria, Australia

Correspondence:
margaret.oconnor@monash.edu

Introduction

The exponential economic and population growth in Saudi Arabia over the past 25 years has resulted in significant benefits, but there are also problems. This latter is the case for healthcare operations. While hospitals are generally well equipped with state-of-the-art medical supplies and technologies, this is not supported by a local, experienced and specialised nursing workforce. The Saudi Government has identified workforce shortage and recruits internationally for health professionals. The international nursing workforce in Saudi Arabia is multilingual, multi-cultural and has a wide range of educational preparation and this has both positive and negative impacts on the nursing care

provided to the largely Saudi population. A mass exodus of this workforce would precipitate a workforce crisis due to the lack of succession planning at all levels of nursing, particularly in areas such as management and senior positions in specialty clinical areas.

Research question and aims

This raises the question: what factors impact on succession planning for nurse managers in Saudi Arabia? The study was designed with the following aims:

- To examine current policies and practices in succession planning;
- To examine the visions of nurse managers and leaders for succession planning.

This is the first empirical study of succession planning for nurse managers in Saudi Arabian health services. The Kingdom is unique because of its long-term reliance on an expatriate nursing workforce and a growing and relatively young population. Fundamental to the study has been the ethical and professional responsibility of the Kingdom to provide an Islamic focus in the delivery of quality healthcare.

Background

The development of nursing management is a major consideration for healthcare organisations. Writing from a United States perspective, Yoder-Wise and Kowalski [1] note that nurses in senior nursing leadership and management are limited in availability and costly to recruit and as a result, front-line and middle management positions are commonly filled by under-prepared and under-skilled nurses.

Bolton and Roy consider that 'the time is overdue for healthcare organisations to establish sound systems of succession planning'. [2 p.589] There is little research on outcomes. Results are inconsistent across the studies of the implementation of succession planning programs within healthcare systems. [3,4] Blouin et al note that health organisations are challenged in providing consistency in workforce planning and this has resulted in a significant lack of effective succession planning strategies and policy for the executive and middle management. [4]

Definitions for succession planning were explored in the nursing and business literature. Within the business literature there seems to be clarity, as shown in the following examples. Wolfe defines succession planning as the *systematic step or design that allows for one to follow another in time or in place and a defined program that an organisation systemises to ensure leadership continuity for all key positions by developing activities that will build personal talent from within.* [5 p.14] From a business perspective Rothwell notes that it should be paired with succession management to ensure leadership continuity in key positions and to retain, develop and encourage individual advancement. [6] And from a health executive viewpoint, Rollins says that *it brings an assessment of talent throughout the organisation*. [7 p.15]

Over the past ten years the Saudi Arabian health system has suffered from a severe shortage of qualified Saudi nurse managers in clinics and hospitals, in both the private and public sectors. The Saudi government, in an effort to overcome the shortage, employs a large, culturally-diverse expatriate workforce to provide healthcare to Saudi nationals. [8] Nurse Manager positions are held largely by Western expatriates, who receive a higher salary and other benefits compared to Saudi managers.

The implementation of a Saudisation policy, a strategy to increase the number of Saudi citizens in the workforce, was introduced 21 years ago. The Saudisation program began with a development plan for filling most vacancies by Saudi workers and started nationally after the realisation that heavy reliance on expatriates would create a huge gap in an unbalanced workforce should expatriates decide to leave the Kingdom. [9] Until the country has an adequate workforce of Saudi nurses to replace expatriate staff, appropriate leadership and care will remain problematic.

Succession planning in Middle Eastern countries is multifaceted and complex, for two dominant reasons. The first concept is the cultural aspect which unsurprisingly includes gender. Since nursing is a predominantly female occupation, even in the Middle East, female nurse managers should be in the majority but the culture does not support the notion. Junco, Dustchke and Petrucci refer to a social system in Saudi where men are regarded as the authority within both the family and society. [10] The second is that although succession planning is not a new concept, the implementation of succession planning in nursing is relatively new and is not universally put into practice. There was thus an urgent need to investigate the extent to which succession planning in nursing is practised in Saudi Arabia.

Conceptual framework

According to Al-Meer, culture is fundamental to an understanding of management in the Kingdom of Saudi Arabia (KSA). [11] A large study undertaken by Bjerke and Al-Meer in 1993 comparing Saudis and Americans, described Saudi society as being based on Hofstede's four dimensions of power; distance, uncertainty avoidance, individualism/

collectivism and masculinity/femininity. [12] Saudis scored high on power distance which might relate to social distance between manager and employees. They are also very loyal to their institution and this would also explain their high levels of uncertainty avoidance. High collectivism is explained by having dislike for conflict, while a concern for others categorises Saudi managers as having a feminine side. Theories of motivation in leadership and in industrial organisations on which that 1993 study was based, do not apply to Saudi society as the theories were developed in the United States. Saudis and Westerners have major cultural differences.

Methods

A mixed method was utilised with a sequential explanatory research design conducted in two phases. A sequential explanatory mixed method design is deductive as it takes the approach of finding general information first, then moving to the inductive. Graphically the design was adopted from Creswell and is shown in Figure 1. [13]

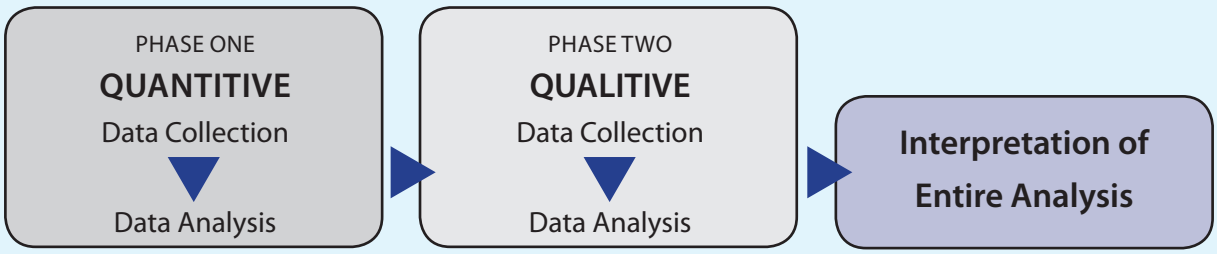
As described, the study was conducted in seven Saudi Arabian hospitals with different policies on succession planning in nursing for leaders and managers. The invitation to nurse managers to participate was made by placing information posters on notice boards in all ward areas in each hospital. News about the study was placed in internal staff newsletters between September 2007 and January 2008. Those that responded participated in Phase One and completed the questionnaire. The Nursing Directors, Human Resource Managers and Senior Nurse Managers were invited to provide their views anonymously, as a contribution to nursing research which may inform the preparation of potential nurse managers and guide nursing services in the future in Saudi Arabia and elsewhere. Those who responded participated in Phase Two through an interview. Both samples included male and female, Saudi and expatriate participants and some were members of the military. All participants had been employed by their current employer for six months or longer. Convenience sampling was selected for Phase One and for Phase Two purposive sampling was used.

Those from Phase One who indicated they were interested in participating in the study were sent an explanatory statement and a questionnaire through the staff internal mail system. The questionnaire was designed by the student researcher, sent to a panel of experts from Monash University and hospital contacts for comments, feedback and validation. Some of the questions were adapted from Rothwell with permission; [6] the remainder arose from a wide range of literature. For Phase Two, participants opted in by responding to an invitation letter. Data collection for Phase One was via conveniently placed secure boxes at three locations in each hospital. In Part 1 of the questionnaire demographic data was collected. In Part 2 a four point Likert scale was used to discover the current implementation of organisational succession planning. The total mean scores for all items were ranked from the highest to lowest; a five-point Likert scale was used.

Part 3 focused on the importance of competencies for nursing managers using a four-point Likert scale questionnaire.

Part 4 consisted of five open-ended questions, designed to enable the participants to articulate their opinions and to identify a deeper understanding of the responses. In this part, the results of these responses were transcribed, coded and analysed quantitatively.

Figure 1: Sequential explanatory design



Upper case letters/lower case letters = major emphasis/minor emphasis

Phase Two consisted of semi-structured interviews of 11 hospital nurse managers/executives. Interviews were conducted with human resources representatives, directors of nursing and nursing departments and front-line, middle and senior nurse managers. The languages of the interviews were both Arabic and English for the convenience and ease of expression of the participants. Three expatriate participant interviews were conducted in English and they were provided with a list of sample interview questions in English at the commencement of the interview. Eight participants were Saudi and their interviews were conducted in Arabic. They were also provided with a list of sample interview questions translated from the English by an authorised translation service approved by the Monash University Ethics Committee. The interview questions were rechecked again by an independent Arabic speaker before interviews began. The student researcher who conducted the interviews was bilingual in English and Arabic. Ethical approvals for the study were received from the Monash University and invited hospitals. Pseudonyms were used to protect privacy.

Data analysis for Phase One was conducted in four parts. In the first three parts, quantitative analysis (closed-ended) and statistical tests were used. In part four, the participant's views (open-ended) were coded and analysed. For Phase Two qualitative thematic analysis was conducted based on Braun and Clarks' six phases of thematic analysis. [14]

Results

The survey was distributed to 449 front line and middle nursing managers at seven hospitals and 245 questionnaires were returned (55%). The total number of Saudi respondents was 11 and expatriates were 234 from more than 50 countries. A full analysis of the demographics and characteristics of study respondents is reported in Tables 1 and 2. The majority of the sample (85%) was women. Most respondents were expatriates (95.5%). Saudi nurse mangers were under represented compared to expatriates (4.5%). The positions of the respondents showed that 33% were unit head managers and 31% were clinical charge nurses, which makes for (64%) of the respondents. On the other hand, clinical nurse managers showed the lowest rate of participation in the study with only 10 respondents (4%). The level of education attainment of respondents at each hospital is described in Figure 2.

Part 2 of the questionnaire was designed to examine organisational succession planning. The 24 items were ranked and analysed to determine the perceived role of succession planning at the participants' organisations. The mean score of this research was 2.74 which is considered to be the lowest degree of agreement scale in this research. Therefore, it can be inferred that the respondents considered that succession planning is still in the development stage.

Table 1: Socio-Demographics Details of Respondents (N=245)

SOCIO-DEMOGRAPHIC ITEMS		FREQUENCY	PERCENTAGE
1– Age of Nurses	25-30	17	6.1
	31-35	28	11.2
	36-40	56	22.9
	41-45	30	12.2
	46-50	57	23.3
	51-55	41	16.8
	56+	16	6.4
2 – Gender	Male	37	15.2
	Female	208	84.8
3 – Nationality	Saudi	11	4.4
	Arabs (incld Saudi)	26	11.6
	South African	38	15.5
	Asian	144	59
	Westerns	16	6.5

Table 2: Socio-Demographics Details of Respondents (N=245)

SOCIO-DEMOGRAPHIC ITEMS	DESCRIPTION	FREQUENCY	PERCENTAGE
4 – Current Position	Clinical charge nurse	77	31.4
	Clinical instructors	27	11
	Clinical nurse managers	10	4.1
	Unit Head Nurse	81	33.1
	Nursing Supervisor	29	11.8
	Assistant Director of Nursing Staff	13	5.3
	Missing	8	3.3
5 – Years in Current Position	Less than one year	59	24.1
	1 – 2	42	17.1
	3 – 5	75	30.6
	6 – 7	21	8.6
	8 – 10	9	3.7
	11 and more	37	15.1
6 – Years at Current Location	Less than one year	13	5.3
	1 – 2	19	7.8
	3 – 5	55	22.4
	6 – 7	34	13.9
	8 – 10	33	13.5
	11+	88	35.9

However, the overall results were inconsistent to some degree with those of the Saudi participants, who indicated that the implementation of succession planning was limited to senior positions and did not target front and middle management in nursing.

Part 3 of the questionnaire was designed to examine managerial competencies. Respondents were requested to indicate the relative importance of the development of competencies for nursing leaders and managers as part of succession planning. Responses relating to competencies for nursing leaders and managers are reported in sequence from highest to lowest mean score. Surprisingly, the overall mean value of items in this part was high at 4.31 (SD .569) indicating that the competencies listed were considered extremely important for the respondents' professional development and managerial advancement.

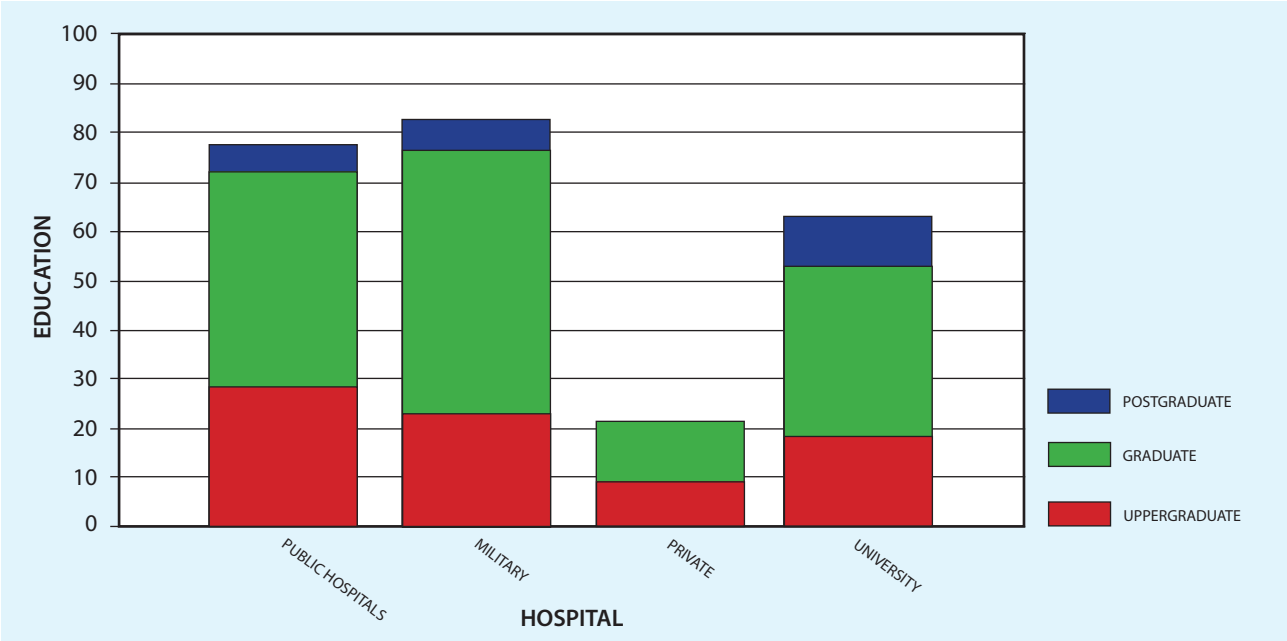
The three highest scoring statements concerned communication (mean score 4.53), scope of practice (mean score 4.52) and working knowledge of the policies of the organisation (mean score 4.46). On the other hand, the lowest mean scores were still rated as being important, including educational programs (mean score 4.14), 'My vision, mission and values are reflected in my work at this organisation' (mean score 4.17) and 'Nursing programs in strategic planning' (mean score 4.20).

Part 4 of the questionnaire covered responses to four questions. The questions were:

- In your opinion what are four ways to improve succession planning for managers?
- What are four methods to improve the work of Saudi Nurse managers' competencies in your organisation?
- What are four resources that are needed to develop nursing management in your organisation?
- How do you think succession planning could improve patient care?

Respondents were invited to answer questions freely in their own words, which were then analysed using thematic analysis to identify the main themes in the responses. These themed responses were identified, classified and prioritised

Figure 2: Education level at each hospital type



in the form of numbered responses from highest to lowest for each individual question. Common themes were developed from the responses to the questions. Once the thematic analysis had been conducted the themes were tabulated and presented in Table 3.

When asked about the best ways to improve succession planning for nurse managers, several important answers emerged. Education and training was sought by 37% and strategic planning and management succession planning by 23%, seeking to better understand the organisational direction and future plans. On the question of how to improve the work of Saudi nurse managers, an important 48% stated education and training, and 13 % said motivation and encouragement. When asked what four resources are needed to develop nursing management in their organisation, 40% said education and training, 24% asked for resources such as text books, equipment, and 20% for more staff.

Table 3 Grouped themes in Phase One

NO	THEME	EXAMPLE
1	Human resources	Recruitment and re-attraction of Saudis and expatriates, workforce planning, Saudisation policy.
2	Nursing development	Career and professional development, education and management training, development of management, succession planning.
3	Organisation's strategic planning	Organisational strategic planning, motivation, support, development, supervision, assessment and evaluation, annual report, vision, future mission.
4	Resources for ongoing managerial development	Information technology, computers, policies, books, communication pathway, mentorship and coaching.
5	Nursing management roles, styles and quality of care.	Knowledge, experiences, characteristics of managers and styles such as fairness, teamwork, relationships, quality of care provided.

Table 4: Classification of interview findings

NO	CLASSIFICATION	THEMES
1	Management quality	1– Management styles 2 – Management dominance 3 – Qualification in management 4 – Vision and planning
2	Development	1 – Education 2 – Mentorship 3 – Career development 4 – Nursing association
3	Organisation	1 – Teamwork 2 – Encouragement and motivation 3 – Communication
4	Barriers to Saudi managers	1 – Expatriates and feeling of intimidation 2 – Criticising female gender 3 – Physician as managers 4 – Nursing administrators
5	Human resources	1 – Succession planning 2 – Saudisation policy 3 – Recruitment and retention

Finally the question about the contribution of succession planning to patient care received the lowest number of responses. This is disappointing since the respondents may have not have thought this question important enough or the question was too difficult to answer. The majority of respondents, 16%, thought a manager's leadership quality and style might assist them as role models to manage with 'grace' and without bias.

Phase Two

The identified themes were grouped under five headings. They revealed several important factors – management quality and styles, development, organisation, barriers to Saudi nurse managers and human resources (Table 4). The interviewees expressed the view that management styles had a crucial effect on their work performance and plays an essential part in presenting the vision and mission of the organisation.

Discussion

There were many paradoxes in this study. Saudi nurse managers were the lowest number of participants in Phase One (4.45%), compared to the number of expatriates (95.55%) in managerial positions and thus were under-represented and their voice barely heard. As noted, Saudi nurses are both desirable from a population perspective and required from the government policy perspective on Saudisation of the workforce. The focus of recruitment and retention needs to move from the international to the local. Female Saudi nurses have society and cultural responsibilities which have traditionally conflicted with management careers and some aspects of clinical careers. Pathways between these two issues are open for exploration and innovation by Schools of Nursing and Midwifery within the Kingdom.

The healthcare system in general and the patients in particular remain in a precarious position until succession planning systems are well-established. This precariousness of patient care was significantly highlighted when, as a result of the 1990 Gulf War, there was a sudden exodus of expatriates from the healthcare system resulting in a loss of leadership and a potential lowering in the quality of patient care. There is no guarantee that a similar world crisis could not occur again.

A number of themes emerged from the data, which on closer examination could be subsumed into major concepts, which have impacted on and unless they are corrected, will continue to hamper the implementation of a succession policy in hospitals in KSA. The quantitative analysis demonstrated that there was a positive attitude to management and to the implementation of succession planning.

However, this positive attitude was negated to some extent by the qualitative responses which highlighted the lack of succession planning in their particular organisation as well as a lack of competencies of respondents and education for nurse managers.

Two recurring themes that emerged from qualitative data were human resource issues with the Saudisation policy, for example workforce planning and recruitment and retention and a lack of staff who were adequately prepared for their managerial role. The third major thematic focus was the problem of further education and training in all areas of clinical management and patient care. The other themes were the quality of the present management, with the need for motivation and encouragement and an indicated lack of resources on a technical level. Finally there was the aspect of the need for leadership in terms of the quality of management.

Despite the dichotomy between the quantitative and qualitative responses, the identified concerns were combined to form five major areas which need to be addressed. The five areas were succession planning, vision and Saudisation, governance, nursing organisation and human resources. The implications for the first two major areas are now discussed.

Succession planning

The need for succession planning in the analysis was clear, although the comments were sometimes cautious. Good succession planning fills management positions with high-quality people who have been groomed to fill the vacancies. The implementation of succession planning does not depend only on leaders or managers, as the responsibility is shared with the organisation and its systems for staff development.

Preparing the next generation of nurse leaders and managers is nothing less than good strategy in implementing succession planning. Succession planning requires identification of potential leadership ability in a number of people across all nursing departments, rather than grooming one person in each department. [15] This process will enable the organisation to provide a group of talented people who are well prepared for their future role when vacancies occur. This research indicates clearly that succession planning in nursing management includes but is not limited to professional and career development, nursing education, future needs of nursing competencies for nurse managers, vision and planning, communication, motivation and encouragement, teamwork and assessment and evaluation.

Vision and Saudisation

The fundamental meaning of Saudisation policies is a national call focusing on the preparedness of Saudi nationals to occupy vacancies and to fill key positions when expatriates leave the country. The assets of the Ministry of Health and other health organisations are vast and part of their resources is used to develop and train Saudi health professionals in all specialities.

The results of this study found a significant shortage of Saudi nurse managers at all seven participating hospitals relative to the number in the overall nursing management workforce who participated in this research. Ninety five percent of respondents were expatriate nurse managers, with the highest group being Asian nurse manager who represented 59% of the expatriate respondents. The high percentage of expatriates compared to Saudi nurses and the high number of Asian nurses is consistent with similar studies set in KSA hospitals. Al-Ahmadi conducted research in a similar setting to investigate factors affecting the performance of hospital nurses. Expatriate nurses were found to be the highest proportion of the workforce with 94%; Asian nurses represented 64% and female nurses 90% of the total study population. [17] An earlier study conducted by Al-Ahmadi under similar conditions and at similar hospitals indicated the percentage of expatriate nurses represented 84%. [16]

It is simply impossible to have effective and sufficient nurse managers and leaders without having a sophisticated system that considers their selection, abilities and development and provides them with education and support to assume their managerial role efficiently. Jaynelle highlighted that dignified succession planning will ensure the future of nurse managers by providing mentoring, competencies and experiences. [18] Proactive succession planning is the key to develop effective nursing leaders to cope with the new challenges they will encounter. [19]

Limitations of the study

The number of Saudi nurse managers who participated in the study was very low compared to expatriates. This is explained by the low representation of Saudis in the Saudi nurse population. A limitation of the questionnaire was the definition of succession planning at the beginning, where some participants may not have read it, nor understood the concept. The principle of succession planning might have caused a threat to some nurse executives who had not groomed or prepared a successor and this was identified when requesting ethics approval from some hospitals and the request denied.

Conclusion

Effective succession planning is built on the framework of a solid organisational vision, mission and the critical skills required to develop the organisation towards a successful future through formal identification by the leadership team. [20] Preparing the next generation of nurse leaders and managers in Saudi Arabia is a sound strategy which is supported by the vision of the Saudisation policy and organisational plans which are in early stage of development for potential successors. This research has shown that there was a reasonably affirmative attitude to management and to the implementation of succession planning but the evidence in practice is limited and is hampered by lack of staff and resources and competency issues. The unique aspects of the Saudi population demonstrate the need for early succession planning in order to direct an appropriate number of the younger generation into the health workforce and particularly into health service management. The challenges will be to meet the educational demand of the emerging workforce and the workplace requirements of the Saudi female nursing workforce, especially those with management capacity.

A succession planning model including the twin concepts of capacity building and coaching was recommended by the World Health Organization in 2006 for Saudi doctors and nurses and it is suggested this is essential for successful implementation of a succession planning program in the future. [21] Nursing research in Saudi Arabia needs to be encouraged and supported with a particular focus on leadership and management styles in health services and barriers to careers within the nursing profession. Some work has begun in working with international mentors for senior staff.

Competing Interests

The authors declare that they have no competing interests.

References

1. Yoder-Wise P, Kowalski K. Beyond leading and managing: nursing administration for the future. Philadelphia: Mosby; 2006.
2. Bolton J, Roy W. Succession planning securing the future. J Nurs Adm. 2004;34(12):589-593.
3. Garman A, Glawe J. Succession planning. J Consult Psychol. 2004; 56(2):119-128.
4. Blouin AS, McDonagh K J, Neistadt A M, Helfand B. Leading tomorrow's healthcare organizations strategies and tactics for effective succession planning. Nursing Administration. 2006; 36(6):325-330.
5. Wolfe RL. Systemic succession planning. Canada: Transcontinental Printing; 1996.
6. Rothwell W. Effective succession planning. Ensuring leadership continuity and building talent from within. 3rd ed. New York: AMACOM; 2005.
7. Rollins G. Succession planning: laying the foundation for smooth transitions and effective leaders. Journal of Healthcare Executives. 2003;18 (6):14-21.
8. Marrone C. Home healthcare nurses' perceptions of physician-nurse relationships. Qual Health Res. 2003;13(5):623-635.
9. Madhi S T, Barrientos A. Saudisation and employment in Saudi Arabia. Journal of Career Development International. 2003; 8(2): 70-77.
10. Junco J Gd, Dustchke G, Petrucci M. The Hofstede model in the study of the Impact of Sevilla Expo 92. Revista de Turismo Patrimonio Cultural. 2008;6(1): 27-36.
11. Al-Meer A. A comparison of the need importance structure between Saudis and Westerners. Journal of Management Development. 1996;15(5):56-63.
12. Bjerke B, Al-Meer A. Culture's consequences: management in Saudi Arabia. Journal of Leadership and Organizational Development. 1993;14(2):30-35.
13. Creswell J. Research design: qualitative, quantitative and mixed methods approaches. 2nd ed. California: Sage; 2008.
14. Braun V, Clarke V. Using Thematic Analysis [Electronic Version]. Qualitative Research in Psychology [serial on the Internet]. 2006 [accessed 2009 May 5]; 3:77-101. Available from:www.science.uwe.ac.uk/psychology/DrVictoriaClarke_files/ThematicAnalysis%20.pdf
15. O'Connor M. Succession planning: a key strategy in nursing leadership education. Nurse Leader. 2004; 2(5):21: 24-25.
16. Al-Ahmadi H. Factors affecting performance of hospital nurses in Riyadh Region, Saudi Arabia. International Healthcare 2009. 22(1):40-54.
17. Al-Ahmadi H. Job satisfaction of nurses in Ministry of Health hospitals in Riyadh Saudi Arabia. Saudi Med J. 2002;23(6):645-650.
18. Jaynelle S. Succession planning: why grooming their replacements is critical for nurse leaders. Nurs Women's Health. 2009;12(6): 525-528.
19. Huston C. Preparing nurse leaders for 2020. J Nurs Manag. 2008; 16:905-911.
20 Stichler J. Succession planning: why grooming their replacements is critical for Nurse Leaders. Nurs Women's Health. 12(6): 525-528.
21. World Health Organization. Country Cooperate Strategy for WHO and Saudi Arabia. 2006 [accessed 2009 June 2]. Available from: www.who.int/countryfocus/cooperation_strategy/ccs_sau_en.pdf

Applying Lean Management to Improve the Pre-Consultation Patient Journey in Outpatient Services: a Hong Kong case study

C K Chan

Abstract

Introduction: **Lean management has its basis in the Toyota Production System, and has developed over time in the manufacturing sector. [1] A set of practical, operational level, lean management techniques has been developed. Although applied effectively in the private sector, especially in production and manufacturing, the approach has also recently been applied in the public sector and in healthcare organisations and systems.**

Methodology: **This descriptive case study presented the lean management philosophy and implementation process, and described the experience of the implementation of lean management to improve the pre-consultation patient journey in the specialist outpatient services of Kwong Wah Hospital in Hong Kong.**

Conclusion: **The use of practical, operational level, lean management techniques by a multidisciplinary health team led to reduced congestion in the patient waiting area, improved patient flow reduction on patient complaints, reduced staff workloads and improved internal air quality.**

Abbreviations: **CQI – Continuous Quality Improvement; QMS – Queue Management System; SOP – Specialist Outpatient.**

Key words: **Lean management; patient logistics; outpatient services.**

Dr Chi Keung Chan BA(Hons), MSc(HSM), DBA, FHKCHSE, FCHSM
Adjunct Lecturer
College of Life Sciences and Technology
School of Professional and Continuing Education
Hong Kong University
General Manager (Administrative Services)
Kwong Wah Hospital and TWGHs Wong Tai Sin Hospital
Hong Kong Hospital Authority

Correspondence:
chancks@ha.org.hk

Introduction

The central focus of lean management includes minimised waste, maximised quality and optimised customer value received. [2] This management philosophy was originally developed by the Toyota Company in the form of the Toyota Production System, which identified and reduced seven types of resource and time waste. They were defects, overproduction, conveyance, waiting, inventory, motion and overprocessing. This philosophy helped Toyota progress from a small business into one of the world's major automobile manufacturing giants. [1] Lean management has been defined as the complete eradication of waste with due respect for staff members. [3] The lean philosophy is being brought to the public sector and to public healthcare organisations. For example, the Scottish government has implemented lean management into its public sector and heathcare organisations. [2] This case study reviewed lean management and applied it to the Specialist Outpatient (SOP) Service of the Kwong Wah Hospital, a general acute hospital in Hong Kong.

Background

Kwong Wah Hospital is one of the acute general hospitals of the Hong Kong Hospital Authority serving Kowloon West Region in Hong Kong. The hospital operates 24-hour Accident and Emergency services, and provides a full range

of general, specialist and allied health services. Kwong Wah Hospital is located in Yaumatei, an urban area with a high volume of traffic, numerous commercial activities and serves a population of around 630,000.

The Specialist Outpatient (SOP) Service is one of the busiest services in Kwong Wah Hospital. [4] Since the Outpatient Building in Kwong Wah Hospital was commissioned in 2000, many problems have been experienced with service development and high patient volume. The increase in patient volume led to an increase in queuing time from 30 minutes to 60 minutes. Complaints about queuing time increased by 20%. The increased patient waiting time led to inefficiencies in the patient waiting area and related facilities. Many associated issues emerged, such as insufficient toilets, an increase in patient enquiries and poor air quality (the carbon dioxide content increased above the satisfactory level to 1000 ppm). These issues led to increased working demands on nurses and counter staff. These examples demonstrated that even where workflow and physical facilities are well-designed, they might fail to adapt to challenges presented by increased patient demand and changing demographics, affecting the balance that the management seeks to achieve between patient service and cost.

Reasons for selecting the pre-consultation patient journey for applying lean management

The pre-consultation patient journey in Outpatient Services was identified for applying lean management for a number of reasons. First, the registration is the first contact by patients with clinical services, and as such, gives a lasting first impression of services the patients receive. It was a pilot for a Continuous Quality Improvement (CQI) initiative in the hospital where management can apply its leadership skills and project management skills to lead a CQI team to work through projects effectively. Management also recognised that the advancement of technology could streamline the operational procedure to the benefits of the patients and staff.

The Lean management methodology

Eaton's five-step lean management process was adopted. The first step of lean management is to prepare for the implementation of lean techniques. [5] There are four key activities in this step.

To begin with, hospital management should be clear about the problem it expects to solve, including identifying the expected outcome. At this stage, sponsors and change agents who will champion the program and who will lead the actual process should be identified. In addition, a communication plan should be prepared to allow others to comment on the process. The team has to clearly define the process, which includes the project mission, scope and boundaries.

The second step of lean management is to set out a roadmap. A roadmap is required to show how the organisation can move from its current state 'as is' to its desired state 'to be'. [5] A lean management tool which assists in this step is Value Stream Mapping. Value Stream Mapping is an innovative process that aims to modify the way that people think about how they deliver services at present and facilitate participants to create a resolution that is closest to being most favourable. [5] There are three aspects to Value Stream Mapping. Firstly, the current state should be fully understood. This includes a selection of core business process and understanding client requirements. Pre-consultation patient logistics in outpatient services must be described. [5] This step is followed by the creation of a 'blue sky' vision. Here, the aim is to get the team to design an ideal state assuming there are no constraints. The ideas generated in this step are essential for the next activity of designing a realistic future state, using the ideas formed in the previous actions.

The third step of lean management is to implement the change, [5] that is, convert the plans created in the previous steps into tangible actions. The team consisting of doctors, nurses, finance and administration colleagues and patient representatives, has to simplify the pre-consultation patient logistic process by, for example, removing non-value-added activities. During this key step, the team has to standardise the process and automates wherever possible. The team has to consider the feasibility of using information technology, construct the overall outline of new business processes and collect comments from different levels of the organisation.

The fourth step of lean management is to sustain the changes. [5] Change cannot be sustained without re-inforcement. Some of the key activities to sustain the changes include managing for daily improvement, management audits, communication and coaching. Managing for daily improvement involves getting the team together quickly on a daily basis to discuss the issues, actions and further improvements. The process requires a lot of management support to prevent it from becoming a 'grumble and cry out' session and to make sure productive changes happen. Communication and coaching are also key activities in this method. The team should communicate with all employees so as to ensure they are aware of the vision of the future. The team should provide continual

information on the progress of the improvement initiative, no matter whether the progress is good or bad. It is also imperative to assure staff that the improvement initiative is both necessary and properly managed. In addition, the team should prepare and properly indicate actions required and those responsible.

The fifth and final step in the process of lean management implementation is to maintain the momentum. This step considers how the team can maintain the momentum of improvement. One of the ways is to go back to the beginning and to start the five steps of lean management over again. [5]

Results of lean management at Kwong Wah Hospital

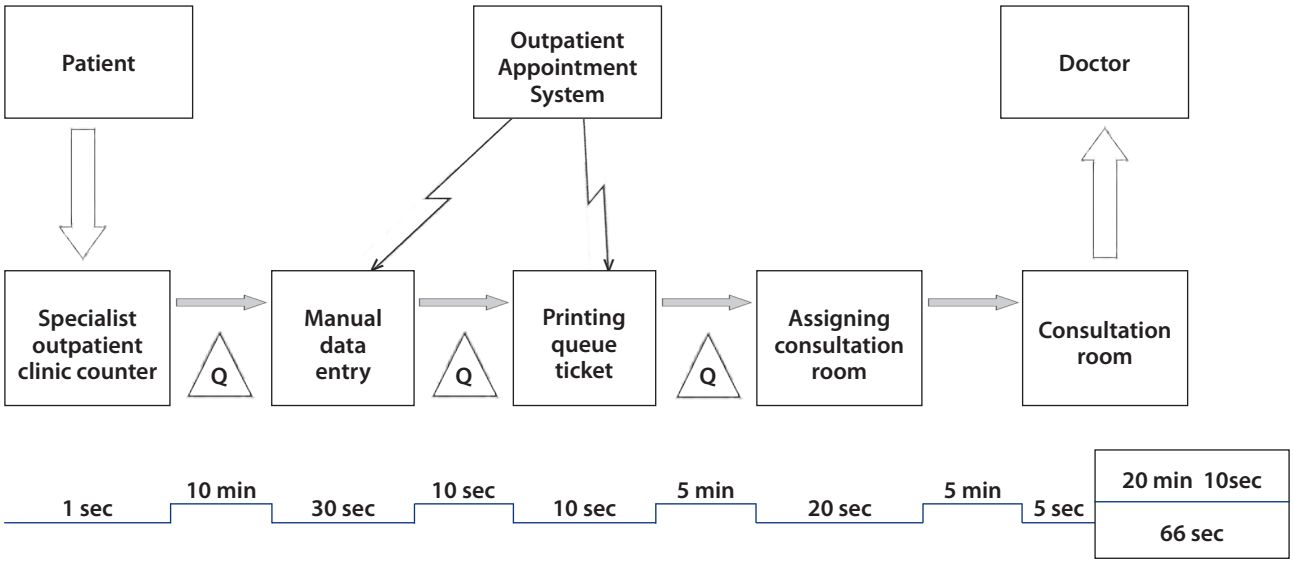
In Kwong Wah Hospital, the Hospital Chief Executive's support as program sponsor was essential as this individual also provided the necessary resources for the implementation of changes required during the lean management process. At the start of the project, a lean management multidisciplinary team was formed to walk through the whole SOP process from the patient prospective. The team conducted a critical analysis of each step to identify whether any streamlining and automation could be implemented. A radical redesign was made to explore the possibilities for reducing congestion in the patient waiting area.

Radical redesign was made to explore whether any streamlining or automation could be implemented. The diversion of patients to the ground floor was achieved by relocating the registration and cashier office to that level to ease congestion. The waiting time was reduced by 33% after using the Queue Management System (QMS) with a patient self-service kiosk (Figure 1) that streamlined the work process by eliminating unnecessary steps. Process diagrams (Figure 2) show the original and streamlined after value stream mapping.

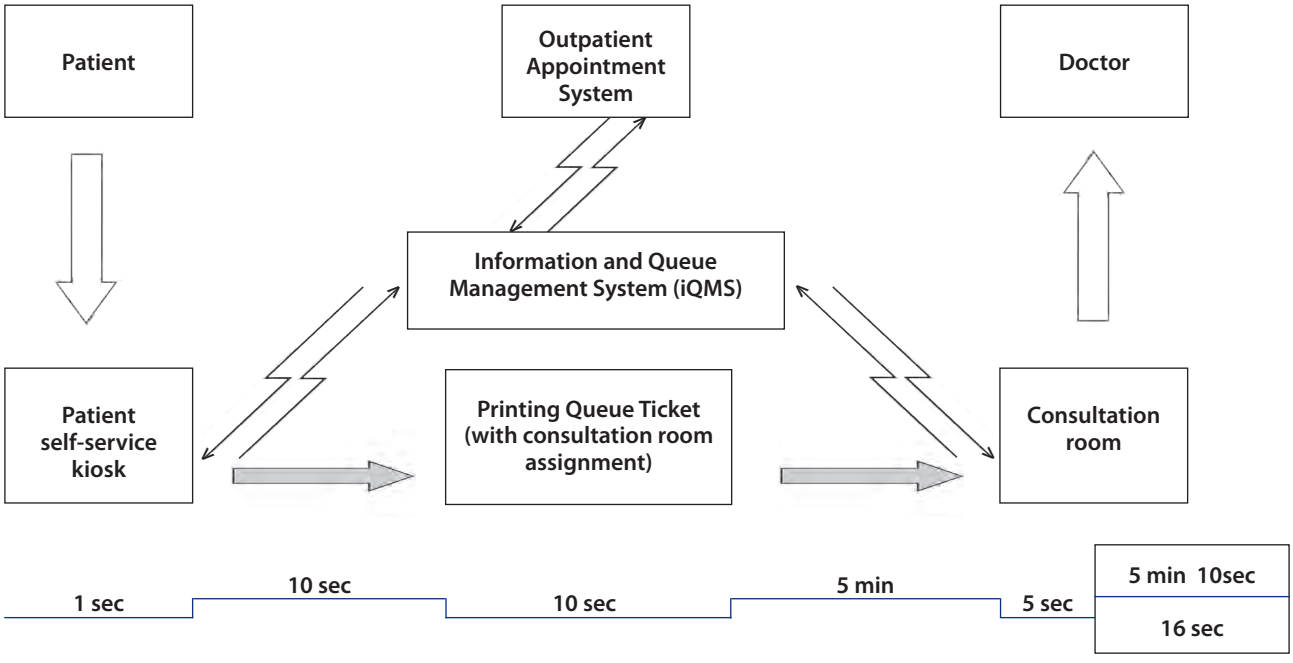
Figure 1: Patient self-service kiosk

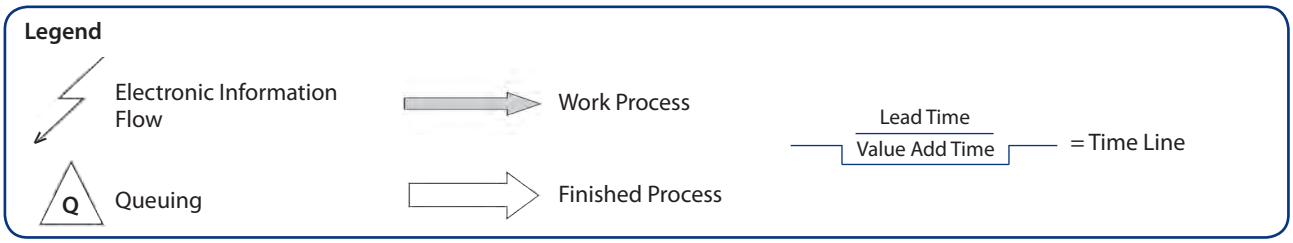
Figure 2: Process diagrams show the original state and future state value stream mapping

Current State Value Stream Mapping



Future State Value Stream Mapping





All patients obtained a ticket with their queue number after attendance at the patient self-service kiosk (Figure 3). The system arranged the queue and consultation time for the patients. Patients did not have to wait in the outpatient area but could return to the clinic around the assigned consultation time as indicated on their ticket. Other procedures, such as calling of patients and retrieval of medical records, were done automatically via the computer network.

The self-service kiosk set up (Figure 1) included an industrial grade PC, a barcode scanner, an optional Hong Kong Identity Card reader, an LCD Screen and a queue ticket printer. With these basic parts, the self-service kiosks functioned well when managing the initial stages of the workflow. For example, the PC component listed all registered patients and users/staff simply printed out an attendant slip by scanning in the barcodes.

It was considered important to keep patients informed of the queuing situation when they arrived at the out-patient waiting hall. To do so, the hospital installed LCD monitors outside each consultation room (Figure 4). A plasma information screen was also in the waiting hall showing the queue number of the patient in each consultation room.

In the consultation rooms, a data capture terminal was installed (Figure 5). A simple scan of the barcodes put patients into a queue. The doctors in the consultation rooms pressed a single key to signal the calling of the next patient.

Figure 3: Patient self-service kiosk arranging the queue and consultation time for patients

On the plasma display itself, queuing numbers were colour coded by specialty to improve the presentation of the information. The online consultation and queuing time statistics were available and used for service monitoring and planning.

Figure 4: LCD monitors showing the queue number of the patient in each consultation room

Figure 5: Doctors press a single key in the data capture terminal to signal the calling of the next patient.

There were some significant changes in the setting of the SOP floor. The environment of the SOP floor was improved by relocating the appointment counters, preparation rooms and relocating clinics from a crowded floor to an adjacent centre. The waiting area was enlarged by 45%, mainly by a drastic revamp of the Outpatient Department layout.

The patient flow was improved on the SOP floor by the implementation of the project resulting in a reduced number of patients waiting on the SOP floor in different timeslots throughout the week and an improvement in internal air quality by 20%.

Discussion

The post-implementation review of the lean management project showed there were a number of dramatic improvements in performance. These included reduced congestion in the patient waiting area, improved patient flow reduction on patient complaints, reduced staff workloads and improved internal air quality. These performance improvements were achieved through ownership of lean project and management commitment. More importantly, staff engagement was crucial which was achieved through effective communication system and team work.

The implication for health service managers and policy makers was that the present case study is a demonstration of how the use of simple information technology can make significant improvements in the manual process of patient queue management. Looking forward, the application of lean management and a multi-disciplinary team approach in other processes in hospitals should be conducted for the benefit of patients.

The strengths of current study were that it identified a set of lean-based indicators and tied them to specific measurement and performance outcomes in a healthcare setting. Besides, this study brought to light the role of multi-disciplinary teams and leadership in the diffusion of change strategy, and the creation of strategic alignment in a healthcare setting.

The weaknesses of the study stemmed from the fact that it was a case study. It was examined during a limited time period and its primary focus was on the implementation of one initiative in a specific service sector in one hospital, the pre-consultation of patient logistics in outpatients. However, this case study provided a solid foundation for further research that can lead to generalisable principles and practices. Further research could be conducted on the suggested lean implementation model derived from this case study and whether it could be successfully implemented in other healthcare settings.

Conclusion

In hospitals, there are a large number of processes which patients have to follow in order to obtain services. The application of lean management to an outpatient service is just one example which illustrates that the long-established work processes in hospital should be subjected to reviews over time or when environments have changed.

The use of practical operational level lean management techniques by a multidisciplinary health team led to reduced congestion in the patient waiting area, improved patient flow reduction on patient complaints, reduced staff workloads and improved internal air quality.

Competing Interests

The author declares that he has no competing interests.

References

1. Womack JP, Jones TD. Lean thinking. New York: Free Press; 2003.
2. Radnor Z, Walley P, Stephens A, Bucci G. Evaluation of the lean approach to business management and its use in the public sector. Scotland: Scottish Executive Social Research; 2006.
3. Ohno T. Toyota Production System: beyond large-scale production. New York: Productivity Press; 1998.
4. Hong Kong Hospital Authority. Hospital Authority Statistical Report 2009 – 2010. Hong Kong: Hospital Authority; 2011.
5. Eaton M. Lean for practitioners: an introduction to lean for healthcare organisations. New York: Academy Press; 2009.

Developing Operational Policies Using Stakeholder Engagement When Building New Hospitals

T Hunt, K Ramsay and C Hackwood

Abstract

Being involved in the build of a new hospital is a unique experience. Although there is much emphasis on design, building and fit out, the development of operational processes is as important. This article describes the journey undertaken in developing operational policies and outlines the highlights and difficulties of the process in an attempt to efficiently and authentically involve all stakeholders. There is an important connection between stakeholder engagement, the process of planning and the development of operational policies in order to stay true to the process of capital development.

This article provides an overview of the experience the project team had in developing operational policies/ briefs when a hospital is built or expanded. This planning experience outlines the process and tools required, the lessons learned and knowledge gained in developing purposeful operational briefs. Nomenclature was changed from operational policy to operational brief for reasons explained in this article.

Practical experience and conversations with other stakeholders within Australia who had been involved in developing hospitals in the past ten years informed this process. Four major learnings from the project are described. Operational briefs need to be considered as an integral aspect of project management of the build, in this case a community hospital, is to be stakeholder driven.

Abbreviations: **AHFG – Australasian Health Facilities Guidelines; ED – Emergency Department; HCAMC - Health Capital and Asset Management Consortium; MAU – Medical Assessment Unit.**

Key words: **Functional brief; hospital capital works; hospital planning; operational brief.**

Tracey Hunt M Nursing, GD OH&S, GD Gerontology, Appl Dip Project Management
Project Manager
Operational Briefs
Facility, Planning and Development Unit
Queensland, Australia

Kate Ramsay
Project Manager
Change Management
Gold Coast University Hospital Project
Southport, Queensland, Australia

Colin Hackwood
Project Manager
Associated Infrastructure Projects
Gold Coast University Hospital Project
Southport, Queensland, Australia

Correspondence:
Tracey_Hunt@health.qld.gov.au

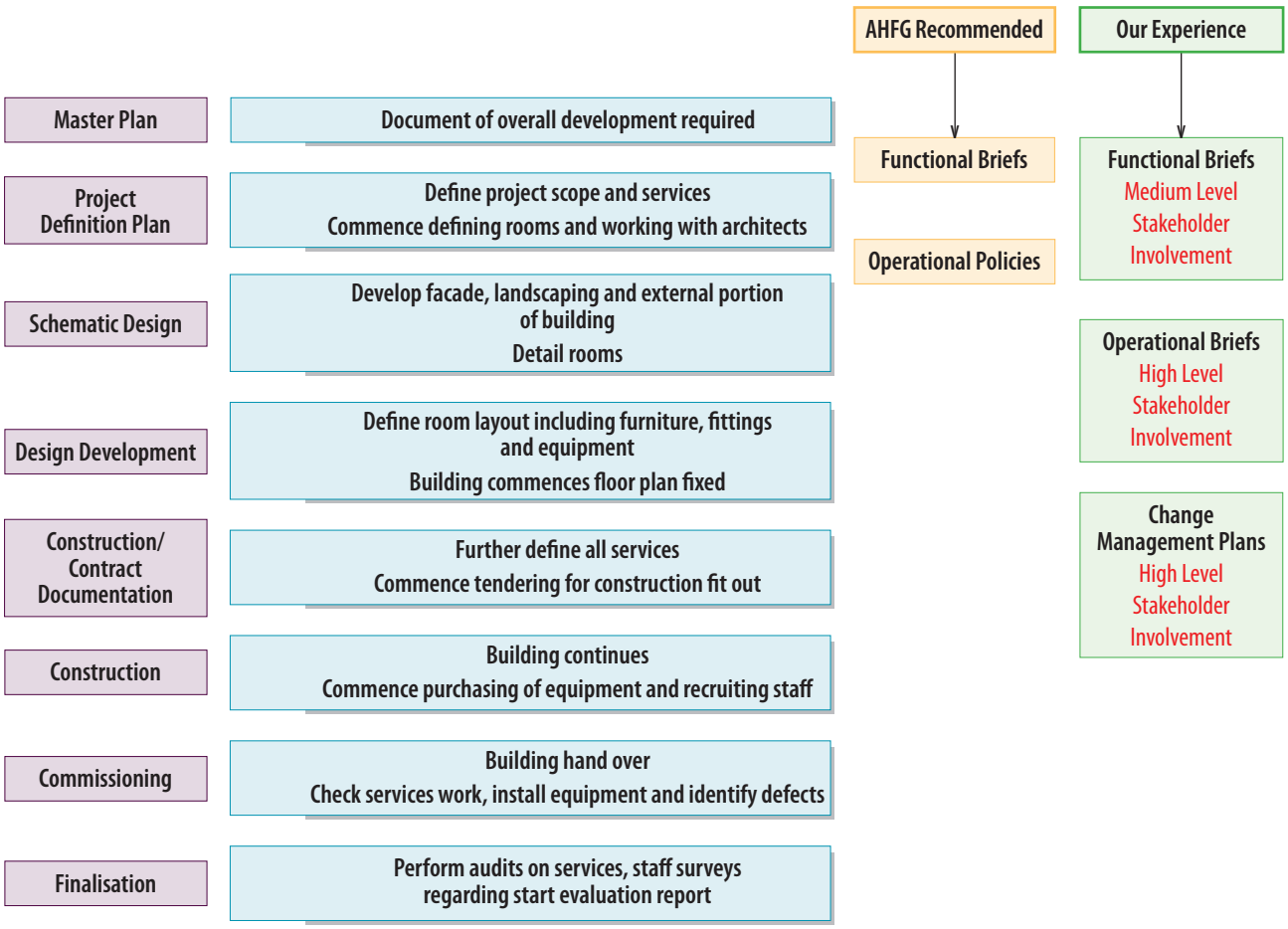
Introduction

This article describes an experience and the lessons learned from the development of operational briefs during the multifaceted project planning stage of building a new hospital in Queensland, Australia. The Australasian Health Facilities Guidelines [1] (AHFG) state:

> In the design phase, the operational policies, traffic and workflow diagrams will be used by the architects, engineers and facility planners to ensure that the range of activities and requirements are reflected in the design. At this stage, necessary compromises can be discussed or changes made where there are financial, building and other constraints.

Developing the operational briefs was delayed compared to the recommended time frames for operational briefs specified by AHFG. This delay and the lack of all but anecdotal information brought a sense of urgency to the need for completion.

Table 1: Capital development process



Source: Developed by GCUH Project team utilising information from AHFG.

The project team understood the significance of involving hospital administrators when planning staff recruitment, costing, equipment purchasing, etc. These are significant parts of the capital development process that provide the intimate details of what is expected to occur within the building and include development of models of care, service planning and workflow design. Project management literature generally lacks the development of operational briefs as an integral, albeit, parallel stage to project planning. Functional briefs are developed during project definition and may continue through schematic design, to be finalised before design development. They inform the final building design. Operational briefs occur once the design is complete, or in our experience commenced part way through this process and continued, parallel with construction. Ultimately the team would have liked to have done more of the operational brief work before completion of design development when the floor plans officially 'freeze'. However, this was not possible and ongoing stakeholder involvement in this process led to continued layout changes that required a stopping point. At some point a line needed to be drawn in the sand or floor plans would never be finalised. The operational briefs detail how the building will be used and therefore require a far greater amount of stakeholder input. Table 1 demonstrates the sequential process from functional brief to operational brief, at the corresponding milestones on the building development process.

The project team in this case had two hospitals to build, one on a very large 'greenfield' site, the other being expansion of the existing fully functioning smaller hospital, described as a 'brownfield' site. The greenfield site was to replace an existing hospital three kilometres away.

The project team was tasked with ensuring that both building projects were stakeholder-driven where possible. Both projects offered healthcare professionals the opportunity to embrace research-led, best practice when developing operational briefs that aligned the service processes and models of care with the 'State of the Art' infrastructure. [2-4]

Healthcare professionals use the AHFG 2007, version 2 developed by the Health Capital and Asset Management Consortium (HCAMC), as a guide. [1] The AHFG (2007) was a first point of reference for the project team. However they proved to be inadequate for the project team needs when developing operational briefs. Therefore, the project team had to rely on anecdotal evidence as there was a lack of documented guidance and experiences from which they could learn and nothing in the contemporary planning literature to guide the process.

Aim

This article provides a practical approach to developing an operational brief using stakeholder engagement. There were varied efforts to source information relating to developing operational briefs including a literature search, consultation with the appointed building service project managers, as well as networking with people previously or currently involved with numerous health building projects across Australia. Each lead to an overall lack of solid information and certainly no succinct method or guide was available.

There was a need to develop and have ownership of an operational brief specifically in relation to the operational aspects of all areas that are represented on the architectural drawings in keeping with planning requirements. The naming convention of operational brief represents a departure from that used in the AHFG 2007. The reason for the departure is that the term 'brief' held greater user friendliness than the term 'policy'.

Context

Phases of development were created for the operational briefs demonstrated in Table 2. [3] This aricle focuses on Phases 1 and 2 and has three main parts. The first part summarises the steps of project management and parallel steps of developing operational briefs; the second part details the steps involved in developing stakeholder driven operational briefs. The final part details the essential aspects of document management and lessons learned from our experience.

Background

Historically, the usual approach is that existing user groups determine the development of the operational briefs under the leadership of the hospital stakeholder group chairperson. However, this approach was changed because of a problem with compliance from users. As a result, the decision to change the naming convention from operational policies to operational briefs was made at a local level to encourage more compliance from users. From the hospital stakeholders' perspective the development of a policy engendered more anxiety than the development of a brief. Anecdotally, reluctance and negative reactions to developing policies as a tool to guide development had been the experience of the project team in many health organisations. This organisation was no exception. When the initial groups of stakeholders were consulted about developing operational polices, there was initial confusion as there already was a large suite of clinical, corporate and state-wide policies. Further consultation identified 'anxiety' as the main reason for poor compliance from previous experience in the arduous task of developing numerous clinical or corporate policies.

Stakeholders who contributed to this process included:

- Executive directors, for both clinical and non clinical services;
- Senior clinical managers – nursing directors, medical directors and allied health directors;
- Senior non clinical services managers – human resource directors;
- Line managers, both clinical and non clinical – nurse unit managers, food service managers, administration supervisors etc; and
- Community based staff with an interest in patient flows throughout the facility.

The anxiety demonstrated through involvement in this process was linked to users believing they could not make important decisions in the absence of other team members or supervisors. They were also aware of the tedious process taken to achieve 'sign off' for a policy and the need to reference them against legislation and standards, with a benchmark to at least best practice.

According to the AHFG 2007, '…Operational policies (briefs) have a major impact on facility requirements and the capital and recurrent costs of the unit'. [1] These briefs should be clearly articulated prior to the commencement of capital planning so that the facility design can reinforce the new practices proposed for the service. It is possible to anticipate the full range of operational briefs required for new units. It is just a matter of identifying each area on the architectural drawing and ensuring it is supported by an operational brief. In essence, every functional area on the plan has to be supported by an operational brief. That is not to say there cannot be a generic brief for common areas and this approach was certainly adopted for generic rooms in medical and surgical divisions.

Table 2: Phases of stakeholder engagement

Operational brief progress plan – Phases of stakeholder engagement							
PHASE	PHASE 1	PHASE 2	PHASE 3	PHASE 4	PHASE 5	PHASE 6	PHASE 7
Title	Development	Content Review /Service Lines	Reconciliation Presentations	Service of Change Plans	Development	Operational Policies and Evaluation	Change Implementation
Purpose of phase	Transition from functional brief to operational brief. Develop model of care concepts. Identify spaces to be occupied and overall expected functions of areas. Identify facilities required to perform service proposed.	ESPG/SPG members to review content of briefs for overall planned service expectations. This is to ensure ESPG responsible for each area have substantial input and oversee operational brief content. ESPG sign off	Reconcile floor plans to brief content. Identifying purpose or potential occupant types for rooms, areas. Identifying conflicting expectations for shared areas. Identify operational changes to move current services/model of care into new environment. Transfer models of care/service concepts into work flow patterns through desk top exercise. Explore impact/relationships of model of care/service on other departments. Change proposed language of document, to reflect actual facilities provided on plans. ESPG	Provide overview of services with a functional relationship to others in order to identify service gaps, expectations out of scope. Service lines will be presented to all relevant stakeholders to cross reference / compare service expectations.	Through Phase 3, areas of operational change will be identified, along with functional constraints or boundaries required to move current services and proposed models into the new buildings. This will include development of change plans (change preparation). ESPG	Policies will be identified for operational processes throughout all phases. Development and registration of the necessary policies needs to occur prior to transition into the buildings.	Changes will commence prior to moving in many cases including preliminary education of changes, pilots/trials, then actual transition where education and change plans will be implemented and evaluation of staff preparedness will be tested.
Expected outcome of phase	Development of expected facilities requirements to fulfil model of care/service.	Ensure Executive are ready to progress current content into detail.	Part 2 – Departmental level Reconcile proposed service/ care to actual planned facilities. Provide more detail of proposed service. ID missed or overlapping areas. Reconcile workforce plan with proposed model of care, with floor plan to ID discrepancies.	This will provide areas such as IPUs to clarify the scope of service to be provided compared to their expected needs. Multiple issues and operational processes are expected to develop from this phase.	In terms of change management there are 4 distinct steps. Identification of changes will occur primarily in phases 3 and 4. Phase 5 will include planning the changes, including staff education, skill mix etc, through stakeholder involvement. Implementation of some changes may be able to occur prior to transition, via pilots/trials of changes and preliminary education.	Development and wide distribution/education of operational policies will govern many of the planned changes. This step is necessary to provide governance and consistency to underpin operational processes and change as they will be included in education.	A smooth transition for the projects could be defined as: Limited quantity of unexpected operational issues. No, or reduced scope of any process interruptions - No or low level implications to patient care and financial impact to hospital. No, or limited delay in moving from one physical location to another related to operational preparedness. Identification and therefore prevention of all clinical mishaps that may occur during transition.

Engaging stakeholders

According to the AHFG 2007, it is possible that staff, including clinicians and non clinicians, may participate in the planning of a capital development only once in their working life and may initially be unfamiliar with capital planning processes at the outset of their experience. To that end, the importance of engaging users is essential. As the planning process is abstract in nature for most people, it is difficult for staff who have not been involved directly in user group consultation to develop a description of a service that may be new. The key to success therefore, is clear communication. This translates as engagement and support of the users as they embark upon a process of reconciling what is in the functional brief (Table 1) with updating models of care, then scrutinising the architectural drawings so that an operational brief reflects the accurate purpose or occupants of their rooms on the plan and further explains the functional relationships with other areas, and ultimately the broader reason for the building design.

The following description of how to assist a user in preparing an operational brief utilises the principles of sound communication. This guide is that only, and will not provide a definitive perspective as each project manager will bring an individual style to the exercise. The necessary tools and process will be described shortly but the key tenet to success is that stakeholders are informed of what they need to do

through clear communication. The ideal situation is that a conversation takes place one-to-one. The target audience comprises clinicians and managers who may have little or no capital project experience or may have skills ranging from novice to expert planner.

Ideas for initially engaging users:

- An afternoon tea and presentation from project managers to explain the importance of the completion of operational briefs.
- A succinct and articulate description of what it is you want and how you plan to achieve an outcome.
- Clear explanation of benefits to users if they engage in the process.
- An inherent respect of the time constraints of the users whether they be clinicians or non clinicians and an outline of the time frames.
- Leadership as a quality emerged early in this process. These leaders were the ones who took an interest, offered to get started and consulted broadly.
- Having a constructive spirit of discontent assisted users to try and find a better way of completing the task, for example this statement from one of the authors of this paper '….the quality of these briefs could be better, how can we help the users?'
- The willingness of key managers/stakeholders to not only engage other members at all levels but to assist them in the delivery of a quality product. The assistance rendered in this case included searching for examples of new or existing models of care in like facilities across Australia and in some cases around the world. [6] The project team identified networking or education opportunities for the stakeholders, to provide them with the real experience of what they were to describe when offering a new concept of service such as bariatric rooms, neonatal intensive care, and food service models.

The tools

The tools utilised for the initial engagement and development of the operational brief were both actual templates, and methods/processes. Figure 1 shows the steps taken to prepare stakeholders to move their functional briefs to operational briefs.

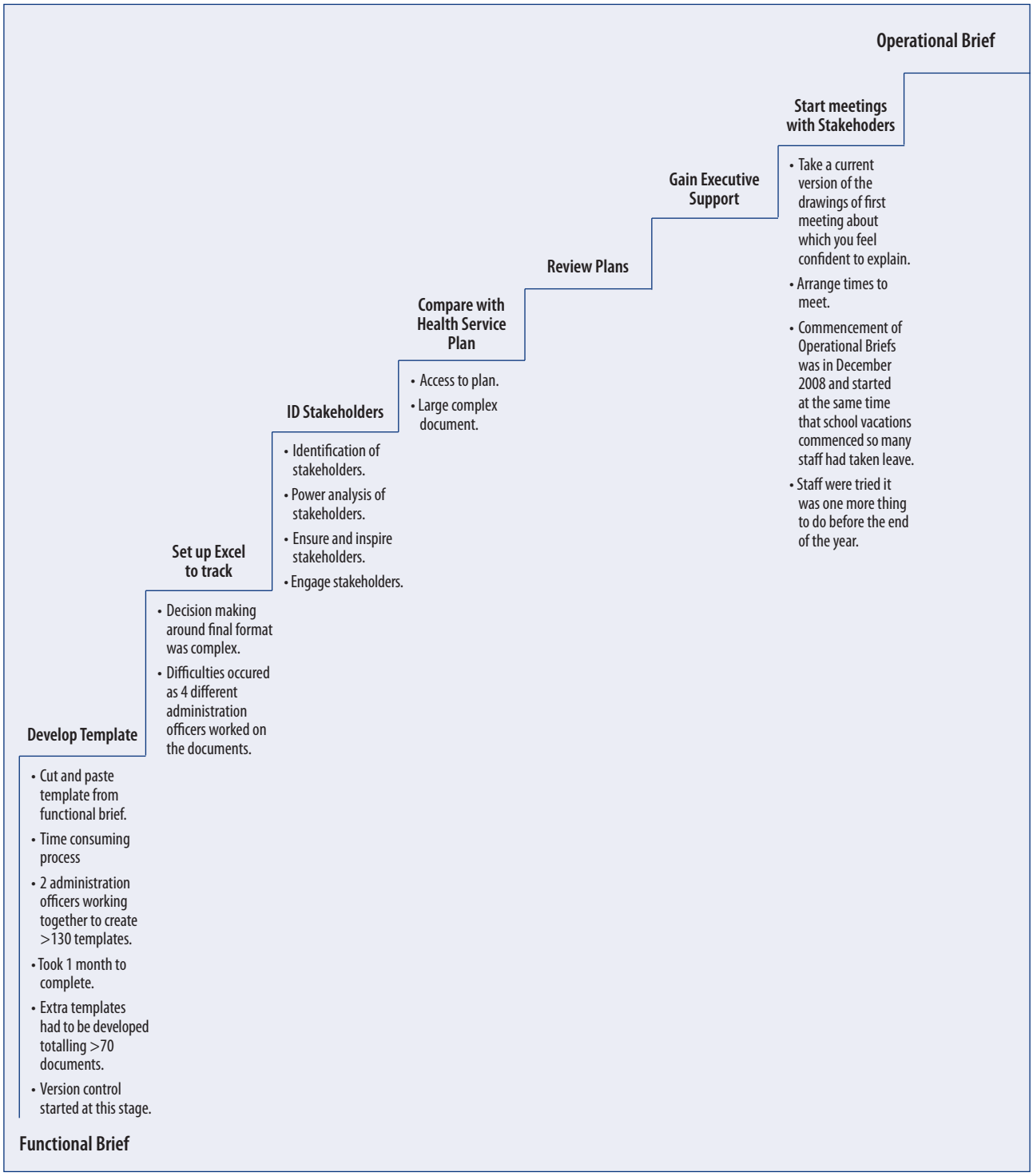
Figure 1: Steps to prepare stakeholders source: developed by GCUH Project Team. The main tool for this exercise is a Microsoft Word version template that was initially adopted from the AFHG 2007 guidelines and then used in the development of the functional brief and adapted to suit this service and the projects. The template provides headings and prompts for content that will provide all the detail required of not only each service/department, but also the inherent relationship they have with many other services both internally and externally to the project. It was required to fulfil every aspect of each service and therefore provide a thorough description of the processes, plus or minus physical features to occur within the structures to be built. Review of the template continued through the developing process as stakeholders would generate issues, such as needing staffing profiles for example. Developing staffing profiles emerged part way through our process, requiring the template to once again be changed to include this heading, and stakeholders to predict these crucial numbers.

A process was developed where each stakeholder group was defined by identifying specific working areas on the floor plans. The relevant hospital staff stakeholders would be guided through detailed plans whilst their description of accommodation needs, and reasons for rooms, location and scope were captured. The project team capturing this information portrayed the nature of the service directly into the template, under related headings using a laptop, so every detail could be clarified at the point of entry.

The briefs were ever-evolving documents, being added to regularly to reflect relationships with other departments' operational briefs as they came to fruition, and also to capture changing practice and models of care as changes evolved. [7] To ensure the living nature of each was captured and tracked, additions were made in a different coloured text, and new tools evolved, in the form of excel spread sheets noting additions, the source of the additional information and responsible stakeholders.

Although the operational briefs were stakeholder-driven in nature, they were constantly compared to the Health Services Plan and the State Clinical Service Capability Framework. The models of care and service were previously indicated on the clinical service planning work that has to occur during the early phase of master planning. The stakeholders were given the task of exploring innovative healthcare delivery concepts and treatment modalities in order to develop comprehensive briefs around the new services mentioned in the clinical service planning. Increased services in our case included a helipad and trauma service, radiotherapy bunkers and associated care areas, and increased level of neonatal care service. These documents provided the framework and limits to the services to be incorporated into the buildings. The project team were often faced with the challenge of ensuring that the content of the operational briefs abided by these guidelines.

Figure 1: Steps to prepare stakeholders source: developed by GCUH Project Team



One of the hospitals being built included over 5,000 rooms where purpose, relationship and patient and services flow needed to be identified, mapped, detailed and documented. To assist that process a desktop exercise was developed. It was first used in the emergency department setting following the scheduled completion of the emergency department schematic design phase when there were concerns raised by hospital staff regarding aspects of the design. The outcome of this was a delay in sign off by the hospital stakeholders.

To prevent further delay and hasten sign off, an intervention was designed to address the patient, staff and service flows through the department to attempt to assuage the concerns of the users. The aim of the exercise was to test the integrity of the models of care in terms of the identification

of any 'bottlenecks' and hold-ups. The desktop exercise was developed in order to enhance the safe and effective processing of patients and services through the department, and to test the imagination and creativity of the staff in getting patients treated efficiently.

The desktop exercise format is not new to emergency medicine and is used in the management of mock disaster responses. The approach is also widely used in a number of industries to include for example the management of chemical hazards and poisons and the study of astrophysics. This approach is used to simulate situations to which staff are required to respond quickly. The value of hands-on learning, long recognised by educators as an effective way to respond to a situation, is possible using this approach. The desktop approach is an exercise format where participants make tactical decisions without actually deploying personnel. Simple desktop exercises are a valuable, effective and efficient means for challenging organisations and for ensuring that team responsiveness is robust.

The desktop exercise then became a standard approach when difficult situations emerged that required group consensus regarding patient flow. The exercise was used in the final planning for the mortuary, the Medical Assessment Unit (MAU), generic ward areas, and cardiology. A response to medical emergency was also used as a basis for a desk top exercise. The scenarios involved the collapse of a visitor in the hospital grounds thus determining how the alert would be raised, who should attend the scene and what equipment they would carry with them. This exercise was useful in determining the types of resuscitation equipment for purchase. The findings from desktop exercises are based on scenarios that test the capacity of an area for example, in the case of the mortuary, an external disaster situation was simulated which required multiple deceased admissions to the unit simultaneously, rather than individual case management. The disaster scenario proved to be a very useful addition to the exercise and informed the development of recommendations which were later included in the final plans. The desktop exercise for the MAU considered patient types and flows from the Emergency Department (ED) to the MAU. It proved useful in two ways: firstly, determining traffic flow and the degree of traffic from ED to the MAU, and secondly, increased the physicians knowledge and understanding of how the two models of care would need to interrelate and change some inherent triaging processes for the system to work.

The process

The following is a dot point summary of the process to develop the operational briefs:

- Review of original functional brief for each service/area/department;
- Review final architectural drawings of each service/area/department;
- Locate operational deficits (if any) in the functional brief as opposed to the critical thinking surrounding the architectural plans; and
- Write and submit first draft of operational brief.

It is important to note that the greatest volume of work has already been achieved in writing the functional briefs. In many cases, the exercise of writing the operational brief involves 'cutting and pasting' from this previous body of work, to form the basis of the brief. New and emerging models of care and advancements in technologies are bound to occur and there will be an opportunity to include these in further iterations of the operational briefs.

Due to the time constraints of healthcare professionals there is a tendency for the development of the operational briefs to be a solitary rather than a group exercise. Where the task was completed by a group the operational brief contained a greater level of detail and was more comprehensive in content. For that reason it is important to assemble staff into small groups if possible, that way there is a cross fertilisation of ideas accompanied by the serendipitous unifying aspect of working together.

Benefits and difficulties of the process

Benefits and difficulties of the process relate essentially to user engagement and working within strict timeframes. The unknown and complex aspects of the process and the expectation of both project managers and stakeholders served to contribute to the challenges of the process.

One of the additional inherent difficulties of the development of the operational briefs is the potential risk of omitting an area that appears on the architectural drawings but is not supported by an operational brief. This can be the case with services that are completely new. An essential feature for the success of the development of operational briefs is the close association between the users' familiarity with the architectural drawings and production of the brief. Lack of familiarity with the architectural drawings may result in areas being missed. This became problematic on two counts. Firstly many people working within the health industry, and presumably in many industries, have little

knowledge of how to read and understand an architectural drawing, particularly of this scale and complexity. It is for this reason that a strategy to ensure knowledge of the floor plans is suggested or to ensure that planning support with this skill is available to each group.

Secondly, although the same stakeholder groups were involved with the architects in developing their areas from the functional briefs, they nearly all had issue with the floor plans on second review. That is, either new staff members would have varying ideas or existing members would have emerging ideas after visits to other facilities to identify varying models of care. Exposure to site visits sheds new light on how to determine and improve the layout of services, causing multiple changes to floor plans. The benefit of operational briefs is that they are essentially an expansion of the functional brief which assisted in designing the layout of what was needed on each floor, and establishes the detail of the processes inside the buildings. The main aim is to ensure the operational brief is well developed before the architectural drawings are 'frozen', to avoid both additional financial costs to the project and the requirement to significantly redesign facilities which are not fit for purpose and have not taken into account the benefit of stakeholders' evidence based models of care and service.

Overall, you can have all the tools, however the content is dependent on high level stakeholder commitment to engaging all hospital staff in the process. Leaders who tried to complete a review of their brief with little or no team involvement, appeared to complete the process within little time. However, future reviews where more stakeholders were consulted resulted in timely and extensive changes to documentation. There is also the risk that elements of the plans or purpose of rooms are missed or incorrect as the physical building progresses, which inflates costs for making structural changes. Documenting the stakeholders input in the development of a brief or activities such as desk top exercises was principle to future versions, and understanding of decisions made early into the project to inform the building planners.

Version control

Version control required a rigorous and disciplined approach. The Project had in excess of 200 different operational briefs. Given that each brief can have up to ten versions by the time changes are made and sent back to the users, a systemised approach was essential. An excel spreadsheet containing the title of each brief was the pinnacle of success in terms of the processing of the briefs. It also emerged as time progressed, with additional columns for adding in generic statements, returning briefs for review, noting stakeholders involved and documenting issues and their proceeding resolution after each review.

The document repository needs to have the capacity to generate a percentage total of discreet bodies of work. For example, the proportion of totally completed department briefs within divisions. Noting the percentages of completeness each day was the best way to see the progressive success of the task.

Major learning summary

Developing operational briefs for the project has been challenging and rewarding. The four major areas of learning are;

- Both the commencement of the operational brief development and engagement of the stakeholders needs to occur earlier. Ultimately development of operational briefs should occur immediately after functional briefs as major stakeholders are already engaged and there is a need to invite further stakeholders into the process at this stage of moving from functional to operational briefs.
- Developing methods to engage the stakeholders. Fostering a sense of user participation and ownership by the project managers results in a sense of satisfaction and achievement for users. Although changing the name from policies to briefs was beneficial to engage stakeholders, it did not prevent the extensive tasks of developing, reviewing and refining the same documents multiple times.
- Well developed operational briefs should include which current practices will continue in the future, as well as new practices, and how they will be implemented, making operational briefs the starting point for change management.
- The development of a meticulous process for version control is central to the success of this process. If users were more engaged by the operational briefing process, the timing and management could have been improved.

Conclusion

The development of operational briefs rather than operational policies enabled the project team to empower and encourage participation by user groups and demystify the process of developing fit-for-purpose facilities and services in a complex health capital development.

Operational briefs were mandated by the hospital executive at the outset and their value as an important tool to guide the major development project was reinforced by the

project team. This tool became one of the major platforms guiding the project and resulted in extremely high levels of consultation with health professionals and enabled input by the staff at all levels.

The operational briefs led to a number of changes to design and documentation at a stage where those changes could be incorporated without penalty or cost. It is imperative to align development of operational briefs with the relevant stages of the building project program to prevent multiple change requests.

Operational briefs and the inherent comprehensive consultation process have led to a better outcome for the community and greater ownership of the product by staff.

Competing Interests

The authors declare that they have no competing interests.

References

1. Centre for Health Assets Australia. Australasian Health Facility Guidelines, Part B Health Facility Briefing and Planning V3. Kensington: University NSW, Centre for Health Assets Australia (CHAA), Faculty of the Built Environment; 2009. P 43.
2. Queensland Health. 'We're building a healthy community' Gold Coast University Hospital Project Definition Plan. Brisbane: Queensland Health; 2007.
3. Queensland Health. 'We're building a healthy community' fact sheet Gold Coast University Hospital Site Functionality Study. Brisbane: Queensland Health; 2007.
4. Queensland Health. 'We're building a healthy community' fact sheet Gold Coast University Hospital Building Health Services. Brisbane: Queensland Health; 2007.
5. Office of Government Commerce. Managing successful projects with Prince2. Norwich: TSO; 2005.
6. Centre for Health Assets Australia. Australasian Health Facility Guidelines V2. Kensington: University NSW Centre for Health Assets Australia (CHAA) Faculty of the Built Environment; 2007.
7. Queensland Health. 'Changing Models of Care Framework'. Brisbane: Queensland Health; 2000.

RESEARCH ARTICLE

Evaluation Of Community Palliative Care Settings: a discussion of the issues

H Tan, M O'Connor and L Peters

Abstract

Introduction: As health services have increased in complexity, evaluation has become an integral part of policy, program development and service provision. Palliative care services have also experienced increased demand for evaluation. This paper explores the experiences and challenges in undertaking independent evaluations of community palliative care services.

Methods: The authors draw on their experiences in two different studies involving the evaluation of after-hours palliative care services. Data collection included the use of questionnaires and semi-structured interviews to explore the experience of after-hours service provision from the perspective of clients, visiting nurses, GPs, after-hours triage nurses and service managers.

Findings: The paper highlights issues about processes and systems of the evaluation itself, rather than the quality of the palliative care provided. Key issues were: project design; achieving an ethical evaluation process; working with vulnerable populations; staff/manager perceptions of evaluation processes; and factors pertinent to funding bodies.

Discussion: These findings are discussed in the light of current literature and strategies for more effective evaluation processes which are appropriate for a very vulnerable population; as well as considering the needs of staff in remote and often staff-poor services, and managers who have responsibilities for healthcare services in which palliative care provision is but a small part.

Conclusion: Suggested strategies to facilitate future evaluation processes include: careful attention to research design and dissemination of outcomes; the utilisation of processes which lead to ownership of problems and solutions by those most involved in the service provision; greater uptake by ethics committees of standardised forms and processes; recognition that vulnerable populations have the right to make their own informed decisions about involvement; and increasing vision in both services and funding bodies about the most appropriate application of research outcomes for best service provision.

Abbreviations: DoHA – Australian Department of Health and Ageing; HREC – Human Research Ethics Committee; PC – Palliative Care.

Key words: Evaluation studies; research design; palliative care services; community.

Dr Heather Tan
Research Fellow, Palliative Care Research Team
School of Nursing & Midwifery
Monash University, Victoria, Australia

Professor Margaret O'Connor AM
Vivien Bullwinkel Chair in Palliative Care Nursing
Palliative Care Research Team
School of Nursing & Midwifery
Monash University, Victoria, Australia

Dr Louise Peters
Research Fellow, Palliative Care Research Team
School of Nursing & Midwifery
Monash University, Victoria, Australia

Correspondence:
Heather.Tan@monash.edu

Introduction

Similar to world-wide developments in palliative care (PC) services, Australia provides care for those 'whose disease is not responsive to curative treatment'. [1] The Australian Government's current focus is to maintain a person's capacity to remain at home for as long as possible, including the possibility of dying at home as preferred [2] and for equitable health service provision in both rural and urban communities. [3]

Evaluation is integral to policy, program development, service planning and funding allocation in many disciplines including health services; [4] hence with service development there has been increased demand for evaluation. To this end the Australian Department of Health and Ageing

(DoHA) funded a guide to the evaluation of palliative care services. [4] This document defines evaluation as a process of collection and analysis of information in order to determine the value, worth, relevance, impact and effectiveness of particular programs or interventions and to inform decision-making and policy to determine future funding allocation. [4] In recent years a number of PC service evaluations have been published. [5-8]

This paper is informed by the experiences and challenges in undertaking two separate independent evaluations of after-hours community PC services, conducted in a range of metropolitan, regional and rural/remote areas of Victoria, Australia and using elements of the DoHA guide. [4] The outcomes of the first study have been published. [9,10] This paper focuses on the processes, systems and issues that emerged during the evaluations rather than on the nature of the PC provided.

Methods

For both studies ethics approval was received from the Monash University Human Research Ethics Committee and relevant clinical committees. The two studies between them engaged with more than 20 different community palliative care services and a total of 15 ethics committees.

In the first project, data were collected utilising semi-structured interviews with service managers, nurses, GPs and with people receiving community PC. [9] Questionnaires exploring issues raised in interviews were distributed to nurses through a PC special interest group (43% response rate) and to GPs through the relevant Divisions of General Practice (22% response rate). [10]

In the second project, baseline data relating to the provision of after-hours care were collected utilising questionnaires from the following cohorts: people receiving community PC care (25% response rate) and their carers (47% response rate) – both distributed by visiting nurses but returned directly to researchers by mail; staff providing care (39% response rate) – distributed through service managers. In some areas service providers requested questionnaires through an on-line service while others requested hard copies to be returned directly to researchers by mail. Follow up questionnaire data (following implementation of measures to improve after hours service) were collected from the following cohorts: patients/carers following experience of after-hours services (56% response rate) – collected by nurses making follow up telephone calls; staff providing PC (33% response rate); and staff providing triage service (56% response rate). In addition service managers were interviewed about their perceptions of the provision of after-hours services in their area (78% participation).

Findings: key issues arising from the evaluation process

A number of key issues were evident in the process of designing and undertaking the two projects. These included: evaluation design challenges and limitations; ethical considerations; working with vulnerable populations; staff/service challenges and funder expectations.

Evaluation design challenges

The single biggest challenge to evaluation design in both projects was the need to accommodate individual needs and practices of a large number of services with many differences in geographical location, service culture, staffing levels and funding availability. Embracing these differences while at the same time collecting consistent, comparable and meaningful data was challenging.

For example, different distribution methods already noted resulted in different response rates. While participation in both online and paper surveys for both projects was low, averaging only 28%, due to differences both between the two studies and within each study, it is difficult to draw conclusions. Of more significance is the difference in response rates for pre and post questionnaires, between groups using hard copy questionnaires (46% and 54%) and on-line access in the second study (33% and 23%).

Confusion relating to pre and post evaluation was an issue with significant numbers failing to complete the online 'post' questionnaire. Anecdotal evidence suggested that staff did not understand why the questionnaires were the same, despite clear explanations of the need for consistency in 'before' and 'after' questionnaires.

Ethical considerations

Two particular issues relating to approval by ethics committees were identified. In both studies, the need to approach a large number of human research ethics committees (HRECs) prior to commencing the projects became complex and time consuming. Despite all committees being registered with the National Health and Medical Research Council, and all following the national code of practice [11] the HRECs had widely different interpretations of the National Statement. This resulted in preparing individual applications on often distinct forms; incorporation of large numbers of changes to associated explanatory sheets and questionnaires; and often long delays in obtaining approval due to infrequent committee meetings. These challenges made it difficult to have consistent evaluation processes across large cohorts of services.

There were also perceptions by some HRECs that people receiving PC are dying and should not be 'bothered' with research, suggesting an apparent lack of balance in considering the risks of negative outcomes versus possible benefits arising from research and evaluation. In some cases there was a lack of understanding of appropriate research and evaluation methods and the need for rigour, for example in consistency of process, to achieve valid evaluation outcomes.

Vulnerable populations

HRECs were not the only point at which issues relating to working with vulnerable populations became apparent.

When there was no direct contact between researcher and people receiving PC or their families (such as the distribution of questionnaires to recipients of PC by visiting nurses – response rate 25%), the issue of vulnerability was sometimes cited by staff as a reason for reluctance to involve them in evaluation activities. However, when patients or carers were more directly invited to take part, such as with interviews in the first study and in a follow-up 'after service use' telephone survey conducted by the PC service nursing staff as part of routine patient follow up, the response rate was higher than expected (56%).

Staff/manager challenges

Shortages of PC trained staff added to their difficulty to engage in evaluation processes, leading to work overload. Significant travel distances, communication difficulties and lack of access to patient records also contributed. For many, the time taken to answer questionnaires or approach clients about their involvement was seen as an extra burden.

It was also evident at staff meetings attended by the researchers and in feedback from both staff questionnaires and manager interviews, that there was considerable misunderstanding and disillusionment about the value of evaluation and research and its relationship to ongoing funding. For some people, past experience of projects undertaken without perceivable outcomes, seemed to have fuelled the perception that participation was a burden remote from everyday clinical practice.

It was evident that some staff and managers regarded evaluation as a threat to the status quo, which was either seen as very good, or the best it could be in the circumstances. Such perceptions were illustrated in comments like 'country people are used to looking after themselves' and 'they (the clients) don't miss what they haven't got'. A particular organisational ethical conflict encountered was requests by service managers for identified data related to negative criticism of the service. Many participating services were very small and so no identified data, either service-specific or individual, were released to maintain the confidentiality of individual responses.

Funder expectations

Some issues relating to expectations of the funding body were observed. Different views about what is useful or effective research were at times evident between the funding body, the evaluators and the service providers. Examples of this include: what constitutes rigorous research; what is realistically likely to impact on daily service provision and is therefore likely to be seen as useful by these providers; and the pressure exerted, particularly by public funding bodies, to address contemporary issues. This latter issue led to multiple investigations into the same field of service provision and hence a number of questionnaires being circulated to staff in a similar time period.

Discussion – possible strategies to address these issues

This discussion considers possible strategies arising from the outcomes of these studies.

Evaluation design challenges

In a climate of evidence-based practice, [2,3] a low response rate is a major hurdle in providing clear evidence of success or failure that could ultimately affect future research and program funding. Several factors may lead to improved responses to evaluation surveys.

One solution to the perception of repeating the same questionnaires in pre and post surveys, is to change the order of sections in the design of the post questionnaire, so giving the impression of a new questionnaire. [12] It was evident in our work that participants, particularly those using the on line survey, abandoned their questionnaire part way through and we suggest that if new questions had been placed at the beginning, a greater completion rate may have been achieved.

The employment of an alternative research methodology like participatory action research may also improve outcomes. While there are a number of approaches to this type of research, in general it involves a participatory and reflective process which engages those involved in the service in identifying problem areas and developing appropriate solutions. [13] It is likely that one of the reasons the hardcopy questionnaires solicited a better response rate is due to the much more participatory role of staff in the development and implementation of changes in the after-hours service provision, compared to those in areas that

opted for the on-line version. The benefits of the 'personal touch' may also explain the increased response rate of patients/carers to the after-hours service questionnaire which was administered personally by a nurse (with patient/carer consent), as part of a routine follow up telephone call, compared to the pre-questionnaires which were left with patients/carers by visiting nurses, no doubt with varying degrees of explanation and possibly not distinguishable from the collection of other printed material provided.

Developing rapport with staff, an obvious necessity in obtaining cooperation and collecting the most useful and relevant data, is a key element of participatory action research. [13] Service managers are essential in soliciting the support and cooperation of their staff. While very time consuming and costly (when utilising multi-site services in widely separated areas), the benefits of staff contact with both evaluating researchers and the project manager were evident in both the greater response to questionnaires and higher satisfaction levels expressed by service managers. This also poses the question of whether on-line questions, although both cheaper and less time consuming to distribute, are actually appropriate for this type of evaluation, especially in rural areas where internet connection can be unreliable. However, when large numbers of diverse service providers are involved it is particularly important to include realistic time and cost factors into evaluation proposals to support the extra travel and to consider time for empowering managers and staff in developing and implementing solutions that meet their specific needs.

Ethical considerations

Recent developments in the national standardisation of application forms and the decision by some providers to accept the approval of another HREC are encouraging and hopefully will reduce the amount of work and duplication. Some suggestions to researchers for streamlining this process from the organisational perspective, including effective pre planning and establishing connection with a key contact person for each HREC, have been outlined. [15]

Issues relating to over-protectiveness of some HRECs and lack of balance when considering potential risks versus potential beneficial outcomes have also been reported. [16] Of particular significance is the issue of inappropriate paternalism. The concepts of soft paternalism (decisions to restrict access of potential participants of a study on the grounds of incapacity to make informed decisions) and hard paternalism (restricting the choices of those capable of autonomous action on the grounds of protecting them from some perceived danger without their consent) have been postulated [17] and reported in other studies. [18] Clearly it is the task of HRECs to provide appropriate protection for vulnerable people who are unable to make informed decisions about their involvement.

Where there was some direct contact with people receiving PC and their carers, we have found that while some did not wish to participate, there were significant numbers keen to change an aspect of the service that may not have met their needs, into something which may bring benefit to others, by contributing from their own experiences in both questionnaires and interviews. This is supported by other evidence that shows that, not only are people receiving PC not distressed by involvement in research, [19] but that involvement in appropriate activities can in fact be therapeutic [20] and offers an opportunity to make a useful contribution to a project that may assist others. [21] This may explain the willingness of many to be involved if they are given the opportunity. Consumer involvement in research is a developing area of interest, as well as being increasingly expected in research designs. [22]

It is vital that HREC members themselves have understanding and awareness of the range of people who require PC, especially as all members may not have a clinical background. Not all those receiving PC are imminently dying and may indeed seek to leave a legacy for others by their involvement in research. Two authors of this paper have seen the benefits of themselves being a member of a HREC and informally educating other members in response to particular ethics applications.

Vulnerable populations

There is no doubt that people receiving PC and their family members are very vulnerable and this group are particularly noted in the National Statement. [11] It is equally obvious that all those involved in their care, including HRECs, service management and professional staff providing day-to-day care, have a duty to ensure that needless risk and stress are not added to an already very difficult situation. However, excessive gate-keeping (even the most well intended), is an ethical issue in itself, which prevents capable people from making their own decisions about involvement and contribution through evaluation processes. [17,23] If a person does not meet clear selection criteria including ability to make their own decisions, then their appointed decision maker does so on their behalf. [11]

Difficulty in recruiting for PC projects is well documented [18,24] and the reasons identified are similar to those already discussed. The combination of more staff education and the increasing willingness of clients to verbalise their

needs and experiences, may lead to easier recruitment processes. The increased positive responses observed with more personal contact, offers support to the notion that people receiving PC do want to make a contribution, [25] as well as confirming that participation of consumers and providers has positive outcomes. [13] The continued use of a participatory approach to research and evaluation, although time-consuming and therefore more costly and necessitating skills in collaboration, does improve recruitment rates. [25] Such approaches may lead to a wider acceptance of research and evaluation as an integral part of professional healthcare practice, including PC.

Staff/manager challenges

Apart from normal human resistance to change and over protectiveness of clients already discussed, the issues relating to staff and managers revolved around the questions: 'does this research address a real need?'; 'does it provide answers that are practical and applicable given the specific challenges we face in our service?'; and 'will the effort I put into participating pay off in terms of better service to clients?'.

Education of healthcare staff and managers about the importance of evaluation is one key to the success or failure of this process. Within the context of a participatory action research process already discussed, such education would be a natural part of both preliminary and on-going discussions about what is needed and how best to address this. [13] Specific issues arising from these studies would be: the role of staff in empowering clients in making their own decision about participation; empowering staff to contribute their valuable knowledge and experience both of their clientele and of the service they provide; and why pre and post questionnaires are useful and important. Particularly in small services this degree of participation is a heavy burden and additional funding may need to be considered to facilitate staff travel and replacements. However, an important benefit of this degree of staff involvement is eventual ownership of the solutions to existing problems, making their implementation both much more likely and more effective.

Another challenge for service managers was that in the small more remote services, PC was often only a very small part of the service provided to the community. Inevitably this impacted in several ways: either there was no funding specifically for PC or such funds tended to blend into over all funding requirements; PC was often provided by non-specialist staff or by part-time specialist staff; and as managers they were able to give only a small portion of their time to PC matters. With current structures and funding models these problems are not easily addressed.

Funder expectations

The funding of research and evaluation by a range of bodies, (both government and non-government organisations), is absolutely vital to the extent that most research would not occur without such provision. However, in the past not all research has been well disseminated either to policy makers or service providers. As already suggested, only research that provides answers to real problems which can be realistically implemented is likely to be regarded as effective research and worthy of valuable time. Others have reported that beneficial outcomes which are never applied, (due to lack of resources, lack of will or other factors), only fuels the fire of resentment and disillusionment among those who see no point in being involved. [26]

The temptation to focus on short-term gains needs to be resisted. Particular issues for consideration in future funding rounds could be whether it will be possible to fund beneficial outcomes of this research; whether the research process utilises the valuable knowledge and experience of those who provide the service; whether the process provides rigorous data upon which good evidence-based practice can confidently be based; and if service providers (staff and management) have a vision of how their efforts can improve the service without sacrificing their own well-being.

Conclusion

This paper has discussed issues and difficulties in undertaking evaluation in community-based palliative care settings. A number of challenges were revealed including: project design challenges, achieving an ethical process of evaluation, working with vulnerable populations, the perceptions of staff and implications for funding bodies.

Strategies to facilitate future evaluation processes have been suggested including: careful attention to research design and dissemination of outcomes; the utilisation of processes which lead to ownership of problems and solutions by those most involved in the service provision; greater uptake by ethics committees of standardised forms and processes; recognition that vulnerable populations have the right to make their own informed decisions about involvement; and increasing vision in both services and funding bodies about the best application of research outcomes for best service provision.

Competing Interests

The authors declare that they have no competing interests.

References

1. Australian Government Department of Health and Ageing. A national Framework for Palliative Care Service Development. Canberra: Publications Production Unit; 2000.
2. Foreman FM, Hunt RW, Luke CG, Roder DM. Factors predictive of preferred place of death in the general population of South Australia. Palliat Med. 2006;20:447-53.
3. Palliative Care Australia. A guide to palliative service development: a population based approach. Canberra: PCA; 2005.
4. Eagar K, Cranny C, Fildes D. Evaluation and palliative care: a guide to the evaluation of palliative care services and programs. Wollongong: Centre for Health Services Development, University of Wollongong; 2004.
5. Pollock K, Wilson E, Porock D, Cox K. Evaluating the impact of a cancer supportive care project in the community: patient and professional configurations of need. Health Soc Care Community. 2007;15(6):520-9.
6. Tolson DMJ, Loftus L, Cormie P. Developing a managed clinical network in palliative care: a realistic evaluation. Int J Nurs Stud. 2007;44(2):183-95.
7. Hiatt KSC, Mulsow M, Pearson SJ. The importance of perspective: evaluation of hospice care from multiple stakeholders. Am J Hosp Palliat Care. 2007;24(5):376-82.
8. Bainbridge D, Brazil K, Krueger P, Ploeg J, Taniguchi A. A proposed systems approach to the evaluation of integrated palliative care. BMC Palliat Care. 2010;9(8).
9. Ceichomski L, Tan H, O'Connor M, Miles G, Schattner, P, Klein B. After hours palliative care provision in rural and urban Victoria. Australia. Asia Pac J Health Manag. 2009;4(1):41-46.
10. Tan HM, O'Connor MM, Miles G, Klein B, Schattner P. GP and nurses' perceptions of how after hours care for people receiving palliative care at home could be improved: a mixed methods study. BMC Palliat Care. 2009;8(13).
11. Australian Government National Health and Medical Research Council. National Statement on Ethical Conduct of Human Research. Canberra: NH&MRC; 2007.
12. Addington-Hall J, Bruera E, Higginson I, Payne S. Research methods in palliative care. Oxford: Oxford University Press; 2007.
13. McNiff J, Whitehead J. All you need to know about Action Research: an introduction. London: Sage Publications; 2006
14. Lucock M, Leach C, Iveson S, Lynch K, Horsefield C, Hall P. A systematic approach to practice-based evidence in a psychological therapies service. Clin Psychol Psychother. 2003;10:389-99.
15. McCauley-Elsom K, Gurvich C, Lee S, Elsom S, O'Connor M, Kulkarni J. Vulnerable populations and multi-centred research. Int J Ment Health Nurs. 2009;18:108-15.
16. Lee S, Kristjanson L. Human research ethics committees: issues in palliative care research. Int J Palliat Nurs. 2003;9(1):13-8.
17. Miller F, Wertheimer A. Facing up to paternalism in research ethics. Hastings Centre Report. 2007;37(3):24-34.
18. Tan H, Wilson A, Olver I, Barton C. Recruiting palliative care patients for a large qualitative study: some ethical considerations and staff dilemmas. Explore (NY). 2010;6(3):159-65.
19. Takesaka J, Crowley R, Casarett D. What is the risk of distress in palliative care survey research? J Pain Sympt Man. 2004;28:593-8.
20. Emanuel E, Fairlough D, Wolfe P, Emanuel L. Talking with terminally ill patients and their caregivers about death, dying and bereavement: Is it stressful? Is it helpful? Arch Intern Med. 2004;164:1999-2004.
21. Sherman D, McSherry C, Parkas V, Ye X, Calabrese M, Gatto M. Recruitment and retention in a longitudinal palliative care study. Appl Nurs Res. 2005;18:167-77.
22. Department of Health. National Health Service Reform and Healthcare Professions Act. London: Department of Health. 2002.
23. Sharkey K, Savulescu J, Aranda S. Clinician gate-keeping in clinical research is not ethically defensible: an analysis. J Med Ethics. 2010;36:363-6.
24. Steinhauser K, Clipp E, Hays J, Olsen M, Arnold R, Lindquist N, et al. Indentifying recruiting and retaining seriously-ill patients and their caregivers in longitudinal research. Palliat Med. 2006;20:745-54.
25. Hopkinson JB, Wright DN, Corner JL. Seeking new methodology for palliative care research: challenging assumptions about studying people who are approaching the end of life. Palliat Med. 2005;19(7):532-7.
26. Ingleton C, Seymour J. In Payne S, Seymour J, Ingleton C, editors. Palliative care nursing: principles and evidence for practice. Berkshire UK: McGraw Hill; 2008. p.527-553.

REVIEW ARTICLE

Is Transport a Barrier to Healthcare for Older People with Chronic Diseases?

K Corcoran, J McNab, S Girgis and R Colagiuri

Abstract

Objective: This review aimed to determine whether lack of transport is a barrier to accessing routine health services for older people with chronic diseases and, if so, to identify the nature and effectiveness of interventions trialed to overcome this barrier.

Methods: We conducted a systematic literature review using MEDLINE, Embase, Cinahl, PsycINFO and the Cochrane Library databases for articles published in English from 1990 to 2010 using relevant MESH terms.

Results: Seven hundred and ninety eight citations were identified from electronic data bases searched and two from references of potential articles. Thirteen studies met the inclusion criteria. Twelve were cross-sectional and one interventional. Of the 13, seven studies reported that lack of transport was a barrier to accessing cardiac rehabilitation (CR) services. Three studies identified transport as a barrier to accessing general services in older adults. Access to transport significantly predicted receipt of definitive cancer therapy. People who missed or cancelled an appointment for asthma care perceived lack of transport as a greater barrier than those who did not. One study which evaluated a transport brokerage service identified a decrease in non-emergency transport costs despite an increase in monthly health services use.

Conclusion: Lack of transport has the potential to negatively influence the ability of older adults to access a variety of health services. In our review this effect was most apparent in CR programs which were the focus of the majority of the studies identified through our searches. There was insufficient evidence to assess the effectiveness of interventions.

Implications: Further research is needed in the Australian context. Interventions need to be trialed to inform the policy response. Health service planners and providers should evaluate the accessibility of their services for older people with chronic diseases and take measures to ameliorate lack of transport as a barrier to appropriate use of health services.

Abbreviations: CR – cardiac rehabilitation; SCIPPS – Serious and Continuing Illness Policy and Practice Study.

Key words: Chronic diseases; access to health services; transport.

Ms Katherine Corcoran
Menzies Centre for Health Policy
University of Sydney, New South Wales, Australia

Dr Justin McNab
Menzies Centre for Health Policy
University of Sydney, New South Wales, Australia

Dr Seham Girgis
The Health and Sustainability Unit
Menzies Centre for Health Policy,
University of Sydney, New South Wales, Australia

Associate Professor Ruth Colagiuri
The Health and Sustainability Unit
Menzies Centre for Health Policy
University of Sydney, New South Wales, Australia

Correspondence:
katherine.corcoran@sydney.edu.au

Introduction

International studies have identified a variety of barriers to health services accessibility including cost, language and cultural barriers, and physical access barriers. [1-3] Cost has been recognised as a barrier to receiving care or filling a prescription and extends to both the insured and uninsured. [4] Australian research has also identified barriers to health services accessibility including language and cultural barriers for Indigenous and immigrant Australians, [5-7] lack of knowledge of particular services, [8] and lack of insurance for dental care. [9]

Studies focusing on physical access barriers suggest that three key factors - lack of mobility (either age or disability related), lack of transport, and distance - may impede access to health services and may interact in complex ways in

different settings and according to illness types, age and/or degree of disability. Distance and transport are frequently cited as barriers in discussions about health service utilisation [10-14] and research has shown that people with disabilities face greater barriers to overall care than people without disabilities, including having greater levels of unmet health needs and reduced service use. [15-16]

The National Health and Medical Research Council-funded *Serious and Continuing Illness Policy and Practice Study* (SCIPPS) was established to develop policy and health system solutions to improve the care and management of people with chronic disease, specifically diabetes mellitus, chronic heart failure, and chronic obstructive pulmonary disease. As part of SCIPPS, a qualitative study involving semi-structured interviews with people with one or more of these diseases (aged 45 to 85 years), and their carers, identified a number of themes related to living with chronic illness. [17-19] One of the themes emerging from this research was lack of transport as a barrier to accessing routine health services.

The policy implications of transport as a barrier to accessing health services are highlighted in the NSW Health transport policy (*Transport for Health Policy 2006-2011*). This policy recognises that transport disadvantage contributes to health inequalities and impacts on the capacity of NSW Health to reduce health inequalities. Transport disadvantage is not explicitly defined in the policy. Nonetheless, the policy states that: '*current public transport services and private transport are often not available or accessible to a significant number of people living in NSW*'. [20]

Much of the work on barriers to accessing health services is qualitative in nature and explores the issues from the subjective perspective of the patient experience. While such perspectives are of considerable importance to the evaluation of health services, the policy and planning response also requires quantifying the extent and impact of the problem. Further, despite the current and growing impact of major chronic diseases globally, the majority of the literature on transport and access to health services has centred on disability and relatively little has been reported about access to health services for people with conditions such as diabetes, chronic heart failure, and chronic obstructive pulmonary disease.

Consequently, our review focused on the quantitative evidence and aimed to determine i) whether lack of transport is a barrier to accessing routine health services for older people with chronic diseases; and, ii) if so, to identify the nature and effectiveness of interventions trialed to overcome this barrier.

Methods

For the purposes of this review we defined transport as: 'the means for people to travel to or from points where the routine or non-emergency health services they require are provided'. This definition includes privately owned vehicles (their own or those belonging to friends or relatives); taxis or rented cars; public transport including buses, trains, trams or other similar means of travel.

Using the principles and conventions established by the Centre for Reviews and Dissemination [21] to develop the protocol for this review, a systematic literature search of the Medline, EMBASE, Cochrane, CINHAL and PsycINFO electronic databases was undertaken. An initial search strategy using the terms 'transportation' and 'health services accessibility' did not identify studies on transport as a barrier to accessing health services as their primary focus. Hence a broader search strategy using a wider range of terms was adopted. The additional Medline search terms were: 'ambulatory care facilities'; 'community health services'; 'primary healthcare'; 'family practice'; and 'delivery of healthcare.' For other databases, search terms were modified as appropriate. Search terms were used as key words/free text searches in titles and abstracts. This broader search strategy identified several quantitative and qualitative studies that addressed multiple barriers to health service accessibility including lack of transport.

Inclusion and exclusion criteria

Searches were limited to studies published between 1990 and 2010 in English. Studies were included if they: investigated barriers to accessing routine ie, non-emergency health services in which transport was identified; were relevant or applicable to the Australian context (from countries which are socio-culturally, economically and politically similar to Australia); and focused on adults with diabetes, chronic heart failure, and chronic obstructive pulmonary disease and/or related disability. Studies that examined transport in relation to cancer or mental health problems were also included as these conditions are also (Australian) National Health Priorities and their management and nature satisfies the criteria of chronic diseases. [22] Palliative care, although an important phase of care for many people with chronic conditions, was not included as it tends to be relatively short-term in comparison to chronic care overall. Nor were studies of drug and alcohol misuse/addictions included as these are behavioural issues not usually directly associated with our index conditions.

Studies were excluded if they were qualitative or not peer reviewed; did not report data specific to transport; or reported transport data from non-relevant services such as emergency/acute care, pre-natal care and pregnancy, childbirth and post-natal care or primary prevention services (eg screening), dental care, HIV and palliative care.

Selection of studies

The titles and abstracts of each article were reviewed for relevance. Full text articles were retrieved for relevant abstracts. The reference lists of these articles were used to identify articles not captured by the previous searches. All articles were then independently reviewed by two authors to extract study participant information and data pertaining to transport and health service accessibility. Each reviewer's data were cross-checked by the other reviewer. We did not test for inter-rater reliability. Results were collated and synthesised.

Results

Figure 1 displays the flow chart of search yield. The initial electronic database search identified 798 citations. Of the 798 citations, 26 met the inclusion criteria and full articles were retrieved. Of the 26 articles we excluded 15 studies. From the remaining 11 studies, we identified a further two relevant studies from the reference lists. In total, 13 studies were included in the review (12 cross-sectional studies and one interventional study) (Table 1). Over half of the studies (n=8) were published between 2003 and 2010. All were set in high income countries with over half from the United States (n = 7).

Of the 12 cross-sectional studies, seven focused on access to cardiac rehabilitation; [23-29] three on older adults' access to general health services, including people with diabetes and heart diseases; [30-32] and one each on access to cancer treatment [33] and barriers to follow-up care for adults with asthma. [34] The intervention study evaluated the effects of transport brokerage services on access to care for Medicaid beneficiaries in the United States. [35]

Access to cardiac rehabilitation

Seven of the studies included in the review focused on access to cardiac rehabilitation (CR). [23-29] All but one of these surveyed patients, the remaining study surveyed directors of outpatient CR. Of the studies surveying patients, one had female participants only whereas the remaining studies had a mixture of male and female participants; the average age of participants was between 61 and 66.6 years of age.

Figure 1: Flow chart of search yield and study selection

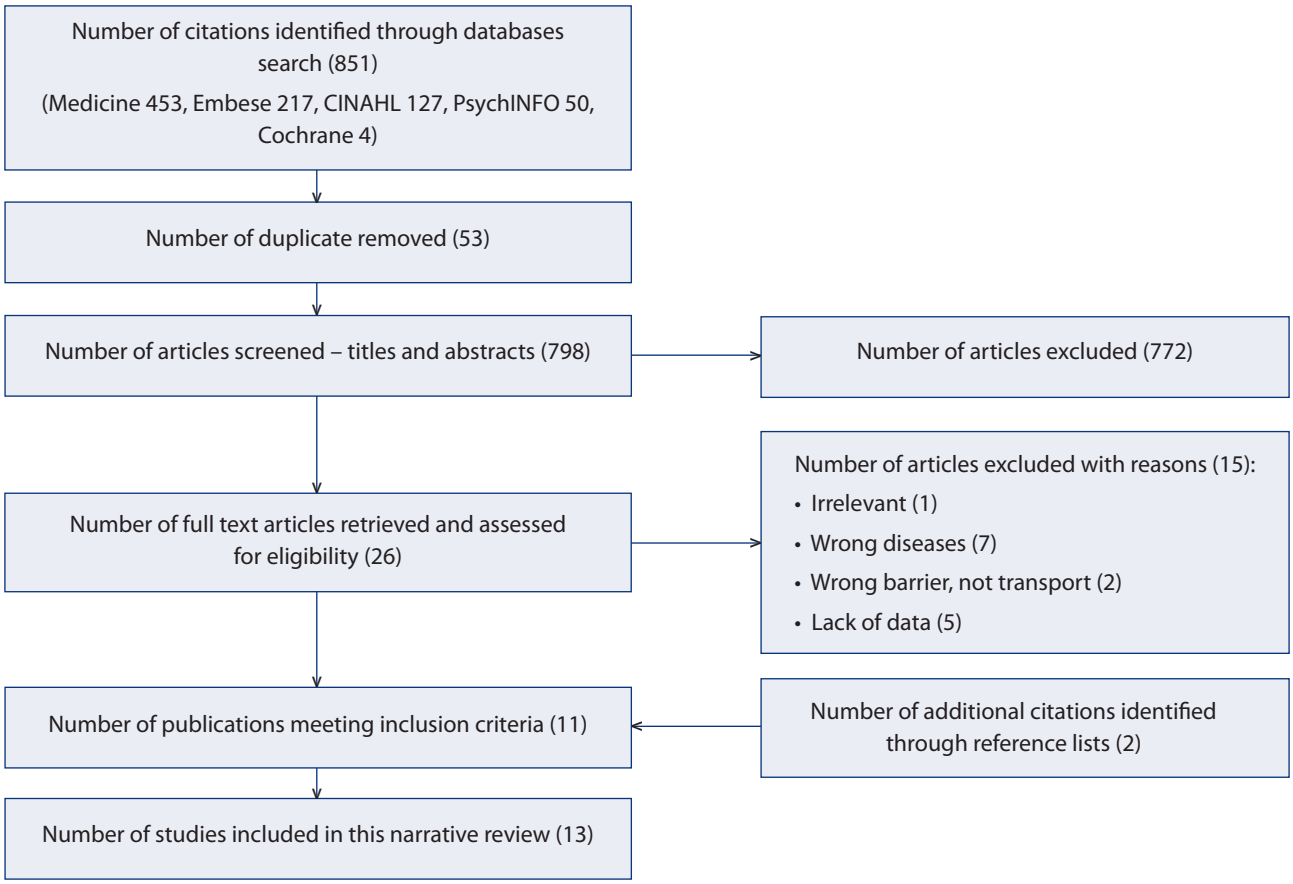


Table 1: Summary of Results

AUTHOR, YEAR, COUNTRY	STUDY POPULATION	OUTCOMES	RELEVANT RESULTS
Cardiac Rehabilitation			
De Angelis et al, 2008 (Australia).	97 patients eligible for CR, average age 66.6 yrs.	Barriers and enablers to CR programs.	84% attended CR and 16% declined. Of those who attended CR, easy access to transport was identified as an enabler by 68%, and 16% identified transport as a barrier. For those who declined, no information was available about the proportion who cited transport difficulties as reasons for non-attendance.
Jones et al, 2003 (Canada).	20 cardiac patients enrolled in CR and 9 eligible for CR but not enrolled.	Factors influencing enrolment in a CR.	All respondents who enrolled in CR had access to a vehicle compared to 78% of those who did not ($\chi 2 = 4.77$, $P<0.05$).
Missik et al, 2001 (USA).	370 female cardiac patients (91 participants and 279 non-participants in CR), average age 66.2 yrs.	Factors related to accessibility predicting women's participation in CR.	Having transportation was significantly greater in the participatory group (88%) than in the non-participatory group (84%) ($\chi 2 = 11.97$, $p = 0.000$).
Ramm et al, 2001 (New Zealand).	220 patients invited to attend CR (response rate 72% for full attendees, 64% for withdrawals; 52% for non-attendees); average age of CR participants 61 yrs.	Factors contributing to non-attendance at an outpatient CR.	33% of those who did not attend CR program and 31% of those who withdraw reported that transport problems were the most commonly reasons.
Rivett et al, 2008 (UK).	101 individuals who withdrew from CR; average age 61 yrs.	Reasons for withdrawal in patients previously engaged in a CR program.	10% of respondents noted 'lack of transport' as the main reason for their withdrawal from the heart watch programme.
Evenson et al, 2000 (USA).	61 directors of outpatient CR; North Carolina.	Barriers to participation and adherence to outpatient CR.	30% of respondents believe that transportation was a reason for not attending CR; and 3% of believe that transportation was a reason patients for dropping out.
Schulz et al, 2000 (Australia).	79 people admitted to hospital and diagnosed with acute myocardial infarction; average 62 to 69 yrs.	Factors associated with and predictive of CR attendance of patients following acute myocardial infarction.	Those who attended CR were significantly more likely to have access to a private transport than those who did not ($\chi 2 = 4.3$; $p=0.038$). No significant difference between the two groups with regard to access to public transport ($\chi 2 = 2.05$; 0.15).
Access to general health services for older adults			
Arcury et al, 2005 (USA).	1059 adults; average age of 52 years; 37.5 % male.	Association of individual transportation access characteristics with health care visits.	Respondents with a driver's license had 2.29 times more health care visits for chronic care and 1.92 times more visits for regular checkup care than those without a license. Respondents who had family or friends who could provide transportation had 1.58 times more visits for chronic care than those who did not.
Fitzpatrick et al, 2004 (USA).	4889 persons ; average age 76.0 yrs; 55.9% had hypertension or borderline hypertension; 12.9% had diabetes.	Patterns of use and barriers to health care in a cohort of Medicare beneficiaries.	Of the 592 with at least 1 barrier, 21.1% (n=125) reported transportation problems as a barrier to health services accessibility. Those with minority status were more likely to be affected by transportation difficulties ($P<0.05$).

Table 1: Summary of Results *continued*

AUTHOR, YEAR, COUNTRY	STUDY POPULATION	OUTCOMES	RELEVANT RESULTS
Access to general health services for older adults *continued*			
Murata et al, 2010 (Japan).	15302 individuals living in semi-rural Japan; average age 74.2 yrs; 38.7% had hypertension; 16.8% had visual impairment; 16.3% had arthritis; 13.2% had heart disease; and 11.3 % diabetes.	Associations between socioeconomic status and access to care.	12.6% of respondents reported transportation as a reason for delay in seeking health care.
Access to cancer treatment			
Goodwin et al, 1993 (USA).	565 patients with cancer of the breast, prostate, and colon or rectum with in situ, local, or regional stage at diagnosis; mean age 72.2 yrs .	Assessment of the role of patient characteristics in the choice of definitive treatment.	Those who were not driving a car or not living with someone who drove had a more than threefold risk of not receiving definitive cancer treatment compared to those with access to transportation. (OR = 3.57, 95% CI 1.85 – 3.70),
			Multivariate analysis showed that access to transportation significantly predicted receipt of definitive treatment. This result did not stand when age was added to the model.
Barriers to follow-up care for adults with asthma			
Hoffmann et al, 2008 (USA).	35 adult with asthma aged 18 or over; 58% of the sample reported a variety of co-morbidities including hypertension, diabetes, and high cholesterol.	Perceived barriers to follow-up care.	Study participants who go to the emergency room for their usual asthma care perceive a 'lack of transportation' as a barrier (F = 3.96; P = 0.02). Study participants who 'sometimes' had to miss or cancel an appointment with their health care provider perceived 'lack of transportation' as a greater barrier than study participants who 'never' had to reschedule an appointment (P = 0.00).
Intervention study			
Kim et al, 2009 (USA).	Adults aged 19-64 yrs with diabetes, living in Georgia (n=12884) and Kentucky (n=5452) .	To assess the effects of transportation brokerage services on access to care, measured by Medicaid expenditures and health services use.	For patients with diabetes, nonemergency transportation costs decreased despite increased monthly use of health services; average monthly medical expenditures and the likelihood of hospital admission for an ambulatory care-sensitive condition also increased.

One study examined enablers and barriers to participating in hospital-based CR in six regional hospitals in South-West Victoria. There were 97 participants in the study - 81 of whom attended CR. Almost all participants were eligible for CR as they had experienced acute myocardial infarction (34%), percutaneous coronary intervention (31%), or coronary artery bypass graft (32%). Easy access to transport was identified as an enabler by 68% of attendees and 16% of attendees noted that transport was a barrier to attending CR. [23]

Two studies examined differences between patients who enrolled and patients who did not enroll in CR. A survey of people who had suffered a cardiac event in the previous three-month period carried out in a northern rural centre in Canada found that all 20 respondents who enrolled in CR had access to a vehicle compared with only 78% of the nine respondents who did not enroll. This difference was significant ($\chi 2 = 4.77$, $p < 0.05$). [24] Similarly, a study in North-eastern Ohio of 370 female cardiac patients with myocardial infarction, angina, angioplasty, coronary

artery bypass graft, or a combination of these conditions, 91 of whom participated in CR and 279 of whom did not, found that a significantly higher number of women in the participant group had access to transport ($\chi 2 = 11.97$, $p < 0.001$). [25]

Three studies examined reasons for non-attendance or withdrawal from CR. [26-28] A study of patients invited to attend outpatient CR at one of two Auckland hospitals after being admitted to hospital for a first myocardial infarction found that the most commonly stated reason for non-attendance was transport problems (33%), and the most frequently stated reason for withdrawal from the program was transport problems (31%). [26] A further study investigated factors associated with and which predict attendance of patients, who had suffered acute myocardial infarction, at a cardiac rehabilitation program in regional Victoria. Of the 116 people eligible for the study, 79 completed and returned the survey - 50 had attended CR and 29 had not. Not having access to private transport was significantly associated with CR non-attendance ($\chi 2 = 4.3$, $p = 0.038$). [27] Researchers examining reasons for withdrawal of patients previously engaged in a Leeds-based community CR program (Heart Watch) offered to people with a history of cardiovascular disease, found that 10% of study participants specified 'lack of transport' as the main reason for their withdrawal from the program. [28]

In a survey of directors of CR (respondents n=61) in North Carolina into barriers to participation and adherence to outpatient CR, 30% of respondents cited transport as the most common reason given for non-participation in CR. [29]

Access to general health services

A study from western North Carolina on the association between transport access characteristics and number of healthcare visits found that having a driver's licence and having family or friends who could provide transport had significant associations with healthcare visits after adjusting for individual, health, and distance characteristics. Study participants with a driver's licence had 2.29 times more healthcare visits for chronic care (95% CI 1.19 - 4.39, $p = 0.013$) and 1.92 times more visits for regular checkup care (95% CI 1.32 - 2.79, $p = 0.001$) than those without a driver's licence. Furthermore, respondents who had family or friends who could provide transport had 1.58 times more visits for chronic care (95% CI 1.01 - 2.46, $p = 0.046$) than those who did not. [30]

The remaining two studies on older adults' access to general health services reported transport problems as a barrier to healthcare accessibility. As part of the Cardiovascular Health Study, researchers reported on 4889 men and women aged 65 or older who were randomly selected from Medicare eligibility lists from four communities in the United States. Of the 4889 respondents, 2.6% reported transport problems as a barrier to healthcare. Just over half of this cohort had hypertension or borderline hypertension and 13% had diabetes. [31] A more recent study in three semi-rural prefectures in Japan examined associations between socio-economic status and access to health services for elderly Japanese. It found that 12.6% of the 15,302 participants (mean age 74.2 years) reported transport as a reason for delay in seeking care. Study participants had a variety of chronic conditions including hypertension (38.7%), arthritis (16.3%), heart disease (13.2%), diabetes (11.3%) and visual impairment (16.8%). [32]

Access to cancer treatment

The only report on cancer patients included in our review studied the role of patient characteristics in the choice of definitive cancer treatment in a group of patients with colorectal, breast, and prostate cancer living in New Mexico. The study used multivariate analysis and found that access to transport significantly predicted receipt of definitive cancer therapy. This result, however, did not stand when age was added to the model. [33]

Access to asthma follow-up

An American study examined perceived barriers to follow-up care for adults with asthma attending the University of Pittsburgh Medical Center. The authors reported that patients who 'sometimes' had to miss or cancel an appointment perceived lack of transport as a greater barrier than study participants who 'never' had to reschedule an appointment ($p< 0.01$). [34]

Effects of transport brokerage services on access to care

Also in the United States, a study compared changes in measures of access to care and health services use before and after the implementation of transport brokerage services in Kentucky and Georgia for adult Medicaid beneficiaries with type 2 diabetes. They found that the implementation of transport brokerage services resulted in an increase in monthly health service use (access), a decrease in hospital admissions, and a decrease in non-emergency transport costs. [35]

Discussion

This review demonstrated that lack of transport has the potential to negatively influence the ability of older adults to access health services and this effect was consistent

across rural, regional and urban settings. These results are consistent with findings from patient interviews in the SCIPPS study where lack of transport was identified as a barrier to accessing health services. They are also well supported by Australasian qualitative studies which have reported lack of transport as an obstacle to appropriate access to health services for older people. [36,37]

Despite the consistency of reports identifying transport as a barrier, our literature searches identified only one intervention study that specifically investigated the link between lack of transport and health service utilisation in people with chronic conditions. This study found that the provision of transport brokerage services resulted in increased health service use, and decreased hospital admissions and non-emergency transport costs. [35] The other studies identified in the review were cross-sectional and only one focused primarily on lack of transport as a barrier to health service accessibility. Transport issues were a secondary or incidental consideration in the remaining cross-sectional studies, and it is salutary that our initial use of the search terms 'transportation' and 'health service accessibility' failed to yield any studies directly linking these two issues.

The impact of transport on access to healthcare and services for people with chronic diseases is an important and under-researched area of chronic disease care. Anecdotally, it is reputed to contribute to, or exacerbate, acute episodes of chronic diseases, chronic complications, non adherence to recommendations for care, and potentially avoidable hospital admissions. Community transport groups Australia-wide provide non-profit passenger transport services that cater to the needs of people who cannot make use of existing private or mainstream public transport systems or where public transport services are not available. However, eligibility criteria set by the various funders and service providers of these community-based transport services determine who can access it and under what circumstances, and in so doing, possibly limit its effectiveness in reducing transport-related access barriers. Nonetheless, in 2009-2010 community transport groups in New South Wales carried over 160,000 passengers on over 2.5 million trips; many of these trips were for health service access. The main funding streams for these services were the Home and Community Care program, and in New South Wales alone Home and Community Care program-funded community transport was worth $37 million. [38] This is no small investment yet there are substantial deficits in our knowledge about who can access it and its effectiveness in meeting the need for non-acute health related transport.

The generalisability of the findings of our review to the Australian context may be limited. This may be due to differences in challenges posed by settings even if the settings sound similar and differences in characteristics of and opportunities/levers for policy solutions, health systems structures and fund resourcing. This further demonstrates the need for locally generated evidence to improve our knowledge and understanding of lack of transport as an impediment to timely and appropriate services and the potential savings for acute care, eg inpatient and emergency department admissions, health gain, and healthcare costs which might be made if adequate transport was routinely available for older adults with ongoing chronic care needs. Chronic, non-communicable diseases currently make up 80% of the total burden of illness and injury in the ageing Australian population [22] and account for 70% of health expenditure. [39] The need for local evidence will be further heightened in coming decades with the social and economic burden of chronic conditions set to increase in western societies because of ageing populations, an increase in numbers of people with chronic conditions, and associated escalating health costs.

Conclusion

This review provides some insights into lack of transport as a barrier to accessing routine health services. Most of this evidence relates to cardiac rehabilitation but little primary evidence was found about transport in relation to the need for ongoing routine clinical monitoring and treatment /care of complex conditions.

There was insufficient evidence to assess the effectiveness of interventions. Further intervention research is needed in the Australian context to determine the extent to which lack of transport is a barrier and examine the role of the community sector in health-related transport for older people with chronic diseases. Interventions need be trialed accordingly to inform the policy response. In the interim, health service planners and providers should evaluate the accessibility of their services for older people with chronic diseases and take measures to ameliorate lack of transport as a barrier to appropriate use of health services.

Acknowledgements

The Serious and Continuing Illness Policy and Practice Study (SCIPPS) is an NHMRC funded program conducted at The Australian National University and the University of Sydney and administered by the Menzies Centre for Health Policy.

Competing Interests

The authors declare that they have no competing interests.

References

1. Jantrana S, Crampton P. Primary healthcare in New Zealand: who has access? Health Policy. 2009;93:1-10.
2. Nachtigall RD, Castrillo M, Shah N, Turner D, Harrington J, Jackson R. The challenge of providing infertility services to a low-income immigrant Latino population. Fertil Steril. 2009; 92(1): 116-123.
3. Hopley M, Horsburgh M, Peri K. Barriers to accessing specialist care for older people with chronic obstructive pulmonary disease in rural New Zealand. J Prim Healthcare. 2009;1(3):207-214.
4. Himmelstein DU, Woolhandler S. Care denied: US residents who are unable to obtain needed medical services. Am J Public Health. 1995;85(3):341-344.
5. Carson PJ. Providing specialist services in Australia across barriers to distance and culture. World J Surg. 2009;33:1562-1567.
6. Colagiuri R, Thomas M, Buckley A. Preventing Type 2 Diabetes in culturally and linguistically diverse communities in NSW. North Sydney: NSW Department of Health; 2007.
7. Hoang HT, Le Q, Kilpatrick S. Having a baby in the new land: a qualitative exploration of the experiences of Asian migrants in rural Tasmania, Australia. Rural Remote Health. 2009;9:1084.
8. Shepherd F, Battye K. Improving access to cardiac rehabilitation for remote Indigenous clients. Aust N Z J Public Health. 2003;27(6): 632-636.
9. Roberts-Thomson KF, Slade GD. Factors associated with infrequent dental attendance in the Australian population. Aust Dent J. 2008; 53(4):358-362.
10. Carter-Pokras O, Brown P, Martinez I, Solano H, Rivera M, Pierpont Y. Latin American trained nurse perspective on Latino health disparities. J Transcult Nurs. 2008; 19(2):161-166.
11. Collins B, Borders TF, Tebrink K, Xu KT. Utilization of prescription medications and ancillary pharmacy services among rural elders in west Texas: distance barriers and implications for telepharmacy. J Health Hum Serv Adm. 2007;30(1):75-97.
12. Eastwood A, Jaye C. After hours healthcare for older patients in New Zealand – barriers to accessing care. N Z Med J. 2006;119(1239):U2102.
13. Pham TM, Rosenthal MP, Diamond JJ. Hypertension, cardiovascular disease, and healthcare dilemmas in the Philadelphia Vietnamese community. Fam Med. 1999;31(9): 647-651.
14. Strauss K, McLean C, Troy A, Littenberg B. Driving distance as a barrier to glycemic control in diabetes. J Gen Intern Med. 2006;21(4):378-380.
15. Sommers AS. Access to health insurance, barriers to care, and service use among adults with disabilities. Inquiry. 2006-2007; 43(4):393-405.
16. Dejong G, Palsbo SE, Beatty PW, Jones GC, Knoll T, Neri MT. The organization and financing of health services for persons with disabilities. Milbank Q. 2002;80(2):261-301.
17. Jeon Y-H, Jowsey TJ, Yen L, Glasgow NJ, Essue B, Kljakovic M. Achieving a balanced life in the face of chronic illness. Aust J Prim Health. 2010;16:66-74.
18. Jowsey TJ, Jeon Y-H, Dugdale P, Glasgow NJ, Kljakovic M, Usherwood T. Challenges for co-morbid chronic illness care and policy in Australia: a qualitative study. Aust New Zealand Health Policy. 2009;6:22 (doi:10.1186/1743-8462-6-22).
19. Jeon Y-H, Essue B, Jan S, Wells R, Whitworth JA. Economic hardship associated with managing chronic illness: a qualitative inquiry. BMC Health Serv Res.9:182 (doi:10.1186/1472-6963-9-182).
20. NSW Health. Transport for Health Policy 2006-2011. North Sydney: NSW Health; 2006.
21. Centre for Reviews and Dissemination (CRD). Systematic Reviews: CRD's guidance for undertaking reviews in healthcare. York, England: Centre for Reviews and Dissemination, University of York; 2009.
22. National Health Priority Action Council (NHPAC). National Chronic Disease Strategy. Canberra: Australian Government Department of Health and Ageing; 2006.
23. De Angelis C, Bunker S, Schoo A. Exploring the barriers and enablers to attendance at rural cardiac rehabilitation programs. Aust J Rural Health. 2008;16(3):137-142.
24. Jones LW, Farrell JM, Jamieson J, Dorsch KD. Factors influencing enrollment in a cardiac rehabilitation exercise program. Can J Cardiovasc Nurs. 2003;13(1):11-15.
25. Missik E. Women and cardiac rehabilitation: accessibility issues and policy recommendations. Rehabil Nurs. 2001;26(4):141-147.
26. Ramm C, Robinson S, Sharpe N. Factors determining non-attendance at a cardiac rehabilitation programme following myocardial infarction. N Z Med J. 2001;114(1132): 227-229.
27. Schultz DL, McBurney H. Factors which influence attendance at a rural Australian cardiac rehabilitation program. Coronary Heart Care. 2000;4:135-141.
28. Rivett MJ, Tsakirides C, Pringle A, Carroll S, Ingle L, Dudfield M. Physical activity readiness in patient withdrawals from cardiac rehabilitation. Br J Nurs. 2009;18(3):188-191.
29. Evenson K, Fleury J. Barriers to outpatient cardiac rehabilitation participation and adherence. J Cardiopulm Rehabil. 2000;20(4): 241-246.
30. Arcury TA, Preisser JS, Gesler WM, Powers JM. Access to transportation and healthcare utilization in a rural region. J Rural Health. 2005;21(1):31-38.
31. Fitzpatrick AL, Powel NR, Cooper LS, Ives DG, Robbins JA. Barriers to healthcare access among the elderly and who perceives them. Am J Public Health. 2004;94(10): 1788-1794.
32. Murata C, Yamada T, Chen C-C, Ojima T, Hirai H, Kondo K. Barriers to healthcare among the elderly in Japan. Int J Environ Res Public Health. 2010;7(4):1330-1341.
33. Goodwin JS, Hunt WC, Samet JM. Determinants of cancer therapy in elderly patients. Cancer. 1993;72(2):594-601.
34. Hoffmann RL, Rohrer WM 3rd, South-Paul JE, Burdett R, Watzlaf VJ. The effects of barriers on health related quality of life (HRQL) and compliance in adult asthmatics who are followed in an urban community healthcare facility. J Community Health. 2008;33(6): 374-383.
35. Kim J, Norton EC, Stearns SC. Transport brokerage services and Medicaid beneficiaries' access to care. Health Serv Res. 2009;44(1): 145-161.
36. Greaves M, Rogers-Clark C. The experience of socially isolated older people in accessing and navigating the healthcare system. Aust J Adv Nurs. 2009;27(2):5-11.
37. Eastwood A, Jaye C. After hours healthcare for older patients in New Zealand - barriers to accessing care. N Z Med J. 2006;119(1239):1-9.
38. Community Transport Organisation. Community Transport Organisation 2010 Annual Report. Parramatta (AUST): Community Transport Organisation Inc; 2010.
39. Australian Institute of Health and Welfare. Australia's Health 2004. Canberra: Australian Institute of Health and Welfare; 2004.

Torao Tokuda

Torao Tokuda

In this issue our 'In Profile' comes from a chance meeting during a visit to Japan by Phudit Tejativaddhana, College member and Assistant Editor of the Asia Pacific Journal of Health Management, with Dr Torao Tokuda, Chairman of the Tokushukai Medical Corporation.

What made you venture into health management?

I am from the small island of Tokunoshima situated in the south, between Okinawa and the mainland of Japan. When I was nine years of age, I lost my three-year old brother who was taken ill in the middle of night, as there was no doctor available to take care of him. I then made up my mind to become a doctor, who would look after any patients even from poor families. With my hard working practice as a student from a remote island, I graduated from the Medical School of National Osaka University to become a doctor. Through my personal experience working as a fulltime doctor and as a night-shift duty doctor for eight years in public hospitals, I came to realise that emergency patients had not been accepted in major urban hospitals like they had in the small isolated islands hospitals, and that patient-focused treatments had been neglected due to a lack of sense of obligation, responsibility and medical ethics, which led to desolated social issues. I was then spiritually enlightened to build hospitals of my own to strive for a society, under the philosophy that 'all living beings are created equal', where everybody can receive quality medical care 24 hours a-day throughout the year. In my organisation we have the Ideal of Tokushukai which is:

- Hospitals where patients can entrust their lives with confidence.
- Health and livelihood of the patients are secured.

We attempt to realise these Ideals by:

- Remaining open 24 hours a-day throughout the year.
- No-predeposits for hospitalisation and no room charge for group wards.
- Grace period for personal 30% share obligations not covered by National Health Insurance.
- Financial assistance to cover living expenses of patients in need.
- No gifts accepted from patients.
- Constant cultivation of medical skills and consultation attitudes.

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

The basic principles of human beings lie in 'helping the weak and fighting evil'. Tokushukai has grown under this ideal and the philosophy that 'all living beings are created equal', to become the largest medical organisation in this country with over 290 medical and welfare facilities including 66 hospitals.

In my hometown, Amami Islands, with a total population of 117,348, I have built seven hospitals and 30 facilities in five islands, installing seven CTs and five MRIs, thus contributing to medical care services in the remote islands.

Overseas, our projects include Tokuda Sofia Hospital (1,016 beds), which opened in 2006 in Sofia, Bulgaria. Tokuda Torao Heart Center was opened on February 25, 2012 in Brazil jointly with Dr. Randis Batista, a famed cardiac surgeon.

In the United Kingdom, we are now in discussions to build a 150-bed hospital on the site of Cambridge University, and an adjacent 5-star hotel and education centre in the adjoining area.

In Russia, management of the Sogas Insurance Company, an affiliate company of Gasprom group, the nation's largest natural gas company, has solicited our participation to build hospitals simultaneously in four major cities; Moscow, Novjurengoj, Sakhalin and Socci, initiating this project with a 1,000-bed hospital in Moscow.

In Africa, we have already opened dialysis centres in Tunisia, Mozambique, Zambia, Djibouti, Guinea, Rwanda and Uganda. An additional ten dialysis centres will be opened in African countries within this year. Furthermore, we plan to build a 500-bed hospital in Mozambique, Zambia, Djibouti, Rwanda and Uganda, respectively with 70% of the construction cost financed by the African Development Bank.

In Thailand, 'Chamlong Hemodialysis Centre' by Maj Gen Chamlong Srimuang was opened with 81 dialysis machines donated by Tokushukai, which made it possible to treat even poor people with less medical fees. Ten sets of dialysis machines were also donated to the public Tabanan-Bali Hospital in Indonesia. Another five sets of dialysis machines were donated to Abidin Hospital in Banda Ache, Indonesia when they were damaged by the tsunami that occurred off Sumatra, thus helping to restore operation. Dialysis Centres in Laos, Mongolia and Nepal have also been opened with five sets of dialysis machines donated to these counties, respectively. We are now in discussion with these three countries for hospital construction projects.

In China, we have been consulted for the management and operation of 2,800 Red Cross chain hospitals located throughout the country while building a model hospital in Beijing. We are also developing a hospital project in the Philippines.

I have neither any personal interest to gain profits, nor greed to extract any profits from our operations in foreign countries. When building a hospital wherever it may be, I never think that it belongs to me, but to the region. The profits will be reinvested under our corporate ideal and philosophy that 'all living beings are created equal' for the betterment of medical and welfare services in the host countries. The ideal and philosophy are steadily spreading from my hometown of Amami to Japan, and to the world.

What is the greatest challenge facing health managers?

Firstly, a thorough implementation of the philosophy based on truth is important. Enhancing level of ethics of staff members, setting up specific objectives working together as a team for total patient-oriented medicine are also important requisites for health managers. Secondly, education is important in order to acquire the therapeutic techniques and the enhanced spirit of hospitality derived from a refined personality. Thirdly and importantly is business performance and cost-savings. It's imperative to have good control of initial costs, running costs, and lowered loan interest.

If the priority order as mentioned above gets disordered, you will no longer be a health manager but only someone making medicine as a tool for money. I think it is a problem that there are so many health managers working for the sake of money.

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

I feel it's a pity and a shame that medical treatment, targeted at wealthy people, prevails in the world. It's an ideal to make a society where everybody can receive high quality medical care, all the time and everywhere without worrying about their medical fees. Anytime, anywhere, and anybody should apply impartially to any rich and/or poor people, urban and/or isolated, developed and/or developing countries as well. We plan to build hospitals in South East Asian countries. There are some people who are poised by money-making intentions due to their misconception that money is best of all, which need to be redirected, with their self-centered minds changed to the spirit of selfless virtue, to be able to contribute to the community, which should help us to change the world.

What is your career highlight?

I suffer from ALS disease, and had a surgical operation on my trachea in 2005. I can neither move my hands and feet, nor eat and breathe normally. Nevertheless, I devote my whole energy to realise my dreams to build hospitals in 200 countries around the world. The projects are steadily moving forward. It's a pride and pleasure for me to have so many positive collaborators who work with me for the social movement of Tokushukai.

They are the most dedicated people despite their individual circumstances, and pressures from the establishment, and ruling agencies that might oppose them. Sympathetic people include, regional residents who joined me to fight for betterment; heart-warming public officials; politicians; many staff members in the past and present; and many patients who trusted our medical and social activities. I still feel highly obligated to fulfill, with utmost efforts, my mission to comply with the requests for our cooperation from many foreign countries. My challenge in life has just begun.

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

I was inspired to become a doctor by my younger brother who passed away, and was very much influenced by my mother. I have never seen any mother since childhood days, who has never ceased to work day and night. She was the most gifted mother in hard work, excessive efforts, and smart savings. She was my mentor who taught me my entire attitudes about life.

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

Medical therapies designed for some rich people should be limited. Health management based on the truth that 'all living beings are created equal', and on the attitude that medical therapies are for patients and not for profit-minded doctors, coupled with humane management attitudes should be the order.

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

The qualifications or requirements for the health leaders should be:

- Firstly, big dreams, hopes, and romantic ambitions to be conceived.
- Secondly, develop people to the full extent of their potential. Generate people to have ambitions, and exercise your leadership by saying, and doing by yourself, and let them do by themselves.
- Thirdly, master the art to judge, to decide and act through exercising your leadership in working longer hours with high density and handling more business volume than anybody else. To fulfill the requirements, profound love for people should be the most essential element of all.

Phudit Tejativaddhana
Thailand

LIBRARY BULLETIN

This Library Bulletin is part of a service offered by the Health Management and Planning Library of ACHSM. 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 $11.00 then $5.50 for each additional article. All prices are inclusive of GST.

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

AGED CARE SERVICES

Dementia: a public health priority

World Health Organisation, 2012

This report, produced jointly by World Health Organization and Alzheimer's Disease International, aims to raise awareness of dementia as a public health priority; to articulate a public health approach; and to advocate for action at international and national levels.

http://whqlibdoc.who.int/publications/2012/9789241564458_eng.pdf

Dementia 2012: a national challenge (UK)

Alzheimer's Society, March 2012

This report describes how well people are living with dementia in 2012 in England, Wales and Northern Ireland. Alzheimer's Society will provide an annual report on how well people are living with dementia to help chart progress and opportunities for action, year on year.

http://kingsfund.chtah.com/a/hBPcfM-B7R$KDB8hjQ-NUKbunZv/link13

Hospitalization can speed cognitive decline in elderly (US)

Janice Lloyd

USA Today, 23 May 2012

Hospitalisation of older people might place them at higher risk for accelerated cognitive decline, according to a study released Wednesday.

http://yourlife.usatoday.com/health/story/2012-03-21/Hospitalization-can-speed-cognitive-decline-in-elderly/53690292/1

Rethinking dementia care in Australia

The Lancet

Vol 379(9825) 21 April 2012 pp1462

Australia was the first country in the world to make dementia a national health priority. It launched a AUS$320 million Dementia Initiative in 2005, which included community care packages, funding for collaborative research centres, an advisory service for care staff, and a national dementia support programme. But, 7 years on, things seem to have gone awry. A new report by Alzheimer's Australia reveals that the country is failing the needs of people with dementia and their carers.

http://www.thelancet.com/journals/lancet/article/PIIS0140-6736%2812%2960615-1/fulltext?elsca1=ETOC-LANCET&elsca2=email&elsca3=Other

And report by Alzheimer's Australia December 2011 report

e-HEALTH SERVICES

AMA sets its own items for managing a shared health summary for the Personally Controlled Electronic Health Record (PCEHR)

Australian Medical Association Limited (AMA), 10 April 2012

The AMA has introduced its own items for preparing and managing a shared health summary for the Personally Controlled Electronic Health Record (PCEHR).

https://ahha.asn.au/news/ama-sets-its-own-items-managing-shared-health-summary-personally-controlled-electronic-health

Industry champions national telehealth strategy for Australia

e-Health HEALTH & WELLBEING, 23 March 2012

The very first national telehealth strategy for Australia, developed by an industry group, has been released for discussion on the Health Informatics Society of Australia website.

The document was prepared by the Australian National Consultative Committee on e-Health which represents the major Australian ICT industry players and other stakeholder groups.

The strategy paper is the first developed by industry as a collective, as opposed to government interests, and details the Committee's thinking as to what is important in telehealth from a systemic national perspective.

http://www.hisa.org.au/resource/resmgr/telehealth/ancceh_telehealth_paper.pdf

Re-engineering Workflows: Changing the Life Cycle of an Electronic Health Record System

Journal of Healthcare Engineering

Vol 2(3) September 2011 pp303-320

An existing electronic health record (EHR) system was re-engineered with cross-functional workflows to enhance the efficiency and clinical utility of health information technology. The new designs were guided by a systematic review of clinicians' requests, which were garnered by direct interviews.

http://multi-science.metapress.com/content/c702138262805010/

EMERGENCY SERVICES

Data briefing: Emergency hospital admissions for ambulatory care-sensitive conditions Identifying the potential for reductions

Yang Tian, Anna Dixon, Haiyan Gao
The King's Fund, 3 April 2012
Ambulatory care-sensitive conditions (ACSCs) are conditions for which effective management and treatment should limit emergency admission to hospital. Nevertheless, ACSCs currently account for more than one in six emergency hospital admissions in England. These emergency admissions cost the NHS £1.42 billion each year.
http://www.kingsfund.org.uk/publications/data_briefing.html

ETHICS

Doctors' unconscious racial biases leave patients dissatisfied (US)

Cooper LA, Roter DL, Carson KA, Beach MC, Sabin JA, Greenwald AG, Inui TS.
Am J Public Health. 2012 Mar 15 [Epub ahead of print]
Physicians are encouraged to remember that each patient is an individual. Exposure to different cultures improves understanding about people's differences, health professionals say.
A key step in reducing racial health care disparities is for physicians to be aware that many people, including doctors, have unconscious biases, said the lead author of a recent study.
http://www.ncbi.nlm.nih.gov/pubmed/22420787/

GOVERNANCE

Social Responsibility: A New Paradigm of Hospital Governance?

Cristina Branda, Guilhermina Rego, Ivone Duarte Rui Nunes 2012
Health Care Anal at Springerlink.com
Changes in modern societies originate the perception that ethical behaviour is essential in organization's practices especially in the way they deal with aspects such as human rights.
http://www.springerlink.com/content/c2h727585528u174/fulltext.pdf

HEALTH CARE

Development of an evidence-based framework of factors contributing to patient safety incidents in hospital settings: a systematic review

Lawton R, McEachan RRC, Giles SJ, Sirriyeh R, Watt IS, Wright J
BMJ Quality & Safety 15 March 2012 [epub].
http://qualitysafety.bmj.com/content/21/5/369.abstract

Factors affecting the value of professional association affiliation

Walston SL, Khaliq AA
Health Care Management Review
Vol 37(2) April/June 2012 pp122-131
The resource-based view of the firm suggests that organisations must obtain valuable resources from external sources to obtain lasting benefits. Professional associations today exist in every industry and offer resources to assist their affiliates' organisations and individual members. Today, there are more than 23,000 national and 64,000 state, local, and regional professional associations that claim to significantly benefit their affiliates. The value of these benefits and what organizational and individual factors that may affect their value have not been explored.

High-performance work systems in health care, Part 3: The role of the business case

Song, Paula H; Robbins, Julie; Garman, Andrew N; McAlearney, Ann Scheck
Health Care Management Review,
Vol 37(2), April/June 2012 pp110–121
Growing evidence suggests the systematic use of high-performance work practices (HPWPs), or evidence-based management practices, holds promise to improve organisational performance, including improved quality and efficiency, in health care organisations. However, little is understood about the investment required for HPWP implementation, nor the business case for HPWP investment.

Reform in Action: Can Implementing Patient-Centered Medical Homes Improve Health Care Quality?

Health Care Quality
April 2012
The patient-centered medical home (PCMH) is a model for delivering enhanced primary care that relies on a team-based approach to coordinate, track, and improve care and focuses on orienting doctors' offices more toward patients' needs. The PCMH makes it easier for patients to have access to health care through extended hours, greater use of phone calls and emails, and more staff coordination in managing all aspects of their care.
http://www.rwjf.org/files/research/73739.5557.reforminaction.canimplementingpatient.pdf

HEALTH FACILITIES PLANNING AND DESIGN

Elder care – Designs to support aging acute care patients

Linda M Gabel
Health Facilities Management
Vol 25(4) pp19-24

Labour of love yields new maternity unit

Birmingham's City Hospital's new maternity unit is an inspiring departure from conventional units. Contemporary design and the latest technology combine to give mothers a safe, yet relaxed, environment in which to give birth.

HEJ reports
Health estate Journal
Vol 66(1) January 2012 pp53- 55

Senior-Friendly: Healthcare Design's Next Frontier
Richard L. Peck, Contributing Editor
Healthcare Design 9 April 2012
http://www.healthcaredesignmagazine.com/article/senior-friendly-healthcare-designs-next-frontier?spMailingID=39100548&spUserID=NjI4NTc5NTQ2OAS2&spJobID=140199645&spReportId=MTQwMTk5NjQ1S0

HEALTH FUNDING

For the Public's Health: Investing in a Healthier Future (US)
Institute of Medicine Committee Calls for Increased National Focus on Prevention, Public Health, April 10 2012
http://www.iom.edu/Reports/2012/For-the-Publics-Health-Investing-in-a-Healthier-Future.aspx

HEALTH PLANNING

Future care: care and technology in the 21st century (UK)
Carers UK
2 March 2012
This is the first in the 'Future Care' series and it explores the current landscape on care and technology.
http://www.carersuk.org/media/k2/attachments/Care_and_technology_in_the_21st_century.pdf

Primary Care and Public Health: Exploring Integration to Improve Population Health
Consensus Report IOM
28 March 2012
Primary care and public health have critical roles in providing for the health and well-being of communities across the nation.
http://www.iom.edu/Reports/2012/Primary-Care-and-Public-Health.aspx

HEALTH POLICY

Major Trends in the U.S. Health Economy since 1950
Victor R. Fuchs, N Engl
J Med
2012; 366:973-977
http://www.nejm.org/doi/full/10.1056/NEJMp1200478?query=health-policy-and-reform

Medicare's Readmissions-Reduction Program – A Positive Alternative
Robert A Berenson MD, Ronald A Paulus MD, MBA, and Noah S Kalman BA.
N Engl J Med
28 March 2012
http://www.nejm.org/doi/full/10.1056/NEJMp1201268?query=health-policy-and-reform

HEALTH SERVICES MANAGEMENT

Personalised Medicine in European Hospitals (EUR)
HOPE and PriceWaterhouseCoopers, February 2012
This report by HOPE, the European Hospital and Healthcare Federation, identifies key elements in the ongoing hospital-based development of personalised medicine in Europe. The report compares the evolution of personalised medicine in six European hospitals located in Denmark, Finland, France, Hungary, Slovenia and Spain.
http://www.hope.be/05eventsandpublications/docpublications/88_personalised_medicine/88_HOPE-PWC_Publication-Personalised-Medicine_February_2012.pdf

Wait Times in Canada – A Summary, 2012
Little change in wait times for Canadian's Knee replacements have longest waits; most radiation therapy provided within benchmarks March 22, 2012 – A new analysis from the Canadian Institute for Health Information (CIHI) reveals that about 8 out of 10 Canadian's receive priority-area procedures – including hip and knee replacements, cataract surgery, hip fracture repair and radiation therapy – within the medically recommended time frames.
https://secure.cihi.ca/estore/productFamily.htm?locale=en&pf=PFC1723

HEALTH SERVICES RESEARCH

Crisis Standards of Care: A Systems Framework for Catastrophic Disaster Response
Institute of Medicine
21 March 2012
The latest report provides a foundation of underlying principles, steps needed to achieve implementation, and the pillars of the emergency response system, each separate and yet together upholding the jurisdictions that have the overarching authority for ensuring that CSC planning and response occurs.
http://www.iom.edu/Reports/2012/Crisis-Standards-of-Care-A-Systems-Framework-for-Catastrophic-Disaster-Response.aspx

Intensive Care Unit Bed Availability and Outcomes for Hospitalized Patients With Sudden Clinical Deterioration
Stelfox, H and others
Arch Intern Med
Vol 172(6) 2012 pp467-474.

Methods for the guideline-based development of quality indicators – a systematic review
Thomas Kotter, Eva Blozik and Martin Scherer,
Implementation Science 2012
21 March 2012
This literature review published in Implementation Science identifies and describes methodological approaches to guideline-based QI development.
http://www.implementationscience.com/content/7/1/21/abstract

Patient-centred healthcare indicators review
International Alliance of Patients' Organizations (IAPO)
March 2012
This review identifies and explores current efforts to measure the patient-centredness of healthcare providers, organisations, national health systems and other stakeholders involved in healthcare provision.
http://www.patientsorganizations.org/attach.pl/1438/1332/PCH%20Indicators%20Review.pdf

HEALTH SYSTEMS

Arrangements for health emergency preparedness, resilience and response from April 2013 (UK)
This document describes changes being made in health emergency preparedness resilience and response to reflect the new health system that will be established by the Health and Social Care Act 2012.
http://www.dh.gov.uk/prod_consum_dh/groups/dh_digitalassets/@dh/@en/documents/digitalasset/dh_133355.pdf

Evaluation of consultant input into acute medical admissions management in England (UK)
A survey of over 100 hospitals in England has found that patients have better outcomes and are less likely to be readmitted to hospital if cared for on wards where the physicians practising acute medical care are on call for more than one day at a time.
http://www.dh.gov.uk/prod_consum_dh/groups/dh_digitalassets/@dh/@en/documents/digitalasset/dh_133355.pdf

Healthy lives, healthy people: towards a workforce strategy for the public health system (UK)
Department of Health UK
This consultation aims to help identify and unlock the potential of the people who are responsible for improving the population's health and wellbeing. It is aimed at a wide audience, reflecting the Government's view that public health is everyone's business, and the findings will be used to inform a new strategy for this group of staff. It covers the challenges and opportunities and workforce and local community issues. The closing date for comments is 29th June 2012.
http://www.dh.gov.uk/prod_consum_dh/groups/dh_digitalassets/@dh/@en/documents/digitalasset/dh_133224.pdf

INFORMATION AND COMMUNICATION TECHNOLOGY

£4 million for technological solutions to tackle healthcare problems (UK)
Department of Health, 28 March 2012
The Department of Health has opened two new competitions with up to £2 million of funding each to develop technological and innovative solutions to tackle two major health challenges.
The challenge is to:
- change people's behaviour in order to reduce the impact of obesity and alcohol related diseases
- improve the number of patients taking their medication as prescribed

http://www.dh.gov.uk/health/2012/03/sbri/

The Triangle Model for evaluating the effect of health information technology on healthcare quality and safety
Ancker JS, Kern LM, Abramson E, Kaushal R
Journal of the American Medical Informatics Association
Vol 19(1) pp61-65.

KNOWLEDGE MANAGEMENT

Influence of team composition and knowledge sharing on the ability to innovate in patient-centered healthcare teams for rare diseases
Hannemann-Weber, Henrike
Journal of Management & Marketing in Healthcare
Volume 4, November 2011 pp265-272(8)
This paper presents a study that investigated the relationship between the composition of interdisciplinary healthcare teams and the intra-team knowledge sharing processes, as well as their joint influence on the generation of new, individualized solutions. Innovative behavior is essential, especially for healthcare professionals treating patients with rare diseases when they are faced with an uncertain, unpredictable care environment and the challenge of creating individualized patient treatment options.

The use of tacit and explicit knowledge in public health: a qualitative study
Anita Kothari, Debbie Rudman, Maureen Dobbins, Michael Rouse, Shannon Sibbald and Nancy Edwards,
Implementation Science 2012
Planning a public health initiative is both a science and an art. Public health practitioners work in a complex, often time-constrained environment, where formal research literature can be unavailable or uncertain. Consequently, public health practitioners often draw upon other forms of knowledge.
http://www.implementationscience.com/content/7/1/20/abstract

LEADERSHIP

Leading Practices and Programs for Developing Leadership Among Health Professionals at the Point of Care
Diane Doran,Marianne Koh, Andrea Dick et al
This report by the University of Toronto's Nursing Health Services Research Unit (NHSRU) reviews both nurse-specific evidence and evidence from other professions to analyze models of leadership development initiatives. The research is intended to support policy development and planning that improves Ontario's health system, and provides recommendations to support policy development and leadership opportunities for frontline nurses.
http://www.nhsru.com/publications/leadership

Organisational and market factors associated with leadership development programs in hospitals: a national study
Kim T H, Thompson J
Journal of Healthcare Management
Vol 57 (2) March/April 2012 pp113-132

MANAGEMENT

Focus on the C-suite: CMO influencer-in-chief
Larkin, Howard
Hospitals & Health Networks
Vol 86(3) March 2012 pp30-34.
This article is the second of a five-part series on the responsibilities of the hospital executive team. The role of the chief medical officer increasingly revolves around influencing physicians and hospital administrators to create working relationships that benefit both. That requires a good grounding in both clinical and business skills. But, while being able to read a financial statement is an essential skill, strategic management and communication may be even more important, says Barbara Linney, VP, career development, American College of Physician Executives.

The New Science of Building Great Teams
Alex "Sandy" Pentland
Harvard Business Review
Vol 90(4) Apr 2012 pp59-70

MODELS OF CARE

The Medical Home: What Do We Know, What Do We Need to Know? A Review of the Earliest Evidence on the Effectiveness of the Patient-Centered Medical Home Model, 2012
Peikes DN, Zutshi A, Genevro JL, Parchman ML, Meyers DS.
Am J Manag Care
Vol 18(2) 2012 February pp105-16.

NURSING

The management of multicultural teams: Opportunities and challenges in retirement homes
Jäger, Max, Raich, Margit
Journal of Management & Marketing in Healthcare
Volume 4, Number 4, November 2011 pp234-241(8)
Demographic and socioeconomic changes in many developed countries are increasing the demand for nurses in health-care institutions, such as retirement homes. This increasing demand cannot be met through a local supply, making it necessary to hire nurses from abroad.

Mandatory nurse staffing levels
Royal College of Nursing (RCN) – Report March 2012
Despite older people often having the most complex needs, this report suggests they regularly suffer from a severe shortage of nurses and health care assistants (HCAs), coupled with an inappropriate skill mix of HCAs to nurses. It calls for a 'patient guarantee', setting out the number of nurses needed on older people's wards.
http://www.rcn.org.uk/__data/assets/pdf_file/0009/439578/03.12_Mandatory_nurse_staffing_levels_v2.pdf

PERFORMANCE MANAGEMENT

Improving patient flow through a better discharge process
Johnson M, Capasso V
Journal of Healthcare Management
Vol 57 (2) pp89-93

PRIMARY HEALTH CARE

EHRs in primary care practices: benefits, challenges, and successful strategies
Goetz Goldberg D, Kuzel AJ, Feng LB, et al.
Am J Manag Care
Vol18(2) 2012:e48-e54

QUALITY

2011 National Healthcare Quality and Disparities Reports (US)
National Healthcare Disparities Report 2011
http://www.ahrq.gov/qual/qrdr11.htm

READING LISTS
The following reading lists have been updated:

- Aboriginal Health Services
- Aged Care Services
- Australian Health Services
- Children's Health Services
- Education and Training
- eHealth Services
- Governance
- Health Economics
- Health Facilities Planning & Design
- Health Services Research
- Human Resources Management
- Integrated Health Care Design
- Leadership
- Lean Thinking
- Legal
- Palliative Care
- Public Health Service
- Resource Allocation
- Risk Management
- Workforce Planning

Please email library@achsm.org.au if you would like a copy of a Reading List. These Lists are also available on the College website at: http://www.achsm.org.au/Reading-Lists2.html

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 Organisation).

Main manuscript

The structure of the body of the manuscript will vary according to the type of manuscript (eg a research article or note would typically be expected to contain Introduction, Methods, Results and Discussion – IMRAD, while a commentary on current management practice may use a less structured approach). In all instances consideration should be given to assisting the reader to quickly grasp the flow and content of the article.

For further details about the expected structure of the body of the manuscript, see below - Types of Manuscript – some general guidelines.

Major and secondary headings

Major and secondary headings should be left justified in lower case and in bold.

Figures, tables and illustrations

Figures, tables and illustrations should be:

- of high quality;
- meet the 'stand-alone' test;
- inserted in the preferred location;
- numbered consecutively; and
- appropriately titled.

Copyright

For any figures, tables, illustrations that are subject to copyright, a letter of permission from the copyright holder for use of the image needs to be supplied by the author when submitting the manuscript.

Ethical approval

All submitted articles reporting studies involving human/or animal subjects should indicate in the text whether the procedures covered were in accordance with National Health and Medical Research Council ethical standards or other appropriate institutional or national ethics committee. Where approval has been obtained from a relevant research ethics committee, the name of the ethics committee must be stated in the Methods section. Participant anonymity must be preserved and any identifying information should not be published. If, for example, an author wishes to publish a photograph, a signed statement from the participant(s) giving his/her/their approval for publication should be provided.

References

References should be typed on a separate page and be accurate and complete.

The Vancouver style of referencing is the style recommended for publication in the APJHM. References should be numbered within the text sequentially using Arabic numbers in square brackets. [1] These numbers should appear after the punctuation and correspond with the number given to a respective reference in your list of references at the end of your article.

Journal titles should be abbreviated according to the abbreviations used by PubMed. These can be found at: http://www.ncbi.nih.gov/entrez/query.fcgi. Once you have accessed this site, click on 'Journals database' and then enter the full journal title to view its abbreviation (eg the abbreviation for the 'Australian Health Review' is 'Aust Health Rev'). Examples of how to list your references are provided below:

Books and Monographs

1. Australia Institute of Health and Welfare (AIHW). Australia's health 2004. Canberra: AIHW; 2004.
2. New B, Le Grand J. Rationing in the NHS. London: King's Fund; 1996.

Chapters published in books

3. Mickan SM, Boyce RA. Organisational change and adaptation in health care. In: Harris MG and Associates. Managing health services: concepts and practice. Sydney: Elsevier; 2006.

Journal articles

4. North N. Reforming New Zealand's health care system. Intl J Public Admin. 1999; 22:525-558.
5. Turrell G, Mathers C. Socioeconomic inequalities in all-cause and specific-cause mortality in Australia: 1985-1987 and 1995-1997. Int J Epidemiol. 2001;30(2):231-239.

References from the World Wide Web

6. Perneger TV, Hudelson PM. Writing a research article: advice to beginners. Int Journal for Quality in Health Care. 2004;191-192. Available: <http://intqhc.oxfordjournals.org/cgi/content/full/16/3/191>(Accessed 1/03/06)

Further information about the Vancouver referencing style can be found at http://www.bma.org.uk/ap.nsf/content/LIBReferenceStyles#Vancouver

Types of Manuscript - some general guidelines

1. Analysis of management practice (eg, case study)

Content

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

Abstract

Structured appropriately and include aim, approach, context, main findings, conclusions.
Word count: 200 words.

Main text

Structured appropriately. A suitable structure would include:

- Introduction (statement of problem/issue);
- Approach to analysing problem/issue;
- Management interventions/approaches to address problem/issue;
- Discussion of outcomes including implications for management practice and strengths and weaknesses of the findings; and
- Conclusions.

Word count: general guide - 2,000 words.

References: maximum 25.

2. Research article (empirical and/or theoretical)

Content

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

Abstract

Structured (Objective, Design, Setting, Main Outcome Measures, Results, Conclusions).

Word count: maximum of 300 words.

Main text

Structured (Introduction, Methods, Results, Discussion and Conclusions).

The discussion section should address the issues listed below:

- Statement of principal findings;
- Strengths and weaknesses of the study in relation to other studies, discussing particularly any differences in findings;
- Meaning of the study (eg implications for health and aged care services managers or policy makers); and
- Unanswered questions and future research.
  Two experienced reviewers of research papers (viz, Doherty and Smith 1999) proposed the above structure for the discussion section of research articles. [2]

Word count: general guide 3,000 words.

References: maximum of 30.

NB: Authors of research articles submitted to the APJHM are advised to consult 'Writing a research article: advice to beginners' by Perneger and Hudelson (2004) and available at: <http://intqhc.oxfordjournals.org/cgi/content/full/16/3/191> This article contains two very useful tables: 1) 'Typical structure of a research paper' and 2) 'Common mistakes seen in manuscripts submitted to this journal'. [3]

3. Research note

Content

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

Abstract

Structured (Objective, Design, Setting, Main Outcome Measures, Results, Conclusions).

Word count: maximum 200 words.

Main text

Structured (Introduction, Methods, Findings, Discussion and Conclusions).

Word count: general guide 2,000 words.

As with a longer research article the discussion section should address:

- A brief statement of principal findings;
- Strengths and weaknesses of the study in relation to other studies, discussing particularly any differences in findings;
- Meaning of the study (eg implications for health and aged care services managers or policy makers); and
- Unanswered questions and future research.

References: maximum of 25.

NB: Authors of research notes submitted to the APJHM are advised to consult 'Writing a research article: advice to beginners' by Perneger and Hudelson (2004) and available at: <http://intqhc.oxfordjournals.org/cgi/content/full/16/3/191> This article contains two very useful tables: 1) 'Typical structure of a research paper' and 2) 'Common mistakes seen in manuscripts submitted to this journal'. [3]

4. Review article (eg policy review, trends, meta-analysis of management research)

Content

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

Abstract

Structured appropriately.

Word count: maximum of 300 words.

Main text

Structured appropriately and include information about data sources, inclusion criteria, and data synthesis.

Word count: general guide 3,000 words.

References: maximum of 50

5. Viewpoints, interviews, commentaries

Content

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

Abstract

Structured appropriately.

Word count: maximum of 200 words.

Main text

Structured appropriately.

Word count: general guide 2,000 words.

References: maximum of 20.

6. Book review

Book reviews are organised by the Book Review editors. Please send books for review to: Book Review Editors, APJHM, ACHSM, 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 ACHSM 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, ACHSM (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 ACHSM on acceptance of the manuscript for publication in the APJHM. This document should be completed and signed and then faxed to: The Editor, APJHM, ACHSM (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 ACHSM 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, ACHSM 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.

INSPIRING CONCEPTS IN HEALTH MANAGEMENT

Surfing the Crest of the Wave

MARRIOTT SURFERS PARADISE RESORT AND SPA, 15–17 AUGUST 2012

ACHSM
Australasian College of Health Service Management

The ACHSM Congress is heading back to the Gold Coast

15-17 August 2012

at the Marriott Surfers Paradise Resort and Spa

The theme of *"Inspiring Concepts in Health Management – Surfing the Crest of the Wave"* will give us plenty of scope to share the latest in leadership and innovation in health service management.

And as always the Gold Coast promises to be more than just an educational and networking destination.

We'd love you to join us . . . visit our website

www.achsm.org.au

for more information!

About the Australasian College of Health Service Management

ACHSM (formerly Australian College of Health Service Executives) was established in 1945 to represent the interests of health service managers and to develop their expertise and professionalism. Today, the college is the leadership and learning network for health professionals in management across the full range of health and aged care service delivery systems in Australia and New Zealand and the Asia Pacific with some 3,000 members from both public and private sector organisations and non-government and not-for-profit organisations.

ACHSM aims to develop and foster excellence in health service management through the promotion of networking, the publication of research, and through its educational and ongoing professional development activities, including accreditation of tertiary programs in health service management, mentoring and learning sets.

ACHSM has Branches in all Australian States and Territories, New Zealand and Hong Kong. Memoranda of Understanding link ACHSM with other health management bodies in the Asia Pacific. As an international organisation, ACHSM is able to draw upon the experiences of researchers and managers in Australia, New Zealand, Hong Kong and other countries within the region to give readers valuable insights into management issues and approaches in a range of cultures and jurisdictions.

MAJOR SPONSORS:

Baxter

Hill-Rom

HESTA SUPER FUND

An Industry SuperFund

Telstra

ACHSM

Australasian College of Health Service Management
PO Box 341 NORTH RYDE NSW 1670
Telephone: (02) 9878 5088 Facsimile: (02) 9878 2272
Email: achsm@achsm.org.au Web: www.achsm.org.au