Asia Pacific Journal *of* Health Management

Volume 2 Issue 1 – 2007

The Journal of the Australian College of Health Service Executives

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Australian College of Health Service Executives
PO Box 341 North Ryde NSW 1670 Australia
Telephone: +61 2 9878 5088; Facsimile: +61 2 9878 2272;
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The mission of the Asia Pacific Journal of Health Management is to advance understanding of the management of health and aged care service organisations within the Asia Pacific region through the publication of empirical research, theoretical and conceptual developments and analysis and discussion of current management practices.

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

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

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

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

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EDITORIAL

Building the APJHM's capacity

M Harris

Unremarkably, the title, *Death of a journal*, recently caught my attention. The main reasons given for failure of the subscription-based professional journal in question were lack of author and reader support due to 'competition for peoples' time and attention, in an environment where there is a danger of information overload', and competition from other journals (print-based and electronic) for quality articles and reader subscriptions. [1, p.197]

What can the APJHM learn from this sorry tale? The main lesson seems to be the highly competitive environment into which the APJHM has been launched. Like any professional journal, to successfully make its way against competition, the APJHM must service important needs of its host College and equally important needs of its readers. In short, it must expand the utility and attractiveness of its host College and expand the capacity of its readers in a number of ways. The APJHM will continue to thrive as it maintains the support of an ever-widening readership within and beyond the Region. Equally - some might say, of greater importance - is the Journal's emerging reputation as a publisher of first class authors in the sciences and arts of Health Services Management, because first class authors choose this Journal in which to publish.

Over the past three issues of the Journal, authors have systematically been surveyed to discover their reasons for submitting highly prized data and manuscripts to this Journal rather than to another. The responses have been illuminating. Twenty one authors offered 27 reasons for submitting their manuscript to the APJHM. These responses constitute the beginnings of a qualitative data set that permits scrutiny for themes and priorities among authors who submit to the APJHM; themes that may well change over time. To avoid premature ageing, the Journal could determine to take an annual look at why the current crop of authors have chosen the APJHM and whether they believe that they have been rewarded for their choice.

Reasons offered by authors for submitting an article to the APJHM in the recent past seemed to fit well under the five headings listed in Table 1. Also listed for each category is the percentage of total author responses that were assigned to each category.

Table 1: Why authors chose to submit articles to the APJHM

REASONS	PERCENT
The perceived readership/data fit	30%
To support and advance the College	26%
The aptness of the readership	19%
The perceived data/Journal fit	15%
Journal editorial procedures	11%

It is immediately clear that authors have an eye to the potential readership of this or any Journal and are apparently influenced most by their perception of who will be reached and who will be reading their data and their work. Virtually one-half of all author comments mention the appropriateness of the perceived reading audience for their writing and the 'goodness of perceived fit' between reading audience and data. This category takes the planning function of the author a little further in that it suggests that almost one third of authors (30%) consider and want to be satisfied that readers and their data will be well matched.

One author in four (26%) has consciously prepared a manuscript for submission to the APJHM because of their membership in the College (ACHSE). There is some variation in motives expressed, but there is commonality in the authors' intention to advance and strengthen the mission of the College. They use words such as 'advance the aims of the College', 'support this much needed Journal'. They write that, as a Fellow or Member of the College, it is logical that they wish to publish in their 'own' Journal.

One author in six (15%) has submitted for publication in the APJHM after being satisfied that there is a good fit between the data being reported and the Journal. This consideration infers a careful reading of recent issues of the Journal to ensure that an article-in-progress will cohere with already published data and/or views. This seems to be of particular importance to authors who are not members of the College and for authors from nations of the Region beyond Australia and New Zealand.

Finally, a few authors, characterised as younger, less experienced researchers and writers mention that they have been influenced to submit to this Journal because of the support provided to authors via the peer review and editorial feedback procedures. Though the least numerous category of author motivation it is an important aim of the Journal to foster the younger generation of researchers, authors and managers, so that the future sources of information and inspiration for health services managers of the Region will be encouraged and trained in the difficult discipline of writing for publication. Many potential authors present their research findings at ACHSE and other health care management conferences but few go the extra mile and prepare an article for publication.

Writing for publication requires analytical skills sufficient to conceive and undertake a research project of relevance to health services managers and then describe the project in careful and compelling language. Senge maintains that practising managers tend to be better salespeople than researchers. They are competent advocates, able to solve problems as they arise and able to garner whatever support is needed to get a particular job done. In addition, organisations reward managers for advocacy skills, while inquiry and analytical skills seem to be more poorly rewarded. [2] The preparation of a well-balanced journal article challenges managers to further develop their analytical skills as well as their publication skills. Where do practising health care managers gain these skills? Is there a role for ACHSE here, perhaps in the facilitation of learning sets for the development of research and writing-for-publication skills?

The importance of building research capacity among health services managers has been recognised internationally 'in order to produce sound evidence for decision-making in policy and practice'. [3, p.1] Activities to build research capacity include the development of research skills and confidence, supported linkages and partnerships, the promotion of research designs that are 'close to practice', the development of appropriate means of dissemination and investment in infrastructure to sustain and support research in the discipline. [3] It has been suggested that action research is an appropriate 'close to practice' research design that can readily be applied to issues and problems in health services management. [3,4] Such an approach usually combines qualitative and quantitative approaches to data collection and analysis plus cycles of action, reflection, dissemination and use of findings nurtured by a supportive learning culture and the development of skills in critical thinking. [4] The case study is another design frequently favoured by organisational researchers. It entails the detailed and intensive analysis of one or more cases, such as an organisation. [4] Cooke proposes that measures of improved research capacity should go beyond the traditional ones (ie publications in peer reviewed journals, conference presentations, successful grant applications) to include impact on professional practice and health services gain. [3]

One measure of the APJHM's success must be an increase in the number of authors contributing quality articles to the Journal. Other measures include the Journal's visibility in the Asia Pacific community of health services managers, reader (practitioner and academic) satisfaction with the quality and relevance of articles and with access to the information contained within the journal. A further measure of a journal's success is its 'Impact Factor'. Rating a journal's 'Impact Factor' is a method for comparing journals regardless of their size. It is 'based on two elements: the numerator, which is the number of citations in the current year of any items published in a journal in the previous two years, and the denominator, which is the number of substantive articles (source items) published in the same two years'. [5,6] Further information about the Impact Factor is available at: http://www.cmaj.ca/cgi/content/full/a6a/8/979

These are turbulent times for journal publishers and health services managers alike. Publishers confront the need to control costs, attract quality articles and respond to reader demands, including online access to journal content. At first glance, the latter may seem like an attractive and reasonable proposition. However, an important question for the College is 'Who would cover the costs of production?' Should authors be asked to pay a fee (most online peer review journals charge authors around $500 to $1,500 per article) [7] or would the College cover these costs by charging higher membership fees? I believe the APJHM can promote its future viability and vigour by staying close to its major constituencies – its host College, its readership and its contributing authors.

Mary G Harris MPH, PhD, FCHSE, CHE
Editor

References

1. Gunn IP. Death of a journal: lost opportunities, new challenges, or both? CRNA. 2000; 11(4):197-201.
2. Senge PM. The fifth discipline. The art and practice of the learning organisation. Sydney: Random House; 1994.
3. Cooke J. A framework to evaluate research capacity building in health care. BMC Fam Pract. 2005; 6:44:1-11 (Online).
4. Bryman A. Research methods and organisation studies. Sydney: Allen and Unwin; 1989.
5. Garfield E. Journal impact factors: a brief review. CMAJ. 1999;161(8): 979-980. Available: http://www.cmaj.ca/cgi/content/full/a6a/8/979 Accessed: 29/01/07.
6. Seglen PO. Why the impact factor of journals should not be used for evaluating research. BMJ. 1997;314:497.
7. Publish Not Perish - a free online tutorial designed to introduce graduate students, junior faculty, and other potential authors to the mysterious world of scholarly publishing, from getting ideas and choosing a journal to submitting and revising a manuscript. Available at: <http://www.publishnotperish.org> Accessed 26/01/07.

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IN THIS ISSUE

In the October issue of the ACHSE Networker, readers were invited to forward photographs of people or places related to the Asia Pacific Region for use on the cover of this Journal. We are very grateful to Nicola Griffiths for the image of the snow capped mountains of the Himalayas that appears on the cover of this issue of the APJHM. We invite further photographic contributions from our readers of places within the Region for future issues of the Journal.

Six original articles, including a commentary and a book review, are presented in this issue of the Journal together with our other regular features: In-profile (Paichit Pawabutr of Thailand), Qs & As and the ACHSE Library Bulletin compiled by Sue Brockway.

In his final Special Feature article (Part 3) about reforming the Australian health system, Podger outlines how his proposed model could be implemented over a three to five year period. He also examines the strengths and weaknesses of the private health insurance system and suggests some improvements that could be made to existing arrangements with a view to the development of a sustainable role for private health insurance in Australia.

Stable claims that Podger has made the correct diagnosis, but questions whether his 'treatment plan' for reforming Australia's health system is achievable. He considers that Podger's approach to implementation is too Commonwealth-centric and maintains that the way forward 'must involve ownership of the solution(s) by all levels of government; and the community at large must be convinced that the new way will ensure even better health services and outcomes'.

Jim Hyde provides a case study of consultative policy making in which Area Health Service Chief Executive Officers (CEOs) participated in the development of the New South Wales Equity Statement. He reports that over the course of their involvement in the project CEO understanding of the concept of equity changed, while their opinions informed the development of the policy. He concludes the equity policy was embedded in the NSW health system 'because CEO leadership and acceptance of the policy enhanced local ownership'.

In the first of the APJHM's article on aged care services, Penny describes some international trends, including, 'new ways of funding that make the best use of public and private resources', an emphasis on primary care and the provision of home-based long-term care, support for informal carers plus approaches to addressing workforce shortages. Workforce strategies listed include improving remuneration levels and qualifications of semi-skilled workers, training based on a set of national standards and the development of a skilled qualified specialist workforce that is appropriately remunerated, with defined career prospects.

Employee commitment to the organisation is the focus of a research article by Brunetto and Farr-Wharton. These researchers used a survey design to examine the impact of management practices on the level of commitment to an organisation of two groups of public sector employees; nurses and administrative employees. Communication factors (eg, access to information needed to undertake work tasks effectively, feedback mechanisms and supervisory relationships that enable work based problems to be solved efficiently) were found to have a greater influence on level of organisational commitment than did other work and administrative factors, such as 'pay'.

Christine Gee, National President of the Australian Private Hospital Association, describes the contribution of the private hospitals sector to the Australian health care system. In this article she provides a profile of the sector in terms of number and size of hospitals, ownership type, patient separations and state/territory distribution. She also explores differences and similarities in service provision between the private and public hospital sectors. The author concludes the private hospitals sector is complementary to the public hospital sector and calls for greater collaboration between the sectors in order to make more effective use of scarce hospital resources.

Drawing on 45 years of experience, Emeritus Professor Paichit Pawabutr, provides fascinating insights into factors influencing his career advancement in health service management within the Thai health system. He perceives the most rewarding time of his career to be shortly after graduation from medical school when he was working in a remote area of Thailand as Director of a health centre and Chief of the District Health Office. A further career highlight included the introduction of a health insurance system for Thailand which eventually led to the current Universal Health Insurance Act.

In the second of the Journal's book reviews, Nicola North summarises the contents and the strengths and weaknesses of the book titled 'Patient Safety: research into practice'. She concludes the book should be on the reading lists of postgraduate students and clinicians involved in management.

SPECIAL FEATURE

A Model Health System for Australia – Part 3: How could this systemic change be introduced and what is the role of private health insurance?

A S Podger

Editor's note:

This Special Feature is the final article in a series of three to be published by the Asia Pacific Journal of Health Management. The author, Andrew Podger, is a former Secretary (Director General) of the Australian Department of Health and Ageing.

Two senior health managers were invited to comment on the reforms proposed by Podger to encourage debate about systemic reform of health care systems. The Director, Centre for Clinical Governance Research, University of New South Wales, Associate Professor Jeffrey Braithwaite, offered his analysis of Podger's proposed model for improving Australia's health system in the previous issue of the Journal. Now, Professor Robert Stable, Vice-Chancellor and President, Bond University, comments on Andrew's proposed approach to implementing a (single) Commonwealth funded health system, including the role of private health insurance.

Abstract:

This paper is the final in a three-part series about the Australian health system in which I propose that Australia should move toward a (single) Commonwealth funded health system.

***Part 1:* The first article described the main strengths and weaknesses of the current health system and briefly canvassed four systemic change options that could deliver more appropriate care and improve efficiency. I concluded that the only realistic systemic change option in the medium-term was one in which the Commonwealth has full financial responsibility, as both funder and purchaser.**

***Part 2:* The second article described my preferred option in detail with reference to how it may work at four levels, viz, national, regional, provider and patient. In so doing, my purpose was to spell out the key design principles I believe are required to ensure the realisation of potential gains from a single (Commonwealth) funder.**

***Part 3:* The third article outlines how my proposed model may be implemented over a three to five year period, analyses the strengths and weaknesses of the private health insurance system and suggests improvements that could be made to existing arrangements that would lead to a sustainable role for private health insurance in Australia.**

***Conclusions:* The (single) Commonwealth funded health model I have outlined in these three articles would facilitate a more patient-focused health system than the one we now have and, at the same time, it would have in-built incentives to improve efficiency and to better control costs. In my view, it would also more effectively address equity by giving more resources to regions and communities (including Indigenous communities) that most need additional support. And, it would allow a more coherent approach to private health insurance offering choice and efficiency without adversely affecting equity.**

I do not see an either-or choice for government between theoretical system changes and practical incremental solutions to immediate problems. If a more incremental approach is pursued, it is important also to have a clear strategic direction to avoid adhocracy. If government is willing to consider systemic change, it must include measures that deliver tangible improvements along the way as well as lead to structures with better in-built incentives for improved performance. Clearly my preference is for the latter.

Abbreviations: AHCAs – Australian Health Care Agreements; COAG – Council of Australian Governments; GDP – Gross Domestic Product; GST – Goods and Services Tax; MBS – Medical Benefits Schedule; PBS – Pharmaceutical Benefits Schedule; PHI – Private Health Insurance.

Key words: patient-oriented care; allocational efficiency; incentive framework; single funder; competition; systemic reform.

Andrew Podger AO
Adjunct Professor, Australian National University and Griffith University;
National President, Institute of Public Administration Australia;
Former Secretary, Department of Health and Ageing; and
Former Public Service Commissioner.

Correspondence:
andrew@podger.com.au

Introduction

This series of articles is taken from the Inaugural Menzies Centre for Health Policy Lecture I presented in March 2006. That lecture built upon a paper I presented to a Productivity Commission roundtable on federalism [1] in October 2005, in which I described in some detail the nature of health systems, including their huge size and their distinctive characteristics (which constrain both the role of markets and the capacity of governments to direct them), the performance of the Australian health system and possible directions for future reform.

The Menzies Lecture, and this series of articles, focus more on the detail of my preferred model for reform. The model is essentially a financial framework involving the Commonwealth as the sole government funder with responsibility for overall policy and regulation, a regional framework for planning and purchasing, and a dispersed approach to providing services. I believe such a framework would facilitate major improvements over time, including effectiveness, efficiency and equity. Such improvements however are dependent upon how the various players respond to the framework and upon the complementary actions necessary to take advantage of the framework.

In this Part 3, I describe how the reform might be implemented, in order to demonstrate it is feasible. I then turn to the thorny issue of private health insurance (PHI) and the problems for both equity and competition under current arrangements in Australia. Sorting these problems out is made more difficult by having multiple government funders of the health system. A single government funder would make it far easier to establish a coherent role for PHI and to improve choice and efficiency without adversely affecting equity.

Implementing the preferred reform model

The takeover by the Commonwealth of full financial responsibility for the health (and aged care) system is certainly feasible, but it would take time, it would involve costs, and there would be considerable risks. Moreover, the benefits will take time, and are conditional on the range of associated changes I have outlined in Part 2.

The Constitution (Section 51 (xxiiiA)) provides the Commonwealth with the power to make laws with respect to the provision of sickness and hospital benefits. I understand this would allow the Commonwealth to provide the hospital services itself, and that there is no reason why those services could not be delivered by a hospital owned and managed by the Commonwealth. That said, it would be wise for the Commonwealth to negotiate any transfer from the states rather than attempt a compulsory takeover.

The objective of a more seamless patient-oriented system would suggest the transfer of financial responsibility not only of hospitals, but also of other elements of state health systems. There would, of course, remain new boundaries with state community services systems but those boundaries would not generally be as disruptive to patient care as the boundaries within health.

The financial implications are very substantial (though less dramatic than the converse option of a state financial takeover). State own-source funding for hospitals and other health services was worth about $13 billion in 2002-03 and this amount has recently been growing faster than GDP. [2] This amount of money could not be found by simply abolishing non-health Commonwealth specific purpose grants to the states. The GST deal would have to be renegotiated. The GST provides around $35 billion (2003-04) to the states. [3] Thus over one-third of the GST would need to be returned to the Commonwealth; and this proportion should grow given the growth of state health spending projected by the Productivity Commission, and the relatively slow rate of growth of other state spending (such as education) that is projected.

A three to five year implementation process would be required to effect the transfer and to bed down the new system. An in-principle agreement with the states would first be required based upon a sufficiently detailed proposition about the financial transfers involved. Subsequently, a dedicated project team under COAG, with associated bilateral task forces, would need to track all government health expenditures to each region, commence joint planning for the initial handover and commence 'due diligence' work.

The initial handover might then focus first on allowing the Commonwealth to share management of state primary health care services, and to take over direct responsibility for all non-acute aged care services. It would involve the Commonwealth establishing a skeleton regional structure, with the capacity to progressively transfer state non-hospital staff and programs. Work might also commence on reviewing hospital management structures in liaison with local committees and professional staff, and on clarifying with states any particular terms for hospital transfers. At this stage, the Commonwealth would also need to establish its new national administrative structure, at least in skeleton form.

This would then lead to the transfer stage, involving the transfer of all state health employees to the Commonwealth, along with financial responsibility for hospitals and other remaining health responsibilities. This would no doubt require redeployment and some redundancies, along with the appointment of new advisory boards, trusts and regional organisations.

Following the transfer, the full responsibilities of the regional purchasing organisations would need to be more carefully designed and progressively introduced, national requirements for casemix purchasing and funding for training and research etc clarified, and national, state and regional administrative structures further rationalised.

The role of private health insurance

The main focus of this series of articles has been on improving the effectiveness and efficiency of the government-funded element of our universal national health system, and setting out a preferred model for purchasing and providing services. That is, in my view, the priority task. A closely related issue but best examined a little separately, concerns the role of private health insurance (PHI) and the optimal model for funding the system. This is not a second-order issue in Australia, particularly given increasing community expectations and demand for choice, but it is not as critical in my view as the first issue I have addressed.

While there are some in Australia who would prefer PHI to play a residual or supplementary role without any government assistance and without community rating regulation, I doubt that it is a politically realistic option for Australia, or that it is the most cost-effective solution in the long run given the extent to which the system would then rely on the quality of government decision-making to contain demand and to allocate resources to services that are genuinely responsive to individual needs and preferences. Even without Australia's long history of substantial PHI covering hospital services that are also available through the public system, both Canada and the UK are facing pressures to widen the role of PHI and the use of both private and public funds to finance services covered by national public health systems.

Equally, however, Australia is extremely unlikely to head down the US route where, at least for those who are not aged or veterans, health care is funded primarily privately, through PHI or similar intermediaries. There is bipartisan commitment in Australia to universal health insurance, and the evident problems in the US of access and equity in particular would not be acceptable here.

Accordingly, to use the terminology of the then Industry Commission's 1997 Report on Private Health Insurance, our system can be expected to remain a mixed one, with both public and private funding contributing to ensure universal health care with a degree of choice. [4] As mentioned earlier, I have assumed this, as one of the design principles for any new Australian health system.

Current weaknesses with PHI arrangements

That said, our current arrangements could hardly be described as cost-effective or even particularly coherent.

Amongst the weaknesses of the Australian PHI arrangements are:

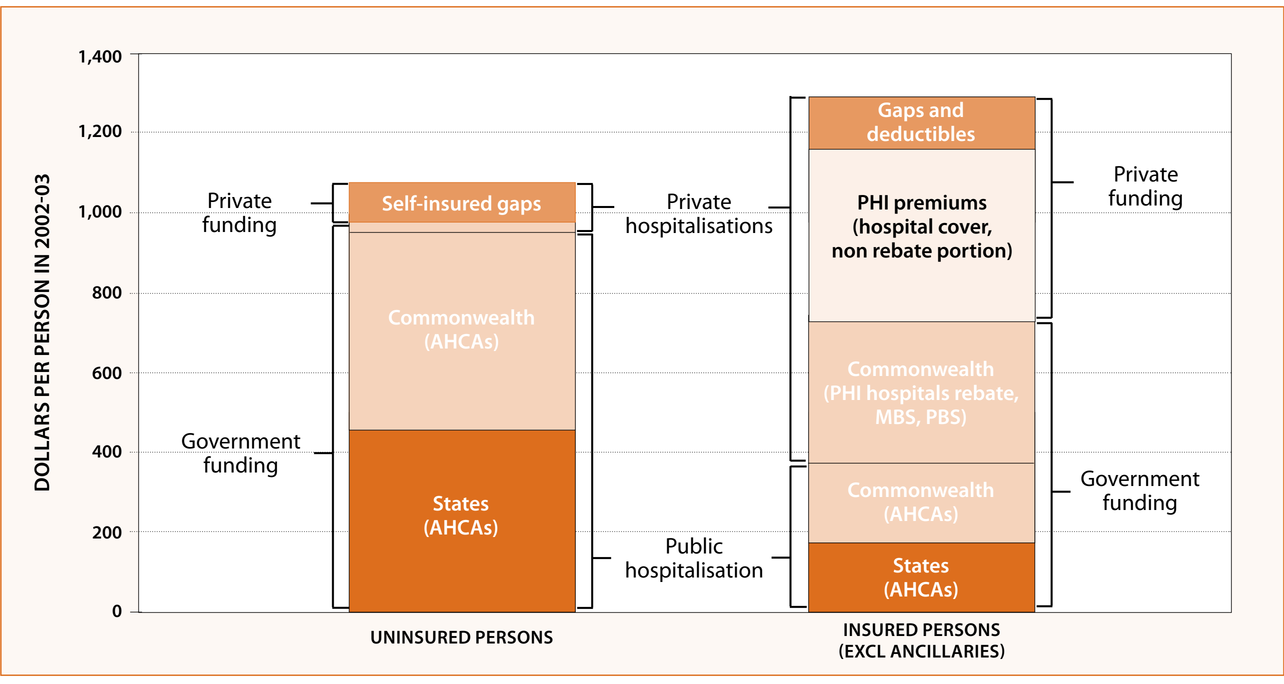
- the uneven playing field amongst hospitals caused by the different funding arrangements from PHI and state governments, with private patient episodes attracting at best only 'default' charges by PHI funds (sometimes less if the patient is directly charged) in public hospitals but full contract charges in private hospitals, and with privately insured patients having financial incentives to go public;
- the limited competition between funds because re-insurance arrangements share out any rewards for more efficiently and effectively managing a fund's membership risk profile;
- the more limited success of PHI funds, compared to government purchasers, to negotiate with doctors on total fees (including out-of-pocket amounts), on billing practice and on treatments on the basis of cost-effectiveness;
- the considerable distortions about the choice to seek insurance caused by tax arrangements as well the PHI rebate and other government funding arrangements;

- the capacity for 'cream-skimming' through the variations in the insurance cover, and variations in front-end deductibles and copayment responsibilities;
- the overall complexity of the system for consumers; and
- the uncertain impact on the health system's equity objective.

Some of these weaknesses, including the last one, can be illustrated by analysing the average level of government and private funding for hospital services for people with and without PHI cover. [5,6,7,8] Figure 1 demonstrates, not surprisingly, that those with PHI cover receive substantially more hospital services on average than those without, drawing heavily on their own resources to do so. I strongly suspect this leads to better health outcomes on average, for example through better access to diagnostic information and elective services such as cataracts and joint replacements. But it also demonstrates that they still draw heavily on government funding, receiving on average around 73 per cent of the amount of government support for each uninsured person. Importantly, this table does not include government support through the rebate on ancillary care, nor does it take account of the Medicare levy surcharge, and of course it represents an average. There is clearly a risk that total government support for some people who are insured is as much or more than they would receive if they were not insured.

As mentioned earlier, the Scotton [9] model of managed competition would involve the government giving everyone the risk-rated premium required to fund their health care services at the Medicare standard, with the choice to direct that premium to their favoured PHI fund (or leave it with a public insurer as a default). It is not, however, a practical option for a considerable time. It is nonetheless noteworthy for several reasons: the role it offers PHI as an alternative purchaser to the government of the full array of health care services; the assumption that those who choose a PHI fund as purchaser have the right to the same level of government support as those who choose to stay with the government purchaser; the ability of those who choose a PHI fund to pay more to get more (by purchasing cover beyond the Medicare standard), without any tax or extra government assistance to do so.

Figure 1: Estimated hospital costs per person per year by, funding source, 2002-03



Source: Derived using data from the following sources: 1) Australian Institute of Health and Welfare. Australian hospital statistics 2002-03. Health Services Series No 22, Canberra: AIHW; 2004; 2) Department of Health and Ageing data on MBS, PBS and the PHI Rebate. Available: http://www.health.gov.au/internet/wcms/publishing.nsf/content/concise%20factbook-table1-july2006 (Accessed 18/10/06); and 3) Private Health Insurance Administration Council data on PHI membership, premiums and medical gaps. Available: http://www.phiac.gov.au/statistics/index.htm (Accessed 18/10/06).

These attributes contribute to the model's simplicity and theoretical elegance, but also reflect some of the risks involved. Given our experience of problems (or at least limited gains from) competition between funds, a model relying even more heavily on the capacity of PHI would need to be carefully developed and tested. The idea that those who opt out, to use a private rather than government purchaser, should receive the full government assistance otherwise available has not been accepted politically in some other areas of social policy in Australia, most evidently in school education. This is a matter for political judgement, but I suspect that those who argue against any assistance are simply revealing their preference for PHI to play a residual rather than complementary role, and that those who argue for support equal to the full government assistance otherwise available are being a little premature about the feasibility of the Scotton model.

Possible measures to address the key weaknesses in PHI arrangements

I strongly suspect that the desire for choice is likely to grow further, rather than diminish, and that we should therefore be looking to ways to improve competition both amongst health care providers and amongst funds, and to improve the capability of funds to operate as effective purchasers meeting the requirements of their members at best price. To move towards a sustainable role for PHI, action is needed to address each of the key weaknesses in current arrangements. I propose four sets of actions: 1) Improving the competition framework, 2) Defining the services PHI should cover, 3) Setting the level and form of government support, and 4) Regulating PHI.

1) Improving the competition framework

The first step in developing a sustainable role is to address the weaknesses in the competition framework.

In the longer term, an even playing field in the acute care area, without distortions for public or private patients or for public or private hospitals, would best be achieved by having all acute care episodes for privately insured patients to be paid by their PHI fund, and all acute care episodes for uninsured patients paid for by the government's regional purchaser (under my preferred reform model set out in Part 2); and with PHI funds able to enter contracts with public and private hospitals without the constraint of default payments. With the government's regional purchasers paying for hospital care for uninsured patients on a casemix basis, both public and private hospitals would be in a position to compete for both uninsured and insured patients' services. The PHI funds would need to ensure their cover included access for free hospital treatment, but subject to the queues and limited choice of doctor and amenity applying to uninsured people. Patient decisions would be based purely on whether they are insured, what cover they have, and the level of service they choose; they would not be influenced by the games the hospitals or funds currently play to press people to 'go public' or to 'go private'.

Without some complementary measures however, such an arrangement would provide windfall financial gains to public hospitals now treating insured patients without charging the funds, with associated additional windfall costs for funds. If we had a single government funder, there would be practical options to address this including paying an amount equal to the additional public hospital revenues involved into the PHI reinsurance pool, or varying the PHI rebate, or otherwise compensating for windfall gains and losses.

Competition reform is far more difficult, however, under the current regime of multiple government funding. For example, the challenge of overcoming the windfall gains and losses mentioned above would be exacerbated by the fact that states would be the winners and the Commonwealth both a direct loser because of higher PHI costs to subsidise, and an indirect loser as the funds and their members would demand full compensation from the Commonwealth for their higher costs and premiums. These complications make this reform option impossible at present. Indeed, even the more limited option advocated by the then Industry Commission (now Productivity Commission) [4,10] to remove the current default benefit arrangements is problematic given current Commonwealth-state arrangements: it might encourage firmer contracting between funds and public hospitals, but it would not address the fundamental incentives for many public hospitals to charge below a real price for private patients. Under the current system of both Commonwealth and state government funding of health, the only short-term measure to improve the playing field would be to require the states in the next Australian Health Care Agreement to fund public hospitals strictly on a casemix basis, reducing public hospital incentives to undercharge private patients and to inappropriately cross subsidise (under this arrangement, like private hospitals, public hospitals would be paid for each patient episode thus seeing each patient as both a cost and a source of revenue, whether the patient is public or private).

A measure which could be implemented more quickly is reform of the reinsurance pool to ensure the more efficient funds are rewarded and the less efficient penalised. This issue has been tossed about now for years, but it is essential if PHI is to play a substantial role in our health system, and if funds are to be encouraged to become more sophisticated purchasers and managers of the health risks of their members. [11]

The other key weakness in the use of competition is the evident difficulty funds have in negotiating contracts with specialist doctors. The common complaint by doctors that the funds are trying to come between them and their patients needs to be firmly rejected: the funds are the third party chosen by their members – the patients of the doctors – to manage the financial risks associated with their health. The members – the patients – expect the funds to keep premiums down and to offer insurance cover where any copayment involved is clearly identified in the insurance policy. This requires the funds to be able to negotiate on behalf of their members both price and location of service. That negotiation may sometimes also go to the cost-effectiveness of the treatment. I accept that any such negotiation needs to recognise the professional expertise and independence of the doctors, but there is a strong case for further review by the Australian Competition and Consumer Commission (ACCC) in consultation with the professions, funds and hospitals to sort out a way to make the PHI products of better value to members.

2) Services PHI should cover

A second element in developing a sustainable role for PHI is to clarify the expected range of services that PHI should cover. Theoretically, the benefits of a single funder would suggest PHI cover the full range of health services, as indeed the Scotton model would entail. With a single government funder, and the strengthening of primary care I have proposed under the preferred model set out in Part 2, however, there would be limited benefits from extending PHI cover into primary care. But there are dysfunctions in the current arrangements. PHI funds should be able to cover out-of-hospital services where these are more cost-effective than alternative in-hospital services, or would reduce the need for admitted services, or form part of the overall hospital care episode. This would encourage funds to consider more cost-effective approaches to care for their members. [12]

Folding into PHI, the separate government funding (through MBS) of specialist services associated with hospital care represents a further possible step towards single funder arrangements for PHI members. It would provide further incentives for funds and hospitals to find the most cost-effective arrangements for providing hospital-related services to members, and could help funds provide members with cover that specifies clearly the total out-of-pocket expenses associated with episodes of care. Those benefits, of course, assume that funds and hospitals are able to negotiate appropriate contracts with specialists. A mechanism would also have to be found for redirecting the MBS savings back to the funds to avoid premium increases. I'll return to this issue of government support for PHI and its members shortly.

While falling short of the Scotton model, this approach to coverage would represent a major move towards single funder/purchaser arrangements for insured people, with associated incentives for improvements in the efficiency and effectiveness of their care. Funds could also choose to offer added encouragement to members to pursue lifestyle and other preventative measures, supplementing the government-funded primary care system, where they considered this to represent value for money in terms of managing the health-cost risks they are responsible for.

Complementing this widening of the coverage of PHI, I believe there is good reason to constrain funds from offering exclusionary products. Such products could in time undermine community rating. While funds do not have to meet the hospital costs of members who present as public patients, these policies also undermine the role of PHI in taking pressure off the public system, the role which justifies the current incentives for PHI membership. To the extent that the longer term sustainable role for PHI is as an alternative option to public hospital and related care, there is a strong case for requiring that it does cover the full range of services otherwise available through the government-funded system.

3) Level and form of government support for PHI

The third element of a sustainable role is to settle the appropriate level and form of government support for PHI. To the extent PHI funds services that would otherwise be available through the publicly funded system, there is a case for taxpayer support. Whether that support should be the full amount or something less than would otherwise be available, is a matter for political judgement. Of course, if the full amount is provided, then PHI would not directly take pressure off the public system: it would merely be an alternative mechanism. The potential benefits of PHI would

be that it may improve the overall efficiency of the system (through competitive pressures) and it almost certainly would provide an avenue through which those who can afford to can get earlier access to services, with more choice and better amenity, thus perhaps acting as a safety valve relieving some of the pressure to relax supply controls on the public system.

My personal preference at this stage would be to hold overall government support for PHI to around 75 percent of the cost that would otherwise be imposed via the publicly funded system. This is about the current average, before taking into account support for ancillary cover and the Medicare levy surcharge.

There are several options for providing this support. The Scotton approach would involve identifying each individual's risk-rated premium for public funded cover, and providing that (or 75 percent under my suggestion) to the chosen PHI fund. That would obviate the need to regulate for community rating, but it would hardly be an incremental step. Another option would be to direct the funds to the reinsurance pool, for allocation to funds on an aggregate risk-rated basis. And there is the option of setting the PHI rebate at an appropriate level, with suitable constraints and/or caps to ensure it does not lead to excessive government support. I do not support returning to direct subsidies to private hospitals, which would undermine moves to single funder arrangements, and the benefits of separating purchasers from providers.

If the PHI rebate is to continue, there is a strong case to contain it to avoid opportunities for some insured people to get more by way of government subsidies than if they remained in the publicly funded system:

- the rebate should not be available with respect to services not otherwise available through the public system – this means dropping the rebate for ancillary services unless some or all of those services were otherwise funded by the government (most significantly, the rebate might be justified for dental services if ever these were covered by the public system);
- the rebate should be capped by setting a ceiling for the PHI premium that would attract the rebate; and
- the additional rebates recently introduced for the elderly should be removed (there is no policy justification for these, which run counter to the whole rationale for lifetime cover which was aimed at attracting and keeping young members and stopping the adverse impact of community rating).

I am also most uneasy about the Medicare levy surcharge arrangement, which is effectively a voluntary means test. If the exemption from the surcharge were regarded as a form of support to PHI, by way of a tax expenditure, it would increase the total government support for many PHI members beyond that which is available via the government funded system. Alternatively, the surcharge may be regarded as a penalty for those on higher incomes who do not take out private health insurance: this presentation of the arrangement may make it seem more acceptable from a policy perspective, but with the rebate and other support being so substantial, and with capacity for people to manipulate their PHI arrangements and rely heavily on public patient care if required, the arrangement is at worst a mechanism for tax minimisation and at best a straight subsidy to the PHI industry.

In summary, if we had a single government funder for the publicly funded system and improved primary care in that system, and if we had PHI covering and paying for all hospital-related services for its members, it would be possible to provide government support to PHI members at around 75 percent of the costs otherwise involved via the rebate and/or via a contribution to the reinsurance pool, allowing PHI after-rebate premiums to be of the same order as at present. Such an arrangement would be coherent, simple and equitable.

4) Regulating PHI

The last element concerns the nature of regulation of PHI. One of the central objectives of the health system is equity, and if PHI is to be the vehicle for more than a residual part of the system, equity is important to PHI. The equity objective could be substantially achieved if the government support were via risk-related premiums, ensuring any personal contribution related primarily to the level of additional care the individual wanted rather than to their personal health risk. In the absence of such a funding arrangement, the equity objective can best be achieved by regulating for community rating. Australia's experience demonstrates the drawbacks of such regulation, but the current lifetime community rating arrangement is probably the best model in terms of limiting those drawbacks.

A sustainable model for PHI in Australia

Drawing these elements together, I suggest a sustainable model for PHI could best be developed within the context of a single government funder for the overall health system, and would involve:

- PHI funds being fully responsible for the hospital-related costs of their members, wherever that care is provided, with incentives for improving efficiency and effectiveness through reformed reinsurance arrangements;
- PHI funds able to cover more than in-hospital services, particularly where such services are cost-effective alternatives to hospital services, and not be allowed to offer exclusionary products;
- Government support for PHI be set at a level no higher than the costs that the public system would otherwise bear (with a suggestion of 75 percent), and be provided via the reinsurance pool and/or the PHI rebate, with suitable restrictions on the rebate; and
- PHI funds continue to be subject to regulation for life-time community rating, unless and until government support is provided via risk-rated premiums.

Such an arrangement would help to build the capability of PHI, and would allow in the very long term the option of seriously considering the Scotton model.

Other observations about PHI

I commented in my Productivity Commission paper that my suggestions are not the same as the Labor Party's 2004 election proposal, 'Medicare Gold'. Yet there are similarities at least in terms of the particular priority I have given to increase Commonwealth financial responsibility for the frail aged, and drawing on the positive experience of the Department of Veterans' Affairs as a single funder of health services for veterans. The main concern I have with Medicare Gold (other than that if the Commonwealth were to accept financial responsibility for hospital care for the aged it might as well go the full distance, as I would strongly prefer), is that it confuses the two issues of multiple government funders and the role of PHI. I was fascinated to read in Mark Latham's Diaries [14] his strong attraction to the Scotton model, and his view that Medicare Gold would be a step towards that model. I cannot see, however, that removing PHI from any role for the frail aged (as implied by Medicare Gold) is likely to help the funds develop the capacity to have full responsibility for the health care of Australians of any age and any health risk. From my perspective, Medicare Gold looks more like a move towards making PHI play a residual role in the Australian health system.

There is a perennial public debate in Australia about rising PHI premiums. With improved competition between funds, and between the providers from whom they purchase services, there would be no need for government regulation of PHI prices. But there does need to be some sensible understanding in the community and the media of likely price movements. PHI premiums must rise over time at least as fast as the effective premiums the government funds for those who are not insured. At present, that is faster than the growth of GDP which is well above the Consumer Price Index. [2] Indeed, it is likely to be higher again if PHI is playing the role of a safety valve, absorbing some of the pressure of public expectations for improved services that would otherwise require even more growth in the public system. Market pressures should moderate this to an extent, but it is also likely that funds will need to use other levers such as tighter controls over providers to alleviate increases in prices.

I am also conscious of critics of PHI who highlight that members paying premiums for additional insurance cover generally find they face copayments which do not apply should they rely solely on the public system. This 'anomaly' (Jeff Richardson uses an exaggerated analogy with the echidna and the platypus) is not so surprising in my view. [15] PHI members do indeed receive additional services for their premiums, and their premiums reflect this. And PHI funds, like all other insurers, need measures to limit 'moral hazard', the tendency of providers and consumers to take advantage of the third party funder. One of those measures is copayments. Governments, of course, rely more heavily on supply-side measures involving queues which is precisely what PHI members are paying to circumvent. The key problem is not that there are copayments, but that the funds find it so hard to negotiate the copayments with the specialists and ensure their members know exactly what costs are covered and what ones are not.

My final observation about PHI relates to sovereign risk. The changes I suggest are significant, but achievable. I would caution against more radical changes. One of the problems for the PHI industry is sovereign risk, which discourages new players from entering into the business and encourages those in the business to be rent-seekers from government rather than focus on improving their performance.

Conclusion

I have covered a lot of ground in these three articles. I believe the Australian health system is generally very good, but it faces new challenges which require substantial reform if the system is to remain affordable and effective. There are some sensible, practical incremental improvements that can and should be made, but I would like to see the national government also grasp the nettle to accept full financial responsibility.

To do so will not be easy, but it can be done, and I have outlined what this might entail and what the system might look like. The model I propose would facilitate a more patient focussed system than the one we have, but would also have in-built incentives to improve efficiency. It would also more effectively address equity, in my view, giving more resources to regions and communities (including Indigenous communities) that most need additional support.

Importantly, I suggest my model could also make improvements to PHI arrangements easier to achieve, and lead to a sustainable role for PHI in Australia.

I do not see an either-or choice for government between theoretical system changes and practical incremental solutions to immediate problems. If a more incremental approach is pursued, it is important also to have a clear strategic direction to avoid adhocracy; if government is willing to consider systemic change, it must include measures that deliver tangible improvements along the way as well as lead to structures with better in-built incentives for improved performance. Clearly my preference is for the latter.

I also recognise that the capacity for government to direct the system is limited. The challenge is to shape the system while allowing it to develop and evolve, in a way that promotes the four objectives of good health outcomes, equity, acceptable cost and the satisfaction of the participants: consumers, providers and investors.

Competing Interests

The author declares that he has no competing interests.

References

1. Podger A. Directions for health reform in Australia. In: Productivity Commission. Productive Reform in a Federal System, Roundtable Proceedings. Canberra: Australian Government Productivity Commission; 2006. Available: <http://www.pc.gov.au/> (Accessed 27/04/06).
2. Australian Institute of Health and Welfare (AIHW). Australia's health 2006. Canberra: AIHW; 2006. p. 286-291.
3. Australian Government. Budget Statement No. 3, 2004-05. Canberra: Australian Government; 2005.
4. Industry Commission. Private health insurance. Industry Commission Inquiry Report No. 57. Canberra: Australian Government Productivity Commission; 1997.
5. Australian Institute of Health and Welfare. Australian hospital statistics 2002-03. Health Services Series No 22. Canberra: AIHW; 2004.
6. Australian Department of Health and Ageing (DHA). Medicare statistics. Canberra: DHA; 2005.
7. Department of Health and Ageing data on MBS, PBS and the PHI Rebate. Available: http://www.health.gov.au/internet/wcms/publishing.nsf/content/concise%20factbook-table1-july2006> (Accessed 18/10/06).
8. Private Health Insurance Administration Council. Membership statistics. Canberra: Private Health Insurance Administration Council; 2005. Available: http://www.phiac.gov.au/statistics/index.htm (Accessed 18/10/06).
9. Private Health Insurance Administration Council. Medical gap information. Canberra: Private Health Insurance Administration Council; 2005. Available: <http://www.phiac.gov.au/statistics/index.htm> (Accessed 18/10/06).
10. Scotton R. The Scotton model. In: Productivity Commission. Managed competition in health care, workshop proceedings. Canberra: Australian Government Productivity Commission; 2002.
11. Productivity Commission. Private hospitals in Australia. Productivity Commission Research Paper. Canberra: Productivity Commission; 1999.
12. In April 2006, the Minister for Health and Ageing foreshadowed such changes to take effect from mid 2007. See Abbott, the Hon. Tony, Minister for Health and Ageing, and Senator the Hon. Nick Minchin 2006, 'More innovation, greater choice in private health', Media Release, 26 April 2006, Canberra.
13. Again, such measures have been foreshadowed by the Minister in April 2006 to take effect from mid 2007.
14. Latham M. The Latham diaries. Melbourne: Melbourne University Press; 2005.
15. Richardson J. 'What can health economics offer?' Working Paper No. 130. Melbourne: Centre for Health Program Evaluation, Monash University; April 2002.

A Way Forward ? – Second response to Podger's model health system for Australia

R Stable

Abstract

The need to ensure that an already good health system by international standards is better positioned to facilitate and/or to provide the best possible services to a population with increasing levels of chronic disease and subpopulations where ill health continues at unacceptable levels has never been greater.

Podger has made the right 'diagnosis' – but is his 'treatment plan' achievable? Is there another way forward?

An approach which gives ownership of the 'solution' to the states and territories as well as the Commonwealth is needed.

Abbreviations: GDP – Gross Domestic Product; MBS – Medical Benefits Scheme; PBS – Pharmaceutical Benefits Scheme.

Key words: health policy; reform; ownership.

Robert Stable MBBS (Qld), MHP (NSW), DUniv (QUT), FRACGP, FRACMA, FCHSE, FAIM, FAICD
Vice Chancellor and President, Bond University
Gold Coast, Queensland, Australia

Correspondence:
rstable@bond.edu.au

Introduction

The attainment of optimal health for individuals within a modern and caring society involves a potentially complex web of interactions between regulators, funders, purchasers and providers. However, nowhere is this more complex than in Australia where the division of responsibility was determined at a time of fierce independence of the (then) separate colonies (which subsequently became the states and territories of the Commonwealth of Australia in 1901), and the need for decentralisation due to poor communication and poor transport across a vast continent. [1] It was also at a time of low complexity and relatively low cost health services with lower individual and community expectations and understanding regarding health outcomes in comparison to nowadays.

In a society such as ours in 2006, optimal health for an individual and for the society as a whole requires both a patient/client-centric and a societal, or a public health, approach. Regrettably, our current health 'system' remains segmented and unit or provider and funder-centric. [2] Having said this, it should be noted that Australia has, without doubt, one of the best health systems in the world. But considering that our investment is now almost 10% of Gross Domestic Product (GDP), and still rising, it could be better. [2]

And decisions continue to be made which don't seem to be in support of a better integrated (ie patient/client seamless service) system. For example, community mental health services in Queensland were taken from the Department of Health (Queensland Health) in the ministerial portfolio allocations after the recent state election; and the services are now provided through the Department of Community Services. Yet mental health inpatient services are provided through Queensland Health in accord with the mainstreaming of mental health services by all states and territories many years ago.

Andrew Podger has called on his extensive knowledge at both the Commonwealth and state levels to stimulate and inform discussion regarding a better health system for Australia. [2,3] His detailed contribution and a subsequent in-depth debate are overdue. Of course, such discussions have always been difficult primarily because of the different levels of government involved, but also due to the many organisations, provider groups and individuals involved. Notwithstanding the recent High Court decision, [4] the current environment where the Australian Government is of a different political persuasion to all of the state and territory governments will make a difficult task even more challenging.

But we have to face this debate for the reasons which are obvious to everybody. Complexity, demands, expectations and relatively finite funds are all progressively becoming more significant issues and governments (politicians), providers and consumers will have to face reality sometime soon.

Podger's model – the Commonwealth Government as both funder and purchaser

Podger has concluded in Part 1 of his article in Volume 1, Issue 1 of this Journal, 'that the only realistic systemic change option in the medium-term is one in which the Commonwealth has full financial responsibility, as both funder and purchaser'. [2] His model involves a regional framework but understandably lacks sufficient detail at this stage regarding how this regional framework would work. Of course, Australia already has a regional framework in the form of the states and territories, and this framework is also currently used, albeit within the current limitations, by the Commonwealth Department of Health and Ageing through state and territory offices with regional directors/managers.

An alternative model – Commonwealth as policy developer, funder and monitor/evaluator – state/territories as purchasers and service providers

Having accepted for years that the status quo is not viable for much longer, I would like to see rigorous consideration of two new models – the one put forward by Podger [3] and another which sees the Commonwealth withdraw to a policy, funding and monitoring/evaluation role with the regions, being the existing states and territories, responsible for all service delivery either directly or indirectly. This has some similarities to Podger's model but, in my opinion, is more achievable as it recognises the states' and territories' involvement and current ownership of the existing (government) health infrastructure. As with Podger's model, it removes confusion as to which level of government is responsible for service delivery.

To minimise issues across regional boundaries, such as the transfer of funds to follow the patients when services are provided outside of the region, regions should have clinical and demographic significance. In other words, the region needs to be large enough in terms of population size to enable all but the most highly sophisticated and complex services to be available within the region. The ability to recruit and retain appropriately qualified staff and issues to do with access must be taken into account. With a population of 20 million in Australia, it could be argued that the number of regions (ie, states and territories) is adequate (or perhaps, one or two too many). However in both models subregions would be necessary.

Under both models, currently financially uncapped schemes administered by the Commonwealth such as the Medical Benefits Scheme (MBS) and the Pharmaceutical Benefits Scheme (PBS) would be cashed out to regions, and hence become capped. This, of course, contains the Commonwealth's current financial exposure. However, by being managed at a regional or subregional level, along with the services currently provided by the states and territories, the opportunities for better planning and integration with the aim of providing better coordinated and hence more optimal services would be significantly enhanced.

Both models reduce, but do not remove, the opportunities for politicians/governments to play the 'blame game', also known as 'political opportunism'. But it would be harder as the roles would be clearer.

A way forward – a national Health Commission

Regrettably, Podger's review of health services was commissioned by, and solely reported to, the Commonwealth Government. The way forward must involve 'ownership' of the solution(s) by all levels of government; and the community at large must be convinced that the 'new way' will ensure even better health services and outcomes. A solution imposed at the Commonwealth level is unlikely to ever be achieved.

Bearing in mind the financial (at both government and individual levels) and the personal costs in terms of suboptimal health outcomes of doing nothing in terms of the growing inadequacies and inefficiencies with the current system, a national Health Commission should be established with 'ownership' by all jurisdictions. The Commission should be given clear Terms of Reference which include providing a recommendation for the most appropriate health system for Australia within three years. The modus operandi of the Commission must be to ensure engagement with all jurisdictions with full transparency in its deliberations and frequent briefings for the community through Discussion Papers and other strategies.

At the very least, this would demonstrate that our politicians/governments understand that the current system needs review in order to address the challenges of today, rather than the challenges of 100 years ago.

Competing Interests

The author declares that he has no competing interests.

References

1. Crichton A. Slowly taking control? Australian governments and health care provision 1788-1988. Sydney: Allen and Unwin; 1990.
2. Podger A. A model health system for Australia Part 1: directions for reform of the Australian health system. Asia Pacific Journal of Health Management. 2006;1(1):10-16.
3. Podger A. A model health system for Australia Part 2: what should a (single) Commonwealth funded public health system look like? Asia Pacific Journal of Health Management. 2006; 1(2):8-14.
4. High Court of Australia. New South Wales v Commonwealth of Australia; Western Australia v Commonwealth of Australia [2006] HCA 52 (14 November 2006). Available: www.austlii.edu/aucases/HCA/2006/52.html (Accessed 20/11/06).

Tackling Health Inequalities: what senior managers think

J Hyde

Abstract

Objective: To describe how New South Wales (NSW) Area Health Service Chief Executive Officers (CEOs) understood concepts of equity in the development of NSW Health's Equity Statement; CEO knowledge and interpretation of a given concept being one aspect of developing policy.

Design and Setting: This paper describes the process through which NSW Area Health Service CEOs were involved in developing the Equity Statement, specifically:

1. Briefings with individual CEOs on key issues and identification of possible difficulties and potential 'equity champions'.
2. A two-hour workshop to explore ('pre-mortem') why the proposed statement might fail.
3. CEO involvement in identifying strategies that promoted equity already operating locally.
4. Consultations with selected individuals about the draft recommendations.
5. Feedback to CEOs.

The article provides a case study of consultative policy making by illustrating how participant knowledge can both inform and be strengthened by involvement in the policy development process.

Results: There was a high level of awareness among CEOs of health inequalities and an acceptance of their responsibility to address them. They saw three main ways of doing this: a) equity of resource allocation for health service delivery within and between regions; b) equity of access to health services based on need; and c) equity of health outcomes. CEOs felt that making the health system accountable for health outcomes would provide pressure for system-wide resource allocation changes. They recognised that factors substantially impacting on health outcomes were outside the control of the health system. Furthermore, finding a balance to which they could be held accountable was difficult. All CEOs saw ensuring needs-based access to services as a key area where they could potentially have an impact; and they specifically saw challenges in a conflict between equity and efficiency, marginalisation of special treatment for disadvantaged people, balancing investment in rescue services and prevention/early intervention, and developing a rational health financing system. The resulting policy has been broadly embedded within the NSW health system with strong local support.

Conclusion: The NSW Health and Equity policy was embedded because CEO leadership and acceptance of the policy enhanced local ownership.

Abbreviations: AHS – Area Health Service; CEO – Chief Executive Officer; NSW RDF – New South Wales Resource Distribution Formula.

Key words: Policy development; equity; policy implementation.

Jim Hyde PhD FCHSE
Victorian Department of Human Services and Centre for the Study of Ethics in Medicine and Society (Monash University). At the time of the project, he was Project Director, New South Wales Health and Equity Statement, based at Centre for Health Equity Training Research and Evaluation and University of Western Sydney.

Correspondence:
jim.hyde@dhs.vic.gov.au

Introduction

A major success factor for interventions by health systems that address the issue of equity is the commitment of leaders. [1] This paper describes how NSW Area Health Service (AHS) Chief Executive Officers (CEOs) understood concepts of equity in the development of the NSW Health and Equity Statement. The paper concentrates on CEO input into the process of policy development through the personal interview process. [2] CEOs were participants in the project, which was conducted between July 2000 and September

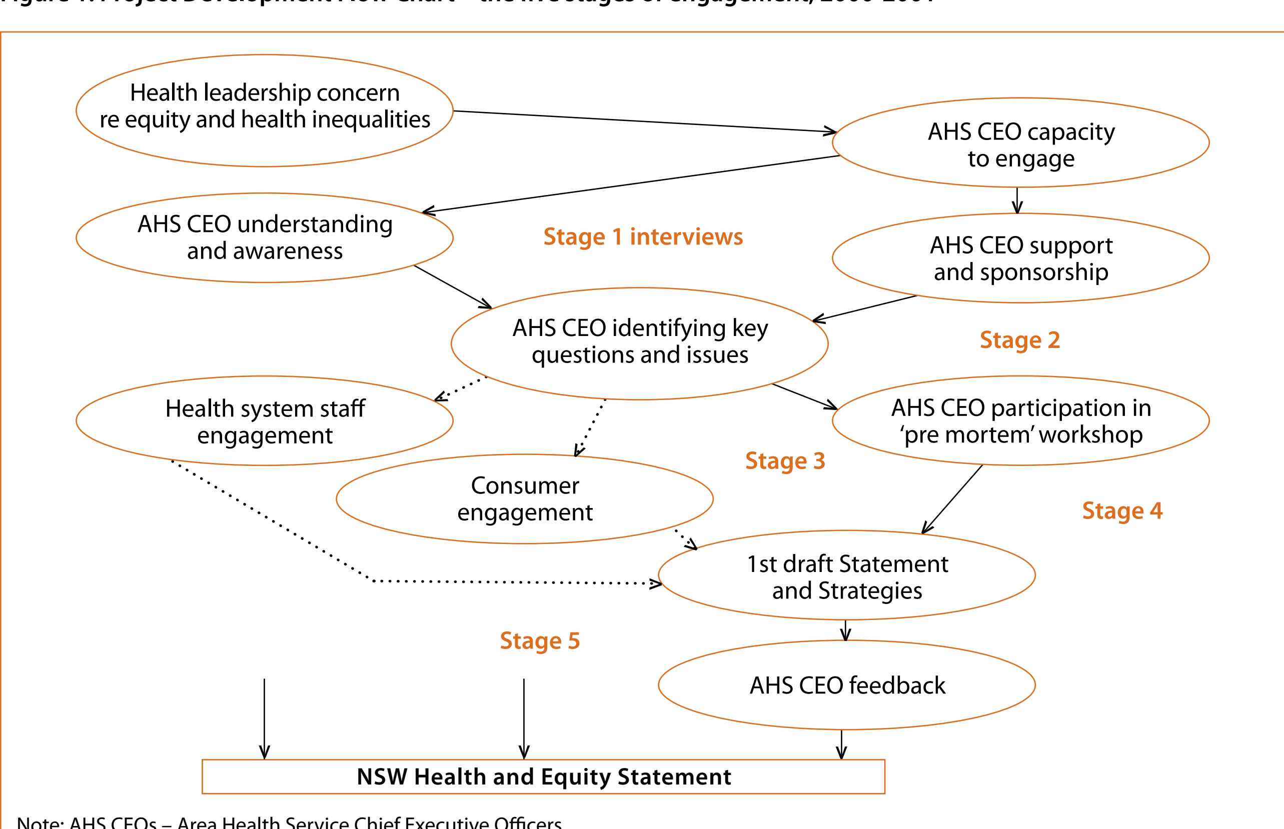
2001, and informed and led some of its development. Consultation workshops with AHS CEOs, and other external stakeholders in metropolitan and regional locations supported the process, which also involved targeted CEO interviews.

This study of CEO engagement in the policy development process has resonance for places other than NSW and provides a case study of consultative policy making. While the paper considers matters regarding policy formation, readers can learn more about equity and health from the following references. [3,4,5,6,7,8]

When NSW Health decided to develop a health and equity statement, the importance of engaging the CEOs was recognised as key to the successful implementation of the outcome. At the time NSW had seventeen AHSs and three other Health Services (NSW Corrections Health, the NSW Ambulance Service and the Children's Hospital, Westmead), funded according to a weighted population formula known as the NSW Resource Distribution Formula (RDF) [9] – with weightings for socio-economic status, age, Aboriginality and rurality. Equity was a key concept in the development of AHSs, though not always understood in its wider sense. The NSW RDF included some aspects of equity from a global perspective but no concept of internal equity at the local or intra-Area level. Equity was generally seen in terms of access to services; often hospital services. However other aspects of equity – equity of health outcomes and equity in health financing – were less evident in the rhetoric of health.

NSW Health is part of a larger cluster of human services departments with a central Human Services CEO Forum to promote collaboration that is replicated (sometimes with additional members like NSW Police) at a regional level. From 1995-2000 NSW Health released a number of equity-based health policies in primary and community health, mental health and Aboriginal health. In Public Health a new understanding that health promotion included capacity building as a core concept, was introduced. [10] These developments culminated in 2000 when the NSW Health Department commissioned the Centre for Health Equity Training, Research and Evaluation and the University of Western Sydney to develop a Health and Equity Statement. This represented a significant investment by NSW Health in a broad and inclusive process to promote an understanding of equity in the system and to bring together key stakeholders to ensure long-term acceptance and sustainability of the Statement.

Figure 1: Project Development Flow Chart – the five stages of engagement, 2000-2001



Method

A case study approach was used involving five stages of consultation and data collection (Figure 1). The first action was the appointment of the Project Team.

1. Project Team

The Project Team had extensive experience in health and a broad understanding of equity and was supported by a Project Management Committee and two Reference Groups. To demonstrate commitment at the highest system level, the Director-General of NSW Health chaired the Project Management Committee. Two Reference Groups were formed to provide advice and support to the Project Team – the first comprised external stakeholders in Health Services including two AHS CEOs; and the second comprised internal NSW Health Department stakeholders. Six key focus areas were identified by these groups: strong beginnings; increased participation; a focus on place; old problems, new solutions; organisational development; and budget and resource allocation.

Technical working groups were convened to address each of the first five focus areas. Three AHS CEOs were members. The sixth focus area was added following the first round of CEO consultations and remained the responsibility of the Project Management Committee. A targeted literature review was commissioned. [11]

2. Interviews with Area Health Service Chief Executive Officers

As indicated in Figure 1, Stage 1 of the project involved interviews with AHS CEOs. One interviewer conducted all initial interviews to ensure consistency. We aimed for the early engagement of CEOs so they could: influence the direction of the project; and have an opportunity to inform the Project Team of local examples of equity-focused programs, projects and interventions including projects that tackled the social determinants of health and health inequalities. The early engagement of CEOs in the study provided the Team with a chance to gauge CEO understanding of and commitment to equity so the Equity Statement could be tailored as an educational as well as operational document. In addition, the early engagement of CEOs enabled the Team to identify potential 'equity champions' and existing equity programs/ projects sponsored by AHS CEOs; recognition of which should facilitate acceptance of the final policy statement.

Interview questions

One CEO was interviewed in an unstructured format from which issues were identified and a structured set of eight interview questions was prepared. This paper reports the findings arising from the following two questions:

- *What do you think are the most important components of equity in the context of the health system and AHS?*
- *What do you think are the most important links between health inequalities, health status and outcomes and equity?*

These first two questions were selected for this paper because they provide the best indication of how CEOs understood and related to equity as a major issue for the health system and for their AHS, and how the policy process was informed. The other six questions are not addressed in this paper because they were more operational and support focused and were not considered relevant to CEO understanding of concepts of equity which is the main focus of this paper. For example, they provided the Project Team with a better understanding of existing interventions, areas of need, gaps in services, possible barriers and other factors required for the development of the final Statement and associated strategies to be achievable and meaningful for the health system.

Interview process and data analysis

Twelve of 20 (60%) CEOs took part in structured interviews of approximately one hour with questions provided prior to the interview. A written record of the interview was sent to participating CEOs within twenty-four hours for them to review.

The Project Team analysed the information, de-identified and consolidated it and circulated a discussion paper to the Senior Executive Forum and later to all staff and stakeholders in the broader consultation process.

3. Workshops to explore potential barriers to success

Stage 2 involved a two-hour workshop (known as the 'pre-mortem' workshop). This workshop involved 17 of the 20 (85%) AHS CEOs plus members of the Senior Executive Forum and other Human Services CEOs. Participants were asked to assume the Equity Statement had been released three years previously and that its implementation had not been successful. Key equity issues were presented, small group discussions identified issues likely to be associated with implementation-failure and ways that successful implementation could be encouraged. Analysis of the information arising from this workshop was included in the draft Equity Statement and Strategies documents.

4. Identification of AHS strategies so CEOs could identify opportunities to build on them
During Stage 3, all CEOs identified the senior AHS officer working on local equity initiatives who could provide details of initiatives; these became the basis of the Equity Strategies document.

5. Individual consultations on draft recommendations to identify levels of support for the strategies and possible implementation problems
The draft Equity Statement and Equity Strategies documents were circulated for feedback to all twenty CEOs during Stage 4 so they could review how their input was used in the development of these documents. Importantly, it was also used to reinforce the partnership approach between the Project Team and CEOs, thus cementing the relationship and strengthening the commitment of identified champions to the policy statement.

6. Feedback on CEOs' concerns being taken up in the final document
Stage 5 of the project involved a further series of unstructured interviews with 15 (75%) CEOs. These interviews were organised during Stage 4 and were carried out by different members of the Project Team working in pairs. CEOs were invited to consult more broadly with their senior staff to elicit comment on the draft Equity Statement and Strategies. The aim of the feedback was to ensure CEOs that their input had contributed to the final Report and thus to cement their support.

Findings

CEO understanding of the concept of equity

Initially, CEO understanding of the concept of equity was varied though most appeared to have an implicit understanding of the key concepts even if unable to articulate them. Among participating CEOs there was a high level of awareness of health inequalities in NSW. All participants accepted they had at least pockets of disadvantage within their AHS and accepted responsibility to address them in three main ways:

1. Equity of resource allocation for service delivery within and between regions;
2. Equity of needs-based access to services; and
3. Equity of health outcomes.

There was good understanding of the distinction between equity of access and of health status and outcomes, and the close relationship between equity and health financing in an operational context.

Over the course of the project CEO responses showed that their understanding of the concept of equity had changed as a result of their involvement. In addition, their responses informed the way the policy was developed and framed.

Question 1: Most important components of equity

CEOs identified three important issues: access, health outcomes and health financing.

1. Access. The importance given to socio-economic status and Aboriginality reflected the growing debate about health inequalities, and in Australia, the appalling health status of the Indigenous community. None equated equity of access with a right to services on demand - equity of access meant the ability to access services on need. Issues raised included rationing some publicly provided services (or moving away from universal provision); concentrating on specialist services focused in the areas of most need; concern at the removal from the Australian Health Care Agreement of an obligation for services to be available on the basis of medical need; and 'market forces' in health or US style 'managed care' seen as restricting access. There was not agreement about such changes.

2. Health Outcomes. All participants recognised that most issues affecting health outcomes are outside the control of the health system, and that the system must become more proactive in orienting general health services toward equity outcomes. Eight of 12 CEOs (67%) recognised health outcomes as the most important aspect of equity in health care and that other equity considerations should flow from an outcomes analysis. There was concern at their ability to maintain balance, especially when faced with increasing demand for highly specialised and expensive technologies in acute care, when improved health outcomes are contingent on achieving equity of access to a broader range of health services in community health and primary health care. Ten of 12 CEOs (83%) believed that extremes in health outcomes and access should be the benchmarks that determined the interventions developed by the health system to provide enhanced services for those outside acceptable health outcomes bands, suggesting that the "inverse care law" was implicitly recognised. As one CEO said: 'Getting the service delivery structure appropriate to the local community is the most important component in achieving equity'.

3. Health Financing. Two factors drew general agreement from participants: a) outcomes equity should drive making resource allocation decisions (8/12 = 67%); and b) expenditure is too high at the high end of acute care where

we are 'tweaking' without gaining much in improvement in health outcomes (7/12 = 58%). The NSW RDF was seen as valuable for achieving equity of resource allocation on a population basis but most CEOs believed it had reached the limits of its effectiveness. Suggested enhancements to the NSW RDF included: a) refining the formula to include more targeted factors such as those with an equity outcomes focus (like remote and Aboriginal health); b) developing resource allocation strategies at AHS level to ensure the state level population focus of the NSW RDF is reinforced by better local targeting; and c) linking resource allocation and quality especially where quality is linked with improvements in health outcomes. There was also strong support for the pooling of resources and for better coordination and planning between all tiers of government to achieve equity of health outcomes. One CEO suggested that:

> *In addressing these issues the system must take a more sophisticated funding and resource approach. Growth funds should not be used for reversal of [inter service] flows and similar maintenance of the system issues but should be used for growth. Similarly fund holding is important and useful but must be transparent. This will allow for equity investment especially in managing a balance between growth, flows and latent demand that appears as new services are developed.*

Other issues raised included developing a more sophisticated approach to resource allocation to ensure that equity investments are managed in a manner that achieves a balance between growth, flows of services and consumers across AHS, support for state-wide highly specialised services, and latent demand that emerges with growth.

Question 2: Most important links between health inequalities, health status and outcomes and equity

All participating CEOs recognised a direct link between health inequalities and equity. In tackling that link, funding and resource allocation were seen to be crucial. Suggestions included: a) changing the balance in funding decisions toward primary health and early intervention; b) resource movement is more easily achieved at an AHS level with a state level mandate for change; and c) addressing the balance of resources for remote communities in addition to other factors in the RDF.

Four issues emerged during discussions with CEOs that should inform moves toward an equity-focussed system:

1. Socio-economic status. Ten of 12 CEOs (83%) noted that social and environmental outcomes flow from income levels and employment, and by the end of the consultation process there was an understanding by all that universal services underpin targeted services that aim to achieve equity. They recognised a need to link clinical conditions with social factors, with funding based on both pre-treatment/intervention, health status and post intervention health outcomes. Three CEOs (25%) rated education as high as income.

2. Indigenous health. Economic, education, housing and public infrastructure were considered to be key issues, particularly in remote communities and especially in Aboriginal communities. Generally CEOs believed the broad picture was well developed but the crisis of demand and a lack of flexibility in funding meant the local level was unable to move away from 'rescue' services to prevention and early intervention. Seven of 12 CEOs (58%) saw Indigenous health as the key equity indicator.

3. Quality. Four CEOs (33%), especially those with large tertiary teaching hospitals, noted the failure of quality and safety to engage the private health sector, which was seen as being important in terms of equity of health outcomes.

4. Investment. Resource allocation and investment decisions were perceived to be a significant issue. Nine of 12 CEOs (75%) were concerned that investments had not been thought through adequately. Five (42%) were concerned that equity and efficiency were not compatible. [12] CEOs believed that investment in equity-focused interventions must be transparent and linked to improvements in health outcomes. This finding reflected CEO concern with 'tweaking' policy decisions directed toward the high cost acute care sector rather than broad prevention and early intervention strategies. Similarly, CEOs perceived that investments from growth funding must be determined by health outcomes, meaning over time a fundamental shift towards population health and primary care. Seven CEOs (58%) suggested transitional funding was needed to achieve this. For instance, one said:

> *The system must determine what impacts on health outcomes – this means a fundamental shift in the system towards population health and primary care with transitional funding (over a generation).*

Within this context, CEOs considered reinvestment of savings and efficiencies should be equity-based and transparent and either directed within a program to ensure more equity or directed to other programs that will achieve improved outcomes for the most disadvantaged. There was also a strong feeling that to achieve stated outcomes, funding must be committed over longer time frames (ten years) where the focus of investment is improved equity.

Discussion

What does this tell us about the thinking of CEOs as this project progressed? During the development of the Equity Statement, CEOs were exposed to strategic discussion and consideration of equity and health inequalities for over twelve months. Initially, CEOs identified three questions:

1. Are health outcomes at a local or micro-level the same as equity at a population level?
2. What is the acceptable range of health status difference? and
3. What are the dangers in approaching equity if the analysis is based on perception and discrimination instead of evidence?

These questions reflect and anticipate concerns and solutions put forward in a number of jurisdictions where policies to tackle health inequalities have been developed or debate has arisen over its meaning. In particular while health inequalities persist in most countries, Australia has been unable to match those developed countries with significant Indigenous populations in improving health outcomes for them in line with the rest of the community. [13] While not explicitly stated by all CEOs, the necessity of universal basic health services with equitable access to specialist services was well understood. As well, the notion of the 'inverse care law' was implicit in the understanding of many.

By Stage 5 of the project, all CEOs had an understanding of the key concepts of equity and recognised the extent of health inequalities as a focus for the health system. Three key strategies emerged from the consultations with AHS CEOs to inform the development of the NSW Equity Statement and Strategies documents. They were:

1. Health's role as an equity advocate in the whole-of-government and broader system must be acknowledged, promoted and pursued if equitable health outcomes are to be achieved;
2. Linkages between health and other service providers that affect health outcomes must be encouraged and pursued; and
3. Information is the key to improving an appreciation and understanding of equity issues.

By the end of the project, CEOs had participated in interviews, workshops, the Reference Group and technical working groups, and reviewed the draft Equity Statement and Strategies to which they had contributed. Many felt that only by making the health system accountable for health outcomes, would there be pressure for system-wide changes in approaches to resource allocation. They recognised that those factors that substantially impact on health outcomes were often outside the control of the health system, which meant finding a balance in dealing with Health Care's role in 'rescue services' and Public Health's role in advocacy to which they could be held accountable. All stated that ensuring access to services based on need as a key area where they could potentially have an impact. They specifically saw four key challenges:

1. Building a focus on equity into mainstream services and the conflict with efficiency;
2. Arguing for different treatment for certain populations based on need in ways that did not marginalise them or bring accusations of special treatment;
3. Dealing with acute health/crisis management issues but allowing time and resources to invest in prevention/early intervention; and
4. Developing a rational health financing system in the Australian context.

What does this mean for health policy makers and administrators? There are two sets of questions that arise: those to do with how health systems are organised; and those that ask about its role. These are questions broader than equity and go to how more general policy making can be informed by specific case studies. With regard to the first, Mintzberg [14] suggests that managing sub-systems in health services requires recognition of the differences between services and how they are managed, and between the needs of each sub-system and how they are managed. The demand for seamlessness is more likely than not to hinder good management outcomes and associated good patient outcomes.

With regard to the second set of questions, the relationship between health and equity has revolved around the relationship between poverty and health outcomes. NSW has attempted under successive governments to address issues of socio-economic status from a population perspective through its funding mechanisms for AHS. Other jurisdictions (though not all) have followed this lead. Marmot [15] says that there are very good reasons for considering the links between health and income (which is one of the key measurements of poverty), health disparities, disadvantage and inequity. They include knowing how to address politically acceptable yet simplistic policies that purport to address health outcomes. Instead we need to understand the chain of causation from economic situation to health outcomes, the extent to which material wealth is equated with poverty

vis-à-vis other factors including social connectedness, and the degree to which social participation and control effect health outcomes and potentially ameliorate poverty and health disparities.

Conclusion

The questions identified by CEOs are key questions. They are relevant to many developed health systems – health policy makers and researchers have addressed many of them and many countries have adopted policies and programs to tackle health inequalities, health outcomes and equity. The United Kingdom has a series of well known reports and studies that have resulted in significant increases in health funding. [16,17,18] More recently, Canada commissioned a major report [19] that examined many of the issues raised by NSW AHS CEOs, making a strong case for re-investment and increasing investment in a publicly funded and controlled health system. The key challenge for governments in Australia is responding to what many senior health policy makers and administrators identify as important, to give them the flexibility to act at the local and regional level, and to support a broad range of strategies aimed at equity-focussed health outcomes. The understanding and awareness of NSW CEOs about these issues reflects the emergence of equity as an important issue. However, the constraints and challenges that they identified also reflect the responses of health systems, in particular, in tackling health inequalities.

The NSW Health and Equity Statement was released by NSW Health in May 2004 and is available from the NSW Health website. [20] Equity remains a key strategic focus for NSW Health. [21]

Acknowledgements

The team that developed the New South Wales Health and Equity Statement included Mrs Elizabeth Harris, Director, Centre for Health Equity Training Research and Evaluation (CHETRE), Dr Peter Sainsbury, Director Population Health Central Sydney Area Health Service, Professor John McCallum, Deputy Vice Chancellor, University of Western Sydney, Ms Sarah Simpson, Policy/Project Officer, CHETRE and the author. While the author acknowledges the input of the team, the views expressed in the article are his alone.

Competing Interests

The author declares that he has no competing interests.

References

1. Bowen S, Harris E, Hyde J. Capacity building: just rhetoric or a way forward in addressing health inequalities. Health Promot Journal Austr. 2001;11 (1):56-60.
2. Unpublished interviews with Chief Executive Officers of NSW Area Health Services, 2000-01
3. Wilkinson R, Marmot M, editors. Social determinants of health: the solid facts. 2nd ed. Copenhagen: World Health Organisation; 2003.
4. Wilkinson R. The impact of inequality. New York: The New Press; 2005.
5. Marmot M. The status syndrome. London: Bloomsbury; 2004.
6. Griffith R, Craze L, Fernandez R, Langdon R, Gentles L. Health and equity: a targeted literature review. Sydney: South West Sydney AHS and University of Western Sydney; July 2000.
7. Whitehead M. The concepts of health and equity. Copenhagen: World Health Organisation; 1990.
8. Harris E, Sainsbury P, Nutbeam D, editors. Perspectives on health inequity. Sydney: Australian Centre for Health Promotion; 1999.
9. The Resource Distribution Formula is explained at http://www.health.nsw.gov.au/pubs/1999/pdf/resdistformula.pdf; and http://www.health.nsw.gov.au/public-health/phb/HTML2002/march02html/rdistribution.html.
10. These policies are available on the NSW Health website at http://health.nsw.gov.au.
11. Griffiths R, et al. Informing the development of the NSW Health and Equity Statement: a targeted literature review. Liverpool: South Western Sydney Centre for Applied Nursing Research; 2001.
12. The position that equity is as valid an economic objective as efficiency was not widely understood. See Richardson J. How should we decide which ethical preferences to include in economic analyses of the health sector. Paper presented to the Health Services Research Association of Australia and New Zealand Conference. 2001 Dec 2-4; Wellington.
13. In fact there are conflicting data in Indigenous health. While some health status indicators such as life expectancy have worsened in recent years others such as infant mortality rates have improved. However the high crime rates in Indigenous communities, extreme levels of alcohol and drug dependency and community violence continue to challenge Australia.
14. Mintzberg H. Managing care and cure – up and down, in and out. Health Serv Manage Res. 2002:15(3):193-206.
15. Marmot M. The influence of income on health: views of an epidemiologist. Health Aff. 2002;21(2):31-46.
16. Acheson D, chair. Independent Inquiry into Health Inequalities, report. London: The Stationery Office; 1998.
17. Wanless D. Securing our future health: taking a long-term view: final report. United Kingdom: April 2002. Available from: http://www.hm-treasury.gov.uk/media/A99/D2/letter_to_chex.pdf.
18. Wanless D. Securing good health for the whole population: final report, United Kingdom: Feb 2004. Available from: http://www.hm-treasury.gov.uk/media/E43/27/Wanless04_summary.pdf
19. Romanow Roy J, chair. Building on values: the future of health care in Canada, final report of the Commission on the Future of Health Care in Canada. Ottawa: Health Canada; 2002. Available from: http://www.hc-sc.gc.ca/english/pdf/romanow/pdfs/HCC_Final_Report.pdf
20. NSW Health. In all fairness: increasing equity in health across NSW. North Sydney: NSW Health; 2004. Available from: http://www.health.nsw.gov.au/pubs/2004/fairnessreport.html. The delay in its release came from concerns in the Department of its implications but was eventually supported by the CEO champions.
21. NSW Health. Strategic directions for health 2000-2005. North Sydney: NSW Health; 2000. Available from: http://www.health.nsw.gov.au/health-public-affairs/sdir/strategic13_10.pdf.

MANAGEMENT PRACTICE

International Trends in Aged Care

A H Penny

Abstract

This article looks at trends in Western countries in the aged care sector, particularly the responses of selected countries to providing health and social care services to an increasing number of older people who are living longer and consuming large amounts of resources. Trends in public and private funding for long-term aged care are identified. Key service delivery trends are discussed and these encompass a focus on primary care led services; the increasing use of home-based care in long-term care arrangements; and the status of approaches to quality improvement and monitoring. Strategies that empower the consumer and support the informal care giver are identified while international efforts to recruit, train and maintain a formal workforce are discussed.

Abbreviations: OECD – Organisation for Economic Co-operation and Development; UK – United Kingdom; GDP – Gross Domestic Product.

Key words: trends in aged care; funding initiatives; service delivery in aged care; long-term care; quality improvement; formal and informal workforce.

Anthea Penny RGON, AdvDipNursing, DHM, MHlthMgt(Hons), FCHSE
Director, R H Penny Ltd
Rangiora, New Zealand

Correspondence:
anthea.penny@xtra.co.nz

Introduction

Governments in Western countries are faced with providing health and social care services to an increasing number of older people who are living longer and whose expectations are to access affordable quality health and social services in their old age. Many of these countries are reforming their systems and positioning their policies, resources and services to meet this growing demand. In these countries governments are grappling with two key questions: first, how to provide future care to the increasing numbers of ageing in their populations; and secondly, how to resource and manage increasing levels of disability and chronic disease. [1]

In previous decades aged care has often been viewed as the 'poor relation' of health and social service provision but there is growing realisation that the impact of increasing elderly populations is both financially and socially too important to ignore. How these ageing people are to be cared for will depend on what society endorses and wishes to achieve and the political policies and funding that emerge. These objectives or goals should be based on the actual needs and wants of older people and those who care for them, the philosophy that drives the quality of care and what society can afford. This article attempts to make a contribution to the overall understanding of the issues and challenges faced by Western countries in addressing the needs of increasing ageing populations and the differing yet similar responses that Western systems are taking to address this issue.

Methodology

The information contained in this article was collected in two different ways. First, a literature review was undertaken of major policy documents and reports internationally from Western countries on aged care trends, funding and delivery systems for aged care, community care, home-based care and care in residential settings. Secondly the author has, in the last six years, led eight international 'Masterclasses' for senior health and aged care managers and clinicians from Australasia to England, Northern Ireland, Scotland, Canada, USA, Denmark, Sweden, Germany and the Netherlands and discussed with policy makers, academics and service providers in each of these countries the issues, challenges, policy and service delivery responses outlined in this paper.

Findings

This section covers five main topics: new ways of funding aged care services, primary care-led health and social services, long-term care, quality improvement and workforce.

1. New ways of funding aged care services

Western countries are seeking more cost-effective ways of resourcing and responding to older people's specific needs, based on the perception that expenditure growth will accelerate mainly as a result of increasing numbers of older people and their associated levels of disability. Public funding is the most important source of financing for long-term aged care but this is still relatively low as a proportion of Gross Domestic Product (GDP) when compared to spending on other health services and spending on pension schemes. Total expenditure on long-term care is reported to range from 0.5 to 1.6 percent of GDP in Western countries [1] and while there are different ways to organise and fund long-term care, expenditure outcomes are similar. [1]

Over half of public spending in OECD countries is on institutional care. [1] In addition to public expenditure the OECD reported in 2005 that private expenditure was also an important funding source particularly in residential care institutions (eg 30 percent of total expenditure); and for individual households this level of expenditure can be substantial. A larger share of publicly funded resources is being devolved to home care. Merlis [2] reported in 2000 that long-term care in Western countries was evolving in the direction of greater emphasis on community-based services while the OECD reported in 2005 that the rate of increase in nursing home beds was static while home care rates continued to increase. [1] Although publicly funded home care has been receiving increasing attention, this form of care has been heavily supported by unpaid informal carers. Increasingly private households in most of these countries share the burden of care; not only in providing informal unpaid care but also by making substantial co-payments under public programs and out-of-pocket spending on care provided both at home and in institutions.

Funding long-term care

A comparison of spending levels across countries reveals quite different ways of organising and funding long-term care. [1] Empirical evidence from the OECD (2005) suggests that differences in program design (eg the amount of funding and level of cost sharing, ageing in-place strategies, the quality of service and the way services are targeted) play a more important role. [1]

Most countries are searching for new cost-effective ways with which to fund and provide a continuum of services for long-term care of older people that is equitable and affordable both for the individual and the government. The main methods being used at the overall system level are:

- Savings based models associated with public and private insurance schemes (as in Germany and Austria);
- Co-payment models with higher consumer payment often associated with means testing of older people's assets and income levels to ensure equitable access. Levels are set in varying ways but include asset thresholds and levels of personal income (as in New Zealand and the United Kingdom [UK]);
- Equity plans and accommodation bonds (as in Australia); [3]
- Partnership models are being investigated in the UK so that anyone assessed as needing care would be entitled to a basic level of care met from public funds. Any care above the minimum is met by state funding matched by private contributions to a specified limit and anything above that is paid for by the consumer;
- Raising the retirement age; and
- access to universal superannuation.

Resource allocation methods

While Western countries are adapting their funding and resource allocation systems some common features for long-term care resource allocation are emerging with an emphasis on consumer choice such as 'personal budgets', direct payment schemes and income payments to informal carers. Personal budgets and support are an alternative means of providing formal home care by a single designated agency. With these schemes, older people or their families are given a budget and can choose from a range of providers including their family to provide direct personal care. With most of these schemes, home cleaning is not provided for in the budget. Quality of care evaluation outcomes from these new service and payment schemes are reported to be similar to outcomes from traditional formal services. Furthermore, levels of client satisfaction are reported to be relatively high due to an increase in client flexibility and level of control over their daily lives. [4]

Independent assessment of need, together with service coordination and ongoing case management of the older disabled or medically frail older person across the continuum of long-term care, is a feature of resource allocation and case management in many countries (eg Australia, Austria, Germany, Japan, New Zealand, Norway, Sweden, and the UK). [1] Evidence of the value of an integrated funding and service delivery approach are emerging with data showing a reduction in hospitalisation and long-term care institutionalisation, together with improved client outcomes and increased consumer satisfaction. [5]

2. Primary care led health and social care services

Internationally, primary care is defined as the first point of contact for the provision of services to meet older people's health and social care needs and it is in the forefront of future arrangements for service delivery. It is now recognised that access to primary care services plays a vital role in helping older people keep fit and live longer and healthier lives thereby lowering levels of disability within this population group. There is growing evidence internationally of the cost-effectiveness of the primary care approach, given its potential to reduce costs associated with approaching death. [5] Recent research in Canada indicated that approximately one third of health expenditure is incurred in the last year of life. [6]

There are a number of primary care trends from overseas that are being implemented to enable older people to keep as fit as possible and remain in their own homes. These strategies include:

- the development of primary care led health promotion and evidence-based disease prevention programs;
- routine screening and assessment;
- management of chronic disease and medications and immunisation programs;
- initiatives to improve access to primary care via nurse led initiatives such as nurse led clinics as in the UK;
- multidisciplinary approaches based in the community as in the UK, Sweden and Denmark; and
- provision of home care and community-based specialist services such as specialist geriatric and rehabilitation services located alongside general practice. Evidence from the UK shows that community-based services can be substituted for specialist health care (mainly hospital based specialist care) and that it is cost-effective. [11]

Evidence of the cost-effectiveness of the provision of a primary care-led service continuum is emerging and current research suggests that use of preventive community-based care (eg care at home and use of day health centres) would improve client outcomes, decrease institutionalisation and increase consumer satisfaction. [7] This approach appears more cost-effective than institutionalisation and meets the older person's immediate needs while at the same time reducing the necessity for more intensive and expensive services 'downstream'.

3. Long-term care

The provision of home-based services

There has been a major shift in public policy internationally towards public long-term care programs that provide increasing amounts of home care to older people. [1,2,7] This larger share of resources in home-based care has resulted in an increased supply of home care providers and community-based services such as personal care, plus an increase in respite care services. It has also led to the development of a variety of consumer choice programs as well as self-determination funding strategies that empower the consumer to purchase and manage their own home-based care. [1]

There is an increasing move (observed in the UK, Sweden, Denmark, the Netherlands, Germany, New Zealand and Australia) to provide high levels of personal care in the home, with or without additional medical and nursing resources and input from other members of the multidisciplinary team. In addition, there is a strong shift towards merging younger disabled and the elderly and utilising strategies that encourage social integration through universal service, transport, community activities, etc. There is a view, particularly in the UK, that an intersectoral approach in service delivery at the community level can contribute more to the long-term care of older people through the provision of integrated services such as transport, social care, welfare, housing and health care.

Key Elements associated internationally with the increasing provision of aged care in the community are:

- A variety of funding streams that are coordinated at the consumer interface;
- Increased community-based packages that are tailored to meet the individual's needs;
- Streamlined assessment processes across agencies and across time associated with a wider choice of options for home-based care;
- The ability of providers to balance risk against safety and support self-determination approaches and older people with special needs to remain in the community;
- Improved support for informal carers for time-out and reimbursement for the constancy of caring;
- Tailored housing that meets older people's disability needs coupled with transport resources that are available in the community; and

- The use of technology in the delivery of health and social care services to people in their own homes is being developed and implemented using a combination of sensor and information and communication technologies either as a direct response to unscheduled calls or as an information gatherer on the health and safety of the home user. [8]

The provision of residential care

In residential care the advent of the large institutional type of facility for aged people appears to be over. Residential care is moving from large institutions with two and four bedrooms to studio/one or two bedroom accommodations with ensuite. In addition, cluster living concepts that offer a more community-based environment are being implemented in the Netherlands, Denmark, Northern Ireland and the UK. In these cluster concepts, individuals with similar care needs are grouped into a house and into neighbourhoods within a larger facility and these houses and/or neighbourhoods provide specialised housing with floor plans/facilities to meet the specific needs of each cluster group. [9]

In Denmark, traditional nursing homes have been reorganised as 'Health Care Centres' with attached independent residences available to rent and a 24-hour multidisciplinary care team on site. There is evidence of improved health status (user perception), greater consumer involvements in activities of daily living, and increased independence without evidence of increased cost. [7]

Similarly independent living flats in low rise buildings, which the resident either owns or rents, are a feature in the UK, Germany, the Netherlands, Sweden, New Zealand and Australia. In the UK, care is provided by separately contracted service provision companies with care delivered to each individual based on their care plan which include specified tasks and timeframes.

The provision of dementia care

Trends in dementia care are focused on keeping the individual in the community and cognitively functioning for as long as possible. New models of care are being implemented in the UK, Northern Ireland and the Netherlands based on small clusters or family unit facilities of six studio bedrooms with ensuite. [10] In these units, daily living facilities are shared and care is provided by one professional caregiver on duty at any one time across a 24-hour period. Residents are kept as independent in their living style and approach as possible with their cognitive strengths maintained through living a 'normal' life. Anecdotal evidence on this approach is promising indicating that levels of individual cognitive functioning are being maintained for considerably longer periods compared with similar institutional-based clients. However residential care is still being effectively utilised using palliative care principles for the highly dependent dementia sufferer and the person requiring end stage dementia care.

4. Quality improvement

The OECD report of 2005 describes the evidence of quality in long-term care in Western countries as variable and in many instances failing to meet the expectations of the public and the consumer. [1] Adverse events and poor quality have been the key drivers of reform. Key evidence of poor care lies mainly in the institutional arenas (which is not to say that home care doesn't have its share of poor care as well but it is harder to monitor) and encompasses pressure sores, the prevalence of chronic pain, the prevalence of the use of tube feeding and the overuse of anti-psychotic drugs. [1] National standards are also variable with quality monitoring at various stages and levels of implementation. Furthermore, the development and measurement of quality outcomes are still in their infancy.

Higher levels of consumer satisfaction have been expressed by those receiving care in the home compared with those receiving institutional-based care. This variation in consumer satisfaction has been demonstrated in surveys internationally [1] and has been one of the key influences in the policy and resource shift to the provision of increased home care. However there are quality issues internationally surrounding home care services that mirror quality issues in institutional care. In addition some concerns have been expressed about the lack of information about services; inappropriate residential care admissions; and the inadequate supply of care for people with dementia.

Efforts to improve the quality of aged care services internationally involve a number of strategies such as: setting and monitoring national standards based on minimum requirements; establishing and monitoring outcomes of care; use of accreditation systems; linking performance monitoring with continuous quality improvement; self-regulatory approaches by providers and/or their associations; consumer empowerment; and market competition. In addition there is a major shift towards assessment of risk and utilising an outcome-based approach. This replaces regular inspection with a combination of spot inspections at less frequent intervals with the rigor of self-assessment that aims at making the process more reliable and transparent.

Consumer empowerment measures have included the setting up of residents' councils and more effective means of dealing with complaints as well as 'mystery shoppers' approaches, such as independent auditors acting as inquiring relatives. In addition, some countries have established an aged care ombudsman that incorporates complaints, advocacy and representation.

5. Workforce

The formal workforce

Most Western countries report workforce shortages in the long-term aged care workforce yet the input of skilled trained health professionals and other skilled personnel is crucial to achieving quality outcomes. There are a number of key issues that are common to all aged care systems internationally but few solutions are forthcoming. Factors affecting the supply of the workforce relate to the unpopularity of the aged care sector as an industry to work in; the ageing of the workforce; and the lack of a trained semi-skilled and professional workforce. Service delivery providers grapple with high rates of staff turnover and low rates of staff retention, both of which are influenced by the way the workforce is remunerated, a lack of adequate training, difficult working conditions and a lack of career prospects.

The key question is whether or not there will be an adequate workforce available in the future to meet higher levels of consumer demand particularly for community-based services or whether the way care is delivered will need to be radically changed. There are few answers to these questions but the UK National Health and Social Care Services are investing in the following strategies:

- Improving the remuneration levels and training qualifications of semi-skilled workers;
- Basing aged care training on nationally identified competency standards with incentives for training that offer ease of access to training opportunities and multi-cultural approaches to learning;
- Adapting the training outcomes to accommodate the introduction of technology.
- Development of a skilled qualified professional workforce (eg the use of 'gerontologist nurse practitioners') that is appropriately remunerated and with defined career prospects; and
- Linking outcomes of training to the quality of care delivered and monitoring this.

The informal workforce

Given the uncertainty of supply of a formal workforce internationally, the focus is turning towards supplying further support to informal carers, who for so long have cared for their older relatives or partners at home in the community. Strategies involve increasing or strengthening respite care arrangements, providing carer allowances as financial reimbursement and recognition for their role at minimum wage rates and making direct care payments so that the carer and their relative have control and flexibility over their daily living arrangements. [11]

Conclusions

Western countries are facing a number of issues associated with increasing elderly populations and the challenges of delivering quality long-term care in the future that is affordable to the government and the individual. Sustainability trends encompass new ways of funding that make the best use of limited public and private resources, in tandem with new models of service delivery that focus on home and community based long-term care, supported by a primary care led service. There is a focus on supporting informal carers who are resourced or in receipt of respite care. In addition there are strategies being developed to empower consumers and their carers that provide choice, flexibility and control over their daily lives. The supply and quality of a skilled trained workforce continues to concern and confound policy makers and service providers internationally and solutions are slow to emerge. The future of our aged care industry lies in finding cost-effective strategies to ensure the provision of quality health and social care services to meet consumers' needs and societies' expectations.

Competing Interests

The author declares that she has no competing interests.

References

1. Organisation for Economic Co-operation and Development (OECD). The OECD Health Project: long-term care for older people. Paris: OECD; 2005.
2. Merlis M. Caring for the frail elderly: an international review. Health Aff. 2000;19(3):141-149.
3. Kendig H, Duckett S. Australian directions in aged care: the generations of policies for generations of older people. Sydney: Australian Health Policy Institute, University of Sydney; 2001.
4. Lundsgaard J. Consumer direction and choice in long-term care for older persons, including payments for informal care: how can it help improve care outcomes, employment and fiscal sustainability? France: OECD Working Paper, Number 20; 2005.

5. Wanless D. Wanless Social Care Review: securing good care for older people, taking a long-term view. London: King's Fund Report; 2006.
6. Pollock A. Compression of health expenditures. Health Policy Research Bulletin. 2001: March;13-15.
7. Wanless Review Team. Social care needs and outcomes: a background paper for the Wanless Social Care Review. London: King's Fund; 2005.
8. Milligan J M. To grandmas: a cluster housing living concept offers a more home-like environment. Contem Long-Term Care. 2002; September;Vol. 9.
9. Barlow J, Curry R, Trejo, M. Integrating telecare into mainstream community services. London: Imperial College; 2005.
10. Arcares Association. New arrangements of housing and care (Informal briefing paper). Netherlands: Arcares Association; 2005.
11. National Health Service. Our health, our care, our say: a new direction for community services. UK: Department of Health; 2006.

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For further information please contact:

Julian Baldey
Business Development Director

T: (03) 9274 9511
F: (03) 9274 9501
M: 0400 083 334
E: julianbaldey@compass-group.com.au

RESEARCH ARTICLE

Comparing the Impact of Management Practices on Public Sector Nurses' and Administrative Employees' Commitment to the Organisation

Y Brunetto and R Farr-Wharton

Abstract:

Objective: To present the findings of a study that examined the impact of management practices on public sector nurses' and administrative employees' level of commitment to the organisation.

Design and setting: A cross sectional study involving a comparison of the perceptions of ninety four nurses and one hundred and fifteen administrative employees about communication and administrative factors and their level of commitment to the organisation. The setting was public sector hospitals and organisations in Queensland, Australia.

Main outcome measures: The study used three validated instruments to measure 'employee satisfaction with communication processes', 'job satisfaction' and 'affective commitment' (which measures commitment to an organisation).

Results: For this group of public sector employees:

1) Satisfaction with communication factors had a greater impact than did administrative factors on their level of commitment to the organisation ($p<0.01$); and
2) Significant differences were observed between nurses and administrative employees in their level of satisfaction with organisational communication ($p<0.01$) and administrative work factors ($p<0.01$), suggesting they experience different managerial processes and practices.

Conclusions: The findings suggest that senior management can influence employees' level of commitment to an organisation by changing the quality of communication and administrative work processes embedded within the workplace. These processes include: 1) the provision of appropriate levels and types of information so that work tasks can be undertaken productively; and 2) effective feedback mechanisms and supervisory relationships so that work based problems can be resolved efficiently. It is these factors that significantly contribute to public sector employees' decision to stay in their current organisation.

Abbreviations: NPM - New Public Management.

Keywords: public sector administrative employee and nurses; employee satisfaction with communication processes; satisfaction with administrative factors; job commitment.

Dr Yvonne Brunetto BA, DipEd, PhD
School of Management,
Griffith University,
Logan Campus, University Drive,
Meadowbrook 4131 Queensland, Australia

Dr Rod Farr-Wharton BSc, MSc, PhD
University of the Sunshine Coast,
Queensland, Australia

Correspondence:
y.brunetto@griffith.edu.au

Introduction

The work environment of public sector employees has changed because of the implementation of New Public Management (NPM) reforms including 'managerialism'. [1,2,3] As a result, many public organisations have adopted private sector management methods and techniques (eg, the selective use of strategic planning, program budgeting and risk management). [1] These reforms are aimed at improving management practices and organisational performance (ie, efficiency and effectiveness). It can therefore be argued that public sector employees should now experience reasonably effective and satisfying organisational communication and

administrative processes. However, within public sector organisations there has been minimal testing of the benefits of the implementation of NPM reforms. [2,4] Moreover, little research has examined the impact of communication processes [5] on employee-commitment to the organisation, and secondly, whether communication factors have a greater impact on employees' level of commitment to the organisation than do other work and administrative factors. Traditionally, it appears that many managers assumed that 'adequate pay' was the key determinant of employees' level of commitment to the organisation. [1,6,7,8,9]

More recently, researchers have reported a significant relationship between the quality of organisational communication processes and 1) organisational performance [2,10] and 2) public sector employees' level of job satisfaction. [11] It is reasoned that management communication practices influence the quality of relationships [12] that develop within organisations and this in turn influences the effectiveness of information dissemination and therefore; organisational culture and learning. Management communication practices also influence employee feedback and negotiation processes and therefore; the level of role ambiguity, conflict resolution, stress, etc, experienced by employees at all levels of the organisation. [12] Good organisational relationships are characterised by high levels of trust between employees and management [10] and productivity improvement through the enhancement of employees' ability to solve problems and make effective workplace decisions. [2] On the other hand, there are costs involved when organisational communication processes are ineffective – particularly if this results in increased turnover. For example the nursing turnover literature stresses the high cost of replacing nurses; estimated to be 150 percent of nurses' annual compensation in the US. [13]

The aim of our study was to examine the impact of management practices on public sector nurses' and administrative employees' level of commitment to the organisation as measured by 'affective commitment'. The reason for using affective commitment (which measures employees' desire to stay in an organisation) was because previous research had identified a significant relationship between 'affective commitment' and 'absenteeism', 'turnover' and 'performance' (such as job productivity). [14]

Organisational commitment

Swailes (2002) argues there are multiple definitions of organisational commitment and most definitions are compromised by their inability to keep pace with the dynamic 'change in practice and the expectations put upon employees'. [15, p. 158] This argument is particularly relevant when defining and, in turn measuring, organisational commitment of public sector employees since the implementation of NPM because not only has their work context changed; the whole concept of tenure has been questioned and somewhat replaced by performance measurement. [1,6]

Given this limitation, it is important to ensure that the term 'organisational commitment' is narrowly defined and measured. This study uses the definition of 'organisational commitment' based on behavioural commitment that has 'become the dominant paradigm' in the organisational commitment literature. [15, p. 162] From this perspective, commitment is argued to be a product of the past actions and behaviours that connect employees to an organisation. Allen and Meyer [16] argue that there are three conceptualisations of attitudinal commitment to an organisation that emerge from this paradigm, however, only affective commitment (which refers to the emotional attachment to, identification with and involvement in an organisation) [16,17] is discussed in this paper. Past research suggests that when effective communication processes are embedded within organisations, employees are empowered with the knowledge and feedback processes likely to encourage them to become loyal and attached to the organisation. These same processes are in turn, likely to reduce employees' likelihood of leaving. [17]

Organisational work and administrative practices within the public sector

The introduction of NPM reforms has impacted significantly on the work and administrative practices of employees, in turn negatively affecting their satisfaction with pay, supervision and organisational policies. [1,7,8,9] Armstrong [18] argues that public sector managers at different levels of organisational hierarchies are now expected to supervise, manage, implement, measure and evaluate performance far more since the implementation of NPM. [6] This is because the focus has been on identifying tangible goals and the processes required to achieve them. As such, public sector employees should now operate in a context where there are policies, procedures and manuals explaining how and what should be done in the workplace and how performance related to undertaking those tasks will be assessed. [2,3,6,19] However, researchers question whether the procedures and manuals are in place to guide employees' work practices [6,8] and whether measurements are appropriate. [20] Moreover,

there is debate as to whether management at different levels of the organisation have firstly, adequately communicated the relevant information and secondly, implemented the policies. [9]

Organisational communication processes

The quality of organisational communication processes is determined by senior management's organisational and strategic priorities and in turn, their attitude and commitment to implementing those priorities; however, the implementation of effective communication mechanisms is dependent on every level of management. Within organisations, the quality of each type of communication process underpins all other processes and in turn, is a significant factor determining organisational effectiveness. [21] This is because it determines the administrative culture within the organisation. The culture is a product of the communication manner used by management (such as 'direct' face-to-face communications versus indirect communications such as memos), and the frequency and tone of words used in an organisation (which in turn produces either a 'results-orientated' culture promoting problem-solving and effective decision-making or a 'process-orientated' culture promoting a standardised response to every problem). [2] Within organisations there are a number of communication constructs that work in unison to determine organisational communication effectiveness. For example, organisational integration measures employees' satisfaction with communication about everyday workplace issues. When employees know what and how they should undertake tasks, then it is not only easier for them to be productive, it is also easier for them to solve work-based problems more competently. [12] Ideally, the implementation of NPM reforms should have improved public sector employees' level of satisfaction with organisational integration, because of the new focus on identifying tasks and developing performance indicators to measure and appraise performance. However, it is unclear whether relevant information about organisational goals, instructions for undertaking workplace tasks and appraisal methods have been adequately communicated to employees.

In summary, it is unclear whether communication factors have a greater impact on employees' level of commitment to the organisation than do other work and administrative factors. To address this question, two hypotheses were developed and used to guide data collection and analysis:

1. Public sector employees' level of satisfaction with communication processes has a greater effect on their commitment to the organisation than does their satisfaction with other management processes and practices.
2. There is a significant difference between public sector nurses' and administrative employees' level of satisfaction with communication and administrative processes and practices and in turn, commitment to the organisation.

Methods

Data were collected by questionnaire from nurses within two public sector hospitals (viz, a regional hospital and a teaching hospital) and administrative employees within two federal government departments; all of which were located within the south-east of Queensland, Australia.

Sample

The two participating hospitals and federal government departments were chosen for convenience of location and willingness to be involved in the study.

A sample of 130 nurses was drawn from the two participating hospitals. Nurses were selected from the day nursing shift (one third of the hospital nurses) within three of the six departments in both hospitals. In the teaching hospital, no specialist nurses (such as renal nurses) were surveyed for convenience reasons. Questionnaires were handed out to every fourth nurse on day shift (in alphabetical order) during a week day in April, 2002.

A sample of 163 administrative employees was drawn from the two participating federal government departments and comprised employees performing similar administrative tasks predominantly (office work, responding to customers' inquiries, providing services). Questionnaires were distributed personally within specified departments in accordance with the wishes of the cooperating organisations in April, 2002.

Data collection

In addition to demographic variables (gender and tenure), the main variables used in this study were communication, job satisfaction and organisational commitment (sometimes referred to in this section as 'affective commitment').

A questionnaire was developed comprising parts of three previously validated and reliability tested instruments, namely, Downs and Hazen (1977) Communication Satisfaction questionnaire, [22], Childers et al (1980) INDSALES questionnaire [23] and Allen and Meyer's (1990)

Table 1: Variables selected from three previously validated and reliability tested instruments

COMMUNICATION SATISFACTION[1]	INDSALES[2]	AFFECTIVE COMMITMENT[3]
1. **Communication Climate** Measures satisfaction with both personal and organisational communication processes. 2. **Organisational Integration** Measures satisfaction with communication about everyday workplace issues. 3. **Corporate Communication** (Organisational Perspective) Measures satisfaction with the communication of broad organisational and financial information. 4. **Personal Feedback** Measures satisfaction with communication about appraisal methods and employees' performance.	Satisfaction with: 1. Supervision; 2. Organisational policy; 3. Pay; 4. Fellow workers.	1. I would be very happy to spend the rest of my career with this organisation. 2. I think I could easily become as attached to another organisation as I am to this one. 3. I do not feel like 'part of the family' at my organisation. 4. This organisation has a great deal of personal meaning for me. 5. I do not feel a strong sense of belonging to this organisation. 6. I am glad to work for this organisation. 7. I am sufficiently acknowledged in this organisation. 8. I feel proud to work in this organisation.

Source: 1. Downs C, Hazen M. A factor analytic study of communication satisfaction.The Journal of Business Communication. 1977:14(3)63-74; 2. Childers T, Churchill G, Ford N, Walker O. Towards a more parsimonious measurement of job satisfaction for the industrial salesforce. In: Proceedings American marketing research. 1980;3(Nov):121-32; 3. Allen N, Meyer J. The measurement and antecedents of affective, continuance, and normative commitment to the organisation. J of Occup Psychol. 1990; 61(1):1-18.

Affective Commitment questionnaire. [16] These instruments were chosen because they contained constructs relevant to public sector employees generally since the implementation of NPM. Variables selected from these questionnaires are listed in Table 1.

The Downs and Hazen (1977) Communication Satisfaction questionnaire, was chosen because it specifically tests satisfaction with those communication processes that should now be more effective since the implementation of NPM. [22] Greenbaum et al, (1988) in a review of communication satisfaction questionnaires, reported that this instrument has a 0.94 test-retest reliability coefficient with high internal consistency of between 0.18 to 0.54. [24]

The INDSALES instrument was originally developed to measure the job satisfaction of industrial sales representatives. [23] It was chosen for this study because it included four variables (identified in previous research) [1,3,6,9] that have impacted on public sector employees generally since the implementation of NPM. These variables are listed in Table 1. Comer et al, (1989) when examining the psychometric properties of this instrument, found that it has a test-retest reliability coefficient of between 0.70 and 0.80 with high internal consistency of between 0.02 and 0.09. [25]

Questions from the Allen and Meyer 'Affective Commitment' instrument [16] were used to measure employees' level of commitment to the organisation. This instrument includes eight Likert-scale items and has a test-retest reliability coefficient of 0.86. Hartmann and Bambacas, (2000) in their review of different scales used to measure organisational commitment, commented that the Allen and Meyer scales had high reliability for measuring employees' sense of attachment to an organisation. [14] The questionnaire used a 6-point Likert-type scale with 1 indicating strongly agree and 6 indicating strongly disagree.

Data analysis

The statistical package - SPSS - was used to analyse data. The analysis involved comparing means using independent t-test and regression modelling to determine whether significant relationships were evident between the variables (eg, stepwise multiple regression analysis was used to identify independent variables correlated with the dependent variable ['affective commitment']). [26]

Results

In total, 72% of nurses and 70.5% of administrative employees who were handed questionnaires responded to the survey, with an overall response of 71% (Table 2).

Table 2: Survey response, by public sector nurses and administrative employees

	PUBLIC SECTOR NURSES	PUBLIC SECTOR ADMINISTRATIVE EMPLOYEES	TOTAL
Questionnaires distributed	130	163	293
Responded	94	115	209
Percent responded	**72.3**	**70.5**	**71.3**

Table 3: Sex profile of respondents, by type of public sector employee

	PUBLIC SECTOR NURSES	PUBLIC SECTOR ADMINISTRATIVE EMPLOYEES	TOTAL
Male (percent)	12.8 (12/94)	31.3 (36/115)	23.0 (48/209)
Female (percent	87.2 (82/94)	69.0 (79/115)	77.01 (161/209)

Characteristics of participants

The majority of respondents were female (77%) with a higher proportion of nurses female (87%) than administrative employees (69%) (Table 3).

Of the 94 nurse respondents, 12 were enrolled nurses, 52 registered nurses (level one), 24 registered nurses (level two) and 6 higher-level registered nurses (ie, 68% were either enrolled nurses or level one registered nurses). In terms of tenure, 51(54%) had worked at the hospital for five years or less and 41(44%) had worked at the hospital for between six and fifteen years.

Similarly, over two-thirds of administrative employee respondents were positioned at the first five levels of the administrative hierarchy. In addition, 64 (56%) of administrative employees had worked for the pubic sector organisation for less than five years and 28 (24%) had been with the same organisation for between five and ten years with the remainder (20%) having been with the organisation for more than ten years.

Key findings

Stepwise multiple regression analysis was used to test the first hypothesis (ie, public sector employee satisfaction with communication processes has a greater effect on their commitment to the organisation than does their satisfaction with other management processes). Table 4 shows the results of these analyses. The first step in undertaking this type of regression analysis is to identify the variable that has the highest correlation with the dependent variable (ie organisational commitment measured as 'Affective Commitment'). In this case, the variable was 'Organisational Integration'. The first regression analysis (Model 1) indicated this variable had the strongest impact on 'Affective Commitment' explaining 26.1% of the variance.

The next step in the regression modelling process was to identify the variable with the next strongest correlation with the dependent variable (ie, semipartial correlations). This was achieved by firstly removing the correlation with the first predictor variable. The variable identified was 'Communication Climate' (Model 2). These two communication variables ('Organisational Integration' and 'Communication Climate') explained 32.7% of the variance indicating they have a strong influence on 'Affective Commitment'. This modelling process was then repeated a further four times until the remaining variables were no longer making a significant addition to predicting 'Affective Commitment'. Using this method, six variables were identified as making a significant contribution to the dependent variable (Table 4); explaining 41.8% of factors influencing employee commitment to the organisation. A test of collinearity found that two additional variables – 'Corporate Communication' and 'Fellow Employees' were highly correlated with one another. As a result they were not entered into the modelling equation.

Table 4: Factors influencing commitment to the organisation (Commit): stepwise multiple regression analysis (n=209)

INDEPENDENT VARIABLES	MODEL 1 COMMIT (BETA SCORES)	MODEL 2 COMMIT (BETA SCORES)	MODEL 3 COMMIT (BETA SCORES)	MODEL 4 COMMIT (BETA SCORES)	MODEL 5 COMMIT (BETA SCORES)	MODEL 6 COMMIT (BETA SCORES)
Organisational integration	.53**	.442**	.476**	.549**	.602**	.617**
Communication climate		.267**	.240**	.214**	.168**	.145**
Supervision			–.187**	–.166**	–.170**	–.34**
Personal feedback				–.161**	–.205**	–.227**
Ogranisational policies					.177**	.37**
Pay						.127**
ΔR^2	26.1%	6.7%	3.4%	2%	2.6%	1.1%
R^2	26.1%	32.7%	36.1%	38.1%	40.7%	41.8%

Model 1: Predictors: Organisational Integration
Model 2: Predictors: Organisational Integration, Communication Climate
Model 3: Predictors: Organisational Integration, Communication Climate, Supervision.
Model 4: Predictors: Organisational Integration, Communication Climate, Supervision, Personal Feedback
Model 5: Predictors: Organisational Integration, Communication Climate, Supervision, Personal Feedback, Organisational Policies.
Model 6: Predictors: Organisational Integration, Communication Climate, Supervision, Personal Feedback, Organisational Policies, Pay.

**Statistical significance, $P < 0.01$ (2-tailed); *Statistical significance $P < 0.05$ (2-tailed)

The second hypothesis examined whether there was a significant difference between public sector nurses' and administrative employees' level of satisfaction with communication and management processes and practices and in turn, 'Affective Commitment' (measuring commitment to the organisation). Table 5 shows the results of an independent t-test and indicates that there were statistically significant differences in the means for nurses compared with administrative employees across each variable – suggesting that they experience a different work context.

Table 5: Variation in nurses and administrative employees' level of organisational commitment and satisfaction with communication and other management practices and processes (Means, Standard Deviations and results from independent t-test) (n=209)

	MEANS[1] 1. NURSES 2. ADMIN	STANDARD DEVIATION 1. NURSES 2. ADMIN	LEVENE'S TEST FOR EQUALITY OF VARIANCE (F)	T – TEST FOR EQUALITY OF MEANS	DEGREES OF FREEDOM
Affective commitment	1.9 4.1	1.2 1.1	1.825	-2.847*	205
Corporate communication	1.3 3.2	.65 1.0	19.204**#	-8.801**	191.96
Personal feedback	2.9 1.9	.85 1.0	2.209	-6.571**	205
Organisational integration	2.5 4.2	1.1 1.2	1.122	-10.165**	205
Communication climate	4.4 1.7	1.1 .96	.000	4.69**	205
Supervision	2.1 2.5	1.0 .96	9.37**#	-1.186	176.7
Organisational policies	4.4 1.8	1.0 .97	.051	4.061**	202
Pay	4.9 4.0	.97 1.1	.277	6.844**	202
Fellow employees	1.4 1.2	1.1 1.0	.078	-4.910**	202

1. 1=Strongly Agree and 6=Strongly Disagree.
**Statistical significance, $P < 0.01$, (2-tailed); *Statistical significance, $P < 0.05$ (2-tailed). # Equal variances not assumed.

Table 6: Association between organisational commitment and eight organisational variables (Correlation coefficients and alpha reliability coefficients)

	1	2	3	4	5	6	7	8	9
1 Affective commitment	1 (.81)								
2 Corporate communication	.009	1 (.86)							
3 Personal feedback	.061	.481**	1 (.67)						
4 Organisational integration	.517**	.151**	.451**	1 (.85)					
5 Communication climate	.182**	.046	.054	.256**	1 (.79)				
6 Supervision	-.38*	.164**	.181**	.39*	-.089	1 (.91)			
7 Organisational policies	.148**	-.098	.31*	-.091	.107**	-.007	1 (.67)		
8 Pay	.37	-.15**	.046	-.21**	.241**	-.3**	.407**	1 (.64)	
9 Fellow employees	.082	.065	.101	.41**	-.081	.191**	-.124*	-.18**	1 (.71)

**Statistical significance, *P*<0.01(2-tailed); *Statistical significance, *P*<0.05(2-tailed); Cronbach alpha reliability coefficients are shown in parentheses on the diagonal.

Secondary findings

Table 6 indicates that a significant association was observed between 'Affective Commitment' and four of the eight independent variables. Of these variables, two were communication factors ('Organisational Integration' and 'Communication Climate') and two were organisational work and administrative factors ('Satisfaction with Supervision' and 'Satisfaction with Organisational Policies').

Discussion

Principal findings

This study has two principal findings. First, employees' level of satisfaction with communication factors does have a greater impact on public sector employees' level of commitment to the organisation compared with other work and administrative factors. Two organisational communication factors – 'Organisational Integration' and 'Communication Climate' in combination predicted 32.7% of employees' level of 'Affective Commitment'. This means that the important variables determining public sector employees' commitment to the organisation were determined by the quality of the information they received from management about how to undertake every day tasks. For a nurse, this may mean information about particular procedures for dealing with patients who present with various conditions, such as, injuries or mental health problems. For administrative employees, this type of information may be about procedures for dealing with a member of the public who presents with a combination of problems requiring a multi-agency response.

Second, the level of satisfaction of public sector nurses and administrative employees with both organisational communication and administrative and work factors was significantly different; suggesting that they operate within different organisational work environments. Overall, nurses were more satisfied than administrative employees across four variables ('Affective Commitment', 'Corporate Communication', 'Organisational Integration', and 'Supervision'). This means that nurses were significantly more committed to the organisation and more satisfied with the provision of information that they needed to undertake everyday tasks than were administrative employees. However, nurses were significantly more dissatisfied with both 'Organisational Policies' and the communication of those policies within hospitals (eg, the communication of sexual harassment policies and procedures) and their 'pay'.

Strengths, limitations and future research

Limitations of this study include the relatively small number of nurses and administrative employees sampled within the four participating organisations and that the sample was confined to hospitals and government departments within one area of Australia. Further research is needed involving different types of public sector employees from different locations so as to determine the generalisability of these findings. Moreover, another limitation of this study relates to 'common methods bias' in using a questionnaire to collect data about public sector employees' perceptions. [14] However, Spector posits that using a survey-based self-report strategy is appropriate as long as it is supported in the literature. [27]

In terms of strengths, the study identified the significant influence that communication processes have on organisational commitment and as such, supports findings from similar research involving private sector employees. [20] Moreover, the findings address a gap in the literature identified by Kikoski [5] and Rainey [4] who argued that the implementation of NPM assumed many organisational communication and management benefits for public sector organisations that had not been tested. The findings from this study contribute to a better understanding about how organisational communication practices (post NPM) impact on different types of public sector employees' level of organisational commitment. In addition, these findings suggest that nurses experience a significantly different organisational work context than do administrative employees, in turn supporting earlier research. [1,6,21]

Implications for health managers

These findings support the premise that management practices at different levels of the organisational hierarchy influence the commitment of public sector employees to the organisation in different ways. For example, senior management can influence their employees' level of organisational commitment by addressing the quality of communication processes and administrative processes embedded within the workplace. Because the cost of retraining skilled employees is high, managers have an even greater responsibility to ensure that the organisational communication and administrative environment enhance their employees' attachment to an organisation, which in turn influences their decision to stay in the organisation. In practice, this means that it is management's responsibility to ensure employees have the necessary information and feedback mechanisms in place to undertake their work tasks effectively and to deliver the outcomes expected of them. Moreover, management is responsible for promoting appropriate supervisory relationships throughout the organisation. It is these factors that significantly contribute to public sector employees' decision to stay in an organisation or leave; hence, they are important factors for senior management to concentrate on improving.

Conclusion

In conclusion, management practices influence their employees' level of commitment to an organisation by affecting the quality of their work environment. Management traditionally believed that administrative and work factors such as 'adequate pay' determined employees' level of commitment to their organisation irrespective of the work climate and conditions. The findings from this research challenge such a view. These findings suggest that communication factors (especially those affecting employees' access to relevant information needed to undertake their work tasks effectively) impact more on their level of commitment to an organisation than do administrative and other work factors (such as 'pay'). Administrative and work factors are important, but not at the exclusion of effective communication and management practices.

Competing Interests

The authors declare that they have no competing interests.

References

1. Morland A, Steel M, Alexander M, Stephen K, Duffin L. Changes at work: the Australian workplace industrial relations survey. Melbourne: Addison Wesley Longman; 1997.
2. Brunetto Y, Farr-Wharton R. A case study examining the impact of public-sector nurses' perception of workplace autonomy on their job satisfaction: lessons for management. International Journal of Organisational Behaviour. 2004;8(5):521-539.
3. Brunetto Y. The impact of growing amongst professionals in Australia: a comparative study of university academics and hospital nurses. Research & Practice in HRM. 2002;10(1):5-21.
4. Rainey H. Using comparisons of public and private organisations to assess innovative attitudes among members of organisations. Public Productivity & Management Review. 1999;21(2):30-149.
5. Kikoski J, Effective communication in the performance appraisal interview: face-to-face communication for public managers in the culturally diverse workplace. Public Pers Manage. 1999;28(2):120.
6. Ferlie E, Ashburner L, Fitzgerald Pettigrew A. The new public management in action. Oxford: Oxford University Press; 1996.
7. Brunetto Y, Farr-Wharton R. The impact of NPM on the job satisfaction of Australian public sector employees. Asian Pacific Journal of Human Resources. 2005;41:289-304.
8. Buchanan J, Considine G. 'Stop telling us to cope' NSW nurses explain why they are leaving the profession. A report for the NSW Nurses Association. Australian Centre for Industrial Relations Research and Training. Sydney: University of Sydney Press; 2002.

9. Newman K, Maylor U, Chansarkar B. The nurse satisfaction. Service quality and nurse retention chain implications for management of recruitment and retention. J Manage Med. 2002;16(4/5):271-292.
10. Hunt O, Tourish D, Margie O. The communication experiences of education managers: identifying strengths, weaknesses and critical incidents. The International Journal of Educational Management. 2000;14(1):120-129.
11. Kim S, Participative management and job satisfaction: lessons for management leadership. Pub Adm Rev. 2002;62(2):23-241.
12. Brunetto Y, Farr-Wharton R. The importance of effective organisational relationships for nurses: a social capital perspective. The International Journal of HRD and Management. 2006;6(2/3/4):212-247.
13. Contino D. How to slash costly turnover. Nurs Manage. 2002;3(2):10-13.
14. Hartmann L, Bambacas M. Organisational commitment: a multi method scale analysis and test of effects. The International Journal of Organisation Analysis. 2000;8(1):89-108.
15. Swailes S. Organisational commitment: a critique of the constructs and measures. International Journal of Management Review. 2002;4(2):155-178.
16. Allen N, Meyer J. The measurement and antecedents of affective, continuance, and normative commitment to the organisation. J of Occup Psychol. 1990: 61(1):1-18.
17. Meyer J, Allen N. Commitment in the workplace: theory, research and application. Thousand Oaks: Sage Publications; 1997.
18. Armstrong A. A comparative analysis: new public management – the way ahead? Aust J of Public Adm. 1998;57(2):12-24.
19. Harris P. Changing patterns of governance: developments in Australian public hospitals and universities. Policy Studies. 1999;20(4):255-272.
20. Poole M, Boyne G, Mendes P. Pubic and private sector managers: a test of the 'convergence thesis' based on cross sectoral and longitudinal data. British Academy of Management Conference Proceedings, 2002.
21. Clampitt P, Downs C. Employee perceptions of the relationship between communication and productivity: a field study. The Journal of Business Communication. 1991;10(1):5-28.
22. Downs C, Hazen M. A factor analytic study of communication satisfaction. The Journal of Business Communication. 1977;14(3):63-74.
23. Childers T, Churchill G, Ford N, Walker O. Towards a more parsimonious measurement of job satisfaction for the industrial salesforce. In: Proceedings American Marketing Research 1980;3,(Nov):121-32.
24. Greenbaum H, Clampitt P, Willihnganz S. Organisational communication: an examination of four instruments. Man Commun Q. 1988;2(2):245-282.
25. Comer J, Machleit K, Lagace R. Psychometric assessment of a reduced version of INSALES Journal of Business Research. 1989;18:291-302.
26. Cohen J, Cohen P. Applied multiple regression/correlation analysis for the behavioral sciences. 3rd ed. Mahwah (N.J); Lawrence Erlbaum Associates. 2003.
27. Spector P. Using self-reported questionnaires in OB research: a comment on the use of a controversial method. Journal of Organisational Behavior. 1994;15(5):185-192.

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The Contribution of the Australian Private Hospitals Sector

C A Gee

Abstract

The objective of this article is to describe the contribution of the private hospitals sector to the Australian health care system. It draws upon publicly available information (supplemented where necessary by industry data) to provide an overview of the size, ownership structure, financing arrangements and service provision of the private hospitals sector. The article offers some analysis of the similarities and differences between the private and public hospital sectors and canvasses several unique characteristics of the private sector. The article also offers an assessment of the performance of the private hospitals sector in terms of the quality of its service provision and value for money. The article concludes that private hospitals and day facilities are a vital resource, without which Australia's health system would quickly grind to a halt. With just under one-third of total hospital beds, the private sector treats almost 40% of patients. It is complementary to the public hospital sector and provides tangible evidence of Australia's balanced health care system at work.

Abbreviations: ACCC – Australian Competition and Consumer Commission; ACHS – Australian Council on Healthcare Standards; APHA – Australian Private Hospitals Association; HPPAs – Hospital Purchaser Provider Agreements; MAC – Medical Advisory Committee; MDO – Medical Defence Organisation.

Key words: private hospitals sector in Australia

Christine A Gee MBA
Chief Executive Officer, Toowong Private Hospital;
National President, Australian Private Hospitals Association.

Correspondence:
cgee@toowongprivatehospital.com.au

Introduction

The private hospitals sector provides slightly less than one-third of total hospital beds in Australia and treats almost four in every ten patients. The sector provides treatment across the majority of hospital services and procedures. However, the private hospitals sector itself, and its contribution to achieving the objectives of Australia's balanced health care system, are rarely canvassed or analysed in any depth; and any discussion that does emerge tends to be informed more often by preconceptions rather than by fact.

The author argues that any meaningful assessment of the private hospitals sector needs to be informed by an understanding of the nature of the sector: its size and diversity, its distinctive funding arrangements, the varying types of service provision and ownership structures. Together with this factual overview, this article canvasses areas of similarity and difference between the private and public hospital sectors and also sketches some current and emerging issues.

Private hospitals sector: profile and ownership

Profile

The private hospitals sector is diverse in terms of size, location, ownership and service provision. [1,2] Private hospitals and day surgeries are located in all states and territories, in rural as well as metropolitan areas. Thirty-five per cent of private hospitals (26% of beds) are located outside the capital cities. [1] The sector includes specialist mental health and rehabilitation hospitals as well as free-standing day hospitals. [1,2] Drawing on the latest available data, Table 1 provides a snapshot of the sector.

Table 1: Private hospitals and day hospital facilities in Australia: ownership type, specialised services, patient separations, total employment, hospital size and location, 2004-05

HOSPITALS[1]	
• Private hospitals	285
• Private free-standing day hospital facilities	247
• **Total**	**532**
BEDS[1]	
• Private hospital beds	24,346 (30% of total hospital beds in Australia)
• Private free-standing day hospital beds/chairs[a]	2,078
• **Total**	**26,424 (32% of total hospital beds in Australia)**
OWNERSHIP TYPE[1] *(Not including free-standing day hospitals)[b]*	
• For profit	167 hospitals; 13 583 beds (56% of private beds)
• Not-for-profit	118 hospitals; 10,763 (44% of private beds)
SPECIALISED SERVICES[1,2]	
• Mental health services	44 hospitals; 1,146 beds (includes specialist facilities and general hospitals with psychiatric beds)
• Rehabilitation services	54 hospitals; 1587 beds (includes specialist facilities and general hospitals with rehabilitation beds)
PATIENT SEPARATIONS AND STAFFING[1]	
• Total patient separations	2.7 million (approx 40% of all hospital separations in Australia)
• Total Employment	48,000 full-time-equivalent
SIZE[1] *(Not including free-standing day hospitals)*	
• 0-25 beds	48 hospitals
• 26-50 beds	72 hospitals
• 51-100 beds	92 hospitals
• 101-200 beds	51 hospitals
• 200+ beds	22 hospitals
LOCATION – PERCENTAGE OF BEDS[3]	
• New South Wales	26.3
• Victoria	26.0
• Queensland	23.4
• Western Australia	11.7
• South Australia	7.7
• Other States/Territories	4.9

Source: 1. Australian Bureau of Statistics. Private hospitals Australia 2004-05. Canberra:ABS; 2006. 2. Australian Private Hospitals Association database. Canberra: APHA (unpublished data). 3. Australian Bureau of Statistics. Private hospitals Australia 2004-05. Canberra: ABS; 2006. (Table 2.2, p. 21).

Notes: a. These beds include chairs, trolleys, recliners and cots and are used mainly for post-surgery recovery purposes only. b. Ownership data are not available for private free-standing day hospitals.

Ownership

According to the Australian Private Hospitals Association (APHA) database [2] and information from Catholic Health Australia, [3] private hospital groups (for-profit and not-for-profit), such as Ramsay Health Care Pty Ltd and Uniting HealthCare, currently account for approximately 58% of private hospitals and 76% of private hospital beds. The remaining 42% of private hospitals and 24% of private hospital beds are owned and operated by a mix of independent for-profit and not-for-profit organisations. The industry trend is one of consolidation, with the proportion of beds operated by private hospital groups increasing from 67% in 2003 to 76% in 2006, while the top six groups (two for-profit, four not-for-profit) have increased their share of total private beds from 55% in 2003 to 65% in 2006. [2,3]

I believe that the main reasons behind the consolidation in the industry include:

- economies of scale;
- access to capital; and
- countervailing the market power of health insurance funds.

Differences and similarities between the private and public hospital sectors

At one level, such as types of procedures and services provided, the private and public hospital sectors are broadly similar (eg, of the 661 different types of procedures and services available in Australian hospitals in 2004-05, the private hospitals sector provided 99.5% [658] of these types of procedures and services). [4]

In addition, many private hospitals provide a similar suite of services to public hospitals. There are private Emergency Departments, many private intensive care beds and a wide range of other specialised units in private hospitals. [4]

Private and public hospitals also treat a similar proportion of elderly patients, for example in 2004-05: [4]

- Patients aged 65 and older comprised 36% of patients treated in private hospitals compared to 35% in public hospitals;
- Patients aged 75 years and older comprised 20% of patients treated in private hospitals compared to 19% in public hospitals; and
- Patients aged 85 years and older comprised 4.2% of patients treated in private hospitals compared to 4.9% in public hospitals.

However, this assessment can mask differences between the sectors that underline the complementary nature of the two sectors which helps to ensure a balanced and sustainable health care system. For example, based on the latest available procedural hospital activity data, the private hospitals sector with around one-third of total hospital beds, provided in 2004-05: [4]

- 77% of knee procedures;
- 70% of major lens procedures;
- 68% of same-day mental health treatment;
- 55% of hip replacements;
- 55% of chemotherapy;
- 54% of major procedures for malignant breast cancer;
- 46% of cardiac valve procedures;
- 43% of all hospital-based psychiatry services; and
- 41% of coronary bypass procedures.

On the other hand, 72.4% (2.9 million) of acute separations in the public sector were for medical (ie non-surgical) Australian Refined – Diagnosis Related Groups (AR-DRGs), compared with 37.8% (1 million) in the private sector. [4]

Perhaps the starkest difference between the sectors can be found in the variation in their relationships with medical practitioners.

Private practitioners and the private hospitals sector

In the private hospitals sector, the medical practitioner is rarely an employee, either salaried or contracted. Rather, the relationship between the hospital and the practitioner is usually governed entirely by the process of granting a doctor admitting and clinical responsibilities/privileges in the hospital. This process would normally be undertaken by a private hospital's Medical Advisory Committee (MAC) or perhaps a sub-committee of the MAC. Therefore, outside of this process, a private hospital manager is not in a position to direct or influence an admitting medical practitioner in the same way that a public hospital might with regard to its employed or contracted medical practitioners.

Issues around indemnity insurance in the private hospitals sector are also important to canvass. Private medical practitioners admitting and treating patients in private facilities are required to hold their own professional indemnity/medical malpractice insurance sourced through a Medical Defence Organisation.

In addition, the private hospital or day surgery is required to hold its own professional indemnity/medical malpractice insurance to provide cover for the entity and which also extends to protect its employees for incidents arising in the course of the employee's employment with the hospital or day surgery. This insurance is sourced from commercial insurers, with most current business written by two syndicates of Lloyd's Insurance, one located in London and the other in Gibraltar.

Unlike public hospitals that usually source their professional indemnity/medical malpractice insurance cover through State Treasury Managed Funds, the individual facilities in the private hospitals sector are completely exposed to any substantial changes in the commercial insurance market. This was particularly apparent in 2000-2002 when the number of commercial insurers offering this type of insurance declined dramatically.

Private sector financing and health insurance arrangements

Private hospitals and day surgeries are financed by their owners and operators. Revenue to support this financing effort is sourced primarily from the treatment of patients. Patients may be partially or fully insured for the costs of their care and treatment from sources such as private health insurance, workers' compensation, transport insurance or the Department of Veterans' Affairs, while uninsured patients elect to meet the costs of their own treatment.

Unlike public hospitals, that might receive additional government funding for capital investment and/or for education and research, other than a very small quantum of funding paid to private teaching hospitals, there is no similar funding mechanism available to the private hospitals sector.

Private health insurance

Most patients receiving treatment in the private hospitals sector are covered by the provisions of Hospital Purchaser Provider Agreements (HPPAs), negotiated between hospitals and health insurers. In most cases this means that hospital owners and operators agree to accept payment by the patient's insurer in lieu of levying charges on the patient.

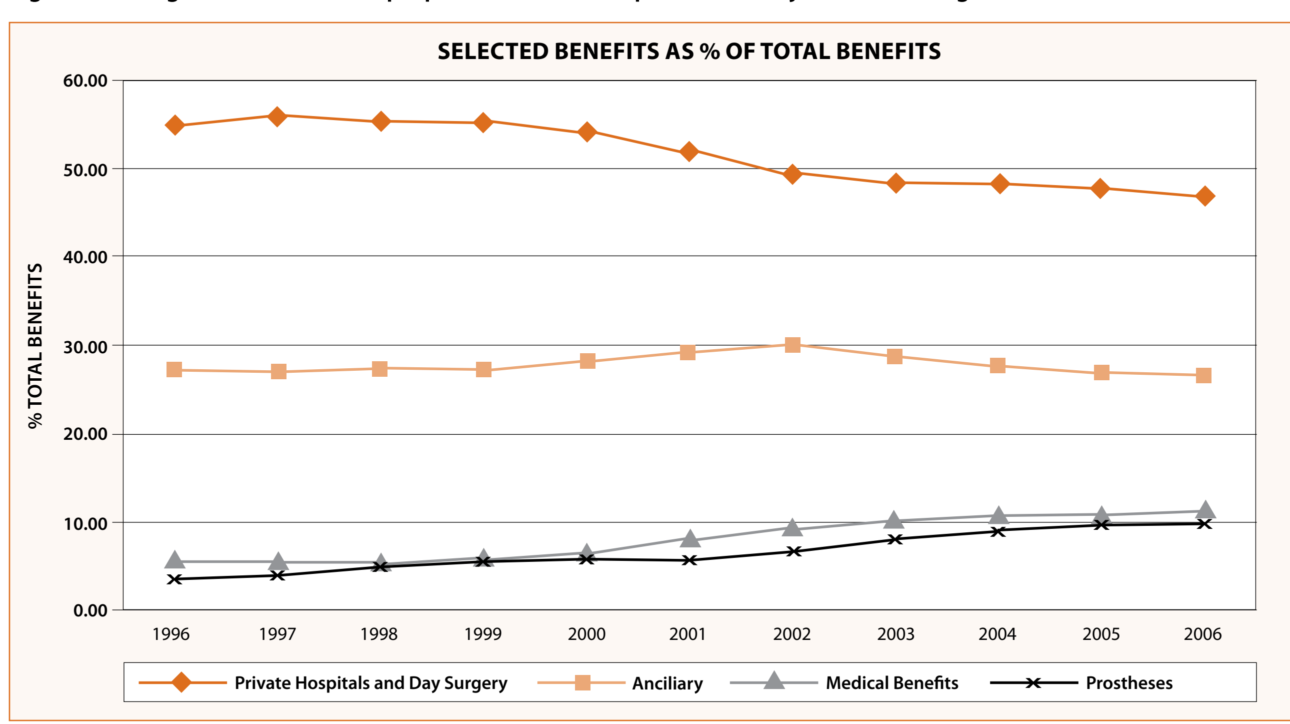
Outside of the major corporate hospital groups, these 'Agreements' are increasingly made on a take-it-or-leave-it basis, with health insurers protected both by their market power and the provisions of the *Trade Practices Act*. There is no compulsion for an insurer (or a hospital) to negotiate or renegotiate a HPPA nor is there necessarily any link between increases in health insurance premiums and the level of benefits paid to private hospitals and day surgeries.

Trends in financing outcomes

The revenue received by the private hospitals sector from private health insurance funds under HPPAs and legislated default arrangements can be presented in a variety of ways. It is most often, and most misleadingly, presented as the benefits paid from health insurers' hospital tables. This is misleading to the extent that benefits paid from these hospital tables pay not only for private and day hospital accommodation and theatre fees but also for public hospital benefits, benefits for medical services and benefits for prostheses.

Due to particular policy measures, the share of benefits paid to the private hospitals sector has been steadily declining since the introduction of the 30% rebate, from some 55% of total benefits in 1999-00 to 47% in 2005-06, [5] as Figure 1 indicates. (Note that ancillary benefits are included in Figure 1 for comparative purposes – these benefits are paid from a separate table.)

Figure 1: Changes over time in the proportion of benefits paid in the major benefit categories, 1996-2006



Source: Data derived from Private Health Insurance Administration Council. Annual reports, 1996 to 2006. Canberra: PHIAC; 1996 to 2006.

Performance of the private hospitals sector

Quality of services

Across publicly available information, the private hospitals sector is at the forefront of the provision of quality services. This is demonstrated in the findings of the first-ever report on the accreditation performance of Australia's hospitals released in 2005 by the Australian Council on Healthcare Standards (ACHS). [6] The report found that:

- Six private hospitals were recognised for their leading practices by being awarded at least one Outstanding Achievement rating. This represents 43% of all hospitals recognised in this way;
- Private hospitals represented 54% of ACHS members, public hospitals represented 44% and public/private hospitals 2%;
- Private hospitals gained a higher accreditation status than public hospitals;
- Private hospitals performed better than public hospitals in all mandatory criteria;
- Private hospitals performed better in the mandatory criteria for: quality improvement; consumer rights and responsibilities; risk management; legislative requirements; and leadership and management;
- Private hospitals achieved the maximum four-year accreditation from ACHS at more than twice the rate of public hospitals (47% to 22%);
- Unplanned overnight admissions for day-stay patients in private hospitals were half the rate of public hospitals; and
- The proportion of patients unable to be admitted to an Intensive Care Unit was ten times higher in public hospitals than in private hospitals.

Value for money

There is no systematic and direct funding of the private hospitals sector by governments, with the exception of targeted projects and grants (eg the Australian Government's Rural Private Access Program). [7] It should also be noted that the Department of Veterans' Affairs provides funding through its Private Patient Scheme for the treatment of eligible veterans in private hospitals and day surgeries. However, agencies such as the Productivity Commission and the Australian Institute of Health and Welfare have hypothecated spending by the Australian Government via the 30% rebate to estimate how it impacts on different elements of the health system. The latest analysis indicates that since the introduction of the 30% rebate (1999) and Lifetime Health Cover (2000): [7]

- The proportion of all government recurrent expenditure flowing to private hospitals (via the rebate) has increased from 3.8% in 1999-2000 to 5.0% in 2004-05;
- Actual dollars have increased from $1.8 billion to $2.6 billion over the period;
- In 2004-05 governments provided $19.6 billion to public hospitals to treat 60% of patients and $2.6 billion to private hospitals (via the rebate) to treat 40% of patients; and
- This translates to $4,584 of government funding per patient treated in public hospitals and $984 for each patient treated in the private hospitals sector (note that private patients also attract some additional government subsidies via Medicare and the Pharmaceutical Benefits Scheme).

On the surface at least, these figures would seem to support the view presented by the Department of Veterans' Affairs to the House of Representatives Standing Committee on Health and Ageing on 4 September 2006 that: *'the work we have done basically suggests that we pay significantly lower prices in the private sector than we do in the public sector'*. [8]

Collaboration: the only realistic way forward

In a recent interview, [9] I outlined my belief that greater collaboration between the public and private sectors will make more effective use of scarce resources and ease some of the pressure points on the whole health care sector.

Clearly, collaboration is not always straightforward and it can be difficult to achieve when hospitals, private health insurance funds, governments, doctors and other sector participants have quite distinct interests. However, I believe strongly that if we look to the interests of the consumer or patient and take these as the guide, then we will start making very sensible decisions and looking at what needs to be in place for the longer term.

Finding a way around the current limitations on the adequacy of training for medical practitioners in order to ameliorate future workforce shortages is an excellent example of what can and should be done.

The funding arrangements for the training of health professionals and, in particular, medical practitioners, have not kept pace with the changing landscape of service provision. As noted earlier, in some specialities the private sector provides the majority of services and if medical

trainees are to receive a well-rounded education, they must be exposed to the full range of procedures in their speciality. Unfortunately, a major obstacle to this occurring in a consistent manner is that, in 2006, the funding arrangements for medical trainees are largely unchanged from two decades ago when the private sector was little more than a cottage industry.

A recent report prepared for APHA by The Allen Consulting Group estimates that *'the private hospital sector as a whole would spend at least $36 million each year on providing education and training'*. Allen Consulting also found that only a little over one million of this funding effort was recovered by way of fees. [10]

The key factor limiting the capacity of the private hospitals sector to expand its efforts in this area is the lack of a consistent and transparent method of funding medical education and training. A wide range of private hospitals, both large and small, provide training opportunities, largely at their own cost. None of these costs can be recouped from private health insurance benefits and nor do state and territory governments permit funding provided through the Australian Health Care Agreements to follow the trainee.

These antiquated funding arrangements simply do not fit the requirements of a modern and mobile health workforce nor a health system with an eye on the future.

Conclusion

This article has aimed to shed some light on the important contribution of the private hospitals sector. The private hospitals sector is rarely discussed, except perhaps as an adjunct to arguments around the merits of private health insurance or in a pejorative way that seeks to marginalise its role in comparison to the public hospital sector. This author believes strongly that private hospitals and day facilities are a vital resource, without which Australia's health system would quickly grind to a halt. The private hospitals sector is complementary to the public hospital sector and provides tangible evidence of Australia's balanced health care system at work.

Competing Interests

The author declares that she has no competing interests.

References

1. Australian Bureau of Statistics (ABS). Private hospitals Australia 2004-05. Canberra: ABS; 2006.
2. Data obtained from the Australian Private Hospitals Association database, Canberra, (unpublished data).
3. Data obtained from Catholic Health Australia database, Canberra, (unpublished data).
4. Australian Institute of Health and Welfare. Australian hospital statistics 2004-05. Canberra: AIHW; 2006.
5. Private Health Insurance Administration Council. Annual reports, 1996 to 2006. Canberra: PHIAC; 1996 to 2006.
6. Australian Council on Healthcare Standards. National report on health services accreditation performance 2003 and 2004. Sydney: ACHS: 2005.
7. Australian Institute of Health and Welfare. Health expenditure Australia 2004-05. Canberra: AIHW; 2006.
8. House of Representatives, Standing Committee on Health and Ageing. [Reference: Health Funding, 2006 Sept 4}. Available: <http://www.aph.gov.au/house/committee/haa/healthfunding/index.htm.> Accessed 5/02/07.
9. Franklin, M. Public and private must work together. Weekend Australian. 2006, November 4.
10. The Allen Consulting Group. Education and training of health and medical professionals in private hospitals and day surgeries. Melbourne: The Allen Consulting Group; 2005.

Paichit Pawabutr

Emeritus Professor and Dean, Faculty of Public Health, Naresuan University, Thailand

In this issue of the Asia Pacific Journal of Health Management, we bring you an interview with Emeritus Professor Paichit Pawabutr of Thailand. Paichit was recently conferred as Honorary Fellow of the College in recognition of his commitment to the establishment of the profession of health management in Thailand and his goal of establishing a Thai College of Health Service Executives in collaboration and with the support of ACHSE.

Emeritus Professor Paichit Pawabutr holds nationally and internationally acquired qualifications in medicine, public health, epidemiology, nutrition, health planning, health economics and a PhD (Arts), Honoris Causa, Rachapadh Institute, Ubolrachathani, Thailand. He is currently the Dean of the Faculty of Public Health, Naresuan University, Advisor to the Minister of Public Health and President of the Primary Care Investment Board, National Health Security Office, Thailand. He has held most senior positions within the Thai health system including a period as a Senator of the Thai Parliament.

His strong commitment to his country, its people and his profession has seen him recognise and accept the challenge of developing the profession of health management in Thailand and work towards the development of a Thai College of Health Service Executives.

1. What made you venture into health management?

After I graduated from medical school in 1962, I applied to work in a remote area which was one of the six areas where the Ministry of Public Health required full-time medical doctors to provide health services for people. I worked at Budthaisong District, Burirum Province in the north-eastern region of Thailand. I had two roles: i) a medical doctor and Director of the Health Centre; and ii) an Acting Chief of District Health Office.

During the two years I worked there I saw that our health system faced severe shortages of resources for both infrastructure and health manpower. I had to seek out donations to fund the health centre and sub-centre as well as for the establishment of the midwifery centre, along with medical equipment and office supplies. The government provided scholarships for descendants of donors to study nursing, midwifery and public health (for junior sanitarian or auxiliary worker positions) by special recruitment criteria.

In that period, there were traditional doctors who had some knowledge of Thai traditional medicine in each sub-district. They were appointed by village chiefs. I had to initiate training for them in basic nursing, first aid, health promotion and prevention of basic diseases without systematic support from the government.

From these experiences, I learnt basic management skills by practice and I found that the key success factors of effective management were the cooperation of community leaders and the communities. I tried to add value to people and saw them as capable individuals who could solve their own health problems by having self-care. As a result of this concept, the first training of village health volunteers was initiated in Thailand.

2. What have been the most rewarding and enjoyable aspects of your career?

I think that being a Director of a first class health centre coupled with being a Chief of District Health Office was the most enjoyable time. This was because I could use both my medical knowledge and skills for medical treatment and my management experiences to manage a small hospital with 10 beds. There was only one nurse and two midwives as well as three other health workers. I could administer health promotion and disease prevention programs, such as controlling Cholera epidemics in my area; promoting family planning; a well for cleanwater; the construction of sanitary latrines; and an expanded immunisation program.

I considered it a privilege to be able to propose to the government that we establish health centres in all sub-districts and provide scholarships for local students to study as junior sanitarians, midwives and nurses. I was able to establish these health professionals in all twelve sub-districts in Banpai District while I was the Director of Banpai Community Hospital and the Acting Chief of District Health.

In summary, I brought modern medical and public health practices to be implemented in these local areas without forgetting the importance of local wisdom and the cooperation of communities in the successful delivery of health services during my management period.

3. What is the greatest challenge facing health managers?

I think that current Thai health managers have to face 'being two in one of Thailand'. This means that the distribution of socioeconomic development in Thai society is not equal: the more development, the wider the gap between rich and poor.

Thailand encourages people to learn about what they should be and have and how they should contribute. Thai society should be the society whose people can share their thoughts and development through the principle of a basic needs approach, using basic minimum need as an indicator. Despite this approach it cannot resist the flow and effect of globalisation.

However the current Thai health managers are now learning to develop our public health along the initiative of 'sufficiency economy' from our beloved and revered King Bhumipol, the Great. I think that it is our challenge to make our public health seriously achieve this 'sufficiency economy' concept.

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

During the next ten years I would like to see the establishment of primary care units from which people both in urban and rural areas can equally access quality health services that are both close to people's places of residence and culturally acceptable. This kind of unit must have at least one medical doctor and allied health workers who can work together as a small multifunctional team. I would like to see these teams working under the direction of professional health managers who must be decentralised and given full authority to manage their own health units. I would like to see comprehensive and continuous care provided by them.

5. What is your career highlight?

I think that my career highlight was when I was the Provincial Chief Medical Officer working at the Nakorn Ratchasima Province, which has the biggest population in Thailand except for Bangkok. Although I was appointed and elected to many higher positions, including, Director General, Permanent Secretary, President of the Thai Medical Council, President of the Thai Medical Association under the patronage of His Majesty King Bhumipol, and senators both by election and appointment, I still feel that my highlight was when I was the Provincial Chief Medical Officer. This is because when I worked there the politics were so stable that, even though we had severe resource shortages, I could implement the primary health care concept and goal of 'Health for All by the Year 2000', adopted from WHO in 1978 as well as a concept of 'All for Health'. At the same time, I was the project director for establishing the regional (city) hospital, Maharaj Hospital at Nakorn Ratchasima province, which is an excellent centre. I was also one of the leading members who introduced horizontal management by coordinating between other governmental offices at provincial levels. We called it 'Intercultural Collaboration Action for Health and for Quality of Life'.

Another highlight was that I introduced a health insurance system to Thailand by providing poor people with health insurance cards. This was a pilot project which led to the current Universal Health Insurance Coverage policy and *The Universal Health Insurance Act*.

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

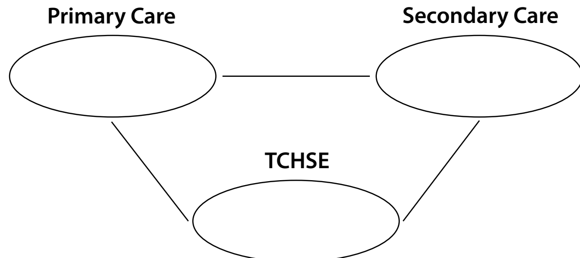
I think that actually there are many factors which influenced my career. First: family background. My maternal grandfather was a Thai traditional doctor who always brought me with him when he went out to see patients. My grandfather was village chief and he was another role model for me. My father was a teacher and taught me good discipline. The socialisation to be a giver from my grandmother and my mother was dominant. Next, the most important influence is my wife, Mrs Rattana, who always provides support to me. I have a good family who is respected by Thai people and this gives me the opportunity to contribute my whole life to health management and medicine. Another role model is the Father of the King Bhumipol, Prince Mahidol, who contributed his whole life to bring better health service quality for Thais. His statement 'Self benefit is secondary, the benefit to mankind is primary', inspires me.

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

I think that in the next ten years health management in Thailand should deal with the concrete implementation of a 'sufficient economy' approach. This means that we should encourage primary health care concepts and practice. For example, we may use technology such as GIS (Geographic Information System) to be a tool for allocating community medical units (primary care units) which have a primary care physician as a gate keeper for our health system. There will be some 10,000 centres throughout the nation.

At the same time, there must be development of secondary care and tertiary care and excellent centres for important and specific diseases of the nation, such as, Trauma Centres, Cardiac Centres, and Cancer Centres distributed throughout the regions.

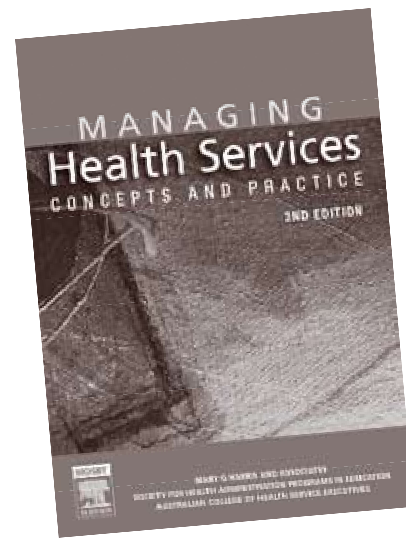
I think that there must be professional health managers to manage these health services. The Thai College of Health Service Executives will be a major organisation in assisting these health managers to achieve the Thai health system's goals as shown in the figure below:



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

I think that emerging health leaders must be able to think outside the box, however they must also respect Thai culture. They must have their paradigm shifted from looking at the supply side to the demand side. Thailand has failed in supply side planning as disadvantaged people have received fewer benefits than the rest of the population. If our health managers are to be concerned for the needs of poor people they must have competency in demand side planning. I think that we can follow Prince Mahidol's teaching that:

> *'True success is not in learning but in its application to the benefit of mankind'.*



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How different are the challenges confronting health managers today from those faced by health managers a decade ago?

In each issue of the APJHM we ask experienced health managers throughout the Asia Pacific Region to reflect on an aspect of health management practice. In this issue of the Journal, our selected participants have been drawn from two ends of the health management career spectrum: those who have retired from mainstream health management and those currently in the system. Both groups have addressed the following questions:

1. What were the main challenges you faced in health say 10 years ago?

2. What are the key leadership challenges in health today?

What were the main challenges you faced in health say 10 years ago?

1 During the 1990s two huge challenges constantly faced all workers in the Australian health system, whether they were frontline doctors and nurses or hospital and community health service managers. These two challenges were insufficient money and resources to meet ever increasing demands; and parliamentary politics. Both challenges remain today and will probably worsen.

These challenges are in marked contrast to those confronting health managers in the 1970s and 1980s, when the priority was to improve health services and meet the huge challenge of HIV/AIDS, ageing of the population and the increased incidence of cancer. At that time, I was Head of the School of Health Services Management at the University of New South Wales. We noted the change of priorities from health development to money and politics, and earnestly debated how we would respond in terms of our recruitment of students and the educational programs on offer. Of particular concern, was the much reduced role in the Australian health system of the well-educated, professional health service manager.

Our response was to develop graduate programs in Public Health which offered a wide range of content choices for students. In addition to traditional offerings such as epidemiology, these Public Health programs included management and financial subjects which would familiarise health care professionals with basic concepts. The response to these programs was overwhelming, with demand doubling in two years and remaining strong to the present day. By way of contrast, the demand for traditional management programs has greatly lessened.

We have no data upon which to base conclusions whether or not our response to the challenges of money and politics has been of benefit to the community. However, the documented support from graduates has been most gratifying.

I would like to hope that in the long term these graduates can change the challenges back to issues of health and wellbeing of the community. That will not be easy.

Emeritus Professor James Lawson AM
Former Director of Hospital and Medical Services for Tasmania; Regional Director of Health for Northern Sydney; Professor, Health Service Management and Public Health, University of New South Wales.

2 Like Jim Lawson, when I think about the mid 1990s, the two major challenges I recall were continual political and/or bureaucratically initiated organisational change and limited resources. But for me there was a third, which I shall mention later.

In South Australia, the Health Commission was undertaking its fourth major oganisational change with the introduction of seven rural regions in place of two. At the same time, a major review of Mental Health Services was under way. Both of these initiatives impacted on my work.

I was at that time Regional Director for the northern, western, Riverland and Kangaroo Island areas of the State. With the reorganisation of Country Health from two Regions to seven, my position, along with that of my colleague, Director of the Southern Region, was changed. I was invited to take

responsibility for the establishment of a Mental Health Service for country South Australia. Up to that time, apart from some limited services, no meaningful, coordinated mental health services existed for rural people. In the main they were required to travel to Adelaide to receive psychiatric services.

It was an exciting and rewarding challenge to create a new service in an environment of service restriction and 'savings'. Apart from an initial injection of funds of $1.5m, all resources for the new service had to be acquired from other existing services. Not an easy task at all!

The third challenge to which I referred earlier was the limited understanding of health services managers and health professionals in general and their lack of active commitment to Mental Health services provision. There was little comprehension in rural areas about the significance, direction or meaning of the First National Mental Health Plan. Accordingly, when I determined to allocate the major portion of the initial grant I had been given to creating Mental Health positions to be associated with rural community health services, little or no support was provided by rural health services managers to assist in effectively establishing the services and supporting the mental health professionals.

Today, despite continuing inadequate support for, or understanding of the important role of the Rural and Remote Mental Health Service, it maintains excellent services to people in rural South Australia. Further, there continues to be health system organisational changes and still 'insufficient money and resources to meet ever increasing demands'. So, over ten years nothing much has changed!

Mr Len Payne BHA, MBA, CPA, FCHSE, CHE
Former Federal President

Australian College of Health Service Executives

3 The challenges I refer to below will be at my time of retirement (1992) – some fourteen years ago.

At the time of retirement and in all the years on the Central Coast - because of the expanding and ageing population (increased by over 200,000) – the main challenge was to increase beds and services by planning, followed by lobbying and all backed up by discreet publicity by the local Board of Directors (Area Health Board).

Once the building and furnishings were in place, a major challenge was to meet the extra service demands. Because of the additional beds, there was the need for additional specialist services in all fields. With additional beds, there was the challenge to reduce waiting lists to meet the expectations of not only the residents of the area, but the referring general practitioners.

Another challenge was because of the ongoing increase in the total number of beds, then 800 spread over five sites on the Central Coast, and the associated increase in specialist medical staff, the progression towards teaching hospital status and the appointment of a Clinical Dean to enable the service to handle the significantly increased student load.

The most difficult task in this development was the recruitment of sufficient staff, particularly nursing and medical staff, at a time when the shortage of such resources was widespread. A further challenge was to be always alert to 'additional funds' from all sources apart from the State Government to meet the demands of our increasing population.

A real challenge was the selection by NSW Health of our Health Promotion Unit to pilot a state-wide campaign to increase the establishment of 'smoke free' areas in licensed clubs and restaurants. Our Unit was selected following its successful pioneering of this concept on the Central Coast.

A challenge during my career, as it is today, was to manage resources effectively and efficiently; to ensure access to the range of services required to meet community needs; to monitor all outcomes; and to understand that the CEO is accountable for all.

Mr Neville Boyce OAM FCHSE FCPA
Former Chief Executive Officer

Central Coast Area Health Services – New South Wales

What are the key leadership challenges in health today?

1 One of the key leadership challenges in health today is moving beyond the rhetoric to actually doing something about improving the quality of work life for staff providing the care. Multiple research studies have shown us that improvements in organisational culture have a significant impact on the quality of patient outcomes and staff turnover. In other words, we need to be able to effectively look after our staff if they are going to be able to effectively look after patients. While at one level this is common sense, at another, the short- term, reactive responses which simply focus on cost, length of stay and clinical risk management do not really enable this to happen.

One of the key leadership challenges therefore is for clinicians to present a story (or multiple stories) about patient care that enables bureaucrats and politicians and other interested stakeholders to understand what we actually do and why it is important to listen to those who provide direct patient care. One of the difficulties in being persuasive is that caring for sick people is necessarily an emotive issue and it is not something that anyone wants to really think about until they are directly affected. It is very hard to translate the language of clinical care into language that is understood by non-clinicians, but unless we are able to do this we will continue to see the parallel universes that are currently occupied by clinicians on the one hand and administrators on the other.

As clinical leaders, I believe our major leadership challenge is to bridge this gap and to show others how it can be done. If we could all 'get on the same page' then we really could change the world! The majority of people who work in health are there because they care about the health of the community. The key leadership challenge, I think, is to create a language and a context in which we can all communicate and one in which we can really respect each other's point of view and collectively work towards making this a health care system of which we can all be proud.

Professor Di Brown RN PhD
Professor of Clinical Nursing

Graduate School of Health Practice, Charles Darwin University and Department of Health and Community Services – Darwin

2 I was asked recently 'What are the key leadership challenges in health today?' Without stopping, I thought this could be answered either in a clinical framework or simply one where management is concerned. As this is being published in the Asia Pacific Journal of Health Management, I choose the latter.

Where does one start? There are so many challenges that today's leaders face and from a country perspective there are three that immediately come to mind:

1 Health services in regional and rural Australia cannot do everything for everyone and we need to learn to build stronger inter-agency partnerships. Not only that, but we have to convince other government agencies and non-government organisations (NGOs) that they should do likewise. We often share the same client – certainly mental health does – so why don't we have better partnerships and do things collectively, not waste time, effort and resources on achieving the same result for the client.

2. Recruitment and retention of staff. All too often we hear 'our most valuable asset is our staff', yet organisations do little to change. They systematically fail to not only retain but recruit staff whenever a vacancy occurs. With a foreseeable reduction in staff numbers, managers and leaders must find innovative ways of recruiting and retaining staff. Professional and staff development are so important yet in times of budget cuts, this is often an area which faces the first cut. A very short sighted result.

3. Know your core business. Don't be sucked into the flavour of the month. The business of health has been around for a long time. It is not an industry such as dotcom which grew rapidly and then took a nose dive from which it has never recovered. Managers and leaders have to be very sure of their core business and need to be respected and valued in their judgements on what is important. They should not be coerced into short-term political gains at the expense of the longer-term need.

John Smith, MSc (HSM) FCHSE CHE
Mental Health Program Manager

Country Health South Australia – Clare Office

3 Being in Hong Kong, health care leaders work in a political, social and economic environment different to Australia's. Our challenges in today's health care system may be unique to Hong Kong. Here I would like to highlight three of them.

1. **Maldistribution of resources**
   Hong Kong faces the problem of an aging population and while the public health care system has been emphasising community and ambulatory care, little money has been invested in these areas. The argument that old services with declining utilisation will automatically give way to new services in greater demand is rhetoric rather than real policy. Maintaining the number of hospital beds is still the priority of clinicians. Health care leaders need to educate the clinicians that inpatient beds no longer form the basis for funding. In addition, they should plan their health services with a community perspective.

2. **Organisational change without defined outcomes**
   To improve service coordination and efficiency, the 'cluster concept' was implemented four years ago in the public hospital system. A matrix structure was put in place with new positions created side by side with the old positions.

Decision making power and control of budgets were centralised to the cluster level, leaving the hospital CEO occupying an ill-defined role. Dual reporting lines were created across each cluster in all disciplines. At this point in time, a review of the objectives, structure and outcomes of the cluster model is imminent to ensure that public hospitals in Hong Kong continue to operate smoothly.

3. **Battered CEOs**

   Due to years of continuous budget cuts, public hospital employees have received diminishing pay packages. New recruits, particularly young doctors, have fallen victims to 'equal work, unequal pay' and poor promotion prospects. Many of them have vented negative feelings towards management. The unions have accused senior health managers of being overpaid at the expense of front line staff. Unfortunately, the media and the public also have the same perception. Under these external and internal pressures, hospital CEOs need to reaffirm their values and their contribution to health care, they need to continue to develop professionally and personally, and to strengthen their leadership role.

Part of the job of health care leaders is to overcome challenges in the midst of a rapidly changing health care environment. I firmly believe that in the future our commitment to patient care and the well being of the community will keep us strong as we face many uncertainties.

Dr Cissy Yu MBBS MPH FHKAM FHKCCM FHKCHSE FCHSE CHE
Hospital Chief Executive

Tung Wah Group of Hospitals
Fung Yiu King Hospital and MacLehose Medical Rehabilitation, Cluster Director, Elderley Services – Hong Kong

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BOOK REVIEW

Patient Safety: research into practice

Reviewed by N North

Bibliographic details:

Walshe K, Boaden R, editors.
Patient Safety: research into practice.
Maidenhead, Berkshire: Open University Press; 2006.
ISBN 0 335 21853 9

The 33 contributors to this book including the editors, are drawn largely from universities and research institutes and reflect academic expertise in health policy, clinical practice and health management. In addition, there are contributions from government bureaucracies and the specialist field of safety and risk management. The book contains 244 pages including the index and its 17 chapters are structured in three parts.

Part One is theoretical and covers clinical, sociological, psychological, quality management, technological and legal perspectives. Similarly in Part Two, multiple perspectives are reflected in a range of techniques to measure, evaluate and investigate patient safety, and are of particular interest to managers. These tools and methods include: taxonomies, incident reporting, use of existing patient data, clinical negligence claims, critical incidence techniques and ethnographic methods. Part Three brings together theoretical and methodological perspectives in three case studies that focus on education (formal and informal), clinical guidelines and improving teamwork and communication and purport to show patient safety in action. Each chapter draws on existing research and bodies of studies that reflect multiple disciplinary perspectives, and each chapter concludes with lists of main points including a reference list pointing to further reading. Health managers will easily relate to these applied themes: quality management, process engineering techniques, a safety culture in organisations, professional development to improve safety, incident reporting systems, critical incident investigative techniques, clinical guidelines and protocols, team performance and communication. Aside from a few examples from and applications to primary care, the book does not focus on patient safety in primary care settings; rather much of the research cited relates to hospitals. Despite an academic writing style, the contents of the book are accessible to non-experts.

The significance of the book arises from research in several countries (United States of America [USA], United Kingdom [UK], Australia, New Zealand and Canada) in the last one to two decades showing that 3-17% of patients in hospital suffer treatment-related harm and medical error; errors frequently attributable to organisational and systems, not clinical, cause. Although the primary readership is the research community and decision-makers who use research, the importance to health services management is in the relationship of patient risk to problems with communication, teamwork, process, organisational culture, management and leadership.

The editors assert that the few available books on risk management and patient safety omit two important issues: patient safety research, and a rigorous foundation for policy and practice; and the bringing together of researchers and practitioners to debate research. Much of the material addresses themes important for research such as conceptual and disciplinary perspectives, methods to measure and investigate patient safety, and a future research agenda. Because it is a specialist area that has emerged only recently and is highly significant to health management, practising health managers will find the book relevant and of interest.

The book does have a bias toward European, North American and Australasian experiences probably because most activity around patient safety is found in these regions.

Nicola North PhD, MA, FCNA(NZ)
Director of Postgraduate Studies
School of Nursing, Faculty of Medical and Health Sciences
The University of Auckland

Correspondence:
n.north@auckland.ac.nz

Reflecting the diversity of authors, the volume is eclectic and multidisciplinary, and while there are advantages in the breadth of perspective, there are drawbacks attendant to an eclectic approach. Researchers will find this book a particularly fruitful resource as it highlights research agendas, hypotheses for testing, research tools and methodologies. In addition, it provides a critical review of the body of relevant research, highlighting its weaknesses and strengths. Much of the latter is brought together in the concluding chapter, although the contributors offer their perspectives throughout.

A matter of concern to a multidisciplinary and eclectic field is that some contributors question the extent to which research findings can be generalised from one context to another. For example, concerns are posed regarding transferability from one clinical specialty or setting to another (hospital to primary care, anaesthetics to family medicine); from one country to another where legal and managerial contexts differ (eg USA to UK, Australia to USA); and from one high risk industry to another, such as the airlines industry or nuclear industry to the health industry. Similar misgivings are articulated regarding the application of medical research methods, such as randomised controlled trials to organisational and management research to demonstrate the strength of evidence of approaches to improve patient safety, and this can be a problem in that medical researchers can be dismissive of the quality and hence the results of research methods commonly used in organisational research. This point highlights why the matter of patient safety is problematic: at its heart lie the disciplinary differences between clinicians, managers and others involved in and passionate about patient safety that ultimately interfere with the multidisciplinary and interdisciplinary initiatives the authors are advocating.

In spite of its title suggesting that here is research ready for application, *Patient Safety: research into practice* does not provide a best practice type approach that can be introduced to rapidly improve patient safety and the management of risk. The editors argue that this is due to the complexities inherent in health services and organisations. These range from disciplinary silos and dominance; resistance to perceived management interference such as clinician resistance to the introduction of guidelines and protocols; ineffective teamwork; professional self-protection; a normalising of risk and adverse events; under-reporting of adverse incidents; a blaming organisational culture; and approaches that isolate incident from context. Indeed only the third and smallest section, Part Three, presents cases reporting the practice of patient safety approaches. Nevertheless, embedded in other chapters, particularly in Part Two, there are many examples, that can be considered for application. It is likely that the paucity of implementation-ready tools and methods is a reflection of the recent emergence of patient safety as a specialist field.

Overall, academics engaged in teaching quality and patient safety in health education will find much in this volume to support their educational practice. This book should be on reading lists of postgraduate students and clinicians involved in management.

Competing Interests

The author declares that she has no competing interests.

Invitation to submit an article or write to the Editor

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

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

ACHSE is now calling for papers for the third and fourth issues of the Journal. The deadline for receipt of papers is 31 Marcg 2007 and 31 July 2007 respectively .

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AGED CARE

Bradley, Elizabeth H and others
The Roles of Senior Management in Improving Hospital Experiences for Frail Older Adults
Journal of Healthcare Management
Vol 51(5) 2006 pp 323-337

Castle, Nicholas G
An Instrument to Measure Job Satisfaction of Nursing Home Administrators
BMC Medical Research Methodology
October 2006 6: 47
http://www.biomedcentral.com/1471-2288/6/47

NSW Health
Aged Care – Working with People with Challenging Behaviours in Residential Aged Care Facilities Guideline
September 2006
http://www.health.nsw.gov.au/policies/gl/2006/pdf/GL2006_014.pdf

Stodel, Emma J and Chambers, Larry W
Assessing Satisfaction with Care in Long-term Care Homes: Current and Best Practices
Healthcare Management Forum
Vol 19(3) Autumn 2006 pp 45-52

GOVERNANCE

Dr Foster Intelligence
The Intelligent Board
2006
(Boards of acute and mental health trusts need a basic set of criteria if they are to provide effective strategic leadership and monitoring of hospital performance.)
http://www.drfoster.co.uk/library/localDocuments/Intelligent_Board_report_v6.pdf

McDonagh, Kathryn J
Hospital Governing Boards: A Study of their Effectiveness in Relation to Organisational Performance
Journal of Healthcare Management
Vol 51(6) November/December 2006 pp 377-391

UK National Audit Office
Improving Quality and Safety: Progress in Implementing Clinical Governance in Primary Care: Lessons for the New Primary Care Trusts
January 2007
(Most primary care trusts have clinical governance structures and processes in place that should assure quality and safety of patient care. But progress in the implementation of these structures and processes varies within and between trusts.)
http://www.nao.org.uk/publications/nao_reports/06-07/0607100.pdf

HEALTH CARE

Australia Parliament House of Representatives Standing Committee on Health and Ageing,
The Blame Game: The Report of the Inquiry into Health Funding
December 2006
http://www.aph.gov.au/house/committee/haa/healthfunding/report.htm

Healy, Judith, Sharman, Evelyn and Lokuge, Buddhima
Australia: Health System Review
Health Systems in Transition
Vol 8(5) 2006
(This report by the European Observatory on Health Systems and Policies takes an in-depth look at the Australian Health System.)
http://www.euro.who.int/Document/E89731.pdf

King's Fund
The Reconfiguration of Hospital Services
Briefing, November 2006
(Examines the background to the current debate on the reconfiguration of acute and community hospital services in England, identifies the main factors driving the changes, explores how these changes are likely to affect patients and asks whether the new models of care will offer value for money.)
http://www.kingsfund.org.uk/resources/briefings/the_1.html

Martin, Stephen, Smith, Peter C and Leatherman, Sheila
Value for Money in the English NHS: Summary of the Evidence
The Health Foundation, December 2006
(Looks at the recent increases in spending levels and asks whether these have translated into a corresponding rise in the quality of care for patients.)
http://www.health.org.uk/aboutus/publications/research/Value-for-money-report-web.pdf

NSW Parliamentary Library Research Service
Commonwealth–State Responsibilities for Health 'Big Bang' or Health Reform?
By Gareth Griffith, Briefing paper No. 17/2006
http://www.parliament.nsw.gov.au/prod/parlment/publications.nsf/0/87738255CB204176CA25722E00251D8D

Power, Prue
Australia's Health System
World Hospitals and Health Services
Vol 42(3) 2006 pp 14-17

Schofield, Deborah J and Earnest, Arul
Demographic Change and the Future Demand for Public Hospital Care in Australia, 2005 to 2050
Australian Health Review
Vol 30(4) November 2006 pp 507-515

HEALTH FACILITIES PLANNING AND DESIGN

Carter, LN and Breunig, DJ
Inside Information: Developing an Effective (Interior) Design Program
Health Facilities Management
Vol 19(7) July 2006 pp 31-36

Designing the 21st Century Hospital: Environmental Leadership for Healthier Patients and Facilities
Papers presented by The Center for Health Design® and Health Care Without Harm at a conference sponsored by the Robert Wood Johnson Foundation, September 2006
(Six papers exploring the environmental impact hospitals have on their patients, staff, and communities.)
http://www.rwjf.org/files/publications/other/Report%20-%20Designingthe21stCenturyHospital-September2006.pdf

Greeley, D
Airing It Out: Ten Key Design Considerations for Emergency Department HVAC Systems
Health Facilities Management
Vol 19(10) 2006 pp 23-28
(HVAC systems in the ED of the future will be designed to be highly visible with regard to airborne contamination and epidemic events.)

Joseph, Anjali
The Impact of Light on Outcomes in Health Care Settings
Center for Health Design
August 2006
http://www.rwjf.org/files/publications/other/CHD_Issue_Paper2.pdf

Spencer, Eugene
Pay Any Price? Common Mistakes in Project Cost Estimating
Health Facilities Management
Vol 19(9) September 2006 pp 39-42

Suter, Esther and others
Evaluation of Planning and Implementation for an Innovative Health Centre
Healthcare Management Forum
Vol 19(3) Autumn 2006 pp 26-31

HEALTH INSURANCE

Parliament of Australia, Library
The Proposed Sale of Medibank Private: Historical, Legal and Policy Perspectives
Research Brief, September 2006
http://www.aph.gov.au/library/pubs/rb/2006-07/07rb02.pdf

Schneider, R
Making Medicare Better
Australian Centre for Health Research, 2006
http://www.achr.com.au/pdfs/Making%20Medicare%20Better%20final%20-%20Russel%20Schneider.pdf

HEALTH MANAGERS

Aldrich, R, Bonevski, B and Wilson, A
A Case Study on Determining and Responding to Health Managers' Priorities for Research to Assist Health Service Decision Making
Australian Health Review
Vol 30(4) 2006 pp 435-441

Liang, Zhanming, Short, Stephanie D and Brown, Claire R
Senior Health Managers in the New Era: Changing Roles and Competencies in the 1990s and Early 21st Century
Journal of Health Administration Education
Vol 23(3) Summer 2006 pp 281-231

HEALTH POLICY

Fielding, JE and Briss, PA
Promoting Evidence-based Public Health Policy: Can we have Better Evidence and More Action?
Health Affairs
Vol 25(4) 2006 pp 969-978

Meyer, Jack A, Alteras, Tanya T and Adams, Karen B
Toward More Effective Use of Research in State Policymaking
The Commonwealth Fund, December 2006
http://www.cmwf.org/usr_doc/Meyer_towardmoreeffectiveusestatepolicymaking_980.pdf

New Matilda
A Health Policy for Australia: Reclaiming Universal Health Care
(A proposal for fundamental reform of Australia's ailing health policies.)
http://www.newmatilda.com/admin/imagelibrary/images/A_health_policy_for_AustralialPGs3VUii1K2.pdf

LEADERSHIP

Bernthal, P and others
Health Care Global Comparison: Leadership Forecast 2005/2006: Best Practices for Tomorrow's Global Leaders
Development Dimensions International
http://www.heartland.org/pdf/19550.pdf

The CEO's Role in Talent Management: How Top Executives from Ten Countries are Nurturing the Leaders of Tomorrow
A White Paper by the Economist Intelligence Unit in co-operation with Development Dimensions International, 2006
http://www.ddiworld.com/economistceo/default.asp

Tholl, William G and others
Passing the Baton – Toward Making a Case for a Canadian Centre for Health Leadership
Healthcare Management Forum
Vol 19(1) Spring 2006 pp 14-20
(The average tenure of current senior health leaders has declined sharply over the last 30 years. This paper suggests that Canada does not do enough to identify, develop, support and celebrate its health leaders.)

MANAGEMENT

Christensen, Clayton M, Marx, Matt and Stevenson, Howard H
The Tools of Cooperation and Change
Harvard Business Review
Vol 84(10) October 2006 pp 73-80
(Managers can use a variety of carrots and sticks to encourage people to work together and accomplish change. Their ability to get results depends on selecting tools that match the circumstances they face.)

Hill, Linda A
Becoming the Boss
Harvard Business Review
Vol 85(1) January 2007 pp 49-56
(The experiences of new managers and the challenges they face.)

Hurley, Robert F
The Decision to Trust
Harvard Business Review
Vol 84(9) September 2006 pp 55-62
(A new model explains the mental calculations people make before choosing to trust someone.)

Kaval, Vincent R and Voyten, Lawrence J
Executive Decision Making: Effective Processes for Making and Implementing Decisions
Healthcare Executive
Vol 21(6) November/December 2006 pp 16-18, 20, 22

MENTAL HEALTH SERVICES

Mental Health Council of Australia
Smart Services: Innovative Models of Mental Health Care in Australia and Overseas
October 2006
http://www.mhca.org.au/documents/MHCASSRlayout29-9.pdf

PERFORMANCE MANAGEMENT

Griffith, John R, Alexander, Jeffrey A and Foster, David A
Is Anybody Managing the Store? National Trends in Hospital Performance
Journal of Healthcare Management
Vol 51(6) November/December 2006 pp 392-406
(Although much public attention has been given to hospital performance, few measures show substantial positive trends, either in variance reduction or overall improvement.)

Persaud, D David and Nestman, Lawrence
The Utilisation of Systematic Outcome Mapping to Improve Performance Management in Health Care
Health Services Management Research
Vol 19(4) November 2006 pp 264-276
(Systematic outcome mapping provides for performance management by allowing for quality improvement to be built into performance indicator development.)

PRIMARY HEALTH SERVICES

Tasmania, Department of Health and Human Services
A Primary Health Strategy for Tasmania: Discussion Paper
October 2006
http://www.dhhs.tas.gov.au/agency/chs/documents/Primary_Health_Strategy.pdf

PUBLIC PRIVATE PARTNERSHIPS

New Matilda
Private Public Partnerships no 'Magic Pudding'
By Tristan Ewins, December 2006
http://www.newmatilda.com//policytoolkit/policydetail.asp?NewsletterID=280&PolicyID=566&email=1

Nikolic, Irina A and Maikisch, Harald
Public Private Partnerships (PPPs) and Collaboration in the Health Sector: An Overview with Case Studies from Recent European Experience
World Bank Health, Nutrition and Population Discussion Paper October 2006
http://siteresources.worldbank.org/HEALTHNUTRITIONANDPOPULATION/Resources/281627-1095698140167/NikolicPPP&CintheHealthSectorfinal.pdf

QUALITY

Australian Commission an Safety and Quality in Health Care
Review of National Quality and Safety Accreditation Standards: Discussion Paper
November 2006
http://www.safetyandquality.gov.au/internet/safety/publishing.nsf/Content/whats-new-lp

McFadden, Kathleen L, Stock, Gregory N and Gowen, Charles R
Exploring Strategies for Reducing Hospital Error
Journal of Healthcare Management
Vol 51(2) March 2006 pp 123-135

Pham, Hangmai H, Coughlan, Jennifer and O'Malley, Ann S
The Impact of Quality Reporting on Hospital Operations
Health Affairs
Vol 25(5) September/October 2006 pp 1412-1422
(The question remains unanswered: How does quality reporting affect outcomes for patients?)

World Health Organization
Quality of Care: A Process for Making Strategic Choices in Health Systems
2006
http://www.who.int/management/quality/assurance/QualityCare_B.Def.pdf

SAFETY

McCloughlin, Vivienne and others
Selecting Indicators for Patient Safety at the Health System Level in OECD Countries
International Journal for Quality in Health Care
Vol 18 Supplement 1, September 2006 pp 14-20

UK Department of Health
Safety First: A Report for Patients, Clinicians and Healthcare Managers
December 2006
http://www.dh.gov.uk/assetRoot/04/14/14/41/04141441.pdf

US Agency for Healthcare Research and Quality
10 Patient Safety Tips for Hospitals
http://www.ahrq.gov/qual/10tips.htm

STRATEGIC PLANNING

Jones, Kerina H
A 3-dimensional Balanced Scorecard Model (BSC) for R&D
British Journal of Health Care Management
Vol 13(1) January 2007 pp 19-22
(The BSC is a multi-dimensional framework which can be used to describe, implement and manage strategy at all levels by linking objectives, initiatives and measures to organisational strategy.)

Zuckerman, Alan M
Advancing the State of the Art in Healthcare Strategic Planning
Frontiers of Health Services Management
Vol 23(2) Winter 2006 pp 3-15

WORKFORCE PLANNING

The Audit Office of NSW
Performance Audit: Attracting, Retaining and Managing Nurses in Hospitals: NSW Health
December 2006
http://www.audit.nsw.gov.au/publications/reports/performance/2006/nurses/nurses-contents.htm

Collins, Sandra K and Collins, Kevin S
Valuable Human Capital: The Aging Health Care Worker
Health Care Manager
Vol 25(3) July/September 2006 pp 213-220

GUIDELINES FOR CONTRIBUTORS

Manuscript Preparation and Submission

General Requirements

Language and format

Manuscripts must be typed in English, on one side of the paper, in Arial 11 font, double spaced, with reasonably wide margins using Microsoft Word.

All pages should be numbered consecutively at the centre bottom of the page starting with the Title Page, followed by the Abstract, Abbreviations and Key Words Page, the body of the text, and the References Page(s).

Title page and word count

The title page should contain:

1. **Title**. This should be short (maximum of 15 words) but informative and include information that will facilitate electronic retrieval of the article.
2. **Word count**. A word count of both the abstract and the body of the manuscript should be provided. The latter should include the text only (ie, exclude title page, abstract, tables, figures and illustrations, and references). For information about word limits see *Types of Manuscript: some general guidelines* below.

Information about authorship should not appear on the title page. It should appear in the covering letter.

Abstract, key words and abbreviations page

1. **Abstract** – this may vary in length and format (ie structured or unstructured) according to the type of manuscript being submitted. For example, for a research or review article a structured abstract of not more than 300 words is requested, while for a management analysis a shorter (200 word) abstract is requested. (For further details, see below - Types of Manuscript – some general guidelines.)
2. **Key words** – three to seven key words should be provided that capture the main topics of the article.
3. **Abbreviations** – these should be kept to a minimum and any essential abbreviations should be defined (eg PHO – Primary Health Orgnaisation).

Main manuscript

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

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

Major and secondary headings

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

Figures, tables and illustrations

Figures, tables and illustrations should be:

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

Copyright

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

Ethical approval

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

References

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

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

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

Books and Monographs

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

Chapters published in books

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

Journal articles

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

References from the World Wide Web

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

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

Types of Manuscript - some general guidelines

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

Content

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

Abstract

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

Main text

Structured appropriately. A suitable structure would include:

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

Word count: general guide - 2,000 words.

References: maximum 25.

2. Research article (empirical and/or theoretical)

Content

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

Abstract

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

Word count: maximum of 300 words.

Main text

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

The discussion section should address the issues listed below:

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

Word count: general guide 3,000 words.

References: maximum of 30.

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

3. Research note

Content

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

Abstract

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

Word count: maximum 200 words.

Main text

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

Word count: general guide 2,000 words.

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

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

References: maximum of 25.

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

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

Content

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

Abstract

Structured appropriately.

Word count: maximum of 300 words.

Main text

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

Word count: general guide 3,000 words.

References: maximum of 50

5. Viewpoints, interviews, commentaries

Content

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

Abstract

Structured appropriately.

Word count: maximum of 200 words.

Main text

Structured appropriately.

Word count: general guide 2,000 words.

References: maximum of 20.

6. Book review

Book reviews are organised by the Book Review editors. Please send books for review to: Book Review Editors, APJHM, ACHSE, PO Box 341, NORTH RYDE, NSW 1670. Australia.

Covering Letter and Declarations

The following documents should be submitted separately from your main manuscript:

Covering letter

All submitted manuscripts should have a covering letter with the following information:

- Author/s information, Name(s), Title(s), full contact details and institutional affiliation(s) of each author;
- Reasons for choosing to publish your manuscript in the APJHM;
- Confirmation that the content of the manuscript is original. That is, it has not been published elsewhere or submitted concurrently to another/other journal(s).

Declarations

1. Authorship responsibility statement

Authors are asked to sign an 'Authorship responsibility statement'. This document will be forwarded to the corresponding author by ACHSE on acceptance of the manuscript for publication in the APJHM. This document should be completed and signed by all listed authors and then faxed to: The Editor, APJHM, ACHSE (02 9878 2272).

Criteria for authorship include substantial participation in the conception, design and execution of the work, the contribution of methodological expertise and the analysis and interpretation of the data. All listed authors should approve the final version of the paper, including the order in which multiple authors' names will appear. [4]

2. Acknowledgements

Acknowledgements should be brief (ie not more than 70 words) and include funding sources and individuals who have made a valuable contribution to the project but who do not meet the criteria for authorship as outlined above. The principal author is responsible for obtaining permission to acknowledge individuals.

Acknowledgement should be made if an article has been posted on a Website (eg, author's Website) prior to submission to the Asia Pacific Journal of Health Management.

3. Conflicts of interest

Contributing authors to the APJHM (of all types of manuscripts) are responsible for disclosing any financial or personal relationships that might have biased their work. The corresponding author of an accepted manuscript is requested to sign a 'Conflict of interest disclosure statement'. This document will be forwarded to the corresponding author by ACHSE on acceptance of the manuscript for publication in the APJHM. This document should be completed and signed and then faxed to: The Editor, APJHM, ACHSE (02 9878 2272).

The International Committee of Medical Journal Editors (2006) maintains that the credibility of a journal and its peer review process may be seriously damaged unless 'conflict of interest' is managed well during writing, peer review and editorial decision making. This committee also states:

'A conflict of interest exists when an author (or author's institution), reviewer, or editor has a financial or personal relationships that inappropriately influence (bias) his or her actions (such relationships are also known as dual commitments, competing interests, or competing loyalties). ... The potential for conflict of interest can exist whether or not an individual believes that the relationship affects his or scientific judgment.

Financial relationships (such as employment, consultancies, stock ownership, honoraria, paid expenses and testimony) are the most easily identifiable conflicts of interest and those most likely to undermine the credibility of the journal, authors, and science itself...' [4]

Criteria for Acceptance of Manuscript

The APJHM invites the submission of research and conceptual manuscripts that are consistent with the mission of the APJHM and that facilitate communication and discussion of topical issues among practicing managers, academics and policy makers.

Of particular interest are research and review papers that are rigorous in design, and provide new data to contribute to the health manager's understanding of an issue or management problem. Practice papers that aim to enhance the conceptual and/or coalface skills of managers will also be preferred.

Only original contributions are accepted (ie the manuscript has not been simultaneously submitted or accepted for publication by another peer reviewed journal – including an E-journal).

Decisions on publishing or otherwise rest with the Editor following the APJHM peer review process. The Editor is supported by an Editorial Advisory Board and an Editorial Committee.

Peer Review Process

All submitted research articles and notes, review articles, viewpoints and analysis of management practice articles go through the standard APJHM peer review process.

The process involves:

1. Manuscript received and read by Editor APJHM;
2. Editor with the assistance of the Editorial Committee assigns at least two reviewers. All submitted articles are blind reviewed (ie the review process is independent). Reviewers are requested by the Editor to provide quick, specific and constructive feedback that identifies strengths and weaknesses of the article;
3. Upon receipt of reports from the reviewers, the Editor provides feedback to the author(s) indicating the reviewers' recommendations as to whether it should be published in the Journal and any suggested changes to improve its quality.

For further information about the peer review process see Guidelines for Reviewers available from the ACHSE website at www.achse.org.au.

Submission Process

All contributions should include a covering letter (see above for details) addressed to the Editor APJHM and be submitted either:

(Preferred approach)

1) Email soft copy (Microsoft word compatible) to journal@achse.org.au

   Or

2) in hard copy with an electronic version (Microsoft Word compatible) enclosed and addressed to: The Editor, ACHSE APJHM, PO Box 341, North Ryde NSW 1670;

All submitted manuscripts are acknowledged by email.

NB

All contributors are requested to comply with the above guidelines. Manuscripts that do not meet the APJHM guidelines for manuscript preparation (eg word limit, structure of abstract and main body of the article) and require extensive editorial work will be returned for modification.

References

1. Hayles, J. Citing references: medicine and dentistry, 2003;3-4. Available: <http://www.library.qmul.ac.uk/leaflets/june/citmed.doc> (Accessed 28/02/06)
2. Doherty M, Smith R. The case for structuring the discussion of scientific papers. BMJ. 1999;318:1224-1225.
3. Perneger TV, Hudelson PM. Writing a research article: advice to beginners. Int Journal for Quality in Health Care. 2004;191-192. Available: <http://intqhc.oxfordjournals.org/cgi/content/full/16/3/191> (Accessed 1/03/06)
4. International Committee of Medical Journal Editors. Uniform requirements for manuscripts submitted to biomedical journals. ICMJE. 2006. Available: <http://www.icmje.org/> (Accessed 28/02/06).

Other references consulted in preparing these Guidelines

Evans MG. Information for contributors. Acad Manage J. Available: <http://aom.pace.edu/amjnew/contributor_information.html> (Accessed 28/02/06)

Health Administration Press. Journal of Health care Management submission guidelines. Available: <http://www.ache.org/pubs/submisjo.cfm> (Accessed 28/02/06)

International Journal for Quality in Health Care. Instructions to authors, 2005. Available: <http://www.oxfordjournals.org/intqhc/for_authors/general.html> (Accessed 28/02/06)

The Medical Journal of Australia. Advice to authors submitting manuscripts. Available: <http://www.mja.com.au/public/information.instruc.html> (Accessed 28/02/06)

Further information about the Asia Pacific Journal of Health Management can be accessed at: www.achse.org.au.