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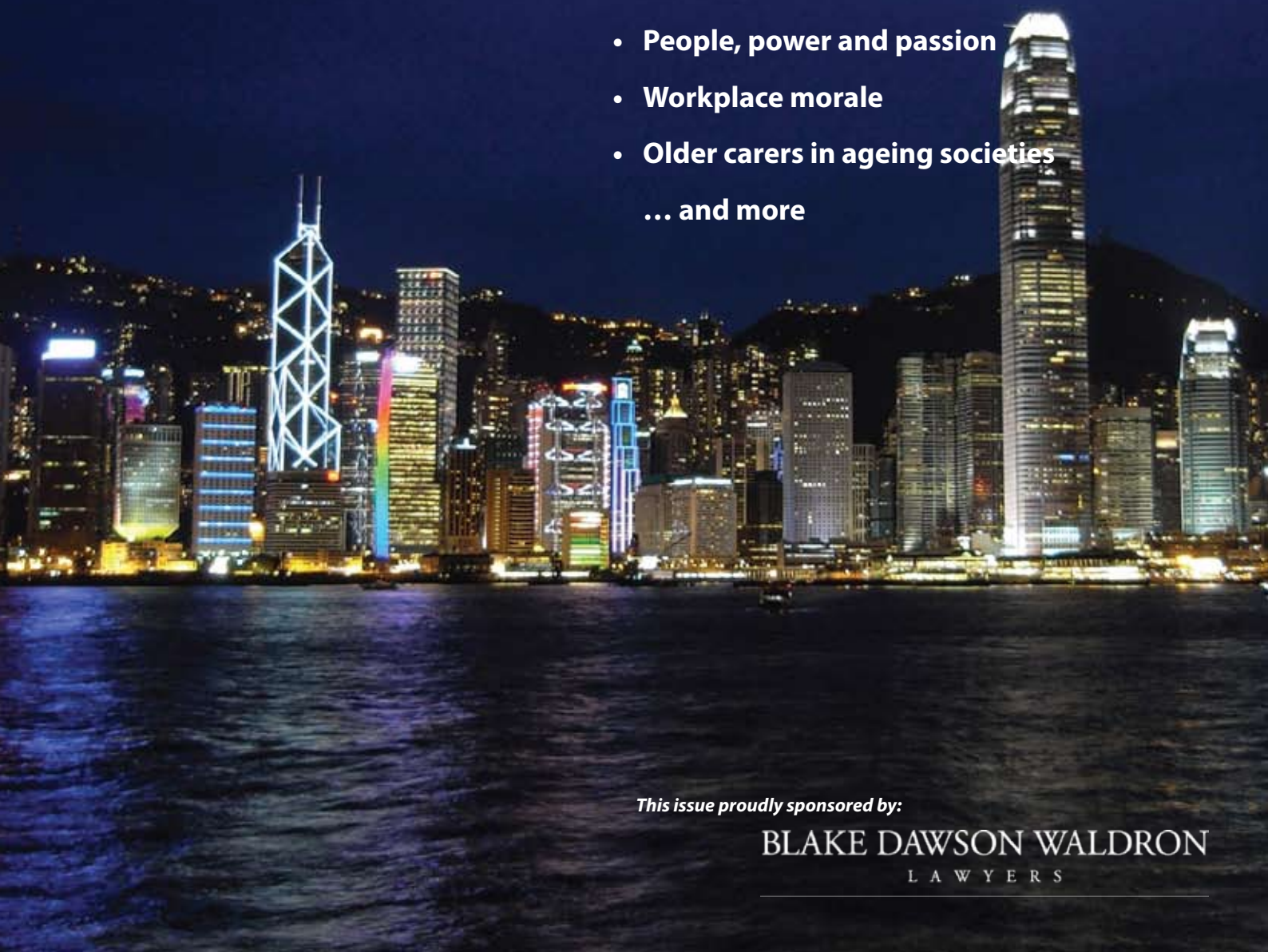
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- facilitating transfer of knowledge among readers by widening the evidence base for management practice;
- contributing to the professional development of health and aged care managers; and
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Changing the Health System or Challenging the Change: a time to reflect and contribute

DS Briggs

It is both a privilege and challenge to accept the role of Editor of a Journal that is new and in its development stage. The Journal has had a good start thanks to the efforts of Mary Harris and dedicated contributions from the College corporately, Editorial board and committee members and willing peer reviewers. Most importantly, good quality contributions from researchers and health professionals in the Asia Pacific Region underpin the early success of the Journal.

One aspect of the Editorial role is to promote involvement of readers, partly by providing commentary, to encourage readers' responses to articles through a Letter to the Editor section. [1, 2] From the initial issue, readers have been challenged by a series of articles on health system reform by Podger [3-5] and ripostes by Braithwaite [6] and Stable. [7] Despite the contemporary nature of the reform issue and the constant call for reform in the Australian context by some commentators, [8, 9] there has been no response to these articles from the Journal's readership.

In the absence of evidence, one can only make assumptions about this lack of response. These assumptions might include the newness of the Journal and a lack of electronic format being a limiting factor, employment circumstances constraining public comment from readers and possibly fatigue from four decades of health system reform. After all, the Australian health care system and most comparative national health systems have seen consistent reform from the 1970s onwards. [10]

In an earlier issue of this Journal contributors were asked 'what were the main issues you faced in health some ten years ago?' Two responses are informative – 'there continues to be health system organisational changes and still "insufficient money and resources to meet increasing demands". So over ten years nothing much has changed'. [11] The second response also suggests 'These two challenges were insufficient money and resources to meet ever increasing demands; and parliamentary politics. Both these challenges remain today and will probably worsen'. [12] Current qualitative research by the Editor [13] has sought the views of 19 health service managers across the Australian and New Zealand health jurisdictions, public and private, about their perceptions of the health system and the managerial role. While the respondents are positive about the managerial role, they view the health system negatively in terms of its constant, complex change and doubt the capacity of the system to adapt and to achieve service integration.

The reflections of experienced practitioners of a decade of change and the more recent views of practising health managers can be further informed by revisiting the earlier work of Alford [14] and Crichton [15] who describe the constraining effect of structural interest on health reform and the increased tendency for government to take control of health systems. Organisations, particularly health care organisations, are mostly about people and Braithwaite [16] rightly cautions about the mechanistic and sometimes one–dimensional approach to reform that restructure often implies and with others, about the lack of evidence of the effectiveness of reform. [17, 18] Dwyer asks what problem is being solved through system restructuring and suggests that structural reform is often not evaluated except when the weaknesses of the reform are presented as part of the justification for the next round of changes. [19] A further review of reform at the national and state/territory jurisdictional levels reported limited progress. [20] Leeder takes an equity perspective on the need for reform, [21] while Mooney and Scott provide a valuable reminder to us all by asking us 'whose health service is it anyway?'. [22, p.76]

The issues challenging the health system are complex and meaningful change at the service delivery level is difficult to achieve while the emphasis on reform remains at the system-wide structural level. Reform, innovation and effective change at this level are not likely to be achieved through tightly coupled organisations situated in centrally controlled

health systems. [19] The challenge is how to release the health system's potential and the literature suggests that this is more likely to occur where organisational disorder in loosely coupled organisations is recognised as having some legitimacy. Attributes of persistence, adaptability and reliability in loosely coupled organisations, ahead of the bounded rationality of well ordered organisations may provide more adaptive responses and take into account the multiplicity of views and the 'pluralism of values' inherent in health systems. [23 p.16] This type of approach requires vision and support for it to succeed within or alongside the traditional hierarchical structures that currently predominate. [24]

Most participants in the health system acknowledge the limiting nature of divided government responsibility for health care policy, funding and delivery. We should not presume however, that the inevitable outcome is that those three functions will improve health care if contained within a structure and a health system at one level of government responsibility. Consistent and unified national health policy and funding mechanisms are essential but, how we organise, manage and deliver health services, that is utilise resources to achieve health care policy, deserves deeper consideration and debate.

In this issue, Lee and colleagues describe the difficulty in sustaining innovative, cost-effective, quality care initiatives both within and across organisational boundaries within an existing health system. They demonstrate that managers are constrained by institutional and funder regulation over access and use of resources. These authors conclude that the obstacle is resource allocation practices within a health system, inhibiting managers from being responsive and proactive. [25]

Given examples of this nature we need to consider other options for structural reform that allow a greater focus on how resources are utilised to provide effective health care delivery rather than comprehensive structural reform. There might be lessons in the current national approach to safety and quality [26] or in Leeders' call for a National Council for Equity in Healthcare. [21] General practitioners and GP Divisions are currently funded by both levels of government to strengthen and deliver a widening range of primary care services. Research suggests potential for this model in strengthening primary care. [27]

Perhaps, a wider extension to health services generally of the primary health care, GP Division model might allow a progressive transformation of Australia's health services. This approach would require a reconstitution of hospital and community health organisations into organisations capable of partnership with a range of intersectoral providers to utilise new funding to meet identified national and local health priorities. It may require a national authority that allocates new and increased funding to coalitions of providers, with existing providers and funding streams being maintained until they progressively transform into new provider organisations.

A further alternative might be to consider the third pillar concept described in a Report commissioned by the Bauhinia Research Foundation of Hong Kong. [28] This approach maintains existing public and private health care sector funding and delivery while proposing an additional mixed sector and mixed funding pillar for new and additional services.

In the feature article of this issue, Lieu traverses the history of reform in the Hong Kong health system, reinforcing the difficulties that one-dimensional attempts at reform tend to produce. Lieu calls for an overarching vision, an assurance of equity and access, freedom of choice and implementation through a coalition that actively engages the community and key stakeholders. [29]

Irrespective of the eventual outcome of health care reform in Australia and elsewhere, it would be encouraging to think that it had been informed by such a framework, with extensive debate and consideration of alternatives and implemented in a manner that allowed health care professionals to focus on effective health care delivery.

David Briggs BHA, MHM (Hons), FCHSE, FHKHSE
Editor

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IN THIS ISSUE

The theme adopted in the previous issue of the Journal to utilise photos for the cover submitted by members and readers has been extended, where appropriate, to correspond with either a Journal theme, feature article or geographic location addressed in the Journal contents. The cover of this issue is unmistakably Hong Kong and is appropriate given the Feature Article is by College Fellow Geoffrey Lieu and is about the reform process of aspects of the Hong Kong health system. It also marks the ten year anniversary of Hong Kong becoming a Special Administrative Region of China. Our thanks to our Hong Kong members and the Hong Kong College for their assistance in securing the photograph. Our particular thanks to Dr T L Que, for taking the photograph and making it available for this publication.

Seven original articles are presented in this issue as well as two book reviews organised by our Book Editor, Angela Magarry, our regular Q & As section and the ACHSE Library Bulletin compiled by Sue Brockway. For the first time a reader's letter is published. Two sub themes have emerged from those presented, the first around quality and safety and the second around the most valuable resource of the health system – people.

In his Feature Article, Lieu addresses the history of health reform in Hong Kong, reform mostly around the hospital system with little if any concurrent reform of other aspects of the health system. He traverses a number of reports that have also called for wider reform including health financing and points to the factors that have seen those reports not implemented. He concludes with a framework that might provide an appropriate approach to broader meaningful reform. The lessons from the Hong Kong health system and the insights provided by Lieu are worthy of consideration by reformers in other health systems.

O'Rourke commences our safety and quality sub theme with a Viewpoint article on health system safety and quality problems that need national solutions. He traverses the issues and reports from the literature that have led to a national concern about safety and quality and the establishment of the Australian Commission on Safety and Quality in Health Care (ACSQHC). O'Rourke utilises the literature and conducts interviews and discussions with leading players in the safety and quality arena in Australia to establish his Viewpoint. He concludes that the Commission will have a critical coordinating role in addressing the issues and in progressing initiatives to address them. He concludes that the Commission will need to demonstrate high level advocacy, encouragement of research, public reporting and leadership in policy to build consensus for action in safety and quality.

Lee and colleagues take the quality of care agenda to a specific service area and demonstrate the importance of engaging of clinicians and managers at the local level to address quality service issues. They clearly demonstrate the difficulty in making sustainable initiatives that demonstrate both efficient and effective use of resources because of institutional limitations placed on clinicians and managers. A further different perspective on quality and safety is provided by Lok and colleagues in researching the incidence and nature of complaints in respect of dental services in a retrospective analysis of complaints in Western Australia. The quality and safety sub theme concludes with contributions from the field about practitioner views in the Q & As section.

The second sub theme of this issue commences with a viewpoint by Cahill on the passion and power of people in the health workforce. This paper comes from a well-received presentation by Cahill at the 2006 ACHSE/RACMA Joint National Congress. The paper traverses identified legal trends in the Australian health industry and suggests that an awareness of these issues empowers health managers with knowledge that will enable better understanding, decision making and care delivery.

DeBoer and Day present an analysis of qualitative data from a larger cross-sectional survey of registered nurses employed in three acute care facilities in South East Queensland about workplace factors and their contribution to the morale of that group. They describe positive and negative factors influencing morale of registered nurses, confirming the

findings of other studies in this area and point to the need for improvement of nurse morale and the need to address reported levels of bullying and abusive behaviour within the profession and described in this study. Cockram and colleagues remind us of the important contribution of carers in the health system and describe a West Australian initiative to better support older carers of people with disability. This is a timely reminder to those of us employed in health systems about the value carers bring, sometimes over life times, and how health professionals might provide adequate support to those in that role.

In the Book Reviews, Magarry reports on the European Observatory 2006 Health Services in Transition Report on the Australian health system and indicates that it provides a thorough and factual description of the system and will be useful to researchers and practitioners alike. Bialkowkoski provides a review of another European Observatory publication, focussed on organisational reform in European primary care. There are over thirty contributors for this book and Bialkowski suggests that it is a relevant and useful reference to all of us who might have an interest in primary care.

In my opinion . . .

March and April are wonderful months of the year. We have lovely days of quite glorious sunshine and although the nights are drawing in, we have Easter to look forward to with chocolate eggs, hot cross buns and four days off work. But what else draws in at this time of the year?

Managers of programs and services in the health sector are given wonderful news! There is 'X amount of dollars to spend'. 'Magic' you might say but here comes the catch. You are then told that it has to be spent by the end of the financial year or you'll lose it. Great, just what you need.

We look around for something good to spend this money on. Programs are not a good idea because there is no guarantee they will be funded next year. What about equipment you ask yourself, but there is only so much that can be used at any one time. You ask staff and they just roll their eyes – they've heard it all before. The time draws close to the cut off date. We are in a panic mode and because of our isolation in country South Australia we don't have access to those resources that our city cousins have, so what do we do? Simple, we spend it on something that is reasonable, but not really essential. We think to ourselves 'if only we had known this six months ago, we could have used some for a program that was struggling'.

Why does this happen every year and why are we always caught short? We are not masters of what programs can be run and/or implemented. Yes we have our budget at the beginning of the new financial year but sometimes we don't know how much – it will be the same as last year, yes but costs have gone up we say. We know our core business so concentrate on that but – and there is always a but – we are directed from time to time to change direction or tack and do something which is not specifically within our area of concern. Ah yes, we are told, but the Minister would like this to be done and a response is required within so many days.

In my opinion, we need to concentrate on our core business because that is why we are employed. Budgets need to be specifically targeted at the core business and if we are required to undertake additional responsibilities outside of our primary role, then additional funding should be provided. We should not be expected to make current government look good at the expense of our primary role. Health should not be the political football that it has become and budgets should be clearly established for the purpose in which they are allocated. Finally, budgets need to be structured so that they are in place for longer than the current financial year and in this way proper planning can be undertaken instead of the knee jerk reaction that is so evident.

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Mental Health Program Officer
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A Tribute to Foundation Editor – Dr Mary Harris

The Australian College of Health Service Executives is indebted to Dr Mary Harris for her work as Foundation Editor of the Asia Pacific Journal of Health Management.

An academic in health services management for the past thirty years, Mary was the ideal choice to take the lead in one of the most important College decisions in recent times, to establish its own peer reviewed professional management journal.

Mary's professional career and academic record are nothing short of outstanding. Her qualifications include Doctor of Philosophy, Master of Public Health and Graduate Diploma in Health Administration. Mary has been a member of the College for 25 years, a Fellow for 17 years, and the recipient of the prestigious ACHSE Gold Medal Award in 2002 for her contribution to the profession of health management. Mary was recently awarded Life Membership of ACHSE. She is also a Life Member of the Society for Health Administration Programs in Education (SHAPE).

Mary has had an impressive professional background. She is a registered nurse, midwife and community health nurse by training and holds graduate qualifications in health administration. Mary has held full time academic roles at the Universities of South Australia, Wollongong, Sydney and Flinders.

Mary was recognised by the Kellogg Teaching Foundation and was a W K Kellogg Teaching Fellow for her early academic work in South Australia.

In the past ten years, Mary had been Senior Policy Analyst, Australian Medical Workforce Advisory Committee and National Health Workforce Secretariat. This role involved research into workforce issues; workforce planning, including projection modelling; project management; writing reports for governments and articles for publication in relevant journals. Mary has also undertaken major community agency work as an adviser and Board member as well as respected consultancy projects.

Mary's publication in peer reviewed journals, books and monographs is extensive. Her recent work, an excellent study written with Janny Maddern and Shane Pegg and colleagues from the Australian and New Zealand Colleges and SHAPE, 'The Changing Roles and Careers of Australian and New Zealand Health Service Managers' received wide acclaim. It has been cited in a variety of contexts to help draw the attention to the need for ongoing commitment to the education, training and career management of health executives in both Australia and New Zealand.

Her other recent project has been the editorial leadership and personal author contribution to the text 'Health Service Management: Concepts and Practice' including the second edition of the text. This publication reflects the expertise, professionalism and leadership that Mary invests in all her work.

The College wishes to extend its best wishes to Mary Harris for a job well done and thanks her for the high benchmark that she has set as Foundation Editor.

DS Briggs
Editor

Sustaining High Performance and Responsiveness: the transformation of Hong Kong's health system

G Lieu

Abstract

The establishment of the Hospital Authority in Hong Kong in December 1990 was a landmark development in the management transformation of public hospitals in a tax-based health system. It introduced a corporate style of management, replacing the highly-centralised bureaucracy approach that had lasted since the 1960s. The liberalising effect modernised and propelled Hong Kong's public hospitals into a new era. Patient volumes surged and the private hospital sector market share shrank by fifty percent. There were concerns about the future sustainability of the system. Attention was directed towards the future health care financing policy and options. Now, 17 years later and despite several proposals introduced to reform the financing system, a new financing policy is yet to be enacted. Moreover, the once highly hailed public hospital system is showing signs of stress: experienced clinicians are leaving for the private sector, supply of doctors and nurses is inadequate, staff morale is dropping and waiting lists in some critical areas continue to be excessively long. This paper explores what happened in Hong Kong's health care reform and suggests a way forward to sustaining the system's high performance and responsiveness.

Key words: infrastructure and financing reforms; sustainability; public engagement; inclusiveness; choice.

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Introduction

Hong Kong is a vibrant city. With one of the world's lowest infant mortality rates and the highest average life expectancies at birth, the health of its people ranks among the best. [1, 2] The health system is efficient by international standards, consuming only about 5.5 percent of GDP. [3] A tax-based financing system funds its public health care sector, which shares 56.9 percent of the total expenditure on health. [4]

The roots of influence of Hong Kong's current health system come from 25 years ago. Beginning in the 1980s, a plethora of reform proposals emerged in Hong Kong (see Figure 1). The proposals fell into two thrusts: infrastructure reform and financing reform. The former were proposals introduced up to the end of December 1990, around the time when the Hospital Authority was established to corporatise and manage the public hospitals. The latter was a series of disjointed financing reviews with no reform action except for the successive publication of five consultation documents or discussion papers.

In the 1980s, when the idea of health care reform of this era first emerged, public hospitals were inefficient and non-responsive to community needs and expectations. Hospital management fell behind international standards. Patient amenities were inadequate and working conditions for staff poor. Staff morale was low and many doctors would leave for the private sector, the preferred provider for patients who could afford to pay for it.

Today, while public hospitals have improved in quality and performance under the Hospital Authority's management, the rest of the health system has remained largely unchanged in terms of its infrastructure and financing arrangements. The health system is concerned about its future development and financing sustainability in light of changing demographics, new epidemiologic challenges, escalating health care costs, rising community expectations and intensifying doctor and nursing shortages. A clear direction and focus for the health system's reform that is supported by the public and key stakeholders has yet to emerge.

Figure 1: The past journey of Hong Kong's health care reform

ORGANISATIONAL REFORM NO FINANCING REVIEW ← → | ← *FINANCING REVIEW NO REFORM* →

Reform Proposal or Report	Cooper & Lybrand – WD Scott report	PHA report	*Primary health care report*	Towards better health	*Lifelong investment in health* — The Harvard report	*Building a healthy tomorrow* — MSA feasibility study

Year	1985	1986	1987	1988	1989	1990	1991	1992	1993	1994	1995	1996	1997	1998	1999	2000	2001	2002	2003	2004	2005	2006	2007

| Health Secretary[1] | | | | T H Chau (1988 – 1990) | | | Elizabeth Wong (Feb1990 – Sept 1994) | | | | Katherine Fok (Sept 1994 – Sept 1999) | | | | | E K Yeoh (Sept 1999 – Oct 2004) | | | | | York Chow (Current incumbent) | | |

| PHA and HA Chairman[2] | | | | S Y Chung (PHA: Oct 1986 – Dec 1990: Dec 1990 – Mar 1995) | | | | | | | Peter Woo (Apr 1995 – Sept 2000) | | | | | | K S Lo (Oct 00 – Sept 02) | C H Long (Oct 02 – Sept 04) | | Anthony Wu (Current incumbent) | | |

| Governor[3] or Chief Executive[4] | | David Wilson (Apr 1987 – Jul 1992) | | | | | Chris Patten (1 Jul 1992 – 30 Jun 1997) | | | | | | Tung Chee Wah (1 Jul 1997 – 12 Mar 2005) | | | | | | | | Donald Tsang (Current incumbent) | | |

| Critical Event | Provisional Hospital Authority formation (1 October 1988)[5] — Hospital Authority formation (1 December 1990)[7] | | | | | | | | | | Hong Kong returns to China (1 July 1997) — Asian financial crisis hit Asia (2 July 1997)[8] | | | | | | SARS outbreak (February-June 2003)[8] — Article 23 mass protest (1 July 2003)[9] | | | | | |

1. Source of dates: http://en.wikipedia.org/wiki/Secretary_for_Health%2C_Welfare_and_Food (Acessed 30 June 2007). The actual title desinations at the time could be Secreatry for Health and Welfare, Secretary for Health, Welfare and Food or Sceretary for Food and Health.

2. PHA = Provisional Hospital Authority; HA = Hospital Authority. Dates are derived from *Provisional Hospital Authority Report* and Hospital Authority Annual Reports.

3. Source of dates: http://en.wikipedia.org/wiki/Governor_of_Hong_Kong (Accessed 30 June 2007).

4. Source of dates: http://en.wikipedia.org/wiki/Chief_Executive_of_Hong_Kong (Accessed 30 June 2007).

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9. Source: WHO (October 28, 2005). H5N1 avian influenza: timeline. Available: http://who.int?csr/disease/avian_influenza/Timeline_28_10a.pdf (Accessed 30 June 2007).

What has happened in the Hong Kong health care reform journey? What may one learn from the experience? What should be the way forward?

Infrastructure reform

1985 – The Coopers and Lybrand – WD Scott report

The first recent health system reform study in Hong Kong was initiated in the early 1980s when the government commissioned Coopers and Lybrand and WD Scott to review and propose a way forward for the medical services delivery in public hospitals. The review came at a time when the management and conditions in public hospitals were not meeting public expectations and standards.

The outcome and recommendations of the review were reported in *The delivery of medical services in hospitals: December 1985*. [5] The report led to the appointment of the Provisional Hospital Authority in October 1988. It was to plan for the formation and set out the reform agenda of the Hospital Authority. The outcome of their work, published in December 1989 in the *Report of the Provisional Hospital Authority*, [6] helped jumpstart the Hospital Authority.

1990 – Health for all: the way forward

In the 1970s, the World Health Organisation identified the significant role primary health care can play in improving the health of individuals and communities. [7] To show its commitment to primary health care, the Hong Kong government appointed a working party in 1990 to review the provision of such care.

The Working Party on Primary Health Care released its report, entitled *Health for all: the way forward*, [8] at the end of 1990.

A key recommendation was the formation of a statutory Primary Health Care Authority, with the Department of Health as its executive arm, to oversee the delivery of primary health care.

The report identified the objectives of primary health care as the provision of preventive and continuing, comprehensive and whole person medical care. The government adopted most of the recommendations that were directed at improving the Department of Health internally [9]. The recommendation of setting up the Primary Health Care Authority was largely ignored because the Hospital Authority was just formed and adding another statutory body would be untimely.

1990 – Hospital Authority

The Hospital Authority was formed on 1 December 1990. It was a statutory body charged to transform the management of the public hospital system and to improve its efficiency and quality. It was a not a reform of the entire health system.

The Hospital Authority reform results during the initial years were impressive. The new leadership brought enthusiasm into the management of public hospitals. Quality patient care and teamwork became the ethos of the public hospital system. Community support was also high. Fueled by nominal charges for even the most sophisticated care, patient volumes increased drastically. Four years after the reform took place, the Hospital Authority's patient volumes began rising rapidly (see Figure 2). By the end of the seventh year, the volumes increased by 40 percent in inpatients and 200 percent in outpatient attendances. Growth continued in ensuing years, even after intensive internal

cost control measures and despite reduced funding from the Government. The volumes reached peak levels around 2002-03 (see Figure 3).

Ten years after its formation, the Hospital Authority had to face reduced budgets and several years of funding constraints. It introduced drastic cost reduction and budget tightening measures. In 2003, the SARS outbreak further stressed the organisation. Volumes began dropping and reached all time lows in the Hospital Authority's history (the general outpatient attendances increased rapidly because of the transfer of the management of the general outpatient clinics from the Department of Health to the Hospital Authority in 2002-03). Today, except for the accident and emergency attendances, specialist outpatient attendances, inpatient discharges and patient days have yet to regain volumes at par with past peak levels.

The residual patient volumes were still huge. This raised concerns about the sustainability of the public hospital system. Some worried that the Hospital Authority might become a 'victim of its own success' [10, 11] as units that served patients well would attract more patients and become overloaded or even collapse over time. The Hong Kong Consumer Council also commented that 'improvement in the quality of Hospital Authority services diminishes allocative inefficiency to the extent that public resources are drawn away from public health services and become less targeted on those who cannot afford to pay'. [12]

As financial constraints progressed, the board and management turned inward looking. The centre pulled back the power and authority of hospital chief executives to enhance efficiency in decision-making. It shifted

Figure 2: Utilisation of Hospital Authority Services, 1989-90 to 1998-99
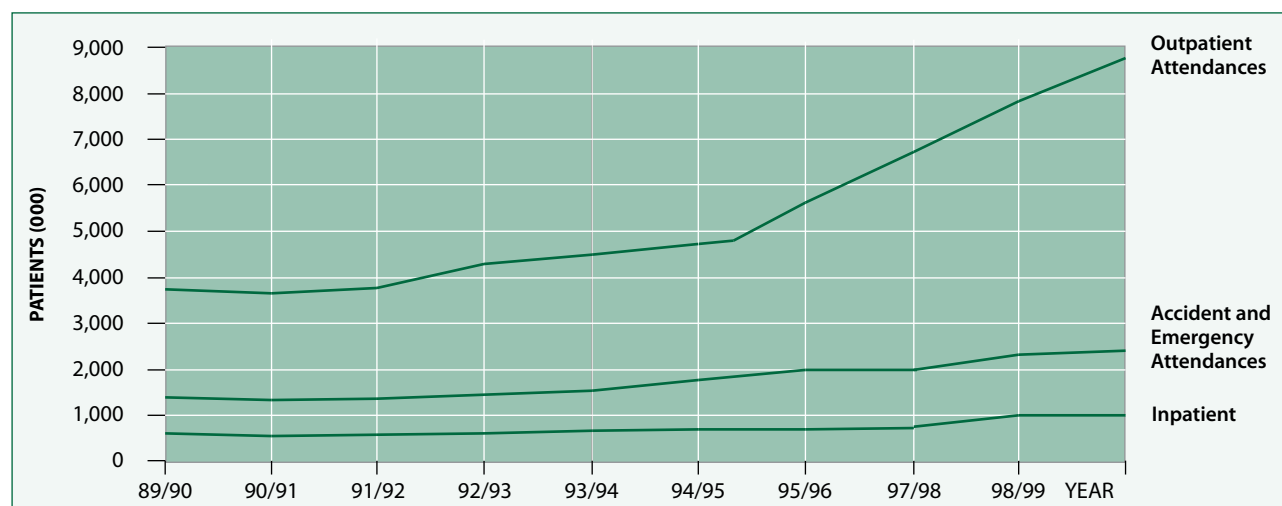
Source: Hospital Authority Annual Plan 1999-2000.

Figure 3: Utilisation of Hospital Authority services, 1997-98 to 2006-07
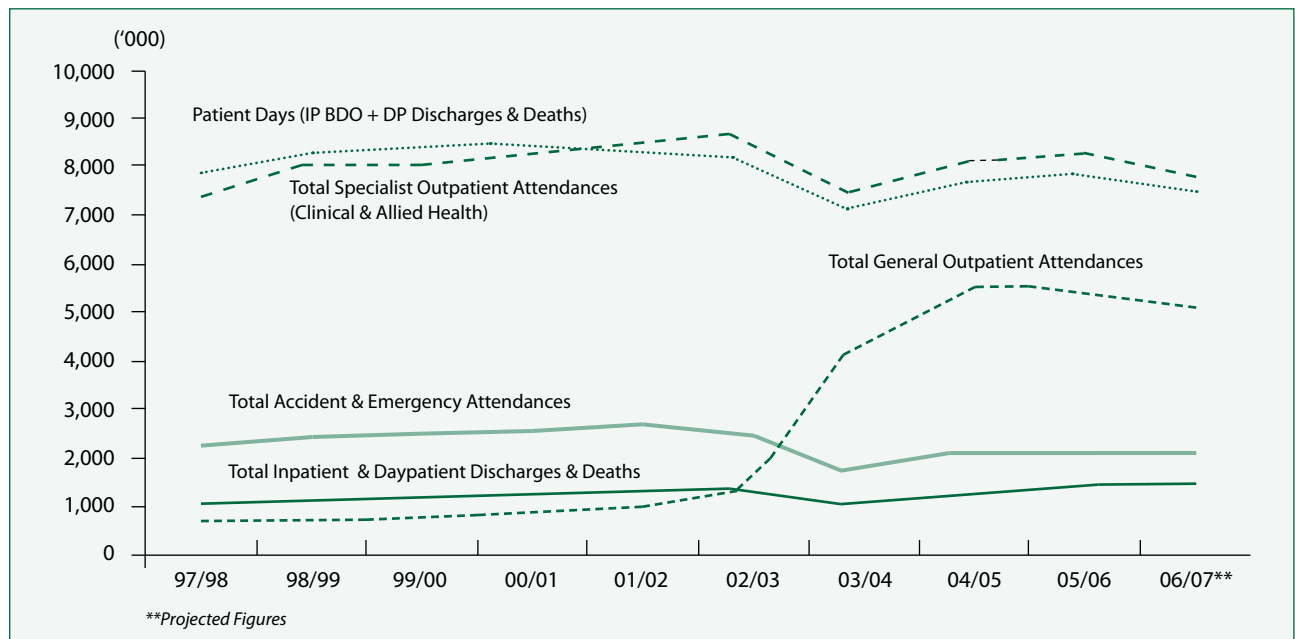
Source: Hospital Authority Annual Plan 2007-08.

individual budgets and control responsibilities to the cluster infrastructure. Money flowed from the head office to the cluster and then to individual hospitals through the cluster chief executives.

Financing reform

1993 – Towards better health

The first financing proposal came in 1993, shortly after the Hospital Authority began transforming the management of public hospitals. In the consultation document titled *Towards better health*, [13] the government highlighted the need to reform the health system and identified five options as possible remedies: fee charging; targeted subsidy; coordinated voluntary and compulsory insurance schemes; and funding treatment according to priority of need.

At the time, the economy was doing well. There was no sign of any urgent financial need. In addition, the Hospital Authority's reform had brought some impressive improvements in public hospitals. Paying more for what was already good was not appealing. As a result, the status quo was upheld.

1997 – Improving Hong Kong's health care system: why and for whom?

In November 1997, with a new Secretary for Health and Welfare in place, the Government commissioned the School of Public Health at Harvard University to again review the Hong Kong health system and propose alternative options

to improve the financing and delivery of health care. In the report, entitled *Improving Hong Kong's health care system: why and for whom?* [14] and released in early 1999, the Harvard Team was highly critical of the Hong Kong health system and questioned the long-term sustainability of the current mode of health care financing. The Team proposed a number of financing options and recommended: (a) a compulsory health insurance (the Health Security Plan) that was essentially social health insurance; (b) a savings and insurance scheme for long-term care; and (c) the breaking up of the Hospital Authority into twelve to eighteen regionally based 'Health Integrated Systems'.

The *Harvard report's* radical proposals were extensively debated but not well received. They encountered strong opposition from the medical fraternity, including the Hospital Authority which felt uneasy about the break-up proposal. There was also little support for compulsory health insurance. Results of surveys of the general public showed that less than 24 percent of those surveyed supported compulsory health insurance. [15] In the end, the study was shelved.

2000 – Lifelong investment in health

In December 2000, eighteen months after the release of the *Harvard report*, the Government made another run at addressing the future health care financing and delivery issue. With another new Secretary for Health and Welfare

(whose portfolio later expanded and was, hence, designated as Secretary for Health, Welfare and Food), the government took into consideration comments received from the public on the Harvard Team's proposals and set out its recommendations in a new consultation document – *Lifelong investment in health* [16] – that covered: (a) organisation and provision of health services; (b) mechanisms for assuring quality of care; and (c) long-term financing for health care services that included targeting public subsidies to those in need and setting up of individual Health Protection Accounts to assist patients paying for their own medical services after retirement.

Most notable of the proposals was the Health Protection Account, a medical savings scheme. It would require working persons between age 40 and 64 to contribute one to two percent of their earnings to a personal account for the individual and spouse to be used to pay for health services in public hospitals or to purchase medical and dental insurance after age 65.

The proposed scheme was not supported by the public or key stakeholders: low income persons opposed it on the grounds that the scheme would further reduce their take home pay; and the middle class and higher income groups felt that they were asked to contribute, on the top of their regular tax contributions, to a system without any promise of getting better service or more choice in return. Some also criticised the meagre amounts of earnings contribution to the medical savings accounts as it would have little meaningful impact on the overall financing of health care. [15] Like previous proposals, no action was taken on any of the recommendations except the recognition of the need to conduct further studies on the feasibility of the medical savings account concept. [17]

2004 – A study on health care financing and feasibility of a medical savings scheme in Hong Kong

As follow-up to the *Lifelong investment in health* proposal, the government conducted a study to assess the feasibility and to recommend a way forward to establishing Health Protection Accounts in Hong Kong. [18] The study concluded that it would be feasible to introduce a medical savings scheme in Hong Kong, although implementing such a scheme in times of economic difficulties should be avoided.

The study was not a consultation paper. Its objective was to clarify a number of issues concerning medical savings accounts. But as such, one might question why this study was not conducted and issues addressed before the release of the consultation document *Lifelong investment in health*.

2005 – Building a healthy tomorrow

On 15 July 2005, the Government, through yet another Secretary for Health, Welfare and Food (whose port folio changed on 1 July 2007 to include only food and health and was thus re-designated Secretary for Food and Health) and in conjunction with a reconstituted Health and Medical Development Advisory Committee, issued a discussion paper, *Building a healthy tomorrow*, [19] describing the future service delivery model for Hong Kong. The model re-emphasised primary health care and the role of family doctor. It suggested that the role of the public health care sector be redefined to focus on: (a) acute and emergency services; (b) services for the low income groups; (c) catastrophic illnesses; and (d) training of health care professionals. There was no specific mention of the financing of this new model as that would be the topic of a future discussion paper.

The intent of this paper was to stimulate discussion in the community. Comments received during the public consultation period would be used to modify the future delivery model and help formulate the future financing strategy. The comments received indicated some felt that the current system was functioning well and should not be changed. Others thought the paper did not provide adequate data to justify a case for reform. Public reactions seemed to suggest a preference for incremental changes to the status quo while preserving the present tax-based financing system as the major source of health care financing. [20]

Lessons learned so far

Hong Kong's recent journey of health care reform has been narrowly focused on the reform of public hospitals. Little progress has been made in other areas. In particular, no end is in sight for the financing reforms. What had or had not happened?

The forward and backward moves of public hospital transformation

The first ten years of the Hospital Authority were marked by impressive gains in both organisational performance and responsiveness. This could be attributable to the powerful leading coalition of the Hospital Authority at that time. Leadership was strong and effective. It had a clear vision and direction for the Hospital Authority and expected high standards of performance. It ensured that a high degree of devolution of decision-making was practised. Management style emphasised quality, participatory management and teamwork. The organisation responded with improved efficiency, better quality and enhanced productivity.

The persistence of moving forward as a corporatised system weakened over time. Accelerated by financial and budgetary constraints, management style became centralised, top-down and directive. The situation resembles, to some degree, what existed before the Hospital Authority was formed some 17 years ago. In fact, in one of the World Bank's publications, it classified Hong Kong's management transformation in public hospitals as a case of *autonomisation, not corporatisation*. [21,22] In autonomised systems, managerial autonomy is diminished to the extent that managers no longer have complete control over all inputs and issues related to service delivery and the system operates under the government's direct oversight and influence.

The outcome of the public hospital reform has never been systematically reviewed. While general improvements have been made, some have accused the Hospital Authority of trying to crowd out the private sector. [23] Others felt that the public sector's over-dominance contributed to the exodus of patients from the private sector and created a shrinking level playing field for private sector providers. To move forward, there ought to be an overarching review of the performance and role of the public health care sector and a clear vision and strategy of how it should move forward in order to be a performing and responsive system.

The failed reform attempts

Since the formation of the Hospital Authority, none of the initiatives on further reforms has been able to move beyond the proposal presentation or consultation stage. The unsuccessful attempts may be attributable to one or more of the following factors:

- rationale for reform not fully convincing;
- reform agenda not fully aligned with societal values and public expectations;
- design approach and perspectives not balanced;
- public and key stakeholder engagement not inclusive enough; and
- poor timing.

Rationale for reform

All of the proposals highlighted the need for new health care financing strategies in light of some or all of the following reasons:

- a rapidly ageing population;
- early onset of chronic illnesses;
- advent of new technology;
- over-reliance on the public health care sector;

- escalating health care costs ; and
- rising consumer expectations.

Some proposals also made explicit the serious consequences of non-action, including the magnitude of adverse financial impact on government if over-reliance on public sector services continued.

In the past, the public had not been fully convinced that reform was necessary due to the vague and distant nature of the issues raised. Also, few people had a full understanding of how the system worked and the pressures and burdens that patients, providers and the government faced. In addition, the assurance that 'no one should be prevented, through the lack of means, from obtaining adequate medical treatment', [24] a trademark of the Hong Kong health system, gave people a sense of security and the felt need or urgency to address future health care financing issues was not imminent. For some members of the public, the existing system works well and should be preserved and not tinkered with. [20]

Reform package

Past reform proposals advocated mechanisms that were generally unfamiliar to the public: compulsory health insurance in *Towards better health*, Health Security Plan (a type of social health insurance) in the *Harvard report*, and Health Protection Plan (a mandatory medical savings scheme) in *Lifelong investment in health*. How the proposed mechanism would affect individuals and society was not fully explained. The concept of 'money follows patient', introduced in the *Harvard report*, was unfamiliar to both users and providers. Both were uneasy about the possible consequences of such a market practice.

The reform proposals also contained elements that would require people, including employers, to contribute more, either in the form of higher co-payments or compulsory contribution for medical insurance or medical savings, to achieve the reform objectives. The public in general did not support the idea of contributing more and patient groups objected to paying higher charges to obtain care patients were currently receiving. [25] Some thought that the government should address existing inefficiencies in service delivery before pursuing the proposed financing reforms.

Enhancing choice was not a dominant feature in any of the reform proposals. Presently, Hong Kong only offers either low out-of-pocket payment services of the public sector or the high fee services of the private sector. For a highly pluralistic society such as Hong Kong, the reform packages offered should optimise choice for patients.

Design approach and perspective

Past reform initiatives seemed to have taken a top-down technocratic approach in developing the reform proposals (see Figure 4). Involvement of the public and key stakeholders was limited. For example, it was argued that *Lifelong Investment in Health* was a:

> . . . top-down approach that focuses on individual responsibility rather than empowerment and in which the government and medicine define the problem rather than the 'community'. This is an approach in which the same power groups determine service delivery and resource allocation in ways that do not respond to community needs, in which community control is low and evaluation of risk factors, quantifiable outcomes and targets predominates. [10]

Moreover, the proposals appeared to have also adopted a short-term and inward looking perspective in problem identification and strategy design. The focus on services delivery was hospital-based. Proposed solutions were mostly directed at solving immediate or short-term problems rather than addressing long-term and system-wide needs. [9] Important long-term issues, such as the potential of developing health care as a strategic industry and the portability of medical benefits for the increasing numbers of Hong Kong residents seeking to reside or retire in the Mainland, were left unaddressed.

The development of proposals should have taken a balanced and inclusive approach, involving more of a participatory and bottom-up approach with a strategic, community-based and outward looking perspective. If this had been adopted, the solutions proposed would have had stronger democratic legitimacy and a greater probability of gaining public and key stakeholder support for action.

Public and key stakeholder engagement

Health policy differs from other policies in at least three unique aspects: [25]

- The medical profession has dominant roles of shaping and constraining health policy;

- The public has little understanding of the complexity of the health system and is unable to judge the quality of service; and

- The nature of decision-making in relation to health is unique.

Accordingly, early and full involvement of both the public and the medical profession throughout the policy formulation and public engagement stages are critical to enhance awareness and understanding, gain public acceptance and support, and, ultimately, engage their commitment to reform.

Unfortunately, past reform initiatives seemed to involve the public and key stakeholders extensively only after the

Figure 4: Hong Kong's health system and policy development approaches.
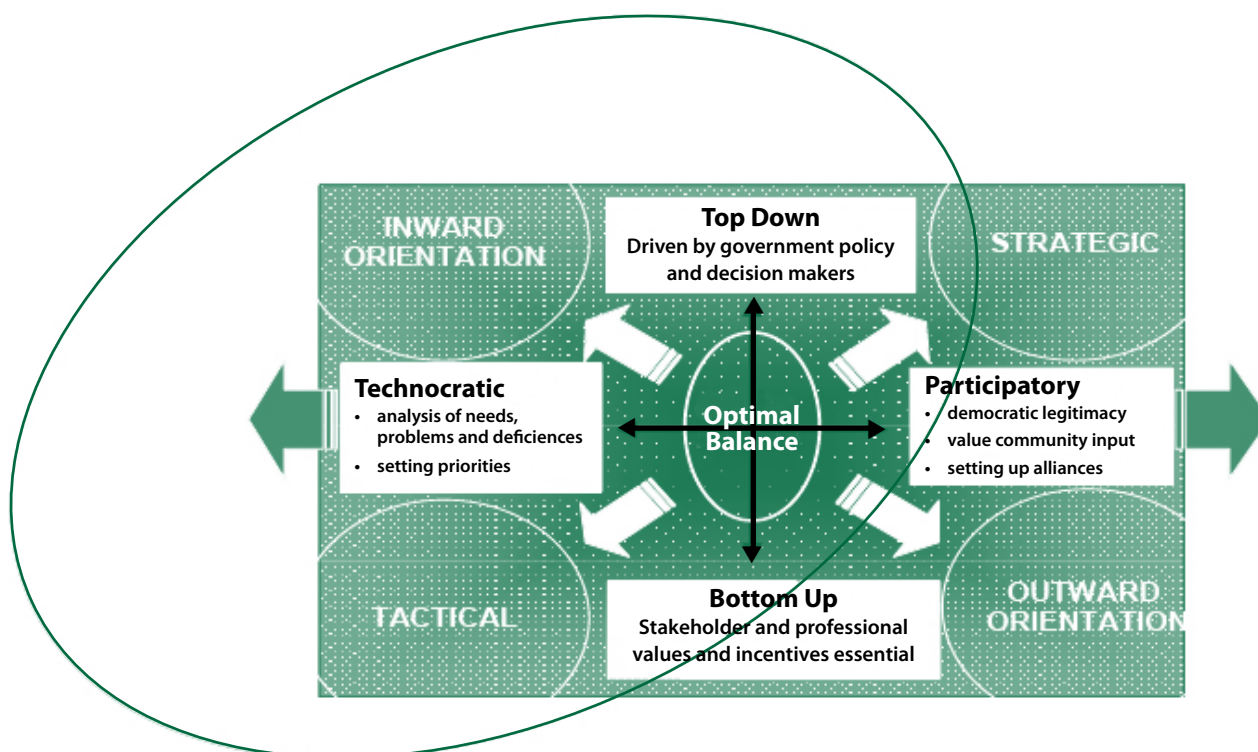
proposals had been released. The consultation period was usually short, inadequate to promoting meaningful and productive dialogues. As a result, the public and key stakeholders tend to view the proposals negatively and take a confrontational stance as the response.

Timing

Timing can have a significant impact on whether or not or to what extent reform initiatives are able to move from strategy to action. Critical events happening in society can also influence people's sense of need and urgency for reform.

For example, the *Coopers and Lybrand–WD Scott report* in 1985 came at a time when public hospital services were deteriorating and performing poorly in addressing growing patient demand, rising community expectations and lowering staff morale. There was a sense of need and urgency to do something. The government pushed to implement the proposed changes and the Hospital Authority was formed later.

The rest of the reform proposals encountered a less fortunate timing. They were unable to command adequate support towards action probably because of one or both of the following factors:

• events in the health system make major change undesirable; and

• the political circumstances and influences of key stakeholders halted further discussion and caused the proposals to be shelved.

The first factor was the case for the *Health for all* and *Towards better health* reports. These two reform proposals came out when the public hospital reform and the Hospital Authority performance were the centre of attention. As the Hospital Authority was making steadfast improvements, it would have been inappropriate to divert attention from the Hospital Authority or to overload the existing system with new initiatives.

The second factor probably explains the shelving of the *Harvard report* and the *Lifelong investment in health report*. The *Harvard report* was released in April 1999 as the economy was still trying to recover from the Asian financial crisis. The public saw the contribution to the proposed Health Security Plan, a mandatory social health insurance scheme, as a tax in disguise and thus rejected the proposal. [17]

Follow-up on the *Lifelong investment in health* report ran into 2003: the year of the SARS outbreak and the mass protest in response to the anti-subversive legislation and the general discontent towards the Hong Kong government.

These events made planned reform near impossible. Public attention was fixated at holding public officials accountable for inadequate performance during the SARS epidemic. This led to the resignation of the Health Secretary and Hospital Authority chairman and effectively put an end to any further consideration of the proposal.

Conclusions

The financing and delivery of health care have been on Hong Kong's political agenda since the mid 1980s. Yet, the various proposals have not formed a coherent reform strategy with purposeful interventions. They came across as disjointed reviews and deliberations, leading to no acceptable strategic outcome or action. While the management of public hospitals has been put on the path to reform, its narrow focus on addressing the public hospitals' inefficiencies, rigidity and the lack of management expertise at the time has left the rest of the system largely unchanged.

More should have been done in articulating the need and urgency for reform. The vision of the future health system should have been more complete and compelling. Had the design approach and perspective been more balanced, (see Figure 4) support for change might have been stronger and advancement to action quicker.

In addition, there should have been an early and inclusive engagement of the community and key stakeholders to solicit their input and support and to build a strong coalition to help drive the reform initiatives. Had this been done, perhaps the reaction to the proposals would have been affected less by the uncontrollable influences of circumstances and by the public reaction at the time.

The way forward

Four learning points extracted from Hong Kong's experience may serve as useful guides for future reform initiatives:

• Responses to past reform proposals suggest that the public and key stakeholders did not see the urgency or rationale for change. As health care delivery and health system reforms are complex issues that are not easy for the layman to comprehend, a *compelling vision* with overarching goals should be articulated and developed through a broadly participatory process to propel the needed sense of urgency for change. By reflecting societal values and people's expectations and concerns, the criteria for determining what is preferred for Hong Kong's future health care should be readily discernible.

• A unique strength of the Hong Kong health system is the policy that 'no one should be prevented, through the lack

of means, from obtaining adequate medical treatment'. This policy offers a *safety net* not only for the needy but also the middle class who cannot afford private sector fees and charges. Past financing reform proposals had left the impression that the public would be worse off in the future. For example, it would cost more for equal care and service. Therefore, the design of the reform package must include the safety net provision and make explicit what it will cover. In addition, the reform outcome must ensure that no one will lose out in the end. It should perhaps follow the concept of Pareto improvement or Pareto optimisation [26, 27] in that no one is worse off even if someone is better off.

- Hong Kong values the freedom to choose. However, options are limited. The current low out-of-pocket payment for public sector services and high fees in the private sector services are the only choices. Those who do not want public sector service but cannot afford the high prices in the private sector are left with few options. As a highly pluralistic society, *choice* should be a dominant feature of Hong Kong's future health reform packages.

- There should be a *strong coalition* to lead the reform from strategy to action and to serve as steward of the system while undergoing reform. Future reform strategies should be purposeful and coherent, making effective and efficient use of available expertise, efforts and resources. A powerful coalition in the form of either a health commission or any designated body of the government should be appointed. It should be charged to develop a clear vision for the future and to oversee the implementation of the reform agenda with broad and inclusive participation of the community and key stakeholders.

Hong Kong's past reform journey has been long and winding. But the health system can do more and better. With a re-elected chief executive and the new cabinet in place for the next five years, Hong Kong is better positioned than ever to act proactively and inclusively, engaging the public and key stakeholders early and throughout the process, to design and build a more responsive and performing health system of the future.

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The Australian Commission on Safety and Quality in Health Care Agenda for Improvement and Implementation

M O'Rourke

Abstract

Health care systems around the world have well documented concerns about their safety and quality. In Australia, concerns expressed have included lack of data on effectiveness of improvement interventions, inadequate measurement and reporting on quality and insufficient application of existing knowledge to influence and improve quality of care. The new Australian Commission on Safety and Quality in Health Care is intended to address these concerns by focussing national action to improve quality of care and safety. This paper reviews current national and international literature and outlines the Commission's planned work on collaboration, governance, agreed goals and more effective use of information, based on research and consultation with key players in the safety and quality arena. Its conclusion is that the Commission, as a national coordinating body, is potentially positioned to address necessary overall system improvement, but needs to carefully consider priority action areas. Monitoring and assessment of its activities will indicate the success of this systematic approach.

Abbreviations: ACSQHC – Australian Commission on Safety and Quality in Health Care; IJC – Inter Jurisdictional Committee; QAHC – Quality in Australian Health Care.

Key words: safety; quality; national approaches.

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Introduction

Numerous studies have indicated deficiencies in the quality of care provided in health systems in developed countries. The Quality in Australian Health Care (QAHC) study [1] reported that around 16% of hospital patients experienced an adverse event, subsequently estimated at around 10% on re-analysis to allow direct comparison with studies from other countries. This figure is consistent with findings from research in the United Kingdom, Canada, Denmark and New Zealand. [2,3,4,5] Around half of the adverse events identified in the studies were considered to be preventable, indicating significant systemic problems in the delivery and management of care.

Recently, a landmark United States study, the Community Quality Index study, assessed the extent to which recommended care and treatment was provided and found that, irrespective of gender, race, socioeconomic status or geography, patients across a broad range of clinical areas received only around half of the recommended care for their specific acute and chronic conditions. [6,7,8] There is no reason to expect that the situation in Australia would be significantly better.

These studies highlight the systemic nature of the safety and quality problems in health care and the need for system-wide approaches. This paper reviews differential approaches to safety and quality to date in Australian health care; identifies continuing barriers to improvement; and considers the potential of the latest national body, the Australian Commission on Safety and Quality in Health Care (ACSQHC), to impact on safety and quality improvement across the health care spectrum.

This paper is based on extensive review of the international literature on governance in safety and quality (some fifty articles reviewed, with major relevant papers outlined as

references); on interviews and discussions with leading players in the quality arena in Australia (including the ACSQHC, accreditation agencies, private health care organisations and not-for-profit bodies like the Australian Patient Safety Foundation); and on research being undertaken on priority approaches for safety and quality in Australia.

Barriers to progress in safety and quality in health care

The QAHC study stunned the health care establishment in Australia. The political response was to establish a Taskforce – the 1996 Taskforce on Quality in Australian Health Care – which made recommendations on standards for care, monitoring, and professional education to improve safety and quality, including classifying and reporting adverse events; clinical practice guides; use of safety report cards; and recertification programs for health professionals. [9] National actions flagged, *inter alia*, included increasing consumer participation; encouraging evidence-based clinical practice; investigating and uniformly reporting adverse events and near misses; and improving accreditation.

In 1999, health ministers in Australia created a national body to advise on and address the problems in safety and quality, and the Australian Council on Safety and Quality in Health Care (the Council) was formed in January 2000.

In many of the safety and quality areas identified prior to the establishment of the Council, some actions and implementation have occurred, but there is still little evaluation of effectiveness or outcome, [10] or sufficient information at a state or national level to determine whether any or all of the efforts over the past ten years have increased safety in Australian health care. This lack of evaluation is potentially problematic and, to many stakeholders, an unsatisfactory situation. A strong view among many stakeholders, and the author, is that regular assessment of safety and quality initiatives is necessary to determine overall progress and to inform future strategies.

Barriers to improvement have also been identified in other studies, including failure to successfully implement existing knowledge or policies; inadequate use of tested methods, leading to unfulfilled potential; [11] poor quality of data or indicators of performance; [12] lack of agreement on the most appropriate measures of patient safety; [13] and inadequate measurement through failure to invest in data and reporting systems. [12]

The nature of health systems has also been presented as a potential impediment to progress, with difficulties inherent in implementing systemic changes within a federated arrangement such as Australia's nine jurisdictions: the Australian Government and eight states and territories. [14]

Clinical variation is still evident between similar clinicians treating similar diseases in similar patients – so, best practice in health care does not always translate into widespread application. [14] Communication failure and barriers to teamwork continue to be major issues in safety and quality, and communication failures are particularly evident in the investigation of sentinel events. [15]

Similar barriers to improvement in safety and quality have also been identified internationally, as well as factors such as the complexity of modern health care, insufficient professional coordination and hierarchical authority structures. [13]

What is needed to improve Australian safety and quality – a round-up of ideas put forward

Various studies have suggested potential improvement strategies. For data systems and reporting, these include systematic measurement of quality and safety outcomes through research on adverse events, and national reports; [9] more judicious use of data to determine whether particular interventions or programs have improved safety; [10] and linked data for benchmarking and monitoring. [16] Other suggestions have included professional bodies, such as Colleges, introducing systems of performance reporting and quality improvement for members; [12] systems for identifying poorly performing individuals, units or hospitals; [16] engaging and training clinicians in quality improvement and use of measurement; [12] public reporting on performance to ensure public confidence and transparency; [17] and mandated measurement and reporting on safety and quality, rather than voluntary reporting systems which often underestimate problems and risks. [10]

For governance, a number of improvement strategies have been suggested including better leadership such as the 100,000 Lives Campaign in the US; [18,19,20] improved over-sighting to promote organisational and whole-system level change; [10] an overarching framework to ensure and monitor the safety and quality of Australian health services; [21] and more coordinated approaches in patient care. [16]

Other proposed safety and quality improvements include financing to provide incentives for safer care, for example through differential Medicare rebates offered for demonstrated superior care, and awards for systems that improve outcomes; [9] system reorganisation with new integrated structures linking local communities and

clinicians; [21] and enhanced education in teamwork and in-service training of health professionals to provide safety tools and methodologies. [9]

Reflecting the Australian debate, international assessment of what is needed to improve safety and quality systems includes a range of strategies covering national centres for patient safety; mandatory reporting of adverse events; legislation to promote patient safety; performance standards for licensing; and stronger enforcement of standards for the safer use of drugs. [22,23,24]

For most stakeholders in safety and quality in Australia, there is general agreement on the range of potential improvement strategies available. The salient issue is the extent to which overarching bodies like the Australian Commission on Safety and Quality in Health Care can effect appropriate change.

Safety and quality governance in Australia

The Council, created in 2000, raised the safety and quality focus in Australia. To continue to build on improvements instituted by the Council, Australian health ministers established a review [25,26] with the aim of implementing safety and quality practices more extensively. The review identified concerns in safety and quality governance such as the limited potential of oversighting bodies to implement change; a lack of structure and process for implementation; and lack of coordination and integration between agencies.

The review set out some important areas for improving safety and quality with key foci being regulation; accreditation; financing mechanisms for safety and quality; and appro-priate standards and guidelines.

As a result of this review, the Australian Commission on Safety and Quality in Health Care (the Commission) was established in early 2006 to lead and coordinate improvements in health care safety and quality; report publicly on safety and quality issues including performance and standards; develop national data sets; provide strategic advice on 'best practice' thinking to drive quality improvement; and recommend nationally agreed standards for safety and quality improvement.

Strategically, the Commission's aims are advocacy for safety and quality; engagement with the broader health system and the community; and raising awareness of quality issues.

A different focus for the Commission and a new coordinated direction in safety and quality

So, given acknowledgement of the various issues and concerns in safety and quality and potential strategies for improvement, how will the new Commission be able

to build on the work of the previous body and focus on implementation? From reviewing with stakeholders the range of barriers and problems and options available, some important lessons should already be clear to guide the Commission's priorities.

First, no one group or sector can achieve change on its own. Collaboration across the health care spectrum is vital to achieve system-wide improvement and a Commission priority needs to be building consensus on improvement directions. Previous safety and quality initiatives were largely focussed on public hospitals. The Commission's remit is now much broader and encompasses all settings of care, from public hospitals to primary care to the private sector. How the Commission extends safety and quality beyond the public sector will be closely scrutinised by stakeholders.

Next, clearly articulated and agreed national goals for improving safety and quality are essential. Safety and quality improvement needs openness and communication and an important area for a strategic body like the Commission is stimulating public and professional debate on quality issues. By reporting to health ministers, the Commission should be able to bring important safety and quality issues directly to key policy makers and to the broader public in Australia. A challenge for the Commission will be to identify and prioritise the most strategic safety and quality concerns that require such high level attention.

Another area is governance. Encouragement of corporate responsibility for patient safety and overall improvement across all jurisdictions will need to be a major objective for the Commission, as well as monitoring of local implementation to ensure compliance in different states and sectors. There is also a strong view that the regulatory framework for safety and quality in Australia can be simplified and made less complex and potentially more uniform across different jurisdictions.

Next, it is evident that there is a need for better use of information - both currently available and through new systems - to focus on health outcomes. The areas of data and reporting - within limits, to ensure efficacy but also to avoid information overload - will be pivotal for Commission work.

These are important underlying factors which will guide and influence the work of the Commission. A major task will be to incorporate these lessons into the Commission's immediate and medium term workplans.

The Commission has stressed consultation and involvement with all stakeholders, and an Inter Jurisdictional Committee

(IJC) with senior representatives from all states and territories has been established to help to ensure decisions on safety and quality in governmental contexts are implemented broadly and consistently across Australian health care settings. The IJC is probably one of the Commission's most important mechanisms as without effective implementation, there is considerable potential for improvement initiatives to be eroded.

The Commission is also setting up a number of stakeholder groups to bring together common interest groups such as consumers, health care professionals, health managers, private hospitals and health funds. The aim is to collect inputs from stakeholders on priority safety and quality areas and incorporate them into ongoing work as a means to ensure coordinated implementation. Engagement with stakeholders through this process, and other Commission initiatives, is intended to build common goals and strategies in Australian health care and to effect improvements which will continue beyond the life of the Commission. According to many consumer stakeholders, a strong emphasis on the consumer role in health policy development is long overdue, and the Commission's community and consumer interactions will be watched closely for discernible impact.

Another important element for a national coordinated approach is the development of a national framework to build on activities already underway in the quality arena, as well as signalling new directions and strategies for the future. An Australian National Framework for Safety and Quality, in the author's view, would assist in identifying barriers to optimal patient care across the spectrum of health care activities and in delineating key stakeholder action areas, responsibilities and emphases.

A number of strategic areas of focus, however, need to be reviewed and considered in developing the Framework, and the following points encompass elements that should guide a National Framework approach and potential Commission strategic directions:

- Identifying, implementing and measuring patient care improvements to impact on common preventable events such as health care-associated infections, medication errors and patient falls;

- strengthening the capacity of the health workforce in terms of safety and quality knowledge and practice through, ongoing training and evaluation of competencies;

- improving the use of information technology to focus on safety and quality through, for example, increased automation of clinical information and decision support tools;

- engaging consumers in the planning, design and operation of health services through more consultative mechanisms and broader engagement processes;

- restructuring systems and processes to focus more directly on safety and quality such as improved patient transfer and handover mechanisms and more systematic continuity and coordination of care;

- providing effective data, measurement and reporting for outcomes assessment through agreed core information and national data sets;

- encouraging governance responsibilities among clinicians, managers and funders through collaboration and concerted action; and

- creating greater consistency and simplification in the regulatory framework especially in the areas of accreditation, licensing, registration and credentialing.

These important areas for improving quality of care need to be expanded and outlined further with all major Australian health players as the Commission moves towards implementation. The Commission has focused initially on simplifying accreditation arrangements, and its consultation processes currently underway in this area will be an important pointer to future successful operations.

Conclusions

Improving safety and quality is a major task for Australian health care. Barriers to improvement include lack of coordination and implementation of existing policies and approaches; continuing deficits in data and reporting; lack of knowledge and awareness; and health system complexity as a rate limiter to progress.

The new Commission was established largely in acknowledgment of the need for improved coordination and integration of polices and strategies to effect sustainable improvement and for a central structure to facilitate implementation of safety and quality initiatives across all health settings in Australia.

This coordinating role of the Commission will be critical in progressing the safety and quality agenda in Australian health care. The Commission, through framework development and collaborative mechanisms, aims to engage and co-opt stakeholders to advance safety and quality principles and improvement models for broad application across the continuum of care. These are significant challenges.

The Commission's principal levers will be advocacy at the highest levels of Australian governments, encouragement of support for safety and quality research, public reporting on safety and quality, leadership in promoting policies and initiatives and building consensus for concerted action. These are important national initiatives and their efficacy remains to be tested.

At an important stage in international developments in safety and quality, Australia has a national coordinating body which is in a position to engage all sectors and stakeholders to work collaboratively for overall system improvement. Monitoring and assessment in the next few years will indicate the success and extent of this approach.

Acknowledgments

Competing interests

The author declares that he has no competing interests.

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Recognising and Enabling Clinician-led Quality Improvement Initiatives: the Spinal Pressure Care Clinic (SPCC)

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Abstract

Objective: This paper describes efforts to manage spinal cord injured patients with pressure areas through a complex multidisciplinary outpatient intervention that was implemented at two different hospital sites. The paper presents the achievements of this clinic-level organisational change project, which showed improved levels of efficiency and effectiveness at both sites.

Approach: The study measured staff activity, severity of condition, surgical intervention and in-hospital length of stay pertaining to two patient cohorts presenting at spinal units in two different Australian hospitals. Data were collected by the clinical team with the assistance of a database manager who reviewed the data collection process periodically and compared across sites. Data were stored within a computerised database.

Results: The intervention led to an 11% reduction in patient length of stay when first trialed and a 68% reduction in length of stay (off a lower baseline) when trialed in a second location. This type of pre-emptive outpatient therapy is now standard care for tertiary spinal services in New South Wales.

Conclusions: Despite clear evidence of practice improvement and clinician-initiated organisational improvements, local managers and funders/purchasers are constrained in providing resources to consolidate documented improvements. This case study highlights the need for building management and funder/purchaser capacity to respond to the organisational and resource implications of successful clinician-led quality improvement initiatives. If quality improvement is an imperative within the current Australian health care system, it needs to become possible for clinic-level achievements to be subsequently made sustainable.

Abbreviations: LOS – Length of Stay; SPCC – Spinal Pressure Care Clinic; SCI – Spinal Cord Injury.

Keywords: clinical practice improvement; organisational change; spinal rehabilitation; pressure areas; multidisciplinary clinical care.

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Introduction

With growing insight into the shortcomings of health care services around the world, [1-5] clinical practice improvement is increasingly regarded as an imperative that applies to clinicians across the board as a way of demonstrating lifelong learning. [6] The production of data about various aspects of clinical work is central to the demonstration of lifelong learning. Such data are seen as guarantor of regular scrutiny and improvement of practice. This perspective is

given special force with the dictum 'you can't manage what you can't measure'. [7]

On the other hand, Deming, who is often credited with this dictum, has made it known that he regards that which is not measurable as equally important for making management decisions. [8] Others too have raised questions about the 'reasonableness' that some assume to be engendered, as if by magic, by presentations of formal data. [9] One event that calls the above perspective into further doubt is the case of the 'Bristol Royal Infirmary Paediatric Surgery Department'. As Stephen Bolsin, Bristol Royal Infirmary anaesthetist at the time, and Mark Colson have noted, despite a wealth of surgery mortality data being available in the hospital between 1985 and 1996, little was done to address the high patient death rates. [10,11]

Bolsin and Colson argue that more effective systems need to be put in place to keep check on what clinicians do: 'there must be effective systems within hospitals to ensure that clinical performance is monitored'. They conclude on the need for 'a system of independent external surveillance to review patterns of performance over time and to identify good and failing performance'. [10] In favouring external surveillance, Bolsin and Colson place their faith in performance monitoring that involves not just peers, but health care managers as well. Indeed, their solution links general data production directly to inspectorial management.

Like Bolsin and Colson, we regard performance management as being overdue and critical. However, we caution against framing data review and performance monitoring activities only in terms of external surveillance and top-down monitoring. This is because it is likely to reduce the ability of clinicians at 'the coal face' to enact self-initiated organisational change, or 'to measure and manage'. In this paper, we present an empirical case study about a spinal outpatient service initiated within two metropolitan teaching hospitals, to support the argument that cross-professional monitoring of data should, in the first instance, satisfy another function; that of recognising and enabling health care practice improvement, initiated by practitioners at the unit-level.

Spinal Pressure Care Clinic, data and practice improvement

The Spinal Pressure Care Clinic (SPCC) that is used to empiricise this argument is a multidisciplinary outpatient intervention which manages clients presenting with pressure sores. It is part of the New South Wales State Spinal Service and was designed using 'post-bureaucratic' design

principles, [12] emphasising frontline staff involvement, initiative and enterprise. The clinic intervention bridges the hospital and community, facilitating inpatient and outpatient service delivery to occur in ways that allow alignment of overall treatment goals. In many cases it focuses on the importance of appropriate timing and location of interventions. An example of this concept is the clinic's aim of relocating traditional inpatient services such as aggressive nutritional supplementation and expensive pressure area care equipment prescription, traditionally only available within hospital situations, into the community sphere. This means people can benefit from these services prior to surgical procedures. The clinic also blurs hospital and community boundaries by commencing the post-hospital discharge process weeks or months prior to admission so post-operative destinations are explored and organised, well prior to surgical intervention. This in turn means that people arrive for designated surgical procedures in better condition with healing wounds and, post-procedure, have appropriate discharge destinations waiting for them.

Methods

A retrospective review of the past records of SCI patients admitted for pressure area operative care at hospital site A (SPCC I) from October 1998 to October 2000 was undertaken by two of the authors (Lee and Jones) in order to establish the average length of stay (LOS) for SCI-related pressure area care prior to the SPCC intervention. The subsequent LOS of SPCC I-assisted admissions was then compared to this baseline at site A. The duration of time allocated by each discipline to managing the patients prior to hospitalisation were collected by all staff members and recorded in a computerised database (units = minutes of intervention). The data were routinely audited by a clinician (Lee) and a database manager (Marial), and queries (clinical and data) cross-checked with team members.

During the period of the SPCC I intervention, those patients who were not admitted for a surgical procedure were considered to have been conservatively managed. The estimate of prevention of admission for pressure area care was derived from 'total procedures performed within the data collection period' compared to 'total patients managed within the period of June 2000 and December 2001' (where SPCC I non-selectively managed 47 patients within 53 episodes of care). It is possible that patients who were admitted outside of the data collection period could have re-presented subsequently to the centre or other centres for operative interventions, however this information were not available for inclusion in this paper.

A similar process was undertaken at site B (SPCC II), except the data of both SPCC II patients and non-SPCC II patients were collected prospectively from April 2003 until October 2006. Patients were non-selectively managed by SPCC II. However, emergency admissions without SPCC II prior involvement or those already admitted without SPCC II intervention were included in the comparison statistics.

The 'costs of cohort' figure was estimated via inpatient length of stay at both intervention sites. This was calculated assuming a bed day cost of $750 AUD per day. The total direct costs did not include the cost of surgical, equipment and community costs, nor indirect and societal costs such as time out of the work force and as such are likely to be an underestimate of true costs.

Data analysis

Between June 2000 and December 2001, 47 SPCC 1 non-selective patients were managed. Plastic surgical operations using the SPCC 'prehabilitation' protocol took place between December 2000 to December 2001. All patients undergoing surgery through the SPCC system suffered a Grade 4 pressure area, the most severe grade on our ranking system from the National Pressure Ulcer Advisory Panel Guidelines. [13] These patients' LOS fell to an average of 88 days, compared to 99 days for grade 4 pressure areas and 97 days for all grades between October 1998 and October 2000. These falls,

described in Figure 1, occurred since the SPCC's initiation in June 2000, with the expense of 234 hours of staff outpatient intervention.

These achievements contributed to 77% of SPCC intervention clients avoiding hospitalisation during the course of the clinic. The rise in efficiency comparing grade 4 pressure areas, the only type operated on during the SPCC intervention, was $8250 (11 inpatient days @ $750/day) per average admission for a SPCC assisted plastics procedure. Figure 2 describes the overall cost savings. Total efficiency savings for the 11 admitted patients was $91,000 for the course of the pilot with additional cost savings resulting from the prevention of admission in approximately four out of five referred patients. This is potentially the most significant impact from the SPCC intervention, from the perspectives of direct hospital cost savings and individual patient quality of life, and from a broader societal perspective of improved health care service provision.

The authors draw to the reader's attention that the rate of operative intervention and the costs involved reflects the follow-up period of the data, which extends only to patients admitted for procedures and their subsequent LOS at the time of closure of the clinic. This does not include patients who may have presented for procedures after clinic closure, nor those who may have presented to other centres for

Figure 1: Spinal Pressure Care Clinic: length of stay for spinal patients admitted with Grade 4 pressure areas pre-intervention (1998) and post-intervention (2000)
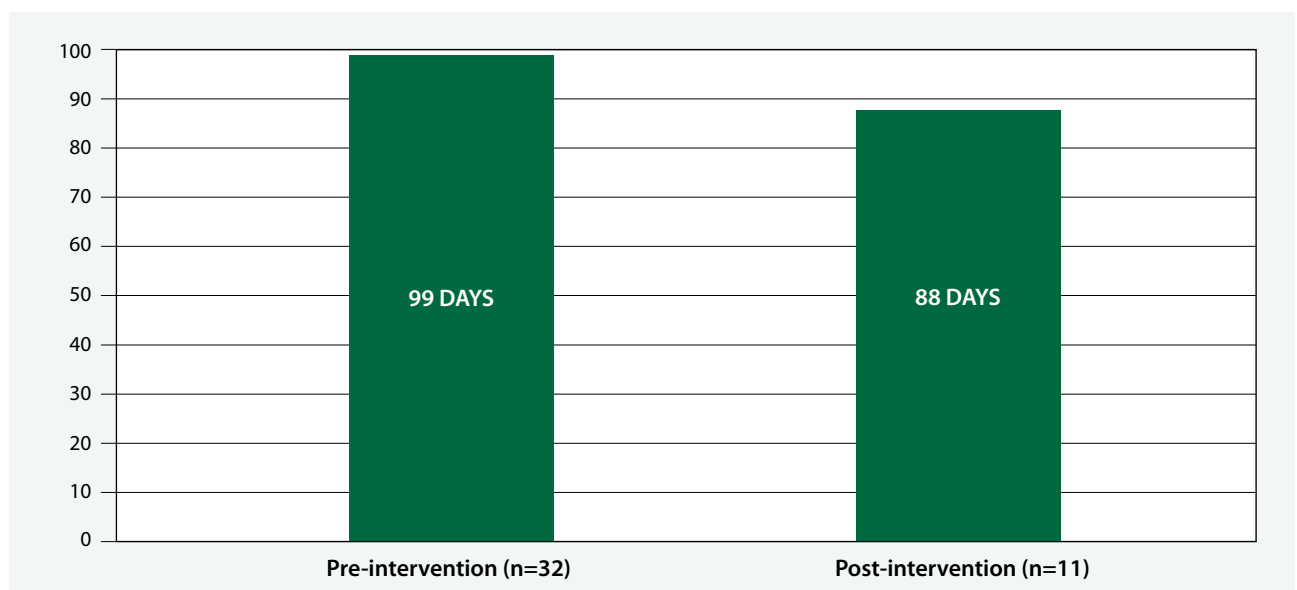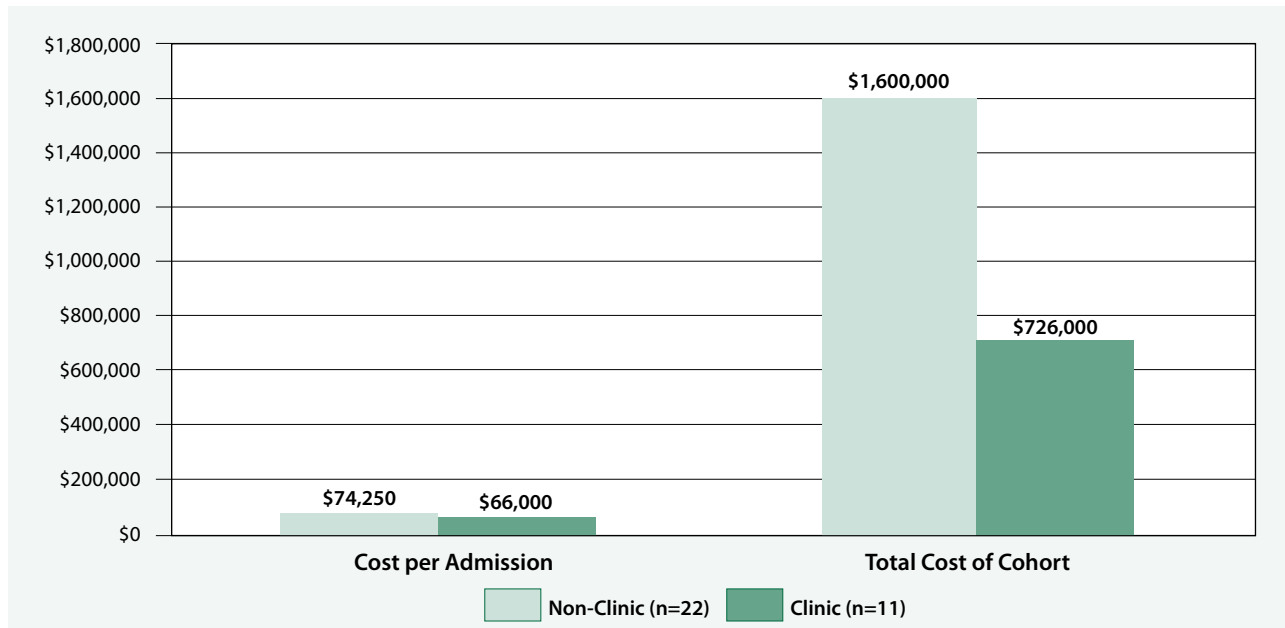
Figure 2: Cost per patient admission and total direct costs: pre-intervention (1998) and post-intervention (2000)

procedures, for whom linked health care data would have been required. It is possible that the actual number of patients who underwent operative procedures is higher than the figures available.

After two years of operation at hospital site A, the SPCC intervention was closed by the clinicians due to insufficient resources. The SPCC model was subsequently re-established in the spinal unit of another Sydney metropolitan hospital (SPCC II). Here, hospital data were gathered from all patients receiving surgery for pressure areas in this clinic between mid-2003 and late-2006, and compared to data of patients treated in the same period who underwent surgery for pressure areas without attending the SPCC II clinic. The average length of stay for non-clinic patients was 192 days, compared to 61 days for SPCC II patients (Figure 3). During SPCC II, state government funding, as opposed to local level funding was obtained. This enabled the employment of staff with prescribed clinical roles to operate the clinic which was previously done on top of routine clinical work. Meanwhile, the original hospital site of SPCC I reactivated the original clinic within a changed clinical structure.

Figure 3: Patient length of stay (days): Non-SPCC II patients compared with SPCC II patients, April 2003 - October 2006
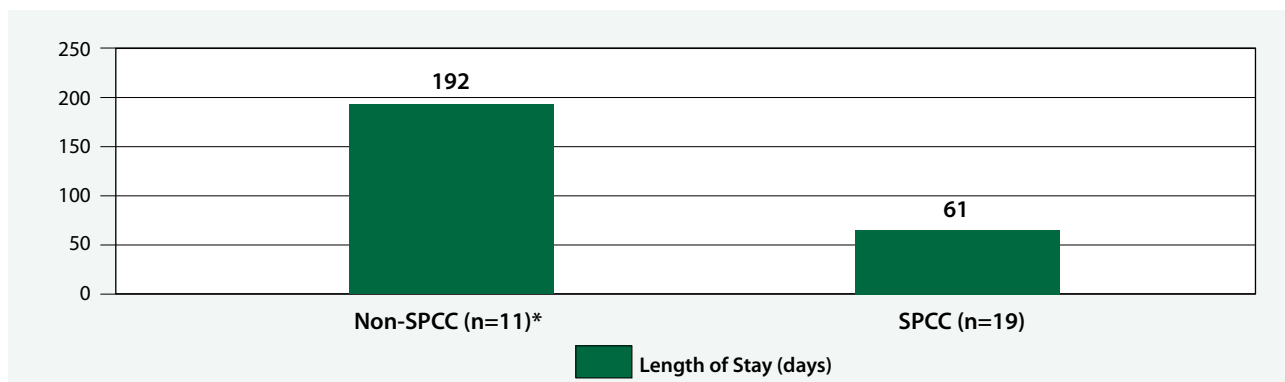
* These statistics do not include one person who died after presenting with pressure related sepsis in the non-SPCC group.

As described in Figure 4 below, non-clinic patients cost, on average, AUD$144,000 per procedural admission, whereas SPCC II patients cost a third of this (AUD $45,750; Figure 4). The data show that the eleven patients who did not go through the clinic cost the hospital a total of nearly 1.6 million dollars. The nineteen patients who went through SPCC II cost the hospital just over half of that.

Unfortunately, this does not reflect the actual flow-on costs on a hospital level where the effective centralisation of specialised care and complex procedures puts sustained pressure on scarce shared resources. This pressure on, for example, hospital beds and theatre time continues to create ongoing challenges to the attempt to improve clinical outcomes beyond the levels described. These constraints on effective and efficient delivery of clinical care are outlined in greater detail elsewhere. [14-16]

of spinal patients. Second, there were the inter-hospital links to ensure that spinal plastics rehabilitation was contextualised by effective pre-operative management of adverse risk factors. These included nutrition, infrastructure and equipment issues, mental/emotional state, appropriate pressure relief and wound care. Finally, there were the unit-internal links and communications that rendered the unit a model as a multi-disciplinary site. These processes took place with the support and cooperation of local nursing, medical, surgical and allied health clinical team leaders and with peer support workers. The simultaneous operations of these links and connections ensured that spinal care practice became a systemised, data-generating and performance-improving unit. [17-22]

The efficiency data cited must be read against the back-ground of a number of other factors that were organisational

Figure 4: Cost per patient admission (direct costs): SPCC II compared with non-SPCC II April 2003 to October 2006
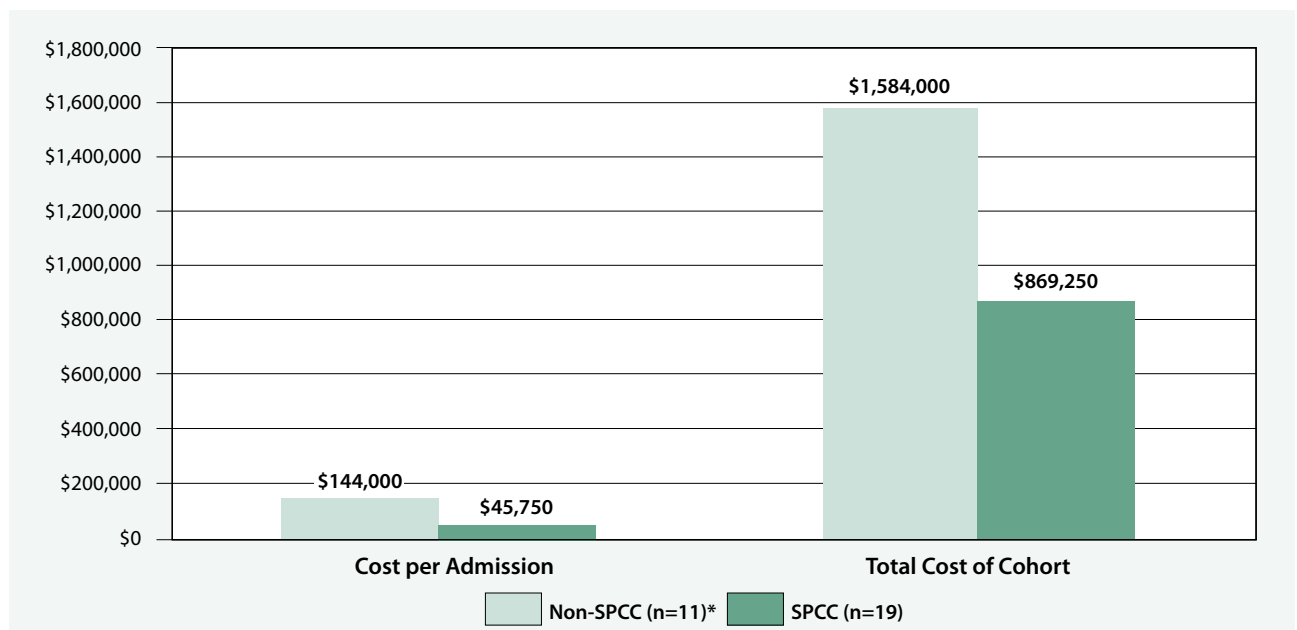
*The cost of one death in the non-SPCC group in a patient presenting with sepsis is not included in this analysis.

NOTE: 192 inpatient days (@ $750 per day) is approximately $144,000 per procedural admission compared to SPCC associated costs of (61 inpatient days @ $750 per day) of approximately $45,750 per procedural admission. The total direct costs of managing 11 patients NOT using the SPCC model was $1,600,000. The total direct cost of managing 19 SPCC model patients was $870,000. This cost does NOT include direct surgical, equipment, and community costs, nor indirect and societal costs such as time out of the workforce.

How were SPCC improvements achieved?

The SPCC achievements occurred against a background of a number of acute and non-acute service integrations. First, there were state-level links that the unit realised by establishing connections across metropolitan, rural and regional care centres that participated in the treatment

and socio-cultural. These are: flexible data management; communication sharing; standardised and multi-disciplinary patient assessment; 'manager management'; systemised care and 'enhanced responsibility and commitment of staff'. Each of these is briefly reviewed and their relationship to the achievements shown is clarified.

Contributing Factors

1. Flexible and reflective data management: Each patient was case managed by a medical and nursing team member. This provided a broad safety net whereby if an omission was made it was likely to be identified and rectified by someone within the team. Even if the omission went unrecognised by the case managers it would be picked up when data were collated. Because omissions or a lack of follow-up data were documented, the person collecting the data was able to take action and request the appropriate person to rectify the situation, thereby improving care outcomes.

2. Communication sharing: A pro-forma letter was designed to incorporate a section with general details (name/date/problem, etc), and which also allowed each clinician a place to record their interventions/recommendations. This prevented repetition within patient notes and saved time. It also enabled pertinent and current information to be dispersed to all group members. The resulting intimate knowledge that team members had of each SPCC patient enabled the team to determine the most opportune time to plan to admit patients. Admission priorities were not decided upon by any one team member but were collaborative decisions, with admission times expedited by the local nursing manager.

3. Standardised and multi-disciplinary patient assessment: The patients were assessed using a standardised pre-assessment form, which helped to identify which team members needed to be involved. Despite the standardising influence of the form, team members were not limited by their traditional clinical roles. The nursing role allowed nurses to comment on wound dressings (a nursing role), but also to identify seating and mattress issues (usually an occupational therapy role), and to initiate referrals autonomously if it was felt necessary (usually a medical role). This role flexibility exposed the unit's clinicians to practices of other disciplines which increases team effectiveness in multidisciplinary clinical teams. Certainly this was an important factor in the SPCC initiative, where its multidisciplinary approach led to a growing understanding of the roles of colleagues, and in some cases the acquisition of some additional basic skills. Team members were encouraged to discuss patient situations, often with the main modality being informal routes of information exchange reinforced with more formal meetings.

4. Managing the manager: Team members were encouraged to adopt 'manage the manager' relationships with community case managers and workers. This was because the unit identified its point of leverage as being the pre-admission phase. Technologies such as telephone, video-conferencing and digital photography were integrated into assessment protocols to allow this to occur.

5. Systemising care: Decisions regarding timing of surgery were reached by consensus between the surgical and rehabilitation teams. This took place when the patient's physical and nutritional conditioning were optimal, and where acute and potential discharge infrastructure and social issues were addressed, or were underway. Specific interventions to optimise wound condition prior to surgery, such as changes of dressings or negative pressure dressings (vacuum) therapy, were co-ordinated with the assistance of the orthopaedic and plastic surgery team. Where possible, a pre-admission contract was made between the patient, community services and the discharge destination, for resources to be available at the proposed discharge date.

6. Enhancing staff responsibility and commitment: [23] The staff in the unit were responsible for securing their own funding. Staff have had to interact directly with the division's business manager and provide a business plan in a relevant language, ie that of economics. This led to the use of effectiveness studies, cost estimates and tracking of relevant clinical outcomes. Every staff member in the clinic was made responsible in this way. This was because of the need to construct and justify business plans aiming to obtain state and area-based funding. This put additional pressure on the clinicians, and also had the danger of staff feeling that more human outcomes, such as quality of life, were not as well expressed in statistics and were being neglected. SPCC attempted to discuss these intangibles among the team as part of the total client equation.

In summary, systemising spinal care delivery centred on a multi-disciplinary and multi-site integration of the clinic's services. The work process integration of these aspects of the care involved creating 'a weave of commitments' that encompassed members of the SPCC unit, community personnel as well as specialists across different specialist areas. This weave of commitments was achieved on the basis of communicative and cooperative strategies described above which put the social context and interpersonal relationships among relevant staff centre-stage.

Discussion

The achievements of the SPCC I and SPCC II interventions and the clinic's managerial innovations might encourage the expectation that practice improvement of this calibre should attract attention and support. Due to ongoing resource constraints at both hospital sites, the clinics have, at various times, been dependent upon clinicians voluntarily working beyond their allocated clinical loads. The inability of SPCC I to garner support without the ructions of clinician-led disbandment and subsequent state-based funding applications, despite the evidence presented in the practice review data, puts paid to Bagian et al's [7] notion that explicit information has a natural and automatic purchase on managerial and bureaucratic decision-making. The question that this problem highlights is, how much practice improvement information is potentially ignored by funders because its content and implications challenge predetermined resource allocation decisions?

Messages about the need to improve the organisation of care have frequently not been heeded. [24] In fact, some notorious cases (eg, Bristol Royal Infirmary in Britain; King Edward Memorial Hospital in Perth, Australia) have highlighted how poor practices can become so taken for granted as to become unheard and invisible. Although increased managerial supervision and surveillance, more frequent monitoring and improved information technological support have all been cited or even imposed as solutions, none of these top-down methods have delivered on their promises. In the final analysis, the main source of improvement seems to be related not to intensity of surveillance and control, but to how clinicians who embody leadership, insight and enthusiasm structure their work processes and relationships. The SPCC study provides evidence to support this view.

We are led to conclude that data and data management cannot be divorced from the clinical practices that instantiate those data. Spiegelhalter and colleagues [11] state that had existing data been properly utilised, 'the divergent performance for Bristol might have been detected earlier'. These same authors also comment that such conclusions are ultimately contingent upon 'good quality data'. It is clear that the quality of data, their reliability and representativeness, cannot be dictated and controlled from above, and remain contingent upon a tight relationship with the processes from which they are abstracted. Put in different terms, clinicians' commitment to the data is crucial. The quality of data is likely to be compromised if their principal purpose is not to reveal to clinicians the outcomes of their own work, but to strengthen top-down monitoring and surveillance. As long

as clinicians do not and are not encouraged to engage with ways of representing their work that is both constructive and reflexive, they will see little reason to participate in producing and using data for any purpose, whether for improvement or monitoring.

It is possible at a local hospital level that there is a divergence between interventions which clinicians see as beneficial and those that hospital managers are able to support. There is not just the challenge of explaining to local managers that increasing near term operating and in-hospital costs and increasing the rate of through-put of surgical procedures will produce SPCC-like improvements and efficiencies. The real obstacle is established resource allocation practices within the system, preventing local managers from being more financially responsive and proactive.

In summary, the case study presented highlights the contradictions and dilemmas that are at the heart of complex care. Improvements and savings notwithstanding, there is limited motivation at the tertiary hospital level to actively attract large numbers of highly resourced intensive cases from outside local catchment areas, particularly if these cases have a reasonable chance of re-presentation for a variety of physical, functional, psychosocial and socioeconomic reasons. This barrier is a common one for high-level disability groups, and often makes co-management of these patients problematic, even when they are insured through and utilise private hospital alternatives. It is clear that improvement data of the kind presented here are but one facet of a complex set of relationships and practices.

Conclusion

An organisational focus on the clinical work is central to clinicians achieving the objectives of effectiveness, efficiency and quality of care. If improvement of existing practices is to become the norm in the way that the literature suggests it should, management agendas that focus principally on cost containment, and clinician agendas that focus principally on patient advocacy, will need to be aligned. [25] Explicit data explaining how specific resource expenditures achieve specific outcomes will need to be mobilised for clinicians and managers to be able to strike agreements about the objectives and direction of clinical practice improvement initiatives.

The onus now rests on clinicians to engage in self-management and lifelong learning [26] by becoming more oriented to producing and acting on clinical activity data. This should transmute into recognition on the part of managers that these attempts at improvement are unlikely

to remain untouched by resource implications. The case study presented in this article showed that when clinicians improve their practices, management is not necessarily in a position to act on their achievements.

An important part of clinical practice improvement, therefore, is building the health departmental capacity to respond to the organisational and resource implications of improvements in the efficiency, effectiveness and quality of specific care practices. Hospital funding needs to be flexible enough to reward and encourage care practices that reduce the burden of complex chronic illness prevalence on the community.

The spinal unit case study presented in this paper provides a model example of how local practices can be linked to information collection systems and improved qualitatively and financially in a 'bottom-up' way. To achieve lasting impact of clinical practice improvement initiatives requires the commitment of those who plan and can intervene in the allocation of health care resources as much as it does the clinicians who have initiated the improvement.

Competing interests

The authors declare that they have no competing interests.

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Patient Complaints in Dentistry: a Western Australian retrospective analysis – 1996-2004

V Lok, E Kruger, M Tennant

Abstract

Objectives: This study analyses the complaints databases from the Dental Board of Western Australia and the Office of Health Review, to highlight the extent and reasons for complaints made against dentists and the wider dental profession.

Design: A retrospective analysis of the records of complaints against all dental practitioners over an eight-year period received by the Office of Health Review (OHR) and the Dental Board of Western Australia.

Results: Data from the Dental Board indicated that complaints against dental practitioners by patients remained relatively consistent over the 8-year study period, and most complaints were related to treatment issues. Data from the OHR indicated that there were more complaints against dentists in the public sector; and the specialist categories that received most complaints included orthodontists, prosthodontists and endodontists. Complaints were made regarding: access, cost, decision making, grievance, information, administrative practice, illegal practice, privacy and treatment.

Conclusions: There was an initial increase in complaints between 1996/97 and 1997/98 reported in the OHR data. Both sets of data reported levels of complaints against dental providers as relatively stable during the study period. Consumer feedback, including complaints, must be an integral part of monitoring and improving the quality of health services.

Key words: patient complaints, dental malpractice, malpractice claims, Australia.

Abbreviations: ADA – Australian Dental Association; OHR – Office of Health Review.

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Introduction

A major concern in the health sector in recent times, is the increasing number of claims made by patients against health professionals. The most widely acknowledged example of this was the demise of insurance companies such as United Medical Protection in 2002, in what some authors have labeled as the 'medical litigation crisis'. [1] The flow-on effects of this have been detrimental resulting in increases in premiums, rising health costs due to 'defensive medicine' and the increased expense of litigation.

In the dental industry, complaints and litigation against dentists are on the rise in some overseas countries. [2-5] The reason for complaints against the dental profession made by patients is associated with many factors. Dental treatment involves the most sensitive areas of a patient's body, and patients often don't know whether dental treatment provided by their dentist is satisfactory or not. If a patient

relates well to his or her dentist, then he or she may assume that the dental treatment provided is good treatment. It is often factors other than the treatment itself which give rise to complaints. [6-8]

This study analyses the complaints databases from the Dental Board of Western Australia and the Office of Health Review (OHR) to highlight the extent and reasons for complaints made against dentists and the wider dental profession.

All state and territory legislation governing the regulation of dental practitioners describes the type of conduct that would either constitute unprofessional conduct or result in the cancellation or suspension of the registration of a dental practitioner. In terms of complaints against health care providers in general, all jurisdictions except South Australia possess health complaints legislation. [9]

The Dental Board of Western Australia is a statutory body, which deals with complaints against registered dental practitioners. It is empowered by the *Dental Act 1939* (WA) [10] that sets out the five grounds for which a dentist may be struck off the register and includes the ground of 'misconduct in a professional respect by reason of carelessness, incompetence, impropriety, infamous conduct, or a breach of the provisions of this Act'. [10]

In Western Australia, the OHR is a statutory body empowered by the *Health Services (Conciliation and Review) Act 1995* (WA). A complaint may be made to the OHR about any aspect of the treatment or care received by a person, irrespective of whether the complainant suffered injury as a result, within a one-year limitation period. The outcome of intervention by investigators of the OHR is likely to result in disciplinary action against the health provider where the finding is that professional misconduct or unprofessional conduct has arisen. Generally, if the complaint by the patient against the practitioner does not require costly and timely litigation, the complaint is usually resolved through the conciliation process conducted by conciliators at the relevant commissions. The conciliation process is advantageous as information disclosed during the process is privileged and cannot be used in civil proceedings. [11] However, although this information is privileged, the evidence of an independent expert witness can be used to provide similar information.

In addition to the above two statutory bodies, the Australian Dental Association (ADA) is a professional body formed by dental practitioners and it participates in the mediation and resolution of disputes prior to the commencement of litigation.

The dental workforce in Australia consists of general and specialist dentists providing general and specialist dental services; dental therapists providing most of the school dental services to school children; dental hygienists providing dental hygiene services; dental prosthetists providing dental prosthetic services; and dental technicians providing all dental technical services. At the time of writing Australians have access to universal health care coverage (Medicare), but Medicare excludes dental services. Access to public dental services is defined by special eligibility criteria administered by the Commonwealth agency, Centrelink. [12] This agency delivers a range of services to the community, including a Health Care Card, a Pensioner Concession Card and a Commonwealth Seniors Health Card for low-income earners and pensioners, which assist cardholders with the cost of medicines and other subsidies. [12] In Western Australia these cardholders are eligible for publicly-funded dental care.

Method

The Dental Board, OHR and ADA were all approached both by telephone and in writing, to provide data to enable an analysis of dental complaints for the purposes of this study.

Dental Board Annual Reports (1997 to 2004) were publicly available and from this source the following data were analysed:

- the number of registered dentists;
- number of inquiries conducted each year;
- the allegation regarding those inquiries;
- the decision of the Dental Board regarding those inquiries; and
- the number of formal complaints received by the Dental Board each year.

The Dental Board data only refer to complaints against dental practitioners including specialists.

The OHR provided an extensive database relating to dental complaints for the years 1996 to 2004 from which the following data were extracted:

- dental complaints for the year;
- number of complaints from private patients for the year;
- number of complaints from public patients for the year;
- the issues complained of by each complainant; and
- the outcome of the complaint.

The ADA was unable to provide information relating to dental complaints, and as such, no data from this source were analysed.

The databases from the Dental Board and from the OHR were analysed using Excel 2003 to enable identification of trends in complaints. A literature search revealed very little published data regarding patient complaints in dentistry in Australia. Ethics approval for this study was not sought as de-identified, mostly publicly-available data was utilised.

Results

Dental Board

According to the data from the Dental Board, the number of complaints against dentists per year has remained relatively stable, ranging from 24 to 37 (2.3 to 3.6 per 100 dentists) per year during the study period (1997 to 2004). During this period, the number of registered dentists per year has increased from 924 in 1997 to 1100 in 2004 (a 19% increase) (Table 1).

Not all formal complaints made to the Dental Board result in either an inquiry being conducted or counselling (Table 1). However, it is not clear from the Annual Reports whether a formal complaint that is lodged proceeds to inquiry in the same year. It is possible that inquiries held during a particular year originated from a formal complaint made some time before. It is, however, apparent that the number of formal complaints on a yearly basis, resulting in Dental Board conducted inquiries, are relatively few in number (Table 1).

The majority of complaints to the Dental Board are a result of treatment related issues. This has been the trend throughout 1997 to 2003.

Office of Health Review

The OHR provided extensive data from 1997 to 2004 regarding complaints against dental practitioners, dental specialists and other dental professionals that it had received during those years.

Dental-related complaints received by the OHR were much greater in number than the complaints received by the Dental Board. The reasons for more complaints being directed at the OHR include the fact that this is a more widely-known avenue for most health complaints, and complaints are not only directed at dental practitioners, but all dental care providers. The OHR and the Dental Board often liaise with each other upon receiving a complaint in relation to a dental practitioner. In most of the years during the period 1996 to 2004, more complaints were made by public patients being treated by government employed dental practitioners (Table 2).

Complaints against dental practitioners were the most numerous in the treatment categories of inadequate treatment, adverse outcomes of treatment and unskilful or incomplete treatment. Negligent treatment also attracted

Table 1: Western Australian Dental Board Data: complaints against registered dentists (including specialists); complaints resulting in inquiry/counselling; and complaints categories 1996/97-2003/04

	YEAR							
	1996/97	1997/98	1998/99	1999/00	2000/01	2001/02	2002/03	2003/04
Number of registered dentists (including specialists)	924	963	966	988	1027	1040	1076	1100
Complaints against registered dentists	29	26	27	35	24	37	26	29
Complaints per 100 dentists	3.1	2.7	2.8	3.5	2.3	3.6	2.4	2.6
Number of inquiries conducted	3	0	4	4	7	2	4	3
Insufficient evidence for inquiry	4	8	5	4	5	7	0	8
Proportion resulting in inquiry/ counselling	24%	31%	33%	23%	50%	24%	15%	38%
Complaint category:								
- Treatment	23	24	19	24	18	33	19	-*
- Non-treatment (eg advertising, business names)	2	2	8	11	6	4	5	-*
- Conduct unbecoming a professional	3	0	0	0	0	0	0	-*
- Dental act performed by prosthetist	1	0	0	0	0	0	2	-*

* Data not provided

Table 2: Office of Health Review data: complaints against dental providers, categories of complaints and resolution of these complaints for the financial years 1996/97-2003/04

		YEAR							
		1996/97	1997/98	1998/99	1999/00	2000/01	2001/02	2002/03	2003/04
Dental complaints:		49	123	131	155	137	146	170	167
Proportion public patients:		91%	89%	48%	52%	11%	70%	91%	74%
Complaint category:									
1. Treatment	Inadequate	9	13	45	62	55	38	66	69
	Adverse outcome	1	1	0	3	1	3	3	7
	Unskillful/incomplete	16	52	15	6	8	18	21	5
	Negligent	1	0	4	5	12	14	0	1
	Other	1	5	10	8	5	8	4	1
2. Cost	Inadequate information	3	11	6	3	7	8	23	14
	Overcharging	2	12	9	17	13	9	10	9
	Unsatisfactory billing	10	16	21	25	22	15	10	13
	Other	0	0	0	0	1	0	2	0
3. Privacy		1	6	5	2	1	2	4	19
4. Access		0	2	7	8	2	8	8	14
5. Information		2	1	6	7	4	12	10	9
6. Decision making		2	2	3	6	3	6	7	6
7. Others		1	2	0	3	3	5	2	0
Resolution of complaints:									
1. Enquiry only		30	78	74	101	80	81	135	111
2. Complaint not upheld		1	0	25	17	22	29	11	19
3. In favour of complainant		1	1	12	18	13	14	10	15
4. Partly in favour of complainant		1	1	9	10	9	8	8	11
5. Complaint withdrawn/lapsed		6	11	2	2	7	4	3	4
6. No further action warranted		4	8	0	0	0	0	0	1
7. Others		6	24	9	7	6	10	3	6

significant complaints in some years. The cost category provided the second most numerous complaints in the unsatisfactory billing, overcharging and the inadequate information categories (Table 2).

Enquiries to the OHR often did not result in a complaint (Table 2). If all enquiries to the OHR resulted in a formal complaint being made, then the figures for complaints against dental practitioners would be much higher. This may be due to the limitation period for complaints to the OHR, which is 12 months. Not all complaints were resolved. Of those complaints resolved, most were not upheld, or found mainly/completely in favour of the complainant (Table 2). A small number of complaints were referred to other bodies such as the Small Claims Tribunal and the Dental Board and were included in the 'Others' category.

Among dental providers, most complaints were against dentists, followed by the dental surgery itself (Table 3). Dental prosthetists also attracted consistent complaints from 1996 to 2004. Dental technicians and dental therapists attracted occasional complaints. Dental nurses and dental therapists, employed by dentists, are protected due to vicarious liability, and patients may target complaints against these individuals. Complaints against specialists were low, and most of these were against orthodontists, then prosthodontists, followed by endodontists. Oral surgeons, paedodontists and periodontists did not attract any complaints during the period 1996 to 2004 (Table 3). The number of complaints (except for a low number in 1996), has remained relatively stable (from the lowest 8.2 in 1997 to the highest 9.9 per 100 dentists in1999). The reason for the low number in 1996 is unknown.

Table 3: Office of Health Review data: number of consumer complaints, by dental provider categories

| | YEAR | | | | | | | |
	1996/97	1997/98	1998/99	1999/00	2000/01	2001/02	2002/03	2003/04
CATEGORY:								
Number of registered dentists								
(including specialists)	924	963	966	988	1027	1040	1076	1100
Dentists (not specialists)	33	71	86	95	75	83	89	80
Specialists: Orthodontists	3	2	4	1	10	6	3	9
Prosthodontists	0	3	1	1	5	1	5	4
Endodontists	0	3	3	1	0	2	5	0
Complaints per 100 dentists								
(including specialists)*	3.8	8.2	9.7	9.9	8.7	8.8	9.4	8.4
Dental prosthetist	1	1	3	5	6	5	6	1
Dental technician	0	3	1	0	0	0	0	1
Dental therapist	0	0	0	0	0	0	1	0
Dental surgery	12	22	33	52	41	49	60	72
Dental support service	0	18**	0	0	0	0	1	0
Total	49	123	131	155	137	146	170	167

* These reported complaints include the totals for all dentists including the specialist categories.

** Reason for high number of complaints in only year unknown. Dental support service include dental auxiliary staff

Discussion

Principal findings

In this study two data sets relating to complaints against dental professionals were analysed; one obtained from the Dental Board and the other from the Office of Health Review. Data from the Dental Board indicated that complaints against dental practitioners remained fairly consistent over the 8-year study period, and most complaints were related to treatment issues. Data from the OHR indicated that there were more complaints from patients eligible for public dental care, while specialities received low numbers of complaints. Complaints were made regarding: access, cost, decision making, grievance, information, administrative practice, illegal practice, privacy and treatment. This data (like that of the Dental Board) also confirmed that issues regarding treatment and the cost of treatment attracted the most complaints.

Main results with reference to other studies

Dental Board and OHR data indicated differences in complaint reporting rates for dentists. The OHR data consistently reported higher rates. Both data sets indicated relative stability in terms of the numbers of complaints over the 8-year period. This differs from overseas data which indicated increases in the numbers of complaints against dental practitioners. [2-5] The only Australian study available for comparison also indicated relative stability in complaint levels over a five year period. [13]

Most complaints in this study were related to treatment issues, and this is again consistent with previous data from the United Kingdom, Denmark, Turkey, Sweden and the Netherlands, [6-8, 14-16] as well as Victoria in Australia. [13] All the overseas studies indicated that complaints are mostly for reasons related to faulty management or performance of treatment. Reasons for complaints in these previous studies also included inadequate treatment; lack of informed consent; lack of care; unauthorised treatment; unsatisfactory technical/aesthetic quality; wrong diagnosis and costs. [6-8, 14-16] A study by Vermaire indicated that the main cause of most complaints against Dutch dentists was the lack of communication between the dentists and the patient, [6] and the Australian study reported more than one third of complaints related to the quality of work provided. [13]

This current study in Western Australia indicated that more complaints were received by patients eligible for public dental care, than by private patients. Patients eligible for public care mostly utilise public dental services, and the availability of these services is not as widespread as private dental services. Patients thus have less choice (or no choice

at all) when selecting a dental provider. This finding differed from a study in Victoria which indicated more complaints against dental care providers from the private sector. [13]

Previous Australian research indicated that users of public clinics recorded the lowest satisfaction scores regarding the dental treatment they received. [17] This previous study found that lower levels of satisfaction with dental care were reported by younger age groups (18-24 years) and health care cardholders who received their most recent dental care at a public clinic. Cardholders who received dental care in 1994 at a private clinic under the Commonwealth Dental Health Program reported considerably higher satisfaction scores. Other groups reporting lower levels of satisfaction include residents of rural and remote areas; and individuals born overseas compared with Australian born individuals. Satisfaction with the cost of dental care was lower in individuals who were uninsured cardholders or non-cardholders who received dental care from private practices. Individuals who were entitled to a healthcare card and were eligible for public-funded dental care but made a dental visit at their own expense to a private clinic reported low satisfaction scores in relation to cost. [17]

In the current study most complaints received were against general dental practitioners. Among specialists, most complaints were against orthodontists, prosthodontists and endodontists. Although this study indicated that treatment was most commonly complained about, it did not distinguish between the different types of dental treatment. International studies however, reported that in the Netherlands and Turkey, oral surgery, endodontics and prostodontics were most often complained about [6,8] and in Sweden and Denmark, prostodontics were the most commonly complained about discipline. [3,14]

In the current study most complaints ended up as inquiries only, and of those that went beyond this stage, most were not upheld or were resolved completely: mainly in favour, or partly in favour, of the complainant. A Danish study indicated that 40 per cent of dental complaints were rejected by complaints boards, while almost one fourth brought in a verdict against the dentist and one third of complaints were settled. [13] This is similar to a United Kingdom study where 30 per cent of cases were rejected and more than 30 per cent were settled or presumed settled. [15]

Policy and practice implications

Although results indicate that levels of complaints against dental providers remained relatively stable over the study years, the process acts as consumer feedback and should be part of continuous efforts to improve the delivery of dental care services, especially publicly-funded care services. As most complaints were about treatment and cost of treatment issues, it implies that this aspect of service provision needs improvement, and possible reasons for this situation should be identified. Previous work suggest that most dento-legal difficulties arise as a result of one of six main problem areas: failure of communication, patient expectations that are too high, practitioners attempting work beyond their capabilities, practitioners not disclosing details of accidents or warning of possible consequences, and practitioners showing indignation instead of compassion when questioned by patients. [15]

Strengths and weaknesses of the study

With the exception of the Victorian study, [13] relevant data from similar time frames to compare with findings from this study were not available.

Unanswered questions and future research

It is unknown if the stability in terms of complaints and litigation in Western Australia against dental providers is also experienced in other Australian states, with the exception of Victoria. Future studies could include more research into this aspect (ie, comparison with the rest of Australia); as well as analysing increased levels of complaints among patients eligible for public dental care; the reasons for the high levels of inquiries only; and analysis of outcomes of investigations and reviews.

Conclusions

This study shows that there is no indication in Western Australia that complaints and litigation due to dental malpractice claims are increasing, or that there is any development towards the reported 'medical litigation crisis' as stated by Parker. [1] However, consumer feedback, including complaints, must be an integral part of monitoring and improving the quality of health services. [18] In order for this to eventuate, there must continue to be an efficient system in place whereby complaints may lodge a complaint and have it investigated by impartial professionals and lay persons.

Competing interests

The authors declare that they have no competing interests.

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What Progress has been made in Safety and Quality in Health Care?

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 addressed the following questions:

What progress has been made in safety and quality in health care? What are the challenges to be faced?

1 Quality and safety have scrabbled for traction in New Zealand health for over 20 years. They found a few footholds in some organisations and some clinical areas. Much of the sector was distracted by successive structural reforms then industrial tussles, while struggling to deliver equitable distribution of resources. Even though the structure of the public sector has stabilised lately, there is residual fragmentation.

Against this background individuals and organisations with a clearer view of the value of quality have come and gone. Some were unrecognised at the time but their achievements have been incremental, all moving the thinking forward. There have been false starts, consuming energy and time with little to show for it. There are successes as well, but they are often localised and we haven't managed to share the lessons and techniques from these very well.

More recently, however, quality and safety have been taken up at the highest levels and there is a perceptible change in priorities. It is hard to say why. Increased media attention? Perhaps. More informed patients who are prepared to engage more closely with health care? Very likely. The thoughtful, persistent and increasingly focused questions asked of the sector by the Health and Disability Commissioner over a decade? Certainly. Pivotal cases have led to better sharing of information between organisations. Leaders who support quality and safety are giving people the sense of freedom to acknowledge that bad things don't only happen at St Elsewhere's – they can happen here. They also give support and permission to do something about quality and safety issues.

Over the next few years I look forward to an increasingly open conversation between patients, clinicians, managers and politicians about how we can collectively move forward on quality. If nothing else, the challenge of delivering safe and effective care with a limited workforce will require action.

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2 One of the fundamental advancements in safety and quality in health care has been the shift from focussing on Quality Assurance (QA) to focussing on Continuous Quality Improvement (CQI). The development of improvement and evaluation tools such as clinical indicators and other benchmarking processes has assisted organisations to more effectively perform CQI. Accreditation processes and health roundtables have also become very useful tools that assist organisations to continuously evaluate and improve services.

One of the significant advancements in safety and quality in health care is the openness and transparency that has resulted from pursuing a 'blame-free', non-punitive culture. I believe this has assisted health care services to proactively (and reactively) identify risks (eg, incident monitoring systems, risk registers etc), allowing for effective risk mitigation to occur. There is also greater awareness of the necessity for services to have robust proactive risk management systems in place. A good example of this is the National Standard for Credentialling and Defining the Scope of Clinical Practice, as it provides a very useful tool for services to help prevent adverse events occurring due to inadequate recruitment systems.

For a Quality Manager, one of the greatest challenges is to build a strong culture of CQI throughout a service. All staff have a role in client safety and quality. A service could have all the best quality tools in the world, however unless the service has a complementary CQI culture, these tools are useless. To build and maintain this culture it is incredibly important that a Quality Manager receives complete commitment from all executive staff. This commitment needs to be demonstrated by leadership. In addition to this it is important that quality staff have authority and accountability to ensure safety and quality requirements are considered and followed through in the same manner as 'business' requirements.

I believe that one of the worthwhile challenges ahead is enhancing consumer participation within health services. Some services have harnessed this very well and are now reaping the benefits, however most services are still in the development phases. This is a challenge that will inevitably fail if not provided with strong support, leadership and commitment from management.

I believe there is a lot of potential for services to further develop the links between quality and financial performance. Ensuring that services are provided efficiently, and in a way that is sustainable, is crucial for the 'success' of any health service. When effectively linked to quality outcomes, monitoring efficiency can potentially be a key driver behind CQI (ie, to ensure appropriate access).

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3 There have been steady improvements in patient safety and quality within the community health sector, however, with the national 'spotlight' on patient safety in acute health settings, many community-based achievements, and the unique challenges faced within the community health setting, have remained relatively 'unnoticed'.

What progress has been made in safety and quality in health care in the community?

- Community health staff work within a primary health care model which respects and values individual needs, and promotes equity and empowerment utilising a health promoting model of care. Involvement of consumers, their families and carers, is a keystone of community health service provision. The community health sector has taken the lead on developing and implementing consumer

participation frameworks, which are slowly being adopted more widely across the acute health sector.

- Developing and maintaining sustainable partnerships with internal, and external, care agencies is another key element of community-based health care services. Examples include justice, education, disability and housing, and a range of non-government agencies, since community health service provision takes place in homes, jails and remand centres, schools and other community settings.

- Improvements have been made to continuum of care processes spanning the acute sector/community interface, more so since the introduction of ACHS's EQuIP 4 quality improvement framework.

What are the challenges to be faced when improving patient safety and quality in community health settings?

- The challenge of maintaining good working partnerships with non-government agencies can lead to variance in care provision. These agencies may work from different codes of ethics, with differing cultures, and at times follow contradictory policy direction.

- The 'uncontrolled environment' of the community can increase the risk of providing quality safe services. There are significant security issues for staff, safety for clients and staff, along with other aspects of care such as infection prevention and control that are not faced within the acute sector.

- Given that the average length of stay within community health services is usually longer and more protracted than an acute hospital admission, it is a significant challenge to appropriately measure performance over time and develop meaningful KPIs for care. Development of appropriate and measurable patient safety indicators for the community setting remains a work in progress.

- Access to information is another challenge faced in the community. Community health providers often don't have ready access to data collected by other providers, and documentation may be kept at several sites by an array of service providers. Communication is heavily reliant on telephone conversations, which potentially increases the risk of error.

- Community health providers see growing numbers of complex care clients with greater acuity remaining at home rather than in the hospital setting.

- Non compliance to care by consumers appears to be an increasing issue, and refusal for care poses a problem in caring for people with disabilities and chronic conditions.

Despite the many challenges, many solutions are at hand. The solution with the greatest potential is having consumer-centric care provision that enables community health providers to work in true partnership with their clientele to ensure that 'structural barriers' are overcome, and patient safety enhanced.

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4 Safety and quality in health care rely on many inter-related factors including sound teamwork, constant and open review, being alert to errors and their rectification and a commitment to keeping abreast of ongoing advances in the many areas that impact upon human health. A safe health care environment also requires happy staff who feel included and valued.

Rural and remote health is especially vulnerable because teamwork may be jeopardised by small teams operating over huge geographical distances, review may be hampered by lack of personnel on the ground, errors may go undetected or unreported because of factors such as organisational culture, power imbalance, reluctance of patients to offend their health care provider and because peer review may be an uncomfortable process in a small community. Knowledge management remains problematic for rural communities again because of distance and access to up-to-date information. Health services that are frequently stressed from restructuring and financially pressured to make service cuts will also be at risk because of the immediate impact on staff well-being.

Despite all this, many advances in rural health care are contributing to good health outcomes for rural people. Perhaps most significantly, there have been encouraging developments to enhance team-based care and educational support particularly in the all-important primary health care setting. These developments include the strengthening of Divisions of General Practice, the building of Aboriginal Medical Services, the advent of regional general practice training providers and strengthened specialist outreach services through the Medical Specialist Outreach Assistance Program. To support the efforts of these organisations distance education technology has been effective in improving access to information and city-based experts.

There will always be challenges to face and surmount, some old and some new. There is no doubt that the ongoing shortages in health care staffing in rural areas may jeopardise access to good health care. The recruitment of overseas trained doctors to meet workforce shortages requires an imperative that suitable orientation, training and supervision programs are provided.

Health care workers are prone to becoming bogged down in routine and process. This is understandable and, indeed, sound routines and a systems approach are necessary. Yet unless there are ways for organisations to lift themselves above their routines to view the bigger picture, the focus on outcomes can become obscured and ineffective processes can remain unchallenged.

We must always be mindful of the balance between income maximisation and the need for the most effective health intervention. The former should not jeopardise the latter.

On this theme, it is always important to remind ourselves to ensure balance is maintained across the spectrum from health promotion to treatment services that are appropriate for a particular rural setting.

Of course an individual with vision, commitment, vigour and good will can make all the difference. We have all met them from time to time and know what they can achieve despite all the odds.

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5 The role of the Health and Disability Commissioner in New Zealand was established in 1994 to implement the recommendations of Judge Cartwright in her 1988 Cervical Cancer Inquiry Report. Judge Cartwright stated that there was a strong need for the establishment of a Commissioner as an independent complaints resolution and educational body, and for a Code of Patients' Rights. The Health and Disability Commissioner is an independent agency set up to promote and protect the rights of consumers who use health and disability services; help resolve problems between consumers and providers of health and disability services; and improve the quality of health care and disability services. The Code of Health and Disability Services Consumers' Rights applies to all health and disability services in New Zealand.

Complaints can be used effectively as a catalyst for improvement for health consumers, when a systems approach is taken. The current Health and Disability Commissioner has encouraged New Zealand health professionals to view themselves as the shark patrol protecting patients from the shark infested waters of health care with all the things that can 'go wrong'.

Recent examples of complaints leading to change locally or nationally include:

- A review of medication chart authorisation and documentation processes in one hospital following a death in another hospital;

- Development of an occupational therapy best practice guideline for the immobilised patient after a family raised concerns about the care of their daughter; and

- An article in the staff newsletter of a district health board to guide staff on gaining consent for student involvement with patients.

The challenge for the future is that data indicate that the percentage of people likely to complain is very low, and further intersectoral work is required to develop a culture where people feel comfortable raising concerns, with the knowledge that their issues will be taken seriously and respectfully with action points taken up if possible.

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6 The large-scale changes in the Australian health care system that have occurred over the past couple of decades have seen the private hospital sector evolve from a small cottage industry into a sophisticated and diverse industry sector. The owners and operators of private hospitals have invested in ongoing improvements in the safety and quality of their services in a variety of ways, however, as is the case in the public sector, there is insufficient national data with which to measure genuine progress at this stage.

I chair the Private Hospitals Sector Committee which has been established by the Australian Commission on Safety and Quality in Health Care. This Committee includes representatives of private hospitals, medical practitioners and private health insurers. Key tasks of this Committee are advising the Commission on how best to implement the national safety and quality agenda across a diverse, national private hospital sector and to drive the creation of baseline data from which to measure progress.

Unfortunately, the capacity of private hospitals to drive and effect change is challenged and compromised by ever increasing compliance-creep. Private hospitals face a frankly ludicrous array of safety and quality requirements which overlap and duplicate each other. These requirements are imposed through state and territory licensing regimes; state-based safety and quality bodies; accreditation agencies and

private health insurance fund contracting arrangements. Far from assuring the safety and quality of patient care, these wasteful multiple reporting arrangements can arguably compromise it by forcing the allocation of staffing and financial resources away from direct patient care.

Australia muddled through for centuries with multiple rail gauges. We simply can't afford to do the same with the safety and quality of our health services. We need a rational and national approach.

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7 The Hospital Authority (HA) manages more than 40 public hospitals in Hong Kong and treats 93% of the total number of patients in the city. The HA leadership has taken a number of significant steps to continuously improve safety and quality in the health care it provides.

There is clear organisational commitment to patient safety as evidenced by a dedicated infrastructure. The components include a Quality and Safety Division, Quality and Risk Management leaders at cluster hospitals, HA-wide electronic incidents reporting system, quality improvement teams, as well as education and training in patient safety and quality service. The Quality and Safety Division has recently revamped the administrative as well as policy and advisory structures for steering quality improvement, clinical safety and community safety at times of major disasters.

The improvement in safety and quality in health care is preceded by a culture change. Steps have been taken to foster a safety culture in the HA, the main pillars being standards and information. The patient safety processes include:

- reporting incidents (just culture and accountability are emphasised for the staff while transparency, ie open disclosure when adverse incidents occur is emphasised for the patients);

- investigating and analysing risk data;

- identifying priority issues;

- improving the patient care processes; and

- sharing lessons learnt.

By adopting a systematic approach, progress has been made on all fronts during the past years. Safety measures include putting in place triage mechanism at the Specialist Outpatient Clinics to manage clinical risks and to accord urgent cases priority treatment, as well as introducing a barcode system to ensure correction patient identification.

The Drug Formulary has been implemented to standardise drug policy and utilisation. Referral guidelines have been drawn up for major specialties and measures taken to help doctors improve quality of service both at the referral source and at the receiving end. Clinical audits have been carried out to monitor performance, ensure quality, benchmark best practices and consolidate expertise. New information systems have been implemented and old systems revamped for efficiency, information sharing and knowledge management. Traditional Chinese medicine is being progressively developed in public hospitals under an evidence-based, research-oriented and collaborative model.

In addition to improvement in service accessibility, efficiency and quality, the HA has also strengthened its capability in handling major incidents. The preparedness of public hospitals for a possible avian flu pandemic has been enhanced by the formulation, revision and promulgation of contingency plans and infection control measures at all levels, and by the organisation of exercise drills to familiarise staff with action plans and emergency measures.

Having achieved progress over the past years, the HA is well aware that sustainability is the most important and imminent issue in determining future success of the public health care system. It has to move forward in three main directions:

- keep modernising its services and facilities to bring them in line with the developments in health care around the world;

- work towards reducing avoidable hospitalisation to manage the growing service demand arising from an ageing population with chronic health conditions; and

- strengthen public-private partnership to promote a wider range of choices for patients. To chart a roadmap for future development, the HA is also exploring options for developing an accreditation program for quality and safety in health care in Hong Kong.

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The Power and the Passion of People in the Workplace*

W Cahill

Abstract

This paper was originally presented as part of a session entitled 'The Power and the Passion of People in the Workplace' for the Australian College of Health Service Executives/Royal Australasian College of Medical Administrators National Congress in Hobart on 4 August 2006. The session also featured Dr Murray N Ross, Director Health Policy Analysis & Research, Kaiser Permanente Institute for Health Policy, United States of America. This paper dealt with a wide ranging series of issues noted to be common trends in human resource and related areas in the health and aged care industry workplace.

The paper discusses identified legal trends in the Australian health industry. These include liability for independent contractors, occupational health and safety issues, use of grievance procedures in employment issues, federal workforce reform issues, susceptibility of senior managers to have their employment terminated and some commentary on checks and balances in public health services delivery. These are identified as current or emerging trends and issues, which managers need to be aware of in their day-to-day activities.

The paper concludes that information about these issues provides health service managers with power through awareness and better understanding, enabling the provision of best possible care.

Abbreviations: ACHSE – Australian College of Health Service Executives; RACMA – Royal Australasian College of Medical Administrators; BDW – Blake Dawson Waldron.

Key Words: legal issues in the health and aged care sector in Australia

* This is an amended version of a paper presented at the ACHSE/RACMA Congress held in August 2006 in Hobart.

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Introduction

There have been a number of identified workplace pressures within the Australian health and aged care industry, observable from contemporary legal practice. These issues are presented as observation from that practice as often there is no clear cut solution available. Awareness of the issues can provide a basis of managing the risk associated with them. In that context, the following quotations are relevant:

Concepts of Power:
  'What do I care about the law? Hain't I got the power?'
  – Cornelius Vanderbilt, 1794-1877

'… Power is something of which I am convinced there is no innocence this side of the womb …'– Nardine Gordimer, South African writer

Concepts of Passion:
  'The opinions that are held with passion are always those for whom no good ground exists; indeed, the passion is the measure of the holder's lack of rational conviction.'
  – Bertrand Russell

Issues affecting the health and aged care industry
Doctor issues – potential liability for independent contractors

Health service providers as employers are vicariously liable for the actions of their employees. Since 1980 it has been established law in Australia that health service providers can potentially be held liable for the actions of independent contractors. This includes independent contractors such as visiting medical officers (the most common form of engagement of independent doctors).

This was settled in the case of *Albrighton v Royal Prince Alfred Hospital*. [1] The case involved an action by a woman as a result of an injury suffered when she was admitted for correction of a spinal deformity as a 14 year-old to Royal Prince Alfred Hospital. She took actions against both the Hospital and the various independent doctors. The Hospital, as part of its defence, argued that it had delegated its duty of care to the independent doctors and therefore had no liability to the plaintiff. This was rejected by the New South Wales Court of Appeal, most notably by Reynolds JA:

> The hospital, by admitting the appellant, could be regarded as undertaking that it would take reasonable care to provide for all her medical needs; and whatever legal duties were imposed upon those who treated, diagnosed or cared for her needs from time to time … there was *an overriding and continuing duty upon the hospital as an organisation*. It was not a mere custodial institution designed to provide a place where medical personnel could meet and treat persons lodged there, as it might have been regarded in years long since gone by *(emphasis added)*. [2]

This case established the potential liability for health care providers for an independent contractor. These principles have subsequently been confirmed by a number of High Court cases confirming that health care providers have a direct and non-delegable duty of care in relation to patients and visiting medical officers. [3] In other words, health care providers can have a potential liability for an engaged, non-employed visiting health professional.

On a related point, post the concerns about the clinical performance of Dr Jayant Patel, the Queensland Government established a Commission of Inquiry. [4] Despite some media coverage suggesting the limited nature of the Inquiry, the terms of reference extended beyond Dr Patel and the Bundaberg Hospital (where Dr Patel was appointed). The inquiry made a number of major criticisms over a lack of credentialing and assessment of the suitability for appointment of Dr Patel (and other doctors) and a failure to follow up and analyse complaints, not only about Dr Patel, but about other doctors. [5] In respect of Dr Patel, there had been 20 formal complaints over a 24-month period and there was a finding by the Commission of Inquiry that there had been a lack of appropriate follow-up.

The Australian Safety and Quality Council has also prepared a number of iterations of credentialing guidelines. [6] Interestingly, these were developed from a Queensland-based document and in the first iteration, the guidelines contained a right of appeal against initial appointment.

Subsequent versions of these guidelines have deleted the right of initial appeal. However, appeal rights in relation to re-appointments and failure to re-appoint or amendments to the nature of the appointment are, in my view, overly strong and the complexity of the appeal process is unnecessary. [7]

In the public health sector, the basis of appointment is typically governed by service contracts entered into between the visiting medical practitioner and the health service, whereas in the private sector, by-laws govern the terms and condition of appointment. In our experience, private sector organisations have far more rigorous by-laws, including terms and conditions relating to the appointment of medical practitioners. This no doubt reflects the potential liability of health service providers for independent contractors as well as the financial implications that a poor performer may have on the private sector. As a generalisation from our experience, private sector providers are more likely to deal quickly with problem performers.

Post tort reform, a further imperative in relation to doctor issues is that all of the medical defence funds operating in Australia now provide a form of legal insurance. This covers both medical appointments and contract disputes. The result, in some instances, is that a doctor has the ability to fund legal expenses of up to $150,000 per annum to initiate actions in this regard. [8] In our experience, the result has been a number of funded actions but with little in substance to support the actions. This can be contrasted with both the public and private sectors, which do not have any reimbursement of legal fees for such claims.

The health and aged care practice at Blake Dawson Waldron (BDW) has been involved in over 60 medical appointment issues on a national basis covering both the public and private sector. This is a continuing trend and, particularly with the advent of legal expenses insurance from the medical defence funds, is likely to be a continuing phenomenon. This needs to be examined in the context of the potential liability for independent contractors as well as the reputational issues involved as a result of unsafe or unethical medical appointments.

Occupational health and safety pressures

All Australian jurisdictions (national, state and territory) have occupational health and safety legislation. [9] Essentially this provides an obligation to ensure a safe system of work. It is a strict liability regime. Interestingly, New South Wales has now recorded 25 plus prosecutions against the health sector by WorkCover, the state regulatory authority. There are virtually none elsewhere. [10]

Does this mean that the New South Wales health sector is operationally inherently unsafe? Or, does this simply reflect the fact that the health sector is specifically targeted by WorkCover in New South Wales with a unit specialising in that area, and a philosophy of prosecution rather than education? There has been no research study to confirm that the New South Wales health sector is inherently more unsafe than elsewhere. In any such study the philosophy of WorkCover in relation to the significant prosecutions in that area would require consideration as an issue.

In a number of states, in both the private and public sectors, we have dealt with issues which can be categorised as related to bullying and harassment of other staff by visiting medical officers. This is another area where managers need increased awareness and where academics might consider extending research interests.

Grievance procedures

There has also been a noted trend in the use of grievance procedures by some staff, as part of industrial disputation and to serve personal objectives. We have noted issues where grievance procedures have been used as the basis of a claim of lack of resources. They have also been used from time to time as a device to avoid issues. The cases where grievance procedures are involved also need careful consideration and input.

Federal workplace reform

The Commonwealth, as part of its Workchoices legislation, reflects a vision for a single federal industrial relations system. This is underpinned by the corporations power (section 51(xx)) of the Federal Constitution rather than the conciliation and arbitration power of the Commonwealth. To satisfy the corporations power, an organisation must be a trading, banking or financial corporation. Case law has confirmed that a public health service established as a legal entity has been regarded as a trading corporation for the purposes of the corporation power. [11]

The federal Workchoices legislation is intended to exclude state industrial relation laws but there will be a varying affect due to the particular basis of prior legislation or industrial relations arrangements, along with the lack of legal entities of some public health services; for example, Queensland where there is a unitary system of health administration (that is, no separate legal entities for health services or public hospitals).

However, the relevance or effect on the health sector is debatable in light of the current arrangements and proposals in place in a number of states. This will include, for example,

New South Wales, where there have been amendments introduced by the State Government to frustrate the referral of the health sector to the federal workplace reforms. [12] A further consequence of the workplace reforms will be an inevitable reduction in the role for the Australian Industrial Relations Commission. It will be more difficult to take industrial action. There are also limits on unfair dismissal but there will be more rigorous rights of entry requirements, for example, with unions.

There are also additional exclusions from Workchoices in relation to unfair dismissals for an employee with less than six months service, and employees of a corporation with a hundred or less employees and for a termination 'wholly or partly for operational reasons'. 'Operational reasons' is undefined in the legislation and obviously should be regarded on a broad basis. It is also noted that this can be 'partly' for operational reasons. As such, there is significant potential for exclusions for such actions.

The High Court challenge to workforce reform by the states and unions was unsuccessful. The Workchoices legislation includes:

- conditions to be set by agreement at workplace level;
- a paring back of award safety nets;
- establishment of the Australian Fair Pay and Conditions Standard; and
- state awards/industrial laws moving to the federal Industrial Relations System over a three year period of transition.

Senior appointments

Based upon our knowledge of the health and aged care industry, there have been a number of senior management personnel who have had their appointment terminated. This has occurred in both the public and private sector. On that basis there is an increasing likelihood that there will be a termination of a senior appointment in a career.

In New South Wales, for example, in the public sector under the *Health Services Act 1997* and cognate legislation, the Director-General of New South Wales Health is the employer of health service executives. The Act provides that the Director-General may remove a health executive from an executive position 'at any time for any and no reason and without notice'. [13] This is counter to the established judge-made law in relation to holders of statutory office, that they are owed obligations of natural justice and procedural fairness.

Public health service organisation

Despite the fact that the Queensland Public Hospitals Commission of Inquiry did not attribute the findings about lack of credentialing and failure to follow up complaints to the nature of the Queensland system, it is hard not to escape the view that this may have contributed. Separate legal entities and boards of directors provide a form of checks and balances in relation to clinical performance and other issues. The fact that the Queensland health system is a unitary system with no separate legal entities and no boards also may have contributed to this.

Interestingly in New South Wales, post the Camden/Campbelltown issues, the government introduced changes whereby there was an increase in the size of area health services and a removal of boards of directors. [14] This removes potential checks and balances. Certainly an argument can be put that there are contradictions between the advantages of checks and balances due to the existence and operation of boards and the loss of such boards.

Emerging legal issues

Other emerging issues that have been identified include:

- Changes in liability or potential liability. It is understood, for example, that a number of medical defence funds have had a significantly reduced amount of claims yet continue to have a similar level of notifications.

- Post tort reform. There has been an approximately 60% decrease in claims. [15]

- Under the direct non-delegable duty of care it is important to be aware of the implications of medical appointments, including both reputationally as well as financially, for health service providers. As well, it is important to note the obligations of natural justice that apply to such appointments.

- Contracting out of services. This needs attention to the development of appropriate specifications and quality standards as well as appropriate termination provisions.

- There is increasing commercialisation activity in relation to intellectual property in both the public and private sector.

- Increased pressure for occupational health and safety.

- Increased issues in relation to privacy and confidentiality.

- Increased *Trade Practices Act 1974* (Cth) issues and continued interest of the Australian Competition and Consumer Commission in this sector. This includes access issues, referrals, appointments, price fixing and boycotts by medical and other health practitioners.

- Additional consolidation of the sectors includes private hospital, pathology, radiology and aged care.

Conclusion

'… knowledge itself is power …' – Francis Bacon, 1597

These issues are observed on a national basis and as such will have implications for health services managers. Information is power in the sense of being aware of these issues. The challenge of course, is how to deal with these issues on an ongoing basis to ensure the best possible care for the clients of health and aged care providers.

Competing interests

The author declares that he has no competing interests.

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Perceptions of Queensland Registered Nurses of Factors Affecting their Workplace Morale

TM de Boer and GE Day

Abstract

Objective: To investigate the perceptions of Queensland registered nurses about factors affecting workplace morale.

Design: Analysis of qualitative data arising from three open-ended questions that were part of a larger cross-sectional survey conducted in late 2002. The original questionnaire contained 163 questions of which 160 were closed (and analysed quantitatively) and three were open-ended.

Setting: The research population consisted of all Registered Nurses (RNs) working full-time, part-time or casually within a convenience sample of three acute care health facilities, providing public or private care, in South East Queensland. The questionnaire was distributed to 843 RNs of whom 343 responded; a response rate of 41%.

Main outcome measures: Workplace factors contributing positively and negatively to the morale of nurses.

Results: Factors most frequently mentioned as having a positive influence on morale were staff interaction, patient care provision, recognition and praise, team interaction, work flexibility and staffing issues.

On the other hand, working conditions and staffing issues were most frequently mentioned as having a negative influence on morale.

Conclusions: This research confirms the findings of other researchers as to the main factors that impact on nursing morale. An unexpected finding was the importance that hospital nurses in Queensland ascribe to work flexibility. This could be a recent development with respect to hospital based RNs or a variable that has previously been overlooked by researchers. A further unexpected finding was the number of comments related to peer and superior abuse, bullying and violence amongst nurses. More research is required to explore these issues further.

Key words: nursing morale, bullying, violence, work flexibility.

Abbreviations: RN – Registered Nurse; ANCC – American Nurses Credentialing Center; NPC – Nurse Practice Co-ordinator.

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Introduction

The level of staff morale can have an impact on a variety of aspects within a health care facility. Low morale among nurses can lead to irritability, fatigue, ill-health and restlessness amongst staff. It has also been correlated with stress, decreased performance, increased professional negligence, increased patient and staff accidents and incidents, absenteeism and turnover, staff motivation and job satisfaction. [1,2,3] Poor workplace morale can also have an impact on nurses' relationships with patients as well as the level of cooperation and creativity within the nursing team. [2]

Current literature indicates there are several key issues that affect nursing morale. Nurses frequently feel they are undervalued and not recognised for the role they fulfil within hospitals. [2,4,5,6] Communication is also an important issue as nurses feel they are not listened to. [5,6] The relationships between nurses and their peers, management and superiors can also affect nursing morale. [4,7] Current literature indicates nurses believe relationships with superiors are becoming increasingly detached. [4] In various UK studies an increase in negative attitudes and backstabbing amongst nurses has also been reported. [8,9] Bullying and harassment is another factor nurses are dealing with in their profession. Nurses feel that there is little done to tackle the threat of harassment or its effects. [10]

An organisational factor that influences nursing morale is the decentralisation of decision-making and teamwork. Various studies commented on the benefits of active participation of nurses in the decision-making process. [11,13,14] Buchen et al [13] found that a hospital in the UK with a 'magnet status', reported increased levels of nurse morale, better staff/management relationships and increased feelings of cohesion and common purpose. Magnet hospitals are places where nurses have autonomy and control over their practice settings; good relationships with their colleagues; adequate support services; enough staff to provide high quality care; time to discuss patient problems with their colleagues; the opportunity to participate in policy decisions; a powerful nursing leader; and an environment that recognises the value of their work. [12] Hospitals must meet 63 criterion to achieve magnet status by the American Nurses Credentialing Center (ANCC).

The contemporary literature also indicates that pay is a major factor influencing nursing morale. [2,3,8,9] Several studies have found that the majority of nurses felt their pay did not balance out with the level of professionalism and the amount of work carried out. [2,9] Furthermore, working conditions such as workloads, cost containment measures and reduced staff have led to demoralised nurses. [2,9,15] These factors may be a result of the limited availability of resources within organisations. [2,3,6] The literature suggests that due to insufficient resources, nurses feel that quality of care has become severely compromised. [2,16]

Other factors that have been found to influence nursing morale include job insecurity as a result of health reforms, [2,3,4] lack of education and promotional opportunities, [2] the design of a work unit [3,17,18] and finally, leadership styles and management techniques. [1,5,6,7]

Most published studies on the issue of nursing morale originate from Europe and America and have been based on surveys using 'closed-questions' that are readily analysed quantitatively and allow little opportunity for respondents to raise new issues. This study is based on responses by nurses to open-ended questions about factors influencing their morale. In this manner the opportunity arises for new knowledge to be gained on the subject of nursing morale.

Methods

This study reports findings arising from an analysis of data from three 'open-ended' questions that formed part of a larger, predominantly, 'closed-question' survey of Registered Nurses (RNs) that was conducted in late 2002.

The study sample was drawn from a population of 843 RNs in a convenience sample of three acute-care hospitals located in South East Queensland. Participating hospitals included two public hospitals and one privately owned and operated hospital. The sample of RNs included full-time, part-time and casual nurses employed by the three participating hospitals. Agency nurses were excluded from the study.

The survey questionnaire was designed by Day, [19] who based it on several available instruments [20,21] as well as questions developed specifically for the study. The three open-ended questions were:

- What are the three biggest issues that affect morale positively in your workplace?

- What are the three biggest issues that affect morale negatively in your workplace?

- Are there any other observations, suggestions or comments regarding morale in your workplace that you would like to make?

Comments from respondents were coded thematically. This was done with the help of the Microsoft Office program Excel. Coded themes were first made on the basis of the variables tested in the original quantitative study and for each category the number of responses was recorded and percentages were calculated. During the process of data analysis the list of themes was modified to suit the diversity of the results.

Ethics approval

The research was approved by the University of New England Human Research Ethics Committee and the Ethics Committees of the three participating hospitals.

Results

Of the 843 RNs who were handed questionnaires, 343 responded; a response rate of 41%.

Characteristics of respondents

The socio-demographic profile of respondents was largely in line with the RN population of Queensland, with 90% of respondents female and 51% over 40 years of age (Table 1). [19,22]

who nominated an aspect of *Patient Care Provision* as the most important issue, commented the morale of nurses was positively affected by patient satisfaction with their care, positive patient outcomes, good patient care, thanks and praise, appreciation and positive feedback from patients and their families, and lastly, having a good patient mix. The factor *Recognition and Praise* included comments such as feeling recognised, valued, respected, and encouraged,

Table 1: Socio-demographic profile of respondents (n=343), 2002

Gender	Female	90%
	Male	10%
Age	> 40 years	51%
	31-40 years	30%
	< 31 years	19%
Relationship status	Married or de facto	51%
	Single	49%
Education	Initial education in a hospital setting	66%
	Initial education in a university	34%
Years working as a nurse	Average number of years working as a nurse	17 (SD = 10.9 years)
Employment	Average number of years with current employer	7 (SD = 7.02 years)

Note: SD = Standard deviation

The main results of the study were divided into two key dimensions: factors contributing to improving morale and factors contributing to a decline in morale.

Factors contributing to improving the morale of nurses

Respondents were asked to provide up to three factors they perceived as having the biggest impact on improving morale in the workplace. A number of nurses chose not to respond or to nominate less than three issues. In total, 672 responses were provided. The results are presented in Figure 1.

The category, *Staff Interaction*, received 12.5% (ie 84/672) of all responses relating to the most important issues leading to an improvement in nursing morale. This factor covered comments about staff behaviour and mood, pleasant workmates, friendships and social interactions, social get-togethers (outside work) and a sense of humour or having fun.

The next three most influential issues were *Patient Care Provision* (11.6%, 78/672), *Recognition and Praise* (11.5%, 77/672) and *Team Interaction* (11.3%, 76/672). Respondents

as well as being praised and thanked for the professional roles nurses fulfil within the hospital setting. Positive factors associated with *Team Interaction* included comments about teamwork and team spirit, feeling accepted, belonging and unity, achieving common goals, shared experiences and vision, and feeling part of an effective team.

Staffing Issues (9.5%, 53/672) was another key theme. This theme covered responses regarding the quality of staff (experience, competency, permanency, consistency and commitment) as well as the quantity of staff (correct or adequate staffing levels, sufficient senior staff). *Work Flexibility* (7.9%, 52/672) included themes regarding the work roster for example, shifts, breaks and time off.

As indicated in Figure 1, ten additional themes, including *Job Satisfaction*, were identified as important issues leading to an improvement in nursing morale and collectively these themes received 35.7% (241/672) of total responses.

Figure 1: Factors nominated by respondents that improve nursing morale
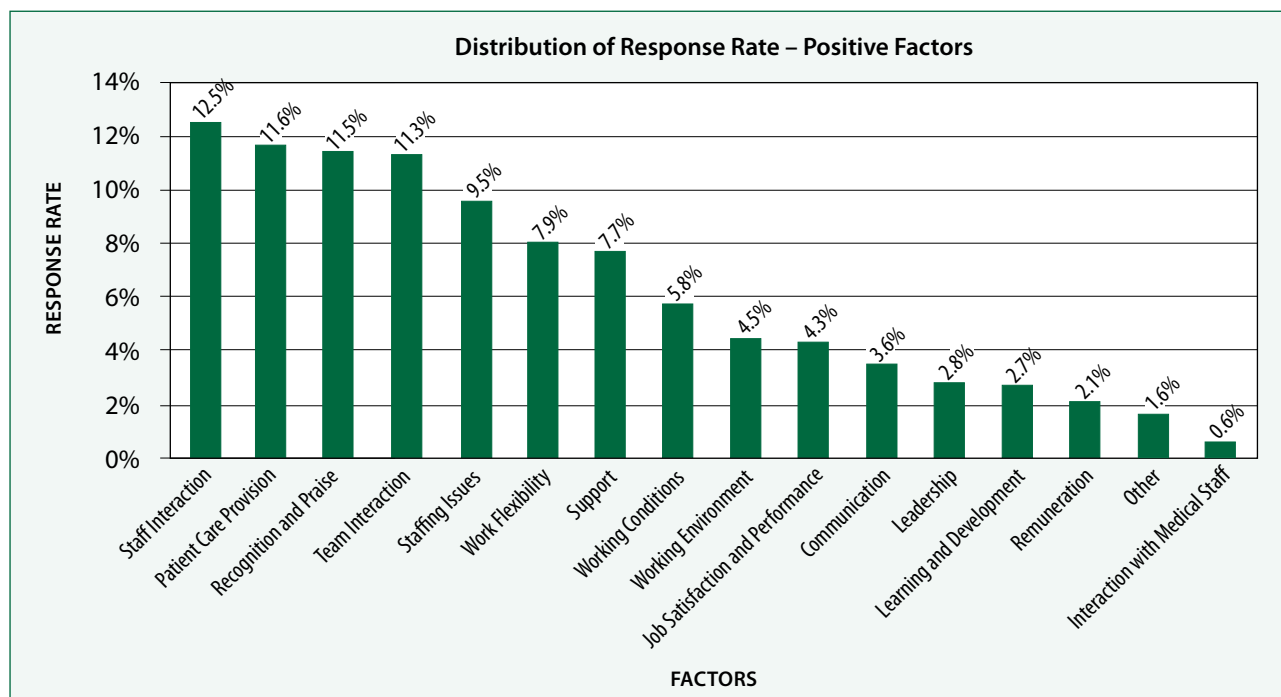
Total number of responses = 672

Factors contributing to a decline in the morale of nurses

Nurses were also asked to nominate the three most important factors contributing to a decline in morale. A total of 868 responses were provided. The responses were categorised and tabulated and the final results are presented in Figure 2.

Respondents nominated two factors, *Staffing Issues* and *Working Conditions*, as most influential in affecting nursing morale negatively within the workplace. In total, these two factors accounted for almost 40% of responses. Just over one fifth of the nurses nominated *Staffing Issues* as being the major issue with a negative impact on morale (21%; 182/868). *Staffing Issues* included comments about staffing levels, decreased skill mix, high staff turnover, sick leave and absenteeism, increased agency staff, stressed staff, inconsistent, inexperienced and unqualified staff. The category *Working Conditions* (18%, 157/868) received the second highest number of comments about factors influencing morale negatively. This category covered comments concerning excessive, unrealistic and dangerous workloads, redeployment to other departments, high patient-to-staff ratio, and inability to provide safe and adequate care due to time constraints and workloads as well as the lack of job security.

After these two categories, the number of responses for each category dropped dramatically. *Work Flexibility* (8.6%, 75/868) covered issues concerning bad rostering, shift work, night shift, work hours and inflexible rostering. *Staff Interaction* (6.9%, 60/868) included comments about staff attitudes, behaviour and personalities, bickering, backstabbing, gossip and rumour, negativity, laziness and cruel behaviour, and staff moods (jealousy, tired, cranky, grumpy and exhausted staff).

Figure 2 shows that fifteen additional themes (including *Abuse Towards RNs, Power and Autonomy and Organisational Direction, Strategy and Management*) were identified among the important factors affecting the morale of nurses negatively and collectively these themes received 45.4% (394/868) of all responses.

Factors affecting nursing morale positively and negatively

It was found that 14 factors had both a positive and a negative influence on the morale of respondents (Table 2). For example, not surprisingly nurses reported that good communication had a positive influence on morale. Conversely, poor communication was perceived to have a detrimental effect on nursing morale levels.

Figure 2: Factors nominated by respondents that result in a decline in nursing morale
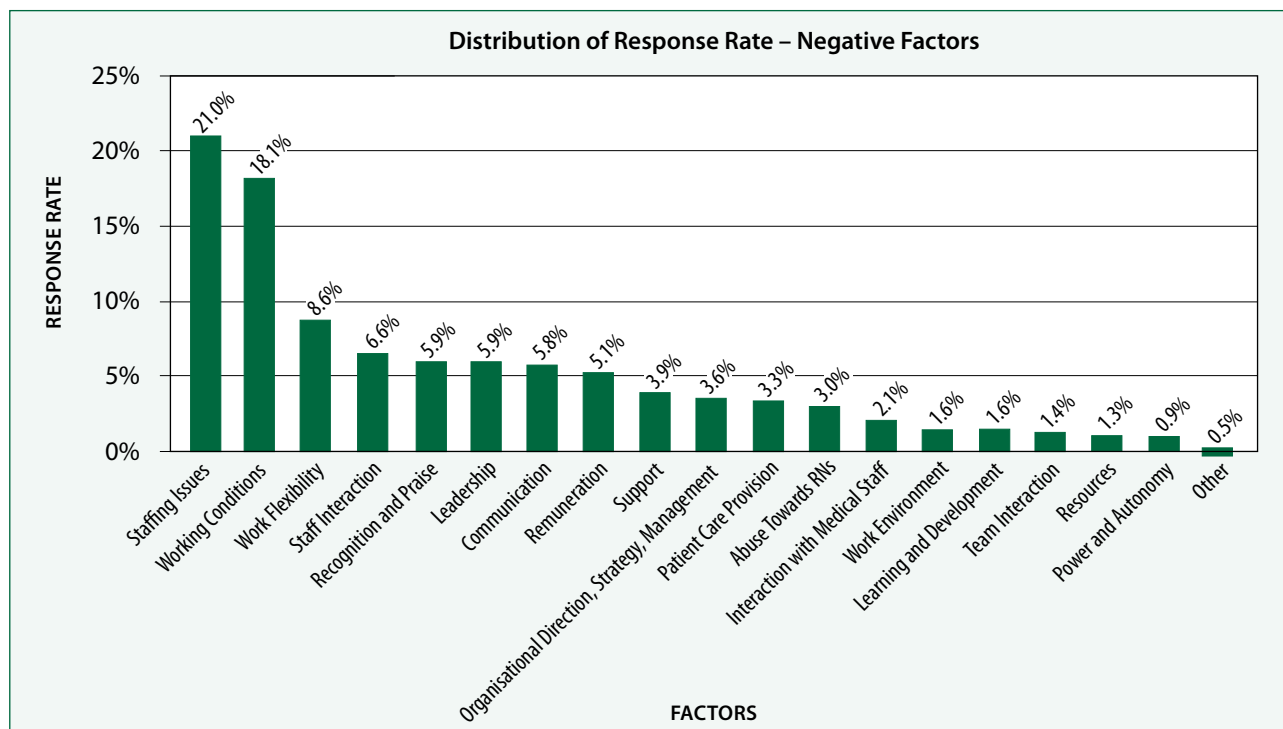
Total number of responses = 868

Discussion

Principal findings

This study found the main factors with a positive influence on the morale of nurses in this study in Queensland were:

- interactions with staff, including team work;

- patient care provision;

- recognition and praise, including support; and

- working conditions, including staffing issues and work flexibility.

On the other hand, the most important factors influencing morale negatively were staffing issues, working conditions and work flexibility (or rather lack of). Collectively these three categories accounted for almost 50% (414/868) of responses in relation to factors having a negative affect on morale.

Main findings with reference to previous research

Interactions with other staff, including their co-workers, superiors and medical staff were among the most important factors affecting nursing morale positively. Nurses commented that the quality of relationships with other staff can either improve or reduce nursing morale levels as suggested by the following comments:

Table 2: Factors reported by Queensland RNs affecting nursing morale both positively and negatively

Communication	Staffing Issues
Staff Interaction	Work Environment
Work Flexibility	Learning and Development
Support	Leadership
Patient Care Provision	Recognition and Praise
Working Conditions	Interaction with Medical Staff
Team Interaction	Remuneration

One person who treats someone negatively can affect how they feel about an organisation. The opposite is also true. Nurses can be your best friend or your worst enemy as only they personally know what the job is like to do…they can build up or destroy in one breath.

The importance of good working relationships was further illustrated by the significance that respondents ascribed to *Team Interaction*. These findings are in line with those of other researchers. For example, Cavanagh [23] found that amongst nurses there appeared to be a strong group identity and cohesiveness. Cox [24] also found that teamwork played a major role in the well-being of staff.

It is widely recognised that providing patient care is the central tenet of nursing. *Patient Care Provision* scored the second highest response rate regarding factors attributed to improving morale. This suggests that nurses believe that the way patients are cared for, patient satisfaction and positive patient outcomes all help to improve morale levels among nurses. For example, one nurse commented: *The biggest impact on morale is the ability to give our patients the care and support so (sic) rightly deserved. That is what nursing is all about.* There was also a high response rate within this category for patient thanks, positive feedback and appreciation. It has been established by other researchers that nurses perceive their jobs to be dynamic and interesting, and that patient care has been described to be the most valued reward within nursing. [15]

Another prominent theme, with the potential to exert both a positive and negative influence on morale, was *Recognition and Praise*. Respondents expressed feelings of being undervalued and 'invisible'. Nurses commented on being frustrated because they were not recognised for their roles or for the tasks they complete well. As indicated by the following comment, some nurses felt they should receive more positive feedback and encouragement: *We need more praise. Everyone knows when something goes wrong but only occasionally when things are done well.* Other research supports these findings that nurses feel undervalued in their roles. [2,4,5,6]

Many comments made by nurses referred to staffing issues such as low staffing levels, inexperienced staff, poor staffing mix, sick leave and absenteeism. Many of the respondents also believed that working conditions were responsible for the high levels of sick leave and absenteeism. Comments grouped under the broad theme *Working Conditions* included 'unsafe working conditions', 'unrealistic expectations' and

'inability to do the job properly because of the workload' as exemplified by the following comment: *Morale has little to do with the job we do and much to do with the conditions in which we do it.* These findings complement the results of Scott [14] who based his work in the UK and Nolan et al who conducted a study in the UK and Sweden. These researchers found nursing morale had decreased for two reasons: first, due to an increase in workloads, and second, because of insufficient staff to do the work required. [15]

Work flexibility scored highly among factors with both a positive and negative affect on morale. Comments from nurses addressed issues surrounding shift work (eg doing too many night shifts, bad rostering, inflexibility with shift work), rostering and time off. For example, one nurse commented: *Allow self-rostering (not the pretence of it).* All of these factors affected morale negatively. Morale was affected positively when rosters were fair; flexibility was given with work hours and time off; when nurses had holidays or days off; and when self-rostering was a reality. These findings are similar to those of Moyle et al [25] who found that work flexibility affected levels of job satisfaction of nurses and assistants-in-nursing working in the aged care sector.

The study included responses from nurses reporting horizontal violence, abuse, bullying and racism. Understandably, this type of abuse affected morale negatively. Interestingly, although some respondents did refer to aggressive patients and families, as found also in the study by Harrison [10] most of the comments in our study referred to abuse from peers, superiors and management. One respondent commented: *Nurses must be kind to patients but not to each other. There is a lot of competition and backstabbing.* This is perhaps an area that needs further investigation. In particular, bullying and horizontal violence by superiors was frequently mentioned. This was supported by comments such as: *The NPC needs to have a full comprehension of what constitutes bullying and harassment.* Similar to the findings of Harrison, [10] nurses believe there is little done within the hospital to alleviate abuse, violence and bullying.

In the UK various studies have demonstrated an increase in the level of negative attitudes and backstabbing amongst nurses. [8,9] In this study many comments regarding nurses' personality and attitudes, such as the following, suggest that this phenomenon may be occurring in Queensland: *Nurses culturally are whingers! Although attempts are made to improve situations they continue to find the negatives.*

Implications for practice and management

It has been established that nursing morale has been low for some time. [2,8,15,19] It is important to understand why this is so in order to take steps to improve the situation. This study has presented several self-reported variables nurses perceive to be the major issues to affect morale levels. Managers of health care organisations could benefit from these findings by developing strategies or intervention programs that aim to improve nursing morale within hospitals and health care organisations. An example of this would be to take a closer look at the elements of the 'magnet hospital model', such as open communication and nursing empowerment. [13] Of course, such words or strategies are empty unless a sound action plan is established with active support by all levels of authority. As previously established, nursing morale is affected by a multitude of factors and this should be taken into account when planning any strategy or intervention.

Strengths and limitations of the study

A major strength of the study was the use of qualitative research. Open questions do not limit the answers given by respondents and thus allow the researcher to confirm existing knowledge or to gather new information and perspectives. A drawback to this kind of research is that the results are difficult to measure. During the literature review it was found that researchers have a multitude of ways of categorising factors affecting nursing morale. There were few guidelines for the categorisation process and as such the process used in this study was guided by the experiences of the researchers and their knowledge of nursing and the health care systems they work within. It is therefore a subjective process of allocating factors into certain groups. Also, the response rate of nurses returning the questionnaire (41%) means there could be some systematic bias. Gulliver et al [25] warn that those who are less satisfied may feel more motivated to respond. Additional limitations include the selection of only three hospitals from one region within Australia. It is therefore impossible to generalise the results. Nevertheless, the findings from our study are similar to those of researchers from other countries. [2,15]

Unanswered questions and further research

The importance ascribed to work *Flexibility* was an unexpected finding of this study and further research could include looking into approaches to providing flexible work schedules and the impact of various approaches on nursing morale. A further research area could include the effects of abuse, violence and bullying that comes from peers and fellow workers on nursing morale. To date, most research has focussed on abuse to nurses from patients and their families.

Conclusion

The most important factors exerting a positive influence on the morale of nurses in Queensland are staff interactions, patient care provision, recognition and praise, team interaction, work flexibility and staffing issues. The most prominent factors leading to a decline in nursing morale are work conditions and staffing issues. These results can help form the basis of intervention strategies to improve morale. Simple actions such as providing recognition and giving due praise could go a long way in boosting morale in the workplace.

Another important factor to note is the prevalence of abuse from peers and superiors in the workplace. A lot of funding has been provided by the government for raising awareness of the prevalence and the effects of bullying in schools. Sadly, some forms of bullying and abuse and their effects, such as low morale, do not cease as we move into the workplace. Organisations would do well to remain aware of the consequences and find ways to minimise, if not eradicate, all forms of abusive and bullying behaviour.

The results from this study are in line with contemporary literature. This suggests that nurses in Queensland, and possibly the rest of Australia, report similar factors affecting their morale as their nursing colleagues in Europe and America. As a result, overseas attempts to increase nursing morale such as the implementation of a 'magnet hospital' model, may have similar positive outcomes in Australia.

One thing is clear, further action is needed to improve the morale of nurses within acute care health organisations in Queensland. A quote from one of the respondents leaves no doubt about the difficulty facing nurses today:

Morale is steadily declining and staff leaving to a point where it becomes a downward spiral of increased workloads, increased frustration, increased staff leaving, until it can't be fixed.

Acknowledgements

Competing interests

The authors declare that they have no competing interests.

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Supporting Older Carers of People with a Disability: an evaluation of a respite care program in Western Australia

J Cockram, P Hancock, J Jarvis

Abstract

Objective: To conduct a formative and summative evaluation of a respite care program for carers aged 65 and over (50 if Indigenous) who care for a person with a permanent disability aged 18 years or older.

Design: The Older Carers' Program (OCP) evaluation was both a process and outcome evaluation. As part of the evaluation semi-structured in-depth interviews with 62 carers, and four program coordinators were conducted. Auditing of program documents also formed a major component of the research design. Explicit quantitative measures took the form of an auditing process that focussed on the number of individual plans on record, documented visits to carers and analysis of the OCP volunteer data base.

Setting: The State of Western Australia, Australia.

Results: The participants interviewed perceived that the OCP had successfully attained its aims and objectives and provided valued support for older carers of people with disabilities in the community.

Implementation of care plans was highly valued by most carers and successfully allayed their concerns for the long-term future of care recipients. Both respite care and care plans resulted in increased quality of life for the majority of carers as well as decreased stress levels and increased support of participants to continue their care giving role.

Conclusions: The OCP is one of only a few such programs in the Australasian region. At a policy level, it is clear that the OCP has met a unique and growing need in the community and provided valued support for older carers of people with disabilities. The OCP for people with disabilities provides a model for future care recipient programs in ageing populations.

Abbreviations: OCP – Older Carers' Program.

Key words: ageing; respite care; older carers; disability.

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Introduction

Forecasts of the prevalence of disability indicate that as the 'baby-boomer' cohort ages, the proportion of the population aged over 65 years will increase from 11% to 16% by 2021. This will lead to an increase in both disability prevalence in the community and the number of older carers. [1] Despite often being a rewarding role, caring can have detrimental effects on physical and psychological health; emotional well-being; finances; life choices and chances relating to career and education; travel; and pursuit of personal interests and hobbies. [2]

The past two decades have seen a growing awareness of the unique challenges faced by carers and recognition of their valuable contribution to society. The Australian carer literature confirms the diversity of carers and care recipients and recommends the implementation of flexible, holistic and coordinated carer programs that reflect the complexities and capabilities of Australia's care giving community. [3] Accordingly, assumptions about care giving (and receiving) are changing. Both researchers and policy makers alike are beginning to incorporate notions of supporting or empowering caregivers and receivers through needs-led

rather than service-led support. However, there is a paucity of research regarding the unique needs and the specific barriers older carers of people with disabilities face in terms of access to respite care services. [4]

The majority of people with disabilities in Australia live at home with their families, usually with parents; or more commonly in later life with one parent, usually their mother. Nowadays, people with disabilities live much longer than they did in the past, with the result that there is also an expanding population of elderly parents who are continuing to care for their son or daughter well into old age. Also, the ageing process may start much earlier for people with disabilities than for others in the general population. [1]

When people with disabilities grow older, many of their needs will be the same as for any elderly person living in the community, but professionals who work for generic services for the elderly may not consider that they have the specialised knowledge and experience to relate to people with disabilities. At the same time, professionals from specialist disability services who have been able to meet their needs in earlier years, may not always feel confident when their clients become elderly and have age-related health and social support needs. Cooperation between the two services is vital to ensure that no one slips through the net. In households where there is an elderly caring parent also needing some care, this cooperation is even more essential. Sources of help and support need to be in place so that they can act swiftly when a crisis arises, and to provide an appropriate package when care in the family begins to break down.

This paper discusses an evaluation conducted in 2005 of an initiative designed by the Australian Red Cross, Western Australia Respite Program Older Carers' Program (OCP). The OCP was established to support the unique needs of older carers of people with permanent disabilities.

Method

The OCP evaluation was both a formative and summative evaluation based on process and outcome measures. Much of the research focused on the extent to which it had met its stated aims and objectives. However, because the program was quite new and innovative, there was a significant further focus upon the processes and activities within the program. The evaluation further intended to seek ways to improve the program in terms of effectiveness and efficiency.

Recruitment of participants

At the time the evaluation research was conducted, in May 2005, the OCP had been in operation for 22 months. The population group was identified as those persons who had been part of the program between July 2003 and March 2005. Of the 96 carers who had accessed the OCP in the specified period, 62 agreed to participate. Participants were sourced from four of the Australian Red Cross West Australian offices that housed a generic and closely related respite care program (Commonwealth Carer Respite Centres). From the Metro North region, 14 of a possible 25 older carers participated and from Metro South, 24 out of a possible 39 were interviewed. The corresponding figures for the South West (rural) area were 16 of a possible 22 and for Goldfields (rural) 8 of a possible 10 older carers were interviewed.

All participants were contacted by telephone and offered the opportunity to participate in an 'at home' semi-structured interview with one of the researchers who took detailed notes. The interview focused on the overall efficiency and effectiveness of the program and the quality of staff. The carers were asked if the needs that they identified in their care plans were being met by the OCP; what needs had not been met; and how the program could be improved.

One of the researchers also conducted semi-structured interviews with four OCP Coordinators. The interviews consisted of general probing questions about how the program worked; what were its best features; what worked best; what did not work; if the program worked at all; what needs were easier to meet; and what needs were deemed too challenging.

The study design also included the collation of demographic and utilisation data from documented records. Explicit quantitative measures took the form of an auditing process that focused upon the number of individual care plans on record; documented visits to carers by OCP Coordinators; evidence of three monthly review visits; and analysis of the OCP Volunteer Database.

Carer and care recipient characteristics

Sixty-one primary carers cared for one care recipient whilst one primary carer cared for three care recipients. Of the sixty-two interviews that took place only two were with people who identified themselves as being of Aboriginal or Torres Strait Islander descent. Thirty (48%) of the primary care givers interviewed were between 70-79 years of age. Twenty two (35%) were aged between 60-69 years. Eight (13%) carers were aged over eighty and two were aged in their fifties (Indigenous carers). Fifty eight (74%) of the primary carers were female and 20 (26%) were male (sixteen couples participated in the interviews).

Sixty carers were caring for their son or daughter. Of the remaining two, one was caring for their grand-daughter and the other for their nephew. Thirty four (53%) of the care recipients were male and thirty were female (47%). The mean age of care recipients was 41 years. The average length of time the OCP carers had been caring was 31.04 years.

Care recipient disability type

The types of disability of the care recipient were collected and disaggregated as far as possible. The number and types of disability of the 62 care recipients were: Downs Syndrome (10), Rhett's Syndrome (1), Developmental Delay (4), Autism (3), Physical Disability (1), Hydrocephalus (1), Acquired Brain Injury (8), Epilepsy (1), Cerebral Palsy (5), Quadriplegic (2), Multiple Sclerosis (3), Parkinson's Disease (1), Other Neurological (2), and Other Intellectual (22).

Care recipient need level

The National Respite Carers Program, Carer Respite and Resources Centres Data Dictionary (2001) [5] categorises carers' level of need into three stages; 'high, medium and low'. 'High need' denotes carers who are experiencing extreme difficulty managing their caring responsibility. 'Moderate need' denotes carers who are experiencing difficulty managing their caring responsibility. 'Low need' carers are usually experiencing minimal difficulties in managing their caring responsibility. Twenty two carers were determined as being in the 'high level' needs category, thirty three were classed as being 'medium level' and seven were determined as 'low level' in terms of need.

Ethics Approval

Ethics approval for the project was obtained from the Human Research Ethics Committee, Edith Cowan University.

Summary of study results

Carers' perspective

Access to respite care

Access to respite care was shown to be generally beneficial to carers, and the value of quality respite care was positively identified by most OCP participants. Similarly, implementation of care plans was highly valued by most carers and successfully allayed their concerns for the long-term future of care recipients. Both respite care and care plans resulted in increased quality of life for the majority of carers as well as decreased stress levels and increased support of participants to continue their care giving role. According to the carers, the three most useful aspects of the program were the visits and support provided by OCP Coordinators; the assistance carers were provided in arranging respite; and the provision of information by the OCP Coordinators.

Ability of OCP to involve carers in decision-making

The vast majority of carers were 'satisfied' that they had been involved in important decision-making processes in defining their own respite care needs. When carers were asked what impact the OCP had on their lives, the overwhelming response was positive. However, in exploring satisfaction levels of their involvement in decision-making, it appears the calibre of the OCP staff directly influenced satisfaction levels. This was illustrated succinctly by a carer who had supported her son with Downs Syndrome for 30 years:

> I was very impressed with the professional caring attitude of the staff. One coordinator in particular I found to be very special, a miracle worker and very helpful. She made me see that I need help and there are people out there who care. Until now I did not get enough help. I don't know where I'd be now if not for this program.

Ability of OCP to consider the financial restrictions on carers

Financial restrictions and issues featured often in the interviews. Many of the carers expressed concerns centred around financial hardship and the impact of financial restrictions on access to transport and respite. Transport issues were found to be an important consideration for older carers as drivers licences are relinquished with increasing age, resulting in a greater reliance on public or alternative forms of transport. In evaluating the ability of the program to consider the financial restrictions placed upon older carers, the following comment by a carer for 38 years was revealing:

> For some carers their age, social, economic and geographical circumstances magnify the challenges and issues surrounding their caring role. I am a carer of a 38 year old daughter with a high need intellectual disability and I have in the past resorted to arranging my own respite. This involves a 16 hour round car trip to the closest available respite and a similar trip to collect my daughter. As I am financially dependent on the Old Age Pension, airfares are not a viable option. A funding application for permanent accommodation has been rejected. Therefore my situation potentially will remain a long-term problem.

Ability of OCP to provide volunteer support

Many of the participants believed that the program had not met the expectation of the involvement of a diverse range of volunteers. The value and positive impact of two identified cases of volunteer support was clearly evident. One volunteer taught basic cooking and healthy cooking and eating skills, in preparation for independent living when

accommodation is available. The other volunteer provided much appreciated respite to a carer in escorting a care recipient to the gym. Other suggested uses for volunteers by OCP participants included: provision of extra respite; assistance with outside maintenance and gardening; and provision of legal information. Carers who had received volunteer support reported feeling less burdened by their caring role and enjoy a higher quality of life than those who did not.

Ability of OCP to provide social support

The ability of the OCP to provide social support directly relates to the impact of social isolation on older carers. Social isolation is a common experience of carers. It was found by OCP participants to be connected to a loss of friendships and loss of social networks; complex social issues relating to cultural beliefs and social values; community attitudes; lack of awareness and judgemental attitudes to mental, physical and intellectual disability; and an inability to participate fully in community life.

Most of the carers reported that the program had successfully provided formal social support to participants through such activities as social lunches and retreats. The program had also successfully provided informal support by involving family in future long-term planning for care recipients. Overall the carers were very positive about this objective being met. Feelings of social isolation were clearly decreased by carers attending social outings arranged by the OCP. A consensus regarding the value of such social support groups was highlighted by a 68 year old female carer of a high-need daughter in explaining, 'it is wonderful to mix with other parents to know you are not the only one struggling with a child with a disability'.

In fact, the ability of the program to provide social support emerged as a major strength. The benefits that carers gained from support groups included: socialising; creating peer support networks; gaining information about the caring role; validation of feelings and experiences; gaining confidence; and reduced feelings of isolation.

Ability of OCP to provide information on available services

The program's intention to provide information and links to relevant services was also realised. The majority of older carers found the information provided by the OCP to be extremely valuable:

> The fact that someone has gone to the trouble of investigating my needs and providing me with information on services, some which I didn't know existed, was really fantastic.

Expressions of relief by participants after being approached by the OCP with information, due to an 'aversion to asking for help', may provide insight into how best to provide strategies to access hidden older carers in the future. The carers felt strongly that providing easy access to information assisted them in their caring role. This positive outcome was seen to be a direct result of the program coordinators commitment to on-going, individualised assistance.

OCP coordinators' perspective

According to the OCP coordinators interviewed, the most valuable aspect of the program was the ability and opportunity to provide on-going support and assistance to a group of often long-term hidden carers. The most difficult needs to meet were identified as inability to provide:

- respite care options due to restrictive availability; particularly prevalent in rural areas;
- alternative activities for care recipients;
- suitable residential facilities for care recipients, especially a critical shortage for people with an acquired brain injury;
- volunteers due to a shortage of suitable candidates; and
- in some instances, appropriate permanent residential respite due to a lack of funding and facilities.

Discussion

Overall the data derived from the interviews showed that the OCP has predominantly addressed the program intention to provide more support to ageing carers of people with disabilities. A major finding of the research shows that increased access to respite as a result of care plans means the program needs to increase the priority given to the provision of care plans to older carers. Data from the interviews support the value of long-term care plans for both carers and care recipients. It appears differences in implementation of care plans between metropolitan and rural areas can be traced to the impact and influence of geographic location and lack of access to viable respite options in the latter.

The financial hardship faced by carers was of considerable concern for most of the participants. A significant number of OCP participants were unaware of their eligibility for some government allowances prior to being informed of these by program coordinators, and the carers appreciated the minimal increase in their income. This continues to be an urgent policy area for governments to find ways of further supporting older carers.

In researching factors that may contribute to satisfaction with respite care, Clarke and Finucane [6] provide support for the hypothesis that social support is an integral factor.

It is suggested that social support during respite care offers a sense of freedom to the carer described as emotional and physical refreshment and renewal. Therefore respite care which also provides opportunities to connect socially, particularly with fellow care givers such as social lunches and retreats, is highly valued. Without these social connections there is an increased probability that carers will experience distress, emotional strain and feelings of isolation.

Older carers face unique challenges in their own deteriorating health and impending mortality, with increased anxiety regarding future options for both the carer and their family member with a disability. Although a concern, Chan et al reported that a significant number of older parent carers do not make long-term plans for their care recipient. [7] Research has also found the main concern of carers aged sixty and over is related to their future planning. [8] This is supported by a substantial number of participants in this study, who expressed fears for the future of their care recipient when they can no longer manage or die. However the current research found that care plans are 'highly valued' a 'relief' and family conferences were 'very beneficial' in exploring future respite options.

Conclusion

It is clear at the policy level that the OCP has met a unique and growing need in the community, despite the small client size and nature of the program. The findings indicated that the program has predominantly attained its aims to provide intensive case management through two major activities - the provision of respite care and the implementation of care plans. In terms of objectives, access to respite care was shown to be beneficial, and the value of quality respite care was extensively supported by OCP participants. Similarly, implementations of care plans were highly valued as they had successfully allayed concerns for the long-term future of their family member with a disability. Both respite care and care plans resulted in increased quality of life for both carers and care recipients, decreased stress levels and supported participants in continuance of their care giving role.

The evaluation of the OCP provides new and important insights into issues of ageing and caring for those with a disability, particularly children who are commonly in an age bracket that would be considered 'old' or aged in most developed nations. The OCP provides a model for future care respite programs in ageing populations. It must be noted however, that there are significant indications that

as populations age at increasing rates, carers and their care recipients will experience increased stress, require more targeted interventions and become increasingly likely to require institutional care. Such programs would need to be comprehensive and targeted at older carers, who based on our research, are prone to be reluctant or suspicious of any program that may affect their caring role in the home.

Finally, the study highlighted a few major social issues in Australian society, ageing, respite care and disability, which tend to homogenise disability and can create services that are inflexible. A new phenomenon that has also emerged in recent decades is the longer life span of people with disabilities, who are outliving their caregivers. This is an important area for further research.

Competing interests

The authors declare that they have no competing interests.

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Dianne Ball

Dianne has recently been appointed to the position of Chief Executive Officer of the Australian College of Health Service Executives. In this issue of the Asia Pacific Journal of Health Management, we asked Dianne Ball a few questions on her career as a health manager and the challenges that such a role brings.

Dianne has more than twenty years of experience gained in a range of management roles in service organisations predominantly in the private and public care sectors, and management consultancy. These roles have included senior management and executive positions in medium to large organisations.

Prior to joining ACHSE, Dianne was a Management Consultant with McKesson Asia Pacific, developing learning and development initiatives, training and human resources capability and quality management. She was also General Manager, Operations at McKesson for some three years. Dianne has also worked at PriceWaterhouseCoopers as Principal Consultant (Strategic Change).

Previous experience in the public health system at Westmead Hospital as Associate Director of Organisational Development and at Royal North Shore Hospital as Assistant Director of Nursing, has equipped Dianne with a real understanding of health management issues. Dianne has also been a Management Trainee in the ACHSE New South Wales Program.

Dianne has a PhD in Organisational change, Master of Business Administration, Bachelor of Health Administration, Graduate Certificate in Change Management, a Company Director qualification and is also a Registered Nurse. As a Fellow of the College for more than ten years, Dianne is very much looking forward to the challenges ahead. Dianne's current interests are to use her experience and skills both in the workplace and in the broader community. Dianne is a member of Rotary International and a Director on the board of a not-for-profit organisation that provides work for people with disabilities.

1. What made you venture into health management?

My career in health started with my general nursing training in the days when it was still hospital based, and I became a triple certificated sister as they called it in those days, having done psychiatric nursing and then midwifery. I always had a thirst for knowledge and a desire to make a positive difference to the world. When nursing, my goal was to do my best for the patients in my care. Then I moved into nursing management where my goal was to do my best for the nurses who were delivering nursing care. As I matured and broadened through experience, so my goals expanded and I became interested in working at the organisational and then Area Health Service levels, still with the intention of improving health service delivery.

I moved away from the health sector for a few years and consulted with PriceWaterhouseCoopers, and only then did I start to appreciate what I'd learned in health, and start to understand what I had to offer. I've had national responsibilities in recent years, which I enjoy immensely, and my goal is still the same – to improve health services – but now I'm focused on working at the system level rather than the organisational or individual level.

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

I have to say that I've enjoyed every role that I've had in my career, and when there were signs that I no longer enjoyed the role, or I could no longer make a difference or learn something, I moved on. I've never been in a situation where I didn't enjoy coming to work and facing the challenges of the day.

In hospital management roles I enjoyed the direct satisfaction of helping the patients: either by intervening in crisis situations; squeezing resources from a hospital that was at over-capacity to allow emergency patients to be admitted (many of whom were elderly and very ill); or by negotiating with doctors and other staff to change their practice and become more efficient, thereby allowing more patients to be treated. I enjoy pushing the system.

When working in corporate roles that are less directly focused on patient care, the most enjoyable parts have been working with my direct reports and younger managers and being a mentor and a role model, and encouraging people to stretch themselves and 'fly'. Helping other people to realise their potential and grow is very exciting, and gives me great satisfaction. Part of this is sharing my thoughts with younger managers, giving them suggestions about how to work with people and influence them, how to cut through bureaucratic red tape, how to manage upwards, and how to differentiate between 'real' issues and perceived issues, which is so important.

From a personal perspective, I thrive when faced with new challenges and I enjoy the apprehension of the first day in a new role when I think to myself 'Now, how am I going to pull this one off?' and within a short period of time you're riding the waves and moving forward.

3. What are the greatest challenges facing health managers?

At the individual level, every manager needs to work out how to balance themselves and ensure they are in their best form physically, mentally and emotionally/spiritually. For me, this was the only way I could cope working in dynamic, challenging roles. And it's a real challenge to look after yourself, especially if working long hours or travelling, as well as coping with constant demands in the workplace.

From the organisational level, it is a challenge to effectively allocate resources to where they are most needed, and not where they have historically been allocated, and being able to look at the outcomes of what we do and not just the activity patterns. As health service managers we need to ask ourselves and our stakeholders 'what is the most effective, beneficial way to use this resource for the greater good?' and encourage consumer input into these difficult decisions.

A second challenge is to be able to move an entity forward strategically while at the same time managing the daily crises that emerge, and not be distracted by the issue of the day. It is a real challenge – and a skill – to be able to get things done, especially when there are diverse stakeholders and conflicting priorities.

Another challenge is at the structural level: determining the appropriate governance mechanisms (both clinical and nonclinical); ensuring that there is an agreed strategy supported by key stakeholders; that there are clear accountabilities and roles; and appropriate infrastructure without excessive red tape. One of the reasons I enjoy working at the structural level is being able to deconstruct environments that no longer work (ie working on the cultural, systems, processes, people and organisational design aspects) and then reconstruct them in a more effective way so the entity can move forward.

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

Having both state and federal funders of health in Australia is such an inefficient constraint that prevents the effective use of resources and distracts managers and bureaucrats from the real game of providing high quality health care. I look forward to the day when the Australian health system will have clearer funding arrangements, preferably from one source.

On many occasions I've experienced the 'game playing' of trying to maximise revenue while at the same time reduce or reallocate costs and the effort involved represents a large hidden cost in our health care system. In my experience, service delivery models are not based upon what will achieve the best outcome for the consumer, but focused on financial arrangements, and this prevents services from being as cost effective as they could.

I would also encourage innovation and creativity by our top decision makers. Over the last twenty years we've seen the impact of resource constraints, and the response by the system still tends to be to do the same thing, but do it faster. But we need to stop and look at how we can do things differently. The Commonwealth has funded a range of programs over the years to encourage innovation and this is commended, but we need holistic innovation, not a piecemeal approach.

5. What has been your career highlight?

My career has been almost equally divided between working in the public and private sectors. I enjoy the ability to work more autonomously and make faster decisions when working in the private sector. But I must admit that I also enjoy the challenges of the public system and the thrill of pushing the boundaries, especially when the political pressures are high. Some of my most enjoyable moments occurred several years ago when the issue of surgical waiting lists first became prominent. An Area Health Service gave me the task of managing our response, and I remember the thrill of

negotiating with surgeons, anaesthetists, nurses and clerical staff to change work practices to increase productivity, which we did. Our Area Health Service performed so well that other Area Health Services visited to learn of our approach and take similar measures. The results were extremely positive in terms of patient outcomes, financial impact, and creating political goodwill both internally and externally.

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

There have been factors which influenced my career. My mother was widowed when I was young and I remember her cleaning houses and encouraging my sister and I to have a career and be able to support ourselves. The goal of being self-supportive has always been at the back of my mind. And when my dear mum said to me at the time of the birth of my twin daughters (and big brother was only 15 months old) 'now you'll have to give up work', that just made me more determined. Now my little joys are 21, 20 and 20 years old and they enjoy me having a successful career.

I didn't have a formal mentor. But I remember mentally assessing senior managers and identifying those attributes that I wanted to develop in myself, as well as those that I deliberately did not want to emulate. I especially admired Ron Tindale, AM (now deceased, from the former Western Sydney Area Health Service) and Kathy Baker (retired, from the former Northern Sydney Area Health Service) both of whom encouraged me and gave me some of their time in my earlier years. I dedicated my PhD thesis to both Ron and Kathy.

When I was nursing I saw a fair amount of life and death and this experience influenced me more than any individual. I remember at the age of 21, as a newly registered Sister, working in the oncology ward. One of our nursing colleagues died from cancer on my shift, and I attended to her. I've always valued life and respected death. And I give thanks to having a body and a brain that works, and that I live in Australia where there are unlimited opportunities.

More than anything, I have felt an obligation to make the most of my circumstances, and to extend myself as far as I can go. I'm pleased with what I've achieved, and now in my mid forties, I'm pleased that I still have the fire in the belly to make a difference, and I still have further to go.

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

To younger health service managers, my advice is simple: complete your academic qualifications early and ensure you study financial management and are comfortable with financial spreadsheets; learn when it's time to move on from a role and have a variety of experiences; find people who can be your mentor and make good use of them; don't accept the status quo. Push the boundaries until there is a very good, legitimate reason to stop. Don't be afraid to challenge and question. It's a positive sign to rock the boat; – that's what you're supposed to be doing. And most of all, enjoy the journey.
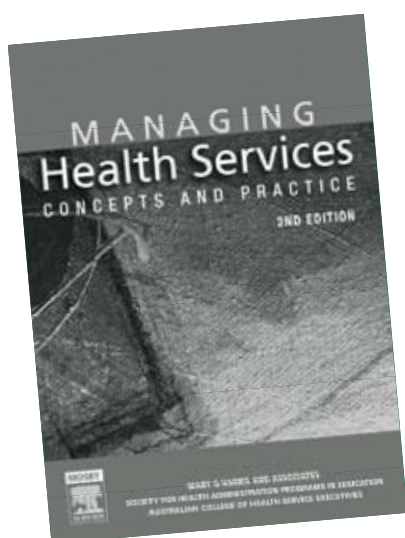
Primary Care in the Driver's Seat? Organisational reform in European primary care

Reviewed by R Bialkowski

This book is the ninth in a series of publications by the European Observatory on Health Systems and Policies on key issues for health policy making in Europe. It has three editors and thirty-one contributors. Each contributor reflects a high level of academic expertise in the fields of health policy, primary care research and clinical practice, and health economics. Contibutors are drawn from universities and research institutions in the United Kingdom and Western Europe, along with contributions from the United States, Canada, Eastern Europe and Australia.

The book is divided into two parts and has twelve chapters. Part One consists of four chapters that present an assessment of the strategic landscape impacting the delivery of primary health care in Europe. The first two chapters examine the issue of coordination and integration of European primary care and then map the primary care services that are available in Europe. The third chapter examines the structural reforms currently under way in Europe and notes that countries are resorting to a common set of policies to restructure primary care services, such as enhancing gate-keeping, developing teamwork, changing methods of remuneration and changing the balance between primary and secondary care.

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The fourth chapter ties these issues together and concludes that for most countries, general practice is not the most powerful level of primary health care but it is one that provides a diverse range of services that often compete with specialist services. In the view of the editors, there is a paradox between the relative weakness and unattract-iveness (to consumers) of primary care versus the policy maker's intention to allocate a more central coordinating role to general practice. This leads the editors to conclude that although primary care-based systems are more cost effective, the paradox remains that although primary care may have considerable potential, there is (as yet) no clear evidence about the effectiveness of its coordination and navigation functions (the driver's role).

Part Two consists of eight chapters that examine three broad themes: the impact on primary care of changing institutional arrangements, changing working arrangements and changing quality standards.

Chapters five to seven examine the first theme from the perspective of changing roles of primary care professionals. The authors contend that although the gate-keeping role in primary care was useful in the past in encouraging integration of services, it can no longer coordinate care adequately. This is because it does not fit the changing structure of primary care: a structure increasingly characterised by diverse points of entry; development of large group practices; part-time GPs; emerging specialist GPs; and the increasing use of nurse triage. The authors suggest that this evolution in primary care is likely to lead to a dilution in both the role of GPs and the authority of their gate-keeper role.

Chapters eight to ten examine the changing working arrangements impacting the key professional groups that make up the primary health care sector. The focus of these chapters is on the changing role and task profiles of primary health care professionals, and the impacts on work behaviour through changes in payment systems and financial incentives.

The final two chapters examine the impact of the rapid adoption of quality enhancing systems designed to improve quality and performance in primary care, and the impact of new information management and communication technologies in primary care.

Although the title of the book implies that primary care should take the 'driver's seat' in the European health care system, the studies as presented leave the question open. Notwithstanding, both individually and as a whole, these studies present a useful situation report on the process of organisational change that has and continues to develop in Europe. This process is aimed at moving and strengthening primary care, as a core component of primary health care, to being the focal point of health care decision-making and responsibility.

The studies identify and examine the challenges that still lie ahead for primary care to clearly mark and pursue its place in a continuing evolving European health care system. While primary care has an identified and significant potential to take on a greater coordinating role, questions remain about its capacity to do so while at the same time retaining enough time to treat patients and retain their trust.

The issues raised in the book reflect much of what is currently being grappled with in Australia and therefore it is a relevant and useful reference for anyone interested in primary care.

Competing interests

The author declares that he 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 fifth issue of the Journal. The deadline for receipt of papers is 30 November 2007.

Health System Review

Reviewed by A Magarry

Bibliographic details:

The 2006 Health Services in Transition (HIT) report on Australia is 178 pages long and set out in nine chapters including an executive summary, reference appendix and abstract. It represents an updated and largely rewritten version of the 2001 report with reference to input from experts in the Australian system. The updated report was written by Judith Healy with Buddhima Lokuge from the Regulation Institutions Network, Australian National University, and Evelyn Sharman from the Australian Government Department of Health and Ageing.

The HIT profiles are country-based reports that provide a detailed description of a health system and of reform and policy initiatives in progress or under development in a particular country. The reports occupy a vital space in the educational resource guides available on health systems and are considered valuable reference guides for anyone interested in gaining a detailed understanding of the organisation, financing and delivery of health services and the regulatory framework within which they operate.

Chapter one sets the context describing Australia to the rest of the world from a geographical and socio-demographical perspective including the economic and political context within which the system has to function. An overview of the current status of the health and wellbeing of Australians is described in comparison to the health of Aboriginals and Torres Strait Islanders.

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Chapter two describes the way in which the Australian health system is organised in terms of levels of responsibility, stakeholders and providers, before describing the complexity of the entitlements and benefits available. However it is perhaps chapter three that is of most interest to anyone wanting a detailed overview of the latest developments in the planning and regulation of the Australian health system as it contains an overview that is largely unavailable elsewhere.

The financing of Australia's health system has often been described as complex and unnecessarily so, and the flowchart on page 61 of Chapter four once again illustrates this point. However the chapter does provide a useful descriptive overview of the way in which the system mobilises finances, allocates funds across the system, and controls expenditure with reference to international comparisons.

Chapter five is simply defined as physical and human resources but it is in fact an accurate description of the issues involved in providing health care because it outlines the problems associated with capital and infrastructure investment and the evolving relationship with the private sector in both stock and information technology support. The latter section of this chapter focuses on the issue of human resources, exploring the current supply and the recent policy initiatives aimed at better distributing the medical workforce and tackling the declining nurse workforce.

Chapter six is simply an overview of the main elements in the provision of health services and is useful for anyone wishing to understand the type and level of care on offer, by whom and at what point in the care continuum. The overview of the regulatory framework supporting aged care, rehabilitation, disability and informal care services is brief.

Chapter seven goes into some detail on the reforms that have occurred to the Australian health system since 1946 that have had a substantial impact on health care, citing changes to Medicare and voluntary private health insurance as key reforms. Under future developments the report addresses the emerging concerns such as coordinated care, workforce challenges and quality and safety and this section is an accurate and educational read.

The report suggest the Australian health system is in a state of transition but as chapters eight and nine demonstrate, it is clear there has been a process of incremental reform and that this approach will continue into the future.

The writers conclude in chapter nine that Australia is a prosperous country with a population that enjoys relatively good health and increasing life expectancy based on access to comprehensive health care of a high standard funded mainly through general taxation. However they make the point that the tension arising from the fiscal and functional responsibilities between the levels of government and interactions with various providers is a major limiting factor for any one actor to effectively plan or regulate for change. This means that there is a reduced capacity to address emerging pressures on the system such as rising and possibly unsustainable costs, long waiting lists for elective surgery, disparities between urban and rural service access and the continuing poor health status of Indigenous Australians.

The report highlights the importance of the role of government in the ability to achieve change in a complex health system such as Australia's.

Anyone interested in gaining a thorough and factual description of the Australian health system would gain valuable and relevant information that would also provide a building block for the reader to further their own particular research interests.

Competing interests

The author declares that she has no competing interests.

LIBRARY BULLETIN

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

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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.

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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.

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