Asia Pacific Journal *of* Health Management

Volume 2 Issue 3 – 2007

The Journal of the Australian College of Health Service Executives

Strategic leadership

Public policy and discourse

Complexity

- **Decsion making**
- **Managers' perceptions**
- **Ambulatory care**
- **End-of-life care**
- **Aged and palliative care**

Asia Pacific health issues

. . . and more

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COVER: Photograph of the Silver Fern taken at Waitomo in the North Island of New Zealand courtesy of Mr Korry Ritsma. The Koru is associated with that well-recognised New Zealand national symbol, the Silver Fern and is a Māori name given to the newborn, unfurling frond and symbolises new life, growth, strength and peace. It is an integral symbol in Māori carving and tattoos. [1]

1. http://en.wikipedia.org/wiki/Koru. Accessed 23 September 2007.

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

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

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

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

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

RESEARCH NOTES

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

REVIEWS

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

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VIEWPOINTS

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

LETTERS TO THE EDITOR

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

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EDITORIAL

Metaphors of healthcare

DS Briggs

The Journal has adopted the practice of selecting a photo and cover design that reflect either an article theme or geographic area representing the location of authors in a particular issue. In this issue, there is a decidedly New Zealand influence. The Feature article, a Viewpoint article, and In Profile are provided by our New Zealand colleagues, supporting the selection of a New Zealand cover theme.

From the photographs submitted, the photo of the Koru was selected. The Koru is associated with that well-recognised New Zealand national symbol, the Silver Fern, and is a Maōri name given to the newborn, unfurling fern frond, symbolising new life, growth, strength and peace. It is an integral symbol in Maōri carving and tattoos. [1] The use of this photo and the above descriptor prompted the Editor to think of the use of metaphors in healthcare management and how apt the Koru might be in that context. It could easily reflect the organic perspective of organisations as opposed to the mechanistic, a metaphor that suggests that the health system and those engaged in it need to be valued and nurtured. It is also consistent with the theme of the feature article by McKernan [2] that suggests evolution, not revolution in reform. When the book review for this issue was received and the reviewer invoked the metaphor of *'three blind men and an elephant'* to give meaning to the health system, it became inevitable that this editorial should focus on metaphors in healthcare management. [3]

The use of metaphors in healthcare and health management research is not new and many such as the term *gatekeeper* [4] are frequently used. Most health professionals would recognise it as a descriptor of how and through whom people access *healthcare*. Our interpretation of the metaphor might differ with perhaps some seeing the *gatekeeper* as a facilitator of access while others interpreting it as a process to ration and control; and there may well be different views about who should be the gatekeeper and what values and ethics might underlie that role. The use of the metaphor thereby promotes debate, analysis and re-interpretation of underlying meaning between us about the essence and meaning of a phenomenon. [5] In management and organisational theory metaphors help us to understand the origin and nature of those phenomena. [6]

The use of metaphors has been borrowed by organisational theorists from the arts and humanities and has also been used in the natural sciences. [5] More descriptive metaphors that you would normally expect to discover in the natural sciences, have come to the Editor's attention in current research that has an interpretative phenomenological approach. [7] The research aim is to gain a deeper understanding of the perceptions of the health system of a group of 19 health service managers across a diverse range of health system settings in Australia and New Zealand. [8]

A respondent to the Editor's research describes the health system in terms of *frogs* and *bikes*. A metaphor derived from a continuing professional development experience of the health manager, the *frog* representing the organic organisational perspective, the *bike* a mechanistic perspective. There are a number of further meanings proffered for this metaphor, the first being that the *bike* can be dismantled and reassembled in different ways, a metaphor for restructure. The question is while we might still recognise it as a *bike*, will it continue to effectively perform as a *bike*? Of course we can't take the same approach with the *frog* but the other meaning ascribed to that metaphor suggests that, like the *frog* sitting contentedly in the pond, some people are content to sit quietly in the health system ignoring all the change and risk their survival by not being engaged and responding to change.

Our Thai colleagues have a similar metaphor that utilises the *frog*. They say 'kob nai kala': *the frog in the shell* – representing the same context as above. They then go on to demonstrate the need for leadership and engagement with 'kob nork kala': *the frog outside the shell*. A useful metaphor that again has relevance to the need for leadership in the feature article in this issue by McKernan. [2]

The enormity of the task confronting health managers in managing in complex health systems is well-traversed by a number of contributors of articles in this issue. Another respondent to the Editor's research talks of feeling powerless like the *princess in the pond*, using a spoon with holes in it to empty the water while nearby tankers are busily refilling the pond! This suggests that being in control is not necessarily with the manager or the clinician during restructure but resides elsewhere and that managers are participants in the change process rather than being in control. [10] Dehn and Day provide us with some insights into the perspectives of one group of Australian health managers confronting change in a complex system and it may well be that this metaphor also has some relevance to that context. [11] Another senior health manager talks of the importance of resilience in the role, utilising the metaphor of patiently trimming away at the *hedge* while waiting for the preferred public policy opportunity to arise allowing the manager to break through the *hedge* and seize the opportunity presented. [8] North and Perkins in this issue, effectively describe the influence of discourse, public policy and paradigm change over time in New Zealand, concluding that its impact on health managers is seldom a consideration in health reform. [12]

Finally, another senior health manager invoked a metaphor of *thoroughbreds* and *donkeys* [8] to suggest that change and the complexity and importance of healthcare required careful selection of health managers with attention and support to potential ability, training and development, particularly in learning how to facilitate and promote change. [13]

Readers might like to reflect on the potential for us to develop a shared perception of the health system, unlike the perceptions of the *three blind men* which can be further explored by reading the book review by Healy. [3] The Letter to the Editor section suggests a way forward in learning from each other. Metaphors of health care are constitutive of our reality through interpretation [4] and their use might stimulate a wider debate around important issues for our profession and the future direction of our health services.

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

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IN THIS ISSUE

In this issue, the Feature article, a Review article and In Profile have a distinctive New Zealand influence, as does the cover. The Feature article is provided by the Director General of the New Zealand Ministry of Health, Stephen McKernan. This article suggests the emphasis in health reform needs to be on evolution rather than revolution, devolution instead of centralisation and discusses the importance of performance management, building sector capability and leadership. Our New Zealand colleagues Nicola North and Rod Perkins continue this theme with a Review article that provides an analysis of a decade of change in discourse and public policy in the New Zealand health system. They describe the differing paradigms of healthcare reform in that time and conclude that the impact of the underlying discourse and paradigms in health reform rarely include a consideration of their impact on and consequences for health service managers.

The In Profile article features David Rankin, a Fellow of the College and, amongst other things, the recently appointed President of the New Zealand Institute of Health Management. Returning to our cover we provide a distinctive New Zealand theme and very much thank Kory Ritsma for this contribution and for the use of the photograph.

Seven original articles are included in this issue as well as a book review, our regular Q&As section and our well regarded ACHSE Library Bulletin. In the Q&As section, we are pleased to receive our first contribution from a colleague from the Philippines, Professor Rene Domingo of the Asian Institute of Management. We appreciate the contribution of all to the Journal and the increased international contributions. A brief report on the Sixth Asian Hospital Conference that attracted over 600 participants is included for the first time, in recognition of the widening readership of the Journal.

An important contribution is provided in the Letters to the Editor column suggesting how the Journal might be effectively used in the professional development of members and to increase their involvement with the APJHM. One of the two editorials also encourages further participation of the readership in the Journal through participating in peer review. We welcome further contact and feedback in these two areas.

In addition to the Feature and Review articles described above, the remaining articles reinforce the perception that health services and systems are complex. Fitzgerald, Dadich and Lum in their Research article describe the decision-making process around unplanned surgical admissions and the priority setting processes of involved personnel. They make findings from this study including the conclusion that the scheduling of unplanned surgery is complex and multifaceted and worthy of further research. Dehn and Day report in their Research note on a pilot study to examine the perceptions of one group of health managers in Queensland, Australia about current hospital management structures in what they perceive as a complex health environment. While health managers in this study recognised the increased complexity of their role, there appeared to be little support for structural changes to address the impact of that complexity.

O'Connor, Peters and Lee provide an overview of end of life care in place in two private hospitals in Australia. This Research article provides information on practices that are not well-reported in private hospital settings demonstrating that current practices reflect the core speciality of the hospital concerned. The Management Practice article of Sandler, Harriss and Bain describes a redesign process for a range of ambulatory care services in a major Victorian healthcare network. This paper again emphasises the theme of complexity in making change in healthcare in moving towards an integrated, single point of entry model of ambulatory care. Allen and colleagues, in a Management practice article, describes how differences in funding similar services for aged care residents through the residential aged care program and multi purpose services might impact differently on palliative care services. This article describes complexity arising from separate funding, accreditation and levels of government responsibility.

Healy provides a book review of the latest edition of the Duckett text, The Australian Health Care System published by Oxford University Press and in doing so invokes the image of *three blind men and an elephant*, prompting an editorial around the use of metaphors in healthcare.

LETTER TO THE EDITOR

Australian Capital Territory Branch Continuing Professional Development

The Australian Capital Territory (ACT) Branch of the Australian College of Health Service Executives (ACHSE) established a Fellowship Chapter in 2006 with the aim of fostering ongoing learning and collaboration amongst Fellows. All Fellows are eligible to join this group. Currently a group of about six to eight Fellows meets monthly.

The program we have adopted is the study of a journal article one month and a mini mentoring session on the alternate month.

Mini mentoring takes the form of a person who has achieved success in their career joining the group for a discussion around five key lessons learnt and five key achievements in their career.

The aim of the Journal Club is to:

1. Build on the Fellowship program;
2. Encourage Fellows to read and discuss current healthcare literature;
3. Contribute to a culture of evidence-based practice;
4. Promote dialogue between different members of the health industry in a relaxed and open manner in order to foster the transfer of knowledge between members; and
5. Generate recommendations for improving the quality of care.

Currently the group reads and discusses articles from the Asia Pacific Journal of Health Management. We have studied the three Podger articles over the last three Journal Club meetings and found the riposte very useful in provoking deeper discussion.

We would like to enhance the Journal Club and suggest that the Asia Pacific Journal of Health Management consider accompanying the lead article with key questions to stimulate discussion. At a later date this could be extended to an on-line discussion group that has the potential to benefit fellowship candidates and rural members.

ACHSE has also been approached with a proposal for the ACHSE librarian to source articles and develop key questions to stimulate discussion.

Thank you for your excellent publication.

Yours sincerely

Ellen O'Keeffe
Clinical Operations Executive Officer
ACT Health

Editor's Response

The suggestions made by Ellen O'Keefe, based on the initiative of the ACT Branch of the College, have considerable merit and potential. Health professionals are generally familiar with journal clubs that often reflect an occupational group, a professional or interprofessional grouping. Alternatively they are a function of a health or educational institution, a specific clinical interest or geographic and/or population-based interest. A journal club based around College members and Journal subscribers that represents the diversity of health management interests, deserves careful consideration.

It may well be that other College branches, groups of College members and Journal readers are participating in similar activities or might have contributions to make about the approach and suggestions made in this correspondence. Therefore, the Editor would like to encourage the contribution of further ideas including a willingness to contribute or participate in such a project through the Letters to the Editor column of this Journal.

DS Briggs
Editor

EDITORIAL

Contributing to the profession, the College and this Journal

DS Briggs

Recently this Editor was asked to participate in a professional development activity that is meant to encourage health professionals in a particular health service to contribute to a proposed journal to 'showcase' the achievement of staff and the services they provide and to disseminate knowledge more widely. The organisers of the professional development activity decided that before encouraging potential contributors they would develop interest in the peer review process.

This demonstrates the importance of peer review in the process of publishing and disseminating knowledge. Like the above group of enthusiastic health professionals, the College and the Editor of this Journal, aspire to not only encourage contributions but to encourage readers and subscribers to consider participating as peer reviewers. This Journal has only been established since 2006 as the official Journal of the Australian College of Health Service Executives. While it is a membership journal, it is also open to subscribers and readers from the wider health management profession in the Asia Pacific region.

The College as a professional member organisation encourages membership from those who have a health management role or interest in health management. There are many ways to contribute through professional development activities, holding College office and submitting articles for publication. Another important opportunity to contribute is by considering the value of being a peer reviewer. Experienced educators, managers, clinicians and researchers are encouraged to contribute to the Journal as peer reviewers. The quality and reputation of the Journal depends on the quality of the articles published and the contribution of peer reviewers is an important element of that process.

The Journal intends to advance the understanding of healthcare management in health services and organisations in the Asia Pacific Region. It encourages original articles that are categorised as: Analysis of management practice (eg case study, interview, commentary); Research article (empirical, quantitative and qualitative, and/or theoretical); Research note; Review article (eg policy review, trends, review or meta-analysis of research); and Book review. [1]

A perusal of the first few issues of this Journal demonstrates the diversity of the interest of contributors in aspects of health management and, by definition the need to have a diverse range of health managers, clinicians, educators, and researchers as peer reviewers. The peer review process is 'blind' meaning that the reviewers are unaware of the contributing authors' details and the authors are likewise unaware of the reviewers details. It is the Editor's responsibility to ensure the rigorous adherence to the anonymity of this process meant to enhance the quality of the evaluation. [2] Each article is sent to two peer reviewers and the reviewers are selected on each occasion based on their areas of interest and expertise. Attempts are also made to draw on expertise that combines theoretical and operational perspectives of the two selected reviewers.

In a recent editorial about the purpose of review, the *Nature Medicine Journal* suggested that good reviewers underpin the quality of a journal. This editorial goes on to suggest that good reviewers provide fair, thorough, detailed and constructive comment to help an author(s) improve their paper. [3] The APJHM has an expectation that the peer review process will be independent, timely and developmental. We request our reviewers to be specific and issue-focussed. We require reviewers to be constructive rather than judgemental and to identify both strengths and weaknesses. In other words, we ask our reviewers to be author-friendly. [2] This approach is not just about being respectful and courteous. The Journal also has a role to encourage and develop the knowledge and capacity of health managers and emerging researchers who may have little or no experience in writing and publishing in this context, as well as being a vehicle for those with a more extensive research and publication record. [2]

Likewise, the participation in peer review is an opportunity for personal professional development and an opportunity to contribute to the profession and the College. It is also an opportunity to extend expertise in a particular area of interest. The Journal is mindful that we are asking busy people to add to their professional contributions and workload. However, increased numbers of reviewers' decrease the requests for contribution from each individual, a factor that is considered each time reviewers are invited or asked if they might like to review a particular article.

If you are interested, contact APJHM at journal@achse.org.au

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SPECIAL FEATURE

Evolution and Leadership in the New Zealand Health System

S McKernan

Abstract

This feature comments on progress six years into the implementation of the 2001 reforms in the New Zealand health system and current challenges. Under the *New Zealand Public Health and Disability Act (NZPHDA) 2000*, 21 District Health Boards (DHBs) with responsibilities to protect and improve health for local populations were established. Although the Ministry of Health continues to fund the health sector centrally and provides some national services, more than 80% of the national health budget allocations are distributed to DHBs for purchase and provision of both community and hospital services.

This paper discusses the implications of the evolution (rather than revolution!) of the New Zealand health system for the multiple roles of the Ministry of Health as the central policy maker, regulator, funder, performance and change manager of the system since the introduction of the *NZPHDA 2000*. Institutionalising change management and building sector capability to be adept at adapting, sharing innovation and reducing the lag time between strategy, policy, its implementation and evaluation, is new business for the Ministry of Health. This feature comments on the platforms that will strengthen a focus on reducing performance variation and creating a health system that diffuses effective innovations to tell the performance story that the community and Government need to hear.

Abbreviations: DHBs – District Health Boards; NZPHDA – *New Zealand Public Health and Disability Act*; PBFF – Population-Based Funding Formula; PHO – Primary Healthcare Organisation.

Key Words: health policy; leadership; centralisation; devolution and innovation.

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From revolution to evolution, centralisation to devolution, national planning to local responsiveness…

Since 2001, New Zealand's health system has had policy and strategy stability in contrast to the rapid reforms of the mid 1990s. The introduction of policy, purchase and provider splits and contracting approaches in the mid 1990s saw those central functions undergo three sets of reforms within six years.

These arrangements were replaced with the *NZPHDA 2000* that established 21 DHBs with locally elected Boards to plan, fund and provide services responsive to local population health needs. Established from 1 July 2001, DHBs are governed by Boards comprising both elected (through local government elections) and Minister appointed Directors and are accountable to the Minister of Health.

The *NZPHDA* requires the Minister of Health to develop a Health Strategy and a Disability Strategy for the nation. In addition, local DHBs are required to consult with their communities and develop a local District Strategic Plan, laying out future directions for the funding and provision of local services based on a health needs analysis of local populations. This emphasis on medium to long-term planning is a cornerstone of the New Zealand health system. Among other strategies, the Primary Healthcare Strategy further embedded the focus on population health approaches by introducing capitation for patients enrolled in a Primary Healthcare Organisation (PHO). Capitation arrangements were established that further devolved

funding and provision of primary and some community care services for enrolled populations to PHOs.

It is mirrored administratively with the establishment of an indicative three year funding pathway for the sector and the allocation of funds through a Population Based Funding Formula (PBFF). The PBFF allocates funds to local DHBs adjusted for demographic variables that reflect the key determinants and drivers of health service utilisation (eg age, sex, socioeconomic status and ethnicity). This has allowed the health system to manage risks within the health budget allocation without continual reference to the central Government funds for additional resources. Service demand pressures driven by demographic growth, scope to manage contract negotiations, industrial relations pressures and operational certainty for the provision arms of the sector are important and significant benefits to the system. Unique within the New Zealand public service management system, it has been an important pillar to allow funders to commit to strategic relationships and service developments with providers over multiple financial years.

The New Zealand Health and Disability Strategies among other health strategies (eg Maori Health, Primary Care, Pacific and Health of Older People) provide important prioritisation parameters for DHBs. There is, however, significant flexibility and autonomy for DHBs to ensure responsiveness to local population health priorities. This flexibility is important in New Zealand. The determinants of health manifest themselves differently in each DHB: mix of rural/urban populations; local influences of indigenous Maori communities; mix and proportions of low socioeconomic and affluent populations; geographic dispersion of communities; and local economic development. As the system has evolved and matured, the limitations of our current settings become more apparent and present some challenges in continuing the emphasis on improving health outcomes for local populations.

Challenges ahead: value for money, driving performance and driving innovation…

Recent evaluations of the New Zealand health reforms of 2001 conclude that there is 'widespread support for the main goals and mechanisms embodied in the NZPHDA model'. [1 p.9] There is widespread support for the local focus of DHBs, the national strategic settings and the requirement for DHBs to conduct their business in the public eye. New Zealand enjoys relatively good health status for the proportion of GDP spent when compared internationally with other developed countries.

There is, however, cautious optimism in the system's ability to deliver on population health outcomes in the long run. Evaluations suggest it is time to review whether the national PBFF reflects cost structure of services sufficiently distinct from determinants of health. Although there is evidence the inequalities gap may not be widening [2] the pace of this improvement, particularly for indigenous Maori populations, must be increased. There has been criticism that increased budget allocations for the health sector have not been mirrored by visible productivity improvements or directly linked to improved health outcomes. There is tension between funding allocations for local priorities and collaborating on regional and/or national priorities. There is significant variation in the performance and delivery of DHBs on many national health indicators. Effective innovations that impact on health outcomes are not easily translated to other parts of the system.

Despite our size (population 4.2million), the New Zealand health system fails on some accounts to take advantage of its size. It seems, that the opportunity cost of a devolved health management system and local responsiveness may be the ability to adapt to shifts in national priorities, significant transaction costs in national decision-making and local reluctance to take on new initiatives and innovations unless it is 'invented in my District'.

Review of the role of the centre…

The central leadership role of the Ministry of Health in a maturing and devolved health management system has, over time, shifted. Throughout the period since 2001, the Ministry of Health has led the change management and establishment of DHBs, transitioning centrally funded and managed services to local boards and devolving funding responsibilities in parallel with accountabilities. The Ministry has set national strategies, shifted policy settings to enable implementation and evolved the accountability and regulatory settings to reflect devolved responsibilities.

In 2006, being newly appointed to the role of Director General, I took the opportunity, to invite sector stakeholders to comment on the state of the Ministry of Health and how it should conduct its business.

The context is in some ways more complex now than it was in 2001. We have a mixed system; although a majority of services are devolved to local DHBs, there is still a significant proportion (approximately 17%) that continues to be funded and managed from the centre. Within a devolved health management environment, the levers available to manage change and enforce accountability are 'softer'. Performance

of one part of the local health system (eg hospital) needs to be assessed within the context of the local conditions facing that DHB and their providers.

The Ministry of Health also maintains the core of what may be regarded as the essential functions of Government in a modern health system; regulator, legislator, policy advisor and funder. There are many opportunities for internal conflict within the Ministry. We are also a player in the sector as a provider and funder of national and local services that are delivered in a DHB's local patch, creating tensions in the accountability relationship.

The sector feedback acknowledged the Ministry's role in this core set of machinery of government functions but sought a different emphasis. Variations in practice and patient outcomes in our hospitals are all too common. Sensible regional approaches to service planning, development and delivery in some areas were not taken up by others. Confirming my own experience as a Chief Executive of a DHB, too often there were programs and initiatives that worked well in one DHB but were not adopted in others. The sector recognised the need for better system-wide learning and sharing of innovations and good practice and sought the Ministry's leadership to support it. [3]

Wide variations in performance between DHBs, hospitals and providers is an issue that is not unique to the New Zealand health system. While not detracting from the critical importance of good policy development and holding the sector accountable, ultimately implementation of those policies and strategies relies on the performance of the system. This is new business for the Ministry of Health.

Looking ahead – platforms for driving system performance

Supporting national health system performance from the centre was at the core of the recent reorganisation of the Ministry of Health [4] and over the next three to five years we will develop the following platforms:

- Strengthened focus on sector capability to support implementation and shared system-wide learning through innovation dissemination and diffusion;
- Establishing Health Targets as a mechanism for focusing performance improvements in the health system; and
- Building leadership capability that can transform our healthcare services and organisations.

The New Zealand health system is rich in innovative service developments that have delivered to localised needs in many areas. The New Zealand health system is poor, however, in the social and relational capital and processes that facilitate the sharing of that learning to the benefit of other parts of the system. In many circumstances, local DHB innovations in areas such as chronic care management are recognised internationally but receive little recognition or even adoption back home. This may be a residual consequence of a competitive contracting regime in the 1990s exacerbated by a subsequent DHB accountability and legislative framework that prioritises local population health needs sometimes to the detriment of national and regional collaboration. Culture takes much longer to change than structures.

An assessment of the barriers to diffusion [5] in New Zealand highlighted that historical, cultural and economic disincentives for inter-organisational collaboration and a lack of relational capital prevent innovation spread and adoption. There is promise, however, in the emerging stability of DHBs and PHOs to create improved environments for innovation spread. The routine evaluation and extraction of innovations for generalisable adoption in other parts of the system is a role the Ministry will provide as a platform for driving performance.

Moving the sector from ignoring localised innovations and developments because it was 'not invented here' to 'looking over the fence' requires a cultural shift that the Ministry must lead and support from the centre. The resulting variations in system performance (and inefficiencies) present a major challenge to being able to demonstrate publicly the value for public investment.

The establishment of a group within the organisation focused on Sector Capability and Innovation provides an important response to the sector's demands for implementation support that is beyond policy and strategy. The working definition of capability [6] being access to the people, systems, structures, resources, processes, information and leadership necessary to realise the Government's objectives is used in this context. It is too early for New Zealand to consider a United Kingdom style Institute for Innovation and Improvement (formerly the Modernisation Agency) as structural change will only further exacerbate current relationship tensions.

This has the potential to blur traditional hierarchies and boundaries between funder and provider, policy maker and implementer. New Zealand's current institutional arrangements require strategic partnerships and collaborative relationships to further realise the benefits of a devolved health management system.

Driving performance, however, needs a process to be able to quantify and measure progress. In August 2007, the Government launched New Zealand's first set of Health Targets. [7] Health Targets emerged as part of a wider central agency review of health expenditure. Developing a set of measurable goals and indicators against which national improvements could be assessed was driven by both a need to publicly and simply demonstrate shifts in performance while also giving the sector clear signals about the Minister's priorities.

Learning from the experience of the other health systems (such as the United Kingdom), New Zealand's Health Targets are a small set of ten that reflect the Minister's priorities. Each Target contains a set of indicators that should be seen within the context of the health service program and service delivery system. For example, immunisation targets are indicative of improvements in, not only immunisation coverage but also the wider Well Child health assessment and development checking program that they are part of. Similarly, diabetes indicators are a reflection of how well patients access the wider system of structured care management for chronic disease. Health Targets are integrated into DHB District Annual Plans and Statements of Intent. Incremental improvements at a local level impact should drive improvements at a national level.

Transforming health systems and healthcare organisations to drive performance improvements is a leadership task of extraordinary breadth, depth and challenge. Twenty-one DHBs, 82 PHOs, multiple non-government organisations, consumer and health professional associations among other important sector stakeholders all form the important leadership capability of the New Zealand health system. Strengthening the relational and social capital of our system is a contact sport. If we are to move from fragmented and partial initiatives to a joined up sector that quickly diffuses innovation, the historical and cultural barriers must be overcome. Inter-organisation exchange and interaction, national networks and opportunities for health leaders to connect and interact will support a leadership cohort capable of transforming systems at both local and national levels.

Conclusion

New Zealand's recent history under the *NZPHDA 2000* has provided an important policy and strategy stability that has set the context for institutionalising population health approaches at both national and local levels. The advantages of a devolved health management system must continue to be realised by the Ministry of Health changing the way it works from the centre to address the very limitations of such a system. Clear priorities reinforced by targets while supporting performance delivery requires cultural shifts – rather than structural change – that promotes system wide learning to drive performance and, ultimately improves health gains for New Zealand communities.

Competing Interests

The author declares that he has no competing interests.

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REVIEW ARTICLE

Health Discourse, Policy and Management Challenges: a decade of New Zealand health service developments

N North and R Perkins

Abstract

Aim: The paper analyses a decade of change in discourse and health policy in New Zealand that has underpinned health system paradigms. It discusses how performance indicators were shifted fundamentally and how this impacted on the work of managers, with a focus on workforce management and relationships with communities.

Paradigms reviewed: The paper begins by briefly summarising the market reforms as a context, and then discusses a transitional period when a public service ethos was re-introduced, characterised by incoherence in its objectives. A return to a population and health outcomes focus followed, requiring collaboration and a population health and primary health focus. The associated strategies and their commitment to service delivery are threatened as ageing of the health professional workforce and shortages lead to difficulties in recruitment, a growing reliance on overseas graduates and industrial unrest.

Conclusions: Discourse and policy impact on the day-to-day work of managers, who need to respond to new performance requirements and priorities and to privilege different relationships and ways of operating. The consequences of health policy change on the work and priorities of managers, particularly when there are fundamental shifts in underlying discourse and paradigms, is seldom a consideration in health sector change.

Abbreviations: CCMAU – Crown Companies Monitoring and Advisory Unit; CEO – Chief Executive Officer; CHE – Crown Health Enterprises; CQI – Continuous Quality Improvement; DHBs – District Health Boards; HHS – Hospital and Health Services; HWAC – Health Workforce Advisory Committee; NIPB – National Interim Provider Board; PHOs – Primary Health Organisations; YTD – Year to Date.

Key words: health managers; health reforms; health system change; New Zealand health system; workforce shortages.

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Introduction

The aim of this paper is to explore how health discourse and policy settings in New Zealand have impacted on the work of those in management and leadership roles over the past ten years. Particular regard is paid to workforce management and relations with communities served by those in provider settings. In order to contextualise the discourse and policy changes in the past decade, we begin by briefly visiting the foray into market-force based reforms of the 1990s. This was a policy direction that severely impacted on managers and clinicians alike but over which they had little influence. Drawing from research studies to illustrate our analysis, we go on to critique the politically-led move away from markets from 1997. This shift was, in effect, a transitional period between a commercial model of health concerned mainly with financial performance, and the devolved, participatory

and population-based health model introduced in 1999. The latter period, we will show, restored health indicators as key performance indicators in a balanced score card approach. Alas, although the anxieties of many critics of the commercial model were calmed by the abandonment of market reforms, new threats have emerged to undermine commitment to improved health for all New Zealanders.

To market, to market...

A series of commissioned reports during the 1980s and early 1990s, with major contributions from an economist, [1] a merchant banker [2] and a leading politician, [3] culminated in market reforms based on a commercial for-profit model. The late 1980s and early 1990s were turbulent times in New Zealand and early health reform initiatives sought to use market forces to improve both the efficiency and effectiveness of the secondary care sector in particular.

Health reform in the early 1990s was unpopular among clinical staff and influential members of the community, indeed among society in general. Much of this was a result of changing power structures and the emergence of a managerial discourse. In 1993, patients were referred to as 'revenue generating units' and hospitals with above average numbers of admissions were described in some quarters as being in an 'overtrading' situation. The 'cornerstone of the new delivery system' in place from 1993 was, as the seminal National Interim Provider Board reform report put it, based on 'negotiated written contracts for service'. [4 p. 58]

While market-led reforms were not unique to New Zealand, the degree and speed of implementation by the right-of-centre National Government were such that they attracted international attention. *Health Policy*, for example, published a special issue on the New Zealand health reforms. [5] By the time the National Government (1990-1996) was forced to form a Coalition Government with the New Zealand First Party at the end of 1996, a consensus was emerging that a harsh commercial focus had not worked in the New Zealand health system, a sector too small to allow the development of a truly competitive market.

Despite extensive criticism of the commercial model of health from economists such as Brian Easton [6] and academics including Toni Ashton, [7] along with the Health and Disability Commissioner, [8] a number of initiatives from the period have endured. These include case-mix funding, greater specificity of service contracts and a focus on better integration of primary and secondary services. There were also considerable gains for some population groups; for example Maori, and Maori-led primary health services have continued and further developed to the present.

A consequence of the short-lived period of a competitive market focused for-profit health system, was conflict between managers (seen as concerned with financial performance to the detriment of health outcomes) and clinicians (criticised for driving up costs). And in spite of the rhetoric that the model would improve health purchasing decisions, communities felt alienated by a system concerned with costs.

Between a rock and a hard place

By 1997, with the steam having run out of the 'rush to market', the National-led coalition government had to contend with Neil Kirton, the junior coalition partner's Associate Minister of Health who had come from the management ranks at Waikato Hospital, one of the country's metropolitan teaching hospitals. Kirton and his New Zealand First Party were vehemently opposed to the market reforms of the previous five years. Consequently, the policy direction changed with the principle of public service to replace commercial profit objectives. [9]

The commercially-orientated Crown Health Enterprises (CHEs) created in 1993, thus transitioned into more public service-orientated Hospital and Health Services (HHS) in 1997. There was a major shift in discourse that flowed on to policy change. Notwithstanding the rhetoric, the governance of the system remained in the hands of largely commercial boards along with the Crown Companies Monitoring and Advisory Unit (CCMAU), which still monitored health boards and used a number of largely commercial indicators to measure performance. [10] Table 1 identifies some of the measures used to monitor HHS performance in 1999 when health services were directed using a public service discourse.

One of the authors, Rod Perkins, [11] was at the time interviewing health service CEOs as part of a doctoral study. These participants' views indicated the incoherence between discourse and performance expectations, describing a situation in which those monitoring the system were totally preoccupied with financial performance (see Table 1). In addition to the indicators in Table 1, performance against budget was paramount. The Chief Executive Officer (CEO) of one of the influential Auckland health boards observed:

> *If there was an interest in quality it would arise only when there was a political risk [11 p. 232]*

Table 1: Examples of indicators used to monitor hospital and health services performance in 1997

CATEGORY	INDICATORS
Operational	Case-mix weighted average length of stay for inpatients only DRG-based case-mix weighted average length of stay for both inpatients and day-cases Resourced beds inpatient occupancy rate Physical capacity beds inpatient occupancy rate Year to date (YTD) overhead expenses as a percentage of total costs Direct personnel salaries per inpatient day equivalent Case-mix weighted elective day stay surgery percentage Staff turnover per full time equivalents
Quality	Customer satisfaction survey – percentage very good Customer satisfaction – quarterly rate of change hospital for acquired blood stream infections
Financial	YTD net income ratio YTD return on equity Debt/ (debt + equity) ratio Acid test (quick) ratio YTD debt service coverage ratio

Source: Adapted from CCMAU performance reporting measures (1999) [10]

Other influential senior managers interviewed about the managerial role during the late 1990s described the manager-clinician relationship as critical, and central to this relationship was trust. [11] The indicators in Table 1 were used as a version of the balanced scorecard to compare the performance of boards in the sector. This impacted through managerial hierarchies and one second tier manager in Perkins' study referred to his interest in CCMAU benchmarking:

> *Those league tables[1] became quite important and I remember their monthly release and seeing whether we had changed our position. I think they had a focus internally and they drove quite a bit of our work in terms of looking at how we could improve things like our percentage of day surgery. [11 p. 233]*

Kirston's aim to bring together commercial and public service objectives provided a particular challenge for managers. Another second tier manager in Perkins' study observed:

> *…The CEO and the Chair quickly looked around the organisation and said 'what are the good business drivers here and what are the bad ones'. At the time I managed Community Health and Mental Health and was aware of the fact that these services were not actually perceived as core business. If they could have been shifted off, they would have been. The ironic thing to me was that 'their' core business (hospital services) were actually the loss making services and I think there was a lack of understanding of the fact that you could make a much better fist out of a business where you could control demand than an area where you couldn't... [11 p. 233]*

By the late 1990s, it had become clear that even with the softening of the market reforms of a few years' earlier with a public service ethos, the system remained essentially transactional in nature, and could not deliver high quality services on their own. To be truly effective a reform program required engagement of staff at all levels within health care organisations. What was required was leadership and people with the ability to implement change. One CEO in Perkins' study observed:

> *The leadership can come from any place, and that's what makes the difference. And the ability to implement. You can't have leadership that is effective without the ability to implement. And managers must be able to manage complexity. [11 p. 237]*

[1]CCMAU produced league tables on a monthly basis. These tables compared CHEs in a number of areas; financial, customer satisfaction and internal business processes (eg occupancy rate).

In summary, prior to the election of a Labour Government in 1999, the system had stalled and many managers saw themselves between a rock and a hard place. While there were obvious difficulties with the previous market-led system, at least its objectives were singular. In the mixed paradigm system that followed, managers were confronted with different agendas arising out of conflicting paradigms. The problem they faced was that it was impossible to engage clinical staff (the drivers of healthcare expenditure) in working towards the achievement of what were seen as Treasury goals. Doctors and nurses in particular found it hard to understand how their individual patients would be advantaged by their working towards the Treasury agenda of controlling and containing Government expenditure, reducing the state's financial exposure in the health sector and reducing health entitlements.

Light at the end of the tunnel

During the 1990s the Health portfolio had become something of a poisoned chalice. Throughout the decade a total of five different National and Coalition Government ministers held the portfolio. Not so in Clark's Labour Government, which had the Hon Annette King as Minister of Health for six years from 1999. In December 2000, a New Zealand Health Strategy was developed, that together with the 2001 New Zealand Disability Strategy, provided the overarching strategic framework. In 2001 primary health care gained prominence through the development of its own strategy. [12, 13, 14]

The *New Zealand Public Health and Disability Act (2000)* provided for District Health Boards (DHBs) (entities bearing a resemblance to the area health boards that preceded the 1990s market reforms) to replace the Health Funding Authority and HHS. These new entities brought together the purchasing and service delivery functions which had been held in separate institutions since 1993. The DHBs required a clear focus on the health of the population in the board region and its improvement. A new discourse replaced the competitive language of the 1990s market system and one construct that took centre stage was 'collaboration'. The strategic direction of the health system now sought solutions to problems that involved multiple agencies.

Shifts in discourse and policy also affected primary health services. Introduced through the 2001 Primary Health Strategy, [14] Primary Health Organisations (PHOs) were formed to provide a platform for primary care development and reform, with one of the challenges being to emphasise health promotion and population health. The general practitioner organisations created in the 1990s (independent practice associations) were based on commercial and competitive models and were dominated by medical interests. In contrast, PHOs were intended to give the community a voice in primary care. Arising from government policy this decade, to contain and restrain spending on secondary care, significant additional funding has gone into primary care, with particular interest being taken in lifting the health of disadvantaged populations. The PHO Performance Management Framework provides significant financial incentives to PHOs to work collaboratively using a CQI approach to increase multidisciplinary teamwork within a population health model. [15]

A consequence of moving from a commercial model to a public service model, is an increased interest in a broader range of performance indicators. While financial performance is still identified as a critical component of leadership effectiveness, it is by no means the only measure. Table 2 contains a number of the aspects the Ministry of Health monitors. [16] In addition to the dimensions identified, patient volumes are monitored closely.

A comparison between the measures in Table 1 and Table 2 suggests that there is now more Ministry of Health interest in the outputs and outcomes from the sector than was previously the case. Table 2 clearly indicates an interest in a population health agenda. DHBs, unlike the provider-orientated organisations they replaced, do not look to institutional solutions to the major health problems facing the communities they serve. Rather they looked to a range of agencies working together with DHB support.

Managers, clinicians and their boards have moved from a narrow institutional view to a broad population health focus. For example South Auckland Health, a DHB with large Maori and Pacific Islander populations, has invested ten million dollars over five years to address the diabetes epidemic in its community. This has involved encouraging collaboration between its providers, public health agencies, local authorities, schools, the food industry, Pacific and Maori groups and others. Managers have had to develop skills in working in relationships where hierarchy is less valued and the power of community is given recognition. The Chair of the South Auckland DHB, in the course of an evaluation of the 'Lets Beat Diabetes Programme', observed in 2006:

Table 2: Examples of indicators used to monitor DHB performance in 2007

DIMENSION	INDICATORS
Financial performance	DHBs are monitored through monthly financial reporting with actual results measured against the District Annual Plan. They also present to Parliament audited reports incorporating both financial statements and statements of service performance
- Governance - Funder - Provider	DHBs report separately on performance in these three areas. The funding arms of district health boards have contracts with private and non-government agencies in addition to contracts with the DHB provider arms
Health status of people with severe mental illness	The average number of affected people domiciled in the DHB region, seen per year. These access rates are reported every three months according to age group and ethnicity
Immunisation of children	The number of two year olds fully immunised. (The Ministry target is 95%)
Oncology treatment and waiting times	The time interval between referral to an Oncology service and the beginning of radiation/chemotherapy treatment
Incorporating health inequality concepts into policy and planning	DHBs are required to undertake health needs assessments and actions or steps to address inequalities
Service coverage	DHBs report on progress achieved towards resolving gaps in service coverage identified in their District Annual Plan
Accessibility to Primary Health Care	Age-standardised rate of general practitioner consultations per high need person, and ditto for non high need people

Source: Adapted from First Quarterly Report: 2006-2007 DHB Crown Funding Agreement [9]

> *The primary goal is in franchising people to be in control of their own lives. Having people expressing independence, not dependence on the State, making their own decisions. I think while all that's the end game, the process is in franchising. You either disenfranchise people or you enfranchise people by the way you operate in a public sense with the population you serve. You marginalise them or you embrace them. And the task you're given can either be an embracing task or a marginalising task. In that context the missing links, and there are two really large missing links, is the collective power of the Maori and Pacific communities.* [17]

Within the present health discourse, focusing on strengthened primary care and empowering communities, evidence-based health care and evidence-based management and policy are receiving attention. Organisational development is being promoted by the Ministry of Health through a range of agencies; for example, Te Pou, an organisation focusing on mental health systems and workforce development. [18]

At the same time efforts to improve the productivity and efficiency of the sector are not ignored; improved ways of delivering elective surgical services are an example. These are elements of the continual improvement approach to health policy and services now applied to the health sector; a contrast to the 'big bang' reforms characterising the market reforms of the 1990s.

In summary the discord and discomfort of many players in the health sector, particularly of clinicians but also many managers, with the for-profit commercial model and a focus on financial performance, was eased with the re-emergence of a public service discourse and focus on health indicators. The transition demanded of managers regarding objectives, priorities, performance, relationships with the workforce and with communities, has been considerable but has been largely achieved.

The clouds gather

In recent years new threats have emerged. This section focuses on one such threat, that of skills shortages. In the skilled human resource intensive health industry, both the overarching health strategies [12, 13, 14] and specific strategies such as the Cancer Control Strategy [19] will be compromised if the present health professional shortages are not eased, and/or different approaches to delivering services developed.

In the area of health workforce policy, as in health services policy in general, historical planning approaches were superseded by a belief the market would deliver. When, by the end of the twentieth century, it became clear that market forces did not produce desired skill sets, a Health Workforce Advisory Committee (HWAC) was established and produced as its first action, a stocktake of the health workforce in 2001. [20] This document drew attention to, among other issues, impending shortages as the present workforce approaches retirement at the same time as demand for services increases. A wide range of health professions – medical, allied health, registered nurses, midwives, pharmacists and others – are listed as skills shortages (including long-term shortages) on the New Zealand Immigration Service website, [21]signalling prioritisation of applications to migrate. To illustrate health workforce concerns, a Department of Labour analysis of advertised registered nurse vacancies in 2004 found that only 63% were filled within 8-10 weeks and on average there were only 1.1 applications per vacancy, in spite of slow labour market growth at 0.8% in the previous decade. [22] In the 12 months to May 2007, an analysis of high vacancy rates put registered nurses as the top ranked in highly skilled occupations (1432 vacancies), though labour market growth remains low. [23]

Dealing with shortages is a daily challenge for managers. A survey of all DHB Directors of Nursing in 2004 confirmed that with continued difficulties in recruiting nurses, overseas recruitment drives were common. [24] A related study showed that after new graduates, overseas trained nurses were the most frequent replacements of nurses who left their primary employment position. [25] Recruitment difficulties are more intense for services outside the major cities, and dependence on overseas graduates is increasingly common. Managers unable to recruit are having difficulty in delivering some services and complying with service and treatment specifications. Delays, shortages and treatment delivery delays are widely reported in the media, illustrated by the following issues covered by the daily *New Zealand Herald*: doctor shortages leading to closure of gynaecology services; (July 26 2007), nurse shortages in Auckland hospitals' operating theatres resulting in repeated cancellations of elective surgery; (January 23 2006), shortages of cancer staff leading to delays in therapy beyond the recommended time; (August 22 2003) and/or patients being sent to Australia for therapy (March 23 2007). [26] Senior managers are thus frequently called to task by the media representing such matters of public interest.

In a complex cycle, uncompetitive pay has contributed to emigration of health professionals, resulting in shortages and stress. This in turn has lead to increased and successful union activity. For example, junior doctors' and nurses' pay settlements have had major impacts on DHB budgets, flowed onto pay demands by other health professional groups, exacerbated shortages as hours are reduced and have led to unprecedented threats of strike action by senior medical staff. [27] Health managers in New Zealand, a lower wage economy than many industrialised countries including neighbouring Australia, are necessarily competing in a regional and global labour market. As New Zealand health graduates move off-shore to work, managers rely increasingly on overseas graduates. [28] With HWAC having completed its work, the role of health workforce development has been absorbed into the Ministry of Health, and has become a Ministry focus in coordination with DHBs. [28] Key challenges to managers include dealing with diversity (of communities and employees), and developing skills and competencies reflecting legislation governing regulated health professions, [29] while also experimenting with different skill mixes in a skills shortage environment.

In summary, with the present challenges, managers again find themselves between a rock and a hard place, but each is of a different kind arising largely from workforce and skills shortages. While health workforce development strategies are emerging and workforce data is improving, managers are nevertheless faced with the daily challenge of meeting demanding performance levels with an ageing workforce characterised by long-term skill shortages, increasing diversity, a greater willingness to resort to industrial action and a resistance to change to different skills mixes and models of care. As workforce shortages impact on service delivery, managers need to account to communities for delays and reductions.

Conclusions

By traversing a decade of health system changes, this analysis has highlighted how paradigms underpinned by discourse as well as policy, impact on the work and

challenges of health managers. Experiences suggest that greater discord occurs when the resulting politically-driven paradigms find little support among key stakeholders such as clinicians and communities (the market reforms 1992-1996), or are fundamentally incoherent (the transition period between 1997-1999). The recent paradigm shift away from a narrow focus on financial performance by refocusing on health outcomes, based on clearly articulated health strategies, has met with widespread approval by key stakeholders. Nevertheless even in a more favourable policy context, managers still must deal on a day-to-day basis with environmental threats that undermine performance.

Competing Interests

The authors declare that they have no competing interests.

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RESEARCH ARTICLE

The Operating Theatre Gridlock: how are decisions made on emergency surgical cases?

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Abstract

Objective: The scheduling of emergency or unplanned surgery constitutes an important area of research in health management. The ambiguity around the identification of clinical states, logistical factors and acceptable timeframes has the potential to stifle decision-making practices among hospital personnel, and have grave consequences for the hospital and patient care. The aim of the present study was to explain decision-making processes around emergency or unplanned surgical cases through an examination of priority-setting among relevant hospital personnel.

Design: The mixed methodology included: (1) the analysis of an unplanned surgical case, deemed to have been exposed to unsatisfactory decision-making practices; (2) consultation with key stakeholders involved in the aforementioned case; (3) the development of a comprehensive survey that reflected the issues raised by those consulted; and (4) the use of the survey in four hospitals.

Setting: The study was conducted in four public hospitals located in the Australian states of New South Wales and Queensland, as well as New Zealand.

Main outcome measures: The study employed two main outcome measures: (1) a semi-structured, open-ended interview schedule, which facilitated consultation with key stakeholders; and [2] a survey that explored clinical, logistical and time-related considerations that influence the scheduling of unplanned surgery.

Results: The four principal findings include: [1] there are divergent understandings of emergency surgery among those who schedule emergency surgery, which in turn, have the potential to spur conflict; [2] processes to prioritise and schedule emergency surgery are inconsistently understood; [3] a consideration of clinical state and logistical factors sometimes merge when priority-setting; and [4] clinical and logistical considerations might stratify priority assessment.

Conclusions: This study indicates that the fusion of clinical, logistical and time-related factors is pivotal in the scheduling of unplanned surgery. Secondly, it suggests that the scheduling of emergency surgery is complex and multifaceted, and warrants further exploration.

Key words: emergency surgery; operating theatres; hospitals; management; decision-making; scheduling.

Abbreviations: ATS – Australasian Triage Scale; CTAS – Canadian Triage Acuity Scale; MTS – Manchester Triage Scale.

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Introduction

Behind the airlocks and surgical masks, the operating theatre environment is often perceived by outsiders as a mysterious and autonomous workshop. However, the operating theatre is a high-cost engine that powers much of the activity in a metropolitan referral hospital, which manages patient injuries that are classified serious to critical. [1] Decisions around the scheduling of surgical cases, particularly emergencies, have consequences not only for the operating theatre, but the hospital as a whole and the patients in its care.

When managing unplanned surgical cases, there are many factors that influence the decision-making process; namely:

1. Clinical need for urgent and timely treatment;
2. The ambiguity that clouds the urgency of clinical needs;
3. The limited ability to plan effectively in an operating theatre because of the changing condition of individual patients and the changing demands on theatre space, instruments and other resources;
4. Potential disruption to elective surgery and the consequent effects on patients, their families and hospital personnel; and
5. Potential gridlock in patient throughput; not only within the operating theatre, but in the emergency department, the intensive care unit and the general wards. [2]

Hence, the efficient management of emergency surgical cases is of great importance to hospital management, government bodies and the wider community.

Despite research exploring medical decision-making practices, [3] few studies have examined the scheduling of emergency surgery. [4] This gap in knowledge is evident by the ad hoc management practices used in many hospitals for organising emergency surgery. [5] Consequently, this area has become a field of interest among hospital managers. It has stimulated the need to investigate decision-making practices in operating theatres and the use of urgency classification systems.

Findings are presented from an exploratory study in which decision-making practices around emergency or unplanned surgery were examined. This was achieved through consultation with clinicians involved in these processes. Before discussing these findings, a review of relevant literature is presented.

Decision-making practices within healthcare

The primary responsibility of healthcare professionals is to promote the well-being of their patients. They are expected to do what is best for the patient and advocate on the patient's behalf. [6] Decision-making has an important role in other societal institutions, yet within healthcare it has a number of unique qualities. It involves a strong focus on restoring patient health; it is responsive to change in both the patient and in the hospital setting; time constraints cannot be negotiated; and there are often major personal consequences associated with the decisions made. This is especially evident in the operating theatre, and for this reason, the scheduling of surgery has been described as a complex activity, [7] a perpetually difficult problem due to an ever-changing environment, [8] and even as a political battle. [9] It appears that healthcare decision-making has a distinct footprint with great significance. [10]

Within the existing literature that explores medical decision-making practices, particularly in the context of surgery, [3] the normative model of decision-making appears to be decision theory. [11] Its ability to comprehensively consider information from diverse sources, especially in situations of great uncertainty, makes it particularly valuable – both theoretically and pragmatically.

In the context of operating theatres, decision theory primarily manifests itself through two models; queuing theory [12] and the Poisson distribution model. [13] The former commonly operates on a first-come-first-served basis, whereby priority is determined by chronology. In the case of emergency surgery, where patient health outcomes are at-risk, this is illogical. [14]

In contrast, the Poisson distribution model operates with greater autonomy and is particularly apt for representing occurrences of a particular event, like emergency surgery, over time or space. [15] The model is premised on a number of assumptions. For instance, events like emergency surgeries can occur at any of a large number of places within the unit of measurement. These possibilities include the hospital; the emergencies do not happen too frequently; the probability that emergency surgery is required does not depend on time or the hospital itself; and the average number of emergency surgeries is constant. [16] The Poisson distribution model thus allows for the random arrival of patients; it assumes independence from other patient arrivals; and it supposes independence from the state of the hospital system. The model may be effective where emergency services are provided according to priority: 'where patients in the queue are selected for care according to a set of clinical priorities'. [14] Consequently, the model has been used to inform the Australasian Triage Scale (ATS), [17] the Manchester Triage Scale (MTS), [18] as well as the Canadian Triage Acuity Scale (CTAS); [19] all of which are used in emergency departments to rate clinical urgency.

Despite its alleged value, the Poisson distribution model is restrictive because the underlying assumptions of the theory do not always hold in the real world. For example, the model assumes an infinite number of patients, or queue capacity, or no bounds on inter-arrival or treatment times, when it is quite apparent that these bounds exist in reality. Anecdotal evidence indicates inconsistent practices when managing emergency surgical cases. This is particularly the case when

determining clinical priorities and when simultaneously admitting several patients who have comparable medical needs. Accordingly, some of those involved in the scheduling of emergency surgery experience frustration and conflict with co-workers.

It thus appears that triaging scales have a limited capacity to effectively manage the complexities often experienced by those involved in unplanned surgical scheduling. In an environment characterised by professional power, [20] the scales occasionally fail to synthesise clinical priority; logistical issues, such as efficient theatre utilisation and patient flow; continued access to public hospital services; and the political pressure to manage waiting lists within a paradigm of economic rationalism. [21] Consequently, planned surgery is delayed if not cancelled; hospital costs are inflated as theatres operate beyond funded sessions; staff morale is hindered with ongoing requests to work longer hours and manage increasing volumes of patients; and, most importantly, patient care is potentially jeopardised. It is therefore imperative that decision-making practices within the hospital setting be understood and improved accordingly. [2]

The importance of multi-actor decision-making in complex healthcare settings is recognised within existing literature. [22] In fact, models like the participative decision-making model are said to acknowledge hospitals as complex, multidimensional systems that are not static. For example, American research on effective, hospital-wide decision-making processes highlights the importance of including both clinical and non-clinical factors and actors. [23] The ideal hospital is described as a complex adaptive system where effective responses to the changing environment occur through rich connections made within the system. Connections between doctors, nurses and managers allow for creative solutions to develop as each have the opportunity to gain a collective understanding from one another.

However, an idyllic view of congenial working alliances fails to recognise the realities of commonplace decision-making processes within a complex healthcare system, characterised by hierarchical divisions of labour. [20] Furthermore, tension between the business and the practice of healthcare reminds us of the influential role of economics in clinical activities. Heightened interdependency between clinicians and managers has led to increasing conflict between decision-makers, driven, in part, by different perceptions of rationality. [24]

Thus, the scheduling of unplanned surgical cases is not contingent on clinical need alone. It involves the synthesis of multiple considerations including clinical priority, logistical factors (that is, the availability of resources, the use of these resources and subsequent impact on other patients), and acceptable timeframes. Research to understand decision-making processes around unplanned surgical cases is both timely and necessary.

Design

A mixed methodology design was developed to comprehensively explore the attitudes and practices of professionals involved in the scheduling of unplanned surgery. First, to understand ineffectual practice, an unplanned surgical case that was deemed to have been exposed to unsatisfactory decision-making practices by hospital personnel and the patient, was analysed. Second, key stakeholders were consulted using semi-structured, open-ended interviews to understand the processes that contributed to the aforementioned case. Third, these opinions were collated and a survey instrument was developed to capture the attitudes and practices of professionals from a range of hospital settings who are involved in the scheduling of unplanned surgery. Fourth, a pilot survey was employed in four hospitals: two were located in New South Wales, one was located in Queensland, and one was located in New Zealand.

Main outcome measures

The research team requested one large hospital to describe an unplanned surgical case that involved an ad hoc scheduling process. It was important that the case typified the complexity of the problems regularly encountered by health managers and clinicians when scheduling emergency surgical cases. In the identified case, the outcome of the process was unsatisfactory to the surgeon, anaesthetists, operating theatre coordinator, hospital management and patient. The case provided the researchers with rich data from which to formulate a survey.

Consultation with key stakeholders

1. Research tools

A semi-structured, open-ended interview schedule was designed to explore the scheduling of unplanned surgery in general and in the aforementioned emergency case. Questions clustered around a number of themes; namely, current practices in the scheduling of unplanned surgery; the influence of clinical and time determinants; the influence of logistical or operational determinants; the role of interpersonal and interprofessional dynamics when

scheduling unplanned surgery; and methods to improve decision-making practices around the scheduling of unplanned surgery.

2. Ethical considerations

Approval to conduct each phase of the study was gained from the university ethics committee for human research, as well as the relevant area health service ethics committees. These bodies adhere to the National Health and Medical Research Council ethical standards.

3. Recruitment process

Eight key stakeholders involved in the aforementioned case study, including the surgeon, the case anaesthetist, the operating theatre manager, the clinical coordinator, the anaesthetic nurse unit manager, the operations manager, the recovery room manager and the patient, were invited to participate in a confidential interview. All consented to participate in the project.

4. Collection and analysis of data

Each interview was audio-taped and transcribed verbatim. Appropriate software was used to aid detailed coding and analysis of the research material, facilitating the interpretation process. An analysis of the research material allowed for themes to emerge, as the research participants constructed their own meanings of situations through the interview process. The research material was found to cluster around a number of core themes. To ensure consistency within each theme, codebooks were developed that included detailed descriptors of each theme, inclusion and exclusion criteria, and exemplars from the research material. Through a reflective, iterative process, theme content was interrogated to explore relationships between and within the themes. The process enabled the researchers to engage in a systematic method of analysis using an eclectic process, whilst remaining open to alternative explanations for the findings. [25]

Pilot survey

Informed by the preceding research phase, a survey was developed to explore the considerations that influence scheduling practices. These factors clustered around three core themes; namely, clinical considerations, logistical considerations and time. Convenience sampling was employed to select four public hospitals from New South Wales (2), Queensland (1) and New Zealand (1). Of the 48 surveys distributed to operating theatre personnel, 67% were completed (n=32). Given the small sample only descriptive analysis was possible.

Results

Interviews

Consultation with key stakeholders involved in the aforementioned case suggested that clinical priority is not the sole criterion for determining patient place in a surgery schedule. The decision-making process was also influenced by the availability of the surgeon and the operating capacity of the theatres at different times of day.

Furthermore, poor communication between hospital personnel and the ineffectual sharing of pertinent information (notably, unexpected delays) exacerbated a sense of frustration whilst waiting for surgery. In the case under consideration, theatre staff and the patient were not duly informed about the constraints around the surgeon's availability. The consequent frustration was noted not only by hospital personnel, but also by the patient. However, the patient's experience of the wait for surgery was not considered by the decision-makers.

The interviews also highlighted disparate perspectives between the operating theatre managers and the surgeon when scheduling emergency surgery. The operating theatre manager focussed on the equitable use of a fixed and limited operating capacity; however, the surgeon focussed on individual patient access to the theatre and the need for consultant supervision during surgery. Thus, while the manager adopted a broad, organisational view of the situation, the surgeon demonstrated concern for specific instances of patient care.

Collectively, the interview material suggests that the term 'emergency surgery' lacks a universal definition among those involved in the scheduling of such cases. The material also indicates that the decision-making process is influenced by a number of factors, including clinical considerations, logistical considerations and time.

Pilot survey

Survey respondents spoke of emergency surgery in highly variable ways. They offered understandings that were guided by policy rhetoric as well as those that were informed by experiential wisdom. Also variable was the ownership of the decision-making process. Some respondents awarded prime responsibility to the anaesthetist or the surgeon; others recognised value in a collaborative approach and awarded responsibility to a team of hospital personnel.

Several respondents applied institutional rules inconsistently. Despite the presence of hospital policy to guide scheduling practices, it appears these are used variably within a given hospital setting. One respondent stated,

'The term emergency surgery is often inappropriately used.' A fellow staff member concurred stating, 'I'm not sure we have defined this… many of our added cases are… not a true emergency.' Given these different opinions, there is potential for conflict between hospital personnel. Despite the availability of organisational policy, respondents conceptualised emergency conditions in dissimilar ways, which in turn, influenced the use of limited resources.

Interestingly, the definitions offered by the respondents reflect the themes identified through the earlier research phase. More specifically, the definitions highlighted the importance of clinical considerations, logistical considerations and time.

There were two approaches to scheduling unplanned surgery. The first involved a qualitative clinical approach, whereby a patient's clinical condition formed the basis for stratification. The second involved quantitative time-based categories to specify the timeframe for surgery. Operationally, the two approaches had similar clinical endpoints; yet, they emphasised different factors in the clinical decision-making process.

The researchers were keen to understand how different conditions, some of which might be vague or associated with social dimensions, shape attitudes toward priority setting. A diverse range of 32 clinical states (that is, conditions a patient might present for unplanned surgery) were selected and respondents were asked to indicate the value awarded to these when deciding clinical priority.

Despite the rather generic description of the selected conditions, some stratification was evident among the responses. Table 1 indicates that haemodynamic instability, ischaemic visceral organs, cardiac injury, caesarean section

Table 1: Descriptive statistics for clinical states[1]

	NUMBER	MEAN	STANDARD DEVIATION
Threatened airway	32	1.22	0.420
LSCS foetal distress	30	1.37	1.299
Haemodynamic instability	32	1.66	1.260
Cardiac injury blunt	31	1.71	1.321
Ischaemic visceral organ	31	1.84	1.293
Ruptured visceral organ	32	1.84	1.110
Blood loss >15%	32	2.00	1.437
Ischaemic limb	32	2.00	1.320
Surgical bleeding	31	2.16	1.440
Vascular repairs	32	2.22	1.184
Central nervous system injury	31	2.32	1.956
Other	3	2.33	0.577
Systemic sepsis	32	2.50	1.344
LSCS maternal distress	30	2.67	2.106
Compound fracture	31	2.94	1.413
Threatened sensory loss	32	3.09	1.489
Threatened loss of mobility	32	3.31	2.023
Coagulopathy	30	3.63	1.921
Age	27	3.78	2.172
Unstable fracture	32	4.47	1.685
Severe pain	32	4.75	1.626
Contaminated wound	32	4.78	2.254
Unsuccessful suicide	28	5.36	2.164
Repair of tendons	32	5.53	2.048
Abscess drainage	31	5.65	1.743
Threatened cosmetic outcome	31	5.97	1.871
Known infectious risk	31	6.13	1.979
Terminal illness	31	6.35	2.009
Intravenous drug user	29	6.41	1.722
Closed fracture	32	6.50	1.685
Uncomplicated fracture	32	6.75	1.918
Diagnostic procedure	31	7.16	1.530

[1] 1 indicates highest priority and 9 indicates lowest priority

foetal distress, ruptured visceral organs and threatened airway were awarded highest priority. The table also indicates that respondents believed that items of lower priority include closed fractures, uncomplicated fractures, patients with known infectious diseases, patients who are intravenous drug users, and patients who are terminally ill.

Logistical or organisational factors help to determine how and when emergency surgery is performed. They involve the availability of staff, the availability of space and the availability of materials. To understand the influence of particular factors on the decision-making process, respondents were asked to indicate the value awarded to a diverse range of logistical considerations when scheduling emergency surgery. Table 2 indicates that the availability of appropriate surgical and anaesthetic staff, as well as efforts to optimise patient condition were awarded highest priority. The table also demonstrates the range of opinion among respondents; this suggests that logistical considerations, as opposed to clinical considerations, are prioritised with greater variation among hospital personnel.

Using the clinical conditions listed in Table 1, respondents were asked to indicate the ideal timeframes for surgery. As Table 3 illustrates, foetal distress and a threatened airway were awarded highest priority, while closed fractures and diagnostic procedures were deemed lowest priority.

Table 2: Descriptive statistics for logistical considerations[1]

	NUMBER	MEAN	STANDARD DEVIATION
Optimising patient's co-morbid condition	32	2.38	1.212
Availability of surgical staff	32	2.44	1.216
Availability of anaesthetic staff	32	2.47	1.414
Availability of ICU bed	32	2.97	1.448
Availability of scrub nurses	32	3.06	1.605
Availability of instruments	32	3.25	1.524
Duration patient has been waiting for surgery	32	3.84	1.868
Completing consent	31	4.00	1.932
Age group	30	4.13	2.177
Previous delayed surgery	32	4.28	1.764
Surgical specialist available onsite	32	4.41	1.932
Cancelling elective surgery	31	4.45	2.142
Availability of ward bed	32	4.63	1.996
Time of day	32	4.91	2.161
Responding to patient opinion	32	5.72	2.247
Responding to anaesthetist opinion	30	5.97	2.539
Morbid patient obesity	31	5.97	2.183
Responding to surgeon opinion	32	6.00	2.463
Staff member at hospital	32	6.03	2.307
Duration surgeon has been waiting onsite for surgery	31	6.13	2.306
Responding to nurse opinion	31	6.19	2.358
Demands from patient / family	31	6.42	1.876

[1] 1 indicates highest priority and 9 indicates lowest priority

Table 3: Descriptive statistics for timeframes for surgery in minutes

	NUMBER	MEAN	STANDARD DEVIATION
LSCS foetal distress	23	20.22	15.989
Threatened airway	22	23.64	28.710
Cardiac injury blunt	22	43.64	73.601
Blood loss >15%	24	49.79	52.076
LSCS maternal distress	23	50.43	52.091
Ruptured visceral organ	25	51.40	36.927
Haemo-dynamic instability	25	52.40	49.077
Ischaemic visceral organ	25	55.00	33.166
Surgical bleeding	27	55.37	48.792
Ischaemic limb	25	60.20	70.570
Central nervous system injury	22	92.05	89.318
Systemic sepsis	26	130.19	150.203
Compound fracture	27	176.67	145.391
Vascular repairs	26	195.00	554.000
Severe pain	23	261.52	387.707
Unstable fracture	26	267.12	308.286
Threatened sensory loss	27	276.11	391.182
Unsuccessful suicide	21	290.95	309.308
Threatened loss of mobility	26	298.27	453.076
Contaminated wound	27	330.00	517.412
Terminal illness	22	527.73	529.777
Repair of tendons	27	529.15	665.937
Abscess drainage	24	537.17	621.850
Threatened cosmetic outcome	23	556.30	601.003
Uncomplicated fracture	26	574.69	628.993
Closed fracture	26	585.77	619.549
Diagnostic procedure	24	666.25	539.709

Interestingly, when stratified by time, the succession of clinical conditions reflects the clinical priorities presented in Table 1; this suggests internal consistency when clinical considerations are prioritised. However, the standard variations were generally high, indicating that time values are assessed quite differently between individuals.

Additionally, respondents were asked to indicate the type of delays they experience when waiting to perform emergency surgery, and the regularity of such delays. It appears that all respondents have experienced delay when waiting to perform emergency surgery. Most respondents had waited for the availability of theatre time or theatre space; the completion of elective cases; and the availability of surgeons.

According to the respondents, a number of logistical factors complicate efficient theatre management and thus, the scheduling of emergency surgery. These include the availability of a theatre and/or equipment; the availability of surgeons, anaesthetists and/or nurses; conflicting needs among hospital personnel for operating time; and the role of the surgical registrar in performing the surgery.

To overcome these issues, some respondents called for greater uniformity in the scheduling of emergency surgery. The development of consistent urgency codes to determine scheduling priorities could become part of a minimum dataset, allowing clinical care to be standardised across all area health services. To assess performance, some of the respondents advised that indicators could include average differences between admission time and procedure start time, and average differences between requests for surgery and procedure start time by urgency.

Conclusion

This exploratory research resulted in a survey tool asking questions about clinical, logistical and acceptable timeframes for scheduling unplanned surgical cases. The decision-making process that surrounds the scheduling of emergency (unplanned) surgery provides the focus for examining the prioritisation of clinical states, logistical

factors and acceptable timeframes. Priority-setting was explored through an analysis of an emergency surgical case that was ad hoc, and consultation with key stakeholders involved in the case. This process helped to develop a survey that was used to capture the attitudes and practices of hospital personnel involved in the scheduling of emergency surgery.

An examination of the surgical case suggested that the factors that hinder the scheduling of emergency surgery include planned non-elective surgery, emergency theatre sessions during conventional business hours, and ineffectual communication between hospital personnel and the patient.

A survey of hospital personnel involved in the scheduling of emergency surgery yielded four principal findings; namely:

1. There are divergent understandings of emergency surgery among those involved in the scheduling of emergency surgery, which has the potential to spur conflict;
2. Processes to prioritise and schedule emergency surgery are inconsistently understood, even within the same hospital;
3. A consideration of clinical state and logistical factors sometimes merge when priority-setting; and
4. Clinical and logistical considerations may stratify the assessment of priority.

However, the study presented here is not without limitations. Most notable is the limited survey sample size. Other limitations include the use of one scenario to inform the development of the survey, as well as the interpretive nature of analysing interview data.

Nevertheless, this pilot study adds to existing literature on medical decision-making processes; particularly around unplanned surgery. It affirms that the synthesis of clinical considerations, logistical factors and accepted timeframes is important. It also suggests that the scheduling of emergency surgery is complex and multifaceted, and thus warrants further research. Specific areas for future research include an examination of the incidence of poor scheduling practices; the drivers to achieving effective practices; the way in which triage assists the scheduling of operating theatre time; and whether a balance can be achieved between the competing priorities within a hospital setting.

The present study may help to improve the scheduling of unplanned surgery. Research like this, which serves to inform relevant policy, has the potential to reduce some of the current challenges that hospitals must manage, including clinical outcomes among patients, potential professional negligence, and operating theatre gridlocks.

Competing Interests

The authors declare that they have no competing interests.

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RESEARCH NOTE

Managing in an Increasingly Complex Health Care Environment: perceptions of Queensland hospital managers

M Dehn and G Day

Abstract

Objective: To pilot an instrument to investigate the perceptions of Queensland healthcare managers towards current hospital management structures in light of the increasing complexity in the healthcare environment.

Design: A structured questionnaire administered to a sample of health service managers in one health service district within the state of Queensland (Australia). The data were statistically analysed using descriptive and multivariate statistics.

Setting: A South East Queensland Health District. Seventy managers from the district were approached with a total response rate of 43% (n=30).

Results: Three-quarters (75%) of the healthcare managers who responded perceived their organisational structures as bureaucratic. At the same time respondents reported an increased level of complexity, resulting in ineffectiveness of the current management structures. While 62% of all managers agreed that the decision-making processes need to take complexity into account, only 17.5% of the respondents called for changes to the traditional features of controlling and directing processes to move their organisations into the future.

Conclusions: Although managers are aware of the need for modifying current management structures and processes, they appear to be unwilling to implement these changes. The preference to leave the structures and processes as they currently are might be related to the fact that changing decision-making processes can have a negative influence on the power of managers. Although the findings of this study are in line with a similar study conducted overseas, this study needs to be replicated on a larger scale before any of the results can be generalised.

Abbreviations: QUT – Queensland University of Technology; SPSS – Statistical Package for Social Science.

Key words: leadership; management; hospital management; structures; complexity; bureaucracy.

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Introduction

Changes within the healthcare sector have quickened and intensified over the last forty years. Technological developments, new forms of treatment, faster turnover and acuity of patients, increasing skills of the workers, external rules and heavy pressures on costs have seen hospitals being incorporated into health systems which have created fuzzy boundaries between the internal and external working environment for hospital managers. [1,2] These changed circumstances raise the question: *How do healthcare managers cope as a result of increasing complexity in the Australian health care environment within current organisational structures and processes?*

The purpose of this article is to report the findings of a pilot study that explores health managers' understanding of how they manage in increasingly complex healthcare environments within the confines of traditional bureaucratic structures.

The origins of hospital organisational structures

The first hospitals built in Australia were administrated by religious and military institutions, along the lines of those operating in England in the 18th century. [3,4] Bureaucratic structures are said to be needed to organise semi and non-skilled labour in a manageable and stable environment. These structures gave rise to a clear hierarchy of authority and the impersonal existence of written rules and procedures. [3] The late 20th century saw healthcare organisations grow more complex as a result of, amongst other things, a broader range of health technologies, treatments and an increasing population. [5] At the same time government authorities and organisations themselves increasingly influenced the management of healthcare by overlaying a statutory framework including regulations, local codes and a myriad of policies and procedures, directives and protocols. [3]

Defining the concept of complexity in healthcare management

Within the last decade complexity has become a keyword in describing management structures in healthcare organisations in industrialised countries. Management thinking has traditionally viewed the organisation as a machine and believed that considering parts in isolation; specifying changes in detail; battling resistance to change; and reducing variation will lead to better performance. [6,7,8] Conventional management thinking assumes that work and organisations can be thoroughly planned, broken down into units and optimised. [9] Clancy and Delaney [10, p.192] argue that 'predicting the behaviour of clinical and administrative processes in hospitals is difficult, if not impossible because such processes are collectively defined as complex systems'. Zimmerman et al [11, p.263] define a complex system as one characterised by 'non-linear interactive components, emergent phenomena, continuous and discontinuous change, and unpredictable outcomes'.

Research among hospitals in the United States shows that the increase in complexity makes health care leaders less effective in coping with internal and external influences affecting their daily work. [1,2,12] The ability for healthcare organisations to adapt quickly to internal and external forces will be a critical success factor in the future. While the clinical workforce has adapted to the challenges by the extension of treatment, care and the associated increase in knowledge and education, management still uses antiquated structures and processes to control the system. [3] This research aims to give a first insight into the way managers on various levels perceive the complexity of the current work environment in one health service district in Queensland. The results of the study will give direction for further research.

Methods

The study was undertaken in one health service district in South East Queensland in 2005. The health service district comprised two hospitals, a large aged care facility and community care and mental health services. The study employed a convenience sampling technique, as the district was easily accessible to the research team.

Study design

The study comprised of a self-administered questionnaire instrument to measure hospital managers' perceptions towards current organisational structures and complexity. The questionnaire was developed drawing on questions from previously validated instruments, on complexity and health managers, [1] and questions related to health managers' perceptions of a range of issues. [13]

Study population and sampling strategy

The study was open to all managers within the health district. A manager in this study was defined as a person with formal management responsibility and delegation for at least one other person. With this strategy the research tried to find out if managers at various levels felt differently about current structures and the principles of complexity. Analysis of the inclusion criteria found that the population of managers in the health district was seventy (n=70).

Main study variables

The survey instrument was comprised of 79 questions that covered variables such as: socio-demographic information; organisational structure; perceptions on morale; current management working situation; and leadership in health care institutions. To measure perceptions towards current structures and complexity, respondents were asked to appraise 34 statements related to nine principles of complexity and leadership. [1] The participants were asked to indicate their intuitive agreement or disagreement with each statement. The questions on the perceptions of morale used a 4-point scale from Very High to Very Low. Other questions (apart from the socio-demographic information) used a 5-point 'Likert' scale ranging from Strongly Agree through to Strongly Disagree.

Data collection methods and procedures

All eligible health service managers were sent a covering letter, questionnaire and a pre-paid return envelope. All managers were sent a reminder letter two weeks after administering the questionnaire.

Data analysis methods

The socio-demographic data was analysed using the Statistical Package for Social Science (SPSS). [14] Secondly, answers related to the 34 statements on current hospital structures and complexity thinking were added up according to the nine different principles of complexity. These were analysed using descriptive statistical methods. Finally, multivariate statistics were used to compare the results of different principles to the socio-demographic information.

Ethical clearance

The research gained ethical approval by the Queensland University of Technology (QUT) Research Ethics Committee and by the Health District Human Research Ethics Committee.

Results

The instrument was distributed to seventy managers within the health district, with a total response rate of 42.9% (n=30). Of the respondents, 27.6% were male and 72.4% were female.

Socio-demographic profile

The age and gender of the respondents in this study represent the general distribution of the health workforce in Queensland. [15] As shown in Figure 1, almost 45% (n=13) of the respondents were nurse managers, 14% (n=4) were medical managers and 10% (n=3) were general administrative managers. The remaining respondents were either shared service providers, persons managing human resources, finance services and supply services or responded on more than one of the previous five categories.

Figure 1: Area of management responsibility

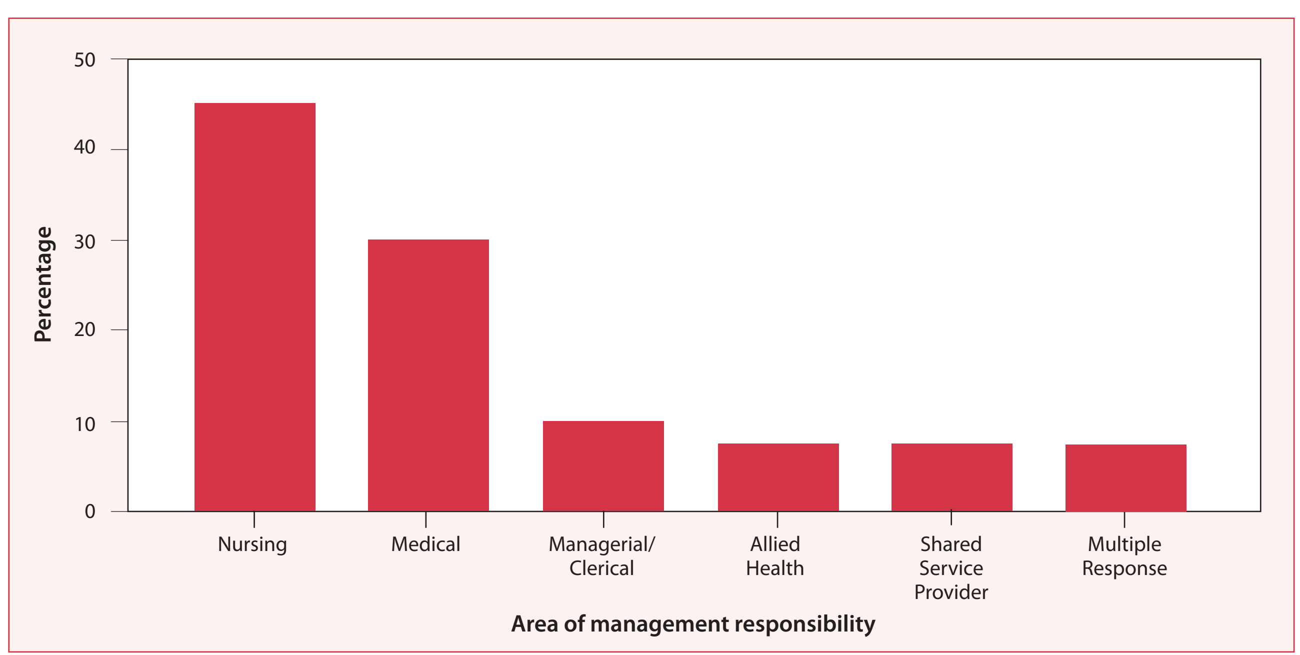


Figure 2: Years of management experience

A majority of the managers 75% (n=22) had less than ten years management experience (see Figure 2). Almost 45% (n=13) of these had less than five years of management experience.

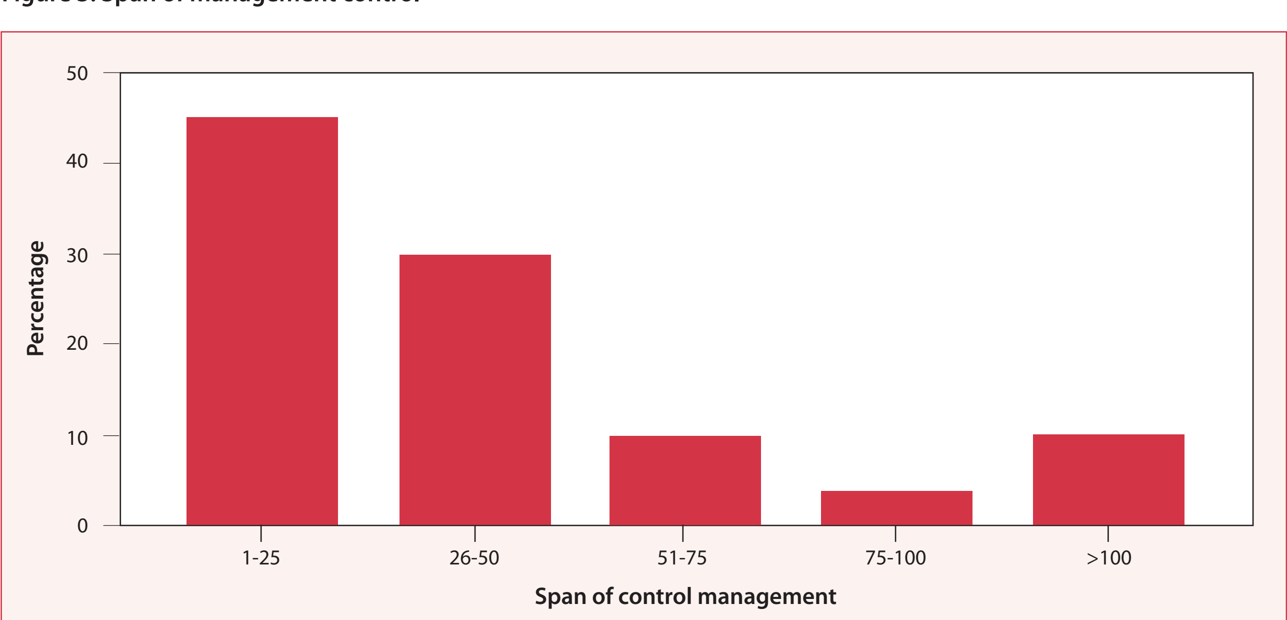
As shown in Figure 3, almost 45% (n=13) of all respondents managed between one and 25 people. Another 31% (n=9) managed between 26 to 50 people.

Over one-third of the respondents 36% (n=10) indicated they had been employed as a manager in the health district between one and five years. The largest group of respondents 38% (n=11) had been employed in the district from six and ten years, with a further 21% (n=6) of respondents indicated they had been employed as a manager in the district for more than eleven years.

Perceptions of current management structures

The first part of this study concentrated on the perceptions respondents had towards current management structures. Three-quarters (75%) of the respondents perceived their organisational structures as bureaucratic. Additionally, 86% of the respondents identified the process structures as hierarchically orientated and 79% realised that their organisational reporting systems were vertical rather than horizontal.

Figure 3: Span of management control



Current working situation

The analysis showed that 39% of the managers supported the idea that controlling work was very important. Half of the respondents (50%) indicated that their working environment was constantly changing and presented new challenges to them as managers.

A majority (90%) recognised that the amount of information a manager had to synthesise was rapidly increasing. Supporting this view, three-quarters of the managers (75%) agreed that administrative work consumed a considerable amount of their daily working time. Over half (55%) of them felt they could no longer cope with the increasing amount of information. Interestingly, 41% of managers believed matrix management structures to be one reason for the creation of uncertainty.

Effectiveness of the current structures

The study sought to gain the perceptions of managers regarding the effectiveness of the current organisational structures in healthcare organisations. While the results were inconclusive, the more bureaucratic the system was perceived to be, the less effective it appeared to be to the respondents. Further, only one fifth (21%) of the respondents agreed that current institutional structures were effective. Three-quarters (73%) of the respondents in this study noticed that they lost a lot of time due to administrative work and more than half of the managers no longer felt able to synthesise all the information they received and therefore rejected the view that decision-making happened quickly in their organisation.

Complexity

All of the respondents (n=30) identified their organisation as complex. As shown in Table 1, more than 75% of the respondents agreed that the current healthcare world was chaotic, that the future was unpredictable and unknowable and that traditional management focused on predictability. In this world of chaos and complexity, 59% of the respondents did not think that their organisation currently achieved excellent results.

Table 1: Respondents perceptions about the complexity in health care organisations (%)

OVERALL STATEMENTS[1]	STRONGLY DISAGREE	DISAGREE	NEITHER AGREE NOR DISAGREE	AGREE	STRONGLY AGREE	TOTAL (%)
The current healthcare world is chaotic.	0.0	13.8	6.9	44.8	34.5	100.0
Healthcare organisations are complex.	0.0	0.0	0.0	51.7	48.3	100.0
Most efforts to improve healthcare organisations have achieved excellent results.	17.2	41.4	17.3	20.7	3.4	100.0
Being a leader in the healthcare environment today is frustrating.	3.4	24.1	10.4	34.5	27.6	100.0
Traditional management principles (ie planning, directing, controlling) focus on achieving predictable outcomes.	3.4	10.3	13.9	72.4	0.0	100.0
Regardless of how accurate or complete information is, the world is unpredictable and unknowable.	0.0	3.4	20.8	65.5	10.3	100.0
Successful leadership in organisations is similar to a machine – manage the 'parts' and the desired outcome will be achieved.	10.3	31.0	17.3	41.4	0.0	100.0
In the current healthcare environment strong direction and control from leaders is essential.	3.4	17.2	20.8	51.7	6.9	100.0
Leaders in today's healthcare environment can control organisations and move them towards a predictable future.	3.4	44.8	27.7	20.7	3.4	100.0

[1] Source of statements: Survey Results. Burns JP. Complexity science and leadership in healthcare. J Nurse. Adm. 2001; 31(10): 48.

Over 60% of the respondents felt that being a leader in the current healthcare environment was frustrating. This is also supported by 48% of respondents who believed, because the future was unpredictable, that they did not have control over their environment. Supporting earlier findings that the working environment is constantly changing, only 24% of respondents believed they had control of their work environment. Another interesting finding is that equally 41% of the respondents either agreed or disagreed with the principle that successful leadership is similar to a machine.

In other results, a majority of respondents (79%) believed according to one of the underlying statements that it is still important to undertake detailed planning even though the future is unpredictable. Over half (52%) realised that it is still important for a manager to provide direction rather than let groups self-organise. In support of the concept of stability, 72% of the respondents agreed with the fifth overall principle that healthcare leaders tend to focus on achieving predictability and stability. Interestingly, no relationships have been found between the socio-demographic status of the participants and their perception of complexity.

Discussion

There is general agreement among the participants of this study that hospital structures are bureaucratic and complex. Analysis of the data shows that bureaucratic management contradicts effectiveness in a complex and unpredictable healthcare environment. Interestingly, Spearman's rho statistic showed a strong negative relationship between the current management structures and effectiveness. The more bureaucratic the system appears the less effective it is. The significance was assessed at $p< 0.01$.

This study found all respondents perceive their hospitals as complex. A high pace of internal and environmental change continuously creates new conditions for themselves and their work area. Additionally, a majority of respondents agreed that the hospital environment is unpredictable and unknowable and half of them no longer feel able to control the organisation they work for and move it into a predictable future. This is in line with Bennet et al [16] Plsek [17] and Zimmerman [2] who related complexity with a high speed of change whereby every change is closely linked with many other changes. Moreover, previous research found that hospital structures find themselves at the edge of chaos. [2,16,17,18]

A clear majority of managers in this study agreed that they, as leaders, should not allow a group (the clinical workforce) to self-organise (52%). The reason for this is unclear, however one argument could be that managers may fear the loss of 'power' by allowing the team to organise themselves. Interestingly, while managers want to retain control over their team, 80% of respondents believed, according to one underlying statement, that it does not make sense to spend a lot of time with planning. This conflicts with the view that 72% of respondents indicated that long-term planning is a central element of their daily work.

Over half of the respondents agreed to the underlying statement that environmental changes are one reason for constant change and they hold matrix management structures responsible for the increasing uncertainty. These results are in line with the literature that found managers are no longer trusting in strategic planning, as the future appears unpredictable and uncertain. [1,19]

Only one fifth of the respondents in this study agreed that current institutional structures are effective and this finding is supported by the literature. [20,21] These studies suggested poor communication and the underestimation of complexity as being responsible for the lack of effectiveness. Plsek [22] supported the view that increased complexity paired with bureaucratic structures causes a decline in effectiveness through slow decision-making.

Unanswered questions and further research

This research was conducted as a pilot study in one setting. Further research across a range of settings is needed in order to establish reliability and validity of the instrument. Consideration should be given to using the instrument across a range or countries and cultures to determine whether increasing complexity in health service management and issues surrounding current organisational structures is a universal concept.

Strengths and weaknesses of the study

There has been no research on the impact of change and complexity in Queensland hospitals to date. This pilot study gives first insights into the dilemma managers have to deal with. The findings of this pilot study were consistent with previous research conducted on health service managers in the United States. [1] However, this study aimed to test the instrument designed to investigate the perceptions of hospital managers about the effectiveness of current hospital structures within a complex environment.

Although the questionnaire was derived from an American study, [1] the terminology was appropriate for this study. The findings of this study appear to provide useful insights into the perceptions of hospital managers and suggest the value of further research into those perceptions and their underlying causes.

Conclusion

Understanding and accepting complexity, as a central element in healthcare management means that managers may need new skill sets to rapidly adapt to the changing nature of health management. Anderson and McDaniel [23, p.90] argue 'what managers need is a new mental model that is more congruent with the nature of health care organisations. The model of professional complex systems makes such a reorientation possible'. Complexity recognises that processes are no longer stable; they need to become more flexible. Giving specific rules makes processes inflexible; guidelines instead could give direction for staff with the opportunity to adapt quickly in changing situations. Similarly, flexibility can only be reached when managers learn to share decision-making to lower levels in the organisational structure. Highly skilled healthcare workers need more autonomy to adjust quickly to changing situations. One way to achieve change is to introduce health management students to concepts such as complex adaptive systems theory, complexity science and other theoretical models that emphasise the unpredictable nature of health service delivery and alternative management approaches. [11]

Competing Interests

The authors declare that they have no competing interests.

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RESEARCH ARTICLE

End-of-Life Care in Private Hospitals

M O'Connor, L Peters, S Lee

Abstract

Objective: To develop an overview of end-of-life care (EOLC) for patients with cancer within the private hospital setting and identify the key factors influencing the care provided.

Design: A cross-sectional multi-method design was used to compare two private hospitals in Melbourne, Australia to examine the provision of EOLC for patients with cancer. Retrospective chart audit, interviews (audio-taped), hospital data and policy document review were used to compare the two hospitals.

Sample and Setting: Medical records of patients with a cancer diagnosis who had died in the preceding 12 months (N=67), and senior staff (N=9) from two private hospitals in Melbourne (Hospital A and Hospital B).

Main outcome measures: Hospital data identified staffing profiles, education and support services. Medical records provided evidence of assessment of deterioration leading to death, symptom management, links with palliative care services, involvement of other staff, and psychosocial, spiritual and bereavement support. Policy documents were examined for references to palliative care and/or EOLC and staff interviews elicited their perspective of EOLC as currently delivered in each hospital. The Palliative Care Australia (PCA) Standards for the Provision of Palliative Care 'palliative approach' were used as a framework for presenting and discussing findings.

Findings: While palliative care was not a designated specialty in either hospital, EOLC was influenced by the core specialities of each hospital. Elements of a 'palliative approach' to care were evident in both hospitals.

Conclusions: The project has provided recognition of work not previously reported, about EOLC in private hospitals in Australia. Areas for improvement include support for staff in relation to education and development of appropriate end-of-life care policies; referral process to specialist palliative care; and spiritual and bereavement care for patients and their families.

The study is timely, with recent proposed changes to private health insurance to incorporate the provision of palliative care services in all settings.

Abbreviations: CSN – Cancer Support Nurse; EOLC – End-of-Life Care; NUM – Nurse Unit Manager; PCA – Palliative Care Australia.

Keywords: End-of-life care; palliative care; cancer; private hospitals.

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Introduction

The formalised delivery of palliative care in Australia is predominantly in the domain of public sector and charitable organisations and much of the data about palliative care is confined to these sectors. While significant end-of-life care (EOLC) occurs in private hospitals, such care may not be distinguishable, with a title of 'Palliative Care'. EOLC is only one aspect of palliative care and for the purpose of this study refers to the care provided in the last three months of life. Due to the paucity of research in this area and the lack of comparable literature, the contribution of the private sector to EOLC has not been appropriately recognised, or acknowledged.

Difficulties experienced by palliative medicine specialists when delivering palliative care in private hospital settings have included the extra costs to patients, concerns over the ownership of patients by private practice specialists, the lack of a multidisciplinary team approach to care, and lack of a bereavement service. [1] Another Australian study in an acute public hospital setting, found the main barriers to providing quality care for dying patients included strict observance of routines and the lack of a shared and consistent terminology to describe care relevant to their needs. [2]

Studies have also addressed palliative care in acute, usually public hospitals, which valued the role of a Palliative Care Team in acute settings, [3-5] highlighting their positive impact on symptomatology and facilitating appropriate referrals and transfers. Another investigated public hospital palliative care costing models, again in relation to teams. [6] There was no literature found that assessed the EOLC of people in a private hospital setting.

Private health insurance for inpatient and home care has been limited, and not well utilised. [7] There are limitations on the length of hospital stay which restrains EOLC in the private sector and there has been slow development of home care.

Palliative Care Australia (PCA) [8] Standards for the Provision of Palliative Care underpin the work of healthcare services and professionals wherever palliative care is delivered. Recent work on palliative care service provision suggests there are levels of care from specialist palliative care (a multi-disciplinary team with specialist staff including doctors, nurses and allied health professionals and access to a tertiary hospital and volunteer services) through to a 'palliative approach' as evidenced in primary health and non-specialist settings. [8]

A palliative approach to patient care is defined by PCA [8] as:

> …an approach linked to palliative care that is used by primary care services and practitioners to improve the quality of life for individuals with a life limiting illness, their caregiver/s and family… incorporates a concern for the holistic needs of patients and caregivers that is reflected in assessment and in the primary treatment of pain and in the provision of physical, psychological, social and spiritual care'. (p.11)

As palliative care is more than the last weeks/months of life (the subject of this study), the PCA Standards [8] for the Provision of Palliative Care and the definition of a 'palliative approach' were used as a framework for developing the data collection tool and presenting and discussing findings.

Data were collected in two private hospitals, Hospital A (185 beds) and Hospital B (74 beds), which both belong to the same hospital group. Hospital A supports a range of specialties and Hospital B included 25 oncology beds. There were significant numbers of deaths in both hospitals.

Objectives

The objectives of the study were to investigate the nature and scope of EOLC as provided within the two private hospitals and identify the key factors influencing the type of care currently provided.

Methods

Approval was obtained from the Monash University Standing Committee on Ethics in Research Involving Humans and the Medical Advisory Committees of both hospitals. A cross-sectional case study design enabled examination of characteristics of care in both hospitals at a given point in time. [9, 10] Qualitative and quantitative methods were used to analyse the different types of data that describe EOLC.

Sample and data collection

Data collection was undertaken between September and December 2005. Relevant hospital data were collected including patient numbers and demographics, deaths, staffing, education and training and support services.

The medical record chart audit was conducted consecutively in the two study hospitals. Using existing data bases each hospital generated a list of cancer patient deaths for the period July 2004 to June 2005. The number of cancer deaths for Hospital A was small (33 deaths) and all 33 records were included in the audit. This dictated the number of records to be used in the study. From a total of 149 cancer deaths for Hospital B, random selection (every fourth death) by the medical records officer obtained a sample of 34 records for the audit.

Data collected from each patient record included diagnosis, treatments, dates of admission and death, length of stay, and number of admissions. Each record was reviewed for evidence of assessment of deterioration leading to death (an indicator of comprehensive assessment), [8] management of symptoms, medications, community supports (including palliative care), requests to die at home, the psychosocial and spiritual support provided, family involvement in decision-making, and involvement of other staff. In addition, field notes were taken and selected notes recorded verbatim to provide examples of various aspects of care such as assessment of deterioration in a patient's condition and outcomes of symptom management. Measurement of quality of care was not part of the study.

Policy documents and interview data were used to develop an overview of EOLC activities. Categories used for analysis were drawn from the PCA Standards; [8] for example, assessment and treatment of symptoms, bereavement and staff support. Semi-structured interviews were conducted with senior key staff: Director of Nursing, Cancer Support Nurse (CSN), a Nurse Unit Manager (NUM), a social worker from each hospital and a telephone conversation with the pastoral care worker from Hospital B.

Analysis

Chart audit data were coded and entered on computer for analysis using SPSS 12.1 for Windows 2003. Frequency distributions were used in a descriptive analysis of the chart audit group and mean scores were calculated where appropriate.

Transcribed interviews and textual data from documents were content analysed. Policies were examined for references to palliative care and/or end-of-life care; interview data were analysed and categories or themes formed.

All information was collated and analysed in order to develop an overview of EOLC as it was currently provided for patients with cancer in the two settings.

Results

Results revealed similarities and differences between the two hospitals, and the main results are reported here. For Hospital A, core specialities included; emergency department, intensive care, day centre facility, interventional cardiology, cardio-thoracic surgery, orthopaedics, obstetrics, urology and colorectal surgery. Core specialities for Hospital B included: medical oncology, chemotherapy, orthopaedics, haematology, upper GIT surgery, non-sub-speciality medicine and surgery, and diagnostic GI endoscopy.

A large number of deaths occurred in both hospitals for the selected 2004-2005 time period (Hospital A = 185; Hospital B = 167). However, the number of cancer deaths differed between the two hospitals with 34 deaths in Hospital A and 149 in Hospital B which occurred in the oncology area. The average length of stay for cancer patients in both hospitals was similar (Hospital A: M = 6.2; Hospital B: M = 6.6).

The audit sample showed most patients from both hospitals had multiple admissions and cancer of the gastrointestinal tract was the most common cancer diagnosis (Hospital A: 15 patients - 45.5%; Hospital B: 13 patients - 38%). In Hospital A chart audit, four deaths occurred in the Intensive Care Unit. Characteristics of the audit sample are presented in Table 1.

Both hospitals employed a discharge co-ordinator, social worker, and CSN; and allied health services such as physiotherapy, occupational therapy and dietitian were contracted as needed. Medical oncologists were available at both hospitals. Pastoral care was provided via a visiting chaplaincy model in Hospital A while Hospital B had its own pastoral care staff which offered a part-time service. No formal bereavement support was offered but Hospital B held an annual memorial service so that social workers from both hospitals might provide some bereavement support.

Some staff (CSN, social worker and oncology NUM) were trained in palliative care, counselling and bereavement support. On the oncology unit a small number of staff had palliative care experience and/or loss and grief training and all staff were oncology trained (including symptom management and aspects of loss and grief).

Table 1 Characteristics of audit sample according to hospital

	HOSPITAL A		HOSPITAL B	
	N (33)	%	N (34)	%
Gender				
Male	19	57.6	17	50
Female	14	42.0	17	50
Age (in years)				
Mean	77		73.3	
Range	36 -100		46 - 90	
Average length of stay (days)	12.8		12.12	
Range	1-39		2 - 55	
Living arrangements				
At home with family	16	48.5	27	84.4

While both hospitals had established links with public inpatient and community palliative care services, only a small number of patients in the audit sample in Hospital A used these services. In contrast, in Hospital B, 17 (50%) patients were involved with community palliative care services or referred for inpatient palliative care during this admission.

At both hospitals, patients were admitted under diagnostic categories and palliative care was not a designated category under the health fund schedules. The funding system is complex, based on episodic payments and each health fund has a different level of funding. In the oncology setting, at any one time 57% of the patients in Hospital B were in the 'no pay' day or 'step down' situation where less or no funding is received during this period.

Overall, in Hospital A, there was sufficient medical and nursing entries in the progress notes to provide evidence of the patient's deteriorating health leading to death. Even in cases of a rapid illness trajectory, there was sufficient information in progress notes to show the deterioration. However, in Hospital B, for 44% of patient charts in the audit there was no clear, documented information to show the deterioration of health that led to death; and in some instances there was no nurse or doctor entry to indicate that death had occurred.

The chart audit for Hospital A showed that patients diagnosed with cancer experienced a range of symptoms and many patients experienced several symptoms simultaneously of which pain was the most common (experienced by 29 patients: 87.8%). In general, documentation regarding symptom management, the interventions and their outcomes was explicit with some objective measures used (eg pain assessment score), however this was not consistent throughout the charts. Similarly, of the range of symptoms documented in the progress notes for Hospital B, pain was the most common; experienced by 31 (91%) patients. Entries regarding symptom management varied from patient to patient, with interventions and the outcome recorded for some, but not others. Overall, there was no clear, regular pattern for writing up symptom interventions and their outcomes.

The main roles of the social worker in Hospital A were complex discharge planning, providing support for patients, their family and staff, and being on-call in crisis situations. Most discharge planning was undertaken by the NUM in conjunction with the discharge coordinators, while the social worker handled more complex cases, in particular, dealing with placement issues. The social worker was involved with four (12.1%) patients whose charts were in the sample, mainly for referrals for home supports and possible hostel placement. Eight (24.2%) charts had entries made by the discharge coordinator, and four (12.1%) had entries by the cardiac case manager.

In contrast, the social worker in Hospital B played a major role in discharge planning for patients and families and was directly involved with 12 (35%) patients in the audit sample. The social worker's documentation was extensive and covered aspects such as the psychological state, emotional impact of the current situation for the patients and family, and the provision of grief counselling and support.

There was occasional evidence in the progress notes to indicate nurse involvement in psychological aspects of care but interview data indicated that within Hospital A there was a limited capacity to provide comprehensive psychological support. In the main, this support was formally provided by the CSN, but outside of this it was unfunded and uninsured. Staff cognisant of the philosophy of palliative care and the need to provide psychological and spiritual care to patients and families, described the difficulties sometimes encountered in trying to make this happen.

Interview data indicated there was organisational support for staff in both hospitals in relation to funding in-house courses or facilitating study leave to attend external education, and the availability of counselling. However, only a few staff availed themselves of the external study leave option to attend palliative care education.

The review of organisational policies for both hospitals showed that the Palliative Care Community Services Referrals policy (Hospital A) was the only one which contained a direct reference to palliative care.

Discussion

The study identified similarities and differences between the two hospitals. An important factor influencing EOLC at Hospital B was the core specialty of cancer care with defined inpatient medical oncology, chemotherapy, and day oncology services. Nursing staff were oncology trained which included some aspects of grief and bereavement. At Hospital A where the core specialty was interventional cardiology, cardio-thoracic surgery with emergency department and intensive care unit, few staff had any education in EOLC or palliative care.

Study findings showed that while the two hospitals differed in size, a large number of deaths occurred in both hospitals. Although the majority of deaths in Hospital B were patients with a cancer diagnosis, in Hospital A the greater proportion

of deaths was non-cancer patients. The focus of this study was patients with cancer but EOLC is equally relevant to non- cancer patients. [11]

The chart audit samples were similar in age and average length of stay with both groups having multiple admissions for their illness. However, the two groups differed in gender with more males (57%) than females (42%) in Hospital A while both were equally represented in Hospital B. There were more patients from Hospital B living at home with family compared with Hospital A. This has implications for domiciliary support as only a small number of patients in Hospital A were involved with community palliative care while half the patients from Hospital B were supported by community palliative care or had been referred for inpatient palliative care during this admission. Continuity of care between settings is known to be valued by people with chronic and life threatening illness; and many people wish to be cared for and to die at home. [7, 12,13]

Although neither hospital had an overt team approach to EOLC, relevant staff in each hospital were available to meet with the NUM regarding individual patient needs. There was access to EOLC expertise provided by medical oncologists but not necessarily access to a palliative care physician; thus varying levels of EOLC skill among medical oncologists would influence delivery of EOLC. The CSN role, well-developed in Hospital B, offered a variety of support services (eg support groups for general cancer and breast cancer, newsletter and workshops) although the main focus of this role was for patients with breast cancer. Both hospitals had experienced staff to provide psychological support for patients and their families as well as support for staff. About 35% of the audit sample in Hospital A were seen by the cancer support nurse and in Hospital B support was provided by an experienced social worker.

At Hospital B, the incomplete documentary evidence in nursing and medical notes of some aspects of care created gaps in the overall representation of EOLC for cancer patients. In Hospital A, documented information relating to EOLC was consistently evident.

Spiritual care is an important aspect of holistic EOLC. [14] Management at both hospitals were aware of the need to provide for patients' spiritual needs and while this was not formalised in specific programs, Hospital A had a policy for spiritual care, with input from mainstream religious denominations through a chaplaincy model. As these visits were not well-documented, it was difficult to know how many patients had received a chaplain's visit or which patients were missing out on spiritual care.

Hospital B had developed a part-time non-denominational Pastoral Care Service which had been in place for two years. While there was no formal bereavement program operating in either hospital, Hospital B provided some support in the form of an annual memorial service offered to families of patients who had died during the preceding year. This service, in place for several years, was organised by the oncology NUM, social worker, CSN and pastoral care worker. Staff also attended the service. A bereavement support program would assist in improving 'survivors' adaptation to life without their 'loved one', ameliorate staff concern about survivors and be a positive asset to the community. [15]

The Hospital B model for EOLC had the features of the 'palliative approach' with links to palliative care services and was well-placed to deliver quality EOLC. Aspects of the palliative approach were evident in the descriptions of the EOLC activities documented in the chart audit and in the interview data collected at Hospital A.

Measurement of quality of care was not part of the study. Rather the intent was to gain an overview of EOLC activities as they occurred in the two private hospitals. For example, it was only possible for this study to note that symptom management was part of a patient's care in both hospitals, not to ascertain efficacy of the medication regimen.

The organisational policy review in both hospitals revealed there was a lack of policies to guide staff in delivering EOLC. Even though belonging to the same hospital group, policies were inconsistent between the hospitals, appearing to have been locally developed. However both hospitals recognised that there was significant work to be undertaken in streamlining hospital policies across the hospital group.

Health insurance cover was described as complex and differed from fund to fund. A number of activities were undertaken at each hospital that would not have received health insurance funding; for example, the bereavement support provided by the social workers or home visits by the CSN in Hospital A. Also highlighted was the fact that deficiencies with the funding system disadvantaged the hospitals financially. These funding constraints put pressure on staff and families who have to consider whether they can afford inpatient care in a private hospital or look to public inpatient or community palliative care alternatives. This was described as a difficult time for families to be making such decisions. In 2005, Hospital B initiated a plan which was forwarded to the health funds with a view to gaining funding for palliative care to be delivered in a dedicated palliative care unit.

Conclusion

The study found that while there is little formalised palliative care in the private sector, many cancer deaths occur in this setting, which remain unacknowledged. Importantly, significant EOLC is delivered in this setting about which little has been documented. While not designated as 'palliative care' beds or units, aspects of EOLC in both hospitals can be described as the 'palliative approach'. Perhaps in response to criticism of the Private Health Insurance Funds, [7] in 2007 there were legislative changes proposed to health insurance funding, including the intention to broaden the scope of cover, to allow for more flexible services that do not necessarily require admission to hospital. There is potential to develop continuous models of care encompassing home and hospital-based care. [16]

Study findings indicate key areas that need to be addressed so staff are supported in delivering EOLC in private hospitals. These include education about EOLC incorporating the adoption of the Palliative Care Australia Standards and a 'palliative approach' to care; review of referral processes (internally to cancer support nurse and externally to community and in-patient palliative care services); and development of appropriate EOLC policy. Appropriate links to a palliative care physician with specialist clinical expertise or indeed a 'specialist palliative care team', would benefit dying patients particularly those with complex symptom needs, and provide advice and education for staff on these issues. A more formal program of spiritual care in Hospital A would assist patients and families and a funded bereavement program would support and acknowledge the experience of bereaved families.

The main limitation of the study was the small sample with only two private hospitals involved. Future work will include a larger sample of hospitals, a range of health professionals, and bereaved carers to gain their perspective; and the development of potential strategies for improving EOLC within this setting.

Postscript

The authors acknowledge that Hospital B addressed some of the gaps identified by the study particularly in relation to education about palliative care and documentation, improving links with community palliative care services and bereavement support. The most significant development has been the allocation of ten palliative care beds (initiated in 2005). Since July 2006, approval has been gained from some major health funds to fund palliative care for up to four weeks. Public criticism of lack of responsiveness of the Private Health Insurance funds to EOLC has indicated a demand for palliative care to be a more fully funded feature of private hospital care provision. [7]

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Competing Interests

The authors declare that they have no competing interests.

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MANAGEMENT PRACTICE

Planning and Implementing a Single Point of Entry to Sub-acute Ambulatory Care Services

V Sandler, LR Harriss, C Bain

Abstract:

This paper describes the process of redesigning access to a range of sub-acute ambulatory care services at Melbourne Health, which is a major public health provider in Victoria, Australia. The redesign process includes the establishment of a single point of entry for referrals. The context is one of high demand for the services with referrals from a broad range of sources. These sub-acute ambulatory care services require specialised areas of expertise for effective service delivery and optimal client outcomes. Government and organisational requirements of optimising efficiency, effectiveness and accountability of all services and clinicians, have been drivers for change in the existing processes. This paper describes and evaluates the previously existing system. It then outlines the development of the integrated model with a single point of entry, the establishment of the triage process and the implementation of the model.

Abbreviations: CDAMS – Cognitive Dementia and Memory Service; CTS – Community Therapy Services; DHS – Department of Human Services; ED – Emergency Department; IT – Information Technology; KPIs – Key Performance Indicators; PAC – Post Acute Care; RMH – Royal Melbourne Hospital; SACS – Sub-acute Ambulatory Care Services; SQL – Structured Query Language.

Key words: sub acute; ambulatory care; redesign process; single point of entry; person centred model of care.

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Introduction

Sub-acute Ambulatory Care Services (SACS) encompass a range of specialist services for clients with chronic conditions and rehabilitation goals. In 2003, the Victorian Department of Human Services (DHS) initiated the SACS framework, in which a number of isolated funding streams were consolidated into a single stream for each Victorian health service provider. The Royal Melbourne Hospital (RMH) is a member of Melbourne Health, and currently has eight SACS. Melbourne Health is a major public health provider in Victoria, Australia. It provides comprehensive acute, sub-acute and community-based healthcare programs to around one-third of metropolitan Melbourne's population, as well as general and specialist services to regional and rural Victorians and state-wide services.

In 2003, the Victorian DHS initiated the SACS Advisory Group to develop a person-centred model of care and associated funding and performance management framework for the delivery of sub-acute ambulatory care services. They consolidated the separate services into a single funding stream to each Victorian Health Service for 2004-05.

The principles underpinning SACS, as provided by DHS [1] are:

- Place the client at the centre of their care;
- Ensure practice is based on the best available evidence;
- Based on an interdisciplinary approach;
- Coordinated and integrated across all settings; and
- Promote health independence.

Until 1 July 2005, each service held a separate budget and reported to DHS in various modes. There were no standardised or integrated Key Performance Indicators (KPIs) regarding operation of the clinics, and budgets were allocated on an historical basis. In line with DHS principles, Melbourne Health set out to develop a single point of entry for these services, providing a centralised intake point for client referrals. To achieve this, a review of the SACS was initiated which encompassed areas such as organisational structure, processes for access, reporting relationships, budgets and data management.

A recent literature review revealed a lack of published information regarding single point referral systems and there were no studies identified in the SACS setting. In three models of primary health care teams in the United States, functional and structural changes to ambulatory services were implemented in order to improve quality of service and corporate productivity. In our context, the single point of entry was also an attempt to implement structural and functional change to improve access to services, productivity and improved quality of the systems involved. [2] The Institute of Healthcare Improvement uses a methodology of collaboration amongst providers, to focus on systems to achieve improved performance by standardising care processes, increasing accurate information available, and having documented decision support and protocols available to the team involved with the client's care. [3]

This paper describes and evaluates the previously existing system, outlines the development of the integrated model, the establishment of the triage process and the implementation of the model.

Description

A single point of entry for SACS aims to provide a centralised intake point for referrals, enabling improved efficiency, service delivery and client access. By integrating SACS into a single organisational structure, RMH aimed to meet the following critical success factors, as determined by DHS:

- Client-focused model of care;
- Single point of referral for SACS;
- Single point of administration;
- Consolidated funding and universal accountability measures;
- Consolidated data set; and
- Key performance indicators.

All Victorian health service providers with SACS are mandated to meet these DHS requirements, and several different models are evolving. A review of the eight SACS at RMH (Table 1), revealed that clients access several services concurrently or serially, and that a majority of clients have been inpatients at RMH. From a client point of view, there needs to be a continuum of high quality service and timely health intervention delivery. From the organisation perspective, there are a myriad of funding streams that

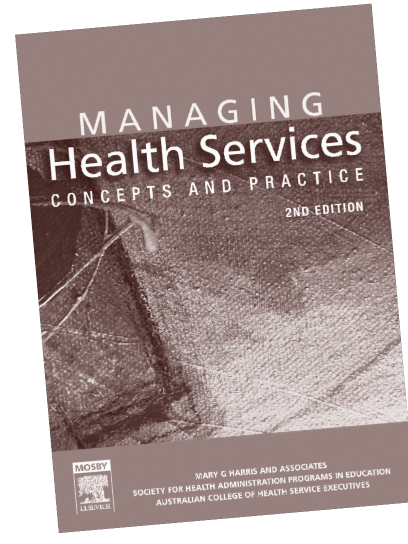

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Table 1: Description of the eight Sub-acute Ambulatory Care Services (SACS) located at Royal Melbourne Hospital (Melbourne Health) in terms of staffing resources and budgets

SERVICE	BUDGET (AUD)*	DISCIPLINES	CLIENT SERVICE EVENTS (%)†
Community Therapy Services (CTS) Operating in five streams: Aged care Amputees Home-based Musculoskeletal (including pain and rheumatology) Neurology	$3,648,097	Dietician Exercise physiology Medical Occupational Therapy Physiotherapy Psychology Speech pathoogy Social work	78.7
Cognitive Dementia and Memory Service (CDAMS)	$314,676	Medical Neuro psychology Nurse liaison Occupational Therapy Social work Speech pathology	4.7
Continence	$306,669	Medical Nursing Physiotherapy	6.3
Pain clinic	$283,157	Medical	5.0
Falls and balance	$274,949	Clinical psychology Medical Nurse liaison Occupational Therapy Physiotherapy Podiatry	2.3
Chronic wound management	$136,309	Medical Nursing Podiatry Dietetics on call	1.0
Neuro rehabilitation	–	Medical	0.6
Spina Bifida (commenced in 2006)	–	Medical Occupational Therapy Physiotherapy Social work	0.4

* Budget allocated by Victorian Department of Human Services in 2003-2004, prior to integration of SACS.

† Client service event is defined as 'an interaction between one or more healthcare professionals with one or more clients for the provision of sub-acute ambulatory care intended to be unbroken in time'. [4] Client service events by service of total SACS (activity) in 2005-2006. Previous to integration of SACS full dataset was not collected by all services.

provide care at various points in a client's journey. For example, funding for inpatient services is separate to funding for Post Acute Care (PAC) which is separate to funding for SACS. From a client perspective therefore, it became evident that PAC needed to be included in the model to enhance continuity and coordination of care. PAC functions to purchase and co-ordinate care in the home for eligible clients leaving hospital. It operates as the interface between hospital and the community sector for clients being discharged from the wards or the emergency department.

The following steps were undertaken as part of the key process for establishing the single point of entry to SACS.

Evaluation of current state

Data and information were gathered for each service to ascertain current levels of staffing, budgets, activity, outcome measures and work practices. This process utilised reports to DHS, Melbourne Health financial reports and human resources reports, medical record audits and interviews with the senior staff running each clinic.

Analysis of this information revealed the following:

- Duplication of processes between the clinics (including assessment of common information, referrals, administration support, management);
- Lack of coordination between clinics and no information technology (IT) system to link information or scheduling of appointments from the different clinics;
- 'Scattergun approach' by referrers in many instances (systems were onerous for referrers when required to refer to more than one clinic);
- Several clinics for whom no activity data was reported; and
- Different practices and criteria for each clinic with regard to resource allocation, catchment areas, waiting list times, etc.

A management plan for integrated services delivery was developed which aimed to address the issues identified. The efficiency of access and flow through the SACS was a high priority for improvement, as well as providing a sustainable mechanism for monitoring and continually improving processes and systems across the SACS. The coordination of the services aimed to minimise duplication of data collection, other administrative processes and client confusion. The following recommendations were made:

- The service model comprises a single point of entry which receives both internal and external referrals and triages these to the appropriate sub-acute services and community services. The initial appointment will be negotiated with the client, and appropriate information sent to them.
- The model will build on the existing streams structure, based on diagnoses (eg pain, continence). Each service will have its own KPIs (to be set by the team and the SACS manager) and will be led by a service coordinator. The coordinators will report to the SACS manager monthly regarding service issues, KPIs and budgets.
- SACS will be led and managed by a SACS manager. This position will report to the divisional director.
- A comprehensive geriatrician assessment must be provided for clients being referred from the community.
- All nursing staff across the services will be integrated to form a nursing team of 8.53 EFT and will provide centre-based and home-based nursing services to clients attending the SACS at Royal Melbourne Hospital.
- Allied health clinicians will meet regularly with their service team, and with their service coordinators for service operation accountability. They will report to the allied health manager for professional leadership. The service coordinators report to the SACS manager for operational accountability.
- The administrative staff will form an integrated team providing administrative support to all SACS.
- The client management system is upgraded to an SQL server plus a scheduler component and an HL7 interface.
- It is proposed that PAC be integrated into the SACS model of care.
- The full development of SACS and alignment of these services with Royal Melbourne Hospital as a Centre for Promoting Health Independence will be a staged, developmental process.

Development of a model for integration of services

The recommended integrated model now had all the SACS funded as one service, managed by one manager with an overall target activity for all the SACS combined. A common scheduling system and booking process was established for all the services. Monthly communication meetings between the SACS manager and employee groups were set up to enable issues related to change management to be effectively addressed. For example, definition and alignment of catchment areas has assisted with demand management.

An integrated model proposed the single point of entry for all referrals to SACS (including PAC). This eliminated duplication in collection of common information and generation of referrals. There were efficiency gains in

administration support and in management. The single point of entry coordinated the referral process for all the clinics which were renamed 'services' to reflect the interdisciplinary nature and holistic approach to care provision. Each service had a dedicated 'service coordinator' role, for which a formalised position description was developed.

IT software was upgraded to increase capacity and included a scheduling module. Data and appointment scheduling from all services were entered on this software, with monthly reports for a range of KPIs for each service. The roles of administrative staff were developed through multi-skilling, to ensure that no process was dependent on one person only. Reports are now submitted as required by the Victorian Department of Human Services, according to the SACS minimum data set. [4] KPIs for each service were set for activity levels; fail to attend rate; number of new referrals; number of discharges and time to initial assessment.

The unit providing PAC underwent significant change to comply with the single point of entry SACS model of care. The new structure necessitated changes to the roles and function of all staff including care coordinators, administration, and management staff. The changes incorporated training on the new IT system (including billing procedures necessary for PAC to broker services from external agencies). There was extensive training to take on the new triage and referral systems for each service. The unit then took on the function of being the single point of entry to SACS and PAC.

Services are now accountable for their own KPIs and activity data, which has prompted deeper understanding of the demands and capacity of their own service, and the options available to address these. This has facilitated improvement in managing waiting times, scheduling appointments and resource allocation. Improvement has come from utilising resources more efficiently, through reducing duplication, standardisation, 'failed to attend' rates, and reducing variation in work practice and quality.

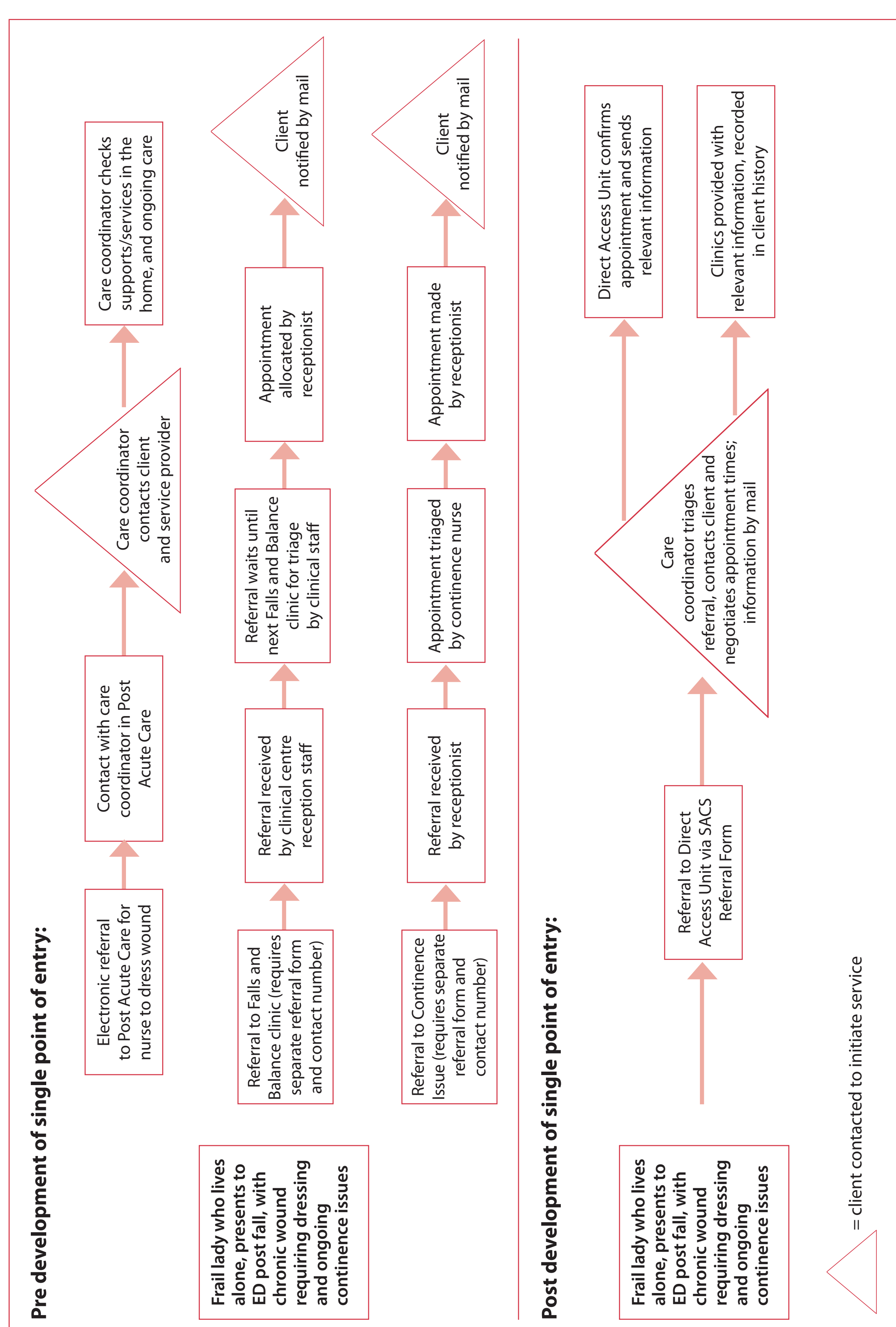
Establishment of a triage process

Detailed triage guidelines were developed by each SACS team for the single point of entry to triage clients to the appropriate services. Face-to-face meetings between the single point of entry team and the service coordinators and staff clarified 'grey' areas in the triage process. It also assisted communication, trust and rapport between the services and single point of entry team. This was necessary because the single point of entry was now taking on overall responsibility of this process, and this necessitated some standardisation between SACS and a shift in culture. The cultural shift was multifaceted and involved clinicians, managers and administration staff coming to view service provision differently, and behave accordingly. Wagner [5] discusses the management of clients with chronic diseases. He advocates the benefits of establishing an effective team which includes managers with knowledge of a population-based health planning approach to health care provision. The staffing of the single point of entry was based on clinicians with these competencies. These clinicians were skilled in providing an holistic approach to care provision and in allocating resources appropriately across the population who are accessing our sub-acute services.

One aspect of the change in culture in SACS was to change from focussing only on the one service being provided for one particular problem, and thereby providing silos of services. Clients' care needed to be arranged from a broader perspective. This necessitates having information and systems available which enable care to be provided as a comprehensive, coordinated system that can address multiple problems in a timely and coordinated way. Another shift was to actively provide care that is centred on the clients' needs and abilities, including where and when services are delivered. This was a move from our current arrangements which were historical or based on what suited the clinicians best. Another change in emphasis was for clinicians to plan service provision for the overall demand for services, including clients not being referred and clients waiting to be seen, rather than advocating mainly for the client/s sitting in front of them.

The triage and appointment scheduling for individual services was rolled out over a period of nine months, with the single point of entry taking on one extra service at a time. Additional clinical and administration staff were allocated to cope with the extra workload. This was achieved by redirecting resources from other SACS sources where there was natural attrition and efficiencies gained. They no longer spent time doing triage and information gathering and duplication was decreased. There was an ongoing focus on building the teamwork within the single point of entry to enable effective establishment of the new roles and the development of autonomy both within the team, and for the team as a whole. Handing over responsibility for the triage function was difficult for some SACS due to the complex nature of the triage criteria for their service. However, over time the process has evolved and acceptance has improved. The entry processes pre and post the implementation of the single point are illustrated in Figure 1.

Figure 1: Example of referral processes pre and post development of a single point of entry (SPOE) for a frail elderly lady living alone, presenting to Royal Melbourne Hospital Emergency Department (ED) after falling at home (not requiring an inpatient stay)



Implementation

The following changes to SACS were implemented during 2004/2005:

- Creation of a single point of entry for all SACS including PAC.
- Creation of extended and/or realigned roles for staff including care coordinators, service coordinators and administration support staff.
- Monitoring of SACS and a single point of entry established and regular reports submitted.
- Collection of data for the new minimum dataset as required by DHS.
- A single referral form developed to provide easy referral to all SACS and PAC.
- Establishment of an adult spina bifida service as part of the transition program from the Royal Children's Hospital.
- Update of client management system with addition of a scheduling module and a financial module.
- Scheduling, data entry and reporting for all SACS using the new integrated software system. This necessitated up-skilling of all relevant staff, hardware upgrades and close liaison with the IT vendor.

Conclusions

A major driver for the development and implementation of the single point of entry has been to improve client access to Melbourne Health services. Overall, the development and implementation of the single point of entry or SACS has been well received by staff and clients alike. Clinicians and other staff were required to understand issues relating to the healthcare journey from the client perspective. As a result, valuable feedback was gained which enabled significant improvements in workplace practices.

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Competing Interests

The authors declare that they have no competing interests.

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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 15 February 2008.

Contemporary Health Management Issues in the Asia Pacific

DS Briggs

Introduction

The Sixth Annual Hospital Management Asia conference was held in Thailand on August 30 and 31 2007. The conference was notable for the number of participants, the diversity of countries and health organisations participating and the quality and diversity of presentations. The conference is organised by a consortia of health and health industry organisations. This paper provides a summary of the issues presented at the conference to allow readers from different healthcare systems in the Asia Pacific to reflect on the similarities and differences in issues addressed compared to those they face in their particular system and organisation.

The Conference

Held over two days, there were over 600 delegates from 31 countries with presentation of papers from speakers from 14 nations. [1] The conference consisted of two plenary sessions and a range of special interest sessions. Additional sessions were available for a 'meeting of the minds' for groups to meet and discuss topics not covered by the breakout sessions and a CEO forum for senior ranking hospital executives. The Asian Hospital Management Awards were also presented for customer service, marketing and promotion, human resource development, technical service improvement, internal service projects, community service, patient safety and quality medical care. [2]

Patient Safety Solutions and their impact on healthcare delivery was the subject of the key note address. Dr Paul van Ostenberg, Managing Director for the Asia Pacific Region of the Joint Commission International, presented international perspectives and the need for national, regional and international collaboration. Dr van Ostenberg also spoke about the role of the WHO Collaborating Centre for Patient Safety [3] and the International Joint Commission [4] that can be further explored from the relevant websites.

There were a number of presentations and sessions on patient safety, risk management, adverse events and bench-marking that placed safety and quality at the centre of the conference. The future of hospitals, health care, the global nature of the workforce and an increasing attention to 'medical tourism' also predominated. The human side of the organisation, leadership, culture, negotiation skills, and value creation also featured. Technology, marketing and business skills were also addressed. [5]

Participants who might reflect on the conference would perhaps consider that the issues were relatively similar across health systems. However, there was also recognition that the impact of these issues was felt differently in each national health system. For example, the global nature of the health workforce means that while some health professionals work across health system, some national health systems now rely on an imported workforce, while others are exporters of the workforce and, as a consequence, struggle with similar workforce shortages.

This one issue will present significant challenges to health systems in training and retention policy and will require some consideration around training and licensing in both national and international contexts. Like the call for regional and international collaboration on patient safety and quality, these other challenges will increasingly require the same approach. The learning and development of health service managers will increasingly require an international context.

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Editor

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REVIEW ARTICLE

Multipurpose Services and Palliative Care: emerging funding challenges and possible solutions

S Allen, K Francis, Y Chapman, M O'Connor

Abstract:

The changing demographics of rural communities in Australia had rendered some health services inappropriate for small acute hospitals to deliver. Many of these small rural acute hospitals, which the government believed were not sustainable, accepted a new concept in healthcare servicing in the mid 1990s; the Multipurpose Service (MPS). [1] MPS combined and consolidated allocated funding from both the state [2] and Australian governments to service the identified needs of the local community and outlying areas through a service plan. [3] Residential aged care is an integral part of an MPS service plan. The provision of funding for residential aged care in MPS is in contrast to the funding of specific purpose Residential Aged Care Facilities (RACF), (*Aged Care Act, 1997*).

The *Aged Care Act 1997* being synonymous with the funding of RACF reformed and revolutionised institutional residential aged care. The *Aged Care Act 1997* provided a funding system which increased payment for a resident's increasing frailty through the Resident Classification Scale, in order to provide extended nursing care to the ill/dying. Caring for the ill/dying has always been a part of institutionalised aged care nursing, though deemed by government to be fragmented in the context of the Guidelines for a Palliative Approach in Residential Aged Care. [4] There is an expectation that residents who are ill/dying who reside in MPS receive nursing care in accordance with the Guidelines for a Palliative Approach, despite the difference in the funding arrangements. This paper will examine the variance of funding relationships associated with the provision of palliative care, between RACFs and MPSs to ascertain whether the funding variation has implications for the delivery of palliative care to residents and offers some options for addressing these perceived problems.

Abbreviations: ACAS – Aged Care Assessment Services; ACHS – Australian Council on Healthcare Standards; ACFI – Australian Care Funding Instrument; ADL – Activities of Daily Living; CAPS – Community Aged Care Places; EQUiP – Evaluation and Quality Improvement Program; HACC – Home and Community Care; MPS – Multipurpose Service; PEPA – Program of Experience in the Palliative Care Approach; RACF – Residential Aged Care Facility; RCS – Residential Classification Scale.

Key words: funding; residential aged care facilities; multipurpose service/centre; palliative care standards; palliative care guidelines.

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Introduction

The Australian government introduced Multipurpose Services/Centres (MPSs) for rural areas as a solution to the growing question of sustainability for acute rural hospitals in a changing rural demographic climate. [5] It is a government expectation that palliative nursing care will be provided in residential aged care organisations and this expectation extends to MPSs. In Australia the multi-disciplinary approach, levels of required service, guidelines and standards for the delivery of palliative care are, according to Sellick et al, [6] relatively new. Death and dying has been and remains, part of the delivery of nursing care to residents in institutionalised care. The Government recognises that a palliative approach would benefit Residential Aged Care Facilities (RACFs) and MPSs, yet no additional funding to realise this expectation has been forthcoming.

To provide a structure for RACFs and MPSs to adopt a palliative approach for residents with life-limiting, or chronic illness, besides those suffering from a diagnosis of cancer, the government, as part of the National Palliative Care Program introduced the Guidelines for a Palliative Approach in Residential Aged Care in 2004. This document has recently been supplemented by the Palliative Care Quality Resource Kit 2005 which outlines the standards for developing and delivering quality palliative care services. This paper examines the funding relationship and differences in delivering quality palliative care within RACFs and MPSs in Australia and provides some options for addressing these perceived problems.

Legislation within Australia

The Australian Government's *Aged Persons Home Act (1954)* provided generous subsidies to not-for-profit, charitable and church organisations to provide institutionalised care for those aged in need of supportive care. [7] This legislation was the catalyst for the escalation of rest and convalescent homes which catered for the needs of the elderly; however it precluded eligibility for state or local authorities in accessing these funds. Thus an inequity in the provision of residential care to the elderly was manifested in not-for-profit (community), charitable (religious) and private (for profit) organisations. [7] The recession of 1972 saw an increase in the demand for aged persons marginally coping at home requiring institutionalised care. This increase in demand for institutionalised care placed enormous pressure on the limited places available in not-for-profit, charitable and church organisations; fees escalated especially in the private sector. [8] The financial burden of caring for an aged relative in residential care fell on family members; governmental controls over fees charged to residents in the private sector were non-existent.

The Home and Community Care Act (1985) (HACC is a jointly funded state and federal program in a 40/60 ratio), alleviated the financial burden on family and government, [9] by providing a range of home services enabling supportive care to be provided within a person's home, thus reducing the demand for institutionalised care.

The viability of small rural hospitals also came under discussion and scrutiny in the early 1990s with state and federal government representatives considering ways to address the health needs of these communities. The outcome of these meetings was the adoption in 1993, of combining HACC and federal resources inclusive of a four year viability payment [10] to finance and service the health needs of rural and remote community areas. These health services operate from a central town location and are known as MPSs. Once the basic health and aged care needs of the community are met, the funds may be used to support other services required by the community. These redirected funds could provide more home-based care services, allied health services, contracted nursing services or health education programs. Changes were also determined for the delivery of institutional residential aged care with the budget of 1996 heralding a totally new concept; *The Aged Care Act 1997*.

The Aged Care Act 1997

The *Aged Care Act 1997* [12] brought sweeping changes to the residential aged care industry. The Residential Classification Scale (RCS) became the funding assessment tool which acknowledged the resident's level of dependence on nursing staff to attend to Activities of Daily Living (ADLs). This documentation places the resident into funding categories within high or low level care classification, and determines the funding remuneration for the facility.

Palliative care programs designed to enhance and support the delivery of quality care

To support the delivery of quality care and alleviate the transfer of residents from RACFs and MPSs to acute hospitals for palliative nursing care, the government through the National Palliative Care Program 2004 commissioned the 'Guidelines for a Palliative Approach in Residential Aged Care'. [13] During the same year a document entitled 'Providing Culturally Appropriate Palliative Care to Indigenous Australians' was distributed. [14] This was followed in 2005 by Palliative Care Australia producing the Quality

Resource Guide – a Toolkit [15] which outlines the standards for the delivery of quality care programs to those who have a life-limiting illness. The government also allocated funding and promoted the Program of Experience in the Palliative Approach (PEPA). PEPA aims to provide primary health care practitioners with the opportunity to develop skills in the palliative approach by undertaking a workforce placement within a specialist metropolitan or larger regional palliative care service. [16]

Palliative care expectations

Government expectation is for the delivery of a palliative care approach through a multidisciplinary team in both RACFs and MPSs as evidenced by the published documents mentioned above. Adoption of these widely distributed documents is voluntary, however, they support and enhance the delivery of quality care services to residents with a life limiting, or chronic illness, besides those suffering from a diagnosis of cancer. Within RACFs, palliative care forms part of the RCS documentation, however, the adoption of RCSs for MPSs is not mandatory and appears to be rarely implemented.

Evaluating the delivery of quality care

Palliative care standards serve as criteria for evaluating service outcomes. They provide two distinctive avenues for assessment; they may be used as a self assessment tool by both RACFs and MPSs or act as an accreditation assessment process within Agencies. The Aged Care Accreditation Standards Agency is a specialised agency which accredits Residential Aged Care Facilities. The Australian Council on Healthcare Standards (ACHS) – Evaluation and Quality Improvement Program (EQuIP) accredits MPSs, and is not a specialised residential aged care accreditation organisation.

Funding arrangements for RACFs

Within the *Aged Care Act 1997* are the Accountability Principles (1998) which govern every aspect of residential aged care. These Accountability Principles determine a RACF's budget income and to a larger extent its expenditure. The 'gate keepers' for admission, resident classification of high or low level care and movement to a higher level within RACFs is determined by the Aged Care Assessment Services (ACAS) who act as delegates on behalf of the government. [12]

Palliative care funding to RACFs

There is no separate classification for the provision of palliative care to residents in RACFs. Palliative care funding is integrated into the RCS from low to high level care. The core values and domains associated with quality nursing practice are outlined in the palliative care guidelines and standards. These documents determine quality nursing practice, when supported by staff education (PEPA) or other professional development courses. Funding is allocated by management from the collective funding of individual RCSs, therefore it is imperative that continual nursing assessment and re-assessment is conducted to ensure a financial return reflective of the resident's current health status.

Funding arrangements for MPSs

MPSs with a residential aged care unit are funded by the federal government, plus the four year viability rate previously mentioned and a flexible care subsidy rate. Flexible subsidy rates are determined annually and contain high and low funding for residential care plus Community Aged Care Places (CAPS). These annual determinants are paid monthly regardless of the occupancy rate or level of care required by the resident. The funding for residential aged care is not quarantined and therefore forms part of the general revenue of an MPS. The requirement of a MPS is that a Service Plan is submitted to the state government outlining the services to be provided to meet the health needs of the community. [17] Management allocates funding to services provided by the MPS according to the priority set out in the Service Plan. The provision of service must be within the expertise/competencies of nursing staff profiles employed by the MPS, or by visiting paid sessional clinical nurse consultants. This latter approach must be reflected in policies and procedure manuals.

Palliative care funding to MPSs

MPSs are allocated high and low level care residential beds when accepted as flexible care by the Australian Government. Residents with life-limiting or chronic illness and those with a diagnosis of cancer requiring palliative care are part of residential care within an MPS which is determined by ACAS. The provision for MPS adopting quality palliative nursing care services/programs is contained in the guidelines and standard previously mentioned. Palliative care education on the core values and domains require translating by management to nursing expertise, through the staffing skill mix of nurses.

Evaluation of the delivery of palliative nursing care is through the accreditation process. No separate funding is available to MPSs for the delivery of quality palliative care programs to residents. The delivery of nursing care to residents residing in an MPS does not conform to the RCS as previously stated, or the retributions of government legislation for not complying or delivering palliative care in accordance with the guidelines or standards. When

a resident's condition deteriorates there is no ACAS requirement to validate the resident's status as there is no increase in the funding allocation to MPSs, therefore there is no incentive to implement the palliative approach. Rurality also acts as a deterrent to implementing the National Palliative Care Program [13] as the accessibility to the PEPA programs is limited by the problems of remoteness from regional or major centres. Staff availability to backfill shifts enabling nurses to attend courses, the time involved and the cost of travel to such courses are factors detracting from nurses attending education programs.

Anomalies

There are certain funding anomalies between RACFs and MPSs in implementing a palliative approach in residential aged care. The RCS provides a tool by which a resident's level of dependence on nursing care is determined. MPSs do not have the capacity to increase their funding as a resident's health status declines, therefore the lack of incentive could contribute to a negative implementation of the palliative approach. Accreditation certification is another anomaly; RACFs have a specialised agency to examine the delivery on palliative nursing care, whereas the Australian Council on Health Care Standards (an acute specialisation agency) with the 'EQuIP' for the community sector suffices for MPSs.

Rurality has a significant impact on the implementation of quality nursing practice; compared to regional or city dwellers, for the reasons described earlier. MPS funding does have a degree of flexibility. The four year viability and flexible residential aged care funding can be diverted to other community needs, providing the residential service obligation has been addressed. [11] Retribution by government is not part of the funding criteria for MPSs. Nurses employed in MPSs are purported to be older, less embracing of new 'best practice' procedures and appear to be entrenched in old doctrines that further impact on recruitment and retention of nurses. Encompassing these claims is the unattractiveness of working with the elderly in aged care. [18]

Funding variations and rurality do impact on the accessibility and delivery of quality nursing care to residents of an MPS who require palliative nursing care. The expectation by government for the multidisciplinary palliative care approach is reasonable; however, it is not a reality in the present funding climate of MPSs, where accountability and compliance is at variance with RACFs. To address these perceived problems the following considerations may provide a solution.

Considerations

The new funding model (the Aged Care Funding Instrument [ACFI]) which is to be implemented from 20 March 2008 to replace the RCS presently in use in RACFs, is to provide 'better matched funding to the complex care needs of residents; reduce the documentation created by aged care providers to justify funding; and achieve higher levels of agreement between aged care staff and department review officers in review audits (known as validation)'. [19, p.1] While these aspects may not apply in the current circumstances in MPSs, this new model of funding and the current timing if implemented would guarantee the quarantining of funding for the provision of complex health and nursing care needs, including palliative care to residents residing in all aged care units. The adoption of this model in MPSs would provide the catalyst for change, aligning RACFs with aged care units of MPSs, allowing for review audits to be conducted and education programs to be attended utilising modern technology of video-linkage, distance education or teleconferencing.

By unifying the funding mechanism of aged care units, a number of benefits would enhance the quality of care for residents residing in aged care units of MPS. These include:

- accountability of the service provider to the Australian Government;
- conformity to service provision standards and outcomes;
- the uniform implementation of the guidelines for a palliative approach;
- mandating of Division 1 (RN) nurses for the delivery of twenty-four hour nursing care to high level residents residing in MPSs;
- removing delegation and remote supervision [20] of nurses providing care to these residents;
- ensuring funding is more in line with residents care needs;
- provide residents', family members and significant others with confidence in the provision of standardised residential aged care; and
- promote aged care nursing as a speciality within a unified workforce.

Another aspect that could be addressed when adopting ACFI in MPSs is to appoint the Aged Care Standards Accreditation Agency as the accrediting body for all aged care units. This would provide and encourage high level quality nursing care, the funding of allied health professionals on a consultative basis, such as palliative care specialists, physiotherapists, occupational therapists or for inclusion of alternative

therapies of massage, music and other aspects to enhance each resident's quality of life, comfort, security and safety.

When 'crystal gazing' into the future, these developments may lead to more nurses qualifying as General Nurse Practitioners with prescribing rights, thus freeing medical General Practitioners from undertaking visits to residential aged care units. It may be with the changes to the state Nurses' Boards to a national Nurses Registration Board in 2008 that the recognition of aged care nursing as a speciality may come to fruition. These changes and others in an ageing population where only those who are old receive care in residential aged care units may enable government funding to economically deliver quality nursing care in a climate of reduced revenue from employment taxation.

Conclusion

This paper has outlined funding legislation pertaining to institutional residential aged care from early times to the introduction of MPSs and the *Aged Care Act 1997*. The dual organisational discourse of funding arrangements and variances has been enunciated. The National Palliative Care Program designed to enhance and support the delivery of quality care to those residents with a life-limiting, or chronic illness, besides those suffering from a diagnosis of cancer has been espoused. The government's expectation for implementation of the program to all aged care units is demonstrated by their continuance of funding additional educational tools for implementing the program. The evaluation of delivering quality nursing care through the differing accreditation system has been acknowledged. The limitations of rurality and the associated problems of accessing education for implementing the Guidelines for a Palliative Approach in Residential Aged Care have been outlined. The National Palliative Care Program while being viewed as a substantive development by nursing proponents and the Australian Government, does present implementation limitations in MPSs which are yet to be addressed. The considerations enunciated in the new funding structure may however be the catalyst for changing this perspective.

Competing Interests

The authors declare that they have no competing interests.

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Is health competing effectively in the tertiary education market for healthcare professionals, and how could we do it better?

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 selcted participants have addressed the following question:

Is health competing effectively in the tertiary education market for healthcare professionals, and how could we do it better?

1 It is important to consider that in the health industry only 47% of workers have qualifications delivered by the higher education system. In the community services industry this number is closer to 30%. Such consideration brings into focus the vexed issue of articulation between Vocational Education and Training (VET) and Higher Education, and also brings greater scope and flexibility to thinking about skill requirements and skill formation strategies [1] and how effectively the sector is competing for its future workforce.

The AHMAC Workforce Strategic Framework urges Industry to make optimal use of workforce skills and ensure best health outcomes. The Framework also recognises that a complementary realignment of existing workforce roles or the creation of new roles may be necessary and that any workplace redesign needs to address health needs, the provision of sustainable quality care and the required competencies to meet service needs. [2] It is not clear how aligned universities are to deliver on this requirement of Industry and therefore this would question their effectiveness in delivering the competencies the labour market needs and in sufficient quantities.

There is also much written about the needs of the future workforce requiring training providers that apply smarter learning methodologies, accelerating and integrating learning on and off the job, better and less bureaucratic recognition of competence plus entirely new approaches to designing qualifications including the recognition of smaller skill sets. The higher education sector, in only viewing itself as being about 'Professionals' and refusing to embrace approaches that recognise the competence of workers trained in the vocational sector, is clearly limiting our ability to grow a competent workforce for the health industry.

The potential changes facing the health industry will make substantial demands on the training system's ability to produce practitioners faster and ensure upskilling and reskilling to meet the changing needs of consumers and fill the gaps created as labour demand increases. [3] New roles in the community services and health industries must be created and supported with appropriate training.

The training reform agenda led by the VET sector involves competency-based training and qualifications linked to industry required job roles. Basic premises include work readiness and demonstrating the skills and knowledge to do a job. Competencies themselves must be directly relevant to a job role. Employers and employees are an integral component of the development of competencies. The development, endorsement and review processes ensure the relevance and currency of competency standards and qualifications. This system and what it offers has never truly been embraced by Universities.

The VET system has a number of advantages which could complement other sources of health workforce supply, which include the following:

1. Enable training and assessment delivery mechanisms that are targeted to people already in the workforce enabling people to continue working and delivering services;
2. Offer a modular approach to education and training combined with work-friendly delivery mechanisms that supports workforce flexibility;
4. Provide shorter course timeframes, providing new workforce entrants more quickly that are 'work ready staff';
5. Enable a competency-based approach to qualifications that facilitates the development and expansion of articulated career pathways, within and between service delivery streams.

The future of integrating work and learning in Australia requires a systematic and integrated approach to skills development involving sophisticated stakeholder management and cooperation between the whole of the tertiary sector ie, universities, VET and schools. Without this there can be no coordinated and efficient skills development for the health industry.

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2 The Australian higher education sector plays a critical role in the supply of health care professionals to work in an increasingly sophisticated environment of demographic change, increased technological complexity and greater consumer demand for equity, choice, autonomy and flexibility. Changing demographics include an ageing and culturally diverse population, the emergence of new infectious diseases and increased numbers of people living with chronic conditions. All this is combined with the need for efficient and effective allocation and management of finite healthcare resources. The higher education sector and the health industry will need to develop close links to ensure they are conversing about the changing status and educational needs of the workforce. Effective workforce planning has proven to be notoriously difficult and aligning policy, funding, training and education programs to meet the quantity, skills and competencies required by the healthcare sector is an ongoing challenge.

A further issue is the perception that the health sector (particularly the public sector) is not necessarily a good place to work. Whether these views are perception or reality doesn't really matter; the impact of being able to attract graduates of choice is the same. Healthcare employers and others responsible for the organisation and funding of the health system need to take into account the various positive and negative drivers and levers that impact on workforce recruitment and retention. I suggest that there needs to be a greater focus on aspects such as job design including career pathway development and new professional roles, communication, respect for all levels of workers, and ensuring that staff feel valued and appreciated for the work they do. A growing and positive trend in the health sector which should assist in attracting graduates is the recognition of the need to provide preceptors, mentors and coaches to support the growth and development of employees.

Stronger collaboration and partnerships with the tertiary education sector will enable the health sector to influence educational expectations and outcomes so graduates are prepared for work in an ever changing and complex health system. The 'match' between education, skills and competency development as well as the expectations of graduates regarding employment choices plays an important part in how successful healthcare sector employers will be in competing for the graduates they really want.

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3 Healthcare institutions, particularly hospitals, need to be managed well to be viable and achieve their social goals. These complex organisations are characterised by scarce resources, demanding customers, and high-pressure environment. For them to operate effectively and efficiently, skilled professionals and managers should provide the needed leadership and strategic thinking. The healthcare industry, however, will have to compete with other industries for these talents as they are produced by the tertiary education schools and universities. Most medical school graduates eventually work in health care institutions as their first jobs, though some get employed in other industries. However, few graduates outside medicine – accounting, engineering, business management, natural sciences – are attracted to working in healthcare establishments, especially hospitals. There are three major reasons for this lack of interest.

Firstly, hospitals and other healthcare institutions, running 24/7, are perceived as high-stress working environments, where quality of life is almost always compromised by regular overtimes, night-shifts, double-shift assignments and week-end duties. Moreover, having to deal with demanding patients and doctors adds to the stress due to long and unpredictable working hours. In fact, medical staff, in spite of their training to work extended hours, quit their jobs because of burn-out. They either retire early or move to less stressful industries. Non-medical staff will certainly have much lower thresholds and staying power.

Secondly, healthcare establishments are usually non-profit organisations. Many are religious and government run. Consequently, pay is not competitive nor attractive.

Hospitals are not perceived as greener pastures to move to. Talents cannot be lured with higher pay, because most healthcare organisations, being non-profit, do not buy the concept of recovering return on investments from this premium pay. Non-standard pay is considered disruptive in this regulated industry.

Thirdly, there is very little career opportunity in most healthcare institutions, which have relatively flat organisations. In the private corporate world, career runways are longer with milestones such as assistant managers, assistants-to, and several levels of vice presidents to look forward to by aspiring staff. These are absent in most hospitals, where middle management is lean. After lower management and department heads comes senior management; the medical director, hospital administrator and the CEO. Top management in hospitals is usually vacated only by old-age retirement, seldom by incompetence or the availability of younger talents in the pipeline.

Given these handicaps of healthcare establishments, we still can find mission-oriented professionals and individuals willing to forgo opportunities offered by the corporate world, and dedicate their working lives to serving the sick and suffering. However, most new graduates of tertiary schools, particularly those from the non-medical fields and sciences, may not be as socially-inclined in choosing their first jobs. Given this universal situation, healthcare establishments should consider the following steps and strategies to compete more effectively in the job market for talents and skills:

1. Improve pay and incentives; benchmark with other industries; link pay to performance, not just to working hours, and years of service;
2. Design and develop a clear and attractive career path for heath care professionals inside the organisation; regularly replenish senior management posts with new blood;
3. Provide stock ownership options to employees. While doctors in private hospitals are usually stockholders, this privilege should also be given to nurses and the non-medical staff; and
4. Provide regular training and training opportunities to health care staff and professionals.

Health care establishments will have to invest not only in upgrading equipment and technologies, but also in enhancing their working environments if they are to remain competitive, effective and relevant.

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Asian Institute of Management – Philippines
www.rtdonline.com

4 I have chosen to answer this difficult question from the point of view of a researcher in health workforce governance. Let me explain.

The first thing I would say is that this question is framed in the language of economics, the language of competition over scarce resources, of the market, of demand and supply. This is the language of human resources for health. My view is that we need a broader perspective in health services research, one that is sensitive to the range of problems and solutions in healthcare systems. Yes, economics are important but political science, sociology, and epidemiology provide important and valuable conceptual and methodological tools as well.

Secondly, this is a global problem; one that cuts across national borders. The International Consortium for Research on Governance of the Health Workforce, of which I am a member, is working to achieve global solutions to health workforce problems. Our vision is better health for the people of the world through collaborative research in health workforce governance – the right providers in the right place at the right time. We are an international collaboration of governments, professional associations, and researchers working with philanthropists to achieve the vision of the organisation. The collaboration stimulates, promotes, facilitates and disseminates research projects that will support evidence-informed decision making on the governance and policy issues that impact the quality, structure and accessibility of the global health workforce to meet the varied needs of the people of the world. Our perspective focuses on health workforce governance. We recognise the need to examine issues in the public and private sectors, and to think about issues from a broader perspective. The Consortium comprises researchers, regulators, professionals and community members from high and low income countries, including Canada, the USA, Australia, New Zealand, India and Sri Lanka. The Consortium aims to provide evidence-informed joined-up solutions to problems concerning the quality of graduates, safety and access to healthcare.

Thirdly, in the Asia Pacific if we are aiming to have the right health professionals in the right place at the right

time, then we need to do some fundamental re-thinking about the health workforce. We are not recruiting enough appropriate students into the health professions. There is inadequate funding from the Australian Government in tertiary education to enable us to feel confident that we are educating good health professionals for safe professional practice. And we know we have serious problems with retention in the health workforce and with servicing the needs of disadvantaged communities, most notably poor and Indigenous peoples, and those in rural and remote areas. As Convenor of HealthGov, a division of the Australian Research Council Governance Network, I invite readers of APJHM to contribute to this endeavour: to provide evidence-informed solutions to health workforce challenges; good professionals, safer patients and improved access.

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5 I would like to evaluate the adverb 'effectively' in three dimensions.

The first dimension relates to the extent outstanding students are attracted to take Health Science as their major subject when they start their tertiary education. For this I would say healthcare disciplines as future careers are still very appealing to students. On average the A-Level examination scores for Health Science students are higher than other fields, with the exception of some finance-related disciplines such as Actuarial Science. The phenomenon is becoming more prominent in recent years, especially for Medicine and Nursing. I suppose this is related to the high social esteem healthcare professionals are still enjoying and the prospect of relatively stable jobs and good income after graduation. So for this dimension the answer is yes.

The second dimension of 'effectiveness' refers to the adequacy of healthcare professionals being produced by tertiary education institutions to meet the market demand. It would be difficult to draw a straight forward conclusion for this dimension because it differs for different health-related disciplines. For doctors the message is conflicting. Leaders in the public sector advocate strongly for training more doctors because of foreseen manpower shortages, while the private sector insists that the number of doctors is already more than adequate even if compared with developed countries. This probably is related to the recent exodus of doctors from the public sector going into private practice because of the obvious surge in demand with the recent boom in the financial market. The situation for Chinese medicine practitioners seems clearer. The large number of privately practising Chinese medicine practitioners, the exclusion of Chinese medicine by public hospitals and the scarcity of training and employment opportunities in other sectors for Chinese medicine practitioners combine to foster a consensus within the profession that the supply from tertiary education institutions is much more than the demand.

For nursing the reverse is true. All health care sectors are fighting for nurses. The gap between supply and demand appears to be widening with the ageing of the population and the rapidly increasing number of long-term care facilities for the elders. Worse still is the fact that more young females with their good academic performance join the medical profession instead of nursing, while young men still reject the idea of becoming a nurse which seems to have a strong feminine connotation. Also the shift from hospital-based training to tertiary education-based training for nurses has dramatically reduced the number of working hands provided by student nurses. It would be fair to say that at this juncture and in the near future, our tertiary education institutions are not producing adequate nurses to meet the demand of healthcare services.

The picture for allied health professionals is a mixed one. Some disciplines such as radiographers and speech therapists are experiencing obvious shortages, while medical laboratory technicians are said to be overproduced because of extensive automation of laboratory processes. For podiatrists, the situation is one of critical shortage and the main reason is the lack of a local program jacking up the cost for pursuing this career, and the apparently nonprofessional image of a job that only cares for people's feet. I am not certain about the field of dentistry, and it appears that there is a balance between supply and demand, although postgraduate subspecialty training for dentistry is rather limited in Hong Kong.

The third dimension regarding effectiveness is whether the graduates are equipped with the attributes that healthcare markets are expecting. Overall I think the tertiary education institutions are doing a good job, despite the fact that most of their courses are conferring undergraduate degrees. For postgraduate education, the Hong Kong Academy of Medicine in collaboration with the Hong Kong Hospital Authority provides a wide spectrum of specialist training courses for medical graduates, while the Institute of Advanced Nursing Studies also takes care of specialty education for registered nurses.

One area that deserves special mention is the field of healthcare administration. There is no undergraduate course offered by any tertiary education institutions for this discipline despite the fact that related postgraduate diplomas or master degree programs abound in Hong Kong. Most of the administrators working in healthcare sectors are generic management graduates to begin with, and only equip themselves with the necessary knowledge in healthcare through in-service training courses. On the other hand, top level managers are usually someone from the other professions, mainly doctors and nurses who are appointed to their positions without much management training. To rectify this I think that healthcare administration or management should be considered a professional discipline of its own right with a distinct career path and education provisions starting from undergraduate level.

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6 In New Zealand, the question is not only whether health competes effectively in the tertiary education market but how well we understand the workforce needs of the health sector in the first place, and how well we manage our workforce once it's trained. Workforce planning was all but abandoned in the 1990s, when a National government decided that matters of workforce supply could be left to the market. Funds were allocated to some areas of clinical training, but in general the hands-off approach led to important gaps in some areas of the traditional workforce, and a lack of strategic thinking about future needs in a time of change. The market did respond to some gaps, with the emergence of training programs for groups such as community psychiatric workers and caregivers in aged care. However, these were ad hoc and not part of any wider service development process.

A change of government in 1999 saw a change in philosophy associated with an ambitious approach to tackling inequalities and health status issues through the New Zealand Health Strategy. This was associated with more coherent policy approaches to workforce. In 2003 a Ministerial Workforce Advisory Committee recommended that three broad areas be addressed: a stronger focus on new areas of priority such as primary health care and disability support; workforce development among Maori and Pacific people as part of the drive to reduce inequalities; and recruitment and retention issues through policies for healthy workplaces, workforce education and research and evaluation.

Since 2003 the government has driven policy strongly on the development of the Maori and Pacific workforce, concentrating on training in mental health and addiction services, as well as across all health professional disciplines. Maori nurses now comprise around 8% of all nurses, still a much lower proportion than in the population as a whole, but higher than for other health professions. For primary care, special initiatives in medical and nurse practitioner training hold promise for addressing shortages in rural areas. How the workforce is supported within the health environment to ensure stability and development has been harder to address, but policies such as support for rural rostering, for example, are assisting in maintaining the rural health workforce.

The overall challenge is to move away from ad hoc responses and position health careers strongly in an increasingly competitive labour market. One strategy is the development of a universal career framework for the health sector. A Career Framework for the Health Workforce in New Zealand (October 2007) proposes a resource for those involved in marketing health careers so that career pathways can be developed and workforce planning linked to this. This initiative is in its early stages, but demonstrates an understanding of the importance of a strong 'branding' for health careers. It is expected to assist in recruitment and retention, and to building a flexible workforce that is aligned to the identified service needs of the New Zealand Health Strategy.

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David Rankin

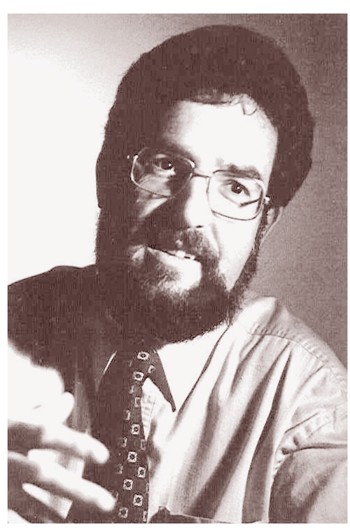
In this issue of the Asia Pacific Journal of Health Management, we bring you an interview with Dr David Rankin who was recently appointed President of the New Zealand Institute of Health Management. We asked David a few questions on his career in health management and the challenges that such a role brings.

David graduated with his medical degree from Otago University in 1982. Having worked in rural General Practice in Victoria for four years, he completed both a Masters in Health Administration and Master in Public Health at Loma Linda University in Southern California before returning to Australia and then moving to New Zealand.

David was the Chief Executive Officer of the Auckland Adventist Hospital, a private surgical hospital, for six years before moving to Wellington as the General Manager, Health Service Purchasing with the Accident Compensation Corporation.

For the past 18 months he has been Senior Advisor to the Ministry of Social Development, providing medical leadership in the Ministry's major reform of the Sickness and Invalid's Benefit system.

David is Chairman of the New Zealand Health Information Standards Organisation, member of the Health Information Strategic Action Group and member of the Council of Medical Colleges. He is President of the New Zealand Institute of Health Management and Vice President of the Royal Australasian College of Medical Administrators.



What made you venture into health management?

Although I have always had an interest in process improvement and change management (according to my parents and siblings), it was while working as a rural general practitioner (GP) in Victoria in the mid 1980s that I was asked to manage the medical centre and join the board of the small local hospital. I found this a fascinating and rewarding challenge. For a short period, the chief executive officer (CEO) of the larger organisation was replaced by a very experienced older medical administrator who encouraged me to gain formal qualifications in health management. He also made sure that I read Drucker's *Management by Objective* which gave me my first insight into management theory.

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

Without a doubt, I get my greatest enjoyment from watching the successful outcome from projects that I have helped design. To start with a purely theoretical policy concept and be able to work through the complexities of politics, funding, resourcing, change management and finally monitor the outcomes is a real challenge. I dream about how systems could be improved to enhance patient outcomes, reduce bureaucracy and free up resources for re-investment in improved health outcomes.

What is the greatest challenge facing health managers?

My greatest challenge as a public servant is to separate political ideology from patient benefit. So much of my energy is absorbed in making changes to avoid political embarrassment or solve short-term crises, without being able to focus on what will improve the patient experience or enhance outcomes. There is often a focus on governance and locus of control rather than on efficient or effective allocation of resources.

We are seeing that in New Zealand at present around the implementation of the government's primary care strategy, where the focus is on the constitution of boards and the control of doctors' incomes. There is little system focus on the integration of primary and secondary care, the efficient or effective delivery of primary care services or the monitoring of health outcomes.

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

I become frustrated when energy is directed towards controlling process rather than focusing on outcomes. Again this is demonstrated in our current system with a focus on the income of GPs rather than on how effectively they are managing their enrolled population. I like the observation that the past focused on how we can do it better, the real question for the future should be why are we doing it at all. There are so many tasks that we try to improve when we should step back, taking a wider systems view to completely redesign process.

So much of what we do focuses on interventions and treatments rather than behaviour change. Medical training is all about diagnosing, admitting and discharging patients (doctors spend the majority of their time training in hospitals) rather than encouraging self determination, changing behaviour and encouraging community responsibility.

What is your career highlight?

There are many events that rank as highlights. Having the opportunity to break from a busy, demanding clinical practice and study for several years in the United States was great. The children were pre-schoolers and we travelled all over the West Coast, camping and eating the cheapest food we could buy.

Having the privilege to be an administrative resident in a large down-town Los Angeles hospital which was in the process of a major turn-around gave me hands-on exposure to many practical aspects of high quality management. The president of the hospital gave his time to tutor me and explain his planning and positioning moves.

Being tasked in New Zealand with establishing a national purchasing framework for the management of elective surgical services for this country's accident insurer was an enormous challenge, but resulted in strong collaboration across both the private and public sectors.

Finally assisting my direct reports to understand the health sector, learn management principles and build relationships, then encouraging them to take up senior positions within the sector has been a privilege.

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

I have had a number of people who have taken me under their wing and provided advice; often to suggest ways to solve problems other than through confrontation and frustration. One of my early mentors suggested that I was born with a desire to wake up and attack the world, even when the world did not want or expect to be attacked. My family has always been invaluable in helping me maintain a balanced perspective.

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

Health is too complex to ever be 'solved', particularly by any one person. I would really like to see a system develop which allows all stakeholders to bring their expertise to the table and contribute to a strategic vision which everyone endorses and results in the best affordable care for as many as possible. Health cannot be solved by clinicians, financiers, systems engineers or managers working alone.

The successful health executive of the future will be someone who can appreciate various perspectives and merge the warring factions to deliver an organisation focused on best practice for the patient.

As chair of the New Zealand Health Information Standards Organisation, I see real progress as we move towards a future where information (clinical, financial, performance and population) is truly an enabler and not a focus of management.

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

It is all about relationships. Clinicians will still be there long after they have engineered a change in management. The relationship between the health services manager and the clinician is fundamental to any change program. Where the relationship is strong, it is possible to establish a partnership based on trust. Such a relationship allows disclosure and exploration of common problems and mutual determination of solutions. This makes management rewarding.

BOOK REVIEW

The Australian Health Care System

Reviewed by J Healy

Bibliographic details:

Duckett, S.J
The Australian Health Care System. 3rd ed. Melbourne: Oxford University Press; 2007

Stephen Duckett has updated his invaluable guide to the complexities of the Australian healthcare system. Health systems are never static but change as the environment changes and in response to hotly contested debates between a myriad of stakeholders. Duckett argues that a health system should not be allowed to meander along, but that pro-active policy choices are needed with a clear understanding of their impact upon equity, efficiency, quality and acceptability.

Attempts to describe the unwieldy entity that is a health system reminds me of the story of the three blind men and the elephant. Each grasped a different portion of its anatomy and thought that the elephant resembled a tree trunk, a fan, or a snake. Duckett has grasped the whole beast in this definitive overview and analysis. The book is deservedly the standard text for students of health policy and administration. Also, the sections are clearly labeled so that busy policy makers and practitioners can find the part of the beast that most interests them.

Duckett begins with a systems perspective on the inputs, throughputs, outputs and outcomes of a health system. Chapter two reviews the diverse health needs of the Australian population of 20 million people; the needs that a health system is meant to be addressing. Three chapters examine the inputs and institutions of the health system: financing, the workforce, and departmental and governmental structures. Other chapters examine the modalities for delivering healthcare goods and services: hospitals, public health, primary and community care, and pharmaceuticals. For example, the chapter on hospitals covers the dramatic changes in patient management over the last few decades, and the supply-side attempts to contain ever-rising hospital costs that soak up about one-third of total health expenditure.

Duckett has decades of experience in administering and researching the health system. It will be interesting to see if his perspective changes in the 4th edition after his current stint in reforming the health system of Queensland, particularly its public hospitals.

The Australian public has high expectations of their health services. The book identifies many areas that need improvement in order to produce more efficient and better quality healthcare, as well as services that are more responsive to users. In summarisng the policy challenges for the future, Duckett argues that the Australian health system has many strengths, at least compared to others around the world, and that only minor structural change is necessary. He acknowledges that some would disagree with that conclusion, given perennial political tensions between levels of government, and the gaps opening up between supply and demand. Policy changes in the structure of the Australian health system, with the notable exception of the introduction of Medicare, have been incremental, given the difficulty of steering the health system with its mix of public and private providers within a federal system of government. It is often said that no one runs the health system. This book illustrates the difficulties of steering the large and lumbering beast that is the Australian healthcare system into the 21st century.

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LIBRARY BULLETIN

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

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Bringing together clinical services in ways meaningful to patients can improve quality by better integrating care.

Pitches, DW and others,

What is the Empirical Evidence that Hospitals with Higher-risk Adjusted Mortality Rates Provide Poorer Quality Care? A Systematic Review of the Literature

BMC Health Services Research

June 2007

The general notion that hospitals with higher risk-adjusted mortality have poorer quality of care is neither consistent nor reliable.

http://www.biomedcentral.com/content/pdf/1472-6963-7-91.pdf

SAFETY

Longo, DR and others

Hospital Patient Safety: Characteristics of Best-Performing Hospitals

Journal of Healthcare Management

Vol 52(3) 2007 pp 188-205

WORKFORCE PLANNING

Shannon, EA and others,

Developing Metrics for Hospital Medical Workforce Development

Australian Health Review

Vol 31(8) August 2007 pp 411-421

The ability to make and defend decisions about medical staffing numbers is enhanced by the ability to compare across clinical boundaries.

Nurse Staffing and Quality of Patient Care

Agency for Healthcare Research and Quality, Evidence Report/ Technology Assessment No. 151

March 2007

To assess how nurse to patient ratios and nurse work hours were associated with patient outcomes in acute care hospitals, factors that influence nurse staffing policies and nurse staffing strategies that improved patient outcomes.

http://www.ahrq.gov/downloads/pub/evidence/pdf/nursestaff/nursestaff.pdf

Myers, Valerie L and Dreachslin, Janice L

Recruitment and Retention of a Diverse Workforce: Challenges and Opportunities

Journal of Healthcare Management

Vol 52(5) September/October 2007 pp 290-298

Organisations that attract and retain a diverse nursing staff and create a climate in which veteran nurses can transfer their knowledge to neophytes, while maintaining or exceeding previous levels of quality, have important lessons for healthcare as a whole.

Hepburn, Valerie A and Healy, Judith

Stakeholders' Perspectives on Health Workforce Policy Reform

Australian Health Review

Vol 31(3) August 2007 pp 385-392

Manuscript Preparation and Submission

General Requirements

Language and format

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

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

Title page and word count

The title page should contain:

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

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

Abstract, key words and abbreviations page

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

Main manuscript

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

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

Major and secondary headings

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

Figures, tables and illustrations

Figures, tables and illustrations should be:

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

Copyright

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

Ethical approval

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

References

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

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

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

Books and Monographs

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

Chapters published in books

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

Journal articles

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

References from the World Wide Web

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

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

Types of Manuscript - some general guidelines

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

Content

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

Abstract

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

Main text

Structured appropriately. A suitable structure would include:

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

Word count: general guide - 2,000 words.

References: maximum 25.

2. Research article (empirical and/or theoretical)

Content

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

Abstract

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

Word count: maximum of 300 words.

Main text

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

The discussion section should address the issues listed below:

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

Word count: general guide 3,000 words.

References: maximum of 30.

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

3. Research note

Content

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

Abstract

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

Word count: maximum 200 words.

Main text

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

Word count: general guide 2,000 words.

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

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

References: maximum of 25.

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

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

Content

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

Abstract

Structured appropriately.

Word count: maximum of 300 words.

Main text

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

Word count: general guide 3,000 words.

References: maximum of 50

5. Viewpoints, interviews, commentaries

Content

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

Abstract

Structured appropriately.

Word count: maximum of 200 words.

Main text

Structured appropriately.

Word count: general guide 2,000 words.

References: maximum of 20.

6. Book review

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

Covering Letter and Declarations

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

Covering letter

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

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

Declarations

1. Authorship responsibility statement

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

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

2. Acknowledgements

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

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

3. Conflicts of interest

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

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

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

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

Criteria for Acceptance of Manuscript

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

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

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

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

Peer Review Process

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

The process involves:

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

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

Submission Process

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

(Preferred approach)

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

Or

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

All submitted manuscripts are acknowledged by email.

NB

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

References

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

Other references consulted in preparing these Guidelines

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

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

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

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

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