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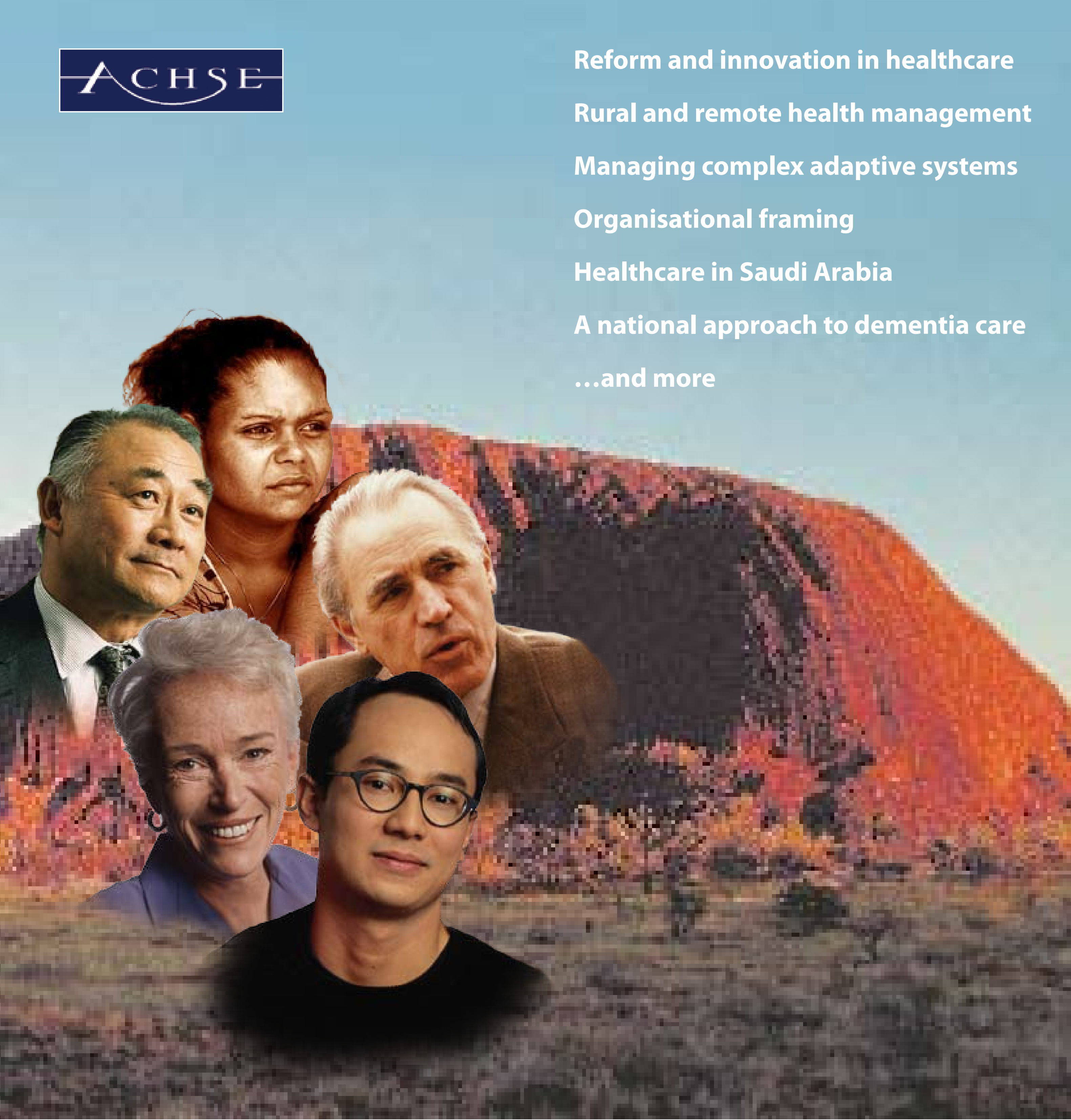

Reform and innovation in healthcare

Rural and remote health management

Managing complex adaptive systems

Organisational framing

Healthcare in Saudi Arabia

A national approach to dementia care

…and more

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Australian College of Health Service Executives

EDITOR
David Briggs BHA, MHM(Hons), FCHSE, CHE, FHKCHSE
Co-ordinator Health Management and Gerontology Programs,
University of New England, New South Wales, Australia

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

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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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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

Bringing the 'Software' of Organisational Behaviour to Health Reform

DS Briggs

This year will be remembered internationally by many in healthcare as the 30th anniversary of the signing of the Alma-Ata Declaration, which affirmed basic access to health services as a fundamental human right and adopted a primary healthcare (PHC) model for the achievement of that access. Reviews or restructures of Australian health systems have also partly been based on the logic of strengthening primary care and managing the challenge that chronic care presents. [1] In Australia, 2008 might also be remembered as the year when the Federal Government began to give effect to promised reform of the Australian health system.

The Alma-Ata Declaration had some focus on poorer communities and developing countries and the Federal Government's commitment recognises the need to improve rural health services and Indigenous health outcomes in Australia. [2] The need for reform of the Australian health system [3, 4] is unquestioned. The poorer health outcomes of rural and remote and Indigenous communities [5] reinforce the need for strong government support to reform.

Hall and Taylor [6] reviewed progress in 'health for all' since the signing of the Alma-Ata Declaration and suggested that PHC did not achieve its goals in terms of the Declaration for a number of reasons; one being that the approach was resisted by government and experts because it required community engagement. They also indicated that this approach was replaced by 'Health Sector Reform' which, they suggest, can be criticised as being driven by economic and political ideology.

All health professionals and health managers would be encouraged about the potential of reform and the opportunity to respond and positively support it. However the potential limitation of health reform based on the criticism of economic and political context needs some consideration. Reform in healthcare worldwide has had that focus for some decades with an emphasis on structural change, a term used interchangeably as being the same as health sector reform. [7] The persistence with mechanistic and economic perspectives to health reform continues, despite increasing views and evidence that they are largely ineffective, [8] have an over reliance on performance management techniques, [9-12] and are frustrating to those focussed on delivering healthcare. [13] This approach mostly ignores increasing evidence that a greater emphasis on socio-cultural perspectives is required. [7, 14-16] This is not to say that all three perspectives are not important, but does suggest a change in emphasis; a rebalancing of approach to include what Blaauw et al refer to as the 'software' of health sector reform. [7]

Rathwell and Persuad, in discussing the difficulty of health reform in the Canadian context that emphasised the application of reengineering and restructure, suggest that evidence of success in this approach is equivocal at the best. They point to an unwillingness of central officials to relinquish power, a lack of clarity over roles and a lack of authority to exercise responsibility at differing levels within the health system. In discussing accountability and governance of health systems, they state that the fundamental question is, does the reform strengthen or weaken the relationship between those organising and delivering care and those in receipt of that care? They also point to the concept of stewardship as a paradigm that has promise for balancing economic efficiency with public interest, a paradigm with an emphasis on trust and ethics. [17] Organisational values and the congruence between those and organisational members' values are also seen to be central to transition and change [18] and underpin the nature of institutions at the system or sector level. [19]

Professional sub-cultures in health systems represent organisational members' values and beliefs and they provide another restraining influence to effective health reform. [20-24] The silos in healthcare delivery remain, despite boundary changes to organisations, again suggesting mechanistic solutions are not effective at the service delivery level and that a greater emphasis on social-cultural perspectives

is required. The constancy of change through reform by restructuring and performance management has also placed health professionals and health managers in difficult and contested contexts. [25-28]

The systemisation and complexity of healthcare have brought new health management roles, requiring different management approaches to that prescribed by traditional management theory. [29, 30] Health managers wear different hats of being a manager and being managed and bring the different minds of the clinical and management professions to their role, each providing an important perspective, but relatively narrow in the broad contextual knowledge required to manage in healthcare. Increasingly they are well qualified but limited in health management experience when they come to the role and, their tenure is often short-term and tenuous. [31] Increasingly they are participants in change, making sense of change to others rather than being central to its implementation. [24]

An acceptance of the importance of social-cultural perspectives to health reform and a greater emphasis on organisational behaviour theory and research are not a panacea to the complexity or challenge of change. This rebalancing also needs to be further complicated by revisiting the PHC concept of community engagement because it provides potential for participation, greater equity of access and some community control over health services, [6] providing a more transparent and balanced representation of structural interests. [32] A rebalancing of reform to accept the importance of these perspectives will present new and greater challenges to researchers, policy makers and both health professionals and health managers. [33] However, engagement of those affected by change and learning from those experiences might provide a more balanced, strategic and effective 'journey of reform'.

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

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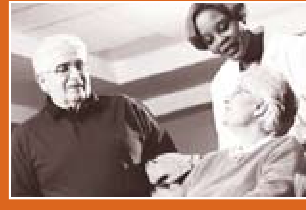

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The Australian College of Health Service Executives was established in 1945 to represent the interests of health service managers and to develop their expertise and professionalism. Today the College is the professional organisation representing health service managers across the full range of health care delivery systems in Australia, New Zealand and the Asia Pacific from both public, private and aged care sector organisations.

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EDITORIAL

Translating Sound Ideas to Successful Practices in Healthcare Organisations: why the sociopolitical environment deserves more attention

JE Lloyd, D Greenfield and J Braithwaite

To survive and thrive, organisations and their managers must search constantly for new ways of doing things, and institute these. The struggle to implement innovations in healthcare has a long history and many examples. [1-3] This history demonstrates that while developing an evidence base for innovations is an important step towards improving healthcare, it is not sufficient in changing practice among individuals, teams and organisations within the healthcare system. The inability to change practice can lead to a scenario where, despite the existence of evidence for overcoming problems, old and perhaps inappropriate practices continue.

Exploring the nature of implementation reveals that embracing innovations is a complex process that draws on knowledge and experience from many disciplines such as political science and management. However, the most common conceptual construct of implementation is as a project management exercise. Under this technical definition a plan is developed, targets are set, strategies are put in place to avoid potential roadblocks, resources are allocated and progress is monitored. [4]

Jane E Lloyd
Research Fellow
Centre for Clinical Governance Research in Health

David Greenfield
Research Fellow
Centre for Clinical Governance Research in Health

Jeffrey Braithwaite
Professor and Director
Centre for Clinical Governance Research in Health
Faculty of Medicine
University of New South Wales, Sydney Australia

Correspondence:
j.braithwaite@unsw.edu.au

This technical approach to implementation is most effective, for example, when implementing large scale information technology projects across multiple sites within a tight time frame. For instance, the establishment of a state-wide information technology system across the New South Wales health system adopted precisely-defined project management strategies and was described as a success in a recent multi-method evaluation. [5] However, a narrow project management approach to implementation may not be sufficient or appropriate for innovations that rely on changing entrenched, socialised behaviour and attitudes of individuals and teams within complex organisations and systems.

In healthcare organisations to date, strategies for implementation have often drawn on the technical approach. However, effective implementation needs both the technical and social: technical because plans are necessary, roles and responsibilities need to be clarified and so on, and social because implementation requires changes in the attitudes and behaviours of individuals and teams. It has been argued that the most rapid implementation occurs in settings with strong administrative leadership and a supportive climate for change. [6] Clearly, there is a need for greater understanding and emphasis to be placed on social implementation processes. The ability to synthesise technical mechanisms and social implementation strategies will underpin more comprehensive implementation across the healthcare system.

It is important to note that implementation is commonly understood as when and how ideas are translated into action. [4, 7] Implicit in this broad definition is an assumption that implementation either occurs or does not: that implementation is either a success or failure. Such a dichotomy does not respect the complex nature of change, evident within multiple-layered socio-political environments like healthcare settings where many implementation

strategies and individual and system reforms, large and small, are occurring simultaneously. Implementation might be better conceptualised therefore as a complicated and contested struggle over the realisation of ideas. [8] This latter definition allows a focus on how the mix of political, social and attitudinal ingredients change during implementation, and highlights the significant influences that organisations and their internal and external stakeholders have on the evolution of innovations. Focusing on the context in which ideas are hammered out requires a significant conceptual shift from examining the quality of the idea and whether or not the idea is adopted in practice.

Individuals, teams, organisations and systems are not blank canvasses; rather they are influenced by their history, values and relationships. The context in which ideas are played out is likely to influence how ideas are recognised, interpreted and valued. The implementation of an innovation involves a dynamic interaction between the original idea and the setting in which it is received. The influence of the context on innovations means that at each point in the implementation process, new circumstances arise that allow different potentials in ideas to be actualised. [9] Once the dynamic interaction that occurs between the innovation and the context is accepted, it is possible to see that innovations are not static, but rather evolve over enduring interactions and time. From such a standpoint it is a logical progression to understand that ideas have not merely the capacity to change but to produce unpredictable outcomes. [10]

There is an important opportunity to examine the capacity for change within healthcare organisations. This would require the exploration of implementation from different perspectives including organisational theory, organisational learning, organisational psychology, the sociology of work and systems thinking among others. Infusing implementation theory with ideas from other literatures such as these will create new intellectual space to understand implementation and how to generate a broader conceptual toolkit of implementation success. It might bring fresh insights to the implementation debate. Where better than the *Asia Pacific Journal of Health Management* to progress this debate and focus on building the management and culture of healthcare services to create an organisational climate and leadership that are open and responsive to new ideas?

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IN THIS ISSUE

This issue has adopted for its cover, the College's National Congress theme, *Health Services Management – Different Faces, Different Places*. The theme emphasises the Journal's objective to provide coverage of health management issues, not only across the diverse Australian context, but also that of the Asia Pacific Region. Seven original articles are presented in this issue as well as two editorials, a letter to the editor, in profile, a book review, our regular Q&As section, and the ACHSE Library Bulletin. Two sub-themes have emerged from those presented. The first focuses on rural and remote health while the second continues to reinforce the perspective that health management and health organisations are complex.

In his Feature article, Wakerman provides commentary on the difficulty of delivering healthcare in rural and remote settings and the central role quality health management should play in ensuring that the human resources, so essential to that role, are adequately supported. A paper by Fraser and colleagues in a Thai-Australian rural context further reinforces the need to empower and support rural health professionals to implement change gained from knowledge translation and cross-cultural learning.

The perspective of senior managers active in rural and remote settings, is provided in the Q&A section on the challenge of addressing the healthcare needs of rural dwellers; timely input given the current emphasis being placed on addressing this area in health system reform. This section includes a first contribution from Indonesia to the Journal and we appreciate that contribution from our colleague Roy Massie. Finally, Nancye Piercey is featured in In Profile and provides an exemplar of a lifetime of committed professional service to the delivery of health services to rural communities, a career that she finds satisfying and that holds personal and professional rewards. The Letter to the Editor also presents a request for readers to participate in current research about professionals who live and work in rural communities, providing a valuable opportunity for rural health professionals to contribute.

In another first for the APJHM, Jannadi and colleagues provide a descriptive review of the current structure and challenges facing the Saudi Arabian healthcare system. This system is facing rapid growth and, although reliant on overseas health professionals, is also investing in the development of the Saudi health workforce, including health management capacity to meet its particular challenges. This article indicates that while health systems globally face different challenges, there can be similar contexts, such as a reliance on overseas trained health professionals, a context relevant to many national health systems, to rural Australia and to Saudi Arabia.

Contributors to the APJHM have a continuing interest in the perspective that health systems are complex adaptive systems. In this issue the focus on the complex nature of the health system begins with an editorial by Lloyd and colleagues about translating sound ideas into practice in health care organisations. This editorial challenges readers to utilise the APJHM to begin the debate so that we might create an organisational climate and leadership in healthcare that is open and responsive to new ideas. Moss, perhaps anticipating the call by Lloyd for more debate, responds to an article in the last issue of APJHM by Dehn and Day (2007, 2:3) about managing in an increasingly complex environment. He suggests a changed approach required to manage complex adaptive systems, together with quality leadership based on increased trust between those involved; approaches that are consistent with the editorials in this issue.

Blackman and Fitzgerald continue the complexity theme with two related articles. The first article acknowledges that healthcare organisations are complex and that managers may be restricted in undertaking change by the mental models they hold. They describe research that had an aim to determine if framing analysis and reframing techniques allow managers to see organisations and problems in different ways and, that such an approach might lead to better decision making and problem solving. The second paper by Blackman and Fitzgerald builds on the research in paper one and proposes a tool kit for adoption of multi-framing techniques in the health context.

Williams and Grenade, in their article on meeting the needs of people with dementia and their carers, clearly demonstrate how a national approach can develop a strategy and framework of policy, funding and standards. This approach allows the appearance of a seamless service delivered by diverse government and non-government organisations with flexibility in approach between state-based organisations. The incidence of dementia is increasing and the service response is multidimensional and complex. The approach described by Williams and Grenade might be worthy of consideration in responding to other national health challenges that set policy, standards and funding while allowing diversity and flexibility of response by service providers.

The focus on policy development, analysis and settings is continued in the book review by Magarry. The book, Analysing Health Policy - a Problem Orientated Approach, edited by Barraclough and Gardner, also emphasises the complexity of healthcare policy settings by the breadth of its coverage and the contribution of informed authors used to bring the diversity of health policy settings to the reader. Again, Sue Brockway, librarian, provides a comprehensive listing of relevant articles and reports that should more than satisfy the reading interests of health managers in the diverse settings we now describe as a health system.

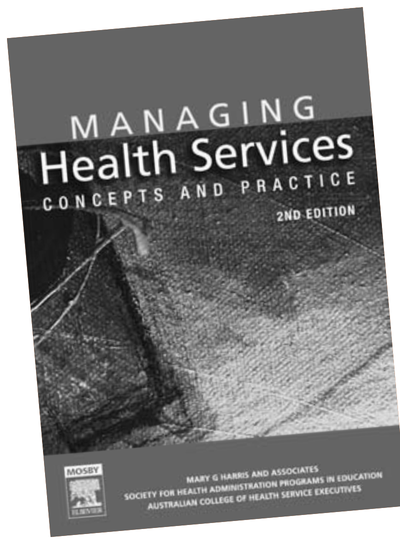
We hope you enjoy this edition of APJHM and look forward to your future contribution to the Journal.

STOP PRESS

Release of Report on the Audit of Health Workforce in Rural and Regional Australia

At the time of publication of this issue of the Journal, the Commonwealth Department of Health and Ageing released 'The Report on the Audit of Health Workforce in Rural and Regional Australia, April 2008'. The full report is available to readers in PDF format from http://www.health.gov.au/internet/main/publishing.nsf/Content/work-res-ruraud

According to the Minister for Health, in the Foreword to the Report, it was commissioned by her at the request of the Prime Minister to identify where workforce shortages exist in rural and regional Australia. The Minister, The Honourable Nicola Roxon MP, confirms the findings that the current supply of health professionals is not sufficient to meet current needs and that the situation will be exacerbated by an ageing workforce. The workforce coverage declines with remoteness and is highly dependant on overseas trained health professionals, particularly doctors. The report identifies the need for better, more reliable data about health professionals to meet the health needs of all Australians. The Report consists of six chapters that conclude with key findings in Chapter 6.



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LETTER TO THE EDITOR

To The Editor,

I would like to invite your readers to become involved in a major initiative to improve services to people living outside the major cities. The delivery of professional services outside of cities is a significant problem for government, business, professional associations and communities. The problem is not restricted to any particular professional group – health, law, finance, education, engineering and agriculture – all report major difficulties with recruitment, retention and service delivery. The demand for service in rural/regional areas is generally greater than supply. The lack of supply is influenced by many factors, including the ageing population, with unprecedented exit levels from many professions compounding the isolation that rural/regional living brings. Add to this the fact that professionals are cosmopolitan and mobile, and it is clear that there are several challenges with respect to the supply of professionals in rural and regional areas, the welfare and development of these professionals, and service delivery when there are insufficient professionals available.

The University of New England (UNE) Faculty of the Professions has initiated a systematic research program across a range of professions, to tackle delivery of professional services to rural areas. The research program will:

1. Aim to fully understand the dimensions of the problem of availability of professional services in rural and regional communities, with a focus on networks of professionals (rather than confining enquiry to any specific group);
2. Develop innovative solutions to the delivery of professional services, either by increasing supply or developing new means to supply services where there are incomplete networks of professionals; and
3. Do so in close collaboration with relevant professions and rural communities.

We will host a Rural Professionals Summit in Bingara New South Wales (NSW) on May 9 2008, in an initial attempt to scope the problem. A small number of delegates from a diverse range of community groups and organisations have been invited, as representatives of the larger population of rural professionals. We intend to explore questions about how rural professional networks operate and what constraints are placed upon them. We want to understand both service delivery and the welfare of rural professionals themselves. We want to explore feasible solutions to assist in ensuring the recruitment and retention of professionals within rural/regional areas. This initial scoping work will generate links with networks of professionals who can guide future research, which is intended to benefit both the professions and the people who depend upon them.

Only a small number of people will attend the Summit, because we want it to be a working group. However we want their thinking to be informed by the larger population of professionals concerned with these issues. To make this possible we have an on-line survey so that as many professionals as possible can let us know what they think and what they would like us to investigate. We would like to invite your readers to let us know what they think by filling out the survey.

The survey is available online at:
http://www.questionpro.com/akira/TakeSurvey?id=935641

We will, of course, be more than happy to let your readers know the results of this work after the Summit.

Professor Paul Martin (paul.martin@une.edu.au)

Dr Amanda Kennedy (amanda.kennedy@une.edu.au)
Faculty of the Professions
University of New England NSW Australia

Dr Sanguan Nittayarumphong FCHSE(Hon)

President Mondon Sanguansermsri, Dr Prawit Taytiwat and Professor Paichit Pawabutr presenting the ACHSE Fellowship gown to Dr Sanguan's wife and children.

It is with regret that we advise the passing of Dr Sanguan, an Honorary Fellow of the College, in Thailand on January 18, 2008. Dr Sanguan's passing after a lengthy struggle with cancer was reported in the *Nation* newspaper on January 19. The paper described him as a 'healthcare pioneer who was regarded as the father of universal healthcare in Thailand'.

Dr Sanguan had commenced a second term as Secretary General of the National Health Security Office in 2007. The National Health Security Office was established in 2002 and both the Office and Dr Sanguan were charged with the responsibility of establishing Thailand's first national health security program. According to the *Nation*, this program 'now serves 49 million Thais who previously had no guaranteed access to health services'.

Dr Sanguan had been awarded an Honorary Fellowship of the College in 2006 because of his contribution to the Thai health system and his commitment to the development of health management as a profession in Thailand. At a ceremony in Bangkok to commemorate Dr Sanguan, the College was represented by President Mondon and Professor Paichit who are Honorary Fellows, along with Dr Prawit Taytiwat, an Associate Fellow of Naresuan University. There were about ten thousand people in attendance at the ceremony, including staff from the Thai Ministry of Public Health, the National Health Security Office and non-government health organisations, as well as family and friends.

Dr Sanguan's membership of the College was recognised during the ceremony and his family was presented with his Fellow's gown. Sympathy from College members was extended to his family and friends.

SPECIAL FEATURE

Management Practice: a commentary

Rural and Remote Health Management: 'The next generation is not going to put up with this . . .'

J Wakerman and C Davey

Abstract

Aim: To identify, describe and comment on critical health service management issues, particularly relating to human resource management, in the rural and remote context of Australia.

Approach: A case study of a Remote Area Nurse manager.

Context: Very remote Australia is characterised by ongoing workforce supply problems, professional, social and geographical isolation of practitioners, relatively scarce health resources, a dispersed and highly mobile population and high morbidity and mortality rates. Many practitioners work in a cross-cultural environment.

Main findings: This case was characterised by generally poor Human Resources (HR) practice. We assert that this resulted from a (1) relatively under-funded environment; (2) resultant poor systems relating to orientation and induction of new staff, communication with remote clinics, quality improvement and pastoral care; (3) a centralised health system structure not well suited to a primary health care approach to a dispersed population; and (4) inadequate preparation of operational managers, associated with inadequate recognition of health services management as a health discipline and related continuing professional development and accreditation requirements.

Conclusion: Given continuing national and international health workforce pressures, the generalisability of these issues needs to be better determined and appropriate policy changes urgently implemented.

Abbreviations: ACHSE – Australian College of Health Service Executives; DON – Director of Nursing; GDP – Gross Domestic Product; HCM – Health Centre Manager; HRM – Human Resources Management; PHC – Primary Health Care; RAN – Remote Area Nurse; SHAPE – Society for Health Administration Programs in Education.

Key words: rural management; remote management; health services administration; health workforce; human resource management.

Professor John Wakerman MBBS MTH FAFPHM FACRRM
Director
Centre for Remote Health
A Joint Centre of Flinders University and Charles Darwin University
Alice Springs, Northern Territory, Australia

Ms Christine Davey RN CM ECN MRHP
Lecturer in Nursing
Charles Darwin University
Alice Springs, Northern Territory, Australia

Correspondence:
john.wakerman@flinders.edu.au

Introduction

This paper is a commentary that utilises an 'instrumental' case study in order to 'provide insight into an issue' [1] of critical importance to effective health service delivery in rural and remote Australia. Case study data were collected through a series of face-to-face interviews and email exchanges with the subject. The paper summarises some of the broader workforce issues in Australia today; the rural and remote context; describes the recent experiences of a remote area nurse; and offers an analysis that focuses on priorities that could improve rural and remote health services management. The generalisability of these issues is an important and unresolved matter.

There are pressures on the healthcare system in Australia today. The ageing population and the epidemic of chronic diseases are, and will continue to have, an effect on the health system. The annual growth rate in health expenditure in the decade to 2003-2004 averaged 4.8%. [2] Population growth over this period was about 1.2%. The proportion of gross domestic product (GDP) spent on health increased from 8.3% to 9.7%. Probably two thirds of this expenditure is on the health workforce.

However, demographic change is affecting both the size of the available workforce, and the nature of the health workforce required. Our national workforce is growing by 170,000 per annum. [3] With ageing and slower population increase, the estimated growth in 2020 will be 12,500 per annum. That is, in the decade 2020 to 2030, the growth of the overall workforce will be less than in one year currently.

Whilst the health workforce has been growing and Australia now has the most health professionals it has ever had, they are ageing, working less hours, increasingly specialised, increasingly 'globalised' and there is a serious geographical workforce maldistribution. [3,4]

One third of Australia's population lives in rural and remote areas. In general, with increasing remoteness, socio-economic wellbeing declines, mortality rates rise and access to health services decreases. [4] The workforce response, however, is inversely related to increasing need. With growth of numbers of doctors in Australia overall, for example, the number of doctors in rural and remote practice is falling. [5,6] There is a growing reliance on overseas trained doctors, who now make up one quarter of the country's health workforce. [3] and over one third of the medical workforce in rural and remote areas. [7]

In this difficult and complex context, what are some of the specific issues for health service managers? The National Health Workforce Strategic Framework states: [8]

> *Leadership, strategic thinking and management ability will be key skills required of all stakeholders. And, for Australia, our geography will continue to provide a special challenge, as will the priority needs of our Aboriginal and Torres Strait Islander population.*

It goes on to comment that:

> *In an era of 'tightening' available workforce healthcare organisations may have to increasingly develop strategies to attract talented practitioners, pay to attract these individuals (or develop other innovative strategies), and search globally for these talents. Policies and programs, which to date have been universal in their design and application may increasingly have to be tailored to the individual, fitting into the stage they are at in their career and with their work-life balance needs.*

So, in a context of decreasing workforce availability, particularly in rural and remote areas, and the need for managers to adopt a more strategic and flexible approach, what are the underlying critical issues, particularly relating to human resource management in the rural and remote context, that the country and institutions such as the Australian College of Health Service Executives (ACHSE) need to address?

'Pat's' story

'Pat' works in remote Australia. It could be anywhere in remote Australia. She had previously worked in a country town of about 17,000 people with a 56 bed hospital. Whilst the issues raised in this narrative may be most starkly evident in isolated communities, the same sort of issues, from her experience, apply to rural areas too.

For the past four years Pat has worked as a Remote Area Nurse (RAN) in two very remote Indigenous communities. She is a recent masters graduate and, according to an academic staff member, one of the best students they had graduated. The combination of her academic achievement and experience as a nurse and a RAN elicited respectful comment from professional peers and academic staff. As a RAN manager, she was responsible for the basic Human Resource Management (HRM) and cost centre management of clinics servicing small, isolated communities ranging in size from 300 to 1000, with staff consisting of resident RANs and Aboriginal health workers, with visiting medical and allied health staff.

She described her remote area experience as:

> *. . . the most challenging and rewarding one of my 27 years of nursing, one never to be forgotten. I remember people warning me about going remote. There were so many warnings of the 'dangers' of working in an Indigenous community, you can't walk around at night, there are no doctors out there to help you, and everyone is drunk. These are just a few comments I remember and mostly from people who had never worked in a remote community.*

The comments to her from people who had worked in remote regions were more positive:

> *'You'll love it' and 'It's the most amazing experience you will have as a nurse'.*

It was a tough environment with serious occupational health and safety issues:

Most of the time I accepted the way things were and working for 16 months without air conditioning in temperatures of 40 plus was just part of the challenge of remote nursing. Having housing where the roof leaked and the ceiling was falling in was also part of the remote life; after all it doesn't rain much in the desert.

However, infrastructure maintenance was a significant problem:

Repair requests became a nightmare, they seemed never ending and never completed and no one seemed to care, as long as there was nurses to open the clinic each day, all was good.

Even more seriously,

'…my daughter and I had a roll over about 350km from the regional centre on my way back from study leave. We rolled the car on a Saturday, thankfully it landed back on its wheels, and we changed a tyre and drove on 400km to the community arriving very late that night.'

Pat also worked in a cross-cultural environment, managed the heath clinic and dealt with a complex clinical array of chronic and infectious disease presentations which challenged her clinical and public health skills and knowledge. In her management role she oriented 14 people over a 12 week period: medical students, postgraduate nurses and RANs who were mostly agency or short–term nurses. This required a huge effort with the persistent tension of competing priorities of clinician and manager. *'Clinical work always comes first and management duties take a back seat.'*

At the same time, there was a high turnover of town-based management staff. This included three managers and two acting managers in charge of remote operations, and three nursing directors and one acting nursing director over the four year period *'… and everyone does something different'.*

Effective communication was problematic:

Looking back now I realise no one ever warned me of the difficulties working in a role where your manager would be hundreds of kilometres away. The never ending long distance paper trail, and of course, it would be lost on a dirt track somewhere because more often than not it would never be received by management.

I never realised how difficult it would be to have a conversation with any member of nursing management. Often I would ring needing advice and there would be no nursing management available to speak with you. I would leave a message and there would be no returned phone call. I discovered over time and with the improvement of information technology (IT) services out bush, it was much easier to contact management via email – at least you would get a reply, even if this was that my email had been forwarded to someone else and I would probably never hear from them. I often wondered if I worked at home would the bosses ever know.

Pat further described her interaction with health service management.

The time I remember personally needing support from management was when [we had the rollover]. On the Sunday, I phoned the after hours manager to report the accident and the reply I received after informing were 'well you must be OK because you are ringing me', and that was the end of any concerns of management. Two days later the nurse I worked with suggested I should have a day off. No one from nursing management ever contacted me or offered help. I think this is when I realised that 'working remote' meant management were remote.

In the three years I worked in the first community, nursing management visited the community once and that was because I was on leave and the new RAN needed some help. There were no audits conducted in the clinic so we could have been doing anything and management would never have known.

At the end of my three years I decided to move to another community closer to [the regional centre] thinking that management would be of more support being closer. The clinic was very dysfunctional with staff that was defiant and didn't follow policies and procedures. There was a staff member who would bypass me and put all her leave forms into management for approval and management would approve them so I never knew when this staff member was on leave.

Professional and social isolation is a critical issue for many remote health workers. Pat had previously attended the RAN meeting in town every six weeks. This was on a Friday and the nurses could then spend the weekend in town to buy groceries, socialise and have some time out. The meeting day was changed to Thursday. They had to go back on the Friday and not spend the weekend in town. Eventually there were so many vacancies that the meetings ceased to happen at all.

When life became very difficult working in this environment I asked the Director of Nursing (DON) to come and visit. In fact four times I asked for nursing management to come and meet with the staff and four times they never came. There was always something more important to be done. It seemed

there was always a crisis bigger then the one I was living everyday but to me being a Health Centre Manager (HCM) was a remote job, not so much physically but mentally. There seemed to be no support from management at any level as I had tried three to four tiers of the management structure, with frustration as the only outcome.

I saw the politicians (like the health minister and the local member) more than I saw management.

Pat finally accepted that she was burnt out and relocated to the regional centre into an alternative position.

I now realise that burnout is not what I did physically working as a RAN, but the mentally draining power poor management has on a RAN.

Discussion

In the context of persistent and worsening workforce problems, this case study has focussed on human resource management issues and describes a number of systemic failures in a remote health service. Whilst clearly there are many competent managers in rural and remote health services, this case is probably not atypical of the situation in many remote areas. [9] Pat's overwhelmingly cynical or negative views are consistent with the symptoms of 'burnout' [10] and do not reflect the 'rewarding' aspects of remote work to which she alludes.

What then are the critical issues that underpin this situation in rural and remote Australia? We propose that the drivers include an overall lack of adequate resources for these services resulting inter alia in increased workload for existing staff; lack of a systems approach; inappropriate service structures; and poor recognition and preparation of managers.

Firstly, it is important to understand rural and remote contexts because (i) HRM issues such as those highlighted here are often magnified through the isolation of many rural and particularly remote health professionals; and (ii) models of service delivery based on population needs will be different to the metropolitan context. [11] The economic, sociological, cultural and demographic nature of rural and remote communities; [12,13] higher morbidity and mortality rates; [4] fewer services; [5,6] dispersed populations and higher cost of living, result in a relatively high level of patient need and poorer access to services. [4,5,6]

Poorer access to services contributes to worsening health outcomes with increasing geographical remoteness. [4] Under-resourcing of rural and particularly remote services relative to need is well-documented. [4,14]

Linked to inadequate funding is the issue of inadequate organisational systems. The systems in place in this health service were not sufficiently robust to tolerate the high turnover of staff at both frontline and regional management levels. There appeared to be a failure of any sort of systematic, regular or urgent means of communication. As a result, managers seemed out of touch with staff needs. There were systems failures, or possibly no systems at all, related to quality improvement or monitoring of clinic activity. As a result, no process, output or outcome measures that could guide development of the service were known to clinic staff or their managers. The orientation system was dysfunctional and this responsibility fell to the local health centre manager. Finally, basic management principles involving lines of reporting were not apparent.

The health service in this case had been subject to periodic major restructuring. Frequent changing of organisational structures is costly, leads to increased stress on staff and managers, loss of morale and commitment to the organisation and often confusion amongst managers, staff and consumers. [15] The last reorganisation had resulted in a more centralised service. Dwyer reviewed the recent reviews of health systems across Australian jurisdictions. [16] There was a common trend to centralisation as well as a common theme that Primary Health Care (PHC) services need to be strengthened. These seem to us to be antithetical, as a PHC approach devolves authority so that local problems can be solved locally. [17] In this case, with centralisation of authority, there was a resultant strong culture of managing 'upwards', without sufficient managing 'downwards'. There weren't many visits from senior managers to remote areas and these visits did not seem to be valued by the organisation.

Operational managers at a regional level were, in the main, clinicians with inadequate preparation for management roles. Managing staff at a distance is also difficult and different. There is a growing literature pertaining to distance management, and management of virtual and dispersed teams. The literature identifies a number of common issues: appropriate staff recruitment and orientation; an appropriate management style; effective communication; shared purpose and clearly defined roles; clear decision-making processes; and adequate infrastructure. [18-22]

Critically in this case, these were management issues that were poorly addressed. The inadequate preparation of these managers reflects the poor recognition of health service management as a legitimate health professional discipline. The major recent national health workforce report does not mention managers as a professional group at all. [3]

It recommends national restructuring of accreditation of education and training courses, but no management training is included. This is despite the fact that the Society for Health Administration Programs in Education (SHAPE) lists 17 accredited management education and training institutions or courses in Australia and New Zealand.

Generalisability of these specific issues is an unresolved matter. Whilst there is evidence that links poor supervision and high workload to stress and burnout in both hospital [23] and community settings, [24] and there is some evidence that these are systemic issues in rural and remote areas, [9,11,25] there is a dearth of published empirical evidence pertaining to the specific nature of rural and remote management problems and what to do about them.

Given this situation, are there policy implications which should be addressed? Firstly, there is little contention over the need for adequate funding to rural and remote health services. Ideally, this would eventuate within the context of a national rural health policy and plan that would co-ordinate federal and state/territory resources. However, adequate funding is not enough. Health systems and service models need to be to designed to meet population health needs and the specific context. Some effective rural and remote PHC models do exist and are amenable to generalisation. [11]

It also safe to suggest that health service managers should have accreditation and employment requirements consistent with those of other health disciplines. Formal registration or formal qualifications should be required. Support for appropriate education and ongoing professional development should apply to managers as it does to other health professions. Within rural and remote services, where distance management is important, training should specifically ensure managers who are competent in implementing:

- Careful recruitment in order to select competent, autonomous staff who have devolved authority.
- Monitoring systems and effective feedback.
- Regular lines of communication.
- Scheduled management visits.
- Periodic 'times out' at head office for staff to ensure consistency and provide pastoral care as needed.
- Prompt management response as problems arise.

And, like other health professional groups, health service managers should be formally linked to award conditions and remuneration. These measures would go a long way in addressing the problems described above.

The concluding words are from 'Pat' and relate to the changing workforce, and implications for rural and remote health services if management practices such as those described in this case don't improve:

> *There is a new era of nurses coming…they are not the passionate nurses we were…they question everything…it's a good thing but managers need to appreciate a new, better educated group…they can be selective. The next generation is not going to put up with this…*

Competing interests

The authors declare that they have no competing interests.

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RESEARCH ARTICLE

Organisational Framing Within the Health Context: a tool kit for adoption – Part 1

D Blackman and J A Fitzgerald

Abstract

Purpose

Health service organisations are extremely complex and undergo almost continual change. However, many managers are restricted in their ability to undertake effective change by the mental models they currently hold. This paper considers whether using framing analysis and reframing techniques enables health managers to see organisations and problems in more complex and alternative ways, leading to better problem solving and decision-making.

Methodology/Approach

This paper is based upon participant observations undertaken during a study into the development of professional identities in doctors and nurses. The data led to the development of substantive level theory and recommendations for practice based upon the work of Bolman and Deal. [1] The context is within one state jurisdiction of the Australian health system.

Findings

The majority of respondents naturally used the structural frame for their analysis which limited the possibility of creativity and innovation within the decision-making process.

Originality/Value

The application of reframing is posited as a way to improve decision-making and problem-solving.

Key words: **healthcare; health systems; mental models; reframing; change; problem-solving.**

Deborah Blackman
School of Business and Governance
University of Canberra, Australia

Janna Anneke Fitzgerald
Centre for Industry and Innovation Studies (CInIS)
University of Western Sydney, Australia

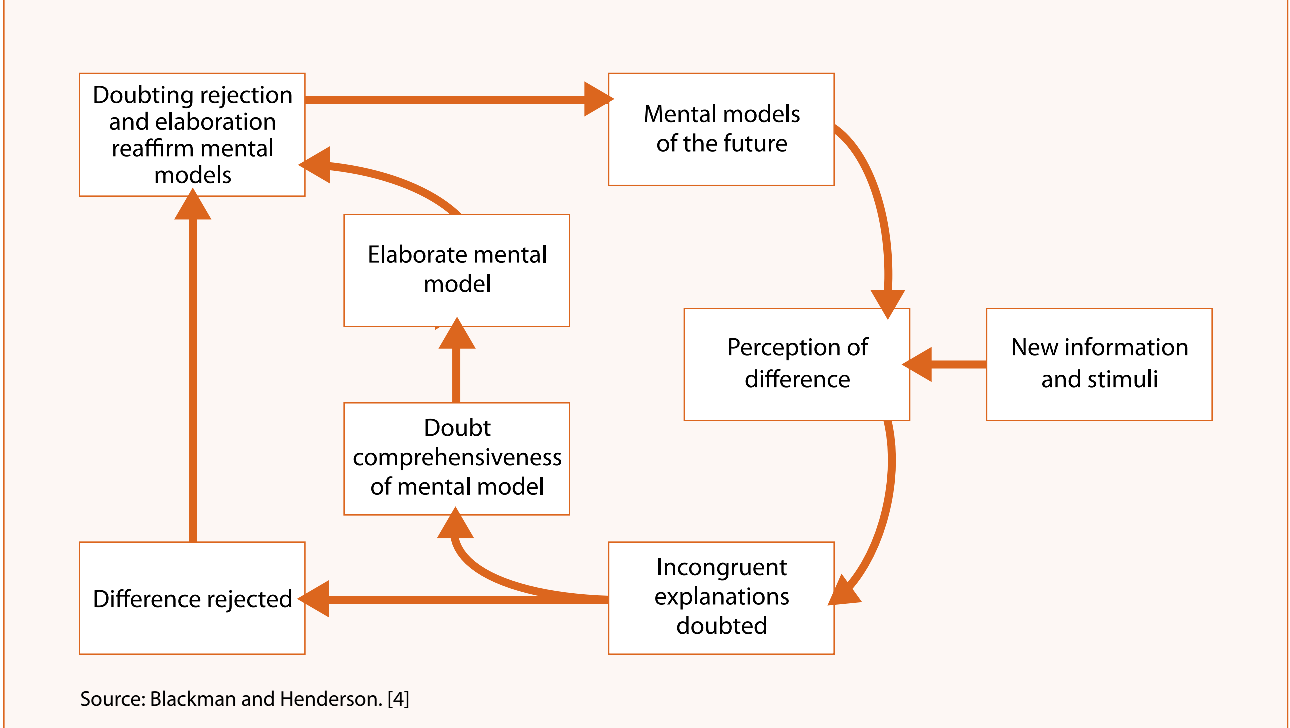
Correspondence:
Email: deborah.blackman@canberra.edu.au

Introduction

Complexity, surprise and ambiguity make organisations hard to understand and manage. [2] This is amplified because most people see the world relatively narrowly – relying on old habits and established ways of thinking framed by their current mental models of the world. [3, 4] Such mental models lead to a reliance on one perspective of the world and repeatedly using one or two solutions to problems. [5, 6] This blocks learning and creativity and limits the real potential for change (see Figure 1). In Figure 1 it can be seen that new ideas may be prevented from entering organisations owing to doubting, which occurs because of uncertainty regarding the source, the veracity or the cohesion of the new ideas.

Consequently, such doubting can lead to a potential closure of the organisation or individuals to new ideas. The problem is how to maintain greater openness or even to develop openness once partial closure has occurred. Framing is posited by some as a way of enabling such openness because it will force an investigation of options and new ideas, even where habits have developed of looking at the world in one specific way, and have led to a prevention of alternates being considered. The argument is that, traditionally, managers look at the world in only one way or through one 'frame', where they try to solve all problems with logic, control and structure and seek to avoid complexity:

Figure 1: A figure of single loop doubting



Source: Blackman and Henderson. [4]

> *One of the most basic problems of modern management is that the mechanical way of thinking is so ingrained in our everyday conception of organisations that it is often difficult to organise in any other way.* [7, p.6]

By adopting one frame, managers are effectively limiting their ability to diagnose the causes of problems and failing to consider alternate possibilities or solutions. It can be posited that if managers undertook the 'reframing' of a problem by using other 'frames' to view the situation, they would recognise that there is no 'one best way' for any problem. [1, 7, 8, 9] This change of perspective should facilitate the use of a contingency approach giving more possible solutions and enabling greater creativity. Increased innovation and creativity are recognised as being vital to organisations as they will enable a greater range of knowledge to be developed and implemented, [10, 11] which is widely accepted as being a major source of both competitive advantage [12, 13] and innovative problem-solving. [14, 15]

There is a similarity in this with the use of metaphorical analysis. Metaphor is defined as the substitution of one idea or object by another, in order to assist expression or understanding. [16] Parallels are drawn between concepts in order to explain and clarify ideas. Consequently, metaphors are considered to be a cognitive lens (and, therefore, similar to a frame) which enables an individual to make sense of the situations being studied:

> *Within an organisation, metaphors can provide a crucial, dynamic contribution as a creative iterative tool that facilitates understanding … Metaphors build off existing knowledge by connecting images, and then relating these images to both social and organisational events and realities.* [17, p.26]

The use of a metaphor provides a conceptual framework which aids the revelation of significant events or aspects of organisational study and permits the creation of new creative possibilities, because abstract subject matter can be seen in a more concrete, familiar way. [18, 19, 20, 21]

Over time many metaphors have been suggested and used to clarify thinking about organisations: garbage cans, [22] jazz bands, [23, 24] soap bubbles, [25] families [26] and human entities, [27] not to mention those suggested by Morgan, [7] which include psychic prisons, machines and brains. In all cases, the idea is that the metaphoric thinking leads to new understandings which, in turn, lead to creative action. [20] The analysis is driven, for the most part, by an examination of data gathered within the organisation. [28]

Reading Morgan [7] provides indications that it would be useful to consider the same organisation from several different metaphors in order to gain multiple understandings. This leads us to the notion of managed re-framing, which takes different metaphorical lenses and asks

managers to consciously consider the same phenomena from multiple perspectives. In this process managers address reasons why they prefer some ideas over others and, in some cases, instinctively reject some notions before they have actually been explored. The more complex the ideas involved, the more likely it is that managers will seek to clarify and simplify them in ways that will make them more manageable. [4] This makes it likely that, the more complex the situation, the greater the possibility of self-reflexivity developing, which will in turn reduce the potential strategies being considered and implemented.

In this paper we will, firstly, outline the nature of current health service organisations as complex environments. This analysis will then be used as the basis for an application of the Bolman and Deal frames. [1] Each frame can be seen to reflect certain metaphors: the symbolic frame is an application of metaphors such as the stage, drama and tribes; the structural frame looks at the organisation in terms of being a machine, a brain or system; the psychosocial frame looks at the world in terms of a collective, a community or a cohesive team; and the political frame uses metaphors such as a chess game, a battle field or survival. The differences which emerge from such analysis are used as evidence that the use of reframing can enhance the decision-making and problem-solving capacities of an organisation.

Health service organisations as complex environments

Modern health service organisations are extremely complex and undergo almost continual change. [29, 30, 31, 32] However, it is recognised that many change initiatives produce little effect [33, 34, 35] and often the change program can make things worse by placing increasing pressure upon managers and employees alike. This, in turn leads to more changes being implemented. [34, 36, 37] However, the complexity of modern health organisations means that events are increasingly hard to predict; the unexpected is to be expected and often there is considerable ambiguity to be found within any given situation. [2]

At the macro level, several forces behind the New South Wales (NSW) Health reform can be identified: these include the changing patterns of population redistribution, inefficiency of a regionalised structure and public sector reforms. [38] There are also significant differences in the complexity and level of healthcare between metropolitan and rural areas. Historically, these imbalances forced changes to the regionalisation structure in 1977, with the addition of another tier of 'areas' for administration and planning purposes. [39] At this time, specific health management problems, such as the unsatisfactory health status of the Australian community, the fragmentation of services and the need for efficient utilisation of resources, were acknowledged. Further, Mackay [38] described the lack of hospital board control over an efficient use of hospital resources and doctor control over hospital expenditure as impediments to cost control. This launched the establishment of area boards and the development of an area health management model to ensure community participation in the management of resources, [38] changing the climate of the complex environment dramatically. This is still in operation today, albeit after several restructures. In addition, external environmental pressures on hospital managers include the constant demands for performance improvement, greater transparency and accountability. [40] Finally, as a result of public sector reforms in NSW in 1990, senior health executives are under public scrutiny via performance agreements, according to strict criteria. [38]

Under these conditions the application of a structural frame provides a quick and logical decision-making guide. However, viewing macro organisational change via the alternate symbolic frame and, for example, understanding the effects of change decisions on organisational tribes, decisions may then take different forms. Seeing that diverse organisational cultural groups (ie professional tribes) have developed differently, different tribes do not adjust or react to change in the same way. According to the symbolic frame, problems cannot be solved until contextual culture is fully understood. This means that a different approach may be required for each tribe. Whilst taking longer, the effect and outcome may be more successful, with less obstacles for implementation.

At the micro level, in addition to the constant restructuring of Area Health Services, healthcare managers have to deal with decision-making in a highly changeable environment. For example, patient conditions are continuously changing and new technology and innovation is being introduced seemingly ad infinitum. [41] This requires health managers to be highly adaptable in an unpredictable and ambiguous climate, characterised by a strongly defined hierarchical division of labour, with strong power tensions between professions (such as between doctors and nurses) and occupations (between managers and clinicians). [42] To make sense of this situation, it is no surprise that managers have resorted to a mindset that is conditioned to utilise routine and structured decision-making, contingency planning, and the creation of policies and procedures.

However, applying the alternate psychosocial frame will allow the consideration of flow on effects on individuals' and groups' (working) relationships and motivations to aid organisational progress. The psychosocial frame allows problems to be solved in ways that will develop the long-term commitment of all parties. Hence, fully understanding the personal sacrifices workers make to enable organisational change is important. Applying multi-framing may be more time consuming and complicated, but the investment of time is rewarding; for example, the retention of experienced staff and their organisational knowledge through an application of the psychosocial frame.

Rules, roles, goals, policies, the use of technology for control and dissemination of information as well as the utilisation of organisational structure to solve organisational problems, are fundamental aspects of the structural frame. [1] We posit that many public health managers have framed their decisions around such a structural lens, ignoring other frames that may be helpful to cope with the complexity faced on a daily basis. This is partly because of historical patterns of behaviour that are taught as a part of skills training; a reduction of ambiguity that is a core element of medicine and gets passed on to the way that decisions on other topics are made. Consequently, this paper considers whether using a framing analysis and reframing techniques will enable health managers to see their organisations and their problems in more complex and alternative ways, leading to better problem solving and decision-making outcomes.

Methodology

This paper is based on participant observations undertaken during a larger study into the development of professional identities in doctors and nurses. Ethical approval was granted by the Area Health Service as well as the university. Observations were conducted in an open environment, unconcealed and discussed with interviewees, who had volunteered and consented to be involved via purposive sampling and snow ball sampling. The sample involved 38 participants who were healthcare professionals and managers, with varying levels of responsibility but with resource allocation and strategic roles.

The researcher was also a manager in the organisation under study and researcher bias was therefore an issue. However, the researcher herself was interviewed by a fellow researcher to fully identify and reflect on the research frames in which she conducted her research. In addition, bias was minimised by supervision from university members who had no experience in a hospital setting, nor any involvement with the organisation. Further, the research was presented at several academic fora, to seek ideas and advice that would assist with broadening the mindset under which the research was conducted. Moreover, bias was limited through a collaborative approach to analysis of observational data with the co-author of this paper.

The data led to the development of substantive level theory which sought to explain certain phenomena at a basic level which could then be tested and developed. [44] Observations took place within a healthcare environment during a 12 month period as a participant observer in a large metropolitan hospital in New South Wales, Australia. The objective of the study was to detail and understand the emergence of an additional professional identity for doctors, nurses and other healthcare workers; namely that of 'manager'. It was considered to be important for the effective research to track management behaviours and to analyse them in terms of their potential effectiveness. The researcher carefully noted copious observations of managerial decision-making in notebooks and transcribed these into memos. The episodes included decision-making practices around the use of resources, including human resources (eg allowing an additional team to do overtime), as well as decision-making around the use of capacity (eg scheduling cases in operating theatres and assisting the flow of patients from the recovery room to the Intensive Care Unit). Researcher observations included notes about using organisational rules and heuristics (references to rules of thumb) as well as the process of saliency of different stakeholders when making decisions.

As a part of this study, the instinctive first reaction that the participants took towards problem-solving and making decisions was also recorded. All interview data and observational notes were entered into a qualitative analysis software application (QSR NUDIST®) for coding and cross-coding. The findings were then analysed against the theoretical framework of Bolman and Deal (see Table 1). The Bolman and Deal framework was chosen for three reasons:

- it is widely used as a management text and could be clearly explained (see below);
- the range of frames enables clear comparisons and differences to be identified; and
- it is possible to identify specific behaviours and patterns which indicate the use of one or more frames.

Table 1: Description of Bolman and Deal's frames

FRAME	DESCRIPTION
Symbolic	Focuses on values, attitudes and beliefs; it recognises the influence of national/social as well as corporate culture and sub-cultures on our thinking. According to the symbolic frame, problems cannot be solved until their cultural context is understood, as otherwise a proposed solution may merely be a surface solution or could even aggravate the situation.
Structural	Emphasises rationality and advocates designing an organisation to fit with its environment, technology and strategy. Every organisation has a structure with its own organisational goals, divisions of work and coordination mechanisms which will influence leadership styles, communication and employee behaviour. The argument is that every problem can be solved by better processes, rules, systems and procedures.
Psychosocial	The focus is on the different needs that people bring to their workplace; it looks at ways to obtain the best 'fit' between the needs of employees and the requirements of management and considers issues like job satisfaction, motivation and group dynamics. An assumption is made that if there is a mutuality of goals supporting the needs of all parties there will be greater motivation and, therefore, greater organisational productivity and success. Consequently, by understanding everyone's perspectives, problems can be solved in ways that will develop the long-term commitment of all parties.
Political	Focuses upon the different interest groups that form within organisations and considers the different sources and uses of power. Political behaviour is considered to be the norm in organisations. It is recognised that conflict is a normal part of life in organisations, so that those using the frame must consider the implications this will have upon the reasons for problems and the potential solutions being proposed. Moreover, the notion that conflict is beneficial for developing creativity and that power is not always negative are a part of the political analysis.

Source: Bolman L, Deal T. Reframing organizations. 3rd ed. San Francisco: Josey-Bass; 2003.

It was assumed as a part of the research that the most likely frame used by managers would be the structural frame which might potentially limit their ability to consider new and creative ideas. Decision-making or problem-solving incidents observed were analysed against the framework looking for evidence of the frames, using indicators described in Table 2 to identify the preferred frames of the healthcare managers.

Table 2: How to identify preferred frames

FRAME	CENTRAL CONCEPTS DISCUSSED	TYPES OF SOLUTION PREFERRED	FORM OF CONVERSATION
Symbolic	Culture, meaning, metaphor, ritual, ceremony, stories, heroes	Looks for the long-term ideas of how to change values and/or stories; looks to change individual behaviors through values and ideas	Why have people done this? What is the meaning of this? How is the history relevant? What do people value or believe?
Structural	Rules, roles, goals, policies, technology, environment	Process change, restructure, review rules, new rules and /or procedures	Around processes, looks for the root of the problem, ascribes faults
Psychosocial	Employee reactions, how to motivate, what will people like	Motivation for staff-development, rewards focused, outcomes oriented	How do people feel? What are the behaviours required or being rewarded?
Political	Power, conflict, competition, organisational politics	Changing balance of power, managing conflict, altering the status quo	If somebody wins, who is losing? What are the battle tactics?

Adapted from: Bolman L, Deal T. Reframing organizations. 3rd ed. San Francisco: Josey-Bass; 2003.

Findings

The primary finding was that healthcare managers, regardless of their background, be it nursing, medical or other, displayed a distinct way in which they analysed situations and made decisions. In most cases their analysis was predominantly from a structural frame, although other frames were used when the structural frame was challenged. For example, although policies and procedures were firmly in place, displayed and adhered to in this particular case study, in practice, clinical treatment is provided at the authority and sovereignty of individual medical clinicians.

Standardisation of practice may be a desired managerial goal (to allow for clarity, prediction of costs and safety), but the strongly anchored, bound and politically, largely unchallenged, medical professional identity prevents managers, including medical managers, prescribing how to undertake, and review, medical treatment and outcomes. However, whilst (medical) clinical matters appear to be out of reach of hospital managers, control over organisational decision-making is strongly reinforced by a structural frame. Nevertheless, it was also evident that aspects of all four frames could be found to matter for different decisions, although often they only emerged if the first solution was not accepted.

Structural frame

In the researched organisation, the research participants commonly used a structural frame to seek solutions to problems. When the system failed to deliver the expected goals (patient treatment figures for example), or where there were problems and uncertainty, the solution included a restructuring of the nature of the organisation and the jobs within it, as well as reforms in policy and procedures. When the system apparently fails, participants indicated that solutions are sought in areas of clinical governance, quality management and business process engineering.

Symbolic frame

When a symbolic frame was used, there was considerable focus upon the historical perspective and the way that things used to be done. In any discussion on how things are done now, there was also discussion about the past. Thus, the culture is bound by the history of the hospital, the way the doctors and nurses are trained, as well as the way that healthcare professionals are perceived by those using the service. Listening to comments and responses from doctors, it was clear that they liked to hang on to an apparently ideal world, which belonged to yesterday. There was often talk about a long affiliation with the hospital and the changes that they had seen, which were couched in negative terms. Any decision to be made triggered a history of why this needed to occur and why either it would not have been done in the past, or it would have been better in the past in some way. This is one example of the impact of history. Other professional groups responded in different ways. Such responses may result in barriers to progress and lead to the formulation of rules which are likely to be trying to re-instate a previously sought after organisational state.

Further, observations indicated a wide range of symbols that can be seen within hospitals: corporate uniforms to clarify who does what; the status symbol of the stethoscope (historically only doctors carried them, now many other health professionals do), which may be seen as a symbol of expertise; the white coat of doctors to ensure everyone knows who they are and respects them accordingly. What also became apparent was that the different groups within the hospitals have different symbols and beliefs and, unless these were recognised, managing each group would be problematic. An earlier study into the construction of professional cultures of managers and clinicians in this same hospital revealed many differences between them. [43] These are summarised in Table 3 and suggest a changed approach is needed for the different professional identities.

Table 3: Difference between managers and clinicians

MANAGERS (MEDICAL MANAGERS, NURSE MANAGERS AND OTHER MANAGERS)	CLINICIANS (DOCTORS, NURSES AND OTHERS WHO ARE NOT MANAGERS)
• Low sense of choice and high sense of necessity, working at the hospital	• High sense of choice and low sense of necessity, working at the hospital
• Believe resource allocation should *not* be based on individual as determined by clinicians	• Believe resource allocation should be based on individual as determined by clinicians
• Believe resource allocation issues have a place in clinical decision-making	• Believe resource allocation issues have no place in clinical decision-making
• Attach little value to their job security	• Attach much value to their job security
• Attach little value to working with friendly co-workers	• Attach much value to working with friendly co-workers

Source: Fitzgerald JA. [43]

Generally, it is assumed that there is an overarching value which is that both managers and clinicians care for the patient. This may well be so, but what is seen as a benefit may vary widely depending upon the cultural perspective being taken by those analysing the case. Those who consider this frame will be more realistic about how the culture will support or prevent the implementation of new ideas within the health service.

Psychosocial frame

There are many elements of the decision-making process that reflect the psychosocial frame, such as pay awards, personnel rights, worker compensation issues and unionisation. However, analysis of the frame might show the reason why the psychosocial elements have developed the way they have. For example, the high emphasis upon structured unionisation is because the healthcare sector is trying to find motivational tools which can be applied as a set of rules for everybody. It is our proposal that an analysis within a psychosocial framework would show that, to be successful, a more chaotic and less prescriptive set of motivation and development tools would need to be adopted.

Political frame

There has been a history of strongly defined professional boundaries, which have led to political tension between doctors and nurses as well as those groups defined as clinicians and managers. Conflict is viewed as inevitable within the political frame. Interestingly, in recent years there have been changes in professional identity which are affecting the occupational boundaries and the division of labour. Examples of these are nurse triage systems and the introduction of hybrid managers, who have a dual role as both a manager and a clinician. In these cases, the decisions are made by doctors and nurses in very different roles with alternate goals, power bases and resources from those they previously experienced. These changes are leading to different forms of conflict, not necessarily less and, consequently, doctor and nurse managers need to be able to negotiate different solutions. Although on the surface the structural focus on rules provides some safety for professionals in new and alternate roles, changes in professional identity may enhance political role conflict, not reduce it. Managerial decision-making and clinical decision-making are two very different roles. Where nurses were historically subordinate to medical staff, managerially they are better educated and, supposedly, better equipped to make decisions. [41] Doctors are not necessarily seen as 'most knowledgeable' on managerial matters. Further, medical clinicians, who are also appointed to an organisational managerial role, are influencing the dynamics of the managerial decision.

What can be seen here is that important elements of all four frames are present in any decision to be taken within a healthcare context. By trying to solve all problems within a structural frame, it is likely that the actual complexity of the situation will not be recognised and the solution is unlikely to address the real problems present at the time. In order to increase the effectiveness of the long-term decision-making, all four frames may need to be considered in terms of both the problems being identified and the solutions being proffered. The next stage for the research will be to formulate a management development technique to support reframing.

Conclusion

We have demonstrated that it is possible for managers to become too set in their worldview and therefore unable to develop a creative and innovative range of solutions to organisational problems. We have established that there is a theoretical argument that the use of different frames, when undertaking decision-making and problem-solving, can initiate discussion about different and additional solutions than originally thought of.

We have used Bolman and Deal's framework [1] and established that the majority of healthcare managers instinctively use the structural frame when making decisions and developing strategies within a healthcare context. Other or additional frames are only discussed if there is some form of challenge to the original decision. We propose that it would be beneficial for healthcare professionals to adopt the use of alternate frames as a way of developing a managed discussion of their problems and challenges, in order to develop a greater understanding of increasingly chaotic and ambiguous situations. We conclude by arguing that it will be advantageous to offer a set of decision-making tools, in the form of a toolkit, that enables healthcare managers to consider how they approach problem-solving and, potentially, expand the possible ideas considered. This toolkit is the focus of a subsequent paper.

Competing interests

The authors declare that they have no competing interests.

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RESEARCH ARTICLE

Organisational Framing within the Health Context: a tool kit for adoption – Part 2

D Blackman and J A Fitzgerald

Abstract

Purpose

The first part of this article identified a limitation in the range of options being considered by healthcare professionals when problem-solving or making decisions. Part two of the article builds upon this idea and describes a process where these limitations can be overcome through the use of multiple framing.

Methodology/Approach

Masters students, who are also healthcare managers, were asked to undertake multi-framed analyses of different decision-making scenarios.

Practical Implications

The exercise enabled the healthcare managers to recognise weaknesses of seeking solutions within a predominantly structural frame, to challenge this narrow application and to explore the benefits and utility of multiple framing.

Originality/Value

The development of a technique used to enable 'reframing' of problems, contexts and potential solutions is outlined. A strategy is proposed which firstly, enables the current management frames to be identified and secondly, adopts a multi-framing approach to problem-solving.

Key words: healthcare; mental models; reframing; change; problem-solving.

Deborah Blackman
School of Business and Governance
University of Canberra, Australia

Janna Anneke Fitzgerald
Centre for Industry and Innovation Studies
University of Western Sydney, Australia

Correspondence:
Email: deborah.blackman@canberra.edu.au

Introduction

In part one [1] we argued that, traditionally, managers look at the world in one way or 'frame'. They try to solve most problems with logic, control and structure, seeking to avoid complexity: 'one of the most basic problems of modern management is that the mechanical way of thinking is so ingrained in our everyday conception of organisations that it is often difficult to organise in any other way'. [2, p.6] By doing this, managers are limiting their ability to diagnose the causes of problems and fail to consider alternate possibilities for solutions. Hence, we are proposing a 'tool kit' to reframe, understand and solve organisational problems.

We propose that if managers undertook the 'reframing' of a problem by using other 'frames' to view the situation, they would recognise that there is no 'one best way' for solving any problem. [2, 3, 4, 5] This change of perspective should facilitate the use of a contingency approach giving more possible solutions and enabling greater creativity. Increased innovation and creativity are recognised as being vital to organisations as they will enable a greater range of knowledge to be developed and implemented, [6, 7] which is widely accepted as being a major source of both competitive advantage [8, 9] and innovative problem-solving. [7, 10, 11] In this paper we outline one method to enable such reframing and argue that it has the potential to increase innovation and creativity within a health service organisation.

Methodology

This paper is based upon management development exercises undertaken with 17 Masters students in three different groups over a period of 18 months. All the students were healthcare professionals and undertaking the Masters course within a healthcare environment. They ranged from junior to senior managers, all having some form of both resource allocation and strategic responsibility. Each group undertook similar cases and scenarios in the same format and order, to ensure that the results were comparable across the three samples.

The research design chosen was an experimental one [12, 13] in that we were undertaking the research during a management development course. In this way it can be classified as action research, where the aim is to initiate change by enhancing critical self-reflection through an examination of one's assumptions, practices and political context. [14, 15] We were working within the critical paradigm where knowledge:

- is not discovered or grasped, but rather acquired through critical debate;
- requires reflection on how our thinking is socially and historically constructed, and how this limits our actions;
- enables people to challenge learned restrictions, compulsions, or dictates of habit; and
- promotes understanding about how to transform current structures, relationships, and conditions, which constrain development and reform; and therefore is emancipating and personally developmental. [16, p.49]

A design was needed that would enable the participants both to create their own understandings of the scenarios and to reflect upon those understandings, to be able to create new knowledge that would enable change. As indicated in part one of this article, [1] for there to be creative ideas there needs to be new knowledge. This is crucial as, without new knowledge, there cannot be changes in the world views of individuals or their behaviour, or innovation. [17] Therefore, we undertook workshops with the participants in which they learned about the different frames and discovered how they could utilise new understandings in their managerial practice.

It was decided to develop a process that would enable the management students to (a) identify their predominant frame or frames and (b) undertake the managed reframing of certain problem-solving situations for the purpose of letting them see the potential of the alternate approach.

Bolman and Deal's framework [3] was used to teach these students and it was the impact of framing over time that was noted for the development of this exercise. After an analysis of the decision-making data from the Masters students, it became clear that a structural frame was predominant. [1] Through self assessment, 13 of the 17 students indicated they instinctively used the structural frame. Four students identified the psychosocial frame as governing their problem-solving, citing the motivation of their staff to be a dominant factor in their decision-making. This was in keeping with previous findings from a large healthcare professional study discussed in part one. [1] Hence, the techniques used with the Masters students were considered to be applicable (after some adaptation) with other healthcare professionals. Over time the Masters students learnt to use the other frames and agreed that, without the teaching of the frames in a managed way, their frame of analysis would not have changed. Students commented about how they initially clearly favoured one frame and learnt to work with other frames over time. Some students commented that changing their frame over time was one of the most important things they had learnt during their studies. The students felt that they were benefiting from the use of alternative frames, as they explained why their choice of strategy was not always working (especially the political frame).

The need to analyse the same cases from multiple frames became clear during our observations. However, experience taught us that this analysis needed to be separated out during the process looking at the case through one frame at a time. This was necessary since otherwise the impact of the differences was not apparent. From these observations a protocol was developed for the management development exercise.

It was important that cases were relevant to the daily work of the students in healthcare settings. Only realistic scenarios could lead to identifying real differences observed by both the educators and the participants themselves. Consequently, scenarios were developed from the data collected when undertaking a study of healthcare managers and how they made decisions. [1] For each scenario a specific decision point in the data was established and then the context developed around it. In some cases those managers involved in the decision-making or problem-solving were re-interviewed to clarify the details of the context. Where possible (and as there was 18 months worth of data this was possible in several scenarios) outcomes were written up so that not only the original decision-making could be analysed but also the possibilities that might have emerged if multiple frames had been utilised. That way, weaknesses that emerged subsequent to the decision taken could also be analysed and discussed to see if the weaknesses would have been avoidable if a broader analysis had been undertaken. We used the scenarios as well as other management and healthcare cases as the source of materials to be analysed.

The data came from two sources: field notes and post management development feedback. During the sessions, observational notes were taken by the facilitators about how the cases were used, how the analysis emerged, what phrases were used by the respondents and whether changes or new

knowledge creation occurred. These notes were analysed to establish whether the management development protocol was achieving the stated goal of enabling reframing to be used effectively. Students were asked to reflect at several stages in the process: during the development itself (see below), in formal feedback processes at the end of the program, and two to three months later. These reflections were analysed for the purpose of identifying if sustained behaviour change occurred.

Management development protocol

The way that students analysed cases was observed, particularly how they initially worked on case exercises, as it was this instinctive reaction that was important to the study. The attribution of the frame was made by noting what topics the students discussed, what was not discussed and the nature of the solutions that they gave. As indicated earlier, managers tended to show a preference for one, sometimes two frames when they analysed a situation. Hence, the first stage in using this approach is to determine which of the frames managers are favouring.

For example, a specific case about the use of quality data can be examined in its contribution to morbidity and mortality reviews. Initially, in the predominant structural frame, we would expect analysis of such quality data to lead to a focus on examining guidelines and protocols. However, when applying a symbolic frame, the history, behavioural patterns and entrenched practices can also be questioned, more deeply examining the quality and safety culture of the hospital. Further, the use of a psychosocial frame may lead to better motivating a clinical team's performance in delivering quality of care. In the same way, analysis of data through a political frame may assist the Head of Surgery or Medicine in negotiating on behalf of management with consultants regarding their clinical practice.

We refined the order of the exercises and their content slightly over the three groups and the process outlined below is what we determined to be the most successful.

There are five phases to the protocol:

- Establishing the original frames;
- Teaching each frame in turn;
- Comparing the frames during an analysis;
- Applying the frames technique to problems; and
- Re-establishing frame usage after a period of time.

Each of these will now be discussed and analysed using the experiences of the Masters students to clarify the steps and learning points we established during this process.

Establishing the original frames

When teaching the multi-framed approach, a case should be given to all the participants in a decision-making team and they should be asked to undertake an analysis of it. Observation of the discussions that take place and consideration of the language used and the solutions chosen should enable the facilitator/team leader to determine which frames predominate (see Table 1).

Table 1: How to identify preferred frames

FRAME	CENTRAL CONCEPTS DISCUSSED	TYPES OF SOLUTION PREFERRED	FORM OF CONVERSATION
Symbolic	Culture, meaning, metaphor, ritual, ceremony, stories, heroes	Looks for the long-term ideas of how to change values and/or stories; looks to change individual behaviours through values and ideas	Why have people done this? What is the meaning of this? How is the history relevant? What do people value or believe?
Structural	Rules, roles, goals, policies, technology, environment	Process change, restructure, review rules, new rules and /or procedures	Around processes, looks for the root of the problem, ascribes faults
Psychosocial	Employee reactions, how to motivate, what will people like	Motivation for staff, development, rewards-focused, outcomes-oriented	How do people feel? What are the behaviours required or being rewarded?
Political	Power, conflict, competition, organisational politics	Changing balance of power, managing conflict, altering the status quo	If somebody wins, who is losing? What are the battle tactics?

Source: Adapted from Fitzgerald A, Blackman DA. Organisational framing within the health context: an argument for its use. Asia Pacific Journal of Health Management. 2008; 3(1): p.19-26.

Teaching each frame in turn

Once the preferred frame(s) are identified, the facilitators and team leaders should disclose to the participants what frame they are using, explain framing and re-framing and outline why it might enable more effective decision-making. This technique will only work if those involved come to it willingly and so the positive aspects of such ideas will need to be explained carefully. [3] Often the undertaking of the next stage helps to gain support for the idea over time.

A case analysis should be undertaken that specifically applies one frame and explores the issues and solutions within that frame. Once this is done for each frame a different frame can be applied to the same case. Again the focus should be upon one frame and solutions within it. Only when all of the frames have been used should a comparison of the answers be made. This can then be done for multiple cases, reinforcing the reframing utility and opportunities for different solutions. A table of the similarities and differences for each frame can be developed and then, from this, an overall set of decisions can be made. The differences between these outcomes and the original ones must be discussed.

Through reframing, the Masters students discovered that they almost never discussed the actual problem, but always immediately focused on potential solutions. By the end of the fourth frame they had frequently re-evaluated the problem in several different ways before they offered a solution, which was a significantly different approach than they had before.

It is important at this stage to undertake reflection with the group as to which frame they find easier, whether they think the order of the analysis matters and whether they are happy with the outcomes and decisions so far. We usually started with the structural frame as it was, firstly, the comfort zone for most students and, secondly, we found that if we did it later they would start to incorporate other ideas and the original impact of the differences could be lost. We also asked them to reflect upon how difficult it was to work with others whose instinctive frame was different from their own. This was interesting to discuss as we knew who favoured the psychosocial frame and could compare this with the structural frame. We asked for reflection after the first analysis and then after all the frames were applied to the case.

Comparing the frames during an analysis

The next exercise is undertaken with the participant group divided into four. Each group will apply a different frame to the same case. Once the initial frame analysis is complete, all four can compare their findings, looking for similarities and differences. This exercise will develop and expand the way the ideas are explored and developed within and about the frames.

Applying the frames technique to problems

At this stage, and once the participants see the potential advantages in this technique, the group can be given further organisational problems to address. Often these arose from their own practice but the scenarios from the previous study [1] were also used to give contextual reality and to be able to compare the actions done with the participants' advice. The facilitators should ensure that the framing technique is used and that participants do not immediately try to place it in their preferred frame. If there are real differences between the advice of the participants and the actions taken, this is discussed. In our context, there were some considerable differences – especially in some of the more complex cases, where reframing led to a major shift in the understanding of the problem itself. In several cases, the actual solution was discussed during the participants analysis but rejected in at least one frame – often in the political frame where the solution was deemed to be unworkable.

Experience with current managers shows that once they perceive the value in developing the alternative perspectives, they manage their own decision-making processes to support using reframing in an ongoing way. The solutions are often more complex, but much more long-term and effective, especially in the areas of cross disciplinary team development and motivation.

The students were also asked to describe how they felt their analysis had changed over time in terms of how they used the frames (if at all). Although these managers were in a class environment during the exercises, their feedback discussions made it clear that the way that they responded in class mirrored how they responded in their work environment. Many conversations and formal feedback responses in end-of-course evaluations were about how the use of the frames within their workplace was changing how they were analysing problems and developing solutions and strategies.

Re-establishing frame usage after a period of time

As outlined above, we received formal feedback at two stages. We were interested in the self-reporting of participants as to whether they (a) had adopted new behaviours and (b) were sustaining their use. The need to evaluate is well understood and there are many models in existence. [18, 19, 20, 21] All of these aim to enable managers to gain empirical

evidence that their training and development activities have contributed to organisational accomplishments. Hence, when using this toolkit for management development, it will be important to review the results, not only at the end of the process, but also after a two to three month gap which will, hopefully, trigger self-reflection and thus knowledge creation once more.

Discussion

In most cases the predominant analyses of the managers' approach to problem-solving reflected one frame (usually structural) and so it was considered important to ascertain whether the possible solutions would change if alternative frames were explored. Traditional management thinking (as exemplified by our data) utilises only one or two frames (usually including the structural frame), uses logic and structure to solve problems and avoids ambiguity and paradox. The focus is upon finding the 'right' answer. It is our argument that expanded thinking by using alternate and additional frames, leads to a use of a multi-frame perspective, which guides the development of a range of options rather than one (often rules-based) solution. Creativity and experimentation emerges, as well as recognition that there is no one best way, rather a variety of alternatives, dependent upon a range of variables and contexts.

In this second part of our research, the use of the frames was demonstrated to enable the participants to reinterpret case studies and gain extra insights into theory and its impact upon practice. Each participant was asked to use specific frames to analyse a case. Sometimes different students were asked to analyse the same case from alternative frames and, occasionally, quite different strategies were explored. Frequently, whilst the analyses were similar, the chosen implementation was different as were the long-term outcomes. Some managers reported that they were employing such techniques in their workplace and indicative comments were: 'I take a bit longer making decisions but I think they are more likely to work long-term' (senior manager 1) and 'I have started getting my team to look at a problem from different frames; the conversations are much more interesting' (team leader 1). Overall, it became clear that the managers were finding application of different frames a useful tool for developing alternative views of the world.

Most of these healthcare managers, who were Masters students had instinctively favoured the structural frame when undertaking their analyses. Further, they had always initiated their analyses by offering a solution and not exploring the scope and aspects of the problem itself. Using the frames as sources of scrutiny and inquiry enabled the Masters students to step back from the issues under discussion and develop more complex and wide-ranging analyses of the problems under review. Complexity theories are concerned with finding order in apparently chaotic systems. Burnes describes such systems as 'systems which are constantly changing and where the laws of cause and effect appear not to apply'. [22, p.310] What complexity theories seek are 'patterns of behaviour which emerge in irregular, but similar form' and which enable some prediction of the apparently unpredictable through processes of self-organisation. [22, p.310] The objective is not to develop rules, as this would constrain an organisation's ability to survive within its environment, [23] but rather to find ways to understand and explain phenomena and be able to make informed decisions about the patterns that can be seen. In this way the frames enable students to manage complexity. The consideration of more significant elements is supported by providing a framework which makes the increased number of ideas useful. Increased ambiguity becomes a part of analysis to be sought and used rather than rejected, thus over simplification is reduced.

As a result of these reflections upon the learning and development experiences of these Masters students, bearing in mind the complexity of the health environment and the predilection for the structural frame, management development courses should include the concept of Bolman and Deal's frames. [3] This will demonstrate to managers why they should adopt the practice of multi-framing in their processes of strategic development, planning and implementation. Further, whilst Bolman and Deal's reframing of organisations is useful for forcing mindsets to include alternate frames, we are not rejecting the idea that there may be more frames in which problems may be analysed. Further research on frames not addressed by Bolman and Deal, such as an ethical frame, would therefore be an important contribution to existing knowledge.

Some limitations of this study include the apparent small number of participants and the possibility that healthcare managers, who are not students, use multi-framing. However, our discussions, observations and revelations of the participants lead us to think that a multi-framing approach to problem-solving is not as prevalent in healthcare organisations as it could be.

Conclusion

Our experience and analysis has shown that the different frames lead to a discussion about different elements of the health context. We have proposed that healthcare professionals should adopt the use of frames as a way of developing a managed discussion of their problems and challenges, in order to develop a greater understanding of increasingly chaotic and ambiguous situations. Individuals instinctively prefer one frame over another and have to be taught how to actively reframe in order to expand their conscious deliberations. We argue that, if this can be done via the process we have outlined, health services management decisions may move away from being rule bound and may start to reflect the wider issues affecting all the context members. Future research needs to track the training and utilisation of reframing techniques by healthcare professionals in order to determine whether decision-making practice changes and, if so, whether it is more effective.

Competing interests

The authors declare that they have no competing interests.

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RESEARCH ARTICLE

A Thai-Australian Rural Health Service Management and Medical Education Study Tour: workplace changes after a year

J Fraser, D Briggs and P Taytiwat

Abstract

Background: Knowledge translation is a global issue. There have been limited studies to assess the impact of cross-cultural exchanges in health service management in developing countries.

Aim: To determine the impact (on rural Thailand health services) of a Thai-Australian health service management and medical education educational study tour conducted in Australia.

Methods: Six senior doctors from rural northern Thai hospitals visited Australia. An immediate post study questionnaire evaluation based on study tour aims was followed by semi-structured interviews conducted 12 months later that focused on knowledge acquisition and changes in practice. Six Thai doctors were interviewed but only five transcripts were returned. Lack of time was cited as the reason for the non-respondent. The authors conducted a thematic and content analysis of transcripts.

Results: The evaluation showed that the study was universally valued by the participants. The twelve-month post study evaluation indicated that acquisition of new knowledge was universal amongst the group, particularly about the Australian healthcare system and programs to recruit and retain rural doctors. This knowledge was transferred to authorities that were considered to have the power to change policy.

The ability of participants to implement changes in their local work environments was varied. A few participants implemented some management changes at the local level. This focused mainly on medical education. Other participants recognised that they lacked authority to make management changes.

A barrier to the implementation of many proposed changes was the lack of authority and/or organisational support to influence the development of new policy. The significance of organisational support was identified by the participants as important to the pre-planning and selection of teams for future programs.

Conclusion: Participants value interactive educational teaching methods. Educational organisations supporting such programs need to clarify their objectives, resource and empower participants adequately on their return to optimise the lessons learnt from cross-cultural exchanges in health service management.

Abbreviations: ACHS – Australian Council on Healthcare Standards; ACHSE – Australian College of Health Service Executives; ACRRM – Australian College of Rural and Remote Medicine; CPG – Clinical Practice Guidelines; GP – General Practitioner; OPD – Out-Patient Department; RACGP – Royal Australian College of General Practitioners.

Professor John Fraser MD, FAFPHM, FRACGP, FACRRM
School of Rural Medicine
University of New England, Australia

Mr David Briggs BHA (NSW), MHM (Hons) (NE) FCHSE, CHE, FHKCHSE
School of Health
University of New England, Australia

Dr Prawit Taytiwat MD, MPA (Hons) (NIDA), AFCHSE, Thai Board Certified in Family Medicine.
School of Health, University of New England, Australia
Faculty of Public Health, Naresuan University, Thailand

Correspondence:
john.fraser@hnehealth.nsw.gov.au

Introduction

Knowledge translation in healthcare is a global issue. According to Davis, Ciurea, Flanagan and Perrier [1] '*The gap between what doctors might do based on evidence-based clinical practice guidelines (CPGs) and what they actually do is wide, variable and growing*'. It is a major health management issue [2] as limited dissemination of new information can limit improvements in health outcomes. This is particularly true in developing countries where there is a lack of research evidence as to what interventions are effective in changing health professional practice, along with a shortage of health professionals and resources. [3] A useful framework for assessing knowledge translation is the Ottawa Model of Research Use which analyses the local environment and identifies adaptive factors and barriers to the implementation of innovation. This model has been promoted as a useful basis for research in this field in developing countries. [4,5]

Paradoxically, globalisation of the world economy [6] has corresponded in an expansion of international medical education including health professional education exchanges. The important rationale for cross-cultural educational exchanges focuses on learning to acquire and transfer knowledge. [7] However, to date there is limited data as to the effectiveness of these interventions in healthcare. [3,8] Knowledge translation in cross-cultural exchanges in the information technology industry found a complex interaction between the value of learning discerned by the individual and opportunities for the application of that learning in the work environment. [9]

Most nations face a shortage of health professionals prepared to work in rural areas with a disproportionate concentration of health professionals working in urban centres. [10] The world's medical workforce is global and migratory. Doctors and medical students are older and more likely to be female. This changing demographic means that there are less full time equivalent doctors available to provide clinical services (as many will retire earlier or combine work with family needs). [10] In many countries doctors also play key roles in the management of health services. [11]

A Thai-Australian Alliance focusing on capacity building in rural health service management and medical education was formed in 2004 to foster cross-cultural collaboration and knowledge transfer in these fields. [12] We asked the research question: 'Is there long-term impact from international cross-cultural healthcare exchanges for practising rural Thai health professionals?'

This paper describes the impact and outcomes of a cross-cultural exchange in health service management and medical education between rural Thai doctors and Australian health professionals, immediate post study and after one year.

Methods

Study tour development

In December 2004, a high level Thai delegation, including members of Naresuan University Faculties of Medicine and Public Health and the Thai Ministry of Public Health, visited north western New South Wales (NSW) to better understand the Australian healthcare system and to study methods of delivering rural medical education in small rural centres. In June 2005, two Australian academics presented health service management and rural medical education papers at seminars at Naresuan University. These developments are described in-depth elsewhere. [12]

A professional development study program was negotiated as the next step for the collaboration and was organised by the School of Health, University of New England, Australia in conjunction with local healthcare providers and Naresuan University, Thailand. From November 18 to December 3 2005, a delegation of six senior Thai doctors based in Northern Thai hospitals visited Australia. The group comprised four men and two women. They worked as middle level managers in health service administration, clinical medicine and medical education. The doctors were asked to volunteer for the study tour and were selected from hospitals that were developing as clinical training sites of the medical program of Naresuan University (with one hospital accepted for medical student placements already). They were accompanied by two senior Naresuan University professors (both male). However, one professor left the program earlier as he had another important commitment in Thailand.

The study tour commenced with a networking opportunity through a formal function organised by the Australian College of Health Service Executives (ACHSE), with representatives from the Australian College of Remote and Rural Medicine (ACRRM), the Royal Australian College of General Practitioners (RACGP), and the Australian Council on Healthcare Standards (ACHS) on November 18 2005. The participants then attended a two-week professional development study tour that included: a train the trainer course in medical education; theoretical presentations in both health service management and medical education; and experiential visits to a range of health services in north western and the north coast of NSW.

The study tour's aims were agreed jointly between the faculty of the two universities and the participants. These aims were to:

- Gain an understanding of Australian approaches to the organisation, management and delivery of rural health services;
- Develop knowledge and identify best practices in the Australian context for the education and professional development of the rural health workforce and practices that will lead to improved recruitment and retention of that workforce;
- Identify current Australian approaches to determining rural populations at risk and specific rural health workforce and service delivery issues;
- Develop an understanding of rural health status and needs; and
- To differentiate service delivery issues in terms of access, equity, rurality and remoteness.

A variety of adult learning teaching methods were used to deliver this course, including lectures, small group learning, simulation, role-play, field visits and case presentations. These were used to generate interest and self and group reflection. [13] The Thai group met to discuss the main learning outcomes at the end of each day of the study tour.

Evaluation

The study tour was evaluated using a questionnaire at the conclusion of the study tour period. The questionnaire was linked to the study tour aims and learning goals and asked participants about the most valuable areas of learning and areas for improvement. The group presented their findings on the final day of the course to a group of Australian lecturers, general practice registrars and medical educators. The immediate post study tour evaluation was followed one year later by semi-structured interviews of the participants conducted in Thai. The interviews focused on knowledge acquisition and the translation and implementation of this knowledge into practice. It explored factors associated with successful workplace change and barriers to proposed change. The interview approach was adapted from the work of Fox, Mazmanian and Putnam who explored knowledge translation in practice by conducting a series of interviews with physicians about reasons for workplace changes in their clinical practice in Canada. [14] We pretested the semi-structured interview schedule amongst the research team and with other researchers. Questions were asked about what changes health professionals had considered. They were asked to rate how effective they were in making changes and to assess barriers and facilitators in the local environment to implementing change.

This evaluation framework was selected, as Fox et al (in our opinion) was a seminal study in knowledge translation and was used as the basis for the development of knowledge translation research by Davis in Canada. [13] To our knowledge, this is the first time this evaluation framework has been used in developing countries. Additionally, the approach used by Fox et al is consistent with the Ottawa Framework of Research Use. [4] This methodology was used as it meant that standardised semi-structured interviews could be administered by a research assistant. While a case study design with in-depth interviews would have provided more detail, we lacked the resources to implement this form of research as the research assistant would have required more extensive training in in-depth qualitative interviewing. Work commitments of participants meant they were unlikely to be able to participate in a more extensive evaluation.

Transcribed interviews were translated into English and approved by the Thai study tour participants. Thematic and content analysis was used with independent validation of results amongst the research team. Research approval was obtained from the University of New England Human Research Ethics Committee.

Results

Evaluation at conclusion of course

At the conclusion of the course all participants (n = 7, including the remaining senior Thai academic) agreed that the study tour was beneficial to their understanding of: the Australian healthcare system; health management concepts and practices; and rural medical education concepts and practices.

Participants were asked to nominate which presentations/visits were the most appropriate, relevant and useful to them. Responses in rank order included: the Australian healthcare system; adult learning and teaching practical skills; rural medical education; health service management; visiting hospitals, surgeries and a public health unit.

These factors were considered relevant as they had the potential to be applied to the participant's work in Thailand as reflected by the following statements made by two participants:

> *I can apply this information and skills for my career and in my work.*

I can apply what I have learnt in my hospital and in my community practice.

One participant felt a visit to the private hospital was not relevant to them as '*(I) can't apply within Thai health system*'. This response can be contrasted with one of the senior Thai academics in the group who commented that he would like to further explore public/private partnerships following this visit.

Participants identified several areas that they expected to be covered in more detail. These included: undergraduate programs for medical students; the Australian way of life; details of General Practice (GP) curriculum; experience of strategic planning for health services; visits to Sydney hospitals; how to write medical education sessions; assessment techniques; risk management; litigation; specialists who are also educators of GPs; the pharmacy system and the recruitment of rural medical students. These areas varied somewhat to the agreed learning objectives for the course.

Evaluation one year after the course

Participant interviews reflected five key themes concerning the capacity of participants to translate knowledge into changes within their workplaces. The key themes were: knowledge and ideas; role delineation; locus of control; change and organisational supports.

Knowledge and ideas

All the participants universally identified the acquisition of new knowledge as highly valuable. They are now familiar with the Australian healthcare system.

It benefits me to better understand the Australian health system [and the] health management system regarding patient referral system. Another benefit I gained is that I learnt the strategy to enable doctors working in rural areas to be retained longer. The last is that I understand their medical education management, which uses rural community hospitals and surgeries as the clinical training sites.

They also valued knowledge about programs to recruit and retain doctors in rural areas of Australia with particular emphasis on vertical integration between medical schools and postgraduate training.

I learnt the strategy to enable doctors working in rural areas [to be] retained longer.

Participants could compare and contrast the Australian and Thai health systems. This included differences in budgeting. '*Australia has good budgeting planning*' and the role of a GP as a gatekeeper in the Australian health system '*I think that the meaning of "GP" in Australian health system is different from ours. Our GP is a basic doctor. However, the Australian GP is a post-graduate doctor.*'

This knowledge was transferred to authorities that were considered to have the power to change policy, while the participants acknowledged that this might take time.

If the high authority thinks that our proposal is good and useful, they may take the concepts and apply them but we need to take time.

Role delineation

Participants separated clinical, management and medical education roles in applying knowledge from the study tour to their workplace.

When we want to apply this concept to our area, we found a difficulty as our doctors' workload for services is high overloaded [sic]. Then, when we have another responsibility for medical education, we have higher work overload.

I am a pediatrician and I have no position in management so I don't have authority in changing the management practice.

Those with existing dual roles viewed the integration of management with medical education training favourably.

It is good concepts of integration[sic] between health services and medical education and allowing the health professionals in health services [to] learn public health.

The diversity of Thai backgrounds (medical education and management) was viewed positively by some participants.

This is because every participant came from different parts of the Thai health system, so we interpreted things by using each individual's experiences or contexts as we perceived things differently. One who was from the community hospital saw one thing while another one, who was the specialist doctor from the regional hospital, saw another thing. One from the provincial hospital saw another way [sic]. So, if they can discuss this with each other, it will be like they put their jigsaws together to be the whole picture and they can see this picture clearer.

Others suggested two separate courses would be more appropriate.

The executives should focus on healthcare system management. The lecturers should participate only for medical education.

I think that setting both of them together was not compatible.

Locus of control

Participants implemented changes in their local work environments where they had influence and a locus of control.

> *I have taken the knowledge and experience gained from Australia regarding learning sources for student and implemented them in the course of community medicine at [the] medical education centre where I teach. I apply the Australian concept of GP in my teaching.*

Others felt they lacked authority to implement any change.

> *No, there's not any change yet. I think what I have changed are my ideas. I can collect ideas… [and report] to our bosses and also the university.*

> *What I think that was unsatisfactory to me is that none of us had authority in changing our health system or rural medical education system. The benefit was only for the individual and it was a high benefit.*

Furthermore, they did not see it was their role to change the health system so that it becomes based on primary healthcare, even though this was an interest of the group.

> *If the government promotes having a GP system, such as having recruitment and selection of high-school students from the rural areas where there are shortages of doctors… I think that we can make a change. If we can do what I suggested, we can retain and sustain GPs in rural areas… What I can do now is that I can only make a good role model as a GP for my student.*

Changes

Participants successfully implemented changes in their local work environments in their perceived area of influence and locus of control. Changes implemented by participants included implementation of new teaching skills, developing community placements for students and training local health professionals in medical education.

> *What I can do is to apply the Australian concept to be implemented at my clinical training sites only.*

Only a few participants implemented management changes at the local level. These individuals had an existing health service management role. This included developing population health approaches to disease management and development of a GP clinic to triage hospital access.

> *Fortunately, my director accepts the Australian concept to which I introduced to him and he applies this concept. We will implement two OPDs [Out-Patient Departments] outside the hospital as the gatekeeper so that the patients do not access hospital services directly. We will have GPs to service these OPDs…I use the gatekeeper concept in this project.*

A barrier to the implementation of many proposed changes identified by the group was the need to influence policy at regional or national level.

> *What is closest to me I can't change, namely how can we make our district health services system to be united [sic]. Presently the community hospital and the district health office as well as health centres are separated independent [sic]… In many areas, we can't coordinate. If we can do this as a united organisational structure, I think that our work will be more holistic and we can reduce the complexity of the hierarchy of control and management structure.*

Restructuring of medical education, health service management, programs to develop rural doctor production and vocational training in rural areas, were emphasised as priorities for Thailand by participants. These changes were felt by participants to be beyond their influence and required policy changes from authorities.

> *For instance, how to recruit and select the potential medical students, how to make the public see this point, it's not my authority and it's not my role as I am not the one who takes responsibility for such management.*

Organisational support

Organisational supports were identified as important to the pre-planning and selection of teams for future cross-cultural educational programs.

> *I think that there are two things: preparing the participants and selecting the potentials. I think that we didn't [consider] what we could do, could really do from our team. Do they have any role or competencies to make things change? Do they have enough authority to change things? If you select the participants at the operational level, you can't change the policy. They can't push anything.*

There was also a need to resource participants on their return to reduce isolation and workload to optimise the benefits of educational exchanges to the sponsoring organisations involved.

> *After we returned from the study tour, everybody has their own world. I mean we experience an overload of our own work. We used to talk that we would like to make our team to promote GPs and push teaching GPs at the small community hospitals but we couldn't make it happen as we do not have authority to do it.*

Conclusion

To our knowledge there have been limited studies assessing longer-term knowledge translation in health service management cross-cultural exchanges in developing countries. This study tour used a variety of educational interventions to transfer knowledge designed to foster self-reflection and peer discussion. These educational methods are more effective in changing health professionals in studies conducted in developed countries [13] and were valued by the Thai participants in our study. Providing learning experiences that are valued is a preliminary stage to cross-cultural knowledge translation in the workplace. [9]

The knowledge gained during the study tour was universally valued by participants and shared with authorities at all sites but only implemented locally where participants had a perceived locus of control to implement change, or were supported by their immediate supervisors to implement change. Participants may value the learning and be motivated to implement changes, but environmental supports and barriers in the workplace will influence whether adoption and outcomes occur. This finding is consistent with the Ottawa Model of Research Use [4] and findings from the information technology industry. [9]

The findings of this study in terms of the influence of the work environment affecting knowledge translation are consistent with the findings of Fox et al with Canadian physicians [14] and other health professional cross-cultural exchanges to increase family medicine capacity in Latin America, [16] Egypt [17] and between France and Mali. [18] These studies have found health professional change to be variable and dependent on the interest of the learner and barriers and facilitating factors in the environment. [4] Barriers occur with the adoption of new practices that require more extensive changes in the health service at a regional level or national level. [18,19] In this study, changes in medical education were implemented more readily as participants had autonomy to implement these changes in their teaching. Health service management changes were not as frequent. This demonstrates the need for participants to be supported on their return by their work environment and line managers to optimise outcomes of such exchanges.

This paper has several limitations. We relied on the self-reporting of the participants and the study tour organisers and authors are the same group. The participants volunteered for the project so our findings may include selection bias. Resource limitations meant we needed to use an evaluation framework which was practical enough to be implemented in rural areas of Thailand. The evaluation framework selected has been used in developed countries to explore knowledge translation. In many ways this evaluative study should be considered a pilot, however, our results suggest this methodology was useful in a Thai rural context. We are unable to comment on the generalisability of our findings to other developing countries. We recognise that a case study using in-depth interviews from multiple sources in the workplace would provide much richer data and would recommend an expansion of this research using this methodology in other settings.

Establishing an effective and sustainable cross-cultural educational program collaboration [20] is dependent on the needs of target organisations. Goals will vary between organisations, individuals and cultures. Educational organisations supporting such cross-cultural programs in health service management need to clarify their objectives especially if they wish to implement changes at a regional level. Pre-planning and selection with sufficient resourcing and mentoring of participants on their return is required. Linkage with the sponsoring organisations is needed to optimise the implementation of lessons learnt from cross-cultural exchanges in health service management.

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Competing interests

The authors declare that they have no competing interests.

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

G Moss

Abstract

Healthcare managers are facing significant challenges [1,2] as traditional approaches fail to address the realities of practising in Complex Adaptive Systems (CASs). That is to say a system in which changes at any point may lead to significant and unpredictable changes at other points in that system – or even in other systems. Recent Australian research [3] has investigated the perspectives of 70 South East Queensland healthcare managers on this phenomenon, their ensuing attempts at sense-making and their conclusions on how to address the challenges as they see them. Three quarters of the respondents perceived their organisations as bureaucratic – which is characterised for the purpose of this commentary by rigid, straight-line cause and effect thinking along with inflexible rule-based control. Although the participants reported ineffectiveness of current management structures, only a few called for changes in structures and processes. It is somewhat disappointing that the status quo remains largely unchallenged.

This commentary seeks to assist managers in making sense of the CAS healthcare environment and in developing management approaches which may be more appropriate and therefore more effective. (Table 1)

Abbreviations: CAS – Complex Adaptive System

Dr Gerald Moss AFCHSE, CHE, FRCA
Acting Director – Medical Services
Sunshine Coast and Cooloola Health Service District
Nambour, Queensland, Australia

Correspondence:
gerald_moss@health.qld.gov.au

Complex Adaptive Systems

The term 'adaptive' is key to understanding the CAS. [4] Yes, the healthcare environment is rapidly increasing in different directions and in breadth and depth within each. That is only a minor problem insofar as increased numbers of managers may be required to provide management support with more experienced managers having oversight. From this perspective the big problem within a classic bureaucracy is that departments may be forced into 'silos' leading to poor communication/co-operation between actors.

However, action at any healthcare entity may affect or be affected by actions at other entities. The propensity for this to occur is increased due to the relative autonomy which rests with many actors. When change occurs actors may adapt to it by attempting to resist or return to the status quo, or they may adapt by moving in a completely different direction which might be for the better or for the worse. This leads to the common experience of having a change in one place leading to unexpected events all over the place. Completely unexpected outcomes are often termed 'surprises'; certainly the actual outcome may well have been a surprise, but that one has occurred is not in itself a surprise. Much good may come out of surprises:

> *Reframing surprise as opportunity rather than a threat can be facilitated when we recognize that efforts to deny, control and prevent uncertainty operate as barriers to reframing, especially among patients, physicians and health care organizations.* [5]

It is this adaption and the ensuing chaos, which challenge healthcare managers. [6, 7,8]

Table 1 compares traditional and complex system approaches to change.

Table 1: Complex Adaptive Systems

TRADITIONAL	COMPLEX ADAPTIVE SYSTEM
Few variables determine outcomes	Innumerable variables determine outcomes
The whole is equal to the sum of the parts (reductionist)	The whole is different from the sum of the parts (holistic)
Direction is determined by design and the power of a few leaders	Direction is determined by emergence and the participation of many people
Individual or system behaviour is knowable, predictable and controllable	Individual or system behaviour is unknowable, unpredictable and uncontrollable
Causality is linear: every effect can be traced to a specific cause	Causality is mutual: every cause is also an effect, and every effect is also a cause
Relationships are directional	Relationships are empowering
All systems are essentially the same	Each system is unique
Efficiency and reliability are measures of value	Responsiveness to the environment is the measure of value
Decisions are based on facts and data	Decisions are based on tensions and patterns
Leaders are experts and authorities	Leaders are facilitators and supporters

Adapted from Olson and Eoyang. [20] Source: the Complex Adaptive System (CAS) model of change based on complexity theory. [19]

The straight-line approach to implementation does not consider the possibility of unintended consequences, or the possibility that the intended outcome will not be realised. Then, if the management structure and process appear to have failed, the manager may be replaced. However, without understanding and a new approach, the next implementation and manager will also fail.

The CAS approach includes expectation that there will be unexpected consequences and seeks to bring about an acceptable level of control through engagement and communication with and between actors. The approach must be founded on trust and good leadership, allowing a degree of flexibility to keep the implementation on course or facilitate a beneficial change in direction if not achieved. Close monitoring and frequent consultative review are of the essence, differentiating strategic management from strategic planning.

Attributes of Complex Adaptive Systems

Through recall and reflection one may verify the following attributes of the CAS as being manifest [4] in healthcare organisations:

- Multiple components; understood by observing their rich interaction;
- Interaction can produce unpredictable behaviour;
- Have a history and are sensitive to initial conditions;
- Interact with and are influenced by their environment; and
- Interactions between elements of the system are non-linear.

The interactions generate new 'emergent behaviours' that cannot be explained:

- Such emergent behaviours cannot be predicted; and
- Are open systems; when observed, the observer becomes part of the system.

The middle manager

The middle manager is the conduit for the transmission of senior management-developed information and direction to the staff. The middle manager knows the staff he/she is responsible for, hopefully enjoys their trust and demonstrates leadership. [9] The transmission of information up as well as down and between silos depends upon staff having the freedom and opportunity to speak up and to question. Successful implementations (and day-to-day management in fact) depend upon the middle manager knowing who the opinion leaders are, who the connectors are, and who the 'mavens' are so as to gather their expertise and support. [10] (Mavens have technical, procedural, political or other knowledge and skills.) Permitting flexibility and freedom to speak does not come easily to those at the top of bureaucracies and reduction in the degree of control they exercise is anathema. Successful middle managers in CASs will have learnt how to manage UP as well as DOWN. [11,12]

Leadership

Managers and staff are challenged by change and the ensuing tendency towards chaos; excellent leadership maintains staff confidence. The leader of tomorrow will be more likely to ask questions than give orders, will able to live with paradox and complexity and as well encourage others. [13, 14, 15]

Trust

Followers have to trust leaders if they are to survive change. Trust is easy to lose and hard to rebuild. The United States healthcare literature [16] supports the place of these key elements in the successful rebuilding of trust.

- Make opportunities for communication;
- Value other people's opinions;
- Be patient; and
- Don't be frightened to take the first step.

Conclusion

Healthcare managers should make the effort to understand, make sense of and come to terms with CASs in theory and practice. [17, 18]

That managers interviewed in the research article [3] under discussion appeared unwilling to implement the changes needed to improve current management structures and processes is a cause for concern. Within bureaucracies managers may be fearful of the consequences if they speak up, may believe they will not be listened to or have become cynical over time. The ability to manage up as well as down would be helpful in this context. [11, 12]

The need for development of leadership skills and building of trust is urgent, as is the acceptance of flexibility, expectation of surprises and willingness to learn from them. [19, 20, 21]

Competing interests

The author declares that he has no competing interests.

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REVIEW ARTICLE

Current Structure and Future Challenges for the Healthcare System in Saudi Arabia

B Jannadi, H Alshammari, A Khan and R Hussain

Abstract

This paper provides an overview of the healthcare system in Saudi Arabia and outlines some of the future challenges in relation to economic and human resource requirements to meet the needs of the growing population and a changing disease profile. Over the past few decades, the Saudi healthcare system has undergone rapid expansion and modernisation. Currently, healthcare services are provided through three agencies; the Ministry of Health, other governmental agencies, and the private sector. The Ministry of Health is the largest provider of healthcare services, with a large number of healthcare facilities distributed all over the country. The Saudi health system attempts to provide high quality services, however it does face a range of complex mid- to long-term challenges which include: ensuring a sustainable financing system; workforce planning issues including provision of high quality training for adequate numbers of local healthcare professionals; to decrease excessive reliance on foreign workers; realignments of health services to respond to changing demographic and disease patterns; and continuation of adequate healthcare services annually to over two million pilgrims from across the world during the Hajj season.

Abbreviations: GDP – Gross Domestic Product; MOEP – Ministry of Economy and Planning; MOF – Ministry of Finance; MOH – Ministry of Health; OECD – Organization for Economic Co-operation and Development; WHO – World Health Organization; WTO – World Trade Organization.

Key words: healthcare services; Saudi Arabia; funding; Hajj; health workforce; disease patterns.

Bandar Jannadi BS Pharm, MHHA, DHSM Candidate
School of Health
University of New England, New South Wales, Australia

Hamoud Alshammari DipPh, BPA, MHHA, DHSM Candidate
School of Health
University of New England, New South Wales, Australia

Dr Adeel Khan BA, MA, PhD
Lecturer
School of Health
University of New England, New South Wales, Australia

Associate Professor Rafat Hussain MBBS, MPH, PhD
School of Health and School of Rural Medicine
University of New England, New South Wales, Australia

Correspondence:
rhussain@une.edu.au

Introduction

The Saudi economy developed rapidly in the 1970s following the discovery of oil reserves. Currently, Saudi Arabia is the largest producer of oil worldwide. [1] Oil accounts for 90% of Saudi Arabia's exports, 75% of government revenues, and 45% of its gross domestic product (GDP). Another 40% of GDP comes from the private sector. [2] In 2005, Saudi Arabia joined the World Trade Organization (WTO) to enhance the multiplicity of its financial resources by encouraging foreign investors to contribute to the Saudi economy. [1] This economic prosperity has led to modernisation of infrastructure in Saudi Arabia including substantial expansion and upgrade of healthcare facilities.

During the last few decades, Saudi Arabia has experienced a large increase in its population. Its current annual growth rate of 3.3% [3] can be attributed to a number of factors including high fertility rates (4.3 births per woman), low contraceptive prevalence and declining mortality. [4] In 2004, the total population of Saudi Arabia was estimated to be 22,673,538, [5] and is expected to reach 36 million by the year 2020. [2]

A distinct feature of Saudi Arabia's demographic profile is the presence of a large expatriate population (6,144,236 in 2004) comprising around 27% of the total population, of which around 75% live in urban areas. [6]

Historical development of the healthcare system in Saudi Arabia

Historically, medical care in Saudi Arabia was based on provision of healthcare services by traditional and folk healers who used traditional medicines such as herbs or other folk remedies including spiritual methods to treat ill-health. [7] Organised healthcare services started in the early twentieth century and began with the issue of a decree, which established a 'Department of Health', in 1926. [8] This Department was responsible for establishing hospitals and clinics in four main cities: Mecca, Madinah, Jeddah and Taif. [8] In 1927, the Department of Health was renamed as the 'General Directorate for Health and Aid', and was attached to the Bureau of the Attorney General. A health council was set up under the presidency of the Attorney General [7] with the aim to enhance standards of health, control communicable diseases and improve public health, particularly during the pilgrimage (Hajj) season. [8] However, limited financial resources were available before 1946, which impeded the development of the modern or 'western' healthcare system. For example, the total number of hospital beds was just 300 for the entire country. [8] By the1950s, a few large hospitals (with 1,000 beds) had been established in the cities of Mecca, Madinah, Jeddah, Taif, Riyadh and Al-Hasa. In addition, some healthcare clinics were also established. [9]

The Ministry of Health (MOH) was established in 1954. [10] During the 1970s, huge revenues from oil exports started being used to fund large-scale and long-term infrastructure development under each successive five-year national development plan. [1] Consequently, the development of healthcare services was expanded and expedited. This rapid growth was accompanied by a national plan to invest in human resource development and training, particularly the training of local (Saudi) healthcare professionals. [7] This is reflected in ongoing government investment in scholarships, training courses, opening of medical colleges and the establishment of the Saudi Council for Health Specialties, which initiated structured training programs for physicians and other health professionals. [11]

The healthcare system in Saudi Arabia is ranked 26th among 191 healthcare systems in the world, in terms of performance, above some of the developed countries, such as Australia as 32nd, and the United States as 37th. [12]

Current structure of healthcare services in Saudi Arabia

The Saudi government is obliged to provide healthcare services to all citizens, as enacted in the Saudi Constitution. Article 31 of the Constitution states: 'The state takes care of health issues and provides healthcare for each citizen', [13] which means that all citizens have full and free access to all the public healthcare services. In reality, healthcare services in Saudi Arabia are provided through a range of different agencies in both the public and private sectors. The MOH is the largest single healthcare provider in the public sector and is responsible for providing healthcare services to the majority of the population. The Ministry manages 218 hospitals, 1905 primary care centres and a range of associated healthcare services such as centres for dental care, quarantine, forensic medicine and rehabilitation, in both urban and rural areas. In addition, there are 27 health institutes and 18 colleges of health science across the country, which are managed by the General Directorate of Health Institutes and Colleges in the MOH. [4]

Table 1: Distribution of healthcare facilities in urban and rural areas, Ministry of Health

FACILITIES AND PERSONNEL	URBAN AREAS	RURAL AREAS	TOTAL
Hospitals	156	62	218
Beds	21,183	9,306	30,489
Primary healthcare centres	1,142	763	1,905
Dental care centres	9	10	19
TB centres	1	1	2
Forensic medicine centres	9	9	18
Quarantine centres	12	10	22
Rehabilitation centres	7	4	11

Source: Health statistical year book. Ministry of Health; 2005.

Table 2: Distribution of healthcare facilities and personnel in the public and private sector in Saudi Arabia

FACILITIES AND PERSONNEL	MOH	OTHER PUBLIC AGENCIES	PRIVATE AGENCIES
Hospitals	218	38	123
Beds	30,489	10,156	12,547
Physicians	20,219	9,343	13,786
Nurses	42,628	19,913	17,453
Allied health personnel	23,116	13,420	7,061
Administrative personnel	10,531	11,761	11,328

Source: Health statistical year book. Ministry of Health; 2005.

Other government agencies involved in the provision of healthcare include the Ministry of Education, Ministry of Interior, Ministry of Defense and Aviation, the National Guard and the Red Crescent Society.[1] Each of these governmental agencies has its own budgetary allocation and manages recruitment of staff and administration of health facilities independently from the MOH. These agencies, with the exception of the Red Crescent society, provide healthcare services through a combination of primary, secondary and tertiary care facilities for the benefit of employees and their dependants. However, some of these agencies also provide a specialised healthcare service to the public for certain conditions, such as open heart surgery, liver transplantation and treatment for cancer. [14] Each agency has its own system for directing its healthcare facilities. For example, healthcare services in the Ministry of Defense are provided through various hospitals and primary healthcare centres, which are managed and operated by the General Department of Medical Services within the Ministry.

The private health sector in Saudi Arabia is owned and operated by private companies, charitable organisations, community groups and individuals. They provide fee-for-service care [14] in hospitals, dispensaries, clinics, laboratory centres, radiology centres and other healthcare facilities. Although the Saudi government started to offer large incentives to investors to increase the number of healthcare facilities in 1975, [15] the contribution of the private sector in the provision of healthcare services is relatively small (see Table 2). Of the total 53,192 hospital beds, only 12,457 (23.4%) are provided by the private sector. [4] However, with projected rapid population increase, the proportionate share of private sector healthcare facilities is likely to increase considerably.

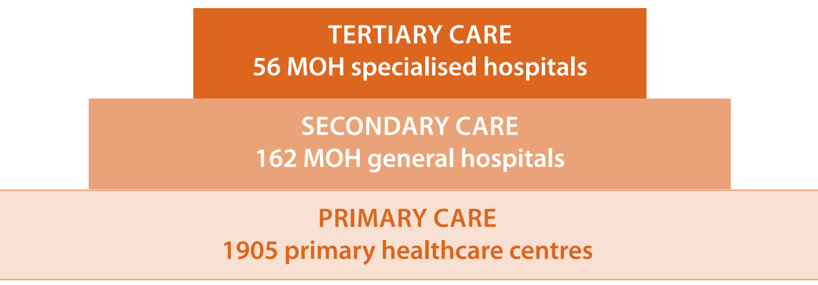
1. In most Muslim countries including Saudi Arabia, the Red Cross has been renamed as the Red Crescent Society

Levels of healthcare services in the public sector

Healthcare services in the MOH are provided through three levels of care: primary, secondary, and tertiary care (Figure 1). Primary healthcare services are provided in healthcare centres, which also act as a gatekeeper to other healthcare facilities. Secondary and tertiary healthcare services are provided in the general and specialist hospitals respectively.

Primary Care: Saudi Arabia, along with 134 countries, was a signatory to the 1978 Alma-Alta Declaration to achieve the World Health Organization's (WHO) goal of 'Health for All' by 2000. Under the aegis of MOH in 1980, health clinics and maternity and childhood health centres in Saudi Arabia started to work together under a new name; 'Primary Healthcare Centres'. These centres provide basic healthcare services; promotional, preventive, curative and rehabilitative services, such as vaccinations, dental care, health education, environmental health, etc. [16] There has been nearly a three-fold increase in the number of primary healthcare centres between 1998 and 2005 (see Figure 2), with a proportionate increase in health workforce as well. There are 4,921 physicians and 11,183 nurses working in the primary healthcare centres in Saudi Arabia. The ratio of physicians to population in the primary healthcare centres was 2.1 physicians per 10,000 population whereas for nurses the ratio was 4.8 nurses per 10,000 population. [4] All these primary healthcare centres are managed by the General Directorate of Primary Healthcare Centres in the MOH.

Figure 1: Levels of healthcare services provided in the Ministry of Health



Source: Health statistical year book. Ministry of Health; 2005.

Secondary Care: Patients are referred to general hospitals from primary healthcare centres for further treatment and care. There are 162 general hospitals in Saudi Arabia, with 21,359 beds, equipped with advanced medical technology and operated by skilled staff. In 1989, the MOH established a set of policies and procedures to organise the functions of hospitals by establishing an organisational chart that clarified responsibilities and activities of departments, divisions and staff. [17]

Tertiary Care: Hospitals at the tertiary care level provide more technically advanced services since they treat patients with complex health problems who have been referred from general hospitals for more specialised care. [17] There are 56 specialist hospitals in Saudi Arabia. These include 20 obstetrics and paediatric hospitals, four eye and ear nose and throat (ENT) hospitals, four chest and fever hospitals, 17 psychiatric hospitals, nine convalescence, leprosy and rehabilitation hospitals, and two cardiac and renal hospitals. [4]

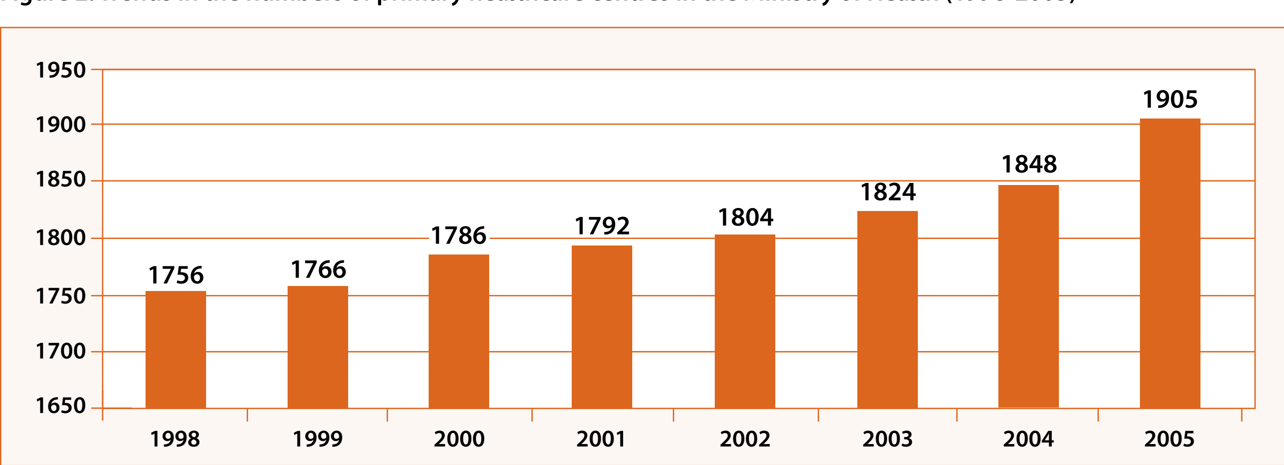
Challenges to healthcare services in Saudi Arabia

There are a number of challenges to the delivery of healthcare services in Saudi Arabia. These challenges relate to a range of factors including funding of services, the balance between public and private resources, health workforce planning and aligning services to respond to the changing disease patterns including the need for expensive diagnostic services. A special challenge unique to the Saudi healthcare system is the provision of large-scale health services every year to over two million pilgrims who visit the country to perform the Hajj pilgrimage.

Funding of healthcare services

As stated earlier, provision of healthcare services is undertaken mostly by the public sector and healthcare services are funded mainly by the government. Within the public sector, the bulk of healthcare spending is undertaken by the MOH since it has the primary responsibility of providing healthcare services to the Saudi population, and most of the hospitals and other healthcare facilities are owned and operated by the MOH. Every fiscal year, a specific budget is allocated to the MOH from the total government budget, by which the Ministry of Finance (MOF) is responsible to transfer the allocated amount of the budget to the MOH. Between 1999 and 2006, the MOH budget ranged from 5.9% to 7.1% of the total government budget (see Table 3).

Figure 2: Trends in the numbers of primary healthcare centres in the Ministry of Health (1998-2005)



Source: Health statistical year book. Ministry of Health; 2005.

Table 3: Trends in budgetary allocations for Ministry of Health (1999-2006)

YEAR	GOVERNMENT BUDGET (SAUDI RIYALS)*	MOH BUDGET (SAUDI RIYALS)*	% (SAUDI RIYALS)
1999	165,000,000	11,339,236	6.8
2000	185,000,000	11,939,043	6.5
2001	185,000,000	13,046,528	7.1
2002	202,072,000	13,740,910	6.8
2003	209,000,000	13,857,430	6.6
2004	230,000,000	14,756,350	6.4
2005	280,000,000	16,870,750	6.0
2006	335,000,000	19,683,700	5.9

* 1 USD=3.75 Saudi Riyals

Source: Health statistical year book. Ministry of Health; 2006.

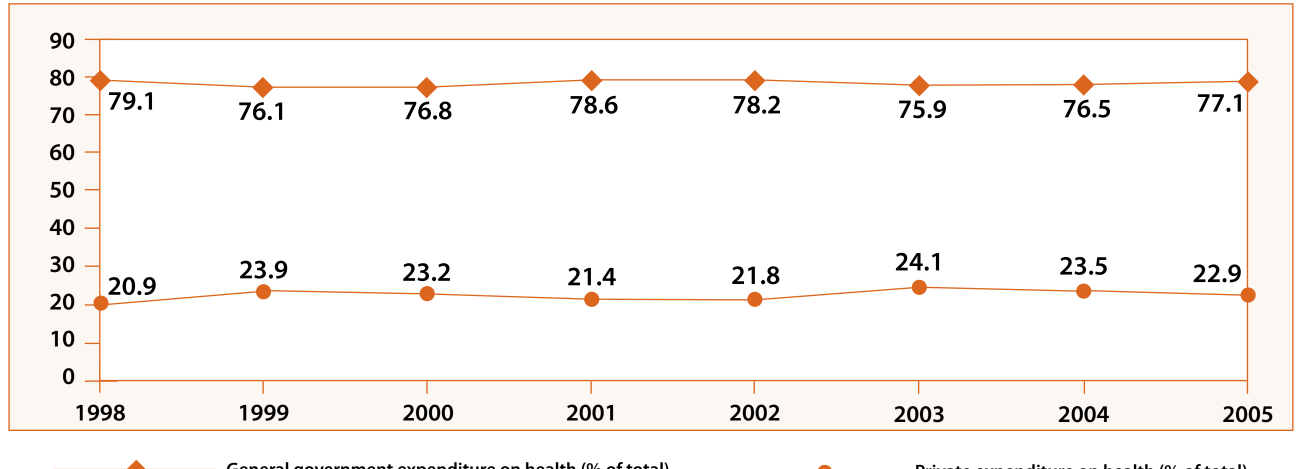
According to the Ministry of Economy and Planning (MOEP) in Saudi Arabia, considerable funds have been expended in the last three decades to finance the costs associated with establishing and modernising healthcare infrastructure both in the public and the private sectors. [18] As shown in Figure 3, most of the projects and associated funding was provided by the public sector. [19] For example, in 2002, public health expenditure accounted for 3.3% of GDP, whereas private health expenditure accounted for 1.0% of GDP. [20]

Health workforce planning

Along with the development, expansion and modernisation of healthcare facilities in Saudi Arabia over the past few decades, there has been a significant increase in the total health workforce across different healthcare settings all around the country. The ratio of physician/population was estimated to be 14 physicians/10,000 population in 2004 compared to an average of 30.8 physicians/10,000 population in Organization for Economic Co-operation and Development (OECD) countries. [20] However, this ratio is considerably above the minimum ratio recommended by WHO for developing countries which is estimated to be 1 physician/10,000 population. [16] Although there has been a concerted effort to expand training opportunities for Saudi nationals, significant gaps exist. Most of the health workers in Saudi Arabia are non-Saudi nationals, [16] which account for 78.7% of the physicians, and 76% of the nurses. [4]

The pressure to increase health workforce capacity and capability will remain high for the next few decades in Saudi Arabia because of the high population growth rate, changing disease profile, and modern healthcare management practices, which include increasing reliance on specialist

Figure 3: Trends in health expenditure in Saudi Arabia (1998-2004)



Source: Adapted from World Health Organisation. Saudi Arabia: national expenditure on health. WHO; 2006.

services. The Saudi government has developed targets for training of clinicians and allied healthcare workers to minimise the shortage in the health workers. In order to achieve the targeted number of health workforce, a set of strategies was adopted by the Saudi Labor Force Council in 2003. [21] These include: encouraging the private sector to invest in the establishment of medical schools and health colleges; increasing the capacity level in established health colleges and institutes; increased opportunities for scholarships in health specialties; encouraging hospitals to establish their own training centres; establishing more teaching/training hospitals; and enlarging the base of medical postgraduate studies. The current five-year National Development Plan (2005-2009) aims to substantially increase the number of Saudi nationals trained in allied health including dentistry. Similar projections have been made for the ninth (2010-2014) and tenth (2015-2019) development plans (Table 4). In contrast to allied health, the targets for training of Saudi doctors are more modest, increasing from 23% in the current plan to about 33% by 2020. Similarly, the targets for training of Saudi nurses are projected to increase from 31% in the current plan to 44% by 2020 (see Table 4). There is also an increasing emphasis on training of healthcare managers through training programs both within Saudi Arabia as well as bonded overseas scholarships for postgraduate studies.

However, despite the substantial budgetary allocation for medical education and training, outcomes remain limited both in terms of their value and scope due to a variety of reasons, including issues in quality of training and its relevance to local needs. [22] There are also sociocultural issues that impede the attainment of set targets. For example, there is significant gender segregation in Saudi society and debate on nursing education for Saudi women is complex and sensitive. In some quarters, there is support for the continuation of gender-segregation and opposition to men and women working together. The alternate view argues for the need for Saudi Arabia to develop its own female workforce as currently the country is dependent upon the importation of an enormous and expensive expatriate workforce including those managing the health system, most notably nurses.

Changes in disease patterns

The prevalence of many communicable diseases in Saudi Arabia has dropped dramatically due to the governmental efforts in the control and surveillance of infectious diseases and epidemics and also due to an improved socioeconomic status of the population. There has also been a significant increase in immunisation coverage. Consequently, the incidence of communicable and parasitic diseases has noticeably declined during the last decade. However, there are geographic pockets such as the southwestern region where communicable diseases are still prevalent. Communicable diseases also pose a significant challenge during the Hajj (pilgrimage) season as discussed in a later section.

The increased cost of public healthcare services is a major challenge for all modernising economies as disease patterns change from infectious to chronic diseases and cancers. Saudi Arabia is no exception as the demographic profile changes with a projected increase in the dependant population proportion, an increase in life expectancy, [23] and a change in disease patterns from communicable to non-communicable diseases, such as diabetes, cardiovascular disorders and cancers. [21] Additionally, traffic accidents are the major cause of death in Saudi Arabia. [21] Decreasing morbidity and mortality associated with road traffic accidents is a challenge, as it requires effective intersectoral collaboration in legislation and enforcement of traffic laws and provision of enhanced emergency services including mobile trauma services.

As a result of changes to disease and injury patterns, healthcare expenditure is likely to increase considerably within the next two decades. [21] Since most of the healthcare services are provided by the public sector in Saudi Arabia, this increasing load on government resources may affect the future quality of healthcare services. Currently, the Saudi government is looking at possible alternatives to the funding of healthcare services. The MOH is also exploring various options for increasing the privatisation of healthcare services in Saudi Arabia, as a strategic alternative to reducing the financial load on the government. [24] A compulsory health insurance program for expatriates was implemented in 2006. It is anticipated that such a program will be implemented in the near future for Saudi nationals as well.

Healthcare services provision in the pilgrimage (Hajj) season

Saudi Arabia has a unique position in the Islamic world since the two sacred cities in Islam are located in Saudi Arabia. Every year about two million pilgrims come from all over the world to perform Hajj. Hosting an event of this magnitude on an annual basis requires comprehensive planning across agencies to ensure provision of adequate housing, transport and healthcare services.

Table 4: Targets for estimated number of health workers in Saudi Arabia (2005-2020)

CATEGORY	8TH PLAN (2005-2010)		9TH PLAN (2010-2015)		10TH PLAN (2015-2020)	
	TOTAL	% SAUDI	TOTAL	% SAUDI	TOTAL	% SAUDI
Physicians	38,104	23	42,300	28	46,846	33
Dentists	4,572	53	5,076	61	5,739	67
Pharmacists	10,830	33	12,269	42	13,315	49
Nurses	76,573	31	86,756	38	96,131	44
Health technicians	51,049	62	57,837	72	64,087	81

Source: Adapted from: World Health Organization. Country cooperation strategy for WHO and Saudi Arabia 2006-2011. WHO; 2006.

Healthcare services provided during Hajj cover all forms of acute illness, infectious and parasitic diseases, and chronic illness. Preventive care is also provided, which includes immunisation and chemo-prophylaxis. [16] For instance in 2005, 2,902 pilgrims were vaccinated against meningococcal meningitis, and 305,625 pilgrims were given prophylactic treatments. [4] Approximately 10,000 clinical and associated administrative staff is deputed to take care of pilgrims in the Hajj period; and there are 14 permanent hospitals and seven seasonal hospitals, with 3,644 beds, in the Hajj area which are operated by the MOH. Nonetheless, health crises may occur during the Hajj season because of overcrowding and the spread of contagious diseases, injuries such as falls and, during the summer season, exhaustion and dehydration as temperatures soar to over 40 degrees centigrade. In 2005 there were 1,212 deaths in the Hajj season [4] Therefore, the Saudi healthcare authorities (such as MOH, the National Guard and the Armed Forces) not only have large-scale contingency plans but also expend substantial effort and resources annually to provide healthcare services on a 24-hour basis in order to minimise the number of casualties among pilgrims' during the Hajj. In addition, on-going projects are undertaken by the Saudi government to ensure pilgrims' safety.

In recent years, the convergence of large numbers of people in specific places within a specified short period of time has also raised security concerns about public safety. Although it is unlikely that the sacred sites for Hajj pilgrimage would become unsafe, such a threat cannot be eliminated altogether. Updating of contingency plans for ensuring health, safety and security of pilgrims will continue to be an on-going challenge for Saudi health authorities.

Summary

This paper provided an overview of the organisation of healthcare services in Saudi Arabia. Key challenges in relation to the delivery of current and future healthcare services were outlined. To date the public healthcare system has been able to cater for the healthcare needs in terms of both human and financial resources. However, a combination of factors such as population growth, improved life expectancy and change in disease pattern from acute to chronic and complex problems is likely to increase the cost of delivery of healthcare. It is anticipated that there will be increasing emphasis on implementing a comprehensive national health insurance system as well as increasing reliance on private agencies for delivery of healthcare services in Saudi Arabia.

Competing interests

The authors declare that they have no competing interests.

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REVIEW ARTICLE

Meeting the Challenge: a national approach to supporting people with dementia and their carers

P Williams and L Grenade

Abstract

Care and support programs for people with dementia and their carers are critical in addressing the increasing social and economic burden predicted by the structural ageing of the population. This paper discusses the strategic approach to dementia adopted by the Australian Government and reports on an evaluation of the National Dementia Support Program (NDSP) developed and delivered by Alzheimer's Australia. It includes a brief comment on international approaches to dementia care.

The NDSP integrates a number of different support programs into one comprehensive funding program.

The evaluation highlighted that it has enabled:

- the provision of an outwardly 'seamless service' to clients;
- national standards and some consistency of services across Australia; and
- increased flexibility to use funds differently to reach a broader clientele.

Some of the challenges identified included:

- overlap of some services;
- increased reporting requirements/administrative demands potentially impacting on delivery of services;
- increasing expectations and demands from a widening variety of clients and organisations; and
- significant unmet need in Indigenous and culturally and linguistically diverse (CALD) populations.

In conclusion, the NDSP provides a national, comprehensive program of funding that facilitates common standards, offers an outwardly 'seamless service' to the community and allows for additional flexibility of delivery within individual states. The commitment to a national strategy, an action based framework and the development of programs like the NDSP makes Australia unique in its efforts to prevent dementia and respond to the needs of people with dementia and their families.

Abbreviations: NDSP – National Dementia Support Program; CALD – Culturally and Linguistically Diverse.

Keywords: dementia; support programs; evaluation.

Dr Peta Williams BAppSc, PhD
Centre for Research on Ageing
Curtin University of Technology
Bentley, Western Australia

Ms Linda Grenade BA, BSW, PgDipSocResEval, MSc
Centre for Research on Ageing
Curtin University of Technology
Bentley, Western Australia

Correspondence:
peta.williams@curtin.edu.au

Introduction

Dementia describes a range of brain disorders which cause a progressive decline in a person's functioning. Alzheimer's disease accounts for 50-70% of all cases of dementia. Currently, there are an estimated 200,000 cases of dementia in Australia. The incidence and prevalence of dementia is expected to rise significantly over the next 20 to 30 years in line with the ageing of the population. This presents considerable challenges in terms of financing, staffing and caring for people with dementia and their families.

The paper is largely based on the findings of an evaluation of the NDSP published by the authors in 2007. [1] Relevant literature, in particular major policy reports and documents

related to dementia and dementia support have also been used. The paper will discuss international approaches to dementia care and support and describe a national program aimed at improving dementia care and support that has been implemented in Australia. The National Dementia Support Program (NDSP) forms part of a national strategic approach to addressing dementia within Australia.

International approaches to dementia care and support

In the developed world, people with Alzheimer's disease and their carers access support services usually through nationally funded general caregiver programs, such as the National Family Caregiver Support Program in the United States and the United Kingdom National Carers Strategy. Specific dementia-related support programs tend to be provided by Alzheimer's associations and the not-for-profit sector. This includes services such as telephone helplines, information, family and professional carer education, counselling, referral and respite.

There are a few government funded national support programs that specifically target people with dementia and their carers. For example, in the United States there are three national dementia-specific support initiatives: the National Alzheimer's Call Centre, the Safe Return Program and the Alzheimer's Disease State Matching Grants Program. [2] These programs operate independently of each other as a result of specific federal budget allocations and are administered through different departments. The United States President's budget for 2008 proposes to eliminate funding for these programs. [3]

The authors were unable to find evidence of any centrally funded support programs of national scope specifically for people with dementia and carers in the United Kingdom. Two recent reports on behalf of the Alzheimer's Society and the House of Commons have highlighted that while there are areas of good practice in the United Kingdom, there has been a widespread failure to develop services which meet the needs of people with dementia and their families/carers. [4,5]

Although the need to keep people with dementia independent and at home for as long as possible has been acknowledged, [4,6] the need for specific services to support people with dementia and their carers has not been sufficiently recognised by governments. [4,7] Funding is generally non-existent, insufficient or piecemeal, and there is an over reliance on the not-for-profit sector.

Many countries do have national policies and strategic frameworks for mental health, older people and carers that address dementia to some extent. However, the need for a coordinated national dementia strategy with specific political and funding commitments has been highlighted as a critical step to address the looming social, health and economic impacts of dementia. [4,8,9] In Canada, while provincial Alzheimer strategies exist, the 2005 House of Commons motion to develop a national strategy has not yet been realised. [9]

In the Asia Pacific region, dementia care is a mix of family and formal (paid) care that reflects the cultural, social and economic conditions of each country and their vastly different healthcare systems. While most countries are not well prepared to provide quality care services for people with dementia, [10] it has been reported that the Republic of Korea (South Korea) has made dementia a health priority and adopted an integrated dementia strategy. [11] Similarly, the Ministry of Health in Singapore has established a dementia care blueprint to coordinate services, training and research and facilitate early identification and diagnosis. [11]

The Australian approach: dementia – a national health priority

Alzheimer's Australia is a federation of state and territory Alzheimer's associations with delegates from each member on the Board of Directors. It was formed in 1989 and represents, at the national level, the interests of its members on all matters related to dementia and carer issues. Since 2001, Alzheimer's Australia has advocated strongly for a national policy on dementia and has commissioned a number of landmark reports highlighting the critical importance of research and planning for dementia care in the coming decades. [6,12,13]

In the 2005 budget, the Australian Government made dementia a National Health Priority. This initiative provided additional funding for research, support for the primary health sector, improved care initiatives and early intervention programs, increased dementia awareness and prevention promotion, and dementia-specific training for aged care and community workers. [14] In addition, the federal, state and territory Health Ministers agreed to the development of a National Framework for Action on Dementia to address the complex service system providing care and support to people with dementia and their carers and the inherent risks of service gaps and duplication. [15] The Framework aims to provide a structure that brings together the Australian, state and territory jurisdictions to provide clear and agreed objectives as well as priorities

for action in relation to dementia care and support. The five priority areas (care and support, access and equity, information and education, research, workforce and training) are fundamental to improving the quality of life of people with dementia, their families and carers and have been identified as having the potential to yield the greatest benefits from a national approach.

The National Dementia Support Program

The NDSP is a federal government funded program delivered by Alzheimer's Australia aimed at meeting the support needs of people with dementia and their carers across Australia. It integrates various dementia support programs previously funded by the Australian Government, including the Dementia Education and Support Program, Early Stage Dementia Support and Respite Project, Carer Education and Workforce Training and the National Dementia and Behaviour Advisory Service. An initial total of A$12.6 million was provided to fund the program for an 18 month period from 1 July 2005 to 31 December 2006. In June 2006, the program was funded for a further three years. It has the following aims:

- To increase the capacity of people with dementia to remain in their homes for as long as they wish and it is appropriate for them to do so, therefore delaying entry to residential care;
- To provide easy access to information on dementia about prevention, early intervention, diagnosis, support and other services for people with dementia;
- To improve information and the support services for people with memory concerns, people with dementia, their carers and families, and the broader community;
- To improve the quality of life for people with dementia and their carers;
- To reduce the risk of carer burnout; and
- To improve the quality of care for people with dementia and provide innovative care options to support people with dementia and their carers.

The NDSP comprises seven sub-programs as described in Table 1. Each state based Alzheimer's Australia organisation is an independent body with different models of operation and management and so there are some differences in how sub-programs are delivered, although all are intended to achieve the same overall aims.

Table 1: NDSP Sub-Programs, description and target groups

SUB-PROGRAM	DESCRIPTION	TARGET GROUP
Helpline and Referral	Accessible telephone based first point of contact to information, advice, and counselling and referral services.	For people with memory concerns, those living with dementia and their carers, and service providers.
Dementia and Memory Community Centres	Accessible, visible community contact point to access information, support and education about dementia and memory loss, risk reduction strategies and referral to related support services.	People with specific memory concerns, people at risk of developing memory concerns, people with dementia; carers, family members and supporters of people with dementia or memory concerns; and the broader community.
Early Intervention Program	Provides targeted support via structured education and support groups; includes provision of emotional and social support, information and advice, education related to stress management techniques, communication skills, and other practical strategies to cope with difficult behaviour.	People with early stage dementia and their carers (family members or friends).
Non-Clinical Advice, Counselling and Professional Support	Provides accessible dementia advice, counselling and referral support.	People with dementia and their carers (family or paid).
Education and Training	Provides training and education including accredited training, non-accredited short courses plus community education.	Aged care workers and family carers of people with dementia.
Awareness Raising and Information	Public awareness raising activities, and dissemination and promotion of dementia information.	Broader community.
Special Needs Support	Includes National Cross-Cultural Dementia Network, Aboriginal and Torres Strait Islander Dementia Network, National Resources Project, Rural and Remote Needs Project, Younger Onset Dementia Project.	Rural and remote populations, Aboriginal and Torres Strait Islanders, Culturally and Linguistically Diverse groups, people with younger onset dementia.

Source: Adapted from Grenade L, Williams P, Horner B, Carey M. Evaluation of the National Dementia Support Program (NDSP). Perth: Centre for Research on Ageing, Curtin University; 2007.

A primary intention of the NDSP has been to consolidate existing initiatives and to build on their successes by developing new services. The most significant changes associated with the program's implementation include:

- Dementia and Memory Community Centres – a new initiative in which funding was allocated to establish at least one Centre in each state/territory to provide access to on-line memory testing and individual cognitive exercise programs; on-line communication forums; counselling, support and referral services; education services; and general health and risk reduction information. Other features include structured, time limited activity programs, on-site libraries, and outreach services (eg mobile 'Memory Vans').
- Education and Training – expansion of the original program to include short-term non-accredited training for care staff, and community education sessions for the broader community.
- Early Intervention Support Program – increased flexibility in the way services can be delivered in order to meet the needs of a more diverse range of target groups (eg people from CALD backgrounds and people living in rural communities).
- Funding for special projects related to special needs groups.

All states are required to report against specific outputs in regard to each sub-program as defined in the contract with the federal government. A national activity based on-line data collection system was introduced in 2006 to facilitate this process. The system is used by each state to collect data for reporting purposes and to manage its clients, whilst allowing for flexibility of procedure and practices. Additional activity reporting and financial reporting that is not linked to this system is also required.

Evaluation of the NDSP

A number of studies have demonstrated the benefits of support programs for people with dementia and their carers, [16,17] including the Early Stage Dementia Support and Respite Project [18] which is incorporated within the NDSP as the Early Intervention Program. The NDSP evaluation was limited to addressing a number of specific components that reflected new initiatives, or where programs had been expanded or provided with increased flexibility in service delivery. The evaluation was also required to assess the program as a whole, in terms of 'appropriateness', 'effectiveness' and 'efficiency'. Information for the evaluation was sourced from available documents, data management systems, staff and client interviews across all states and territories, questionnaires and focus groups. This was primarily qualitative in nature. The evaluation was conducted over ten months during 2006. [1]

Findings

This section discusses the main themes that emerged from the findings. One of the major strengths of the NDSP was the integration of a number of different support programs within one comprehensive system of funding. Alzheimer's organisation staff identified a number of benefits resulting from this approach. In regard to clients, it enabled the provision of an outwardly 'seamless service' that created opportunities for movement through programs as the needs of the individual changed. The organisation was able to recognise the changing needs of the individual and to direct that person to alternate services as appropriate. Having a combined program was perceived as providing the client with a number of choices regarding how they might access the organisation, depending on their need at the time. For example, people with memory concerns who might otherwise be reluctant to contact a specialised dementia organisation could attend a non-threatening service such as a risk reduction program and then access other support and referral services.

Having a nationally funded and coordinated program was also regarded as maintaining national standards and consistency of services, thereby presenting a coordinated portfolio of information and services to the community. Staff reported that it promoted a sense of confidence in the quality of the products and services being provided. The consolidation of funding enabled some increased flexibility to use the funds differently within sub-programs. Individual states could choose to offer more of a particular program at a central location, thus decreasing total costs so that the financial efficiencies could be used to offer a more tailored service, such as an intensive residential Early Intervention Program for regional clients. This enabled services to be provided to a broader range of clients, such as people with younger onset dementia and people living in rural or regional areas. The extent to which this happened varied between states.

The evaluation also indicated that the information provided through specific sub-programs was particularly relevant to the needs of users. Carers and people with dementia who attended an Early Intervention Program commented that information about practical coping strategies, legal and medical issues, and available services and supports was most valuable. Community and residential staff who

attended various education sessions reported that practical techniques for dealing with difficult behaviours, learning how to communicate better, how to apply a problem-solving approach and awareness about 'why different people behave differently', were particularly relevant.

People with dementia and carers reported a number of benefits related to their contact with the sub-programs of the NDSP. Many family carers reported that their interaction with these programs had improved their capacity to care for the person with dementia for longer and at home. Many people emphasised the benefits of having the opportunity to be with others in similar situations and share their experiences and concerns in a 'non-judgemental' environment. Having 'fun' together and socialising was identified by many clients and carers as critical to their sense of wellbeing and overall capacity to cope.

A number of issues related to the program were also identified. Despite the benefits of a national program as described, it also appeared to have placed additional pressure on many staff. Frequently, already stretched staff now worked across a number of sub-programs and/or had acquired responsibilities in addition to those previously held.

Areas of overlap across some sub-programs also created concerns. For example, counselling may also be provided through the Helpline, Dementia and Memory Community Centres, and specific counselling services. Since all the counselling services essentially have the same aims, the distinctions between them appeared artificial and unnecessary, creating difficulties for activity/output and financial reporting. In addition to reporting difficulties related to program overlap, staff often stated that reporting requirements were becoming increasingly onerous partly due to NDSP requirements but compounded by reporting to multiple funding sources. This was creating considerable administrative demands that had the potential to impact on the delivery of services.

Staff identified an increasing need for information from the general public ('worried well' or curious), people who knew someone with dementia, health professionals, service providers and community groups. The capacity to meet increasing expectations from these groups, as well as the increasing support needs and demands of people with a diagnosis of dementia and their carers, was a significant concern across all NDSP programs.

The evaluation revealed a significant unmet need amongst Indigenous and CALD populations. This is generally influenced by population spread and demographics, staff and service networks and finite capacity. The evaluation was specifically focused on CALD populations and found that those states with staff with designated responsibilities in this area appeared to have been more strategic in their approach and reported a wider range of strategies.

While the Early Intervention Program was highlighted by users as appropriate to their needs at the time, the evaluation identified an unmet need for programs for people with 'middle stage' dementia and their carers. A growing demand for more varied methods of delivery (retreats, intensive, evenings, etc) as well as less structured formats to meet the needs of specific groups (eg Indigenous, some CALD populations) and new populations (eg people with younger onset dementia and singles), was also identified.

Discussion

The evaluation provided evidence that the NDSP is meeting its aims. Information provided through various sub-programs was relevant to the needs of all groups. People with dementia and family carers reported that access to programs and the associated contact with other people in similar situations improved their sense of wellbeing and capacity to cope. Family carers reported that various sub-programs improved their capacity to care for the person with dementia for longer and at home. Community and residential staff reported that education and training courses improved their ability to care for their clients.

The implementation of the NDSP has enabled the Alzheimer's organisations to provide a more 'seamless service' with national standards and consistency whilst also providing a more flexible structure that enables a more diverse client need to be addressed. In addition, the program has broadened the reach of the organisation to the wider community by providing programs and services that are more acceptable and accessible.

All states identified efficiency in the national framework of the NDSP as it brought together programs which were integrated by their nature into a single funding model, provided a more straightforward partnership arrangement with the federal government and allowed for more integrated planning of services. However, the overlap of sub-programs and consequent issues related to definitions, data collection and reporting are significant. This is likely to be at least partially addressed through the new NDSP contract between Alzheimer's Australia and the federal government which allows for further integration of some sub-programs. Any further flexibility in terms of how organisations can

use the funding within the program is likely to lead to the development of new and innovative services that respond to the varied needs of the client at a particular time. In relation to data collection and reporting, several staff suggested a need to review the reporting requirements. The evaluation recommended the development of a National Minimum Data Set with agreed minimum reporting requirements that meet the needs of all stakeholders. [1]

In addition to the pressures of meeting the virtually infinite need for information, education and training, some NDSP programs themselves appear to be increasing the demand for information, education and support, or at least have the potential to do so. Similarly, information provision, either informal or structured within education courses, has the potential to lead to a need for counselling. Staff were very aware of the need to balance rising expectations of service against the level of available funding. The evaluation concluded that the NDSP was in general appropriate, effective and efficient. Sub-program contents were considered appropriate and relevant to the needs of the clients who accessed them.

Conclusion

This paper discusses the strategic approach to dementia taken by the Australian Government and the delivery of a coordinated national dementia support program developed and delivered by Alzheimer's Australia. Australia is the only country in the world with a national policy, a national framework for action plus nationally delivered consistent programs. This model aims to create a strategic, collaborative and cost-effective response to dementia across the country. The Australian NDSP provides a national, comprehensive program of funding that facilitates common standards, offers an outwardly 'seamless service' to the community and allows for additional flexibility of delivery within individual states.

Alzheimer's associations are the lead organisations for planning and delivering programs to meet the needs of people with dementia and their carers. In Australia, Alzheimer's Australia advocated strongly for a national policy on dementia, commissioned quality research relating to the critical need to address dementia and its consequences and, through its consumer-led focus, facilitated the development of programs such as the NDSP.

Making dementia a National Health Priority has raised the profile of dementia as a chronic illness within the community. It has increased the demand for all Alzheimer's association services even further as growing public awareness of dementia results in greater need for information and services. All Alzheimer's Australia associations have reported an increase in requests for expertise from a range of organisations in applying for funds for services and/or research and an increased involvement in community, provider and government lobbying and public relations. This has led to greater administrative demand and a changing role resulting in the need for operational core funding separate to services funding. As operational funding is limited, this may impact on program delivery in the future.

The shift to providing some risk reduction/prevention programs appears to have tapped into a new and potentially large market. The acceptance of this health promotion role by the Alzheimer associations may affect the capacity of the services to meet the needs of current and new clients with a diagnosis of dementia who need support.

Although there are important and significant differences in the way health sectors are organised and financed in different countries, it is essential to continue to learn from one another and to contribute to the exchange of ideas in regard to dementia care, particularly given the pace of change. The commitment to a national strategy, an action-based framework and the development of programs like the NDSP makes Australia unique in terms of its efforts to prevent dementia and to respond to the needs of people with dementia and their families.

Competing Interests

The authors declare that they have no competing interests.

Acknowledgements

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The approach to the organisation and management of healthcare for rural dwellers varies within countries and across countries. What single initiative is most needed to begin to redress continued deficiencies in access to healthcare and poorer health outcomes for rural and remote communities?

In each issue of the Asia Pacific Journal of Health Management we ask experienced health managers throughout the Asia Pacific Region to reflect on an aspect of health management practice. In this issue of the Journal, our selected participants address the question above.

1 Suggesting a single fix for rural and remote health is as knotty as asking which of my three daughters I love the most. The health of the 30% of Australians who live in rural and remote areas is clearly not as good as their urban cousins, and the initiatives required are as varied as the reasons – poor access to healthcare, dangerous occupations, rancorous inter government relations and cost shifting, shameful Aboriginal and Islander health status, workforce shortages, poor service co-ordination, lack of transport, risky lifestyle choices, poverty, isolation and limited education, are some of these.

The media are fond of headlines that imply solutions relate solely to workforce – if we could hire another 1,000 doctors, or stem the number of doctors or nurses retiring, or wait till the surge of new graduates arrives in the bush, or pinch several thousand more overseas trained specialists, we would have a solution. It is true that workforce shortages are often the first constraint on service development in rural areas, and whilst we need to look further at a skilled and responsive workforce, we also need to grapple with key underlying causes such as the supply and demand for healthcare – which is a national issue not just rural-centric.

We need to moderate the increasing demand for healthcare and change the way in which it is supplied. Australia spends less than 2% of the health dollar on illness prevention and health promotion. The current reform agenda seems to prioritise elimination of waiting lists, developing more acute services and whizz bang technology that will actually increase workforce problems, rather than investing in illness prevention and health promotion as part of what needs to be done to solve the health workforce shortages of the future. We need to recognise that investment in self care, such as chronic disease self-management, is also part of the future workforce solution.

At a supply level, we need to look at workforce redesign. Professional reform in the health sector - reducing the barriers between professions, national registration, increasing flexibility, working together better in teams, eliminating demarcation disputes – would build a workforce capacity to provide all rural and remote Australians with access to high quality care.

For rural services, where funders frequently provide resources for a position one or two days a week (contributing to structural poverty and rural economic stagnation), consideration needs to be given for full time generic healthcare workers that can be trained to work across specialties, funding streams and even across sectors.

These are difficult political challenges when most Australians see a local hospital and local medical practitioners as the panacea to their healthcare problems, and health professionals continue to guard their particular patches with zeal.

Mr John Lawrence GradDipBus (Mgmt), DipArts (Aboriginal Studies)
Executive Director
Kilmany UnitingCare, Victoria, Australia
Past Chairperson
National Rural Health Alliance

2 When rural/remote and urban health services are compared within any country, the economies of scale needed combines in varying degrees with poor access to clean water, food and transport to alienate rural and remote dwellers from healthcare resources. There may also be many cultural and religious barriers to seeking help outside tribal, cultural, geographical or religious boundaries.

Irrespective of country, rural and remote communities have common problems in accessing healthcare with health outcomes poorer than those living in urban communities. That is not to say that every urban community has good health outcomes, but that those in rural and remote will be relatively poorer.

Communities in which disease is rife, and clean water and good food are not accessible, focus purely on survival, spending all their energy looking for food and water. Maslow's Hierarchy of Needs clearly demonstrates that only when food and clean water is available will people be able to make choices about other needs such as accepting health interventions.

Once the need for clean water has been met, the health of the community begins to improve considerably. For instance, the well-known swimming pool study in Western Australia's remote Aboriginal communities considerably reduced skin and ear infections in children, increased school attendance, decreased juvenile crime and provided healthy social interactions for the whole community.

A woman in a third world country speaking on the benefits of the construction of a well in the village, is relieved that her children no longer have to walk hours each day to get water while she forages for food. She can now grow some food, keep her children clean and free from waterborne disease and send them to school.

Once basic needs have been met, primary healthcare services may be accepted if they are provided in a culturally-sensitive environment with elders or respected members of the remote community.

Even in Australian small communities, a change in the local doctor will often see a miraculous reduction in people requiring healthcare until the new doctor has established a rapport with the 'right' community members.

Public transport between rural/remote communities and regional centres even in western society can be non-existent or daunting for those unused to travel. In many countries war, terrain, weather extremes and modes of travel can make travelling to healthcare services extremely dangerous.

Initiatives that supply healthcare services within the community are usually led by volunteer, charitable and religious organisations. However it will take a strong commitment by governments to develop well-funded public health services which have a presence in remote and rural communities and are part of those communities, if better health outcomes through improved access are to be achieved.

In Australian communities, encouragement of Aboriginal health workers has made primary healthcare services more accessible, but does not address the acute care needs of remote populations.

A very recent initiative has seen Aboriginal children from remote communities bought together for Ear Nose and Throat surgery. However, unless the conditions which have caused so many children to require surgery are somehow improved, as per the swimming pool study or development of clean water and food sources, then one would not expect long-term improvement in health outcomes.

Low socio-economic status, political and cultural issues are known to be associated with poor health outcomes and concentrated in rural areas. Although the tyranny of distance can be overcome by taking services to remote communities and the use of new technologies, any improvement in health outcomes other than those achieved through access to clean water and nutrition is inevitably going to be a slow process.

Ms Marion Holden BNS, MHA, FCHSE, CHE
Chief Executive Officer/Director of Nursing
Whyalla Aged Care Inc, South Australia

3 In order to begin to address the poorer health outcomes for rural and remote communities, health systems worldwide must resolve increasing and widespread workforce shortages. In Australia, sustainability of health service delivery particularly to inland and remote communities is increasingly under pressure through an acute shortage of staff. Workforce shortages exist across most disciplines and are exacerbated by the competition for skilled health workers within Australia and globally.

By international standards, the quality and availability of health services is extremely high in Australia. However, rural communities suffer poorer health outcomes and this is even more evident in the disparity suffered by Aboriginal people compared with other Australians. The reports into Aboriginal health conducted across Australia all point to poverty, marginalisation, isolation and alienation at

many levels causing family breakdown and dysfunction in communities with the loss of cultural identity and meaning in people's lives.

The known and most prevalent health risks include: housing and associated environmental health factors, education levels, poverty, gambling, unemployment, hygiene, nutrition, alcohol and drug consumption.

While health professionals are clearly able to confirm that the removal of current risk factors will result in improved health of the community, it is equally clear that traditional approaches by health services alone will not address the underlying causes and reasons for the existence of these health risks at their present level.

The response must address the underlying health risk factors and to do that, a cross-government, cross-agency approach is needed, in partnership with Aboriginal people.

The solution is clearly much more complex and is imbedded in the social and economic conditions experienced by Aboriginal people. Alleviating these underlying issues is central to addressing the related health risks. A focus on healing within the community and a genuine partnering of health services and communities is essential.

To make the best use of resources, all health service providers must work in partnership and with a coordinated approach, rather than in isolation or competition.

Mr Kim Snowball BCom, CPA
Chief Executive Officer
WA Country Health Service, Western Australia

4 The most important overall principle is to align all the forces towards the same objective of meeting the healthcare needs of that community and the larger system it is in. From my experience of working both locally as a hospital chief executive and centrally in the headquarters, I have the following recommendations.

First and foremost, we must understand the system under which funding is granted to the healthcare service and work along that line, collaborating with all parties to provide a win-win solution to all. The reality is such a funding mechanism is consciously or unconsciously hidden from you. I find that in organisations where accreditation by a third party is carried out, such mechanisms are required to be made transparent and known to at least the in-charge and seniors of specialty departments. In Hong Kong, for example, accreditation is not yet practised in public hospitals. However, you will find yourself in better command if you understand what are One-line Vote (OLV), Capital Works Reserve Fund (CWRF), Resource Allocation Exercise (RAE), Equipment Capital Block Vote (CBV), Information Technology Capital Block Vote (CBV), and various other donation funds, as well as the mechanisms behind such decisions. Allocation can be affected by opportunity, rational rationing and irrational politics. Failure should be regarded as a norm and repackaging with better data in the next planning cycle as a necessity.

Secondly, we must have a team who are committed to work for the better health of the local people in that community. The competency and energy level may vary among staff. Selecting the right leadership, meeting weekly initially, then monthly for team building, strategy planning and implementation, making long and short-term operational decisions, as well as learning and refreshing new thoughts and paradigms are all essential. I have seen the ill-effects of leaders using structural reform to drive change which ends up creating fear. I prefer to supply the misaligned staff with better information and the less energetic ones with the options of taking up the right excitement in the right area, which indeed is a necessity for life and good for mental and physical health. This in-house enhancement of team capability should aim at preparing the service for future development and strengthening the relationship between the local team and the parent funding body.

Thirdly, you must formalise the application and come up with a written, evidence-based proposal to re-dress the imbalance. Such a submission should be timed and combined with the understanding that during economic downturn, it has a high chance of failure, but it serves the important function of priming the organisation for need. In our experience, funding will come with the pick-up of the economy. The worst situation would be missing such opportunity because of unpreparedness of the local healthcare organisation in the deprived region or because of a misalignment of objectives with the larger system.

Adaptation of this advice to your own situation is important. Keep going in the right direction, gather more evidence and forces, and use the right means in the right way to meet the coming opportunity.

Dr Man Yung Cheng MBBS(HK), FRCP, FHKAM, FHKCHSE, FCHSE, CHE, FRACMA
Former HCE of HKSAR Tuen Mun Hospital
Chief Manager(Clinical Specialty Co-ordination)
Hong Kong Hospital Authority, Hong Kong
Vice President
Hong Kong College of Health Service Executives

5 The New South Wales Rural Doctors Network (RDN) recruits and retains General Practitioners in rural NSW (Australia). Particularly in the remote north west of this state, an adequate healthcare workforce is critical to provision of rural health services. The most needed initiative in an environment of deepening shortages across all the healthcare professions, is the application of the 'worst first' principle to policies and associated programs at the three levels of government (federal, state, local), linked to locally-based solutions designed by appropriate community groups and backed by the provision or funding of local infrastructure. While traditional models of health and medical care continue to contribute to healthcare provision, some alternative solutions that are showing promise in towns battling shortages include 'walk in-walk out' practice arrangements for health professionals, a patient-centric team approach to integrated primary healthcare, new Medicare item numbers for practice nurses and for care plans for those with chronic illnesses. In the NSW north-west, for example, the circumstances were established where housing, surgery infrastructure, management and practice personnel were provided for doctors by a non-profit agency. Doctors could conduct their own practices in the facilities made available and simply pay a fee to cover the services received. This approach enabled the recruitment and retention of doctors to towns that were remote and normally had great difficulty attracting doctors. Across several towns that adopted this approach, the number of doctors tripled and a much wider range of medical and associated health services became available. Community-based health forums met regularly to solve local problems and represent issues to state and federal agencies when necessary, thereby maintaining momentum on health issues despite the generally high turnover of personnel in such locations.

Dr Estrella Lowe (PhD)
Manager
Rural Medical Services Initiatives
New South Wales Rural Doctors Network

6 The health of the 30% of people who reside outside the metropolitan areas of Australia is worse than those who reside in cities. [1] Residents of rural and remote Australia experience higher death rates and poorer health outcomes as the result of higher levels of socioeconomic disadvantage (lower incomes and lower levels of education), poorer access to health services, higher levels of personal health risk factors such as smoking, and environmental issues associated with road travel and occupation. The higher proportion of Indigenous people living in remote and very remote areas (12% and 45% respectively) compared with metropolitan centres, combined with their poor overall health, is reflected in high rates of death in remote areas. [1]

Governments at State and Commonwealth levels have struggled to redress the health inequities for rural and remote residents of Australia. Following the first National Rural Health Conference in Toowoomba 'A fair go for rural health or a fair go for rural people', [2] a number of initiatives and policy directions have been funded. Programs have been provided to deal with workforce recruitment and retention, more appropriate models of services for rural and remote communities, public health and primary healthcare programs.

The success of such programs is dependant upon the quality of health management and leadership at all levels of service delivery. The role of the manager for a health service in rural and remote Australia has been recognised in that it can influence a whole service and professional team because of the leading role the manager plays in creating an environment for others.

Rural and remote health service managers maintain quality services in a range of mainstream and related services such as hospitals, area health services, Aboriginal community controlled health services, aged care facilities, private practices, multipurpose services, Divisions of General Practice, University Departments of Rural Health and Rural Clinical Schools.

The NRHA (2004) policy paper on 'Supporting health service managers in rural and remote Australia', [3] recognised health service managers as an essential part of the multi disciplinary healthcare team. The paper noted that quality managers are a prerequisite for bringing the best available healthcare to a rural or remote community within finite resources.

One way to improve health outcomes for rural people would be to act upon several of the NRHA (2004) recommendations relating to support of health service managers. The first would be to strengthen and support the health management workforce in rural and remote Australia by recognising that it is a specialised area of practice through a number of management development opportunities.

In order to address the 17-year gap in life expectancy for Aboriginal people there should be opportunities provided for Indigenous people to become health service managers in mainstream and Indigenous healthcare settings.

These include building upon the evaluations of previous Indigenous management development programs and targeting Indigenous health service managers for culturally appropriate support, ongoing professional development and mentoring leading to expanded career opportunities.

Finally in a world of evidence-based practice for rural health service managers, there is a need for evidence to support future planning. Identification of gaps in the rural health service management skills base with a view to future post graduate or competency based programs which target these areas is required. There is also a need to begin to collect workforce data on rural and remote health service managers to support the planning of future rural health service management workforce.

Ms Sue McAlpin PhD Candidate MHSc GradDipHSM TTTC DNFA FCHSE CHE APD
Senior Lecturer and Course Coordinator Nutrition and Dietetics
Charles Sturt University, Wagga Wagga, New South Wales, Australia
Past Chair
National Rural Health Alliance

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7 Access to health care for poor people and remote communities particularly in developing countries is influenced by the dedication of health workers, the geographical settings and acceptance of modern health care by the remote communities which are strongly influenced by their social, economic and culture perspectives.

There will be no single intervention to increase the health status to communities who live in the remote areas without the strong motivation and dedication of health workers. These health workers, to be effective, must be willing to work in remote places, and must be equipped with sufficient knowledge and skills in health as well as monetary incentive and rewards.

The approach from healthcare organisations and their management to those working in poor and remote communities must be to provide up-to-date training. These health workers need health programs related to improving health administration, health financing and medical records in community health centres; better procurement of drugs, vaccines and medical supplies; maintaining medical equipment and supporting equipment in the community health centres in remote areas. Last but not least, is learning how to collaborate with other sectors related to health such as local government, education, public works, and heads of communities.

Dr Roy GA Massie MD, MPH (SPH Boston University US), PhD (IIHD Queen Margaret University Scotland UK)
Health Researcher
Centre for Health Systems and Policy Research and Development
National Institute of Health Research and Development
Ministry of Health
Republic of Indonesia
Jalan Percetakan Negara 23A Jakarta Indonesia 10560

Email: roymassie@yahoo.com

IN PROFILE

Nancye Piercy

In this issue of the Asia Pacific Journal of Health Management, we bring you an interview with Nancye Piercy, who for the past ten years has been Chief Executive Officer (CEO) of the Riverina Division of General Practice and Primary Health. This milestone follows a successful career in the management of public hospitals and health services in New South Wales (NSW), Australia.

Nancye has 50 years of experience in the NSW health system. She has held senior administrative positions in a number of public hospitals progressing to regional health administration and her current role. Nancye was the first female appointed to the positions of accountant and CEO in NSW public hospitals and Assistant Regional Director in NSW Health. Nancye has always been at the forefront of new health initiatives and was instrumental in the establishment of the Rural Clinical School in Wagga Wagga and Coast City Country General Practitioner Registrar Training.

In 1995 Nancye received the Public Service Medal from the Governor General of Australia for outstanding public service to NSW Health and in 2007 was the recipient of the Louis Ariotti Award for Innovation and Excellence in Rural and Remote Health.

Nancye is strongly committed to quality management and the need for organisations to meet industry standards; to this end she has retained her role as an Accreditation Surveyor with the Australian Council on Health Care Standards for some 20 years. Nancye is a current Councillor and Treasurer of the NSW Branch of the College (ACHSE).

Nancye is an active participant at health forums and conferences and has used her wide knowledge and broad experience of the health system to continue to contribute to the development of health services at local, state and national levels.

What made you venture into health management?

I had the choice of accepting a scholarship to teachers college, maths was my forte, or waiting a few months till I was 17 to join the next intake of student nurses at Inverell District Hospital. I chose the latter and took a temporary position in the hospital office, but it wasn't long until I realised I was not cut out to be a nurse. I covered my eyes at the sight of blood and when they cried, I cried.

So my career in hospital management began. In my early years I completed a certificate course in accounting through external studies and later, after marriage and a family, I gained a Diploma in Health Administration through Mitchell College of Advanced Education.

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

I am passionate about the provision of quality health services and still get great satisfaction out of implementing programs and services which contribute to the prevention, treatment and management of illness. Over recent years I have been able to facilitate primary health programs working with general practice in areas such as pre-diabetes, palliative care, cancer, dementia, falls prevention, men's health, youth health, cervical screening and many more. To see such programs established in collaboration with numerous stakeholders is tremendously rewarding.

What is the greatest challenge facing health managers?

The main challenge is to utilise the scarce health dollar to achieve the best outcomes for the individual and the community. Other challenges facing all health professionals

include making the system work, setting goals, determining strategies and achieving outcomes whilst balancing the heavy demands of the job with family, personal and health commitments.

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

One level of government funding for health services across the total primary and acute sectors.

What is your career highlight?

Looking back I think it was 1989 when I was appointed to the highly sought after position of CEO of Wagga Wagga Base Hospital. This was at a time when it was possible to introduce innovative health programs and when staff were encouraged to use their initiative to identify improvements in service and care delivery, which contributed to high staff moral.

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

I was very lucky to have some great mentors during my 50 years in the health industry including my first CEO, Scottish-born George Chalmers, who taught me how to value the health dollar. Later Chris Mooney, Regional Director of Health, really showed me the value of understanding the politics of every situation. When I was Deputy CEO, Horrie Rex not only supported me, but gave me a free hand to implement change throughout the organisation.

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

I am concerned there is no clear career path for those potential leaders currently in the health system. The continual restructuring and centralised decision-making is seeing potential managers and leaders of the future leave the health industry for more stable but maybe not so rewarding careers in other fields. While we need the dedicated health managers to hang in for the long haul, it is worth it?

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

Complete your academic studies and become proficient in financial management. The dollar influences everything we do and I don't think it is going to get anymore plentiful. Be passionate about what you are doing and promote team work. Management cannot work in isolation so listen to the clinicians; they are on the ground seeing it first hand. Establish good relationships with other key stakeholders, it is surprising what they can contribute.

Invitation to submit an article or write to the Editor

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

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

ACHSE is now calling for papers for the seventh issue of the Journal. The deadline for receipt of papers is 1 July 2008.

BOOK REVIEW

Analysing Health Policy – a problem-oriented approach

Reviewed by A Magarry

Bibliographic details:
Barraclough S and Gardner H, editors
Elsevier Australia (2008)
ISBN: 978-0-7295-3843-5

This book is a collection of original research chapters on policy analysis and Australian health policy. The editors, Simon Barraclough and Heather Gardner, are both well known to readers in health policy but it is refreshing to see a whole new range of commentators invited to comment on their respective fields of interest under the guidance of these respected authors.

This book has 287 pages including an index and comprises twenty-two chapters divided into four sections. The first section provides a necessary overview of health policy with a problem-solving approach, as described in the book's title, before moving onto health policy as a process in chapter two. A very thorough and innovative assessment of institutional problems is provided in chapter three by the former Secretary of the Australian Department of Health and Ageing, Andrew Podger. Chapter four centres on population health with reference to expenditure data and analysis and fits nicely into the use of Health Impact Assessment as a tool within policy development, canvassed in chapter five as a possible solution to poor population health outcomes. Section two is devoted to governance of the health system. Chapter six provides a thorough discussion of the various problems that arise from the existing division of federal-state responsibilities for healthcare in Australia. Chapter seven then discusses the public service, its governance and reforms and the effect on the public interest.

The nature of the health workforce problem in Australia is discussed in chapter nine. The chapter acknowledges the complexity that arises from attempting to plan in a multi-professional context but stops short of providing solutions, leaving it to the existing reform agenda to make progress.

Chapter ten discusses the rising use of complementary and alternative medicine and the issue of practitioner regulation. The authors leave room for the reader to examine the issue of efficacy and this is an effective entry into the topics covered throughout section three on values in health policy. Recent and often controversial issues such as access to information, health identifiers, and trust in policy and healthcare providers are discussed in chapters eleven and twelve. The problem of end-of-life care is discussed within the existing legal framework in chapter thirteen. Chapters fourteen and fifteen address the issues of appropriate healthcare and medical error and its management.

Section four provides the reader with a focus on emerging health policy problems; commencing in chapter sixteen with ageing and what lessons may have been learnt from other countries that may have application to the Australian context. Chapter seventeen discusses the Pharmaceutical Benefits Scheme (PBS) allowing the reader to gain a better understanding of the reform issues in the PBS in the context of accessibility and equity in managing costs to the consumer. Chapter eighteen discusses mental health from strategy to investment and future reforms. Chapter nineteen is of interest to anyone who has wondered whether robots could ever be involved in delivering or assisting in healthcare. Chapters twenty, twenty-one and twenty-two all seek to examine the tangential issues of health policy in rehabilitation, food hygiene and Indigenous communicable health.

The editors have attempted to apply to health the approach found in the literature of policy analysis which is the identification and description of policy problems with a view to exploring realistic solutions. Hence this book presents a fresh look at the diversity of challenges facing health policy development in Australia. It is possible to read a chapter in isolation, but, as a whole, the text is comprehensive and educative, worthy of the student of policy or continuing health executives, maintaining a professional interest in the health policy field.

Angela Magarry RN, CGFNS, BHA, MPS, FCHSE, CHE
Director, Policy and Analysis
Universities Australia

Correspondence:
a.magarry@universitiesaustralia.edu.au

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.

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

ABORIGINAL HEALTH SERVICES

Changing Shape: Workforce and the Implementation of Aboriginal Health Policy
Lloyd, Jane E and others
Australian Health Review
Vol 32(1) February 2008 pp 174-185
The development of Aboriginal-led, evidence-based policy is vital to the future of Aboriginal health.

Expenditures on Health for Aboriginal and Torres Strait Islander Peoples 2004-05
Australian Institute of Health and Welfare, February 2008
http://www.aihw.gov.au/publications/index.cfm/title/10546

Success Stories in Indigenous Health: A Showcase of Successful Aboriginal and Torres Strait Islander Health Projects
Australians for Native Title and Reconciliation, 2007
ANTaR's findings show that Indigenous-led health care initiatives often get the best results.
http://www.antar.org.au/images/stories/PDFs/SuccessStories/success_stories_final.pdf

AGED CARE

Development of a Systematic Approach to Assessing Quality within Australian Residential Aged Care Facilities: The Clinical Care Indicators Tool
Courtney, Mary and others
Australian Health Review
Vol 31(4) November 2007 pp 582-591

High-Performing and Low-Performing Nursing Homes: A View from Complexity Science
Forbes-Thompson, Sarah, Leiker, Tona and Bleich, Michael R
Health Care Management Review
Vol 32(4) October-December 2007 pp 341-351

The Role of Understanding Customer Expectations in Aged Care
Leventhal, Leib
International Journal of Health Care Quality Assurance
Vol 21(1) 2008 pp 50-59
More information: LeibLeventhal@bigpond.com

CLINICAL GOVERNANCE

An Overview of Clinical Governance Policies, Practices and Initiatives
Braithwaite, Jeffrey and Travaglia, Joanne F
Australian Health Review
Vol 32(1) February 2008 pp 10-22

EVIDENCE-BASED POLICY

Bridging the Gap: The Role of Monitoring and Evaluation in Evidence-based Policy Making
Adrien, Marie-Helene and others
UNICEF, 2008
This publication tries to bring together the vision and lessons learned from different stakeholders on the strategic role of monitoring and evaluation in evidence-based policy making.
http://www.unicef.org/ceecis/evidence_based_policy_making.pdf

Evidence-informed Health Policy: Using Research to Make Health Systems Healthier
Moynihan, R and others
Norwegian Knowledge Centre for the Health Services, January 2008
The objective was to identify organisations around the world that are in some way successful or innovative in supporting the use of research evidence in the development of clinical practice guidelines, health technology assessments, and health policy, and to describe their experiences.
http://www.kunnskapssenteret.no/filer/Rapport_08_01_EIHP.pdf

HEALTH CARE

Challenges in Australian Policy Processes for Disinvestment from Existing, Ineffective Health Care Practices

Elshaug, Adam G and others

Australia and New Zealand Health Policy

31 October 2007

Many health care interventions were adopted prior to the standard use of assessments of safety, effectiveness and cost-effectiveness. This paper examines key challenges for disinvestment from these interventions and explores potential policy-related avenues to advance a disinvestment agenda.

http://www.anzhealthpolicy.com/content/4/1/2

Globalisation of Healthcare

Schroth, Lynn and Khawaja, Ruthy

Frontiers of Health Services Management

Vol 24(2) Winter 2007 pp 19-30

The mobilisation of health services globally is concurrent with the expectation that healthcare services will be validated through standardisation of quality and safety measurement systems.

Managing Healthcare Services in the Global Marketplace

Fried, Bruce J and Harris, Dean M

Frontiers of Health Services Management

Vol 24(2) Winter 2007 pp 3-18

Leaders need to consider developing a global strategy that includes identifying and addressing global pressures, exploring opportunities and taking practical steps to prepare for an increasingly 'flatter' world. Decisions need to be made in light of financial, legal and ethical considerations.

Review of Government Services Provision 2008

Australian Government Productivity Commission, Part E

January 2008

State and territory spending on healthcare grew by an average of 6.2% annually in the decade to 2005-06, while Commonwealth spending grew by an average of only 4.9%.

http://www.pc.gov.au/gsp/reports/rogs/2008

HEALTH FACILITIES PLANNING AND DESIGN

Analysis of Departmental Area in Contemporary Hospitals: Calculation Methodologies and Design Factors in Major Patient Care Departments. Final Report

Allison, David and Hamilton, D Kirk

January 2008

A study of recent departmental areas in contemporary hospital projects to determine if net-to-gross ratios for the design of major hospital departments had changed significantly during the recent period of rapid change in the field.

http://www.aia.org/SiteObjects/files/Net%20to%20Gross%20final%20report%201-2008F%20public.pdf

Building Differentiation of Hospitals: Layers Approach

Netherlands Board for Healthcare Institutions Report 611, 2008

The "layers approach" is an analysis tool for considering investment decisions in hospitals.

http://www.bouwcollege.nl/Bouwcolege_English/Planning_and_Quality/Cure/073609_building_web.pdf

Centralised and Decentralised Nurse Station Design: An Examination of Caregiver Communication, Work Activities and Technology

Gurascio-Howard, Linda and Malloch, Kathy

HERD Health Environments Research & Design Journal

Vol 1(1) Fall 2007 pp 45-57

Examines a traditional centralised nursing station using a total patient care delivery model and a highly-computerised, decentralised nursing station using a team nursing model.

Engineering Services and Sustainable Development Guidelines

NSW Health, Asset and Contract Services, Technical Series TS11

Updated December 2007

As engineering services account for approximately 35-40% of the capital costs in the construction of health care facilities, NSW Health is seeking to improve the delivery of these services by adopting a more innovative approach to engineering services design.

http://www.healthfacilityguidelines.com.au/hfg_content/guidelines/hfg_ts11_complete(2)_1-168.pdf

Hitting the Target

Nolin, Scott A and McCurley, Tim

Health Facilities Management

Vol 20(11) November 2007 pp 33-36

Ten steps for developing a successful capital construction budget.

The Marriage of Form and Function: Creating a Healing Environment

Litch, Bonnie K

Healthcare Executives

Vol 22(4) 2007 pp 20-22, 24, 26-27

Nursing Unit Design and Communication Patterns: What is "Real" Work?

Becker, Franklin

HERD Health Environments Research & Design Journal

Vol 1(1) Fall 2007 pp 58-62

Little attention has been given to how nursing unit design influences informal communication patterns, on-the-job learning and job stress and satisfaction. Yet the literature consistently cites communication among diverse caregivers as a critical component for improving quality of care.

Standing Tall
Harris, Debra
Health Facilities Management
Vol 21(1) January 2008 pp 21-26
Using design to reduce patient falls in the acute care environment.

HEALTH FUNDING

National Public Health Expenditure Report 2005-06
Australian Institute of Health & Welfare, 2008
http://www.aihw.gov.au/publications/index.cfm/title/10528

Report into the Operation and Future of the Australian Health Care Agreements and the Funding of Public Hospitals
TFG International Pty for Australian Centre for Health Research, March 2008
http://www.achr.com.au/pdfs/AU_ACHR_Report_Mar081.pdf

HEALTH SYSTEMS

Health at a Glance 2007: OECD Indicators
OECD, November 2007
It provides striking evidence of large variations across countries in indicators of health status and health risks, as well as in the inputs and outputs of health systems.
http://www.sourceoecd.org/rpsv/health2007/index.htm

Improved Health System Performance through Better Care Coordination
Hofmarcher, Maria M, Oxley, Howard and Rusticelli, Elena
OECD, December 2007
http://www.olis.oecd.org/olis/2007doc.nsf/ENGDATCORPLOOK/NT00005926/$FILE/JT03237930.PDF

INQUIRIES

National Health and Hospitals Reform Commission
The Commission has been established to develop a long-term health reform plan for a modern Australia
http://www.health.gov.au/internet/main/publishing.nsf/Content/nhrc-1

The Royal North Shore Hospital Inquiry: Final Report
NSW Parliament Joint Select Committee on the Royal North Shore Hospital, December 2007
http://www.parliament.nsw.gov.au/prod/PARLMENT/Committee.nsf/0/2067FBC90D0E6EB4CA2573B700008FBB

NSW Government Response to the Report of the Inquiry
http://www.health.nsw.gov.au/pubs/2008/pdf/rns_inquiry.pdf

Special Commission of Inquiry into Acute Care Services in NSW Public Hospitals (The Garling Inquiry)
http://www.lawlink.nsw.gov.au/lawlink/Special_Projects/ll_splprojects.nsf/pages/acsi_index

LEADERSHIP

A Leader's Framework for Decision Making
Snowden, David J and Boone, Mary E
Harvard Business Review
Vol 85(11) November 2007 pp 69-76
Wise executives tailor their approach to fit the complexity of the circumstances they face.

Racial and Ethnic Disparities: Why Diversity Leadership Matters
Dreachslin, Janice L and Hobby, Fred
Journal of Healthcare Management
Vol 53(1) January/February 2008 pp 8-13

Solve the Succession Crisis by Growing Inside-Outside Leaders
Bower, Joseph L
Harvard Business Review
Vol 85(11) November 2007 pp 91-96

What Every Leaders Needs to Know About Followers
Kellerman, Barbara
Harvard Business Review
Vol 85(12) December 2007 pp 84-91
The distinctions among followers are as important as those among leaders and have critical implications for how managers should manage.

MANAGEMENT

Embracing Commitment and Performance: CEOs and Practices Used to Manage Paradox
Fredberg, T and others
Harvard Business School, 2008
Chief executives of high-performance, high-commitment companies do not frame choices as "either-or" but rather "both-and."
http://www.hbs.edu/research/pdf/08-052.pdf

The First 100 Days: How to Accelerate the Learning Curve for Executives
Fritz, L Rita and Vonderfecht, Dennis
Healthcare Executive
Vol 22(6) November/December 2007 pp 8-12, 14
Bringing new executives into an organisation creates challenges. What is needed is 'a structured onboarding process'.

Nine Qualities of a CEO
Solomon, Shane
World Hospitals and Health Services
Vol 43(3) 2007 pp 27-31

Relationship between Managers and Doctors
Centre for Innovation in Health Management, University of Leeds, 2007
The purpose of the National Inquiry into Management and Medicine was to explore the changing nature of relations between management and medicine, and the possibilities for more effective ways of organising and managing health systems.
http://www.cihm.leeds.ac.uk/themes/managers

MENTORING

Why Mentoring Matters in a Hypercompetitive World
Delong, Thomas J, Gabarro, John J and Lees, Robert J
Harvard Business Review
Vol 86(1) January 2008 pp 115-121
Competition among professional service firms is fierce, not just for business but for talent. A strong mentoring culture can help you attract and retain the best, the brightest and the most reliable.

NURSING

Capacity Management of Nursing Staff as a Vehicle for Organisational Improvement
Elkhuizen, Sylvia G and others
BMC Health Services Research
Vol 7, 30 November 2007
Capacity management systems create insight into required resources like staff and equipment.
http://www.biomedcentral.com/content/pdf/1472-6963-7-196.pdf

Glueing it Together: Nurses, Their Work Environment and Patient Safety. Final Report
Duffield, Christine and others
Centre for Health Services Management, UTS, for NSW Health, July 2007
Managing today's clinical environments requires skilled nurse leaders who understand but can also manage this complexity to ensure a safe work environment for staff and positive outcomes for patients.
http://www.health.nsw.gov.au/pubs/2007/pdf/nwr_report.pdf

PATIENT CARE

Patient Centered Care: What Does it Take?
Shalley, Dale
Commonwealth Fund, October 2007
Despite increasing support for patient-centered care delivery, the model remains vastly underused. This report identifies seven key factors for achieving patient-centered care at the organisation level.
http://www.commonwealthfund.org/publications/publications_show.htm?doc_id=559715

PRACTICE DEVELOPMENT

How Can Frontline Managers Demonstrate Leadership in Enabling Interprofessional Practice
Suter, Esther and others
Healthcare Management Forum
Vol 20(4) Winter 2007 pp 38-43

How to Change Practice: Understand, Identify and Overcome Barriers to Change
National Institute for Health and Clinical Excellence, December 2007
This guide aims to improve patient care by giving practical advice on how to encourage healthcare professionals and managers to change their practice in line with the latest guidance.
http://www.nice.org.uk/media/AF1/73/HowToGuideChangePractice.pdf

PRIVATE HEALTH INSURANCE

Adventures in Health Risk: A History of Health Insurance in Australia
Gale, Andrew P and Watson, David
Institute of Actuaries of Australia, 2007
http://www.actuaries.asn.au/IAA/upload/public/1.f_Conv07_Paper_Gale_Adventures%20in%20Health%20Risk.pdf

Joiners, Leavers, Stayers and Abstainers: Private Health Insurance Choices in Australia
Knox, Stephanie A and others
CHERE, October 2007
http://www.chere.uts.edu.au/pdf/wp2007_8.pdf

QUALITY

Hospital Quality of Care: Does Information Technology Matter? The Relationship between Information Technology Adoption and Quality of Care
Menachemi, Nir and others
Health Care Management Review
Vol 33(1) January-March 2008 pp 51-59
Hospital adoption of IT is related to improved clinical outcomes.

Work-Arounds in Health Care Settings: Literature Review and Research Agenda
Halbesleben, JR and others
Health Care Management Review
Vol 33(1) January-March 2008 pp 2-12
As health care professionals try to balance technological and regulatory demands with the need to provide patient-centred care, in an efficient and cost-effective manner, they may see a need to improvise or work around intended work practices.

READING LISTS

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

- Aged Care Leadership
- Leadership
- Staff Appraisal
- Workforce Planning

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

SAFETY

Independent Investigation of Serious Patient Safety Issues in Mental Health Services: Good Practice Guideline
NHS National Patient Safety Agency, March 2008
It describes the three main stages of the independent investigation process, examining the initial service management review, internal NHS mental health trust investigations and strategic health authority independent investigations.
http://www.npsa.nhs.uk/patientsafety/alerts-and-directives/directives-guidance/mental-health

TEAMS

Eight Ways to Build Collaborative Teams
Gratton, Lynda and Erickson, Tamara J
Harvard Business Review
Vol 85(11) November 2997 pp 101-109
Even the largest and most complex teams can work together effectively if the right conditions are in place.

Teaching and Learning Teamwork: Competency Requirements for Healthcare Managers
Leggat, Sandra G
Journal for Health Administration Education
Vol 24(2) Spring 2007 pp 135-149

WAITING LISTS

Hospital Waiting Lists Explained
Parliament of Australia Library Background Note, March 2008
http://www.aph.gov.au/library/pubs/bn/2007-08/Hospital_waiting_lists.htm

WORKFORCE PLANNING

Options for Expanding the Health Workforce
Brooks, Peter M, Robinson, Lynn and Ellis, Nikki
Australian Health Review
Vol 32(1) February 2008 pp 156-160
The health workforce needs significant expansion to cope with the service demands of an ageing and chronic diseased population.

Team Climate, Intention to Leave and Turnover Among Hospital Employees: Prospective Cohort Study
Kivimaki, Mika and others,
BMC Health Services Research
October 2007
Does team climate, as indicated by clear and shared goals, participation, task orientation and support for innovation, predict intention to leave the job and actual turnover among hospital employees?
http://www.biomedcentral.com/content/pdf/1472-6963-7-170.pdf

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.

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