# Asia Pacific Journal of Health Management

Volume 3 Issue 2 – 2008

*The Journal of the Australian College of Health Service Executives*


**Health Reform**

- **The SHAPE Declaration**
- **The impact on health managers**
- **Designing work environments**

**Improving Practice**

- **Clinical privileging**
- **Integrated healthcare delivery**
- **Excellence framework in patient centred care**
- **Future dialysis service models**

**…and more**

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ASIA PACIFIC JOURNAL OF HEALTH MANAGEMENT



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Email: journal@achse.org.au.
ISSN: 1833-3818 (Print)

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EDITORIAL

# A real opportunity for SHAPE and ACHSE to lead the national debate for health system reform

**G Isouard**

At both the Commonwealth and state level, the agenda for healthcare reform is moving rapidly. The National Health and Hospitals Reform Commission (NHHRC) is currently reviewing the health system to make recommendations for sustainable improvements to the performance of service delivery. [1] Several states have also undertaken inquiries over the past two years in response to major issues identified in the delivery of patient care within the public health system. [2,3]

The need for improvement is evident. Rising health costs, the growing impact of chronic disease, an ageing population and the inefficiencies derived through a disjointed funding and policy mechanism, are just a few of the many challenges ahead. Despite current national health expenditure being in excess of $94 billion, [4] significant issues exist in terms of access and equity, safety and quality, poor health outcomes for Indigenous people and others with special needs, workforce shortages and a lack of focus on the promotion of health and wellbeing.

Despite evidence that health reform strategies rarely realise the targeted efficiencies and improvements, [5,6] the Federal Government has placed quite high expectations in the current NHHRC review in terms of delivering better outcomes and sustainable improvements. [1]

This current debate on how the health system should be reformed is of major interest to the members of the Society for Health Administration Programs in Education (SHAPE). SHAPE's mission is to promote excellence in aged care and health service management education and research in the Asia Pacific region. It provides an academic forum to debate educational issues, encourage innovation and enhance research. Our academics lead the way in the research of health systems structure, policy development and service delivery.

As such, at the recent National SHAPE Symposium, conference delegates determined that SHAPE was ideally positioned to lead the call for informed public debate on health service reform. In particular, the Symposium presentation and research work by David Briggs formed a central focal point to those discussions. [7] The delegates developed a number of guiding principles that would form the framework for what was ultimately termed the 'SHAPE Declaration' of 2008. It defines our position regarding reform in terms of policy focus, systems enhancement, service delivery and governance. The central importance of health service managers and the need for government commitment to their education and development, is included as critical components of successful reform implementation.

David Briggs kindly agreed to consolidate the discussions and findings in the form of a paper (included in this issue). It was determined that the Australian College of Health Service Executives (ACHSE) would be approached to support and partner SHAPE in this venture. This of course received a positive and enthusiastic response from our close partner, the ACHSE.

The current review by the NHHRC has obvious implications for all healthcare professionals and academics within SHAPE and ACHSE. Our combined expertise, leadership skills, qualifications and professional knowledge of the healthcare system provide a great opportunity to contribute to the public debate. In partnership we are strongly positioned to provide sound leadership and advice to Government on the effective organisation and management of health services and health reform.

**Associate Professor Godfrey Isouard**
National President
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In launching the 'SHAPE Declaration' in this issue, I urge all SHAPE and ACHSE members to support and contribute to our call for informed public debate. The immediate intention is to forward copies of the paper to the NHHRC and the Federal Minister for Health and Ageing, and then to arrange meetings with them so as to assist the reform process. Your feedback on the 'SHAPE Declaration' and suggestions on how best to move forward are greatly valued and appreciated.
I look forward to working closely with you in this important initiative.

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# Informed Public Debate Required on the Management and Direction of the Australian Healthcare System

A key role of the Australian College of Health Services Executives (ACHSE) is to facilitate and provide a forum for informed public debate in regard to the management and direction of the Australian healthcare system. ACHSE is well-placed to provide such a forum, with its membership drawn from a vast array of healthcare professions from both clinical and non-clinical disciplines.

The National Health and Hospitals Reform Commission (NHHRC) has been established with an agenda for review and reform of the Australian healthcare system. This presents an ideal opportunity for ACHSE, in conjunction with the Society for Health Administration Programs in Education (SHAPE), to facilitate and lead informed public debate as to how the Australian healthcare system can be organised and be effectively managed in the most optimal manner.

The promotion of education and continuing professional development is enshrined within the ACHSE Mission. It is the considered view of ACHSE that it is essential that there is a commitment from government, health departments and healthcare providers to invest in and value health management education, while supporting the continuing professional development of the health management workforce. Commitment is also required for investment in the nurturing of emerging leaders in health. These commitments are required to enable the Australian healthcare system to be effectively led and managed by well-qualified and experienced health managers.

In supporting the 'SHAPE Declaration' ACHSE calls for a more informed public debate on the contribution health service managers make to the health system; the qualifications and credentialing of health service managers; and the need for significant investment into health management education, leadership and continuing professional development of the health management workforce. The College is committed to partnership with SHAPE in taking action to have the management and leadership of the health system included in the national debate on the long-term health reform plan.

**Robert Grima** FCHSE
***National President***
**Australian College of Health Service Executives**

# IN THIS ISSUE

The photograph on the cover of this issue recognises an important milestone in the history of our health services: the establishment of the Royal Flying Doctor Service in the early 1900s. The choice of photograph is important for a number of reasons. It signifies the continuing importance of the challenge we face in improving health outcomes for Indigenous persons and rural Australians in general. It recognises that in 2008 ACHSE conducted its National Congress in Alice Springs with international colleagues from the United Kingdom, New Zealand, Hong Kong and Saudi Arabia, to name a few participating countries. Importantly it demonstrates to us that Australian health services were developed, not by government but largely by philanthropy and charitable, non-government organisations. It vividly reminds us that more than 75 years ago that same health system demonstrated innovation in healthcare delivery through the convergence of technology; aviation, radio and medicine.

The important lessons described above are reinforced in the Editorial and Special Feature article of this issue. The National President of SHAPE provides a guest editorial in launching the SHAPE Declaration on the Organisation and Management of Health Services and calls for public debate around the direction of future health reform. The Editorial is supported by a statement from Robert Grima, National President of the ACHSE, emphasising the importance of training, education and the continuing professional development of well-qualified and experienced health service managers. The Feature article, written by David Briggs, was developed from the implications of research findings by the author, with subsequent contributions from SHAPE members of Health Management Academic Programs across Australia and New Zealand.

It is encouraging to also receive feedback and opinion through our Letters to the Editor contributions. Christopher Bain raises the issue of hospital occupancy and the impact on the quality and safety of patient care. There is little published research on this issue in Australia's performance management-focussed health system, despite the expression of increased public and professional opinion. In relevant published research in the United Kingdom with comparative OECD data, there is promise that a focus on this area and an examination of alternative models of care might be better than the current focus on, and linkage of, occupancy and hospital waiting times as being important. Further contributions are welcomed.

We publish a number of relevant management practice articles in this issue. Monagle et al describe an initiative in clinical privileging in an Australian context, an important element in clinical governance and patient safety approaches. Jackson and Nicholson describe a framework for successful integrated healthcare delivery. Integration is a much sought after objective of health reform and the authors' descriptive experience, evident in the article, provides innovative ways forward in this area. Aguilera and Walker describe the implementation of a balanced scoreboard approach with the objective of helping managers and clinicians enhance the clinical and corporate governance of their units.

These contributions are followed by a Research article by Liang and Brown that describes the experience and perceptions of a group of senior health executives subject to a period of health reform through restructure in one State health jurisdiction in Australia. The authors describe a highly qualified workforce, the changing roles and circumstances that attracted these managers to the role and the high turnover of senior executives when the emphasis of reform is on restructure and performance management. Oommen et al provide a different perspective of health reform by providing a review of the literature on innovation in workplace design focused on the open plan office environment. They conclude that managers need to have a better understanding of the workplace environment to determine what environment is best suited to workforce productivity and job satisfaction. A further Review article is provided by Bennett et al who suggest new directions and models for renal dialysis to reflect the reality of an ageing population, changing residential accommodation arrangements and patient needs.

In Profile features Joy Vickerstaff. Joy is well known to many College members and reflects on a career in nursing and health management and the factors that made her journey successful and satisfying.

The Q&A responses published in this issue reflect the views of relatively young, emerging healthcare managers about the challenges and directions of our healthcare system. Their contributions display a maturity of experience, education and training and demonstrate great potential that needs to be supported and encouraged to provide for the future leadership of our health services. Finally, Sarah Mott provides a review of the book *Managing Clinical Processes in Health Services*, edited by Sorensen and Iedema, with contributions from a number of colleagues to chapters within. The Journal issue is completed with the valuable Library Bulletin contribution from Sue Brockway that is always well-received by our readership.

# LETTER TO THE EDITOR

***To the Editor,***

There have been a number of calls for improved support for health service research, [1] and recent debate [2] has highlighted 'hospital occupancy' (HO) as an issue affecting patient care and therefore relevant to health service management and research.

The current debate has focused on the premise that reducing HO to a figure of 85% will improve the functioning of hospitals and patient care. However, the question remains, what is the scientific evidence for the figure of 85%? Why is the figure not 80%, 83%, 90% or 93%? It defies logic and clinical reality that it should be near or beyond 100%, yet we have no clear direction on why it should be 85%.

In terms of associations between high occupancy and, for example, the levels of Methicillin Resistant Staphylococcus Aureus (MRSA) infection, [3] the evidence supports an association and a plausible causative effect but bears further examination as to the definitive intermediate mechanisms. In terms of other evidence around ideal HO, the quoted science is the ten-year-old simulation (in-vitro) work by Bagust, [4] and the 2001 paper from the World Health Organization (WHO) Commission on Macroeconomics and Health. [5]

That paper does quote HO statistics from Fiji, Turkey (p 35) and Africa (p 37), but it fails to demonstrate evidence for the link between overcrowding (HO>85%) and adverse effects of whichever type. It is also worth noting that the reason for this economic paper was to examine 'technical efficiency' in health in developing countries – which we are clearly not – although we can always do better in regard to managing and distributing the resources we do have. Importantly also, the author plays down the utility of transferring the findings of the paper.

We all agree that our health system needs more investment. However, given the potential investment differential between running hospitals at say 85% versus 90% HO; and the complex decisions involved in how to trade off access and quality and which facilities, programs or services to target – all in a patient focused priority fashion – we need to do better in terms of understanding the problem. I would argue that it is logical, prudent and 'evidence-based management' to have the best possible information available in order to answer questions like 'what is the optimal occupancy of a hospital?' and indeed then the question 'with which objectives in mind?' Health service and operations research can only assist in this regard.

**Dr Christopher Bain**
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# EDITOR'S RESPONSE

This contribution to the Journal is welcomed and timely and we look forward to receiving further contributions through research articles and letters similar to that provided by Dr Christopher Bain.

A recent contribution to the *Lancet* has also addressed the issue of hospital bed occupancy and MRSA. [1] That article discusses earlier confirmatory evidence from a Department of Health for England report [2] that describes a significant correlation between occupancy and infection rates in a range of hospitals studied. The article contrasts those findings with those of OECD countries, and the Netherlands in particular, who generally have lower occupancy and infection rates. The article points to differences in care delivery between the two countries where, in the Netherlands for example, there is a recognised medical specialty to deliver care to nursing home residents as perhaps, being influential.

This *Lancet* article continues to suggest that in England half the adult emergency admissions are avoidable and challenges the health system to set a target to halve that rate. In Australia there is a national health performance indicator that measures a range (but not necessarily all) of potentially preventable hospitalisations, currently at 9% with little change in the rates over a recent five year period. [3]

There are risks of definition and methodology in cross-country comparisons but the question asked by Bain and the *Lancet* article suggests there may be a lot to be gained in attempting to first focus on the data we have available to us in considering reform and secondly, through a greater understanding of the reasons for the difference in comparative national health systems, become more innovative in implementing and achieving reform. Perhaps funding and an entity that focuses on innovation and improvement ahead of structural reform might assist.

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

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SPECIAL FEATURE

# SHAPE Declaration on the Organisation and Management of Health Services: a call for informed public debate

**D S Briggs**


## Abstract

*Purpose:* This article presents a Declaration by the Society for Health Administration in Education Programs (SHAPE), to promote public debate on the reform of the organisation and management of health services.

*Methodology/Approach:* The Declaration was developed from the SHAPE 2008 Symposium and was primarily based on a research study conducted by the author. The draft Declaration was circulated to SHAPE members who participated in the Symposium and other interested senior health managers and feedback was encouraged. Contributions received were incorporated into the final Declaration.

The research study involved semi-structured interviews of a diverse purposive sample of 19 health service managers across Australia and New Zealand, conducted from 2004 to 2008. The literature review and the implications for policy and practice from the findings of that study were utilised in the preparation of the Declaration.

*Main Findings:* The success of reform internationally, mostly through restructure and the adoption of management techniques, has been questioned in terms of effectiveness, cost and negative impacts on health systems. In Australia there have been constant calls for reform, a number of formal Inquiries into health services and the creation of a National Health and Hospitals Reform Commission (NHHRC).

*Conclusion:* This Declaration proposes a public debate about how health services might best be organised and effectively managed and proposes principles and parameters for reform. Well-qualified and experienced health managers are considered to be of central importance to the effective organisation and management of health services and to the success of future health reform.

*Abbreviations:* NHHRC – National Health and Hospital Reform Commission; SHAPE – Society for Health Administration Programs in Education.


*Key Words:* health reform; health management; health organisations; health policy; education.

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## Preamble

Healthcare systems in most countries have experienced decades of change as governments attempt to respond to forces impacting on health systems. [1-6] This change has invariably resulted in the restructure of health providers into large, centrally controlled health systems. [7, 8] Healthcare is a significant industry in most national economies. In Australia this industry now has an annual expenditure in excess of $86 billion, representing 9% of GDP compared to the United Kingdom at 8.3% and the United States of America at 15.3%. [9]

In terms of the Australian health workforce, 7% or more than 748,000 members of the civilian workforce is employed in health industries, with a growth rate of 14% compared to 10% in the overall civilian workforce in the 2001-2006 period. In that same period the number of workers in health occupations increased by 23% while medical and nursing administrators increased by 69%. This describes the increased presence of clinically qualified health workers in a management role. It also compares with increases of generalist medical practitioners at 8% and professional nursing workers at 12%. [9] Despite difficulties with defining who are health service managers, there were some 26,000 employed in the health and community industries in 2001 with a growth rate of 10.1%, compared to the overall health workforce of 10.6% since the 1996 census. [10]

Generally speaking, Australia's indicators of health are good and compare favourably in international comparisons. [9,11] There are areas of under achievement, notably for groups such as the socio-economically disadvantaged, Aboriginal and Torres Strait Islander peoples and those who live in rural and remote areas. [9] However, there have also been constant calls for health reform [12-16] with a number of recent state-based inquiries [17-21] and at the national level, the establishment of a National Health and Hospitals Reform Commission (NHHRC). [22] The success of reform internationally, mostly through restructure and the adoption of management techniques, has been questioned in terms of effectiveness, cost and negative impacts on health systems. [23-33]

These circumstances have prompted the members of the Society for Health Administration Programs in Education (SHAPE) to call for informed debate on how health services might best be organised and effectively managed. To inform that debate the following principles and parameters have been adopted. [34]

## Principles

1. Public policy should focus on improving health outcomes and not be prescriptive but provide frameworks of responsibility and cooperation at the program delivery level.
2. Reform should focus on the needs of communities and populations and structural arrangements should be determined in the light of that focus.
3. If government and public policy focus on principles and guidance, [35] then providers should be structured to meet the diversity of need and demonstrate good governance and management through proper engagement of structural interests.
4. Effective models of community engagement need to be incorporated into public policy and the governance of health services.
5. Health managers should be appropriately qualified, skilled and adept in managing complex health service organisations.

## Parameters

Successful implementation of reform is more likely to occur within the following parameters of organisational arrangements:

1. Health service structures should reflect the diversity of need and differences in geographic location of populations, culture and healthcare needs.
2. Health services at the service delivery level need to have the capacity to achieve intersectoral collaboration.
3. Governance should take into account how adequate levels of accountability, trust and stewardship can be restored to the health system. [23]
4. Debate about the degree of centralisation and decentralisation should consider the issue of how far those responsible for delivering care should be situated from those who receive care; [23] and that to be effective, managers need to be able to manage out and down to staff and communities and other stakeholders as well as up to central authorities.
5. The relationship between providers and recipients of care requires that health service managers need to be accessible to multi-disciplinary clinical teams and be capable of developing environments, cultures and systems to support the delivery of safe, quality care.

## Transitional reform

This Declaration suggests a transitional approach to reform based on partnerships and joint ventures at the health delivery level, while government provides a policy, funder and effectiveness evaluation role. These approaches would require intra and intersectorial arrangements and incentives for newly funded initiatives while existing provider arrangements transform into those arrangements. This approach requires that well-qualified and competent management is engaged at all levels of reform and healthcare delivery.

## The central importance of qualified and experienced health service managers

This Declaration affirms that if it is appropriate for health professionals who deliver care to be registered, licensed and required to evidence continuing professional development, then the same circumstance should be

applied to those entrusted with the management of those health professionals and the resources consumed by the health system. This suggests minimum standards of health management education, structured health system experience and continuing professional development. Health managers need to be capable in a number of areas.

These include:

1. Being trained and experienced to lead and manage in a range of differing health system and organisational arrangements.
2. Possessing a deep contextual understanding of health systems, public policy, professional cultures and politics.
3. Having competency in organisational sensemaking as negotiators of meaning, active participants, constructors, organisers and persuaders within health systems. [36]
4. Being drawn from a range of backgrounds including those with clinical and non-clinical experience and qualifications who can demonstrate broad contextual health knowledge that demonstrates more than one logic. [37]
5. Understanding how clinical work should be structured and managed and work actively with clinicians and others to deliver coherent, well-managed health services. [38]

## Education and development of health service managers

This approach requires a commitment from government, health departments, providers, colleges and educational institutions to invest in and value education, experiential and work-based training and continuing development of the health management workforce. It will require a collaborative effort on the part of these stakeholders to develop cadres of well-qualified and experienced health managers who should be equipped and restored to a more central role in health system reform. [34]

In adopting this Declaration, SHAPE encourages those stakeholders supportive of this approach to participate in the development of the debate to achieve these objectives.

## Competing Interests

The author declares that he has no competing interests.

## Acknowledgements

The author acknowledges the support, encouragement and contributions of members of SHAPE in the preparation of this article. The author also acknowledges the support and contribution of colleagues and supervisors, Associate Professor, Dr Mary Cruickshank and Dr Penny Paliadelis, University of New England, Australia, to the research study that informs this paper.

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# Clinical Privileging: don't just tell me – show me!

**J Monagle, B Shearer and C Kelly**


## Abstract

*Background:* Clinical privileging in hospitals in Australia has traditionally relied on confirmation of medical registration and specialist qualifications. Appropriate registration and fellowship has been deemed to signify competence across all aspects of a given specialty. Thus, consideration was not necessarily or formally given to individual practitioner training or competence. Furthermore, consideration of organisation needs or 'fit' was often limited.

*Aim:* To develop a framework for individual credentialing and privileging that acknowledges individual training and competence and organisational needs and 'fit'.

*Methods and Discussion:* Southern Health, in Victoria, Australia, nominated a pilot unit (anaesthesia) for the development of individualised credentialing and privileging. Relevant local and international documents, local and national expertise and recently published national guidelines were used to define core and specific areas within the broader discipline. These were matched with the capabilities and needs of each of the campuses within Southern Health. A matrix of competencies (privileges) was developed for application to each individual and sites within the service. This process has been implemented and further refined.

*Conclusion:* Individualised credentialing and privileging processes are possible. Each clinician's strengths and weaknesses can then be managed within the constraints and supports of the environment in which the practitioner works. Furthermore, a lack of organisational fit for an individual can be identified and subsequently rectified or accepted. This process will continue to be developed across the other disciplines within Southern Health.

*Abbreviations:* ALS – Adult Life Support; CH – Casey Hospital; CICC – Cranbourne Integrated Care Centre; DH – Dandenong Hospital; KH – Kingston Hospital; MMCC – Monash Medical Centre Clayton; MMCM – Monash Medical Centre Moorabbin; SH – Southern Health; TOE – Transoesophageal Echocardiography.


*Key words:* credentialing; privileges; clinical competence; organisational fit.

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## Background

Southern Health (SH) is an integrated multi-campus public healthcare provider in outer South East Melbourne, Victoria. It incorporates four acute hospitals, one free standing day surgery facility and one aged care facility. SH provides a fully integrated range of services from community health care to tertiary/quaternary referral services. During 2006-07, SH treated approximately 163,000 patients, performed 36,562 operations and delivered 7395 new Victorians in just under 2000 beds. Each of the acute hospitals has a specified contributory role, determined by clinical and non clinical resources and facilities and by overall organisational requirements.

Historically, SH, like many acute health services, undertook limited credentialing at the time of appointment of senior medical staff. Clinical privileging was automatic and based on assumptions made about the broad scope of college training, the practitioner's indication of special interest or skills and assumed to be associated with the appointed role. Such privileges would extend across all campuses and there was little consideration of the actual skills or competence of the individual in sub-specialty domains, the needs of the organisation (or indeed the interest of the appointee in these needs), or the appropriateness of the environment provided by the organisation.

In 2005, a review of these processes was triggered by an internal realisation of the shortcomings of this traditional system as well as external focus provided by a number of high profile failures of credentialing processes in Australia and elsewhere; along with the publication of the National Guidelines for Credentials and Clinical Privileges by the Australian Commission on Safety and Quality in Healthcare. [1] This report highlighted requirements for credentialing to focus on three important factors:

**Broad qualification-based assumptions:** *The aim is to ensure . . . an acceptable level of knowledge, skills, attitudes and competence consistent with standards established by their registering professional bodies and [that they] are practising safely.*

**Institutional and environmental capabilities:** *. . . will also consider performance and reflect on the constraints and support imposed by the available resources including staff, equipment and physical …*

**Individual training and performance:** *Healthcare professionals will be required to provide evidence of their qualifications including registration and/or equivalent training, experience and current competence in the delivery of professional healthcare services for which clinical privileges are requested.*

In this context, SH considered it mandatory to review and strengthen its credentialing processes. In line with the national guidelines, SH developed a new framework for credentialing senior medical staff. The SH Anaesthetics Department was one of the first craft groups to participate in the pilot. The following is a brief description of that initial experience, as well as later developments led by the Anaesthetics Department.

## Methods and discussion

Implementation of the pilot model in anaesthetics occurred in a stepwise fashion:

### Fellowship training review

The content of the training for fellowship of the Australian and New Zealand College of Anaesthetists (and other pilot groups) was reviewed and an attempt made to identify the knowledge and clinical and practical skills which could reasonably be expected to be attained by all fellows. This was compared with similar skills lists developed for anaesthetists elsewhere including the United States [2] and Europe. [3] A number of procedures or skills were complex, performed infrequently and/or had clearly defined post-diploma training pathways or competency assessment pathways.

Utilising the above information, a decision-making process was established to determine what aspects of anaesthesia were thus classified as core or additional. Core referred to those functions all anaesthetists in all settings were considered capable of by virtue of their basic post-graduate qualification (such as conduct of general anaesthesia in adults, or performance of central venous catheter insertion). Additional referred to functions that all anaesthetists were likely to have been exposed to in their training, but may not have received sufficient in-training exposure or subsequent ongoing expertise to have developed or maintained a high degree of competence (eg neonatal anaesthesia or pulmonary artery catheter insertion). Initial additional functions only isolated paediatric and cardiac surgery. Subsequent feedback from the anaesthetists within SH identified a number of other areas where the additional criteria applied. A review and discussion of a wide range of anaesthesia procedures was then performed. This process was undertaken by the Heads of Units of Department of Anaesthesia and Perioperative Medicine, and their clinical leader, the Medical Director of the Critical Care Program (also an anaesthetist).

### Delineation of the roles of the various campuses of SH

Unlike a number of other Australian states, Victoria does not have a state role delineation framework. We therefore found it necessary to review the capabilities and requirements at each site to define what services each campus both required and was capable of supporting. This was necessary to avoid potential 'wild cat' service development by appropriately credentialed individuals in an inappropriate setting.

### Development of the credentialing matrix

Based on the information identified above, a matrix of functions which could be undertaken on each acute site was developed. Functions marked as core were areas that all anaesthetists working within SH had to be competent with, to allow for the conduct of the organisation's business and is described in Table 1. There was a clear and agreed basis on which approval for additional functions could be given to each individual anaesthetist. This process involved a review of the following steps for each additional function for each anaesthetist:

- Specific documented post fellowship training at an appropriate organisation;
- Letter of support confirming above from a recognised appropriate organisation; and
- Documented experience and a letter of support from Director of Anaesthesia or another sub specialty practitioner.

Such processes have been considered previously for specific sub-specialty practice. [4] This matrix underwent several reviews before the final version was determined. These reviews involved collaboration between senior anaesthetists and medical managers. Table 1 represents the final matrix.

This matrix was then completed in a four-step process:

1. Each individual anaesthetist utilised the pro forma to request clinical privileges. This was available in online and hardcopy formats. Evidence of relevant training and/or experience was required to support the applications.

**Table 1: Credentialing matrix**

| PROCEDURE | TYPE | SOUTHERN HEALTH NETWORK SITES | | | | | |
|---|---|---|---|---|---|---|---|
| | | MMCC | MMCM | DH | CH | CICC | KC |
| Arterial and central venous cannulation | Core | | | | | | |
| Central neuraxial blockade (spinal, epidural) | Core | | | | | | |
| Chronic pain – diagnosis and management | Additional | | | | | | |
| Conduction anaesthesia (major and minor nerve blocks) | Core | | | | | | |
| Paediatric anaesthesia: down to what age are you comfortable anaesthetising?* | | | | | | | |
| Paediatric anaesthesia: less than 6 months old (including neonatal anaesthesia) | Additional | | | | | | |
| Management of cardiac anaesthesia (including TOE) | Additional | | | | | | |
| Management of general anaesthesia | Core | | | | | | |
| Management of sedation/monitored anaesthetic care | Core | | | | | | |
| Management of single lung anaesthesia | Core | | | | | | |
| Obstetric anaesthesia | Core | | | | | | |
| Ophthalmic anaesthesia including eye blocks | Additional | | | | | | |
| Pulmonary artery catheter insertion and management consultation | Additional | | | | | | |
| Resuscitation (ALS accredited) | Core | | | | | | |
| Neonatal/paediatric resuscitation | Core | | | | | | |
| Transoesophageal Echocardiography (TOE) | Additional | | | | | | |

* This question allows for each anaesthetist to define their personal level of practice, outside of other 'defined' criteria.

**SITES:** MMCC – Monash Medical Centre Clayton; MMCM – Monash Medical Centre Moorabbin; DH – Dandenong Hospital; CH – Casey Hospital; CICC – Cranbourne Integrated Care Centre; KH – Kingston Hospital. All sites are located within the Southern Health (SH) network.

2. The program automatically referred each individual's completed documentation to their Unit Head. The clinical privileges sought were reviewed against documented training, ongoing experience and competence. This is consistent with developing practices in other parts of the world. [5] Where the Unit Head was concerned about an individual's ability to undertake a certain procedure, this was discussed with the individual and an agreement reached about whether to credential the individual for that procedure or not. This was supported with protocolised appeal mechanisms to ensure transparency in the process.
3. Once applications were validated by the Unit Head they were referred to the Medical Director of the Critical Care Clinical Program for a final validation before being entered into the electronic recording system.
4. The Medical Advisory Committee Credentialing sub-committee then acted as a final governance step and reviewed credentialing requests approved by the Medical Director of the program. This was particularly useful where individuals had requested credentialing outside their normal scope of practice or those which crossed craft group boundaries eg, a non-anaesthetic specialist requesting specialist privileges.

## Evolution of the process

Refinement of this process and its application to other clinicians has occurred over a period of two years. Those individual anaesthetists who were first entered into the pilot system are again due for review.

Ongoing use of the system and evolving organisational and clinical needs have resulted in the identification of further core competencies which we will require of anaesthetists employed by SH. Importantly, these are not necessarily competencies which might be necessary in other hospital systems. Rather they are a requirement determined by the unique, multi-faceted clinical needs within our health service.

Although there is significant focus on centralised accrediting organisations or verification organisations, [6,7] these can only go part way to addressing the fit of the practitioner skills to the organisation. Organisations must maintain a significant role in the credentialing and privileging process to ensure that the physician and organisational skill mix and requirements are matched. Maintaining a profile of staff capabilities to match organisational requirements influences many aspects of the work place, including job satisfaction, performance commitment and career success. [8]

Thus, SH has determined that all anaesthetists must be able to manage and demonstrate ongoing competence in the following areas:

- Management of anaesthesia crises (Effective Management of Anaesthesia Crises course or equivalent);
- Advanced airway management;
- Neonatal resuscitation; and
- Paediatric resuscitation.

Evidence of updates in each of these areas will be required for each triennial review of clinical privileges into the future. This is supported through the on site Simulation and Skills Centre which is able to develop and deliver targeted training and education. Training and skill development opportunities enhance organisational performance and individual career development. [8]

## Issues

The biggest issue identified during this process was the increased administrative burden on individuals and the organisation as a whole. Additional administrative resourcing was required to ensure the process succeeded.

Significant stakeholder engagement and input is required to support local determination of hospital role delineation and core skills requirements within a craft group. For the practitioners, complying with each individual organisational plan potentially leads to significant administrative duplication. Development of centralised credentialing (ie, basic qualification verification) procedures would decrease some of the redundancy, helping to meet physician concerns regarding the burden of such processes. [9] This would also allow each organisation to focus on and deal with local issues related to hospital role delineation. That is, focus could then be on matching individual skills with organisational needs and capabilities.

The credentialing and scope of practice program within SH has matured rapidly in those clinical areas where the initial pilots were undertaken. The incorporation of broad-based feedback including that of the participants, the identification of new needs from clinical events as well as organisational needs and the willingness of the anaesthesia leaders to mandate necessary skills and competence, have underpinned this rapid development. Further work will be undertaken in 2008 to improve and evaluate the system.

## Conclusion

Although guidelines may be difficult to either find or develop, and their application to local circumstances can lead to difficulty, individualised privileging processes are possible. Such processes allow assessment of each clinician's strengths and weaknesses, and allow these to be managed within the constraints and supports of the environment in which the practitioner works. This process will continue to be developed across the other disciplines within SH.

## Competing interests

The authors declare that they have no competing interests.

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# Making Integrated Healthcare Delivery Happen – a Framework for Success

**C Jackson and C Nicholson**


## Abstract

*Background:* **Current Australian healthcare reforms call for a smooth integration of care delivered between the acute and community sectors – a major health system weakness to date. The authors have a significant history of successful innovation in this area as lead clinicians in the National Demonstration Hospital Programs 3 (1999-2001) and 4 (2002-2003); National Divisions/Hospital Integration Program (1999); Queensland Service Integration Workshops (2002-2004); Mater Electronic Health Referral Summary (MEHRS); the Brisbane South Centre for Health Service Integration (2003-2005); and Brisbane Inner South E-referral Program (2004-2005).**

*Aim:* **This paper aims to describe a proven model for successful, reproducible health service integration.**

*Method:* **This paper describes the *Service Integration Framework (SIF*) – a methodology developed as the implementation tool for the successful service integration initiatives described above. It has as its core:**

- **a specific service integration change management methodology; and**
- **key foci around clinical practice, training and professional development, information and communication technology (ICT), and appropriate clinical and organisational governance.**

*Main findings:* **The SIF has underpinned a number of sustained and successful large-scale integration initiatives utilising the key framework and strategies described. These are illustrated with two case studies – one involving a strategic service initiative and the other an operational initiative.**

*Conclusion:* **The SIF provides clinicians and healthcare organisations with a proven approach for developing and maintaining sustainable service integration to maximise efficient accessible care delivery in an increasingly complex health environment.**

*Abbreviations:* **BSCHSI – Brisbane South Collaboration for Health Service Integration; GPAC – General Practice Advisory Council; ICT – Information and Communication Technology; MEHRS – Mater Electronic Health Referral Summary; NGOs – Non Government Organisations; SIF – Service Integration Framework.**


*Key words:* **change management; health service integration; governance; clinical model of care.**

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## Introduction

Internationally, health policy is moving to enhance the integration of health service delivery from diverse sources to increase efficiency and support increasingly complex chronic disease and aged care needs. [1,2,3] However 'joined up' service delivery from government, NGOs, private and community sectors has proven challenging, as differing cultures, funding mechanisms, and outcome measures within organisations struggle to accommodate the new reality. Descriptions of successful and sustainable service integration involving multiple health partners are rare in the literature. [4,5] We describe an approach, trialed in large Australian service integration initiatives since 1998, which has allowed both the development and sustainability of

major, inter-organisational integration initiatives involving government, NGOs and private service delivery providers. [6,7,8,9,10,11]

## Method

Using relevant literature and operational experience in this area over the past ten years, we describe the Service Integration Framework (SIF). This model underpins success across a number of challenging service integration programs nationally [6,7,8,9,10,11] and allows organisations approaching healthcare integration to do so with an evidence-based approach, maximising productive outcomes and on-going sustainability.

The SIF dictates that effective service integration requires the inclusion of the following five (5) essential elements to be sustainable long-term:

**A. The foundation:**

1. Effective Change Management.

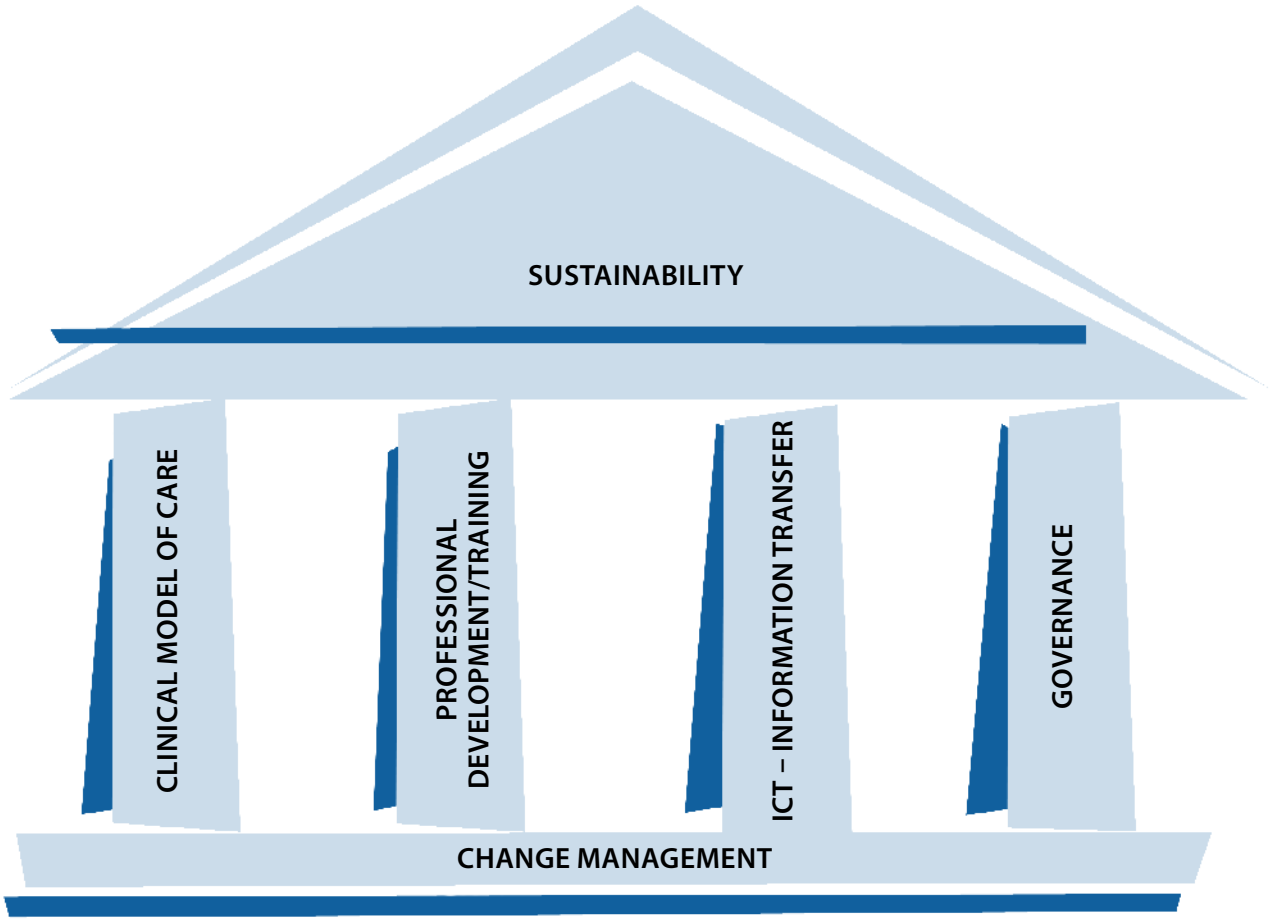
**B. The four pillars:**

2. An integrated Clinical Model of Care;
3. Professional and team development appropriate to the new model;
4. Overarching governance arrangements for the new approach; and
5. An integrated infra-structure, in particular Information and Communication Technology (ICT).

**C. The outcome – sustainability:**

The inter-relationship of these elements is described in the SIF model below (Figure 1).

**Figure 1: Service Integration Framework[1]**




[1]A (Effective change management) + B (integrated clinical model of care + appropriate team professional development + integrated ICT to support the model of care + integrated governance arrangements) = C (A sustainable outcome).

This paper gives an overview of each of these elements and concludes with two very different case studies utilising the SIF in productive and sustained service integration outcomes. The first case study, the Brisbane South Collaboration for Health Service Integration, is a strategic multi-organisational service initiative, and the second, the Queensland Standard Care Pathway for the Management of Diabetes Mellitus in Adults, an operational example of how the SIF has been applied.

## A. The foundation: effective change management

Our change management strategy combines the approach of two proven models, Kotter [12] and Judson. [13] These follow four key change management steps for our purpose; change management to integrate service delivery.

Integrators promoting new models must:

**(i) Firstly, carefully analyse and plan the change;**

- Establishing a sense of urgency by relating common external environmental realities to real and potential crises and opportunities facing organisations.
- Forming a powerful coalition of individuals across organisations who embrace the need for change and who can rally others to support the effort.
- Creating a shared vision to accomplish the desired end-result.

**(ii) Then, effectively communicate the change;**

- Organisations must communicate their vision via numerous communication channels, on multiple occasions and at many levels of the involved organisations both internally and externally.

**(iii) And finally, gain acceptance of new behaviours and change from the status quo to the desired stage by;**

- Empowering others to act on the vision by changing structures, systems and procedures in ways that will facilitate implementation.
- Planning for and creating short-term wins by publicising success, thereby building momentum for continued change.

**(iv) Consolidate and institutionalise the new state;**

- Consolidating improvements and changing other structures, systems, procedures and policies.
- Institutionalising the new approaches by publicising the connection between the change effort and organisational success.

Having established this sound foundation, the next step is to build the four pillars of sustainability.

## B. The four pillars

**1. An agreed effectively-integrated model of care**

Whilst stand-alone pathways and clinical guidelines are now commonplace, only a fraction involve a care continuum between primary/secondary, and community/acute care. Yet we have found such clinical models of care to be both possible and increasing in importance. [14,15] The following principles are essential to the development of such models:

(i) full and frank discussion and engagement between clinicians from all involved organisations regarding the purpose and content of the desired model of care;

(ii) the development of a common and valued shared clinical dataset;

(iii) having a clinician champion in each setting; achievement of a shared agreement on the core approach to care delivery;

(iv) keeping a constant focus on patient-centredness and the achievement of the desired clinical outcomes;

(v) describing clear roles, responsibilities and deliverables for all clinicians involved; and

(vi) ensuring appropriate incentives for clinicians to follow the care continuum.

An appropriate shared record/clinical prompt and patient information sheet regarding the clinical outcomes sought are also highly beneficial, as are computerised decision-support tools (see case study 2).

**2. Professional and team development appropriate to the new model**

An integrated clinical model of care is of no benefit without the multidisciplinary professional development that underpins it. This creates the skill set, context and incentives to promote a new patient team – across care settings and organisations. Key elements include:

(i) recognition that effective uptake and application of the clinical model is as challenging as its creation;

(ii) joint meetings, planning exercises, information exchange sessions regarding the new clinical model with local clinical teams;

(iii) inclusion of integration criteria into job descriptions, key selection criteria, orientation and performance review;

(iv) unstructured as well as structured opportunities to develop as a team (eg BSCHSI's shared cappuccino machine in the case study);

(v) outreach visits and academic detailing of the new model and its implementation; and

(vi) multidisciplinary undergraduate and postgraduate training (multidisciplinary learning) in the new approach.

**3. Overarching governance arrangements for the new approach**

Appropriate and innovative governance models are essential to the success and sustainability of integrated health service initiatives. [16] Jackson, Nicholson et al (2008) [17] used a systematic review and key informant methodology to identify internationally sustainable governance models for an integrated service environment. The three potential governance models, which 'fit' within the required integrated service delivery paradigm for future Australian healthcare include:

(i) the creation of an incorporated body, with governance responsibility shared across integrating organisations, and with pooled resource allocation capability for a given population/region (eg Sunrise Health Service Aboriginal Corporation, Northern Territory);

(ii) an incorporated body established by integrating organisations, with its own funding pool and responsibility for defined areas of common business overlap between organisations (eg Advanced Community Care Association, South Australia); and

(iii) a formal and agreed governance arrangement between organisations to 'share' resources in delivering services across a finite geographical area, (see case study 1 the Brisbane South Collaboration for Health Service Integration). [17]

These models allow organisations working toward better integrated health services to utilise an evidence-based framework which best suits their appetite for risk-sharing and autonomy. [17]

**4. An integrated infra-structure, in particular information and communications technology**

A basic and essential ingredient to support integrated care is effective communication with systems that span provider and organisational boundaries. [16,18] Without it, integrated care can become fragmented, frustrating for the health professional and dangerous for the patient.

Timely, legible and relevant clinical information transfer between acute, primary and community care providers is critical to improving the integration of acute and primary care systems. Clinician leadership and engagement, patient consent and effective change management are critical success factors to achieving this outcome. [7,9] The Mater Electronic Health Referral Summary (MEHRS), [7] operational since 2001, was developed to ensure important patient clinical information was available to each patient's healthcare team on discharge from hospital. The MEHRS provides an example of how critical success factors have been applied to achieve timely and legible transfer of relevant clinical information.

Such communication systems require:

(i) clear strategies and protocols – referral mechanisms providing a team approach based on patient need;

(ii) integrated information management tools that identify key quality and safety datasets that need to be shared: referral forms, discharge summaries, and integrated patient records;

(iii) information security;

(iv) ability to work with the available technology;

(v) utility for busy clinicians;

(vi) regular audit and review; and

(vii) appropriate budget, infrastructure and skill sets across the involved organisations. [7,9]

## Results

**C. Sustainable integration via the Service Integration Framework**

**Case study 1: The Brisbane South Collaboration for Health Service Integration** (BSCHSI), [19] Queensland's General Practitioner/Hospital Integration National Demonstration Site was established in 2003. It was a multi-organisational collaboration involving Brisbane South Community Health Service (Queensland Health); the South East Alliance of General Practice, Brisbane; and Mater Health Services, Brisbane, who agreed to work collaboratively together to facilitate the development of an 'integrated' healthcare culture.

1. *The change management* strategy brought together the executive leaders from the key organisations who committed to working together and creating a sense of urgency to achieve shared outcomes. Clinician leadership and a strong patient focus were pivotal to operationalising key initiatives. Effective communication strategies assisted with building alliances and teamwork resulting in greater feelings of equity, trust, respect and goodwill between organisations and individuals. This resulted in more than 90 people from three organisations 'bedded down' and largely positive about the rewards of co-location after only 12 months. [10]

2. *Integrated clinical care:* the BSCHSI Falls Management and Prevention Project (Falls MAPP) devised and implemented an integrated multi-disciplinary falls prevention and management guideline between community and hospital. [20]
3. The integrated approach to *professional development* resulted in effective and continuing inter-professional learning between seven University of Queensland health disciplines. [8]
4. Establishing improved communication between providers with the use of *information communication technology* has been a key focus. [7] BSCHSI established a pilot e-referral and e-booking system between local general practices and hospital outpatient departments. [9]
5. The BSHCSI demonstrated an integrated governance arrangement [17] underpinned by an ongoing memorandum of understanding between partners.

**Case Study 2: The Management of Diabetes Mellitus in Adults – the Queensland Standard Care Pathway 2000**

This Pathway, auspiced under Queensland's General Practice Advisory Council (GPAC), involved dozens of organisations and professional bodies endorsing a single evidence-based pathway for use in diabetes management by all involved disciplines, in public and private environments, and by Colleges and Guilds across an entire state.

1. *Change management* began 12 months prior to the Pathway's launch. We engaged all professional groups and disciplines involved, sourced evidence and literature reviews with them and independently, listened to and acted on their concerns and priorities. Ongoing and effective communication was a feature of the process.
2. An integrated *Clinical Pathway*, informed by all stakeholders, was developed, involving a difficult, but essential, balance between consensus and evidence. Strong clinician leadership in the process was essential. Drafts of the Pathway were widely circulated and revised prior to endorsement by GPAC in late 1999.
3. *Information Communication Technology* was a key element of displaying and disseminating the Pathway. 10,000 posters were produced and distributed across the state for doctor's consulting room walls, hospital outpatient departments, and treatment stations. A patient pamphlet mirroring the poster was also produced and disseminated. The pathway was also compiled into 'bite size' pieces via HTML format for use in decision-support on clinician's computers.
4. Queensland Health and Divisions of General Practice, Colleges and Guilds ran *professional development* sessions for their members or employees.
5. An integrated *governance arrangement* under GPAC allowed appropriate and equitable access to decision-making regarding pathway development and implementation.

The Pathway is still in use widely across Queensland and is currently under revision.

## Discussion

The healthcare literature contains many examples of promising integration initiatives that have flourished short-term and then disappeared. [21] Our case studies and references attest to the validity and longevity of the SIF approach within the Australian healthcare context. The SIF has been applied in diverse settings with positive and sustained integration outcomes. It is flexible enough to allow application generically, yet focused enough to allow both clinicians and executive to choose from a variety of strategies to accomplish the five key elements. The authors acknowledge that the framework is untested in international settings as yet. However, the strategies have been developed to be generic across funding models, system infra structure and locality and many have been trialed successfully in isolation in non-Australian settings.

## Conclusion

Communities internationally are relying on governments and healthcare organisations to maximise access to increasingly scarce healthcare resources by better integrating local service delivery. [16] Complex service integration between organisations or services with different cultures and funding models is possible, but difficult to sustain without attention to strategies such as those outlined above. The Service Integration Framework provides clinicians and healthcare organisations with a proven approach for developing and maintaining sustainable service integration.

## Competing Interests

The authors declare that they have no competing interests.

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# A New Framework to Ensure Excellence in Patient-Focused Care: the nursing directorate's Balanced Scorecard approach

**J Aguilera and K Walker**


## Abstract

**The Balanced Scorecard (BSC) implemented at St Vincent's Private Hospital (SVPH), Sydney, Australia has the key objective of helping managers and clinicians enhance the clinical and corporate governance of their units individually and the hospital as a whole. It does this by systematically mapping out key strategic objectives, measures, targets, initiatives and accountabilities to aid in the delivery of quality and safe patient-focused care. In effect, the BSC helps managers and staff execute strategy by turning the aforementioned initiatives and accountabilities into action.**

**This paper discusses the methods by which enhanced clinical and corporate governance is achieved, including a systematic approach to the identification of strategies tailored to improve current care delivery marked by achievable and measurable targets. It also presents the results of implementation which include, but are not limited to an increase in: patient satisfaction scores throughout the hospital; percentage of patients pre-admitted; percentage of patients risk assessed; and a decrease in: hospital identified MRSA, falls and medication incidents; patients transferred to rehabilitation; and average length of stay.**

***Abbreviations:*** **ADON – Assistant Director of Nursing; BSC – Balanced Scorecard; DON – Director of Nursing; FTE – Full Time Equivalent; MRSA – Methicillin Resistant Staphylococcus Aureus; NUM – Nursing Unit Manager; SVPH – St Vincent's Private Hospital; VMO – Visiting Medical Officer.**


***Key words:*** **strategy; targets; measures; performance management; patient outcomes; governance; balanced scorecard.**

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### Hospital demographics

St Vincent's Private Hospital (SVPH) Sydney, Australia is a 250 bed not-for-profit acute surgical hospital operated by the Sisters of Charity Health Services, located only ten minutes from the Sydney central business district. It enjoys a well established reputation as one of metropolitan Sydney's leading hospitals catering for a wide range of surgical specialties. It is also known for adopting innovative techniques such as DaVinci Robotics as well as performing high-risk surgery not performed elsewhere. Over 400 visiting medical officers and 500 nursing staff provide care for an ever ageing and more complex population base drawn from the city, across the state of New South Wales and beyond Australia.

### Background and rationale

Clinical and corporate governance is currently one of the top priority agenda items for the healthcare industry. [1,2] Consequently, ensuring the quality, safety and excellence of clinical outcomes for patients is the paramount concern for the executive of the nursing directorate at SVPH. As nursing and patient care is the core business of our hospital, nursing frequently takes the lead in implementing new initiatives

with the aim of keeping SVPH at the forefront of innovation. In this respect, the Director of Nursing (DON) and his team drafted a three-year strategic plan (2005-2008). A key component of this process highlighted the need to develop better systems and processes for governing clinical practice in order to ensure optimal outcomes for patients, doctors and nurses. The framework by which we aim to achieve this goal is a systematic and rigorous approach to clinical governance called the Balanced Scorecard (BSC).

This framework was developed as a new performance model for companies in the USA. [3,4,5,6] The literature points out that conventional financial reporting processes have been somewhat inadequate and based on accounting systems that were originally developed for non-interactive and independent organisations. [5,6] As well, it notes that undue emphasis has been placed on financial over other targets such as patient satisfaction or clinical outcomes. [7,8] The literature also suggests that there is often a disconnection between strategy, vision and operational issues in large organisations. [4,5] The BSC has been promoted as an effective tool for aligning these three signal elements of operational excellence. A significant idea underpinning the development and launch of the BSC was that it drove a fundamental change in the underlying assumptions about performance measurement and the way it should be conducted. [9]

This focus on operational excellence notwithstanding, the BSC is equally important for developing a strategic approach to innovation in contemporary healthcare organisations. With the rapid and continual development of new technologies (human, systems and biomedical), executives are compelled to find ever more productive methods for achieving organisational excellence through innovation in order to stay at the leading edge of their sector. Innovation, as Jonash and Donolon [10] remind us, is inherently difficult to measure and conventional methods for doing so often tend to focus only on one aspect of the business such as the customer or the finances. The BSC takes a different approach in that it measures all four vital parameters of an organisation's role and function. At SVPH, these four key perspectives are:

1. customer (our patients, staff and the Visiting Medical Officers [VMOs] who are the primary providers of the medical/surgical services);
2. internal processes (our operating structures and systems);
3. learning and growth (the way we support and enable our staff to deliver the services we offer); and
4. finances (the so-called fiscal bottom line).

We have aligned these four perspectives with the nursing directorate's three strategic themes embedded in the 2005-2008 strategic plan. These themes comprise:

1. achieving operational excellence in the way we conduct ourselves and our core business: patient care;
2. enhancing quality and safety of patient care; and
3. the cultural transformation of the organisation towards one that is reflective, collaborative, innovative, evidence-based and dynamic.

These strategic themes are, of necessity, complex and not easy to measure or develop targets for. In order to implement these themes, three 'councils' comprised of managers, educators and clinicians have been established to undertake the work involved with relevant strategies. This is where the BSC best defines its utility and effectiveness as a tool. It helps not only executives and managers, but also those closer to the point of service delivery – in nursing's case, the clinical nurses at the bedside – to articulate, implement and then evaluate the quality of their patient care and more significantly, the quality of patient outcomes.

Using the BSC turns what could be a messy and disorganised process into a much tidier and rational one. It compels staff to think through each new idea from concept through to execution and finally to measurement and evaluation. It has been noted that the business of evaluation (the most onerous aspect of any change management or implementation) is the one least effectively conducted or monitored by organisations. [11,12] Not the least of the reasons underpinning this observation is that evaluation requires resources and a commitment to demonstrating effectiveness of various systems and processes. This in turn means holding individuals in the organisation accountable for the execution of the various strategies for which they are responsible. The BSC enables managers at the point of care delivery to access their outcomes data and feed this information back to staff at regular meetings in the clinical areas. In this way everyone becomes involved and responsible for improving quality of care in a way that is meaningful to their local context. It also induces a degree of competition between clinical areas when the results are available to all to see. We are in the process of considering how we might use the data from the BSC to influence the development of and enhance compliance with hospital policy and procedure. This is central to effective clinical governance.

In preparing ourselves for implementation of the BSC we were able to source relatively little literature that is critical of the framework. Most commentary is broadly descriptive and tends to accentuate its positive effects rather than any other and as is exemplified in the literature cited here. However, Wicks notes that while the BSC was originally developed as a tool to better communicate strategy it 'provides little guidance when actual outcomes fall short of desired outcomes'. [13] Furthermore, Wicks also suggests that while the BSC shifts the evaluative emphasis from financial outcomes, it still under-emphasises the employee perspective. Moreover, Wicks argues the BSC is founded on a 'control-based management philosophy' [13] which under-recognises the significance of the skills, knowledge and commitment of staff whose contribution is paramount to ensuring the effectiveness of healthcare.

These caveats acknowledged, the nursing directorate considered the advantages of implementing the BSC far outweighed the disadvantages. The nursing executive will subject the framework to critical analysis at the expiry of the current strategic plan to ensure it continues to meet our needs and to allow for modifications to its operation, should they be required.

## Implementing the new framework

One of the first steps in implementing the BSC was to develop a 'strategy map' to identify:

1. the key objectives to be implemented;
2. the measures by which to track the effectiveness of implementation;
3. the targets to be reached;
4. specific initiatives to be taken with finite time lines; and
5. who amongst the nursing executive is responsible for achieving the desired results.

Once the map was complete the following step-by-step process was rolled out during 2005. In early 2005 the DON introduced the idea of the BSC approach to the nursing executive and in doing so some of the literature discussed in this paper was distributed to the nursing executive. The DON undertook an intensive course with the Balanced Scorecard Collaborative and the nursing executive – the peak governing body for the directorate – produced the first generation BSC as an integral element of developing the strategic plan for 2005-2008.

The second generation BSC was adopted incorporating our strategy map, addressing the three key strategic themes and three key stakeholder groups. Next, two half-day workshops were conducted with all Nursing Unit Managers (NUMs) and Assistant Directors of Nursing (ADONs) to enable each clinical area to develop individual strategy maps relevant to their specific needs and priorities. In order to facilitate uptake and enhance the utility of the framework, the DON and the nursing executive decided to automate the BSC throughout the nursing directorate using especially designed software. At SVPH all managers have computer access as do individual registered nurses. In this respect the organisation is fortunate and it would have been much more difficult to implement the BSC without such a resource.

The DON and a business consultant discussed the adoption of a commercially available software product for the nursing directorate across all the patient care levels. This software is designed to allow data to be entered and accessed by individual users of the BSC thus further ensuring maximum utility. This required four training sessions for the NUMs, Clinical Nurse Educators and ADONs on the use of the software. As well, the business consultant introduced the executive and NUMs to a methodology that allowed an analytical approach to enhance creativity and innovation while dealing with 'fuzzy' problems.

This process took approximately six months and was undertaken only by the nursing directorate. The organisation has adopted a 'watch and wait' approach before considering adopting the BSC framework across other hospital departments. This has not created any major difficulties as the nursing directorate is relatively autonomous and it is the largest department at SVPH. Because the work of the hospital is centrally concerned with clinical care it was argued that nursing should lead the way in this initiative. At the time of writing the remaining departments are in the process of planning for implementation over the next 12 months.

## Outcomes: what has the BSC achieved?

Comparative results following the implementation of the BSC (2005-2007) demonstrate an increase in patient satisfaction scores throughout the hospital (from 88% to 96% in 2006-7); the percentage of patients pre-admitted (43% to 68% in 2007-8); and, the percentage of patients risk assessed (40% to 90% in 2006-7). These very pleasing results were a direct result of the NUMs and their staff being able to track on a month-by-month basis how their targets were being met and if the indicators showed room for improvement then staff took action to address the deficits accordingly.

The results also demonstrated a reduction in hospital identified MRSA (0.045% to 0.033% in 2006-7); falls and medication incidents (0.27% to 0.18% in 2007-8); patients transferred to rehabilitation (84% to 50% in 2006-8) average length of stay (5.2 days to 5 days 2007-8); vacancy rates (10% (50 Full Time Equivalents [FTEs]) to 4% [20 FTEs] n = 500); and turnover rates (19% to 15%); agency utilisation (16% [80 FTEs] to 8% [40 FTEs]) and the labour rate has been contained despite increases in costs per FTE. Similarly, these very good results have been enabled by the BSC because of the way it allows managers to focus on specific targets and measures for which they are now held accountable. These kinds of metrics make visible otherwise intangible processes and outcomes which further improve the likelihood of effective and efficient clinical and corporate governance at the local clinical area.

## What lessons have we learnt since implementation?

In the two years since implementing the BSC we have discovered that it requires sustained commitment from the nursing executive; embedding cultural change of this magnitude is undoubtedly the most onerous aspect of successful implementation. Staff have a tendency to return to previous modes of thinking and behaving even after careful change management. However, we have kept the focus firmly on the BSC by reporting results regularly at staff forums and each individual clinical area meets with the DON to discuss data from the scorecard as a basis for discussing the potential for improvements in care provision. This responsibility falls largely to the NUMs on each of the clinical areas whose performance management is linked to the results they achieve through the BSC.

Effective implementation clearly demands education of and buy-in from managers and staff. This process was a well planned, systematic and timely series of focussed education and staff development activities. It is likely that refresher programs will need to be implemented as staff turnover and attrition affect the organisation's ability to keep abreast of major change processes and as new people come onto the staff they will need to be inducted into the use and value of the BSC.

## What we would do differently

While we have defended the nursing directorate's leadership in implementing the BSC, a hospital of our size would benefit from engaging the whole organisation in the process from the outset. The clinical, corporate and support functions of a healthcare facility are the three main policy platforms around which effective clinical governance is organised (and as enshrined now in the Australian Council of Healthcare Standards EQuIP IV criteria for hospital accreditation). Each of these discrete functional areas overlaps with the others, which provides further evidence of the need for an integrated approach to introducing the BSC.

In summary, the BSC approach has greatly assisted the nursing directorate in deriving its strategy from the mission and values of the Sisters of Charity while it has encouraged a greater focus on the strategy by staff. In doing so this has also enhanced our ability to execute the various strategies each area has developed to improve quality and safety of care (which is commonly the area of greatest failure). We have found the BSC operates as a very effective communication tool by aligning strategy, measures and targets while helping to hold relevant senior staff responsible for implementing their strategic objectives. And finally, it has elevated the profile of the strategic plan to all levels of nursing staff by making strategy something concrete and achievable as opposed to something only managers and directors need worry about. Indeed, we argue that unless there is uptake of and commitment to strategy at all levels of the organisation, the chances of its success as a guiding vision for the future are unlikely, if not impossible, to be realised.

***Postscript:*** The authors are proud to announce that the Balanced Scorecard initiative as described here was the winner of the 2007 Press Ganey Associates (Australia) Success Story competition announced in late August.

## Competing interests

The authors declare that they have no competing interests.

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RESEARCH ARTICLE

# The Twenty-first Century Face of Senior Health Executives

**Z Liang and C Brown**


## Abstract

***Purpose:*** **The public health sector in the State of New South Wales, Australia, commenced a major restructure of the roles of Senior Health Executives (SHEs) in 1989/1990. This study sought to investigate the demography, roles and responsibilities of SHEs within the New South Wales (NSW) Health Department (NSW Health) post-1990.**

***Methods:*** **A postal questionnaire was administered to those employed as SHEs in New South Wales between 1990 and 1999 (accessible population 71, N= 29).**

***Findings:*** **Data from the postal questionnaire found SHEs spent most of their time providing leadership, engaging in planning, liaising with external bodies, and monitoring and evaluating services and performance. A large proportion of SHEs had a tertiary qualification and felt that, in many cases, serendipitous events had contributed to their achieving senior positions.**

***Originality:*** **This is the first study since the restructuring of the New South Wales public health sector in 1989/1990 examining the changing roles of SHEs. The findings of the study provide a foundation for further work with a focus on developing educational programs to enable the performance of roles required of health-care managers in the twenty-first century. This paper builds on previous publications that addressed the literature and qualitative aspects of the study. [1, 2]**

***Abbreviations:*** **ACHSE – Australian College of Health Service Executives; CEO – Chief Executive Officer; NZIHM – New Zealand Institute of Health Management; SES – Senior Executive Service; SHAPE – Society of Health Administration Programs in Education; SHE – Senior Health Executive.**


***Keywords:*** **health administration; restructuring; government employees; educational demands.**

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## Background

It has been argued that the traditional bureaucratic approach to public sector management is not working [3] as public sectors are required to improve performance and demonstrate greater transparency and accountability. [4] As a result, various corporate change strategies and private sector managerial models have been adopted by the public sector aimed at strengthening management capacity in government operations. [5] Healthcare restructuring has been a global phenomenon since the early 1980s as an integral part of public sector reform. [6] One of the most significant changes in healthcare was the adoption of private sector management principles and practices during the 1980s and early 1990s. [7] However, the implications of such strategies on the roles of Senior Health Executives (SHEs) have not been fully explored.

New South Wales, the most populous state in Australia, has pioneered the healthcare structural reforms in that country. In 2003, New South Wales had an estimated population of 6.7million, with approximately 72% of the population living in metropolitan areas, 20% in inner regional areas, and 8% in outer regional and remote areas. [8] The New South Wales public health system (NSW Health) is the largest healthcare employer in Australia, with almost 90,000 full-time equivalent staff.

In New South Wales, structural reform in the health system was marked by the introduction of the area health management model in 1986, [9] which took more than ten years to implement in both metropolitan and rural areas. Under the area health management model, New South Wales has been divided into a number of 'areas'. The term 'area' has been used since 1974 to describe a comprehensive health service that contains a hospital of two hundred and fifty to four hundred and fifty beds, nursing homes and associated community based services, but excludes tertiary referral hospitals. [10] In 1988, many of the area health services were amalgamated, substantially increasing the population in each area up to 640,000, in order to allow for greater re-deployment of resources by having most area boards responsible for several hospitals. The area management model regarded 'area' as the most appropriate level to meet the various criteria for comprehensive high quality service provision, cost efficiency, co-ordination and responsiveness to local communities, [11] and it also pulled together all hospital state-funded services and community health services under the same area structure. [10]

The most important changes that affected senior management in the New South Wales public health system were the introduction of the Senior Executive Service (SES) in 1989 and performance agreements introduced for SHEs in 1990. [2] The SES comprises public service department heads, senior executives of public service departments, heads of public authorities and senior executives and some senior positions in education. There are eight SES levels in total with level eight being the most senior.

The performance agreement for SHEs was the main document that defined the key accountabilities of the position. This was a key part of the performance management cycle that included regular feedback, coaching and review through the year. [12] As stated in the NSW Health Policy Directive, effective performance management could increase motivation, foster productivity, improve communication, and encourage professional and managerial development. [12] For the first time, health plans and budgets were directly linked to the performance of the organisation and its SHEs. The goals, key initiatives and targets for the SHEs for the next financial year were detailed in the agreements.

The reforms, the process of the reforms, and the instability they brought, have not only resulted in changes in SHE practices, but also in the competencies required for SHEs. Moreover, senior SHEs are believed to have carried extra responsibilities in implementing various changes, exercising a higher span of control and accountability, and being responsible for the effective and efficient running of healthcare organisations with high quality and flexibility. [3, 13-15] International studies show that while skills such as decision-making, planning and evaluation were seen as important in the 1980s, and are still ranked as important and relevant, leadership skills, skills in managing and leading change, and financial skills have been consistently more highly valued by senior healthcare managers in the 1990s and early 2000s. [16-19] Studies also suggest that healthcare reforms have resulted in changes to managers' career paths, the convergence of roles, new competencies and demands for higher educational qualifications for SHEs. [2] The number of SHEs in possession of postgraduate qualifications appears higher in studies from the 1990s and early 2000s than from the 1980s. [1] Furthermore, whilst it has been suggested in the past that background influences were seen as key in shaping career paths, [20] it is unclear whether, in the rapidly changing healthcare system of today, this is still the case.

Since the introduction of the SES in the NSW health system in 1989 and the performance agreements for SHEs in 1990, no study has been conducted to examine the possible effects the reforms have had on SHEs. This research follows two major studies of SHEs conducted in Australia in the middle and late 1980s: Rawson's study in 1985; [20] and the study by the Australian College of Health Service Executives (ACHSE), the Society of Health Administration Programs in Education (SHAPE) and the New Zealand Institute of Health Managers (NZIHM) in 1988. [21] This article builds on previously published aspects of a study that examined the experiences of those in SHE positions in the NSW health public system between 1990 and 1999. [1,2]

## Methodology

A questionnaire was distributed, by mail, to those employed as SHEs in the NSW Department of Health and NSW Area Health Services between 1990 and 1999.

**Definition of Senior Health Executives and sampling method**

Although a number of studies on the SHE workforce have been conducted, the definition of what really differentiated levels of managers in the healthcare sectors and which criteria applied to the selection process have not been clearly stated . Very commonly, administrators in health authorities and hospital Chief Executive Officers (CEOs) were selected to represent the SHE Group, such as in studies conducted by SHAPE (1989) and Rawson (1986) in Australia, Dalston and Bishop (1985) and Guo (2003) in the USA, and Kanzanjian and Pagliccia (1993) in Canada. Rawson's study used salary as one of the selection criteria. [20] Using salary as the selection criteria for SHEs was not realistic for this study, given it covered a period of ten years, where the assumption could be made that salaries between the early part and later part of the study period could be very different.

After the introduction of the SES, the NSW Department of Health included the following positions as their SHE:

- Director General, Deputy Director General and Divisional Directors or General Managers from the Department of Health;
- CEOs of area health services;
- Senior staff who reported directly to the CEOs; and
- Hospital managers.

This definition brought the total number of SHE positions in New South Wales between 1990 and 1999 to 1,568. In order to improve the value of the study, data was collected from only those who reported directly to the Minister of Health and the Director General of Health providing a relatively homogenous sample in terms of position. This reduced the target population to 273 in the ten year period and meant that the current study did not include managers with a direct responsibility for management of hospitals.

The majority of targeted individuals stayed in their positions for more than one year, reducing the number of targeted SHEs to 79. After excluding those who were deceased or had only acted in the position for less than a year, the target population for the current study was further reduced to 71. Sixty out of the 71 potential respondents (80%) were contactable. They were either members of ACHSE, Australia or their contact details were publicly available.

**Questionnaire design**

The purpose of the structured survey questionnaire was to gather information on characteristics, employment status and background influences of the targeted SHEs, and to identify the tasks on which the SHEs spent the majority of their working hours. The structured questionnaire was based on the questionnaires developed by Rawson's [20] and Harris et al's [15] studies. The aim was to gain information on:

- Sex;
- Age;
- Family situation;
- Background influences;
- Senior executive level;
- Senior executive position held at the NSW Department of Health;
- Tertiary education;
- Tenure in the senior executive position during the study period; and
- Major tasks undertaken.

In this study, senior executive level was used to identify the level of seniority of the respondents. Likert Scales 1 to 5, representing very dissatisfied to very satisfied, were applied to the forced-choice question regarding participants' satisfaction with different aspects of their work. For the question examining background influences, participants were asked to select the six background influences most relevant to their managerial career from a list of 18. They were also given the opportunity to specify other background influences that were important to them which were not listed.

As no study has been identified examining what SHEs or health managers really do, a new list of 15 key responsibilities/tasks for SHEs was compiled in consultation with two task lists from the Australian Bureau of Statistics, [22] for SHEs, and the NSW Department of Health (2004), [23] for CEOs, both of which covered the period of tenure of the participants in the study.

**Data analysis**

Data were manually entered into a database. Descriptive statistics and chi squares, where appropriate, were produced using SPSS© version 12.

## Results

**Response rate**

In total, 31 out of 60 sent packages were returned, and 29 questionnaires were completed. The sending of reminders only generated one extra response (which was not a completed questionnaire).

This represents a response rate of 41% of the target population (n=71) or 48% of the accessible population (n=60). As postal surveys generally have response rates between 20% and 40%, [24] a response rate of 48% of the accessible population is seen as satisfactory.

**Representativeness of respondents**

Fourteen percent (14%) of the respondents to the questionnaire survey were female (n=4), while 86% of respondents were males (n=25). When comparing the gender distribution of the respondents to the accessible population (83% male), there were no statistically significant differences. CEOs from rural New South Wales appeared relatively under-represented among respondents (38%), but this represented no statistically significant difference to their representation in the accessible population (48%). Thus despite the comparatively low response rate, the sample was representative of the accessible population in terms of gender and location of employment.

**Characteristics of respondents**

Seventy nine percent (79%) of all respondents were no longer employed by the NSW Department of Health (n=23). Seventy nine percent (79%) of all respondents were under the age of 50 when they started their most senior position with NSW Health (n=23) and of these 65% were 35-44 years of age (n=15).

Seventy six percent (76%) of respondents stated that they were married (n=22), and a further 7% were in a de facto relationship (n=2) when they were in their most senior positions. Approximately half of the respondents (52%) had primary responsibility for a child or children of school age or below during their most senior position during the period under investigation (n=15).

All the respondents possessed tertiary qualification(s) ranging from certificate to doctorate. Among them, 31% held a bachelor's degree (n=9), whilst a further 52% had also obtained post-graduate qualifications (n=15). Among the tertiary qualifications, 72% were in administration or a related discipline (n=21) and 28% were in social science (n=8). Furthermore, 14% of respondents (n=4) were actively working toward a qualification whilst in their most senior position.

Nearly half of the respondents (48%, n=14) were classified under or equal to SES level 5. CEOs from rural New South Wales were more likely than Sydney CEOs to be classified at lower SES levels. Ninety one percent of rural CEOs (n=11) were classified as under or equal to SES level 5 whilst 10% (n=3) of CEOs from metropolitan areas were classified as under or equal to SES level 5 (expected numbers of CEOs above SES level 5 were less than five in rural and metropolitan areas precluding calculation of a chi square).

Among all respondents, more than half (55%) stayed in their most senior position for less than or equal to three years (n=16) during the period under investigation. Twenty one percent of all respondents stayed in their most senior positions from three to five years (n=7) whilst 24% stayed more than five years (n=6). The average number of years the respondents had stayed in their positions was 3.1 years (2.8 years for women and 3.2 years for men).

Of the 15 tasks provided to survey participants for selection, two tasks were not selected by any of the respondents. These two tasks were:

- Ensured legislative and statutory compliance within the division or department; and
- Ensured the security and development of assets and resources.

The top four tasks most frequently selected by respondents were:

- Leadership to both staff and stakeholders was chosen by 90% of all respondents (n=26). In full, this was described as 'provided leadership to staff and stakeholders with clear vision and direction, including ensuring clear alignment between various levels of corporate goals, and led the implementation of management strategies'.
- Organisational planning was chosen by 72% of all respondents (n=21). In full, this was described as 'determined organisation objectives, policies and programs and set standards and targets'.
- External relations was chosen by 72% of all respondents (n=21). In full, this was described as 'maintained community and business relations, including consultative processes with the community, other health providers, area health professionals and stakeholders'.
- Monitoring and evaluation was chosen by 48% of all respondents (n=14). In full, this was described as 'appraised the activities of the department, division or area according to strategies and objectives, and monitored and evaluated performance'.

**Background influences**

Respondents were asked to rank the top six background influences in order of importance. The five most important background influences as selected by respondents were:

- Early experience and responsibility;
- Early leadership experience;
- Being in the right place at the right time;
- 'Stretching' by immediate superiors, and
- Formal education in administration at a university.

## Discussion

### Higher educational qualifications

The current study showed a high percentage of respondents with tertiary degrees (83%) ranging from bachelor to doctoral qualifications, of whom 38% reported possessing a master's degree or higher. This confirmed previous findings [25-27] that today's senior health managers possess much higher educational qualifications than those in the 1980s. The fifth background influence selected in the current study confirms the need for SHEs to advance their education.

### Reasons for high turnover among participants

High turn-over and burnout among SHEs was commonly identified in the 1990s literature as a result of the pressure and impact of healthcare reforms. [28] In particular in the United Kingdom the merger of National Health Service Trusts has been found to initiate stress in managers due to increased workloads and general uncertainty. [29] The current study confirmed the issue of high turnover among SHEs, finding an average tenure of three years among the sample. High turnover among the study population was also reflected by the high percentage (79%) having left the NSW Department of Health.

The current study suggests that turnover among SHEs is an important issue to be addressed, especially during the implementation of changes within the system or the organisation. The following strategies can be developed to minimise the severity of turnover:

1. reduce the pace of the reform process to sustain the outcome of changes;
2. provide ongoing professional development programs to SHEs to develop advanced skills in fulfilling the new managerial demands; and
3. provide leadership programs to SHEs to equip them in effectively managing and leading the reform process.

### Differences among CEOs from rural and metropolitan areas

The study indicated that CEOs from rural NSW were classified at a lower SES level, with 91% of them (n=10) classified as under or equal to SES level 5 whereas only 10% of metropolitan CEOs were classified as under or equal to SES level 5. According to SES Guidelines developed by the NSW Premier's Department (2005), [30] the level of a position is based on the work value of the position, not the skills or experience of the occupant of the position. Therefore it may be assumed that CEO positions in rural areas carry fewer responsibilities than those in Sydney metropolitan areas. However, documents that indicate the differing requirements and expectations for CEOs from rural and metropolitan areas have not been found, and there is no literature or other studies explaining why this difference may exist. Further investigation may be advisable to explore the implications of such differences.

## Background influences

Background influences for becoming a SHE identified by this study are different from those identified by Rawson's study. [20] Both Rawson and this study found that the top two background influences for becoming a senior healthcare manager are: early experience and responsibility, and early leadership experience. However, the number three and four background influences between two studies are different. Being in the right place at the right time, and 'stretching' by immediate superiors were selected by the current study, replacing an overall sense of mission in life, and family support identified in Rawson's study. Changes in the number three and four background influences can be seen as a reflection of the unstable and continuously changing healthcare system. Senior health executives were promoted to the most senior positions at the time of the healthcare restructuring which may have provided them with unexpected opportunities. At the same time, the career path of clinicians may have been changed when they were unexpectedly offered senior management roles. [31] These may be examples of being in the right place at the right time and 'stretching' by immediate superiors.

## Major roles and responsibilities

This study identified four main tasks for SHEs to perform: leadership for both staff and stakeholders; organisational planning; external relations; and monitoring and evaluation. 'Monitoring and evaluation' is a role that has not been mentioned in previous studies. This may reflect the changes in SHEs roles in recent years.

Further exploration of what competencies are required for SHEs to fulfil the four major roles is necessary to guide the development of appropriate training and professional development programs for current and future SHEs to more effectively prepare them for their demanding and challenging managerial roles.

## Limitations of the study

This study did not include hospital CEOs. Given the significant changes implemented to public hospitals in New South Wales such as abolition of hospital boards, changes in funding arrangements, tightened budgets and control, and high financial pressure etc, impacts on hospital CEOs may also be profound. The changes may lead to changes in CEO managerial practice. The findings of the current study do not represent this group.

Although the response rate was within the normal range for postal surveys, [24] the number of survey participants is still small. However, comparison with those figures that are available (gender and location of employment) showed that the sample was representative of the target population.

## Conclusion

Since the introduction of the SES in 1989, no study has attempted to examine the changing roles and responsibilities of SHEs, including their characteristics, employment status, background influences and the major tasks they undertake. This study has found a number of phenomena similar to those found in other studies carried out worldwide in the 1990s. These common phenomena include senior healthcare managers generally possessing higher qualifications in the 1990s than in the 1980s and high turnover among SHE positions due to a number of significant factors such as an unstable healthcare system, lack of support and supervision, and job insecurity.

The study also found that two of the major background influences identified are different from those identified by Rawson. [20] These two newly emerging important background influences – 'being in the right place at the right time', and 'stretching' by immediate superiors – may be a reflection of the unstable and fast pace of restructuring healthcare systems, which may have contributed to the high turnover among the SHE positions, but on the other hand created opportunities for clinicians or middle level managers to be promoted to top-level managerial roles.

Four main tasks to be undertaken by senior health executives between 1990 and 1999 were also identified. Among them, monitoring and evaluation of services and performance has not been seen as an important component in the roles of senior healthcare managers in the past. This most significant finding suggests the need for further investigation and consideration when reviewing the current educational programs that prepare senior healthcare managers for senior-level managerial roles.

## Competing interests

The authors declare that they have no competing interests.

## Acknowledgements

We would like to thank all the people who participated in the questionnaire survey, and the invaluable support from the Australian College of Health Service Executives (ACHSE). In particular, we would also like to acknowledge and thank Mr Bill Lawrence, who at the time was the National Director of ACHSE, for his guidance in the conduct of this study. We would also like to acknowledge the valuable contributions to the study design and data collection methods of Professor Stephanie Short, who was Professor of Public Health at the School of Public Health, Griffith University at the time of the study.

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REVIEW ARTICLE

# Should Health Service Managers Embrace Open Plan Work Environments? A Review

**V G Oommen, M Knowles and I Zhao**


## Abstract

*Introduction:* **In an era of changing workplace reforms, health service managers are embracing innovative work place designs, such as open plan work environments, where employees may have more flexibility. Managers are constantly seeking different ways of transforming their workplace so that their corporate culture and image can be improved. On the one hand, they must respond to corporate pressures to reduce the costs of building facilities and on the other hand they are indirectly introducing different types of issues that affect their employees.**

*Method:* **A review of the literature was conducted by examining textbooks and journal articles in relation to the various issues that affect employees in an open plan work environment.**

*Results:* **Research evidence shows that employees face a multitude of problems such as the loss of privacy, loss of identity, low work productivity, various health issues, overstimulation and low job satisfaction when working in an open plan work environment.**

*Conclusion:* **Managers need to have a better understanding of open plan work environments before embracing such workplace designs. A multidisciplinary approach is recommended when decisions are being made in relation to which type of environment is better suited to the requirements of their employees as this has an impact on workforce productivity and job satisfaction.**


*Key words:* **open plan work; office space; work productivity; job satisfaction.**

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## The effectiveness of new designs for a new era

In the 21st century, health service managers are moving towards embracing innovative workplace designs when designing healthcare facilities in which employees can have an improved work environment. [1] With the effects of globalisation and with the concept of work flexibility being acceptable in many organisations, the focus has now shifted to the ability to rapidly move into a flexible, open plan work environment where the individual can start work immediately. [2] The term 'open plan' refers to an office space that is divided into relatively small workstations by low partitions. [3] The workstation is arranged so that there are no high walls or doors separating the occupants. [3]

In an era of budget cuts and insufficient resources, managers are placed in a situation where newly developing organisations adopt open plan work environments, compared to the traditional use of closed office rooms. It is estimated that organisations can save up to 20% in development costs when creating an open plan work

environment. [4] Some of the arguments that are put forward in support of such open plan work environments include: a reduction in building costs thus enabling resources to be used more efficiently elsewhere; individuals have an equal amount of space; enhanced communication; more workers can be accommodated into the work space; increased collaboration between employees; employees are able to interact with each other which in turn may improve productivity and creativity. [5-7] Moreover, from an energy saving perspective, open plan environments are more energy efficient for heating and cooling than traditional closed office rooms. [5, 6]

Recent trends in newly established healthcare facilities show that most of the organisations are moving towards open plan work environments. [7] As traditional closed office rooms are becoming outdated, managers conclude that such new designs are important in providing a better work environment and improved communication between staff. It is generally accepted that employees who are more comfortable with their organisation's environment are more likely to generate better work outcomes. [8] Moreover, employee satisfaction is regarded as one of the important factors for an organisation's success and performance as it improves morale and reduces staff turnover. [9] Various researchers have demonstrated that the physical environment is important for employees as it affects job perception, attitudes and job satisfaction. [10-13] In the same manner that people value the organisation in which they work, similarly the physical setting is an equally important factor for employees. [14]

Health service managers need to understand the uniqueness and the relationship between the physical environment in which employees work and the impact it has on them. The physical environment in which a person works allows some behavioural patterns to take place, supports certain activities, and restricts others from occuring. Work environments must, therefore, be designed in such a manner that they facilitate work and do not act as barriers to productivity. The intricacy of human preferences and the processes that people pursue to satisfy them have significant implications for the way work environments are designed. Because of elaborate multifactorial demands, workplace design must go beyond cost saving to cater for the multifaceted, social and psychological needs of employees. [15]

The concept of an open plan work environment is seldom discussed in the health literature. The idea that open plan work environments contribute to employee satisfaction merits closer scrutiny as it comes with a multitude of issues. In the majority of cases, such open plan work environments are approved without consultation with the organisation's employees. Health service managers should consider the effects of such new concepts on the health and performance of their employees before embarking on such designs.

The aim of this review is to provide health service managers with a better understanding of the different issues that arise with open plan work environments. More specifically, this review will analyse some of the major issues pertaining to open plan work environments and their impact on employees.

## Methods

A review of the literature was conducted by examining textbooks and journal articles which were sourced through academic databases which included PubMed, Medline, PsycINFO, CINHAL, EBSCOhost, Emerald Management Xtra and ProQuest. A search was performed in the databases that included several keywords such as, open office, open office environment, open space work, open plan work, open plan design, open workplace, shared workplace, traditional office, office workspace, office crowding, office noise and office privacy.

Two authors (Vinesh G Oommen and Isabella Zhao) independently reviewed all the articles and textbooks that were sourced through academic databases and library search engines between November 2007 and January 2008. No date limit was imposed on the search. A modified 'appraising the evidence' assessment form [16] was used to assess the quality of the articles that would help determine whether the article should be included in the review. The decision was based on four criteria, namely: (a) significance of the article to the research topic; (b) the context of the study; (c) source of data; (d) and the type of study. [16] If any discrepancy was found in our evaluation we discussed and reached an agreement for each study. Articles were excluded if they were not published in English. Once all the articles were retrieved, a snowballing strategy was used to locate relevant references from the bibliographies of existing research articles in an ongoing process of assessment, inclusion and synthesis. As a snowballing strategy is more efficient in locating articles than solely depending on databases, [17] this was used extensively to identify important sources of information that would otherwise be missed. Textbooks were sourced through library search engines to further elucidate other aspects of open plan work environments, organisational behaviour, organisational change and job satisfaction. Where accessible, bibliographic citations, abstracts and references were downloaded into Endnote

X2 (Thomson Reuters), bibliography management software for evaluation. Following the review of relevant articles and textbooks, the sources were organised and analysed.

## Issues with open plan work environments

Employers need to understand the interconnection between the physical and social systems that occur at work. Physical systems include the existing work environment, technology and job requirements. Social systems comprise people, their values, job opinions and organisational culture. These two systems are often called the dynamic sociophysical system. [18] Six different subsystems can be identified within this overall sociophysical system. These include people, job, social processes, organisation, technology and environment. [18] All of these subsystems are interrelated and a change in one of the subsystems can have either positive or negative consequences for the other. For example, people who have worked in a traditional closed office setting might find difficulty in adjusting to an open plan work environment. This might change how they work, their communication patterns and, being in a new environment, how they adjust to everything that is foreign to them. Managers, therefore, need to let go of the concept 'one size fits all' as people in the workforce are different and each person is unique.

The whole perception of the open plan work environment is that it gives employees the flexibility to work in different areas within an organisation regardless of time and place. While some employees gain a sense of freedom and mobility, others find moving around from one workstation to another stressful. In many organisations employees are territorial and are hesitant to share their physical space with other staff. [19] As human beings, people tend to be territorial not only in their personal life, but also when they work in organisations. [20] The classic example of territorial marking that employees perform is by highlighting ownership of workstations by putting their names on them, applying signs, photos and labels that communicate to others that this workstation is theirs: in other words, this 'territory', is already occupied by someone else. This indirectly communicates to others who should or should not enter and how one should conduct oneself when inside their territory. Malmberg [21] suggests that the whole concept of territorial behaviour comes from an evolutionary perspective which is a common behaviour shown by all primates. This includes marking territories of personal space in organisations in which they work. One of the fundamental reasons why employees are territorial in organisations is because they want to show others their identity and status in the organisation. [21]

Organisational psychologists have long argued the importance of giving identity and status to people in organisations as it satisfies their psychological needs. [22] This whole concept of identity comes from the hierarchy of needs model which was postulated by Maslow. [23] Maslow [23] proposed a hierarchical structure of needs, the basis of which is that lower-order needs must be fulfilled before higher-order needs. As the lower-order needs become satisfied, the higher-order needs become salient. The structure, in the order of the lowest level to the highest, is as follows: physiological needs; safety needs; belonging and love needs; esteem needs; self-actualisation needs; and aesthetic and cognitive needs. [23]

From an organisational perspective, physiological needs could include the desire for shelter and sensory stimulation. Safety needs include personal space and privacy. Belonging needs, when taken in a work environmental context, refer to maintaining social interaction and establishing group identity. Esteem needs are the expression of self-identity and status. Self-actualisation needs involve personalisation and the freedom of choice in determining behaviour and environment. Aesthetic and cognitive needs refer to intellectual understanding of environmental structure and beauty.

## Issues with privacy and noise

The term privacy is difficult to define as there is no universally accepted definition. Moreover, each person sees privacy in different ways. A few authors have argued that it is more meaningful to examine privacy in terms of interests that individuals have, rather than to think about privacy as a right. [24, 25] Clarke [26] defines privacy as 'the interest individuals have in sustaining a personal space, free from interference by other people and organisations'.

An empirical study conducted by Justa and Golan [27] showed that privacy in the office includes the capacity to regulate access to one's self or group, specifically the capacity to limit others' access to one's workplace. In an office setting, privacy depends on the extent of physical enclosures. The more the physical enclosures are present, the more an employee can have their privacy. In a healthcare organisation, privacy plays an important role in daily work. As most of the health professionals' job involves analysing some form of complex information, privacy at work becomes an important factor for two reasons. First, employees doing intricate tasks may be subject to interruption or overload from social stimulation. Secondly, distractions or interruptions that arise may be unfavourable to effective functioning as the intricacy of the job intensifies. [28]

Marans and Spreckelmeyer [29] showed that employees working in traditional closed office rooms had a higher level of job satisfaction as there was more privacy, compared to those employees in an open plan environment where problems of visual and conversational privacy were very pronounced. Working in an open plan environment without walls or glass where others can see a person working is perceived by people in different ways. Even though such an environment may lead to an increased opportunity for interaction, this may also lead to other issues in relation to loss of privacy. The loss of privacy can be in terms of people being seen when they work or in relation to work related conversations being heard. [30] Compared to the traditional closed office rooms where there are no privacy issues, an open plan work environment can lead to an increased level of noise resulting in loss of concentration and low work productivity. Field and Fricke [31] point out that the common noises found in an open plan that contribute to loss of concentration in employees include noise from photocopiers, telephone conversations, air-conditioning, elevator sounds, employees talking, and people constantly moving to and fro. Noise can lead to stress, which can increase the probability of accidents happening in workplaces as employees get irritated and are not able to concentrate. [32] An important part of a person's work is to be able to carry it out without any distraction. In an office setting, most of the work is done quietly as employees need time to analyse, read and write. As noise is a dominant disturbing force in almost any office environment, this can lead to employees achieving less in a given period of time.

Many people working in healthcare organisations often fall into a professional category and have a certificate, diploma or an undergraduate degree. [33] It is estimated that 75% of today's healthcare workforce are educated workers. [33] In an era in which technology plays an important role in delivering healthcare, employees working in such organisations are dealing with complex information that requires concentration to process, examine and construe. Whether the healthcare personnel are dealing directly or indirectly with the general population, such work needs to be uninterrupted. Zalesny and Farace [34] showed that employees who relocated from a traditional office to an open space work environment were dissatisfied with their work environment as they had less privacy and more interruptions and diversions.

Research has identified 'noise' as a likely cause of employee dissatisfaction with the work atmosphere in terms of low motivation to work, [35] reduced performance [36-38] and irritation. [39] Sundstrom et al [12] showed that 54% of the 2000 employees surveyed said that noise of people talking and the telephone ringing was a cause of distraction at work.

Employees working in an open plan work environment have lower job satisfaction due to lack of control over their physical environment. [40] This is due mainly to lack of personal privacy and lack of privileged communications. [40] Sundstrom et al [41] and Hedge [4] found that higher disturbances and less privacy were seen in larger open work environments. The researchers found that almost all highly skilled jobs were more negatively affected by the environment, as these jobs required more privacy in order to perform well. Moreover the researchers found that in all types of jobs, employees normally favoured privacy over ease of access. Sundstrom et al [41] found a positive correlation between privacy and performance, even amongst those employees whose jobs were not highly skilled.

Even though some employees do not take noise and privacy as an issue, for others it results in low work productivity and dissatisfaction with their job. [42] Furthermore, some staff might be so overwhelmed by their environment that it might lead to a stimulus overload. Overstimulation can originate from too many people, too many communications, too close proximity with other employees and small amounts of space. [43] An open plan work environment is a classic example of an environment that creates potential for overstimulation. The whole concept of overstimulation comes from the theory which states that certain features of a physical environment can cause a person to be in a state of stimulus overload. [44] In the context of an open plan work environment, staff may actually shy away from an overstimulating workplace leading to dissatisfaction with work. The latter is likely because employees may have problems concentrating on their work due to conditions arising from their physical environment. [45]

According to Hackman and Oldham, [46] dissatisfaction with a job usually leads to poor work performance. Herzberg's motivation-hygiene theory [47] states that the environment in which a person works is an important factor in avoiding dissatisfaction. Herzberg [47] argues that it is important for employers to maintain 'hygiene factors' (being used similar to the term environmental) for employees in order to avoid unpleasantness at work and to promote equal treatment. For instance, in some healthcare organisations only the senior executives get their own office and other employees may get a workspace in an open plan work environment. This can lead to dissatisfaction at work for some employees and for others it may not.

## Issues with personal space and social density

Denying an employee their personal space in a work environment can lead to aggression and insecurity. [21] One of the primary reasons for this phenomenon is the way that a person works and perceives their environment, which may often conflict with other employees. [19] For instance, the way a person organises their workstation might be different to others. The same person would like to see their workstation kept the same way whenever they return to work. If many employees use the same workstation, there could be problems associated with misplaced resources, misfiled and confidential items left behind. Moreover, this type of work environment gives fewer opportunities for staff to express their status in the organisation.

Another issue that arises with an open plan work environment is the concept of social density. [48] Social density refers to the number of people that are seated closely in an open plan work environment regardless of the space that is available. [43,49] Paulus [43] and Sundstrom et al [41] argue that many people dislike socially dense work space conditions and people who dislike such working conditions have a higher turnover and leave the organisation. People who are seated closely together in an open plan work environment may suffer from physiological and psychological reactions such as stress, fatigue, and increased blood pressure levels. [50] This occurs because the employee's psychological privacy is disturbed and they think that someone is always watching them. [50] Studies conducted by DeLange et al [51] and Sluiter et al [52] have shown that physical or mental exhaustion and musculoskeletal problems are commonly seen in people working in open plan work environments.

Research has shown that some employees working in open plan work environments are more prone to eye, nose and throat irritations than employees working in traditional closed office rooms. [53-55] According to Godish [56] people working in an open plan environment are more prone to acquiring flu from other employees who are carrying the influenza virus. In some countries such as the Netherlands and Germany, the whole concept of open plan work environments is discouraged based on research evidence, as it has shown to have a negative impact on employees. [57]

## Discussion

In spite of several issues that arise with an open plan work environment, it is imperative to note that not all employees have the same problems. The problems that employees have vary in magnitude as people adapt differently to varying environments. In fact, a variety of factors have been shown to mediate between employees and open plan work environments which include job complexity and job type. [4, 41, 53]

Just because a workplace has an open plan design, does not mean low employee productivity. Employers need to survey their employees to learn what sort of difficulties they face with such workplace designs and take appropriate measures to counteract this. Before creating such designs, employees need to be consulted as they will be the people who will be working in such environments. Mullins [58] has argued that employee involvement in organisational design is directly related to job satisfaction. Employee participation in the process appears to be important whether participation results in change or not. [58]

In an organisation, employees need to be able to adapt the physical environment to fit their own requirements, to control its use and create personal spaces that will enhance their work productivity. This will give the employee some feeling of belonging to that particular space which satisfies their psychosocial desire for status and identity in the organisation. McKenna [59] suggests that if an employee is able to control their work environment this will increase job satisfaction, reduce stress and enhance work productivity.

As discussed previously, privacy in a work environment depends predominantly upon the physical environment. That is, privacy increases in the workplace when more enclosures are formed by walls or partitions. Moreover, employees attain greater privacy in individual offices with walls to the ceilings and doors. Employees with different jobs may perceive privacy differently and the type of jobs may create different needs for privacy. Even though open plan work environments currently remain the predominant design approach, health service managers who have control over sanctioning such designs must take into account the impact these designs have on their employees.

Due to the complexity that arises when building healthcare facilities, the need for liaison with other professionals becomes more important. A multidisciplinary approach is vital when decisions are made rather than using a unidisciplinary approach in relation to workplace designs. This advocates closer cooperation between building designers, health professionals, organisational behavioural researchers, and other professionals. Health service managers need to ensure that they have a better understanding of both the positive and negative aspects of an open plan work environment as shown in Table 1 before they undertake such workplace design.

**Table 1: Open plan workplace – managerial considerations**

| POSITIVE ASPECTS | NEGATIVE ASPECTS |
|---|---|
| Cost-effective design | High level of noise |
| Equal work space for employees | Loss of concentration |
| Enhanced communication | Low work productivity |
| Increased collaboration | Issues with privacy |
| Flexibility to work in different areas | Lack of status |
| Accommodates more employees | Feeling of insecurity |
| Energy efficient heating and cooling design | Job dissatisfaction |
| | More chances of workplace conflict |
| | Prone to stress, acquiring flu, physical exhaustion, musculoskeletal problems, fatigue and increased blood pressure levels |
| | High staff turnover |

## Conclusion

Managers need to pay more attention to the complex systems that take place in the work environment. This involves understanding the association that occurs between employees and their physical environment. If managers fail to address the psychological dimensions when planning and developing healthcare facilities, complex issues like low job satisfaction and decreased work productivity will arise. Moreover, a workplace has to be a place where employees are satisfied when carrying out their work. Strategic planning for the office of the future will involve better knowledge of how people interact with their environment, the type of work that they do, the technology they use to do it, their social communication patterns and the organisation within which they work. Therefore, workplace design solutions responding to this change could become more dynamic than ever before.

## Competing Interests

The authors declare that they have no competing interests.

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REVIEW ARTICLE

# Dialysis residential care: a future dialysis service model

**PN Bennett, K Torpey and K Bannister**

## Abstract

**People with chronic kidney disease are ageing and have increasing co-morbidities. The current delivery of renal replacement therapy, dialysis and transplantation, needs to adjust to changing patient needs. This paper proposes a potential future service delivery model featuring a dialysis residential care facility and a care coordination focus. The residential care facility would be composed of four levels of care; high, hostel, independent and outpatient. The paper argues that this model may result in decreased morbidity, improved patient quality of life and may prove cost effective. Patients' nutritional status, medication adherence and transport efficiency may be improved. We propose this model to stimulate further debate in order to meet the needs of current and future chronic kidney disease patients.**

***Abbreviations:*** **APD – Automated Peritoneal Dialysis; CAPD – Continuous Ambulatory Peritoneal Dialysis; CKD – Chronic Kidney Disease; GP – General Practitioner; LOS – Length of Stay; NP – Nurse Practitioner.**

***Key words:*** **dialysis; aged care; service delivery; care coordination.**

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## Introduction

People living with Chronic Kidney Disease stage 5 (CKD 5) require renal dialysis or transplantation to maintain health. Worldwide, there will be an estimated two million people requiring renal replacement therapy by 2010 [1] and furthermore, people requiring dialysis will be older, have more complex co-morbidities and will require greater healthcare resources. [2,3]

Dialysis treatment can require a patient to attend a dialysis facility at least three times per week. This results in an expensive, resource-consuming, pervasive therapy. This paper presents an alternative to the current hospital and satellite dialysis model that is dominant throughout the world. The proposed model will consist of a residential dialysis facility supported by care coordination. Although versions of this model have been reported previously, [4-6] we believe this is a new proposal to address a growing issue. We will argue that this new model will improve patient outcomes, decrease morbidity and possibly decrease healthcare costs.

## Current model

The current model for dialysis mainly consists of hospital haemodialysis, satellite haemodialysis, home peritoneal dialysis and home haemodialysis. Hospitals treat the new patients entering onto the dialysis program, some acute renal failure and the 'fragile' patients who do not meet the patient acuity requirements for satellite haemodialysis units. [1]

Satellite haemodialysis facilities were introduced in Australia as 'self care' units in the 1970s. [7] Satellite units have had a rapid growth worldwide [8,9] and in 2006 provided 43% of all dialysis treatment in Australia. [10] They were originally designed to accommodate patients who could perform the entire treatment themselves with minimal assistance from dialysis-trained staff. Lower staff-patient ratios, a community setting and increased independence were features of the early satellite units, [11] decreasing the costs of dialysis treatment. [12]

Australian satellite dialysis units today are now caring for older and sicker patients. In Australian satellite units, 23% of all new patients commencing dialysis in 2006 were over 75 years of age, [13] up from 13% in 2000. [14] This trend is likely to continue. Subsequently, satellite units have had to cope with older and more dependent patients. This was not the service satellite dialysis units were originally designed for.

Home haemodialysis contributes to improved patient outcomes, [15] and although there has been renewed and increased rhetoric about this modality, there has been a decrease in the number of people commencing home haemodialysis worldwide. [16] Various factors, such as funding arrangements, resources and patient preferences, have contributed to slowing the uptake of home haemodialysis. [7] We believe that the older, less independent person commencing renal replacement therapy is not willing, and is often not able, to perform home dialysis successfully.

In Australia, twenty one percent of all dialysis patients receive peritoneal dialysis. [10] Patients are offered either Continuous Ambulatory Peritoneal Dialysis (CAPD) or Automated Peritoneal Dialysis (APD). APD has increased in popularity over the past five years, [10] as it is usually performed overnight, allows a person greater freedom, is less time consuming and has demonstrated higher adherence rates. [17] We suggest that the increased APD uptake in Australia reflects the requirements of the more elderly, co-morbid people who prefer APD as a dialysis option.

Transplantation has provided improvements in quality of life, [18] costs and mortality compared with dialysis, however transplant rates are low in Australia and have not improved in the last 30 years. Our transplant rates remain constant while our dialysis incidence increases by approximately eight percent per year. [10] Unfortunately, we predict the transplant rates in Australia will not increase sufficiently to alleviate the pressures on hospital and satellite dialysis units.

The result of the traditional hospital, satellite, home model is what we see today. We currently have over-utilised hospital dialysis units [19,20] full of people who should not be there. [21] Our experience has been that these patients overflow into hospital inpatient beds increasing bed usage and unnecessary hospital Length of Stays (LOS). Nursing and medical staff concentrate on the technical requirements of the dialysis treatment, failing to address the complex primary health needs of these long-term, chronically ill people. [22] Our satellite units take up this slack and frequently are not sufficiently resourced and not designed to provide care for the complex needs of the increasingly co-morbid aged person requiring dialysis care. It is our experience that rehabilitation and primary healthcare needs are not prioritised.

Today patients are being transported from aged care facilities to haemodialysis units, requiring costly transport resources. [23] Patients performing dialysis at home may have limited support [24] and have restricted access to respite. [25] We believe the current system does not meet the needs of our dialysis population.

## The residential care dialysis model

We argue that the present model of care is not meeting the needs of the current dialysis population and will definitely not meet the needs of dialysis patients in the future. The patients commencing dialysis are getting older and more dependent. [3,26] The largest increase in patients commencing dialysis is the over 75 age group. [26] We propose that a new model of care featuring a residential dialysis facility may provide an improvement in the delivery of dialysis services. This proposed model might improve patient outcomes and patient quality of life while decreasing the high cost of dependant dialysis patients currently trapped in the hospital system.

The facility would be predominantly nurse-managed, with a medical advisory board consisting of a nephrologist, general practitioner and gerontologist. Medical care, such as medical emergencies, would be managed in the same way they are managed from current satellite centres. In saying this, we believe this model has the potential to decrease unnecessary emergencies given the increased acceptance and confidence with gerontic and palliative care.

The residential dialysis facility would be developed similarly to existing aged care facilities and encompass different levels of care from high care to independent living units for couples and individuals. This would be designed for the major purpose of providing dialysis, both haemodialysis and peritoneal dialysis, to patients at various levels of dependency. Attached to the residential dialysis facility would be a day care haemodialysis treatment area providing dialysis for residents and outpatients. A haemodialysis and peritoneal dialysis home training service could be incorporated into this facility. Thus, the residential day facility would have four levels of care: High, Hostel, Independent and Outpatient.

High Care would be available for patients not sufficiently well to move back home with community support. These may be people who require rehabilitation, wound care or care related to dementia. Thus it is designed for patients who are physically dependent and require high level nursing care. High Care would also facilitate a hospice facility for terminal patients and support for their families. Nursing and allied health staff would be cognisant of chronic kidney care, palliative care and high level gerontic care potentially resulting in improved patients management.

The second level of care, Hostel Care, would be for the semi-independent person who might need slight assistance with activities of daily living. This may be assistance with meals or medications. Hostel Care is for the dialysis patient currently living alone with minimum support at home and perhaps unable to independently travel to dialysis. The facility would have the flexibility to offer high quality dialysis such as APD or nocturnal dialysis requiring limited nursing support.

The third level, Independent Living, would house people requiring dialysis in units with close access to the dialysis unit providing their treatment. They could perform therapies such as APD with minimum support if required. The units could be for patients and their partners. Limited support staff would be required at this level.

The fourth level of care is for those who are currently living at home and would provide them with an area that specialises in aged care dialysis with access to rehabilitation professionals and resources such as physiotherapists, podiatrists and occupational therapists. These people might become more dependent over time. This model would enable these people to move through the care levels without the necessity of being admitted to an acute hospital.

Ideally, management of the residential care facility would be between a private dialysis vendor and the supplier of the residential aged care facility. Instead of a private dialysis vendor, the dialysis aspect could be managed by a public hospital renal unit. The alternative is that the residential aged care facility would have overall responsibility but would sub-contract out the dialysis component to either a private dialysis vendor or to the public hospital renal unit. The variations proposed would depend on local conditions.

Ideally, the private dialysis vendor would provide staffing. Even in the situation of the dialysis unit being run by a public hospital, the dialysis component in terms of machines, consumables and staff, would be outsourced to a private dialysis vendor. It is expected that the aged care facility would provide staff for the residential and nursing care component. It is possible that some of these nursing staff might have dual roles in providing dialysis care and aged care. Nephrologist cover would come from public hospitals or interested private nephrologists.

In Australia, funding would be a combination of both federal and state government funds. We would anticipate that funding from state governments would be on a price-per-treatment basis for dialysis. For peritoneal dialysis this is a little more problematic but the benefit of peritoneal dialysis is that it would be a much cheaper proposal than haemodialysis. Once again the trade-off is that this would be a much cheaper dialysis option for state governments than having patients in acute wards of public hospitals.

## Benefits of the residential care model

### Decreased costs

Dialysis and associated costs are significant. [27] They include the direct costs of human and material resources, transport to and from treatment and hidden costs such as the social costs associated with chronic kidney disease. We argue that our proposed model would reduce costs associated with acute hospital admissions, reduced hospital LOS and reduced transport costs. Reduction of acute hospital admissions would result from improved coordination of care and facilities at the residential dialysis care facility, reduced LOS would result from earlier discharges due to improved capacity at the residential facility and reduced transport costs would result from patients close proximity to the dialysis services while living in the residential facility. Although the initial costs of developing a residential dialysis facility would be significant, the decrease in recurring costs would decrease significantly.

Our proposed residential care facility would not be more expensive than current facilities and it would include a residential care facility and a dialysis unit. Cost savings come from the efficiencies in having aged dialysis patients close to their treatment (transport, staff salaries, administration and data management).

Current inflexible patient scheduling decreases the flexibility of hospital and satellite dialysis facilities. The trend of encouraging more frequent dialysis could be managed far better in our facility given the negligible transport issues that restrict this treatment today. Our residential dialysis facility would be more flexible leading to cost savings. Examples of these cost savings would be the increased use of frequent dialysis, increased APD (with minimal but necessary nursing support) and the flexible 24 hour use of the dialysis machines (increased nocturnal dialysis) which

increases the use of the capital equipment and decreases treatment and depreciation costs.

**Decreased hospital admissions**

Our model provides the potential for decreased admissions to and decreased length of stays in acute hospitals. This is through the coordination of care of an attached Nurse Practitioner (NP) and General Practitioner (GP) resulting in improved standard of dialysis care.

Coordination of care for dialysis patients has been the Achilles heel of our historically developed (but not always planned) current model. Time-poor nephrologists and dialysis nurses are in difficult positions to contribute to the overall complex care that CKD patients require. Coordinated care models in dialysis have been shown to improve patient outcomes and decreased hospital admissions. [28] Our residential dialysis facility model would feature coordinated care by a NP or GP. We believe that the facility manager would engage with the GP and NP to coordinate a patient -centred, advanced care plan.

**Improved quality of life**

We argue that this model would improve quality of life for people living with CKD based on better care coordination, improved dialysis treatment and lower acute hospital admissions. Each person living in the residential dialysis facility would have a coordinated care plan agreed by them for their future care needs. The care plan, based on the Flinders Model [29] and Primary Health Care (PHC) principles, will be a shared plan with the resident and significant others, with the assistance of appropriate healthcare professionals. Patient goals, embracing initiatives such as advanced care directives, would be reviewed frequently and enable the most appropriate healthcare interventions where required. This would result in a considered uptake of patient-centred care with the patient being the major player in their treatment plan.

Improved dialysis treatment would be provided to patients. Longer and more frequent dialysis, using the facilities overnight and decreased transport time would contribute to the improved patient care. This model would facilitate greater uptake of APD, long nocturnal and short frequent dialysis which has been shown to increase flexibility, decrease morbidity and mortality and improve quality of life of people requiring dialysis. [6,15]

Our residential care dialysis model would decrease hospital admissions through improved dialysis treatments, improved nutrition and improvements in healthcare provision such as medication management. CKD patients have high rates of malnutrition [30,31] and are required to take 10 to 20 tablets per day. [32] A residential facility would be able to monitor and improve the nutritional status of patients by individually assessing and assisting with nutritional requirements and by assisting with the complex medication management for these people. For example, a dietitian would only need to be in the one place where most of the nutritionally at risk patients would reside.

Overall, the major advantage of the residential model is its ability to assist those who are losing independence and improve the care of these people. We are not suggesting that this would replace home dialysis training, peritoneal dialysis and smaller satellite dialysis units in regional areas. We believe that different forms of this model can integrate and support current home, peritoneal and satellite dialysis programs.

## Implications for healthcare

Currently in Australia (and many other countries) states or regions have set up state-wide renal networks. These networks have advised on the establishment of services, which includes decisions on the development of new satellite dialysis units. Our residential care proposal would require collaboration between both the state renal networks and federal government for the development and establishment of a residential care facility. We believe that this application is likely to be successful as the concept has major benefits particularly the freeing up of acute beds in public hospitals.

In the city of Adelaide (approximately one million people) where the authors reside, we predict that two such step-down facilities will be developed (one each in the northern and southern suburbs of the city). However, these centres would not replace existing satellite or community dialysis facilities where many local and Indigenous patients dialyse. The new facility fills a transition gap between patients who are leaving a public hospital and are waiting to return to home dialysis or are unable to return to home dialysis due to co-morbidities. Therefore, these facilities will not replace existing community dialysis facilities.

Measurement of the success of the proposed model would be fundamental to its success. Liaison with national data registries, in our case ANZDATA, and reporting mechanisms to health authorities and specialist organisations, would need to be established. In addition, close inclusion of academic colleagues would facilitate common research collaborations with the aim of measured positive patient outcomes such as improved quality of life and decreased morbidity measured by decreased hospitalisation.

There is both a local and global requirement for us to re-think our dialysis service models. Dialysis patients are ageing and becoming more dependent [3] and we will need to continue to adapt to these changes. The residential dialysis proposal has implications for health administrators, clinicians, researchers and patients. We believe health administrators are obligated to search for new service models to address the burgeoning costs and poor patient outcomes of chronic kidney disease. Clinicians can explore and debate the benefits and negatives of new service delivery models. Researchers can explore and further refine the effect of this new model using rigorous research methods. Patients will benefit from positive changes addressing need in dialysis service delivery.

## Limitations

The residential care model we have presented has not been tested and is still a theoretical proposal and thus there has been limited empirical research to support the model's influence on improved outcomes. A full cost and funding analysis is beyond the scope of this article as it was written to encourage discussion and stimulate us all to re-think our own dialysis services. We envisage that this model can be incorporated into a mixed private/public managed partnership however this is yet to be examined.

## Conclusion

This paper has presented a strategy that may contribute to improved service delivery and improved patient outcomes for people with chronic kidney disease requiring dialysis. In particular the proposed residential dialysis facility would benefit those people who require greater assistance than the current model offers. We believe that this idea is worth pursuing and is worth researching in order to assess its value to healthcare for persons with chronic kidney disease.

## Competing interests

The authors declare that they have no competing interests.

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# As a young and emerging healthcare manager, what do you see as the challenges for the health system of the future?

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 we have selected our young health managers of the future and asked them their views of the challenges ahead.

While the challenges confronting the 'health system of the future' are well-documented, the solutions remain elusive. Although my response considers the question from the Australian healthcare system perspective, the challenges of health inequities, demographic change, new technologies and increasing consumer expectations are common to international experience.

Our healthcare system of the future must be responsive to the changing health needs of an ageing population. Management of complex and chronic disease presents a new challenge to a system predominantly organised around acute, episodic care. New models of care, professional roles and methods of service delivery will be required and greater system integration will be essential.

As the population ages and demand for health services increases, there will be a proportionally diminishing supply of potential health workers. Generational change will also see a workforce with very different attitudes to work and career. Managers will need to understand, engage with and motivate 'Generation Y' and 'Z' to deliver the health services of the future.

Advances in technology will undoubtedly provide many exciting opportunities in terms of new treatments and new methods of service delivery. Advances in areas such as pharmacology, medical imaging, nuclear medicine, genetics, nano-technologies and IT are just some examples. However with advancing technology comes not only opportunity, but increasingly difficult resource allocation decisions.

Heightened consumer expectations of our health system will ensure that safety and quality will remain a continued focus for clinicians, managers and policy-makers. Greater levels of public and regulatory scrutiny will demand clear accountabilities in clinical and corporate governance.

Our present population health profile points to several local challenges for the future. If we are to support equity as a principle of our health system, then improving the current health status of Indigenous Australians is essential. Ensuring access to services for rural populations will continue to pose logistical and workforce challenges. More generally, the forecast epidemic of the chronic 'diseases of affluence' will require a coordinated, system-wide response. Meanwhile the risk of new global disease pandemics will require continued management.

Demand for health resources will always exceed supply in the health system of the future. Continued growth in the share of Gross Domestic Product (GDP) allocated to health expenditure may ultimately see a more comprehensive debate on difficult issues of allocative efficiency. Structurally, there is frequent evidence to suggest that the fragmentation and complexity of our current system will limit our capacity to meet the challenges of the future. Incremental improvement to the present arrangements is perhaps more likely than wholesale change.

Clearly the challenges facing the health system of the future are complex. Rapid and continuous change in healthcare organisations is likely to be the norm, yet the fundamentals of management in this environment will remain the same. Health and healthcare systems will always be about working with people – consumers, care providers and the community. Developing solutions together is part of what makes health such a rewarding industry in which to work.

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2 One of our greatest challenges is reducing the disproportionate burden of chronic disease in the Aboriginal population. This is one of the greatest challenges, not only for our healthcare system, but for all young and emerging healthcare managers.

The population of New South Wales has experienced significant health gains in recent years. However, these improvements have not been equally shared by Aboriginal people. Aboriginal people continue to experience greater health risks, poorer outcomes and have significantly shorter life expectancies.

It is important to acknowledge that many poor health outcomes are related to the continued socio-economic disadvantage experienced by Aboriginal people in New South Wales, such as:

- Poverty;
- Lower educational uptake;
- Isolation – both geographically and socially;
- Overcrowded housing; and
- Poor nutrition. [1]

As managers, we must provide strategic direction to improve the health outcomes of Aboriginal people. The partnerships we develop with healthcare providers are of particular importance. We need these partnerships to provide equitable access to mainstream and primary healthcare services.

Community consultation with Aboriginal people has identified that the main issues and barriers to accessing healthcare are:

- No regular general practitioner;
- Limited after-hours support services;
- Shortage of Aboriginal workforce across all services;
- Affordability of medical services, specialists, medication, travel and accommodation;
- Transport options;
- Geography – proximity to Country; and
- No follow-up on discharge, no treatment plans. [2]

I am personally disappointed that our healthcare system, which is meant to provide universal access, has not yet responded to such basic service and care needs. However, this provides a clear indication of what needs to done:

1) **Develop Aboriginal Health Workers (AHWs)** who are the crucial link between the patient, their families and the specialist health and community services.
2) **Work in partnership with Aboriginal community controlled organisations** which have built strong relationships with the surrounding Aboriginal communities. If these services are to continue to improve health outcomes, increased support will be required in many areas, such as:
   - specialist services provided in a culturally-appropriate environment;
   - development of disease management programs; and
   - shared medical records so that healthcare needs and follow-up programs can be targeted to the right people.
3) **Integration between Aboriginal and specialist care services.** Many AHWs currently work in isolation from specialist care programs and mainstream health services. Integration is needed to facilitate access to mainstream programs specific to Aboriginal people along with clinical skills development in these programs for more AHWs. This will improve access to and increase participation in healthcare programs that the majority of the New South Wales population now take for granted.
4) **Better understanding of your Aboriginal community.** It is most important to acknowledge that each Aboriginal community is different in terms of history and community relationships. Health service managers need to promote communication with the community, and to understand their needs. This will allow flexibility in our approach to delivery of the essential health services to patients and families.

What do you do to improve access to your services for Aboriginal people?

**Mr Paul Preobrajensky** RN, DHSN, GCAGN, MHA, AFCHSE, CHE
*Area Performance Manager and Project Director, State-wide Program*
Health Service Performance Improvement Branch,
NSW Health, Australia

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3 As a young person beginning a career in health services management, this is my one-and-a-half cents worth (not two, I'm being fiscally responsible) on the challenges for the health system of the future.

**Population health needs**

The structure of the Australian population and its health needs are changing. The primary determinant of the manner in which we provide health services should be the health needs of the population. The challenges currently facing the Australian healthcare system appear to be a result of the fact that in the past 200 years or so, our primary method of providing healthcare (doctors + nurses + hospital beds = healthcare) has not sought to keep pace with the changes in these health needs. It would be irresponsible to consider that these health needs are unlikely to change again over the next 100 years. To meet these changes, we have three resources at the system's disposal:

**1) Finances**

This one is not looking good. Consider that capital availability only increases at the rate of economic growth (4% if you're optimistic) whereas innovation and technological improvements in the health sector increase at a rate determined by the combined intellect of health professionals. With this gap anticipated to increase, the capacity of the system to meet provider and consumer expectations of universal access to all innovations is expected to decrease. Resource scarcity is only likely to get worse. We will need to ensure that any resource investment maximises the outcomes for the population. History would suggest that centralising such decisions does not achieve this aim.

**2) Infrastructure**

Generally, this is a product of the approach we have historically taken to providing healthcare. Also, it costs a lot. Unfortunately, hoping that our current approach to this resource will be sustainable is likely to be misguided. For the public sector, in view of the significant construction and ongoing costs of this resource, it is likely that it will be more cost-effective to fund the private sector to deliver some public services than embark on ambitious infrastructure expansion projects.

**3) Workforce**

The current health workforce also remains a product of the manner in which we have historically provided healthcare. The structure of the population and by consequence, the available workforce, will limit our capacity to deliver services unless we fundamentally reconsider the way we do things. I believe in the ability of people to work together. Therefore, motivating change in the workforce is most likely to be the best strategy to meet the health needs of the population in the future. Subsequently, my concluding point is about leadership.

**4) Leadership**

It would be easy to say that the health sector has a lot of vested interest groups with conflicting agendas and that it's all too hard. Instead, I believe that sticking to a dialogue on the health needs of the population, combined with leadership and commitment from all concerned, will provide the capacity to meet the challenges for the health system of the future. I look forward to the opportunity to be involved.

**Mr Damian May** BBus (HRM), BHSc (HSM), AFCHSE, MAHRI
*ACHSE Management Trainee*
Human Resources Project Manager
Ramsay Healthcare, Queensland, Australia

4 Investment into prevention, health promotion and primary healthcare has been a hot topic of late. [1] The recent release of the World Health Organization Health Report 2008 – *Primary Healthcare: now more than ever*, is indicative of this trend and details the pitfalls of a hospital-centric health sytem. [2] Yet despite calls for a prevention-oriented healthcare system, a whole-of-system approach reflective of intersectoral engagement, and increased community participation, [3-5] there has been minimal discussion about the type of workforce required to meet these objectives in a productive and cost-effective manner. Indeed, there has been a lack of willingness across state and national governments, and even within some professional health and medical bodies, to acknowledge that a different workforce - with an eclectic range of skills and competencies - may well be required. This contrasts the more familiar discourse that places an expectation on the existing health and medical workforce (often with specialist skills) to merely go about their work differently during health system reform. We consider this to be a major challenge facing young and emerging health managers.

Over the past couple of decades there has been a substantial growth in tertiary courses, at both undergraduate and postgraduate levels, which has built a highly capable health promotion and public health workforce that is well-positioned to move the population health agenda forward. There has also been an incremental investment in undergraduate double degrees (for example BHsc/BEd) that will equip the future (health) workforce to work across, move between or be located at the nexus of traditional sectoral

boundaries, such as health, education, justice, housing and so forth (increasingly from the outset of their careers). This creates an amazing opportunity to invest in primary healthcare. In fact, one could speculate that workforce growth between, rather than within, sectors might advance a prevention agenda in a way that more readily supports intersectoral action focused on the social determinants of health. It will be up to emerging health managers to tackle this reality head-on.

Support mechanisms have been put in place to build health promotion and prevention capacity among students and early career professionals in Australia – particularly through professional organisations with a public health orientation. [6-7] To promote further discussion about reconceptualising the prevention workforce, it is time to acknowledge the views of emerging health promotion and public health professionals in parallel with those of their peers. [7-8] Indeed, discussions during a workshop breakfast hosted by the International Union of Health Promotion and Education at the recent Population Health Congress in Brisbane, indicated that these emerging professionals want to be engaged in discussion about what the future health system, and the respective focus on prevention, might actually look like. [5] This is particularly salient if they are to lead the prevention agenda into the future.

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Regional Student Representatives and Members
South-Western Pacific Regional Committee of the International Union for Health Promotion and Education (IUHPE) and IUHPE Student and Early Career Network (ISECN) Global Working Group

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5 There are many issues that are having, and will have in the future, a significant impact on our health system here in Australia and these have been well-documented over recent years. Most of these developments have been brought about by our ageing population, chronic disease and the increased demand for health services. To compound these challenges, life expectancy has increased because of continuous breakthroughs in technology, medical science, pharmaceuticals as well as improved lifestyles. Also, our population has an ever-increasing expectation of the health system, demanding more expensive high technology equipment and pharmaceuticals, as demonstrated by the Pharmaceutical Benefits Scheme becoming the fastest growing area of government expenditure.

The success or failure of the Australian health system has more recently been driven by a political and social agenda where the focus has been on public hospital emergency departments and waiting lists. When failures have occurred, they end up on the front page of every newspaper in the country driven purely by heightened political debate and disregarding the daily pressures front line workers are faced with – many of which we have all experienced during our working lives.

What is to be done? As a healthcare manager, I see THE challenge for our health system is for us to begin to develop an effective response now to these long recognised issues which have been identified, discussed and debated for years. While acknowledging that much has been done in trying to address these issues, and there are often many 'Inquiries' into health system failures going on at one time, one must question just how effective these inquiries and responses have been in changing and improving 'The System'. Although there is evidence that spending on health by both state and federal governments has increased there is little evidence of improvement.

If we are to develop an effective and sustainable health system, new strategies need to be developed. These must involve the need for all Australians to re-think our attitude to healthcare; specifically, effective, fair and adequate funding of the system and effective and efficient management of those funds. If we are to improve our health system and aspire to 'world's best practice' then, clearly, more funding is required. However simply injecting more funding into the states for public hospitals will not necessarily address the problems they (we) are facing. An increase in funding

must come from government and this implies an increase in tax for all Australians; the government must also encourage more Australians to have private health insurance ensuring that premiums are set according to income.

Just as important as the effective, fair and adequate funding of the system is the effective and efficient management of those funds. It is here that all of us involved in healthcare – governments, doctors, nurses and other healthcare professionals including managers at all levels – must take leadership, responsibility and accountability.

There has been, and continues to be, bickering and buck-passing between state and federal governments, their health department bureaucrats and duplication of services. This writer believes that effective reform can only be brought about by the federal government assuming complete control of the health system. That would hopefully ensure that the ever increasing number of bureaucrats that spend a lot of time and money justifying their existence whilst draining front line services of funds is significantly reduced. This would enable funding to be directed into frontline resources, training and recruitment.

Well-meaning attempts have been made to involve the private health sector with the public system. These however have had limited success because of conflicts arising from different political foci and views that are reflected in exclusion of any private care providers from the Australian Health Care Agreements. Private health insurers and providers of care, in my opinion, play a significant role in helping meet the demand for acute hospital care. The government must recognise the impact an improved public/private partnership would achieve and change the existing models of funding to include some private financing through tax subsidies and private health insurance premiums. The universal health insurance proposed above would be an essential component in an enhanced public/private partnership, whereby tax revenues could be targeted to meet identified service gaps and problems as well as fund universal programs.

All very simple really, all it takes is courage and commitment...

**Ms Catherine Gannon** BNur, GradCertMktg, MHSM
*Bed Manager*
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Ramsay Healthcare, New South Wales, Australia

6 Currently, the Australian healthcare system is facing the same problem that is confronting all affluent developed countries. The rising demand for healthcare services due to an ageing population; obesity and chronic disease, and a critical workforce shortage are some of the key health challenges that Australia may face over the coming years. These problems, if not addressed earlier, may undermine the effectiveness and efficiency of the healthcare provision and topple an already overloaded system in the next decade.

An ageing population will pose big challenges to existing healthcare systems. It is estimated that the proportion of the population over the age of 65 will increase from 12 per cent to around 20 per cent over the next 30 years. This means that changes will be required in the type of healthcare services delivered, the coverage of health insurance schemes and the direction of medical research. Additionally, it is predicted to have a huge economic impact as well. The reduction in the available workforce relative to the non-working population will slow the growth in per capita Gross Domestic Product (GDP), assuming constant productivity growth. It is estimated that by the mid 2020s, ageing will reduce Australia's per capita GDP growth to half its current rate. [1]

Chronic disease is a growing problem in Australia with conditions such as cardiovascular disease, cancer, diabetes mellitus, injuries, mental illness, arthritis and musculo-skeletal problems placing an increasing burden on health costs. According to the Australian Bureau of Statistics, these conditions, targeted as national health priority areas, accounted for 36 percent of total health expenditure in 2000-01. [2] Over the coming decades, prevention, early detection and treatment of these conditions will remain a key health challenge.

A further problem is the obesity endemic that is currently gripping Australians, especially lower socio-economic section groups and the Indigenous population, whose health status is worse than the health of people in third world countries. In 2004-05, an alarming 53 percent of all Australians were either overweight or obese, an increase of 44 percent compared to 1995. Study after study has found that being overweight or obese is associated with a number of health problems, including diabetes mellitus, heart disease, high blood pressure, high blood cholesterol, arthritis and mental illness. This places a large burden on the healthcare system in terms of expenditure on hospitalisation, medication, diagnostic services, and other out-of-hospital medical care including general practice and community health services.

Any increases in health costs due to ageing and obesity should be manageable, particularly if governments put greater emphasis on preventive measures and early intervention, which could limit the incidence of chronic diseases. Similarly, better relationships between the private and public sector, providing greater access based on need rather than the ability to pay, and tackling the workforce issues can be a way forward in effectively fighting these challenges.

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7 It feels somewhat like punishment to make readers trudge through yet another list of challenges for the health system of the future. We all know what they are: you lot are going to get older and we're going to have to care for you somehow – oh, and we won't have enough people or money with which to do it. On top of the growth in total demand, the increase in chronic illness, co-morbidities and social isolation will require healthcare services to function much more effectively as a true system. 'Good Luck with that!' I can hear you all chiming.

What gives me a thrill is the idea of becoming the sort of health manager who is a worthy respondent to those challenges. With hints continually surfacing that the anticipated Australian Health Care Agreements will define an environment of reciprocal accountability between the states and the Commonwealth, there's little doubt that increased accountably will trickle down to the managers within the organisations providing the services.

An obvious starting place therefore, lies in our ability to measure and report the ebbs and flows in the performance of our health system. I might be alone on this one, but there's something so deliciously satisfying about entering beautiful data into a well-designed system and producing a brilliantly sculpted report at the end. And, at the risk of opening myself up to some serious rebuttal, they needn't be perfect data; just those data that have ventured past that magical threshold into the realm of usefulness…mmmm, it gives me goosebumps just thinking about it!

Now, I know what you're thinking: 'but what if the public misinterprets the reports?'. The truth is, the media – bless them – will always grab the reports and twist them to put a spin on a story. How do we deal with that: stop measuring our performance; hide the information from the community; or engage all the stakeholders in a process of education and consultation about performance and priorities?

In response to some of the other challenges, the innovative solutions seem to have already been developed for us. For instance, there appear to be several IT systems in existence that arguably have the ability to capture performance and ultimately improve all elements of quality; including, most importantly, patient safety. What's more, some jurisdictions seem to be cracking the code to the ever-elusive electronic medical record. If you listen to one entertaining presentation by NHS' Simon Eccles, you'll be grabbing a set of pom-poms and chanting with me 'Ra, Ra, EMR!'.

Had I actually given you that list of challenges for the health system, there's no doubt workforce issues would have featured in bold font, with a double underline. This is another complex concern that most of us agree is not going to be resolved by simply pumping more money, for more of the same, into the system. But again, the answers are already known and well-described by Victorian Health Services Management Innovation Council Chair, Brendan Murphy; we just need to make them happen.

Perhaps what the emerging managers need to excel at is navigating the labyrinth of implementation obstacles to finally make these brilliant ideas a reality across Australia. Maybe we could start by contributing to the baby-step of implementing a nation-wide unique patient identifier? Blimey, let's be brave and make it opt-out!

**Ms Briana NL Geelen-Baass** BPO, GradCertHlthPolMgnt, MHA, AFCHSE, CHE
*Business Manager, Ambulatory and Surgical Services*
The Royal Victorian Eye and Ear Hospital

8 Ultimately whether we like it or not, it is likely that we will be a patient of a health service system somewhere in our lifetime. So will this service we get keep the promise given to discerning patients at the point of negotiation and consent? Will it support our desire to maintain/regain health balance and wellness in a satisfactory way? Did intervention occur at just the right time in spite of the daily changing financial, political, social, local or even global spectrum of events? Are these aspirations too naïve, premature or ideal to be challenged at this time?

I imagine one of the future healthcare service challenges may be fluttering somewhere around the question of whether the 'bird in the hand' outcome of what a patient gets, is as satisfying as the 'birds in the bush' outcome of what they think they could have got in an alternative system whose advertising appears to offer so much magically more.

Strategic health service management using the wisdom of our collective knowledge, learned through the sometimes unfortunate and sometimes inspiring lessons of the past, would aim to formulate a systematic set of plans, agreed on by all involved to achieve desired and broadly acceptable outcomes. Sustainable and smart use of precious resources must be the mantra of our times. We must consciously and collectively resolve to survive, and to survive well-integrated and together. Connectedness between the components of our health services and essential agencies must be a top priority if we are to get the right balance for the right results. Some key challenges that face us daily whether as manager, clinician or health service user include communication, expectation, participation, joint and mutual responsibility for outcomes and a sense of belonging and ownership to where we happen to find ourselves located. Infrastructures that are genuinely holistic and inclusive can potentially make or break the greatest of our healthcare system's foundations and structures, and they do. Does our healthcare service facilitate and support our participation to bring about wellness or does all the responsibility for our fate lie with our service providers?

Factored into a wider canvas of our specific demography, and particular economies locally, nationally and abroad, are a range of issues that require close scrutiny and analytical attention. These include the impact of a rising population on resources, unemployment, immigration, retirement and extended life-expectancy rates of the growing numbers that comprise an already ageing group. Is our retiring workforce being offset by rising numbers of new people entering work?

How to sort it all out? Smart strategies need to achieve mutually agreeable and inclusive results. Leadership and management requires a style of optometry (and optimism) with an eye on the horizon while keeping the other firmly focussed on the ground to avoid pitfalls and remain credible. Such high quality Health Service Management (HSM) optometry is required to support the clarity of vision new managers such as myself need as they emerge, determined to avoid sclerotic vision, cataracts and the perceptual disabilities of some prior systems. Hopefully also, they are determined to listen to and extend the inspiring work of great managers of the past who kept their eye on the horizon while maintaining focus on what they witness in their own backyard. With such acuity, determination and 'optimism', new managers will be able to process complex challenges using the brilliance of a broad bird's eye panorama that still includes key details, and forge an effective link in the chain of an enduring kind of HSM that will fly well into the future.

**Ms Diena Grant-Thomson** BSpThy, MSPA
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# Joy Vickerstaff

*In this issue of the* Asia Pacific Journal of Health Management*, Angela Magarry, Executive Director, Policy and Analysis, Australian Vice-Chancellors Committee, interviewed fellow Australian Capital Territory (ACT) compatriot, Joy Vickerstaff on the eve of her retirement from health. Joy Vickerstaff is the Executive Director of Nursing and Midwifery Services at The Canberra Hospital. Since October 2006, Joy has also been the acting ACT Chief Nurse. She will retire in 2008.*

*Joy graduated as a registered nurse from Balmain District Hospital, Sydney, and was awarded the Hospital's Gold Medal and the AM Kellet Memorial Prize, for first place in the New South Wales Nurse's Registration Board examinations. She subsequently undertook Midwifery training at St George Hospital, Kogarah, again graduating with the hospital medal and first place in the State examinations.*

*Following this, Joy undertook a diverse range of roles in clinical, educational, management and leadership positions. Joy holds a number of Board memberships and is active on many committees and working parties. She has contributed to healthcare services through a number of professional nursing bodies, Australian Council on Healthcare Standards (ACHS) and the Australian College of Health Service Executives (ACHSE). Joy is a Fellow of the College. Her ongoing professional interests include safety and quality, and the ethics of resource allocation.*

*The College extends its appreciation to Joy Vickerstaff for her commitment to healthcare management and years of involvement with ACHSE.*

***Associate Professor Joy Vickerstaff*** *MCogSci, BA ,DipNEd, DipNAdmin, CertHlth Econ, FRCNA, FCN, FCHSE, CHE*

### *What made you venture into health management?*

I was guided into health management out of a strong interest in management and I also love a challenge! I could see major challenges to the nursing profession from dynamic changes in the healthcare environment and I wanted to ensure change was managed so as to benefit all concerned.

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

One of most rewarding and enjoyable aspects of my position relates to the opportunity that exists for nursing as part of the health professional team. The Magnet Hospital accreditation process that occurred while I was Executive Director of Nursing Services at The Princess Alexandra Hospital in Brisbane in 2004 was a major highlight, as it was the first hospital in Australia to receive the accreditation. I have striven to frame my involvement in health policy in the Australian Capital Territory along similar lines, as I believe the most important contribution I can make to nursing is in the influence I can exert from my leadership position. I am pleased to be able to contribute in the national nursing policy environment as the challenges continue!

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

I would very much like to see an application of the Magnet accreditation award developed as one of the keys to best practice for the future management of nursing in Australia. The process empowers nurses in nursing. Magnet is not for every organisation to strive for however parts of the process can work everywhere.

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

I have received my inspiration from others around me. I view mentoring as appropriate where the discussion results in the inspiration to continue. I believe the current challenge in nursing is how to retain quality in constant change.

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

Contemporary healthcare management requires a capacity to be adaptive to change. I see the future being about adaptation to changing patient outcomes and striving to be proactive in that context. There must be a continued commitment to ensuring nursing is knowledge-based.

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

Be inclusive in managing change, seek legitimate authority from staff to advocate and implement change and read the literature available. The most effective advice on complex managerial issues is often from professional networks, colleagues and mentoring. Talk about change.

Note: This In Profile was prepared with the assistance of Angela Magarry FCHSE who interviewed Joy Vickerstaff.



## *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 eigth issue of the Journal. The deadline for receipt of papers is 31 December 2008.**

BOOK REVIEW

# Managing Clinical Processes in Health Services

**Reviewed by S Mott**

**Bibliographic details:**
Sorensen R and Iedema R (editors).
Managing Clinical Processes in Health Services.
Sydney: Elsevier; 2008.
ISBN: 9780729538251

This well-presented Australian text comprises fourteen chapters by a wide range of authors with academic, policy and/or clinical expertise in health services management. It uses evidence from contemporary literature and related research to lay the foundation for what is known about managing clinical processes in health services. It takes a national perspective informed by global contexts. The complexity of healthcare is acknowledged and explored throughout the book with a multitude of suggestions for improvement.

The book is structured in three parts: the environment in which health services are delivered and managed; operational aspects of managing clinical processes; and issues of accountability for health service outcomes.

The need for health systems to be transformative is the underlying message of the first section. Chapter one, written by the book's editors, is an interesting tour around the world in comparison to Australia's performance on a range of health criteria. The other two chapters in this section discuss the value and politics of healthcare.

Part two explores the operational environment from a number of perspectives. Transdisciplinary and integrative approaches are presented as the most cohesive manner in which to deliver health services. Chapter eight (Willis, Dwyer and Dunn) is particularly moving, as it features one of the author's children, Keown, who spends several years closely associated with health services as he battles and eventually succumbs to cancer. Keown's experiences and those of his parents serve to show the importance of integrated teamwork.

An area often not best attended is the accountability for and outcomes of patient service delivery. Part three includes contemporary thinking on quality and safety. Chapter ten, by Boaden and Harvey, demystifies approaches to clinical quality improvement. The need for managers and clinicians to work together is emphasised, especially in the area of systems improvement.

This book has been very well edited to ensure consistency whilst maintaining each chapter's individual literary style and content. Every chapter contains several pauses for reflection. These are helpful for readers who are consuming the entire chapter as well as those skimming the content. The questions raised in these pauses would make useful triggers for small group discussion in the workplace.

Another useful mechanism to keep the reader engaged is the use of Implications for Practice boxes. These provide information and pose questions for consideration. Case studies are used throughout the book to provide the realism of health service management. The references throughout the text are up-to-date and/or seminal publications.

This text is informative and challenging and a most useful adjunct to publications in contemporary journals.

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# LIBRARY BULLETIN

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

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## AGED CARE

**Do Your Homework on Laundry Design**
*H&A Hospital & Aged Care*
July 2008 pp 19-21
Experts say laundry design should take a greater priority for aged care facilities.

**Evaluation of the Impact of Accreditation on the Delivery of Quality of Care and Quality of Life to Residents in Australian Government Subsidised Residential Aged Care Homes**
Department of Health and Ageing, October 2007
http://www.health.gov.au/internet/main/ publishing.nsf/content/ageing-iar-final-report.htm

**Modelling Costs of Dementia in Australia: Evidence, Gaps and Needs**
Nepal, Binod and others
*Australian Health Review*
Vol 32(3) August 2008 pp 479-487

**Residential Aged Care in Australia 2006-07: A Statistical Overview**
Australian Institute of Health and Welfare, 2008
http://www.aihw.gov.au/publications/index.cfm/title/10589

## DENTAL SERVICES

**Overview of Commonwealth Involvement in Funding Dental Care**
Biggs, Amanda
Information and Research Services, Parliament of Australia Library, August 2008
http://www.aph.gov.au/library/pubs/rp/2008-09/09rp01.pdf

## HEALTH FACILITIES PLANNING AND DESIGN

**Business Case for Building Better Hospitals through Evidence-based Design**
Sadler, Blair L, DuBose, Jennifer and Zimring, Craig
*HERD Health Environments Research & Design*
Vol 1(3) 2008 pp 22-39

**HCAMC Emerging Issues Workshop No 1 – Operating Theatres, Adelaide, 21 April 2008**
Centre for Health Assets Australasia, 2008
A workshop to share research and receive feedback from clinicians, managers and designers regarding latest trends in clinical practice, technologies and design.
http://www.fbe.unsw.edu.au/chaa/3.4.0_eventscalendar.asp

**HCAMC Emerging Issues Workshop No 2 – Health Planning Unit, Royal Brisbane and Women's Hospital, 4 August 2008**
Centre for Health Assets Australasia, 2008
Speakers outlined current trends and information about what is currently being planned or built.
http://www.fbe.unsw.edu.au/chaa/3.4.0_eventscalendar.asp

**Hillingdon Hospital Single Room Pilot Ward**
NHS Trust, March 2007
A 24-bed unit with 100% single room accommodation along with supporting services.
http://www.sykehusplan.no/data/booklet_070423_3.pdf

**Inflationary Pressures (In Capital Construction Projects)**
Nolin, Scott,
*Health Facilities Management*
Vol 21 (5) May 2008 pp 21-25

**Interim Guidelines for the Economic Appraisal of Capital Projects June 2008**
NSW Health Guidelines: GL2008_013, July 2008
http://www.health.nsw.gov.au/policies/gl/2008/pdf/GL2008_013.pdf

**Interior Design Manual: For New Construction and Renovations of Hospitals and Clinics**
US Department of Veterans Affairs, May 2008
http://www.wbdg.org/ccb/VA/VADEMAN/dmidhonh.pdf

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**READING LISTS**

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

- Emergency Services
- Human Resources Management
- Managerial Skills
- Performance Management

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

# Manuscript Preparation and Submission

## General Requirements

### Language and format

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

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

### Title page and word count

The title page should contain:

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

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

### Abstract, key words and abbreviations page

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

### Main manuscript

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

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

### Major and secondary headings

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

### Figures, tables and illustrations

Figures, tables and illustrations should be:

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

### Copyright

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

### Ethical approval

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

## References

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

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

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

**Books and Monographs**

1. Australia Institute of Health and Welfare (AIHW). Australia's health 2004. Canberra: AIHW; 2004.
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Further information about the Vancouver referencing style can be found at http://www.bma.org.uk/ap.nsf/content/LIBReferenceStyles#Vancouver

## Types of Manuscript - some general guidelines

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

**Content**

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

**Abstract**

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

**Main text**

Structured appropriately. A suitable structure would include:

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

Word count: general guide - 2,000 words.

References: maximum 25.

**2. Research article (empirical and/or theoretical)**

**Content**

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

**Abstract**

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

Word count: maximum of 300 words.

**Main text**

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

The discussion section should address the issues listed below:

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

Word count: general guide 3,000 words.

References: maximum of 30.

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

**3. Research note**

**Content**

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

**Abstract**

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

Word count: maximum 200 words.

**Main text**

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

Word count: general guide 2,000 words.

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

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

References: maximum of 25.

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

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

**Content**

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

**Abstract**

Structured appropriately.

Word count: maximum of 300 words.

**Main text**

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

Word count: general guide 3,000 words.

References: maximum of 50

**5. Viewpoints, interviews, commentaries**

**Content**

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

**Abstract**

Structured appropriately.

Word count: maximum of 200 words.

**Main text**

Structured appropriately.

Word count: general guide 2,000 words.

References: maximum of 20.

**6. Book review**

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

## Covering Letter and Declarations

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

**Covering letter**

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

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

**Declarations**

**1. Authorship responsibility statement**

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

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

**2. Acknowledgements**

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

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

**3. Conflicts of interest**

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

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

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

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

## Criteria for Acceptance of Manuscript

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

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

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

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

## Peer Review Process

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

The process involves:

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

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

## Submission Process

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

(Preferred approach)

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

   Or

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

All submitted manuscripts are acknowledged by email.

### NB

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

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

ACHSE is seeking expressions of interest

# NHS UK Health Executive Workshops Liverpool and the United Kingdom

## Sunday 8 June – Tuesday 16 June 2009 *(proposed dates)*

To build on the successes of a similar program that we managed in June 2008, ACHSE is seeking expressions of interest from CEOs and senior health executives to join us for another planned trip to the UK to listen, learn and exchange experiences with like-minded health leaders on such issues as:

- Transformational leadership
- Innovation and improved service delivery
- Continuous improvement of the patient journey
- Leadership and taking personal responsibility for outcomes
- Cost, quality and safety

We'll again be tapping into the extensive and professional development learning and networking that the NHS Confederation Annual Conference offered delegates in 2008 by incorporating the 2009 event into this week-long activity.

The NHS Confederation Conference alone provides a timely summary "update" overview of the main issues and strategies facing all public-funded national health services – and offers an ideal opportunity to focus on emerging key international issues. This is the UK's largest annual gathering of senior health service influencers and decision-makers.

Let us know early enough about your personal interests and these can then be accommodated into the final program of flexible executive workshops. These activities will really build on the key innovations that the NHS Institute for Innovation and Improvement has been working on these past few years – and comes at a critical time as the Australian Rudd Government – through the National Health and Hospitals Reform Commission – publishes its long-term health reform plan to provide sustainable improvements in the performance of the health system (June 2009). Much of what we now need in Australia already exists in the UK.

And this is what one of the 2008 Workshop attendees had to say about this study tour/workshop:

***"Overall, this will be hard to top as far as an organizational study tour is concerned. This trip has probably been the highlight of my management career thus far."***

**Aiden Cook**, *Director of Medical Imaging Technology*, Toowoomba Health Services, Queensland Health

To register your interest, please email Sue Thomson **nationalpd@achse.org.au** or call on **02 9878 5088**