Chapter 1

Introduction

Organisational and system change have become common characteristics of health systems in developed countries internationally, and consistent with this, the South Australian health system has been caught up in a cycle of change and restructuring for almost thirty years. Neo-liberal reforms to public sectors (which have characterised advanced economies since the early 1980s) have played a key part in this process of constant change in the Australian and South Australian health systems and across the public sector more generally for the last twenty years and have influenced the nature of these changes throughout this time.

This thesis analyses a case study of an attempt by South Australian health care agencies to develop and implement a regional health service. The case study is used as the basis for analysis and critique of the nature of and difficulties experienced in implementing collaborative organisational change within the health system of an advanced economy. The study describes and analyses the key aspects and themes of the case study within its historical and political contexts in order to understand the reasons for constant change, and the structural and systemic impediments to successful reform within health systems of advanced economies such as the South Australian health system.

Aims of the study

The focus of this thesis arises from the observation of increasingly rapid changes that have been occurring within the South Australian health system and across the South Australian public sector and which have been particularly evident from the mid-1990s to the current day. It builds a systemic understanding of the nature of these changes, their origins and drivers.

The thesis case study involves a regionalisation process initiated by a group of four health care agencies in southern metropolitan Adelaide to increase regional coordination and collaboration in order to improve health service provision and health outcomes for consumers, and to manage the increasing financial and service demand pressures that the agencies were experiencing. Following many years of informal and ad hoc collaboration between staff working in these agencies, the four agencies agreed to formalise their collaboration, and through an extensive consultation process developed a model to achieve this. This model proposed a new regional structure within which they would all operate. The proposed model, which was for the creation of a single regional health service incorporating the four agencies, and a subsequent proposed model for a loose federation between the agencies, were not supported by the newly created South Australian Department of Human Services. This resulted in a gradual shift back to the domination of institutional priorities among the agencies, although during the development of a regional approach, there had been a clear focus on regional service delivery priorities and an intent to move towards a population health focus within the region.

While using the specific case study as a basis for discussion of collaboration and organisational and system change, this study focuses on a number of key issues that have broader implications for the health system in South Australia, including:

- the roles and relationships of bureaucracy and service provision in the policy process and the reasons for and implications of differing agendas between the bureaucracy and health care service providing agencies

- the consequences of a clash in policy agendas within the implementation of policy when 'top down' does not meet 'bottom up'

- the reasons for and nature of constant change within the health system

- the implications of trying to manage organisational change in a complex system where outcomes are unpredictable and control over the change processes is difficult to grasp.

The thesis contributes to understanding the implications and influence of global trends on local health policy initiatives through focusing on a particular example of health care reform at a local level, considering the implications of broader policy change on this process and relating these to global trends in health care reform. In doing this it also considers the factors that support or impede the implementation of health care reform. It achieves this by reflecting on the following key research questions and sub-questions:

1.   How has the relationship between bureaucracy and health care service providing agencies been influenced by global trends in policy processes?

  - What are the global trends that are influencing the changing role of bureaucracy and how have they been influenced by local context?

  - How are these global and local trends influencing the relationships between bureaucracy and health care agencies?

2.   How is organisational change managed in a complex and continually changing environment?

  - What elements of the health system support and impede the implementation of health care reform through organisational change?

  - What are the key issues that support and impede organisational change to improve coordination and collaboration within the health system?

This study reflects on the research questions by placing the case study within the context of its history and policy environment and then considering key emerging themes from the analysis of the case study to build an understanding of the key issues that influence organisational and health system change. The key themes discussed in the thesis are trust and interagency collaboration; power and control within the health system; and the tensions between centralisation and regionalisation. Each thematic discussion includes a literature review on the key theme and analysis of the data from the case study to build on current knowledge about each theme.

Chapter 2 of the thesis sets the scene for the study by providing its broad international and Australian context through an analysis of the implementation and impact of managerialism and economic rationalism on Australian public services and the Australian health system. Chapter 3 then discusses the theoretical and methodological underpinnings of the study including the role of policy networks and policy processes in organisational and system change. In considering the experience of change within health systems, the chapter presents the concept of 'churning' as a metaphor for describing continuous efforts to achieve change in a turbulent environment. The chapter then develops a discussion of the concept of negotiated order (Strauss 1978) as a way to understand the underlying difficulties in advancing health care reform. In order to develop a deep understanding of the case study, the methodological approach of the study is multidisciplinary in nature, incorporating a number of social science disciplines including sociology, political science, historical analysis and organisational theory. It is a qualitative study with an interpretive, critical theory-based approach which contributes to and develops an understanding of the nature of the power and trust relations within the health system through analysis of a specific case study. To achieve its aims, the study employs a variety of methods including interviews, participant observation, focus groups, document analysis and a survey. Chapter 3 also discusses the challenges for the researcher in undertaking this study and addresses some of the key ethical issues that were critical in its development.

Chapter 4 provides a history of administrative reform in the South Australian health system with a particular focus on two key developments – the establishment and evolution of the South Australian Health Commission and the introduction of the separation of purchaser and provider functions. The chapter discusses the relationship between these examples and the introduction of managerialism and market based reform in the South Australian health system and provides the background context for the case study.

Chapter 5 is a detailed narrative account of the case study which involved four agencies that unsuccessfully attempted to create a regional health service in the southern metropolitan area of Adelaide. The agencies named the process they used to develop a regional collaborative approach 'Designing Better Health Care in the South'. This chapter describes the different agendas and perspectives of participants from the agencies involved in Designing Better Health Care in the South, and of the state bureaucracy, the Department of Human Services, which prevented the implementation of the proposed regional model. Analysis of the case study in the following chapters contributes to developing an understanding of the nature of and difficulties in implementing system and organisational change within health systems in developed countries such as Australia.

Subsequent chapters analyse key themes that emerge from consideration of this case study. Chapter 6 reviews the literature on models of governance as contested views about governance were of significant importance within the case study of Designing Better Health Care in the South. The chapter outlines the history of the experience of regionalisation and centralisation within the South Australian health system and continues the development of the concept of churning, which is a result of an ongoing search for elusive solutions to policy problems that are complex and intractable.

Chapter 7 focuses on the key themes of trust and interagency collaboration. Analysing data from the case study, this chapter describes the important role of trust in collaborative interagency activities and discusses the impact of mistrust on the management of organisational change. Chapter 8 builds on this analysis further by analysing the key themes of power and control in the health system as they are revealed through the case study. In focusing on this theme, Chapter 8 considers the impact of power on the relationships between bureaucracy and service providing agencies, and between organisational management and professionals working within these agencies, in creating a 'strife of interests' that results in ongoing tensions within the health system (Sax 1984). The chapter concludes with a discussion of negotiated order and its contribution to understanding the complex nature of the health system,

the power relations within it, and the difficulties in implementing health care reform. The thesis concludes in Chapter 9 by identifying the key findings from the study. It considers the causes of churning within the health system, and the role of negotiated order and its contribution to churning and maintaining existing power structures within the health system. The chapter concludes by considering possible ways forward in achieving reform within the health system as a negotiated order.

Chapter 2

The Public Sector and Health Care Reform: The International and Australian Context

This chapter provides an overview of the international and national policy environments which are having a significant impact on reform within the Australian and South Australian health systems at the time of this study. The broad international and national context described here includes consideration of the origins of managerialism and the emergence of a variety of new approaches to the organisation of public administration in Australia which have collectively come to be called 'the New Public Management'. The chapter considers the impact of New Public Management on health care reform internationally and on the health system in Australia[1]. Through this discussion, the chapter develops an understanding of the political and public sector reform context that underpins the case study of Designing Better Health Care in the South.

Public sector reform in Australia

A feature article by Miles Kemp appeared in the Adelaide *Advertiser* on Saturday, 29 July 2000 titled 'Out of Service' . It described the impact of the South Australian state government's efficiency drive on the public service. The article criticised the significant state government investment of $90 million on private sector consultants, who were described by the article as being 'unaccountable' and lacking long term commitment to the public. It romanticised the role of public servants, using words such as 'characteristic public service modesty' and 'good old-fashioned public service thoroughness' to describe the role of a public servant who, while checking a formula used in calculations during negotiations for the lease of ETSA (the state Electricity Trust) to private companies, uncovered a significant omission in the

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[1] See Appendix 1 for a historical timeline of major events in the development of the Australian health system from 1972 – 2000.

formula which could have resulted in the state being required to pay significant compensation to the companies involved. The article then detailed reductions in numbers of public servants in service areas such as health and education and, through interviews with the secretary of the Public Service Association (the public sector union) and the Chief Executive of the Department of Premier and Cabinet (described as 'the state's public service head'), raised concerns about some of the consequences of cuts to public service employees who were either being replaced by temporary staff or consultants, or were not being replaced at all. The newspaper article was not entirely scathing of this approach, acknowledging that there have been some benefits from the government's efficiency drive, but described some results of the strategy as having been 'catastrophic', leading to poorer service and higher prices as a result of privatisation and outsourcing, and the creation of 'a massive top-heavy management structure' of ten super-departments created from the amalgamation of fifteen government departments.

The approaches described in *The Advertiser* article are symptomatic of international trends in public sector reform which have been the source of animated debate between academics and public service reformers in Australia over the last twenty years. This public sector reform agenda in part has its Australian origins in the social democratic reforms to the Commonwealth bureaucracy initiated during the term of the Whitlam Labor government from 1972-1975. This period commenced a process of revolutionary and ongoing transformation of the organisation of the Australian public sector that has been significantly driven by three key intellectual catalysts for change – the social democratic, the economic rationalist and the managerialist. Each of these intellectual movements is based on different values and ideologies and has different origins (Orchard 1998). However, they have sufficient commonalities to be combined to determine the direction of public sector reforms, resulting in significant change to the role and function of the public sector from the 1980s to the beginning of the 21st Century.

The public sector reform processes have led to significant changes in conditions of employment, methods of budgeting and in relationships between service providing agencies and central bureaucracy. They have occurred concurrently with significant deregulation and privatisation of public services and a focus on reducing public spending, restraining public investment and limiting taxation (Considine and Painter 1997). Considine and Painter argue that these:

> … organisational strategies and reforms … came from a mixture of international and local sources, and were differently applied by governments of various political persuasions. Equally, we see a process of development (and degeneration) in a number of the reforms which speaks of a significant level of local adaptation, contest and experimentation. This suggests that managerialism has achieved a particular character in each period and place of implementation (Considine and Painter 1997, p2).

These changes are evident in both the Australian and South Australian health systems.

The origins and development of managerialism in Australia

The social democratic philosophy of the Whitlam Labor government supported a commitment to the role and responsibility of national government in intervening on behalf of citizens and consumers to regulate the impact of the private sector on the rights and welfare of the individual (Beilharz et al. 1992). The Whitlam government was supportive of a model of strong central government to respond to the population's needs through the public provision of services (Orchard 1998).

Following election in 1972, the Whitlam government implemented a series of significant reforms including, in 1972, the establishment of a progressive Community Health Program; and in 1974, the establishment of Medibank, Australia's first universal health insurance scheme (which was progressively dismantled by the subsequent Fraser Liberal/National Party Coalition government and later re-instated as Medicare by the Hawke Labor government in 1984), and of special purpose payments to the states to fund free 'standard ward' public hospital care. These Australian reforms formed part of a package of reforms through which new and

innovative policies were implemented in numerous areas including health, education and social welfare.

To achieve these reforms, the Whitlam government had made significant demands of the federal bureaucracy. New departments were created rapidly along with new roles for the bureaucracy, including those of ministerial advisor and of the central policy review unit. Problems experienced in the implementation of government reforms led to concern about the conservative nature of the public service, its remoteness from and resistance to new ideas and change (Beilharz et al. 1992). H.C. Coombs, a key advisor to Whitlam, chaired the first major review of the public service since World War II, the Royal Commission into Australian Government Administration, which aimed to make the public service more responsive to political and democratic processes.

> This wide-ranging review came in the midst of a period of unprecedented change and stress and reflected a growing dissatisfaction with the role of traditional bureaucratic institutions. … The Royal Commission was an attempt to review what had happened over the previous 10 years or so, to examine the needs of both government and the public, and to set out new guidelines for a more responsive, innovative and effective public service (Beilharz et al. 1992, p111).

The Coombs review (1976) sought to achieve two ends that were difficult to attain consecutively. It sought to create a public service that would maximise democratic control and participation, while also seeking to establish a system that would respond efficiently to executive command. The review attempted to 'open up the bureaucracy' both to influence from the community and from government in response to social change. It identified ways in which the public service gave greater power to people who were already privileged and argued for changes in the bureaucracy's composition to address this concern. The conflicting roles of the public sector as provider of independent non-partisan advice to government, and the requirements of ministerial accountability to Cabinet for the actions of the bureaucracy were also acknowledged as problematic (Beilharz et al. 1992). These same issues have been played out at the South Australian state government level, with the tensions between

ministerial accountability and independent advice evident in the establishment of the SA Health Commission and subsequent efforts by various health ministers to control and contain the Health Commission's and health system's independence. This is discussed in Chapter 4.

Peter Wilenski, a bureaucrat and social democrat reformer at this time, argued that the experience of the Whitlam years highlighted three types of public administration reform that would be necessary for the effective implementation of a social democratic reform agenda: the increased ability of bureaucracy to accept and implement change; the increased ability of the bureaucracy to be innovative in adopting social democratic policies and programs; and a focus on equity and compassion in the administration of programs (Wilenski 1986). He believed that the achievement of a supportive and responsive bureaucracy would require greater political control of the public service, the abolition of tenure for senior public servants so that sympathisers to the Government's reform cause could be appointed, that ministers should be directly involved in budget processes and that equity should be a key focus of policy analysis. While acknowledging the value of experience and corporate knowledge achieved through a structure of career public service, he also believed that these attributes could prevent adaptation to new activities and to rapid change (Orchard 1998).

Pusey (1991) describes social democracy as a quest for balance between economy and state on the one hand and a quest for balance between coordination from 'top down', with the norms of democracy grounded in civil society and expressed 'from the bottom up'. In contrast, he defines managerialism as a clustering of problem-solving and organisational skills taken from the private sector. These management skills are perceived by proponents of managerialism to be context and value-free and universally applicable, so that the senior executive work of the public and private sectors appears to be similar (Pusey 1991). Pollitt describes managerialism as the '… seldom-tested assumption that better management will prove an effective solvent for a wide range of economic and social ills.' (Pollitt 1993, p1). It is therefore significant

that the roots of managerialism in the Australian public sector can be found in the social democratic ideology of Whitlam's reformers and in their efforts to reform the public sector which were intended to increase the responsiveness of the bureaucracy both to a social reform-oriented government and to the community in implementing the government's social reform agenda.

Following the dismissal of the Whitlam Labor government in 1975, the subsequent Fraser Liberal/National Party Coalition government and the Hawke Labor government up to the mid-1980s increasingly focused on contraction and efficiency improvements, accompanied by a growing public perception of the failure of the bureaucracy (Considine and Painter 1997; Orchard 1998; Pollitt and Bouckaert 2000). By the end of the 1980s, a 'new managerialism' had emerged based on a belief that the small business logic of entrepreneurial management and the 'market solution' were the way forward. The combination of this new understanding of managerialism with strategies to scale down public services overlapped with the rise of economic rationalism, although not all managerialists of the 1980s were economic rationalists. However, by the 1990s, these views increasingly coincided (Considine and Painter 1997).

In 1987, Hawke committed his re-elected Labor government to 'micro-economic reform', with ideas of public sector restructuring being drawn explicitly from economic theory, including the separation of regulation from policy delivery and the introduction of competition. Hawke's micro-economic reform agenda continued into the 1990s, resulting in the 1994 agreement between the Commonwealth and states to adopt the National Competition Policy (Davis 1997). This policy agenda aimed to remove barriers to intersectoral, interstate and ultimately international trade, and to expose public monopolies to competition. The National Competition Policy opened both private markets and major government service delivery activities to competition. This reform process required regulation of ownership and the introduction of the separation of purchaser and provider models in government agencies that purchase but do not provide public services (Davis 1997). It has had a key role in health policy

in South Australia, particularly from the mid-1990s, resulting in the implementation of the purchaser-provider split (discussed in Chapter 4), and was an influencing factor in the initiation of Designing Better Health Care in the South.

The managerialist reforms culminated in the 1990s with the rise of the New Public Management, the shift towards entrepreneurial management, contractualism and privatisation. Hancock describes the key features of this shift as involving:

> … similar styles and models of management in the public and private sectors; a shift from process (bureaucratic) accountability to accountability through quantifiable results; an emphasis on generic management skills, devolution of management control under strict rules of reporting, monitoring and accountability; disaggregation of bureaucratic structures around separation of core from peripheral functions, policy advice from service delivery; the preference for privatisation, contracting and contestability; the use of specific, performance-based contracts; further emphasis on private sector management practices, including performance-based pay, corporate image making and new management information systems; the preference for monetary incentives for performance, and 'stress on cost-cutting, efficiency, and cutback management' (Hancock 1999, p50).

Orchard (1998) argues that during the Hawke/Keating period (1983-1996) the functioning of the Commonwealth bureaucracy was gradually and increasingly linked to government priorities, reflecting the intentions of the 1970s social democratic reformers. The resulting devolution of management, new approaches to budgeting and democratisation reflected themes common to both social democratic and managerialist ideologies. However, the priorities of social democratic government were increasingly being shaped and determined by economic rationalist arguments about the need to limit government and to pursue greater efficiency and competition through adoption of the private sector market model in public sector activity (Orchard 1998).

Concerns about the rise of managerialism and trends in public sector reform based on business practice were being expressed increasingly among academics by the late 1980s (Davis 1997), with counter arguments being posed by a senior and influential group of public servants, including John Paterson (1988) and Michael Keating

(1990). The supporters of the new managerialism defended it as emphasising results over processes, management over administration and flexibility over tenure (Davis 1997). Critics argued that the managerialist era of public policy under the Hawke government reflected a narrow economic understanding of the basis of social, economic and public life, and a narrow view of the most appropriate management strategies for Australia's public institutions (Orchard 1998). Pusey's *Economic Rationalism in Canberra* (1991) provided empirical evidence to support these criticisms, demonstrating that people educated in modern economics increasingly dominated senior positions in the Commonwealth bureaucracy. Pusey also showed that the most powerful central agencies of the Commonwealth – the 'inner triangle' which consists of the Departments of Prime Minister and Cabinet, Treasury, and Finance had come to dominate market-oriented departments, such as Trade and Industry, and program and service departments, such as Health and Education (Pusey 1991). Through this domination, the managerialist reforms in the public sector have contributed to the economic rationalist aims of efficiency, deregulation, lower government expenditure and greater reliance on market forces to increase consumer choice (Self 1990; Pusey 1991).

The influence of economic rationalism

Economic rationalist thought has its origins in a currently dominant ideology of modern western societies known as 'neo-liberalism'. This ideology gives a central role to the market which is seen as a rational system of resource allocation and a promoter of individualism based on the rights, responsibilities and opportunities of the individual[2]. Apart from government having a role in providing a legal framework for the functioning of the market, a neo-liberal approach supports minimal state involvement in directing market activity. Understandings and beliefs based on neo-liberalism can be seen as the source of the current decline of the universalist welfare

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[2] There has been growing opposition to neo-liberal reforms from groups such as the People's Health Movement, an international coalition of grassroots organisations dedicated to changing the prevailing health care delivery system which it argues is failing to address the deteriorating health of impoverished people in developing countries, and from academics (for example Braithwaite 2001; Pollock et al. 2002; Price and Pollock 2002).

state in Australia, as the welfare state came to be seen as too paternalistic, and interfering in the lives, freedom and choices of individuals. Consequently an earlier form of the welfare state began to be re-created with the election of the Fraser government in 1975 (Beilharz et al. 1992). This model was based on a charity, residual model of support rather than a universal model.[3]

Economic rationalism is based on an ideological commitment to the market system, combined with promotion of individualism and consumer choice, and a critical attitude towards community responsibility which forms the basic premise of the welfare state (Self 2000). Economic rationalism formed part of the political ideology of liberal democratic governments, such as the Thatcher government in the United Kingdom (1979-1990) and the Reagan government in the United States (1980-1988). This commitment to the market and its role in society was accompanied in Britain, the US, New Zealand and Australia (and to a lesser extent in Canada) by a strong belief that government had become too big and too expensive, and that wherever possible its activities should be transferred to the market or to voluntary organisations. Self explains that the basis of these arguments:

> … lies in beliefs that markets are more 'efficient' than government over the provision of most or almost all services, that markets work best with a minimum of regulation, and that consequently the less governments do the better. A further significant argument is that, insofar as government is necessary, it should be remodelled according to the principles of competitive markets. Taken together these dogmas represent a powerful thrust towards some loosely defined goal of minimum government which would work primarily as an auxiliary to the market system and would reflect the market's image (Self 2000, p99).

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[3] A residual model of the welfare state existed prior to the social reform agenda of the Whitlam government. This was evident in the post World War II 'Page Plan' which provided a framework for a national health system for disadvantaged members of the community, while the majority of the population were expected to finance their own health care needs through contributory private health insurance funds (Sax 1984). The Page Plan was based on reliance on the individual rather than community responsibility and worked largely through subsidies and regulation of private insurance funds. Prior to the election of the Whitlam government in 1972, a number of inequities and failures had become apparent in this plan, where 17% of the population had no insurance or access to public benefits and a further proportion were under-insured (Swerissen and Duckett 1997).

Kettl (2000) argues that public sector reform internationally has tended to originate from two different philosophies – the Westminster and the American. The British Westminster system had been exported to Australia, New Zealand and Canada and the reforms adopted have influenced all of these countries to a significant extent. Kettl explains:

> The Westminster-style strategy began by redefining what government ought to do. It led to the privatization of functions that officials concluded government could or should no longer do… The Westminster governments have launched sweeping, comprehensive reforms that have sought to restructure government and what it does, from top to bottom.
>
> The American-style strategy sought cheaper, more effective government without shrinking the scope of governmental activities. It has attempted to incorporate the best practices of business into government's operations, from customer service to a focus on results. Its reforms have been incremental rather than sweeping and comprehensive (Kettl 2000, p62).

In Australia, the bureaucratic change agenda that has been prevalent since the 1970s has been motivated by the desire of politicians to assert their will over a bureaucracy that, based on the Westminster system, provided independent advice and displayed impartiality, but could also potentially delay action on ministerial policies that it did not support, and therefore could frustrate their implementation. This desire was a result of an increasing recognition that permanent departmental heads of public service departments could not be apolitical and that governments should acknowledge this and appoint departmental heads with whom they could work (McCoppin 1995).

The adoption of an economic rationalist approach, which propounded the role of the market, combined with the agenda for bureaucratic change, resulting in a number of strategies to reform the public sector, including: significant cuts to the numbers of public servants through contracting out and privatisation; senior public servants commonly being appointed on short term contracts; increasing politicisation of the senior levels of the public service through the appointment of outside people to executive positions and through the increasing use of consultants; and the introduction of financial incentives such as performance-based pay (Self 2000). In contrast, the market ideology also included goals such as to 'let the managers

manage' (Keating 1990) and that the role of central bureaucracy is 'steering not rowing' (Osborne and Gaebler 1992) which gave more freedom to senior public servants to make decisions, although within tighter financial constraints. These elements have been combined in the composite of values and strategies loosely brought together in the doctrine of New Public Management (Pollitt 1995; Hancock 1999). They are evident within the South Australian health system and are discussed in this context later in this thesis. The following sections of this chapter discuss the impact of New Public Management strategies and approaches on trends in international and Australian health care reform.

The impact of market-based public sector reform on health systems internationally

To a varying extent, there has been a shift in most western countries towards viewing health services as commodities which can be bought and sold, determined by the preferences of consumers (Melhado 1998). Pressures to contain costs, increase efficiency and raise standards in many western countries have resulted in a range of health care reforms that have the logic of the market as their basis (Saltman and von Otter 1995; Baum 1998; Drache and Sullivan 1999). Health care reform strategies that have resulted from this approach include privatisation of public services and the commodification of health care; cost cutting and downsizing; decentralisation and regionalisation; separation of the role of purchasers and providers through the application of private sector organisational forms; and a focus on short term measurable outcomes (Ham 1997; Saltman and Figueras 1997; Baum 1998). These strategies have been applied to different extents in different countries and are also in evidence within the Australian and South Australian health systems.

Saltman and Figueras (1997) provide a comparative analysis of the development of health care reform in Europe from the early 1980s. They found that most European countries have undergone health care reform in response to pressures to contain costs, and that organisational arrangements initially established to promote equity, access

and health status have been increasingly constrained by cost-containment as a priority. They explain:

> In the late 1980s, many European governments began to re-examine the structure of governance in their health systems. In countries where the state has traditionally been the central actor in the health sector, the presumption of public primacy, along with a strong state role in nearly every dimension of health sector activity, is being reassessed. National policy-makers in countries in northern Europe, the Mediterranean region and central and eastern Europe have felt compelled by a combination of economic, social, demographic, managerial, technological and ideological forces to review existing authority relationships and structures. In countries where the state has played a less central role in the health sector, mainly acting to set out ground rules and to referee between quasi-public, statutory and/or private insurers and providers, a similar process of reassessment is under way, although from a different starting point (Saltman and Figueras 1997, p39).

They argue that although there have been variations in the pressure for change in different parts of Europe, certain parallel trends can be established in relation to governance. These include the decentralisation of some state functions to a regional level, the privatisation or contracting out of other functions, and an increasing focus on patient choice and consumer participation. They state that the greatest pressure for change has been in relation to the role of the private sector in operating, and in some cases, financing health care. The growing focus on governance in the public sector is related to the increasing impact of New Public Management approaches and the changing view of the role of the public sector and the state. This directly relates to the case study and is discussed in Chapter 6.

The conception of health care as a social good that benefits both individuals and society which is predominant in most European societies has supported the rationale for solidarity and universal coverage in the design of health care financing systems. In contrast, market-style incentives are based on the conception of health care as a saleable commodity. However, unlike other goods and services, health care is driven by peoples' needs, not their wants, and in many countries it is becoming increasingly evident that health care does not readily fit the market model (Kuttner 1998). Drache and Sullivan (1999) argue that after a decade of market-style reforms in the UK and

New Zealand, health expenditures as a proportion of GDP have gone up, and that privately financed health care is generally more expensive than the publicly financed alternatives (Drache and Sullivan 1999). The transaction costs of contract-based relationships (such as the costs of pricing services, negotiating contracts and increasing government regulation), have been found to outweigh improvements in efficiencies resulting from these reforms (Saltman and Figueras 1997). The market-style health care reforms of the UK, Sweden and New Zealand have received the most international attention, and these countries have retreated, at least in their rhetoric, from their reliance on competitive incentives to drive health care reform with increasing discussion of the important role of cooperation (Saltman and Figueras 1997; Gauld 2002).

International trends in health system reform

Numerous health systems have implemented strategies to separate the roles of purchasing and providing health care. The role of purchaser is to hold health care service providers accountable for the quality, efficacy, cost and outcomes of the care provided, increasing pressure on providers to improve performance through competition. Bureaucracies are being restructured to enable them to emulate private sector companies and through the separation of the roles of purchasing and providing, are being distanced from service provision, directing desired health and service outcomes through contracts. The UK and New Zealand were the first countries to adopt the separation of purchaser and provider and the introduction of the internal market within their public health systems. This approach emerged from the UK White Paper *Working for Patients* (Department of Health 1989) which outlined the aims of the Thatcher government for reforming the National Health Service, including to improve value for money, reward efficient and high quality service provision and to encourage greater responsiveness to patients while maintaining the National Health Service principles of equity of access for equal need. Following the 1997 election which resulted in the Blair Labour government coming to power, despite the rhetoric to the contrary, there was a high degree of bi-partisan support for

keeping the key features of the 1991 reforms that had established an 'internal market' in the UK National Health Service. The key differences between the Labour and previous Tory policies were in their emphases, with cooperation between purchasers and providers being promoted rather than competition and annual contracts being abolished in favour of longer term mutually agreed 'Health Improvement Programmes' (Dixon 1998). The experiences of the UK and New Zealand highlighted the difficulty of preparing contracts that adequately define the obligations of each party, and the high information costs of attempting to monitor these contracts for limited gains (Deeble 2000). This was also the experience in South Australia, with particular difficulty experienced in attempts to develop appropriate service agreements for agreed specified outcomes between the funder, the purchaser and the providers. The separation of purchasing and providing roles within the South Australian health system is discussed in Chapter 4.

Privatisation has been adopted as a strategy to increase the transfer of costs and responsibility for health care financing and provision from the public to the private sector. Saltman and Figueras (1997) argue that privatisation is the ultimate form of decentralisation, where public authority over decision-making is replaced with private ownership and funding, and where market incentives are introduced to encourage greater efficiency and improved quality into health care provision and management. They also identify the significant disadvantages of privatisation. Private investment and management require financial returns that are consistent with those that are achievable in other private markets. They found that privatisation can lead to re-centralisation as privately managed companies consolidate to achieve economies of scale. The US, which has the greatest private sector participation in health care, has also created the largest public regulation apparatus to monitor and regulate private funders and providers. A greater reliance on market mechanisms for funding and providing care has been found to result in increased regulatory control by governments to ensure quality and to prevent discrimination against the most vulnerable groups requiring care, as private funders attempt to maximise their returns (Saltman and Figueras 1997).

The decentralisation of state functions, another key health care reform strategy in many western countries, is seen as a means to encourage improvements in service delivery, improvements in needs-based resource allocation, and priority setting that involves the community in decision making about resource allocation. Decentralisation is seen to enable community participation and local self reliance as well as to improve accountability and responsiveness to local needs. There are numerous models of decentralisation, and certain elements of health care systems may be more decentralised or more centralised than others. In Germany for example, health care services are decentralised, while the monitoring and regulation of the numerous health insurance funds is undertaken in a more centralised manner. In the UK, following referendums in Scotland and Wales, there has been devolution from central to lower levels of government responsibility, including for health care. The tensions between centralisation and regionalisation as a form of devolution are central themes in this study, and are discussed in detail in Chapter 6 as part of the analysis of the Designing Better Health Care in the South case study.

Consumer choice and patient empowerment are also key issues driving health care reform. There is a growing expectation among consumers that they should participate in decision making about their health care, the selection of their doctor and hospital, and increasingly, about health care policy decisions and their impact at the local level. A focus on individual choice is associated with an emphasis on market principles such as competition, and is usually linked to the notion of consumer sovereignty. Many countries have introduced charters of patients' rights. For example, in Holland, patients' rights were introduced in legislation in April 1995, which treats the relationship between patient and doctor as a 'special contract' within civic law and includes the rights to informed consent, information, access to medical records, confidentiality, and medical liability (Saltman and Figueras 1997).

The World Health Organization's *Global Strategy for Health for All by the Year 2000* (1981) and *Ottawa Charter for Health Promotion* (1986) pre-dated many of the

trends described above. However, the health promotion/prevention approaches advocated in these documents have not received as much prominence internationally or in Australia as the reforms described above. This is in part a result of the strong international shift in focus to a market model of health care due to the increasing dominance of neo-liberal approaches to public sector management, and also a result of the dominance and power of the medical model of health, an issue that is discussed in Chapter 8. *Health For All by the Year 2000* and the *Ottawa Charter for Health Promotion* were developed when the Public Health movement was at its peak, and, although not receiving the same priority attention as acute care and treatment, led to an increased focus on primary health care and the social determinants of health in many countries, including Australia. However, the *Jakarta Declaration on Leading Health Promotion into the 21st Century* (World Health Organization 1997) signalled a shift in the philosophy of the World Health Organization towards a market based approach to health care, with a focus on health sponsorship and partnership with the private sector. The issues of cost containment and pressures for demand management continue to be given greater priority than population health, equity and prevention within health systems in Australia and other developed countries.

The apparent commonalities between health care reform trends in developed countries are a result of common pressures on different health systems. Although countries (and in some cases, regions within countries) are starting from different premises, the pressures to contain costs, the concern about the sustainability of the welfare state, and the increasing expectations of consumers that all that is possible should be available to them, have resulted in similar approaches being used to address these pressures. However, different historical contexts, different health system structures, and different social values have also influenced the shaping and direction of reforms in the health system. The final section of this chapter discusses the impact of market based reforms on the Australian health system.

The arrival of market-based public sector reform in the Australian health system

The Australian health care system is complex, with different sources of funding (from Commonwealth and state governments, the private sector and individuals), and with different approaches being taken by the states to their funding, purchasing and care management responsibilities. (The Australian health system is described in Chapter 4.) However, all Australian states appear to have similar aims, which are consistent with many international trends, and include the reduction of perverse incentives for expenditure and the containment of costs while maintaining the quality of care (Hindle and Braithwaite 1998).

The effects of the trends described previously in this chapter are evident in the development of health care reform in the Australian context over the last twenty years. The growing dominance of neo-liberal arguments increased the focus in health care planning on the importance of competition, individual responsibility, deregulation and the pursuit of efficiency (Swerissen and Duckett 1997). This focus is evident in a number of health care reforms implemented by Australian governments of both Liberal/National Party Coalition and Labor persuasions from the 1980s.

The pressure for health care reform in Australia, as in other developed countries, is a result of a number of key factors. Demographic change, specifically the ageing of the population and the increasing number of people with disabilities or chronic illness, is expected to increase health expenditure because of the anticipated increased demand on health services[4]. The continual development of new and often expensive technologies contributes significantly to increased expenditure on health care through the development and use of new drugs, treatments and equipment[5]. Along with these

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[4] However, there is some debate about the impact of ageing on health care expenditure because the greatest demand for health services comes in the last year of life, regardless of age (Healy 2004).
[5] While not all new technologies and procedures are more expensive than those previously available, their introduction can incur substantial capital costs for new equipment, renovated facilities and additional personnel.

developments, changing consumer expectations and increasing consumer demand for the latest available medical techniques have also contributed to the rising cost of health care. In conjunction with factors to do with safety and quality of care, these developments have placed pressure on health care providers and contribute to the increasing cost of health care delivery (Saltman and Figueras 1997).

These pressures have been experienced in all developed countries and have acted as both the driving force and the rationale and justification for health care reform. Combined with the public sector reform agenda described above which has had a significant impact on public service planning and provision throughout Australia, these pressures have led to changes in the way that the health system is perceived both by political parties and by the public. The introduction of 'razor gangs' to downsize the Commonwealth public service under the Hawke and Keating Labor governments, the creation of the Senior Executive Service within the public service along the lines of an American rather than a Westminster model of government (1984), the restructuring of the Commonwealth public service from 27 departments to 13 super-departments (1987), and moves to privatise or outsource government functions and utilities, as well as to shift the balance of financing to increase the role of the private sector have all contributed to the policy shift that has reflected the significant influence of a changing ideological perspective on the role of the public sector in health and other human services towards a neo-liberal market-based and individualistic approach and away from support for the central role of the welfare state in its universal rather than residual form. The consequences of this ideological shift, which increasingly came to the fore in Australia in the late 1980s and 1990s, have greatly influenced planning and policy and bureaucratic culture, and consequently service delivery in the Australian health system and are paralleled in reform strategies within the South Australian health system.

There are a number of key health care reform strategies that have signalled the growing acceptance of market-based reform in the public sector in Australia. These include the National Health Strategy, the health outcomes movement, the trial of a

model of service coordination and funds pooling for individuals with chronic illnesses in a form of managed care, and policies to increase uptake of private health insurance.

The National Health Strategy was a major health reform project that commenced in November 1990 under the Hawke Labor government and ran for a period of 2 years. The issues and strategies proposed within the National Health Strategy documents have had a significant influence on thinking, debate and planning in the Australian health system today and show evidence of the growing adoption of market based approaches in health care planning. For example, the National Health Strategy raised issues such as separation of funder and provider to create competition between providers, integration of services, continuity of care and packages of care being tailored for individuals (particularly those with chronic illness), area health management and resource allocation, and funds pooling. However, it also produced an issues paper titled *Enough to Make You Sick: How Income and Environment Affect Health* (National Health Strategy 1992) which focused on equity issues, and therefore the Strategy was not entirely dominated by a market-based approach to health care planning. The Strategy foreshadowed the development of a number of significant health reform strategies including the Council of Australian Governments' (COAG) reforms[6], which included the Coordinated Care Trials, the National Public Health Partnership, the purchaser/provider split, and various models of service integration/regionalisation to improve health outcomes for the community and the effectiveness and efficiency of health care delivery.

The 1990s also saw a growing focus on the measurement of health outcomes which appears to be related to increasing demand both from consumers and funders of health services for greater measures of accountability, and reflects attempts to contain costs (Noyce and Schofield 1997). Health goals and targets and measurable health

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[6] The Council of Australian Governments (COAG) comprises the Prime Minister, Premiers, Chief Ministers and the President of the Australian Local Government Association and meets periodically to discuss issues of national significance.

outcomes are being used for monitoring and have contributed to a growing focus on disease and injury. The identification of national health priorities has been significant in that it provides a national view of health and a framework of priorities and targets on which all Australian state governments can focus their efforts. Attempts have been made to link resource allocation and accountability for resource use to health outcomes through the use of mechanisms such as service agreements.

The proliferation of Commonwealth funding programs has been found to undermine continuity of care through fragmentation of services and often restrictive and inflexible funding guidelines. This issue prompted COAG attempts to improve the coordination of services through the Coordinated Care Trials. COAG endorsed the need for reform of health and community services in 1994, and in 1997, following an extensive consultation process, launched the Coordinated Care Trials to trial new ways of funding, managing and providing health care to people with chronic conditions or complex health care needs. The Coordinated Care Trials involved the pooling of Commonwealth and state funds across a number of health and community service programs to enable services to be packaged around individuals to more effectively meet their needs. The Coordinated Care Trials were one way in which the Commonwealth investigated a form of managed care for particular population groups in Australia with the aim of improving allocative efficiency and controlling costs while maintaining or improving the quality of care (Duckett 1998b).

In Australia, the 1980s and 1990s saw rationing of hospital services and waiting lists being used as means to control demand for health care. This period saw growing tensions between the Commonwealth and state governments over Medicare funding with continuing debates about the level of funding and about cost shifting between states and the Commonwealth. Concern about the pressures on public hospitals was used as a justification by the Howard Liberal/National Party Coalition government to introduce strategies in 1999 and 2000, such as an increased Medicare surcharge for higher income earners without private health insurance, a taxpayer funded 30% rebate for holders of private health insurance and the introduction of 'Lifetime Health

Cover' to coerce the Australian population to take up private health insurance, which, because of the popularity and success of Medicare among the Australian public, had declined steadily since the 1970s (Hall 1998; Duckett and Jackson 2000; Hindle and McAuley 2004). This strategy provides a clear example of the shift in Australian health policy towards a market-based approach to health care financing and delivery and an ideological commitment to the primacy of the private sector and to individual choice.

These health care reform strategies illustrate the key directions taken by Liberal/National Party Coalition and Labor governments over the last twenty years. In line with health care reform in other countries, the focus of national reforms has been on decentralisation and privatisation, on separating the roles of purchasing and providing services and on seeking new ways to deliver services that manage demand and contain costs. Although cost containment itself is not a health care reform, it has provided a significant motive for health care reform in Australia over the last twenty years (although this priority has been undermined more recently by a contradictory ideologically-driven policy which has resulted in the introduction of the 30% private health insurance rebate, increasing Australian government expenditure on private health insurance by $2.35 billion per annum (Duckett and Jackson 2000; Hindle and McAuley 2004)).

This chapter has provided an overview of the origins and introduction of market based reforms in the Australian public sector and health system, in this way providing the broad historical and health care reform context for the introduction of Designing Better Health Care in the South. The next chapter describes the theoretical concepts and methodological approach that are used in the analysis of the case study. It provides an overview of the debate concerning policy development and change, introduces the concept of negotiated order and considers how this concept can contribute to an appreciation of the tensions and power relations within the health system that have a crucial influence on the potential for and difficulties of progressing change.

Chapter 3

Methodology and Theoretical Approaches

This chapter describes the main theoretical concepts used to examine the case study of unsuccessful organisational change. The theoretical concepts include theories about policy development, and the role of policy networks and achieving policy change. The chapter introduces the concept of 'churning', a phenomenon which occurs when change is ongoing and never completed, and the theoretical concept of negotiated order and how it can be used to understand the challenges in achieving change in the complex and contested health system. The chapter also describes the methodological approach used in the study, the methods used for data collection and analysis and the ethical and political considerations that have been raised for the researcher by this research.

Theories of policy development

The conventional model of the policy cycle used in the analysis of policy development processes includes a cycle of phases that progress in a linear and sequential fashion through agenda setting, policy formulation, decision making, implementation and evaluation. The segregation of the policy process into a series of consecutive stages has been used in policy analysis because it has allowed analysts to focus on and study particular aspects of the process in detail and separately from the whole. However, it reflects an ideal for how policy should be developed, but does not necessarily reflect the reality of the policy development experience (Hill 1997). This understanding of the policy cycle does not explain the influences on the policy process that arise from its context and history, and it does not provide a causal model for change. It gives an unrealistic sense that policy development is a rational, sequential process when in fact policy development can be idiosyncratic. Policy formulation is influenced by broader contextual events and changes and by the changing power relationships between groups lobbying for the adoption of particular

approaches and responses to policy problems. The policy cycle may also not be completed and fully implemented, as it can be overtaken by events such as organisational restructuring, a change of government, or the adoption of other priorities. It is therefore both inaccurate and misleading to consider policy development as following a sequential, cyclic process that is separated from its context.

The policy cycle is not a single iterative loop, but more accurately should be understood as a series of loops where previous decisions influence future formulation. The conventional policy cycle model does not adequately display the complexity of the policy development process and does not accommodate the role of the actors involved, and their interests, the context and the ideology within which policy making occurs and the instruments that are available for its implementation (Howlett and Ramesh 1995). The choices made concerning which issues are selected as problems to be placed on the policy agenda determine the location of responsibility for a policy problem and for its resolution. These choices result in the identification of the 'heroes', the 'villains' and the 'victims' of the selected policy problem (Stone 1997). Applying the conventional policy cycle model does not develop understanding about how issues are selected as policy problems, how responsibility for problems is determined and why particular policy solutions are chosen over other possible options. These theoretical concepts will be used in the analysis of the case study.

Lindblom argues that in Western democracies policy develops in an incremental, 'step-by-step' fashion, where change is gradual. He states that policy development is an ongoing process 'of successive approximation to some desired objectives in which what is desired itself continues to change under reconsideration' (Lindblom 1959, p86). This incremental process of policy decision-making works through negotiation, bargaining and compromise and results in decisions about policy directions that are politically feasible rather than necessarily desired. Later students of public policy decision-making have argued that the incremental approach can only be effective where there is continuity of problems and strategies used to address them.

However, the complexity of the policy subsystem affects the possibility of achieving agreement or opposition to a policy option and the ability to make decisions is constrained by access to information and time limitations, and by the intractability of the policy problem that is being addressed. In this context, incremental change is likely to occur where policy subsystems are complex, there is low consensus, and constraints on decision-making are high, reducing the likelihood of large scale change. Where policy subsystems are simple, constraints on decision-makers are low and consensus is high, more significant policy changes are more likely to occur (Howlett and Ramesh 1995).

The model described above provides a useful matrix for understanding policy decision-making processes. Human services systems, such as the health system, by their nature are always highly complex and very political, and are the source of strongly held differing views by numerous interest groups competing for control of the policy agenda. The model suggests that because health care policy is a highly complex area where there is low consensus, incremental change should be the norm and that major shifts in policy are unlikely or very rare. As can be evidenced in the previous discussion of health care reform in Australia, since the 1970s change in health care policy has been ongoing. It could be argued that the adoption of New Public Management across the Australian public sector and the adoption of market-based reform within the health system reflect a significant paradigm shift in understanding the role of the public sector, and of the publicly funded health system. Although much of the change from the 1970s could be viewed as incremental in nature, the adoption of market-based approaches within the health system suggests a significant shift in policy paradigm, and therefore could be viewed as a major shift in policy.

In his treatise on revolution in the physical sciences, Kuhn (1970) argues that paradigms are based on commonly shared ideas and understandings that tie together knowledge-based communities, such as scientists or policy-makers. He argues that

scientific progress occurs through revolution rather than incremental evolution and that paradigm shifts cause a fundamental break from the past and lead through a period of crisis and anomaly, where observations of occurrences cannot be explained adequately by the existing paradigm, to efforts to understand the anomalies and finally to the emergence and acceptance of a new paradigm that accommodates the anomalies. The change process proposed by Kuhn involves extended periods of equilibrium and incremental change punctuated by short periods of upheaval and revolution resulting in substantial changes in the way phenomenon are perceived. This is consistent with the model proposed by Howlett and Ramesh (1995) and described above, and also reflects experience in the Australian health system during the last thirty years. In applying this model to policy development, Howlett and Ramesh explain:

> A policy paradigm is … an intellectual construct intimately linked to policy subsystems. It is essentially a set of ideas held by relevant policy subsystem members – a doctrine or school of thought such as Keynesianism or Monetarism in the case of economic policy subsystems – which shapes the broad goals policy-makers pursue, the way they perceive public problems, and the kinds of solutions they consider for adoption. Its effects are pervasive because policy-makers take it so for granted that they are often not even aware of its influences. While a considerable amount of thinking usually goes into the formation of a paradigm, it is not always coherent, reflecting the limitations innate to the study of public problems and the complex compromises public policy-makers must contend with (Howlett and Ramesh 1995, p190).

However, paradigm change is a result of a sociological process as well as being an intellectual process, and the length of the transition period between paradigms is determined by the depth of attachment to the existing order and the level of opposition that can be mounted by apologists for the old order (Hall 1993). Paradigm shifts occur not only because of intellectual debate, but because of the changing power relationships between key interests in the policy development process. This is very relevant to an understanding of the power relations that are analysed in the Designing Better Health Care in the South case study.

The work of Carolyn Hughes Tuohy (1999a) that explores policy change in Britain, the United States and Canada contributes further to this understanding of policy change. She argues that decision making systems in health care that are established during periods of policy change develop distinctive logics that impact on future changes, and as a result:

> ... windows of opportunity for major structural and institutional change – for shifting the balance of power across the state, the medical profession, and private finance or for changing the mix of hierarchical, market-oriented, or collegial instruments – are rare. (Tuohy 1999a, p264).

For major structural or institutional change to succeed, two conditions are required at the level of key decision makers: a consolidation of authority; and a broad political agenda that gives a central place to health care reform (Tuohy 1999a).

Both historical decisions that have been made prior to a particular policy change, and the ideas and philosophy that prevail at the time of policy change, have a major influence on decision-making and provide what Tuohy describes as the 'accidental logic'. She cites Putnam as saying:

> History matters. ... What comes first (even if it was in some sense 'accidental') conditions what comes later. Individuals may 'choose' their institutions, but they do not choose them under circumstances of their own making, and their choices in turn influence the rules within which their successors choose (Putnam 1993, p8 cited in Tuohy (1999a, p6).).

History and the ideas and philosophy that prevail at the time of the opening of the 'window of opportunity' for policy change, determine the policy change choices that are available at that time. Policy windows are influenced by factors such as changing social or economic conditions, changing political circumstances or changing administrative apparatus. External crises increase the likelihood of a policy paradigm change because they create a sense of anomaly. The options for change that are available are determined by current thinking and understanding at the time of the opening of the policy window (Tuohy 1999a). This concept has proved useful in analysing the case study and will be applied to the case study later in this thesis.

As discussed in Chapter 2, the increasing costs of health care and the rising demand for services within the Australian publicly funded health system created a sense of crisis, resulting in the possibility of a paradigm shift towards an approach supported by the ascending ideology of the time, neo-liberalism, that was significantly influencing public sector reform, and resulted in the adoption of market-style reforms in the health system. The fact that this direction for health care reform was chosen was a consequence of the interest groups that were dominant at the time the policy window opened. These groups provided the consolidation of authority and the bipartisan political agenda that formed the direction of health care reform at this time.

This thesis does not view the policy cycle as linear or necessarily rational, but rather, as based upon windows of opportunity created by political will combined with the currency of an idea and agreement on a policy problem. Such agreed policy problems are usually grounded within the dominant ideology, which is now predominantly pro-market. The understanding of the policy problem also determines the sorts of solutions that are viewed to be acceptable. The interpretation of the policy problem and its possible solutions are determined by the ideological premises of the dominant interest groups, including politicians, bureaucrats and dominant interest groups within the community, and are also built on the history of what went before. A dramatic change in policy is only likely to occur with a shift in power among interest groups to groups with differing ideological premises, and an opening of a new and different window of opportunity which brings together new policy ideas and ways of viewing the policy problem, with the political commitment and will to implement the newly influential interest group's solutions.

Policy communities and policy networks

Considine (1994) argues that policy analysis must include analysis of the key actors and their roles, of who has influence, who is excluded and who achieves their goals through the policy development process. The concepts 'policy community' and 'policy network' have been used to contribute to an understanding of how the range

of interest groups influence policy decision-making. Policy community can be defined as all of those individuals, groups and organisations with an interest in a particular sector (such as the health sector) (Wright 1988). A policy community is made up of groups such as government agencies, pressure groups, media, and individuals with an interest in the policy field such as academics (Pross 1992). Different policy communities can have different values and base their belief systems on different ideologies, resulting in differing views about both the identification of policy problems and their solutions. Policy networks form in response to specific issues and may come from the same or different policy communities, but share common values, a common approach to the policy issue and tend to have an immediate stake in the particular issue that has drawn them to action. Policy networks tend to be open, allowing actors to move between policy communities as their interests and concern are raised or appeased. In the case study the concept of policy networks is useful in understanding the relationships between key stakeholders involved in Designing Better Health Care in the South.

The policy community has a social dimension and encompasses commonly understood belief systems, codes of conduct and established patterns of behaviour (Pross 1992). The relationships of actors within a policy network are governed by 'rules of the game' which guide the behaviour of the actors towards each other (Wilks and Wright 1987). These rules include: pragmatism, consensus, fairness, accommodation, secrecy, trust, the 'depoliticisation of issues', mutuality, and an expectation of consultation between network members. The policy subsystem is made of a number of policy networks, policy brokers, and 'sovereigns' who determine the final policy decisions.

Street level bureaucrats are key actors within policy networks because they include professionals such as doctors, teachers and social workers who work within public service delivery agencies. These professional groups have significant discretionary freedom and autonomy because of their specialist knowledge and skills, and because their work requires judgement and discretion to make decisions about services in

complex situations. As a result of their autonomy and the implications of the decisions that they make about the services that are provided, their decisions determine public policies on the ground (Lipsky 1980). Hill explains the need for street level bureaucrats:

> In individual services there is a need to make a choice between the case for a reliable service which can be changed only by initiative from the top, and a less predictable service which may nevertheless be flexible in practice. The organisation which makes extensive use of professionals is one in which there is high expertise in the lower ranks, a complex task to perform, difficulties in developing effective patterns of supervision and a need for flexibility and openness to change. A strong group of arguments for autonomy come together. In this sense, professionals are street-level bureaucrats who have been able to develop special claims to autonomy. … (T)hey claim to differ from other public officials in that their relationships with their clients are governed by ethical codes and by altruistic values which others lack (Hill 1997, p211).

Doctors working within public health services are street level bureaucrats of particular relevance to this study because of their dominant role within these agencies and because of the dominance of the medical model within the case study and more broadly within the health system.

Changing policy paradigms

Times of policy change increase the demand for new ideas and result in a search among international experiences for alternative policy answers to a nation's problems (Marmor 1999). It is very rare for cross-national experiences to be carefully investigated and thoughtfully considered, but rather they are often adopted on the basis of compelling stories without rigorous evaluation. The nature of health care reform as comprising a package of different approaches and strategies rather than a single homogeneous entity that is carefully debated and reflected on contributes to the lack of awareness of the ideological basis of reforms and to decisions to adopt particular reform strategies based on ideology or pragmatism rather than on evaluative evidence. Kettl states:

Trading reform ideas often has been troublesome. Reformers have been tempted to pick the ideas they like and ignore the hard ones. They frequently have failed to build the infrastructure required for the most difficult ventures. Governments often borrow from the private sector without stopping to consider the profound differences between them. Moreover, governments have borrowed private sector ideas just as private reformers have found them unworkable or inadequate. With the high-speed communication of the Internet and the heavy pressure for continued cost cutting and improving productivity, the constant search for management ideas will likely continue around the globe (Kettl 2000, pp64-65).

A lack of consensus between members of a policy community leads to conflict over decisions that are made and when familiar policy paradigms are challenged, policy communities become unstable (Coleman and Perl 1999). There are three levels of government response to challenges to policy paradigms. Firstly, the policy community can be invited by the government bureaucracy to review the policy mix. Secondly, the central actors in the policy community and the range of policy outcomes that are open for consideration can be altered through changes in administrative arrangements or re-structuring to enable a shift in policy paradigm. This strategy can result in the re-definition of boundary rules and the re-allocation of influence between the different networks so that a policy paradigm shift can be more effectively managed by the government. Finally, if neither of these options resolves the anomaly caused by the challenge to the policy paradigm, the shift in policy debate is likely to lead to deeper policy controversies and questions about the validity of the policy paradigm in its entirety (Coleman and Perl 1999).

Governments can initiate this process to introduce significant policy changes not advocated by or emanating from the policy community. This strategy can also shift the power relations between policy networks and destabilise previously stable policy communities. An example of this approach is highlighted by Richardson (2000) in his discussion of the strategies of the Thatcher government in the UK to impose new policy paradigms based on new ideas such as deregulation, privatisation and contracting out despite the significant dissent of powerful lobby groups within various policy sectors, such as the British Medical Association and the Confederation of British Industry. He explains:

In Britain, by the mid-1980s, the balance of power had shifted decidedly in favour of government in terms of setting the agenda and initiating policy change. Thus, the policy process could often take on an *episodic* character – bouts of an impositional style as new policy ideas were introduced by the Government, followed by old style consultation via (often reconstructed) policy communities and networks. … In essence, the old policy communities lost control of policy framing and agenda setting and had to react to agendas set by others (Richardson 2000, p1010).

This strategy can be used by governments when they intend to implement policies that depart from an incremental approach and so challenge the position of power and influence of the current dominant policy network. The strategy enables the reduction of power of the existing policy networks, providing a period of anomaly in which it is possible to change policy paradigms and to introduce new approaches that have not emerged from consultation with or lobbying by the dominant existing policy networks. This strategy is not necessarily a negative one because the role of democratically elected government is to provide the leadership, to shape the debate and to ensure that policy decisions are broadly socially appropriate, rather than driven by the vested interests of powerful existing policy networks and communities. However, the process of seeking to change policy paradigms, in conjunction with the constant search for new management ideas and reform strategies (Coleman and Perl 1999; Kettl 2000), has contributed to the phenomenon of churning within the health system.

"Churning" as a metaphor for ongoing change within the health system

This thesis aims to contribute to an understanding of the difficulties in achieving effective reform within the health system, and to understand why the experience of attempts to reform the health system has become one of churning. Despite the amount of change occurring within the public sector, there appears to be a continual effort to bring about further change. Continuous change can be a result of disappointment at the results of previous change attempts, which may not have achieved their desired outcomes but may have resulted in unanticipated consequences. It may also be a result of adjusting change strategies to address the unanticipated outcomes of a previous reform, or it may be cumulative and linear, with

one change strategy being implemented on top of another. Success may also lead to further change, as governments seek to push a reform process to its limits to discover the possible extent of further efficiencies (Peters 2001). Peters states:

> Simple inertia, or intellectual commitment to particular styles of reform and particular styles of governing, has produced an apparent inability among decision makers to react to failure in ways other than to do more of what has already failed. Thus, no matter whether managerialist changes resulted in definable benefits for government or for the public, elites involved in the process of producing change were likely to continue to implement yet more changes of roughly the same type (Peters 2001, p161).

However, churning is a particular phenomenon arising from unsuccessful, incomplete and ongoing change. It occurs as a result of constant efforts to achieve change that are not informed by previous experiences, that are often trying to tackle very complex 'wicked' problems (Rittel and Webber 1973) with simple solutions, and that result in a lot of 'thrashing around' without clear outcomes (Hill 1997). This has become a common experience in many health systems, including the health system in South Australia.

Organisational restructuring results in increased short term cognitive order for senior executives of an organisation because in the short term it leads to an improvement in the apparent fit between the organisation and its turbulent environment, and appears to resolve problems and create order at the higher, strategic level, which is the focus of top executives. In contrast, organisational restructuring results in increased cognitive disorder among middle managers and employees lower in the organisational hierarchy because it raises questions for them about how to progress the work of the organisation reliably within a changing environment where established practices and processes are disrupted (McKinley and Scherer 2000). During a review of large scale managerial change within the UK health system, Ferlie found:

> While reforms are superficially presented as dramatic change in agency life, reforming can also be seen as a standard and repetitive process. … (R)eforms are easy to start but difficult to finish. Reforms may be oversold or raise undue expectations, leading in turn to the perception of fresh problems for

which ever newer reforms were needed, so that reforming became a steady state. Reforms can also come in cycles, given strong fads and fashions in the stock of managerial knowledge, and also because many agencies are forgetting rather than learning organizations (Ferlie 1997, p185).

The consequences of churning appear to be confusion among staff about the justification for and intended outcomes of reforms and low staff morale (Finlayson 2002). This was evident in the case study, and is discussed in Chapter 8.

Churning is the phenomenon that is most commonly experienced when a policy problem has been identified by government or the bureaucracy for which an effective response is beyond their capacity (usually because the problem is intractable, very complex and multifaceted). This may be because it is a 'wicked' policy problem. The result of a commitment by government to address an identified very complex policy problem, when government does not have the capacities or influence to resolve it, is that policies and their solutions are framed in ways that are consistent with the dominant current understandings and views of the problem. The solutions often create further problems, or do not adequately address current perceptions of the policy problem and so they are constantly adjusted, often over a relatively short time either by bringing in incremental changes and 'tinkering' with the solution, or by adopting a new idea, or one that has been trialled elsewhere, and superseding previously supported solutions with this (Peters 2001). There is usually no evaluation of these processes, so that the system does not have the opportunity to learn from what has been done before the next 'solution' is identified and implementation commences (Pollitt 1995). As a result, the system experiences constant uncompleted and often disjointed attempts to bring about change.

The 'pendulum swing' between centralisation and devolution of decision making authority described in Chapter 6 is an example of continual system restructuring within the South Australian health system which is evidence of an ongoing search for an ideal policy and governance solution to tensions between central control and local responsiveness. However, each partial or incomplete change process leaves something behind that influences future changes (Tuohy 1999a). For example, in the

case of the swing between centralisation and regionalisation in South Australia, each move to regionalise or centralise authority and decision making within the health system has been influenced by previous efforts, even though the justification for each swing between regionalisation and centralisation may differ because of the accepted ideological frame in which it has been adopted. The phenomenon of churning will be discussed further later in this thesis.

The concept of negotiated order adds further to an understanding of the role of policy networks in the policy process and highlights the difficulties in achieving significant and substantial policy change. Because systems such as the health system are dependent on the interactions, negotiations and competing interests of powerful interest groups, the health system, of necessity, functions as a negotiated order.

Negotiated order and health policy change

The development of the negotiated order theory has its basis in symbolic interactionism and the understanding that meaning and communication are central to the problem of social order (Berger and Luckmann 1966). Much of the early study of negotiated order is based on social psychology, focusing on the individual worker and their capacity for and processes of negotiation (Strauss et al. 1963). However more recently, increasing work has been done to investigate the value of using this approach in understanding organisational cultures and negotiations within and between organisations (Strauss 1978; Fine 1984). Strauss et al (1963) first introduced the term 'negotiated order' in order to analyse and understand the nature of change that occurred in two North American psychiatric hospitals, and to address the question of how social order was maintained in the face of change. The relationship between stable social orders and negotiation processes was a key issue in the development of the concept of negotiated order. Strauss et al (1963) argued that negotiation is essential to the existence of any organisation, that specific negotiations are dependent upon the structural conditions of the organisation and that these negotiations are patterned rather than random, following lines of communication, and have temporal limits in that they are reviewed, revised and reconstituted over time.

In undertaking the analysis of successful negotiation processes for the development of cooperative national structures, Strauss identified the following key features of an effective stable negotiated order. He argued that in a negotiated order participants recognise both their differing interests and their overriding common interests. Relationships within a negotiated order are strengthened over time by regular and repeated interactions, for example through meetings, and through sharing information and working cooperatively on mutual problems and issues of interest. The leadership is experienced at negotiating and regular meetings are a normal part of the way that the leaders work. This prevents the leaders from continually having to revert back to negotiating their relationships and motivations. Negotiations are both vertical (up and down the hierarchical structures of the agencies involved) and horizontal (across the intra- and interagency groups). Although there will always be power differentials between the negotiating groups, each participant in the negotiation does not operate from their points of strength, but rather maintains a focus on the common agreed goal. Overt negotiations are crucial to achieving the desired outcomes. In describing these key elements of an effective negotiated order within the international examples that he analysed, Strauss explains that:

> … virtually all negotiations were overt. They were "aboveboard," explicit – and so pains were taken to be very clear about every step of the negotiations, about the issues, about the agreements that resulted from each round of negotiations, and about the anticipated financial, institutional, or political arrangements that flowed from the agreements (Strauss 1978, p161).

One criticism that could be raised against the negotiated order theory might be that it does not readily explain change because the theory relates to existing power structures and therefore the status quo. Some negotiators may have disproportionate power over the capacity to define the situation in which the interactions that form the basis of the negotiated order occur (Hallett 2003). Rather than negotiating, they may also use coercion and control strategies as alternative modes of action to achieve their goals. In these cases, the powerful negotiators may control the agenda and prevent issues from being raised and therefore negotiated (Lukes 1974).

The negotiated order theory emphasises the existence of potentially unstable organisational relations that are fluid and continuously emerging, based on the complex array of interactions (which can be based on negotiation, coercion and/or manipulation) between key groups and individuals, and in which continual change is the norm. In interagency interactions, when negotiated order has not been established, relationships have been found to be chaotic, unpredictable and ineffective (Bennington et al. 2003). The achievement of stability and order requires the constant effort of participants (Strauss 1978). Therefore, within a negotiated order, change is as much a part of organisational life and relations across a complex system as is consensus and stability. The phenomenon of churning described above can be understood as an outcome of these processes.

In relation to complex and highly conflictual systems such as the health system, it can be argued that the presence of a negotiated order is evident because the functioning of the system requires ongoing negotiation, review and re-negotiation over time, as new policy issues and challenges emerge that affect the capacity of the system to be responsive to the different needs and priorities of its stakeholders (Elmore 1978). Negotiation occurs because the power relations between the different groups within the health system (which include the central bureaucracy, consumers, health care agency administrators and professional groups) are dependent on each other. No group can function in isolation from the whole. Therefore the ability of one of these groups to achieve their aims (which are not necessarily shared by the other groups), is dependent to a significant extent on the choices and decisions and the willingness of the other groups to compromise. As a result, there is a strong common interest in achieving an outcome that is, at minimum, not destructive of the aims of any group within the system. Consistent with this notion of mutual dependency, Ham argues:

> Bringing about change entails slow and painstaking work in which reformers need to engage clinical leaders and opinion formers in persuading their colleagues to do things differently. In the process, various methods are likely to be needed to achieve change, and there is no evidence that any one method is superior to others. … (S)ubstantial change is most likely to take place in organisations in which managers work together with clinical champions to introduce new ways of working. In other words, both clinical and managerial

leadership are needed to bring about improvements in these organisations (Ham 2003, p1979).

An understanding of the nature of a negotiated order sheds light on the role of partnerships and collaboration, and of power and control within the health system. As a negotiated order continues to evolve and change over time, with opportunities to negotiate on particular policy issues being dependent on the context in which negotiation is allowed to occur or is prevented from occurring, the sustainability of the negotiated order is reliant on repeated, multi-issue negotiations, and incentives to make the system work as a whole, rather than for individual components of the system to 'win' (Strauss 1978). This issue is elaborated on in Chapter 7 in relation to building organisational trust and interagency collaboration.

What is clear from this overview of policy processes and policy change, is that policy making should be understood as an inherently political and social process, based on the development, maintenance and demise of support for coalitions which achieve prominence for an extended or brief period because of political influence, power and opportunity, and which determine the nature, scope and focus of policy at this time, and the possibility for there to be policy change. This understanding informs the interpretation of the case study.

An interpretive qualitative approach was adopted in this study because it is the most appropriate methodology for the study of the interactions between participants involved in an attempted organisational change process, and for developing an understanding of the reasons for the failure of this change process. It also facilitates a detailed consideration of the case study that enables the application of the theoretical ideas discussed above. The next section of this chapter describes details of the methodological approach adopted in this study.

Study methodology

In-depth understandings of complex social problems can best be gained through the use of interpretive qualitative research methods. To achieve a deep understanding of

social experiences, qualitative researchers use methods such as participant observation, unstructured or semi-structured interviews and analysis of documentary evidence. The origins of these methods of qualitative field research can be found in social anthropology and its study of other cultures and peoples (Burgess 1984). Interpretivist research in the field requires a degree of flexibility and responsiveness to changing situations because it is based within real life contexts and generally seeks to actively engage or involve informants beyond the initial provision of data in order to understand their reality (Lincoln and Guba 1985).

A qualitative interpretive approach is appropriate for this study because it enables the development of a deep understanding of the case study of unsuccessful collaborative organisational change, of the reasons it did not succeed and of the experience of the staff and leaders involved in it. The approach has also, of necessity, been an evolving one, needing to be flexible and responsive to ongoing change so that, as shifts within the policy context and environment became apparent, methods could be adopted and analysis undertaken that would accommodate and incorporate these changes. Patton and Westby explain:

> The advantage of qualitative portrayals of holistic settings and impacts is that greater attention can be given to nuance, setting, interdependencies, complexities, idiosyncracies, and context (Patton and Westby 1992, pp8-9).

This thesis accepts that people's understandings and perceptions of the change process in which they were involved are valid data in their own right and that as such, these data can provide an understanding of the significance and implications of this change process for the health care agencies and staff involved in it. They can also provide a basis for a higher order theoretical interpretation of the organisational change process as has been undertaken in the analysis of the case study.

In order to understand organisational change, including the 'why and when of change', it is essential to consider the change process in terms of both its inner and outer contexts, taking into account the economic, social and political environments in which it is situated, including understanding the history of these environments, and

also the internal influences on the change process, such as the resources that are available, the organisational structure, culture and politics. Analysis of both the content and the process of change, including the actions and interactions of stakeholders as they negotiate proposals for change is also crucial to an understanding of organisational change (Garside 1998). Consistent with this approach, and in recognition of the complexity of the case study, this thesis places the case study within its historical and policy contexts and considers in detail the content and development of the proposed change process, and the relationships and interactions between stakeholders during their attempts to develop and implement organisational change.

The thesis focuses on a case study of an organisational change process that was initiated by a group of agencies working within the southern region of metropolitan Adelaide and that was overtaken by a system-wide change, which was a result of a state government policy change (described in detail in Chapter 5). Yin (1994) defines the case study approach as an empirical inquiry that investigates contemporary phenomenon within their context. He argues that the case study is an effective research strategy when the researcher has little control over events and when 'how' and 'why' questions are being posed. Making a case study the focus of this thesis has enabled the particular case to be described holistically, in detail and depth. It has also enabled both a detailed account of the 'story' of the case within its context and the theoretical analysis and interpretation of that story in order to further understanding about health care reform more broadly and achieve analytic generalisation (Yin 1994).

The research for this study took place over a three year period from July 1998 to July 2001. During the majority of this time I was based at the Flinders University, Adelaide, working as a senior researcher on a three year evaluation of Designing Better Health Care in the South and the subsequent developments that followed from this project. The evaluation project used an action research approach to enable it to be both flexible and responsive to change and to contribute to supporting

organisational learning among the partner agencies involved in Designing Better Health Care in the South (Kemmis and McTaggart 1988). Action research incorporates both the acquisition of knowledge (the research element), and the achievement of change (the action element). It is usually participatory and involves the stakeholders in the research process. For this study, the research did not involve reflection on my own practice, as is often the case in action research (apart from the normal reflection that arises from a research process), but rather, it involved reflection on an emerging process and feeding developing understanding about that process back to those involved. The evaluation project therefore produced a number of reports and provided opportunities for discussion and debate with the partner agencies involved in Designing Better Health Care in the South. This approach was essential for this study because the study was not retrospective but 'live', and therefore needed to evolve with Designing Better Health Care in the South and accommodate the impact of its changing and unpredictable environment. As a result, this thesis has enabled the analysis of an unsuccessful organisational change process within a turbulent environment. The case study provides a good example of the consequences of churning within the health system, and of the difficulties in implementing organisational change in this context.

Methods used

Some of the data collected for this thesis came from the Designing Better Health Care in the South evaluation project and I was responsible for its collection, analysis and dissemination, while other data was collected separately for the purpose of this study. A number of methods were used to illuminate different aspects of the story within the case study and of participants' experiences and perceptions. The use of multiple methods also enabled triangulation between methods (Burgess 1984). The methods used during this study included in-depth telephone interviews; a random mail survey of staff of the four agencies involved in the organisational change process; a series of focus groups with senior clinicians and administrators, and with Department of Human Services Senior Executive staff; document analysis of documentation from South Australian Health Commission files and from the agencies' files about the

contextual and historical background to Designing Better Health Care in the South. The methods used during this study will now be described in detail.

In-depth phone interviews

Minichiello et al define the in-depth interview as:

> …conversation with a specific purpose – a conversation between researcher and informant focussing on the informant's perception of self, life and experience, and expressed in his or her own words. It is the means by which the researcher can gain access to, and subsequently understand, the private interpretations of social reality that individuals hold. This is made public in the interview process (Minichiello et al. 1990, p87).

The key stages for organising and conducting in-depth interviews are: contacting potential respondents and explaining the research to them, establishing rapport, trust and empathy, and ensuring that good quality accurate data is obtained during the interview (Baum 1998). These key stages were followed carefully in order for the in-depth interviews to provide quality data for analysis.

I undertook a series of twenty nine phone interviews which were conducted between 23 March and 30 April 1999 with members of the original steering committee who had prepared the proposal for the development of a regional health service and with others who had had a significant role in the consultation, planning and development process, including health care agency managers, administrators, clinicians, staff and industrial representatives, and agency Board members. These people were identified by the Chief Executive Officers and the Project Manager of Designing Better Health Care in the South. Thirty six people were invited by letter to participate in a phone interview. The letter was followed up with a phone call to seek their agreement to participate, to organise a time for the interview and to gain consent for it to be tape recorded. Five people declined to be interviewed, one could not be contacted and one interview could not be organised due to work commitments and leave. The interviews took between 15 and 45 minutes and were semi-structured. A number of topics for discussion had been identified and were asked of all respondents. These formed an agenda of topics to be covered in each interview, or as Burgess (1984)

states, an *aide memoire*, rather than being a list of set questions to be rigidly followed. Clarifying and follow up questions were asked of respondents to gain more detail or further understanding when interesting divergent points were raised during the subsequent discussion.

The phone interviews were intended to ascertain participants' understandings about the issues that arose and the events that took place during the development of Designing Better Health Care in the South. They covered the following themes:

- The respondent's involvement in Designing Better Health Care in the South
- Their view of the importance and achievability of the different objectives of Designing Better Health Care in the South
- Factors that they perceived supported and inhibited the ongoing development of interagency collaboration between the four health care agencies that had been partners in Designing Better Health Care in the South.

With the permission of the respondents, interviews were recorded and transcribed for analysis. The results of the phone interviews were compiled, analysed and presented in a report to the Chief Executive Officers and Chairs of the Boards of Management of the four agencies. Participants were informed that this would be the venue for presentation of results and that their confidentiality would be assured.

Random mail survey

A mail survey was sent out to a random sample of medical, nursing, allied health and administrative staff working within the four agencies and in a small group of other agencies for which the largest of the four agencies had administrative responsibility. The mailing list for the survey was generated from the agencies' lists of employees and reflected the occupational composition and relative sizes of the agencies. Consequently, Flinders Medical Centre received the greatest number of surveys because it was the largest institution, followed by the Repatriation General Hospital, Noarlunga Health Services and then Southern Domiciliary Care and Rehabilitation

Service. The proportional distribution of occupational groups within each agency (medical, nursing, allied health and administrative) was also reflected in the sample.

The survey aimed to assess staff perceptions and experiences of health system change taking place in South Australia. The survey questionnaire was developed and piloted in January 1999 and sent out to 552 staff in March 1999. Follow up reminders were sent out in April and May. A response rate of 37.7% (208 surveys were returned) led to a decision to send out a second round of surveys to an additional 216 randomly selected staff in June 1999 so that a total of 768 surveys were mailed out to staff of the four agencies. A reminder letter was sent out in July 1999. The total response rate to the survey was 36.6%. 281 surveys were returned.

The significant non-response rate could have been a result of people's busy-ness and work pressures, or their reluctance to cooperate in completing a survey that had no direct benefit to them or their work. It could also have been a result of their lack of knowledge about what is happening in the health system. Nine staff contacted me by phone or email to say that they did not feel they had enough knowledge about changes in the health system to comment and thirteen people wrote similar comments on their questionnaires. It is therefore possible that a greater number of staff who were not aware of changes in the health system did not respond to the survey at all. Despite assurances of confidentiality, there may also have been some concern from staff about being identified. A number of staff made critical comments about the changes that they saw taking place in the health system at that time, about the management of the health system and of their own agency and about the pressures on staff. 21.6% of all surveys that were returned did not identify the respondent's agency. (Respondents' names were not required.) This suggests a level of concern about confidentiality.

The survey instrument included three key sections:
- Respondents' knowledge and perceptions of the achievements and potential for achievement of seven specific examples of developments within the health system

that were underway at that time. These included for example: Coordinated Care Trials, National Health Goals and Targets, Designing Better Health Care in the South, the Divisions of General Practice, and the incorporation of the SA Health Commission into the Department of Human Services

- The effect of a number of specified factors on the respondent's agency, which included for example: efficiency in the provision of services; the effective use of resources; ability to cope with workload; staffing levels; waiting lists; discharge planning; emphasis on prevention; extent of coordination between health agencies etc. Respondents were asked if they perceived each of these factors as improving, deteriorating, there being no effect, or not applicable to their agency

- An opportunity for respondents to comment about the impact of developments within the health system on their work and about their hopes for the outcomes of these developments.

The examples in sections 1 and 2 of the survey were developed in consultation with the project reference group (described later in this chapter). Following analysis of the survey data, a report was presented to the Chief Executive Officers of the four agencies and a summary article identifying the key issues coming out of the mail survey was published in the newsletters of each of the participating agencies to inform respondents of results.

Although only the third section of the survey has been used to inform this study, the first two sections provided context for the answers that respondents gave to questions in section 3. Two open ended questions within the third section of the survey were of particular relevance to this study. These questions sought respondents' comments on the impact of changes in the health system:

- What positive and/or negative effects do you think that health system developments are having on how you carry out your work?

- What would *you* like to see happening as a result of the health system developments that are being implemented at the moment?

In adopting a survey as a research method, it is important to recognise that there are limitations in the use of surveys because each person answers the questions in different circumstances, bringing to it their own assumptions, history and values which cannot be further investigated by the researcher if confidentiality is to be maintained (Baum 1998). However as a means to describe generally the prevailing attitudes about change within the health system, this survey provided some useful insights, particularly when combined with data collected through other more interactive methods.

Focus groups

Focus group discussions are group interviews in which a topic is introduced to a group and the interviewer becomes the facilitator of a guided but open discussion (Hughes 1993). The focus group has its origins in market research and continues to be widely used by market researchers. In focus group discussions it is common for the interviewer's role to become blurred to the extent that they become a participant in the discussion rather than an observer. Agar and MacDonald (1995, p80) describe focus group discourse as 'somewhere between a meeting and a conversation'. Focus groups discuss and debate issues. Ideas are generated that would not necessarily have emerged in an individual interview, and, where participants have an emotional stake in the topic being discussed, the focus group can be a stimulating experience (Kidd and Parshall 2000). However, focus groups can also lead to participants modifying their views, or their statements of their views, as a result of conformance or self-censoring, conflict avoidance or acquiescence. Participants' views can also shift during participation in a focus group discussion because of the opportunity to discuss issues with others and to hear other viewpoints. These issues are important considerations and were taken into account during my analysis of the transcripts and notes from the focus groups.

Towards the conclusion of the period of data collection, from August 2000 to February 2001, a series of five focus groups was organised. Three of the focus

groups were held with senior clinicians and administrative staff with a key role in providing integrated health care services or developing models for service integration. A focus group was also held with the Chief Executive Officers of the agencies (three of the Chief Executive Officers attended, one had recently resigned and had not yet been replaced), and a focus group was held with Senior Executive staff from the Department of Human Services. A total of thirty seven people participated in focus groups.

Participants in the three clinicians' and administrators' focus groups were selected by the project reference group and the Chief Executive Officers of the four agencies. Two participants heard about the focus groups from others who had been invited to participate and contacted the researcher seeking permission to attend. They were also included. For the three clinicians' and administrators' focus groups, three possible dates and times were offered and people were invited to nominate the time that was most suitable to them. The venue was also varied for each group in an effort to make it as easy as possible for people to attend at least one of the sessions. Focus groups were taped and transcribed for analysis with the participants' consent.

The focus groups were semi-structured, and informed by a preliminary discussion paper that had been circulated to each participant prior to them attending. The preliminary discussion paper was prepared prior to the first focus group. It was intended to help participants to understand the context in which they were working and to allow the groups to commence from an assumed base of knowledge. Section 1 of the discussion paper was developed through a literature review and provided an overview of the changes affecting health systems worldwide, intended to show that the sorts of changes experienced in South Australia were fairly typical of those happening elsewhere in the world. Section 2 reported preliminary findings from the evaluation over its first two years. This section was developed further following each focus group to incorporate the outcomes of each discussion and to further advance the understanding of the next group. The preliminary discussion paper enabled the focus groups to be a cumulative and iterative process where each benefited from and built

on the discussions that went before. The final version of the discussion paper was sent out to all participants. Following analysis of the focus group data, a report was prepared on the focus group process and the key identified themes and was provided to the Chief Executive Officers of the participating agencies for discussion in a focus group, and subsequently to the Senior Executive of the Department of Human Services for discussion in a separate focus group (van Eyk and Baum 2003).

Document analysis

Burgess (1984) explains that documentary evidence can be divided in three ways, as primary or secondary sources, as public or private documents and as solicited or unsolicited documents (where solicited documents are provided at the request of the researcher, for example diaries kept to cover a specific period of time). Documents and records provided a rich source of information about decisions that preceded the period of data collection and my presence in the region, as well as a source of information on decisions and goals determined by the SA Health Commission Executive at a juncture of major change in the health system (Patton 1990).

Documents were provided to me by the Department of Human Services on the basis that the section of the thesis which analysed and discussed the documents would be provided to a senior staff member of the Department for approval prior to inclusion in the thesis to ensure that no sensitive or confidential information was divulged. This request was complied with. Chapter 4 is based on the document analysis and discusses the historical context of the case study. This chapter was viewed by the Director of the Research and Evaluation Branch within the Department of Human Services, who confirmed that no confidential information had been disclosed. Other documents such as minutes of meetings, annual reports and the Designing Better Health Care in the South Interim and Final Reports were public documents and did not require this approval.

Data analysis methods

Tesch (1990) argues that qualitative data analysis should be undertaken concurrently with data collection and should not be rigid. She outlines a series of principles which she has extrapolated from analysis descriptions detailed by researchers and methodologists in their publications. In summary, these principles are: that data analysis involves the creative categorisation of data into a meaningful organising system which is predominantly derived from themes within the data and remains flexible; that reflection on the data is recorded as a series of memos to provide accountability and assist the researcher's shift from the data to the conceptual level; and that the results of data analysis are combined, resulting in 'the emergence of a larger, consolidated picture' (Tesch 1990).

In this study, I coded all interview and focus group transcripts, documents and qualitative survey responses thematically using NUD*IST software (Non-numerical Unstructured Data Indexing, Searching and Theory-building) as a tool to assist in sorting, categorising, searching and linking data throughout the data analysis process. The 'memoing' described by Tesch (1990) was done both through NUD*IST and also through a research journal which I maintained throughout the study, both to document my developing thinking and understanding, and to help me to track my progress, because it can be difficult to 'maintain the threads' of part time study. I used content analysis of interview and focus group transcripts and document text to identify patterns and themes in the data. The data was classified and coded according to emerging themes following thorough reading, re-reading and reflection. The use of NUD*IST assisted this process and the management of a large amount of textual data.

Bulmer (1984) argues that there should be a continual interplay between data and the formation of theoretical concepts. He describes this as the "'flip-flop' between ideas and research experience" in interpretative research (Bulmer 1984, p260). Data analysis for this study was ongoing throughout the process of data collection, and continued following its completion. Reflection on the meaning and inter-connections

of the data and their broader theoretical conceptualisation was also ongoing in a 'to-ing and fro-ing' between the actual data, thematic development, and the identification and development of conceptual issues as the study developed. The use of a research journal as a strategy for memo-ing assisted this 'flip-flop' between ideas and the research experience, and the resulting theoretical conceptualisation as well as helping to draw together insights from different aspects of the data. Reports that were developed for the project reference group, including the six monthly progress reports that reflected on developments in the case study also informed this process.

Role of the researcher

I began as researcher for the evaluation project in July 1998, seconded from a senior policy officer role within the Department of Human Services (and formerly the SA Health Commission). I was seconded from the Department at a time when it was being formed and was undergoing a major restructuring exercise. I worked on the evaluation project for two years before formally commencing this study.

My role as a student working on my thesis was both enhanced and complicated by my role in the evaluation project. Being researcher for the evaluation project assisted my access to people and events within the southern region. I developed good working relationships with the four Chief Executive Officers of the agencies involved and with a number of staff within the agencies who then felt able to confide in me. I was invited and free to attend any relevant meetings and do not believe that my presence inhibited people's openness. This was particularly apparent in meetings that I attended with the Chief Executive Officers and Chairs of the Boards who spoke quite openly in my presence about their concerns and debated how to deal with them.

The role of evaluation researcher also had some less positive consequences. I increasingly lost contact with staff within the Department of Human Services who could inform me about the reasons behind decisions and changes occurring within the Department. A growing reluctance by Departmental staff during this time to discuss any concerns openly contributed to this loss of contact. This reluctance related to an

increasing sense that criticism by Departmental staff was unacceptable and could have personal consequences. The occasional opportunity to attend conferences and other gatherings where I could informally meet with and talk to staff with whom I had previously worked helped to overcome this problem to some extent. However, I felt increasingly isolated from events within the Department and found maintaining contact progressively more difficult with time.

My position as a seconded employee of the Department of Human Services at times raised concerns for me about findings coming out of analysis of the data that I was collecting and contributed to my anxiety about consequences for my career, both from this study and the evaluation project. It was difficult to find ways to write about my findings without compromising them, while aware that they were not necessarily welcomed by key people within the Department, but also that people provided information to me with the expectation that it would be used, although used carefully to protect confidentiality. In an environment where criticism, or even critical reflection, was not valued and was actively discouraged, my involvement both in the evaluation project and in this study resulted in my feelings of anxiety and concern, while in contrast, the openness and generosity of participants in contributing information and their often very limited time, contributed to my sense of responsibility to continue and to try to make this study a positive contribution to moving forward.

Once I began direct work on my thesis (in the second year of the evaluation project), I found it challenging to be working on a project and also engaged in postgraduate research on the same topic. The boundaries often became blurred and I had to continually refer back to the plan for this study in order to keep it focused on its original intentions. Project work has quite different requirements from academic study and the level of analysis and theoretical development are very different. The challenge for me as a researcher in this situation was to achieve sufficient distance from the evaluation project and issues that were the focus of the evaluation to be able to adopt a sufficiently analytical perspective necessary for a more academic study of

what had happened. I felt that I needed to conclude the evaluation project to be able to have the disengagement to undertake this critical analysis and reflection. However, the reading and thinking that I undertook for this research also contributed to the development of the evaluation project, and the discussions I had with the project reference group were invaluable in the development of my ideas and understanding for this study.

The problems I experienced in engaging with the Executive of the Department of Human Services made it difficult to be sure that the interpretation of the Department's perspective on Designing Better Health Care in the South was reasonable and accurate, particularly as I had a very close working relationship with the Chief Executive Officers of the four agencies that were seeking to progress Designing Better Health Care in the South. Literature reviews on organisational change, power and trust, the focus group with Executive members of the Department, and analysis of Departmental documents helped to address this potential imbalance in perspective and to address the issue of objectivity during the analysis of the available data. During the data analysis, I also considered the range of perspectives that could have been alternative explanations for the different participants' actions and motives. However, in every study of this kind, objectivity is a challenge which needs to be addressed through a recognition of the potential for differing interpretations of actions and motives and an acknowledgement of the study's limitations. Studies of policy are inevitably subjective to some extent and the sources of this subjectivity need to be acknowledged in order for the reader to assess the quality of the argument. I have sought to address this issue through the data analysis methods outlined above and through the active participation of a project reference group in debating the study's interpretation and findings. It should be recognised however, that objectivity in policy research is rarely possible and that rather than claiming objectivity, it is preferable for researchers to acknowledge their own biases and perspectives in their analysis and the interpretation of their results.

Role of the project reference group

A reference group was formed at the beginning of the evaluation project which comprised a person with extensive experience, knowledge and skills in evaluation and public health advocacy, a person with practical understanding and experience of the management of a hospital in today's difficult time of budget constraints, and a person with experience and knowledge of the health system, hospital administration and management. I brought to this group my experience in policy analysis and the thinking and reading that provided the basis for this study as well as for the evaluation.

While the establishment of a project reference group is considered a normal part of supporting and guiding a project, it is not commonly part of thesis development, which is more normally the sole role of the academic supervisors. I found that the presence of the project reference group during the first year of the development of this thesis, which overlapped with the final year of the evaluation project, was invaluable and provided a useful additional dimension to the support and advice provided by my academic supervisors. The focus of the project reference group was on making sense of a regionally initiated strategy to bring about organisational change situated within a complex and challenging period in the history of the South Australian health system.

The reference group met twice a month for a period of three years. These meetings gave me an opportunity to have regular discussions about my developing understanding of the implications of the change processes that took place in the health system during this time and significantly contributed to my reflection on and understanding of the change processes I was studying. The complexity and changeable nature of this study meant that it was very helpful to me to have a group of intelligent and informed observers contributing to debates and dialogue in order to make sense of the constant changes that occurred during the timeframe of this study. The contribution and participation of a reference group with different experiences and perspectives was very effective. As a team, the reference group broadened the

perspective possible for me as a single researcher working in isolation on an issue, and the group also helped to maximise the potential interpretations of data during the study and provided a valuable form of triangulation (Thomas et al. 2000).

The evaluation project was funded by the Australian Research Council SPIRT Program (Strategic Partnerships with Industry – Research and Training) and the four health care agencies involved in Designing Better Health Care in the South and the Department of Human Services were all industry partners in the project and contributed financial and in kind support. The project was based with the agencies in the southern metropolitan area of Adelaide, and as a result of tensions between the agencies and the Department (described in Chapter 5), despite the original intention for the Department to be represented on the project reference group, a representative of the Department only attended one meeting in the last year of the evaluation. This inevitably affected the focus of the project, although efforts continued to be made to engage the Department in discussion throughout the project's term.

Ethical issues

There are two fundamental ethical issues that have been essential considerations in the development of this thesis. These are the issues of confidentiality and of gaining consent. It was very important that respondents' identities were protected and that this study should cause no harm, or have no negative consequences for those who contributed to it through their participation. Therefore, all participants in this study were assured of their confidentiality and anonymity and every care has been taken to protect their identities.

Although it delayed access to Departmental documents, it was essential that permission to access this material should be achieved through formal and legitimate channels. I therefore formally wrote to the Chief Executive of the Department of Human Services requesting access to Departmental documents. Consent was given for access to documentary evidence with the proviso that confidential information would be treated as such and that a member of Department of Human Services senior

staff would determine the appropriateness of the inclusion of this material. To alleviate ongoing concerns about the use of this material, I offered to show this Departmental representative the section of the study that was based on Department of Human Services documents and attempted to be as open as possible about this. Following analysis of documentary material from the Department of Human Services, all of this material was returned to the responsible officer within the Department. Apart from this, all data, including transcripts and tapes are stored securely and any identifying information, such as names, titles or positions that could identify individuals, has been removed from this material.

Ethics approval for the data collection for this study was obtained from the Social and Behavioural Research Ethics Committee of Flinders University, which required the assurance of confidentiality of participants and careful negotiation with the Department of Human Services as the provider of the documentary material about its use.

The politics of research

Becker (1970) maintains that all good research makes somebody angry. It is important to acknowledge that politics plays a key part in any research involving people, and particularly where this research involves policy decisions and people's values. It is particularly challenging in a research context to determine how best to present unwelcome findings so that they contribute to positive outcomes rather than to further barriers of defensiveness. The political nature of this study, the sensitivities around protecting participants' confidentiality and the apparent anxiety about any work that might openly criticise or even question policy directions contributed to the difficulties I encountered when undertaking the study. It was important to both recognise the politics of research in this context and to find ways to talk and write about this study that moved beyond the personal and the detailed to enable understandings to be developed about broader issues, such as the nature of change in the health system and the difficulties built into relationships between bureaucracy and service providing agencies. Thus, this study moves from a detailed case study

account of a series of events and a number of perspectives on these events, to a more generalised discussion of the issues that emerge from this case study that are applicable to furthering understanding of the nature and consequences of continual health care reform for the health system and its component parts.

The next chapter describes the history of two examples of health care reform in South Australia. As well as providing the historical context for the following case study, this history provides a description and discussion of the struggle between the various state health ministers, their Department and the health care organisations, for control of the health policy agenda in South Australia. This has a direct relationship to the discussion in Chapter 2, reflecting many of the tensions and developments that have occurred nationally, in particular in relation to the introduction of managerialism and New Public Management, and the adoption of market-based approaches to health care reform.

Chapter 4

Health System Reform in South Australia

This chapter provides the South Australian historical and reform context in which the case study is located. Following an overview of the structural and financial arrangements of the Australian and South Australian health system, this chapter describes the establishment and evolution from 1976 of the South Australian Health Commission until its amalgamation into the Department of Human Services in 1997, which has been the key focus of administrative reform of the last thirty years in South Australia[7]. The chapter then describes another significant reform, the separation of purchaser and provider functions and the concurrent 'realignment' of the Health Commission which commenced in 1994. This reform is particularly significant because it signalled the adoption of a market model of health care in South Australia. The chapter relates this state historical context to the discussion of the international and national context of managerialism and New Public Management that was developed in Chapter 2, and considers the adoption of managerialism and more recently of a market model of health care in South Australia and how these approaches to public administration have influenced the direction of health care policy in this state[8].

The historical description of the establishment and evolution of the SA Health Commission provides an insight into the emergence of managerialism in the South Australian health system and the resulting tensions that arose between government and bureaucracy and between bureaucracy and health service providers. It also provides an understanding of the historical origins of the governance arrangements in

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[7] See Appendix 2 for a historical timeline of major events in the development of the South Australian health system from 1973 – 2000.

[8] Managerialism was discussed in Chapter 2. Its focus is on ensuring a responsive bureaucracy to the reform agenda of government through the adoption of management strategies, including a strong central policy role and the devolution of decision making closer to the point of service delivery. New Public Management brought together managerialism and economic rationalism and sought to implement private sector management strategies in the public sector, including the adoption of market-based strategies throughout the public sector.

the health system in South Australia which have had implications for the way that health care agencies and bureaucracy interact, including the struggle to maintain independence on the part of the agencies, and the struggle for control by the bureaucracy and by a series of South Australian health ministers since the establishment of the SA Health Commission.

The second topic of focus of this chapter, the introduction of the separation of purchasing and providing functions within the South Australian health system, provides insight into the application of a market model to the health system and its consequences for relationships between bureaucracy and health service providers. This separation of purchasing and providing functions, which commenced implementation as part of a broader reform strategy initiated within the SA Health Commission, provides the wider contextual background for Designing Better Health Care in the South, which in part was a response by a group of agencies to this centrally initiated reform strategy.

The Australian health system – an overview

Before presenting the historical description of administrative reform within the South Australian health system, it is necessary to describe the complex nature of the financial and service delivery structures that constitute the Australian health system. The term 'health system' is commonly used in Australia to describe a complex array of organisational, service and system arrangements and relationships, primarily focusing on treatment and care for those who are ill. The health system in Australia is complex, partly as a result of the federation of Australian states and the system's public and private (both private not-for-profit and for profit) institutional components and funding arrangements. The use of the term 'system' is a convenient way to describe a collection of entities that are related to one another in ways that are not necessarily integrated, coherent or systemic. In reality, the Australian health system is made up of a multitude of smaller systems, institutions and activities that are interconnected to varying degrees. Whilst 'system' is a convenient term to group this

collective arrangement, it does not therefore necessarily reflect their ways of functioning and linking.

The Australian health system is unique to this country but has a number of common characteristics with other health systems. The British National Health Service has had a significant influence on the Australian public health system since World War II through a model whereby the government provides most health services to the entire population without significant charges. As described in Chapter 2, the separation of purchaser and provider functions in health care funding, planning and delivery, which occurred in the United Kingdom in the early 1990s also had a significant influence in Australia and in South Australia. Similarly, the Australian Medibank and subsequently the Medicare universal access taxation-funded health insurance scheme is based on the Canadian model. Influences from the United States are reflected in moves to increase the role of private health insurance and private health care providers in the Australian health system. The United States is also a source of new policies and developments in technology, funding and health care organisation which continue to influence Australian health policy to the present day.

The Commonwealth Government, through the Department of Health and Ageing, provides funding for health services within the Australian public health system, funding general practice, subsidised pharmaceutical drugs that are included on the Pharmaceutical Benefits Scheme, and a range of services, including providing subsidies for nursing homes and domiciliary nursing. The Commonwealth Government is also responsible for funding national community health activities and programs, such as the National Women's Health Program and the National Drug Strategy. Funding from the Commonwealth to the states is negotiated every five years through the Australian Health Care Agreement (formerly called the Medicare Agreement), with the current agreement running from 2003-2008. These agreements detail Commonwealth and state mutual expectations, funding levels for public hospitals using the casemix funding model, and performance criteria.

In 2001, Australia spent 9.2% of GDP on health, a total of $66.6 billion. Hospitals represented the largest expenditure of the health care system, accounting for 55% of total health spending at the state level and 27.8% at the Commonwealth level (Australian Institute of Health and Welfare 2003 p192). The Commonwealth-funded Medical Benefits Scheme and the Pharmaceutical Benefits Scheme have played an important role in controlling the cost of general practice and pharmaceuticals through standard fees, although there is ongoing pressure on these schemes. Changes in Commonwealth private health insurance funding policies were described in Chapter 2, and include the 30% rebate for private health insurance and the Lifetime Health Cover policy which penalises people who wish to take out private health insurance after they reach 30 years of age. The 30% rebate in particular has led to increases in private health insurance fees and therefore in the amount provided through public subsidy to private health insurance companies (Duckett and Jackson 2000; Hindle and McAuley 2004).

General practices are part of the private medical practice industry in Australia, with general practitioners predominantly working in private practices on a fee for service basis, the majority of which is funded by Medicare through a scheduled fee. General practitioners are the gatekeepers to the health system for the majority of patients. Patients are required to be referred by general practitioners to speciality, diagnostic and hospital services. Since 1992-93 the Commonwealth has provided significant additional resources for the establishment and development of Divisions of General Practice across Australia with the aim to broaden the role of general practitioners, to promote the development of local general practice networks and encourage information exchange between them, and to encourage the coordination of general practice activities (Palmer and Short 2000). The Commonwealth also has responsibility for the provision of hospital and medical services to war veterans, their widows and dependants through the Department of Veterans Affairs.

While the local focus of this study precludes a detailed discussion of the impact of changing Commonwealth policy at the state and local level, it is important to

acknowledge the role of the Commonwealth government and the impact of Commonwealth policy decisions on the state health system and local health care agencies. This includes, for example, the funding of Divisions of General Practice as a strategy to build primary health care by the Commonwealth government, and the opening of Flinders Private on 17 January 1999[9]. This private hospital was established during the time of this study and collocated with Flinders Medical Centre, the major teaching hospital that was a partner agency in Designing Better Health Care in the South. While these policy initiatives and others initiated by the Commonwealth government had an impact on the agencies in the southern region of Adelaide, they are not central to this study, although they contribute another source of reform initiatives and an additional layer of complexity to the context in which all Australian health care agencies function.

The South Australian state government, similar to other state governments, has responsibility for financing hospitals and a range of community health services. However, each Australian state has its own distinctive organisational arrangements and problems. In South Australia, the Department of Human Services was the central bureaucracy that undertook a policy, planning, funding and administration role during the period of data collection for this study. As well as providing the central bureaucratic function for the South Australian health system, the Department of Human Services had responsibility for public housing and family and community services, such as the areas of child protection, ageing and disability.

The South Australian Department of Human Services was modelled on the Victorian Department of the same name which was established under the Kennett Liberal government as part of a major restructure of the public sector, and which involved the adoption of a market model based on contracting and competition (Hancock 1999). Both Departments had a strong focus on integration, although the Victorian Department of Human Services focused on integration within regional networks of

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[9] As discussed in Chapter 2, privatisation is an extreme form of decentralisation from the public to the private sector which is often adopted as part of a neo-liberal reform agenda.

health services in order to achieve 'value for money', and the South Australian Department of Human Services focused on integration between health, housing and community services in order to achieve coordination across these systems and to control the health care budget. Both Departments adopted approaches that increased the concentration of formal power in the central bureaucracy and limited the influence of interest groups on policy development and service delivery (Hancock 1999). These issues are significant to the case study and are discussed further in Chapter 8.

At the completion of this study, the governance arrangements in the South Australian health system were changing. However, at the time of the study, the South Australian health system had the following key governance arrangements. Metropolitan hospitals and other health services had institutional boards of governance and were legally incorporated. In metropolitan Adelaide, the individual hospital and community-based health service boards of governance and the Department of Human Services played a major role in service policy, planning and funding. In country areas some health units had individual boards of governance while other health unit boards had voluntarily amalgamated. In addition seven country regional boards also existed and had a role in service planning for their regions and a responsibility for resource allocation to individual services. The Department continued to play a role in service planning and funding in the country although it had partially devolved this role to the regions.

At the time of this study, there were 73 health units incorporated under the SA Health Commission Act, including 46 country health units, 7 country regional boards, 2 metropolitan community health services (a result of merging and amalgamating locally-based community health centres in the mid-1990s), 8 metropolitan hospitals, 3 disability services and statewide drug and alcohol, dental and child and adolescent health services.

As this thesis was being finalised in late 2004, the South Australian Department of Human Services had been divided and restructured into a Department of Health and a Department for Families and Communities. Health care agencies across metropolitan Adelaide were regionalised under three newly established boards, two of which were regional (northern and southern) and one was population based (focusing on women, young people and children). Given the extensiveness and combined scale of these changes, this potentially has been the most significant restructure that has occurred within the South Australian health system at one time, arguably of greater magnitude than that which resulted in the establishment of the SA Health Commission in 1976 (discussed later in this chapter). The current restructure involves redesign of the Central Office bureaucratic functions, with a number of these functions being moved to the regional level, simultaneously with the regionalisation and un-incorporation of the legally separately incorporated health care agencies within the metropolitan area of Adelaide and the establishment of northern and southern metropolitan regional health service boards.

This chapter will now describe the history of the establishment of the SA Health Commission and will then discuss the introduction of the purchaser provider split within the South Australian health system. These two administrative reform processes provide the state-level historical and policy context for the subsequent case study, Designing Better Health Care in the South. They are also significant markers in the introduction of managerialism and a market model of health care into the health system in South Australia.

The establishment of the South Australian Health Commission[10]

In 1967 Dr Brian Shea was appointed as Director-General of Medical Services in South Australia. At this time South Australia's health services were managed by three separate departments – the Hospitals Department, the Department of Public

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[10] This section of the chapter relies heavily on the historical work of Ian L.D Forbes (1996). Interviews with Professor John Blandford on 4 August 1998 and Dr Neville Hicks on 17 August 1998 also provided valuable insight and information for this section of the chapter. They were both former Commissioners of the SA Health Commission.

Health and the Department of Mental Health. Some health services were publicly funded, while others were funded by non-government, voluntary and charitable organisations. Shea believed that the Hospitals Department had become too large and hierarchical, and unresponsive to the local needs of the community. New South Wales and Victoria had already established Health Commissions and moved away from the model in existence in South Australia, seeing this separation of control as being dysfunctional to the health system. The separation of the Hospitals Department, the Department of Public Health and the Department of Mental Health in South Australia was seen by Shea as problematic and, consistent with the models adopted in NSW and Victoria, he supported a more holistic and coordinated approach to health system management, in line with early managerialist approaches. Dr Brian Shea and Dr Philip Woodruff, who was Director-General of Public Health in South Australia, agreed that an independent review of health and hospital services would be appropriate in order to plan the reorganisation of the state's health services. As a result, in 1970, under the Labor Premier, Don Dunstan, the South Australian state government set up the Committee of Enquiry into Health Services in South Australia chaired by Charles Bright.

The Bright Report – Creating the Health Commission

The Bright Report (Committee of Enquiry into Health Services in South Australia 1973) was submitted to Parliament in January 1973. It recommended the establishment of a single authority, external to the public service, which would unify control of health services that were provided or subsidised by the state government. The Bright Report recommended the creation of a health system structure in South Australia with a broader focus than hospitals, that recognised the important role of community health services and of the influence of social circumstances on health[11].

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[11] This understanding was consistent with the work of Thomas McKeown (1979), who highlighted that, excluding vaccination against smallpox, non-medical interventions, such as improved living standards which resulted from economic development, were responsible for improving the health of the population and increasing life expectancy. McKeown argued that economic reform was the major impetus behind the decline in infectious diseases in 18th and 19th Century England. Szreter (1988; 1997) has more recently argued for a revision of this argument, demonstrating that the redistribution of

Bright's review was consistent with reforms occurring under the national Whitlam Labor Government which in 1973 established and commenced funding the Community Health Program across Australia. The Bright Report recommended that the health authority should have an advisory role, independent of the public service with an arm's length relationship with the Minister, and that it should be flexible. The report argued that this would enable the proposed health authority to address the fragmentation in the South Australian health system, which it stated was largely within the government component of the system and that the numerous voluntary bodies working within the health system would find it easier to work with an independent authority than a government department. The Bright Report supported Shea's view that it was no longer appropriate for hospitals to be managed through a hierarchical structure where hospital employees were employees of a centralised government department. Bright recommended that the Public Service Board participate in establishing salaries and conditions for employees of the health authority, with opportunities for staff to move between the public service and the health authority, while the health authority remained independent of the public service. He proposed that the health authority should have at least five members, with at least one being a medical graduate, and all should be appointed by the Minister. The health authority was to be directly responsible to the Minister. Its members should be part time, with none of them being a full time officer of the health authority. This was a significant reform agenda which viewed the diversity of agencies providing health services as part of a system and supported the adoption of a coordinated approach that was consistent with early developments in managerialism in Australia.

The state government was rapidly increasing spending on capital works and on health and hospital services in South Australia as hospitals, such as the Royal Adelaide Hospital, required development and upgrading. As a result, state expenditure on

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wealth through state and political interventions, rather than economic growth itself, delivers health benefits in a society. He argues that the health of the community is largely determined by the nature and extent of state interventions to mediate the negative effects of economic growth.

hospital capital works per capita moved in the late 1960s and 1970s from being second lowest in Australia, to being second highest (Forbes 1996). The reforms and increased spending on the South Australian health system were one aspect of the broader social reform agenda of the Dunstan Labor Government which included social policy reforms in many other areas including a broadened social welfare reform agenda, electoral reform, the decriminalisation of homosexuality and Aboriginal land rights (Oxenberry 1995). Consequently, this was not an era of financial constraint, but of social reform initiatives.

The Bright Report emphasised the importance of the independence of the proposed new health authority to ensure its effective working relationships with the diverse range of health services that were public, private and voluntarily run. The managerialist focus on centralising control of budgets and programs, on Ministerial control and on a drive for efficiency and effectiveness was not in evidence. However, the model proposed by the Bright Report was not implemented in its entirety. The delay in the establishment of the SA Health Commission reflected managerial concerns about the role of the proposed health authority, and the model that was finally implemented became increasingly executive rather than advisory. The SA Health Commission Act of 1976 brought about the independent incorporation of hospitals and their administration by Boards of Management, as well as the incorporation of health units to be managed by management committees and to employ their own staff under the Act.

The Health Minister in the new Liberal Government elected in September 1979, Jennifer Adamson, appointed Charles Bright as chairman of a committee to advise her on changes to the Commission and on the development of a model of the Commission as an advisory body. She announced major changes to the Commission which were incorporated into amendments to the Act in 1980 and included the Chairman becoming the Chief Executive Officer of the Health Commission. The Chairman was to be directly accountable to the Minister, with the requirement that, to ensure independence and avoid conflicts of interest, this position could not be held by

a public servant. These changes were intended to make the Commission a more effective coordinating body.

On 1 July 1980, following the completion of Charles Bright's advisory role, the position of Chairman and Chief Executive Officer was filled by Bernard McKay. McKay decentralised decision-making concerning the delivery of health services and focused the Commission's Central Office role on planning, policy development, coordination, resource allocation and evaluation. Decision-making about service delivery was given to three sectors, established on 1 July 1981 – western, central and southern. In this model of 'sectorisation', each sector had a country and metropolitan component. Hospital boards were given greater powers to manage their budgets, and health units were incorporated and given greater autonomy. Regional Executive Directors were appointed to develop the sectors and to manage the resources allocated to each sector. This model was consistent with early managerialist reforms in that it focused on strategic planning and centrally determined goals with decision making being decentralised closer to where services were provided (although the sectors were administered from within the Central Office, where the Regional Executive Directors were located).

In 1980 the South Australian Treasury announced that institutions could no longer expect to receive their funding based on historical precedent and growth. In the early 1980s the Commonwealth Government also brought in formula funding. These events signalled the beginning of a focus on cost containment within the health system in Australia and in South Australia.

The era of cost containment begins

In November 1982 the Australian Labor Party was re-elected under John Bannon and in February 1983, the Government commissioned a review into public and private hospitals in South Australia chaired by Sidney Sax, which examined the administration of public hospitals, assessed the State's present and future need for

hospital facilities and reviewed aged care services. At this time Sax was a Visiting Fellow of the Australian National University and an eminent academic in Australian health administration. The Sax Report titled *Report of the Enquiry into Hospital Services in South Australia* (SA Health Commission 1983), found that public and private hospital services in South Australia underwent a period of expansion from the 1960s and that the increase in the supply of beds was a result of government policies to improve access to hospitals, particularly in the rapidly expanding outer metropolitan areas to the north and south of Adelaide. New hospitals were built at Modbury and Bedford Park (the Lyell McEwin Hospital and Flinders Medical Centre respectively) to cater for these populations and capital for hospital development was readily available. The report found that from the early 1980s, funds for hospital refurbishment and for new capital development diminished and costs escalated; the health system in South Australia seemed to lack stability as a result of frequent changes; and the morale of hospital and Commission staff was low (SA Health Commission 1983). As a result of the reduction in new capital development funding and the pressure experienced because of escalating costs during the early 1980s, more recent developments in the health system have been viewed as cut-backs and a drive for cost containment.

Gary Andrews, who was a member of the Sax Committee, was appointed to the position of Chairman of the Health Commission and commenced in July 1983. At this time, further amendments were also made to the SA Health Commission Act. At its commencement, part time Commissioners had been appointed under the Act as a way to bring a wide range of representation from health, local government, business, finance and community interests to decision-making. This intention had not become reality and the number of part time Commissioners was reduced with their role increasingly being restricted. From 1987, the Commission officially operated under the direct supervision of the Minister. The Commission had become an executive body rather than the advisory body originally intended by Charles Bright.

Two reviews were undertaken during Andrews' term as Chairman. The first was a review of the SA Health Commission Central Office completed in June 1986 and chaired by Ken Taeuber. Taeuber was a former Director-General of Lands and Commissioner of the Public Service Board. The Taeuber review (SA Health Commission 1986a) recommended changes in the organisation of Central Office, including a reduction in its size and a change in its operation, resulting in the disbanding of sectorisation from 1 July 1987 and the replacement of the sectors by three Divisions – Metropolitan Health Services, Country Health Services and Statewide Health Services Divisions. A new Planning and Policy Development Division and a Corporate Services Division were also established. The restructuring of the Commission into these Divisions signalled a move towards a stronger central role in policy development and planning and the increasing focus on an approach that viewed the health system as requiring a consolidated central coordinating function.

The previous model of sectorisation had been considered to be successful by people working in health care agencies because it had provided identified points within the central bureaucracy to which staff in health care agencies could relate, and therefore met a need of service providers. It was seen by them to have provided links between country and metropolitan services, with links also being established between these services and specific staff within the central bureaucracy, resulting in effective working relationships that were responsive to regional community needs. However, this model was not viewed as positively by staff in the central bureaucracy, which suggests that the model met certain needs for links into the bureaucracy at the agency level but did not meet the needs of the central bureaucracy, which was required to oversee the coordination of the system and manage the health system budget. Although the intention of sectorisation was to increase health system responsiveness at the local and regional levels (discussed further in Chapter 6), the model did not enable the central bureaucracy to manage and coordinate the system, because Regional Executive Directors focused on resource allocation and service delivery at the regional level and there was no centrally consolidated strategic planning and policy capacity to coordinate the system as a whole.

The second review initiated during Andrews' term as Chairman was chaired by John Uhrig, a high profile figure in management in the private sector. The Uhrig Report (SA Health Commission 1986b) made recommendations concerning the organisation, financial management and accountability of the South Australian metropolitan public hospital system. The major recommendation of this review was for the establishment of a metropolitan hospital authority to replace the nine separately incorporated hospital boards. This recommendation was not supported, although a Metropolitan Hospitals Coordinating Group was formed in an effort to improve cooperation between major metropolitan hospitals and the central bureaucracy. In line with other recommendations from this report, the SA Health Commission Act was amended to ensure that the roles, functions and responsibilities of the Commission and the hospitals were clearly defined, and there was support for the concept of planning for the metropolitan hospitals as a system, based on clinical programs and hospital support services.

Despite increasing pressures for cost containment, the 1980s was also a time of significant social policy development in South Australia. This was demonstrated in the health system by the development of the community health movement[12], the establishment of the Social Health Office in 1986, the development of the *Primary Health Care Policy* (SA Health Commission 1989) and the unendorsed green paper *A Social Health Strategy for South Australia* (SA Health Commission 1988b) which, despite its lack of endorsement, had a significant influence on later state health policy, planning and program development (Raftery 1995). At the broader level, the State Labor Government also endorsed *A Social Justice Strategy for South Australia* (Department of Premier and Cabinet 1989) which provided a social reform agenda for all human services in South Australia. The Minister of Health, John Cornwall, who was also Minister of Community Welfare, led efforts for the amalgamation of health

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[12] Community Health Centres were established in South Australia in 1973-74 with funding from the national Community Health Program and were state-funded from the 1980s. In 1981 the SA Community Health Association was incorporated as a lobby group for the community health movement in South Australia.

and welfare departments, recognising the relationships between health and welfare services and the need for greater coordination between them (Oxenberry 1995). Despite efforts to contain costs within the health system, the 1970s and early 1980s were a period of increased public expenditure on social reform in South Australia, including increased expenditure on education, housing, job creation and programs for women and Aboriginal people. This period saw the South Australian government spend more per capita on welfare, ethnic affairs and grants to community agencies than the more populated states of New South Wales or Victoria (Milio 1992; Raftery 1995). However, in parallel with this social reform agenda, the increasing focus within the health system on cost containment, coordination, and the development of central strategic policy and planning functions were all evidence of the increasing influence of managerialism in South Australia.

On 30 October 1986, Gary Andrews resigned as Chairman to resume academic activities. He and John Cornwall had disagreed on a number of occasions about the extent of ministerial control and the direction of the Health Commission (Forbes 1996). Cornwall acknowledged that while the original intent of the legislation was clearly to allow the Commission to operate at arm's length from its minister, it was essential to have some formal lines of accountability to enable ministerial responsibility. This was consistent with the early managerialist aims of the Whitlam Labor Government discussed in Chapter 2 to ensure a responsive and accountable public sector. The SA Health Commission Act was amended in 1987 to accommodate this view, with the relevant clause being changed to read:

> In the exercise of its functions, the Commission is subject to the control and direction of the Minister.

Following his resignation, Andrews was replaced in November 1986 by W.T (Bill) McCoy. McCoy had been the Medical Superintendent of the Adelaide Children's Hospital for 13 years, and was deputy chairman of the Commission before being appointed Chairman. Bill McCoy retired in 1991 having focused in his term on increasing efficiency and cutting 'fat'. However, public health within the Health Commission had also been strengthened under McCoy, and he believed that the

Commission's epidemiology and infectious disease control sections in particular had achieved a world standard during his term (Forbes 1996). On his retirement, Barry Hailstone commented in *The Advertiser* (5 August 1991) that some of McCoy's most important but least popular contributions to the South Australian health system had been in the area of containing costs.

In summary, the original intention of the health authority proposed by the Bright report in 1973 had been very different from what was in place twenty years later. A combination of factors including the increasing cost of running the health system, a growing focus on efficiency and effectiveness, a shift towards centralised planning and central policy development and efforts to increase Ministerial control of the central health authority which had originally been established as an independent body, signalled a move by the Health Commission to a managerialist approach. The appointment of the Executive Directors of the sectors during the time of sectorisation, and subsequently of the SA Health Commission Central Office Divisions, resulted in the establishment of a defined group of senior managers within the Central Office of the SA Health Commission with responsibility to coordinate the health system and make decisions about resource allocation and planning. 'Executive', which was the name given to the regular meetings of the Health Commission Executive Directors and Chairman, met weekly to consider strategic issues and undertake planning for the health system. This represented an increasing emphasis on the role of bureaucratic management in planning and policy development and the increasing central control of budgets and programs. As a result of recommendations from the Bright Report, health units in South Australia were established as distinct legal entities, separately incorporated under the SA Health Commission Act, with individual boards of directors. However, they were dependent on the SA Health Commission for core funding and were required to comply with broad policy directions from the central bureaucracy.

The subsequent history of the SA Health Commission presents an ongoing struggle by various health ministers to gain control of the Health Commission through

attempts to introduce legislative change; of the bureaucracy to gain control of the health care providers and introduce greater accountability into the health system; and of the health care providers to maintain their independence in determining the services that they should offer and the way that these services should be provided. These three areas of tension were key drivers in the development of the SA Health Commission during this time and were an expression of the changing relationships, roles and power balances within the South Australian health system.

In 2000, following the incorporation of the Health Commission into the Department of Human Services (which occurred in October 1997), and after a number of attempts by different health ministers since the creation of the SA Health Commission, the SA Health Commission Act was finally amended so that the Minister for Human Services could direct hospitals and health services in all areas apart from in relation to human resource decisions. In *The Report of the Auditor General for the Year ended 30 June 2000*, this amendment to the SA Health Commission Act was explained:

> In May 2000 the Act was amended to explicitly provide that hospitals and health centres incorporated under the Act are subject to the direction of the Minister for Human Services. The Minister's capacity to direct is limited by the Act which also requires any directions to be in writing and particulars of any directions to be included in relevant hospital or health centre's annual report (Auditor General of South Australia 2000).

The move to managerialism created tensions between the central bureaucracy and service providers for control of decision making about services and the allocation of resources because of the independence of the health care agencies. The developing role of the central bureaucracy in relation to coordination, system planning and policy development, budget management and cost containment contributed significantly to these tensions. A managerialist approach also accentuated the division between management and clinicians in health care agencies and contributed to a shift in the locus of control from clinicians to managers within these agencies as well as within the wider health system (as evidenced in the establishment of the SA Health Commission Executive) (Hunter 1991; Davis 1995; Clarke and Newman 1997). These issues are discussed further in Chapter 8. These trends were occurring

internationally and in part were a result of growing financial pressures on health systems and increasing concern about the sustainability of the welfare state.

In South Australia, the contradictions inherent within a managerialist approach were apparent in the tensions between moves to decentralise decision-making to the regional level to foster flexibility and responsiveness, and to centralise control of the budget, policy and planning roles to the central bureaucracy to build coordination and control. These tensions were particularly apparent in South Australia because of the legal incorporation of health units which therefore had a degree of independence of decision making, even though they were funded by and required to follow broad policy direction from the central bureaucracy. The differing agendas between service delivery agencies and bureaucracy are consistent with, and parallel to the tensions between management and clinicians within a health care agency, so that the cost management priorities of bureaucracy and hospital management can be inconsistent with the priorities of service providing agencies and clinicians for optimum service provision and the right to determine appropriate treatment for patients. These tensions will be discussed further in later chapters with specific reference to the case study.

The introduction of the separation of purchaser and provider roles within the South Australian health system further widened the gap between the agendas and priorities of the bureaucracy and service providing agencies. This strategy introduced a market model to the health system in South Australia. The concept of the separation of purchasing and providing functions within health systems has been introduced in Chapter 2 and will now be described as it was applied in the South Australian health system in the mid 1990s.

The separation of purchasing and providing roles within the South Australian health system [13]

The collapse of the State Bank of South Australia, which occurred in 1993, resulted in the virtual bankruptcy of the state leading to a period of recession and reduced funding in the 1990s as both the Labor Government and the subsequent Liberal Government (elected on 11 December 1993) pursued debt-reduction strategies. These strategies led to the contraction of the public sector and of the health budget in South Australia (Baum 1995; Moss 2002).

The newly elected Liberal Premier, Dean Brown, appointed a Commission of Audit to review the state's finances. In April 1994, the Commission released its report titled *Charting the way forward: improving public sector performance* (South Australian Commission of Audit 1994). The Commission of Audit supported the intention of the Government to cut spending and reduce the public debt. It also recommended that the Health Commission be replaced by a new Department for Health, managed by a Chief Executive Officer who would report directly to the Minister. It recommended that the Health Commission contribute to the overall savings target of the state government[14] and that the roles of purchasing and providing services within the health system should be separated.

1994 was a year of significant turning points for the SA Health Commission. As well as the report of the Commission of Audit being released and recommending significant savings be found from within the budgets of a number of government departments, the Executive Director of the Policy and Planning Division returned from a trip to the United Kingdom and prepared a paper for the SA Health

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[13] This section of the chapter is largely based on official SA Health Commission documents provided by the Department of Human Services, as well as an interview with Dr David Filby, Executive Director, Policy and Planning Division, Department of Human Services on 27 August 1999.

[14] The implementation of this recommendation resulted in the contribution of $35m by the SA Health Commission to state government savings in 1994/95, the financial year directly following the release of the report of the Commission of Audit (cited in the SA Health Commission Annual Report – 1994/95). In subsequent years, further Health Commission funds were contributed to SA Government savings.

Commission Executive on the funder/purchaser/provider issue and about the roles of the Health Commission Divisions within that model. The model described in the paper relied heavily on the arrangements in place in the United Kingdom and New Zealand at that time. The focus in the United Kingdom was on increasing efficiency, customer responsiveness and quality. In New Zealand, the focus was on population health, integrated services for individuals, management of financial risk, value for money and accountability.

The paper to Executive recommended that service agreements should be developed between the Health Commission as purchaser and the health care providers, based on what the purchaser wanted for consumers rather than which services the providers wanted to offer. 1994 also saw the release of *A Hospital Service Improvement Strategy* (SA Health Commission 1994) which proposed the implementation of a casemix funding model that used clinical protocols to determine hospital costings. Casemix funding was introduced in South Australia in conjunction with significant health budget cuts and other quasi-market reforms such as privatisation and outsourcing (Duckett 1998a; Draper 1999). Its implementation arose from the need to classify the work of hospitals into clinically homogeneous groups with similar patterns of resource use, enabling the comparison and evaluation of different approaches to the clinical management of the same conditions (Australian College of Health Service Executives n.d).

Casemix is a system for describing, comparing and funding hospital work. The unit for cost allocation for casemix is patient stay. Casemix funding for inpatient services is based on diagnosis related groups (DRGs) being used as clinical resource categories to group the types of patients treated in order to determine payment to the hospital. In this way, hospital budgets can be determined according to their performance or output, rather than based on history or negotiation. The casemix funding system is generally viewed as providing tools for better planning, resource allocation and management and for the monitoring and evaluation of health care (Owen 1998; Brook 2001). It has forced hospitals to address their resource use and is

intended to make clinicians accountable for the resources used as a result of their decision making (Draper 1999). However, casemix has been found to have certain perverse incentives for hospitals, including the potential to encourage undesirably high admission rates; to maximise the activities for which hospitals are paid and minimise those which are of value but which cannot be priced and for which they are not paid (for example, areas such as health promotion and illness prevention) (Duckett 1998a). It has also increased the burden on post-acute community services through rewarding early discharge (Draper 1999). In South Australia, casemix-based funding of recurrent expenditure in metropolitan public hospitals and country regions is provided in order to undertake a target amount of inpatient and non-admitted patient activity. Capital investment is budgeted separately (Moss 2002).

In 1995, the South Australian Government began a period of significant public sector reform it described as the introduction of the Government Management Framework. The aim of this reform strategy included:

> … improving the performance of government in a climate of increasingly complex social and economic demands.

> With local variations, most other Australian jurisdictions have responded similarly to the need for micro-economic reform in the environment of the 1990s by examining their government structures and processes (Department of Premier and Cabinet 1999).

The Government Management Framework aimed to improve public sector management with a particular focus on value for money in the provision of public services; responsiveness of the public sector to Government priorities; improving the effectiveness of coordination between agencies; and agency management being accountable for the use of resources. Early work on the Government Management Framework that was endorsed by Cabinet in late 1995 included the assessment of models of planning, management improvement, and the definition of the roles of purchasers and providers. Other work under the program included budget reform so that budgeting could be driven by consideration of inputs, outputs and outcomes; whole-of-Government planning and management; debt reduction through outsourcing certain government services; the restructure of the South Australian public service

from 34 departments to 10 portfolios; and the establishment of a Senior Management Council of portfolio Chief Executives, all of which indicated the adoption of New Public Management approaches within the health system. The SA Health Commission's discussions concerning the introduction of purchaser/provider separation were supported by the Government Management Framework which proposed the same strategy for other Government departments. This initiative demonstrated clear evidence of an increasing move towards market models within the public sector during this time.

Blight's health system management reform agenda

In 1994, within the Health Commission it was suggested that the model for separating purchasing and providing functions should include the establishment of Regional Boards to replace the Metropolitan and Country Health Services Divisions as purchasers. However, Ray Blight, who became Chairman of the SA Health Commission following the election of the Liberal Government in December 1993, strongly held to the notion of a single purchaser within South Australia because he argued that the size of the state would not support multiple purchasers. In August 1994, Blight stated in an internal paper that he circulated to staff of the SA Health Commission titled *Management of the State Health System*:

> It is no longer appropriate to see the role of the health system as principally that of a health service provider. Rather, the State health system should concentrate on understanding the requirements of its communities and then obtaining the necessary services from the most efficient and effective providers whether they be private sector, non-government or traditional public service organisations. This separation of the funder/purchaser role from that of service provider is the logical foundation for the introduction of further competition in service provision for the purpose of maximising 'value for money' in quality service provision (Blight 1994b).

To a degree, the purchaser/provider model was already in existence within the South Australian health system because health units were separate legally incorporated entities. However there were a number of unclear functions both within the central bureaucracy and within some agencies that had both purchasing and providing roles and this was no longer considered to be appropriate because there were potential

conflicts of interest where these roles were not clearly separated. Despite this, the language of competition was new to the South Australian health system and reflected national developments at this time, such as the implementation of the National Competition Policy described in Chapter 2.

In mid-1994 Blight made a presentation to staff explaining and justifying the separation of purchasing and providing roles which he titled *Doing the Splits*. In his presentation, he stated that the government purchased health services on behalf of the population and provided services through its administration and management of hospitals and other health care services. He stated that:

> This dual role can lead to conflicts of interests if the needs of the purchaser, as the agent for the community, do not coincide with the needs of the providers (Blight 1994a).

He also stated that separating purchasing and providing functions would result in a shift in the balance of power in health care away from providers and towards consumers and purchasers who buy services on their behalf; that it would provide flexibility to substitute forms of health care to enable appropriate and timely responses to community needs; and that it would enable evaluation of alternative forms of service provision from competing agencies and encourage comparison and competition between providers. He followed this justification by stating that this model would target the more efficient use of health resources so that funds could be freed up to:

- plough back into the health system – ie getting more benefit from the same level of resources; or
- diverting funds for other purposes – ie getting the same level of benefit from fewer resources.
- Provides a framework and set of criteria for making health resource decisions so that decisions to award contracts for procedures based on value for money considerations can be more easily justified in the face of sectoral (provider) protests (Blight 1994a).

Consideration of the purchaser/provider separation model was also evident at the Commonwealth level. This was highlighted in the 1993-98 Medicare Agreement which sought to fund projects to clarify and define the funding, purchasing and

providing roles of health managers; and to examine the effectiveness of the mechanisms to create incentives for improving effectiveness, efficiency and quality of services through arrangements that distinguished between purchaser and provider roles in the health care system. In July 1994, the Executive Director of the Policy and Planning Division submitted a project proposal to the Commonwealth to fund the development of protocols for funder/purchaser/provider reform and received $50,000 for a 6 month project to support the move of the SA Health Commission to a funder/purchaser/provider separation model.

The separation of purchaser and provider roles within the health system formed one component of Blight's 'Management Reform Agenda' which included four distinct strategies, intended to be implemented in South Australia over a period of several years. These included: the regionalisation of country areas; the introduction of casemix as a pricing tool in public hospitals; the introduction of service agreements with service providers to increase accountability; and the realignment of the Central Office of the SA Health Commission to separate the purchaser and provider functions that were currently co-existing within it (Blight 1994b).

Realignment of the central bureaucracy

From 1995, the SA Health Commission Central Office became inward focused in planning for and working towards 'realignment'. The use of this term, rather than the more commonly used 'restructuring' or 'reorganisation' was explained in a memo from Blight to the Health Commission Executive which had strong New Public Management rhetorical overtones:

> … the organisational rearrangement seeks to realign rather than restructure the existing environment. Whereas restructuring tends to focus on changes in the disposition of staff to administrative units and on changes in reporting requirements, the realignment process aims to positively affect the culture of the Health Commission and to contribute to the aggressive pursuit of improved performance across the SA health system.

The Executive level of the Commission was reviewed and the position of General Manager was created to provide a single entry point for all service providers into the

Central Office of the Health Commission[15]. A Purchasing Office was created in early 1997, which maintained the purchasing function within Central Office rather than it being regionalised. The establishment of the Purchasing Office was described by Blight as 'the primary goal of realignment'. The activity to clarify purchasing and providing roles and accountabilities was entirely focused on the realignment of the central bureaucracy at this time. It could be argued that there was a degree of artificiality about the process because both purchasing and funding functions were contained within the SA Health Commission (which is inconsistent with separating these functions), while the health units were already separately legally incorporated entities. The discussion of contractual arrangements, service agreements and the growing focus on accountability of health care agencies to the central bureaucracy at this time were a demonstration of the move towards a market-based approach in the management of the health system.

Implementation of the realignment commenced on 30 September 1996 and was intended to occur in three phases: the creation of a framework for the realigned Central Office; the refinement and operationalisation of the framework; and the engagement of health care agencies and regions in clarifying the roles and responsibilities of Central Office and the field. It was intended that costs would be contained so that the realignment would not lead to an increase in the real cost of operating Central Office. Blight also stated on a number of occasions that the purpose of the realignment was not to reduce costs or staffing levels. Rather, the realignment process required the transfer of staff to new roles and the filling of new positions to meet functions that had not previously been carried out within Central Office. Executive level positions were advertised resulting in changes to some Executive Directors with new individuals filling these positions in some cases and some of the former Executive Directors departing the Health Commission. The South Australian Government Budget Estimates paper of 1 July 1997 stated that the realignment was almost completed with 80% of staff translated across to new

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[15] It is noteworthy that this new position was another attempt to provide a point of contact for health care agencies into Central Office, a strategy previously implemented under the model of 'sectorisation', discussed previously in this chapter.

positions. It stated that almost all Executive level positions had been filled by this time and that there had been no increase in staffing levels in Central Office and no additional Executive level positions had been created.

The reaction of health care agencies

The hospitals actively opposed the purchaser/provider split and the realignment of Central Office. Hospital opposition was led by the Chief Executive Officer of Flinders Medical Centre. Concern was expressed by this group about the introduction of competition to the health system and the consequences this could have for interagency collaboration and cooperation to improve service outcomes. There was also concern that these strategies would result in the central bureaucracy attempting to 'run health units by remote control'[16]. The introduction of the purchaser/provider separation could be argued to be another effort on the part of the bureaucracy to bring the health care agencies under the control of the bureaucracy, in part in an attempt to manage and contain costs, and in part to introduce further accountability and control of the agencies into the health system.

When it became evident to the Chief Executive Officer of Flinders Medical Centre that the health care agencies could not shift the single purchaser policy determined by the Chief Executive Officer of the Health Commission, she argued that Flinders Medical Centre and a group of agencies in the southern metropolitan area should become a 'sub-purchaser' to purchase services in response to the needs of the local community. As Blight was insistent on maintaining his view that the state was too small to sustain more than one purchasing body, this proposal did not proceed. From 1996 to 1997, the Health Commission was considering options for establishing regionally based networks of services across South Australia as part of a state-wide coordinated care approach in line with much larger examples of managed care

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[16] Quote taken from correspondence from a Chief Executive Officer of one of the health units to the Chief Executive Officer, SA Health Commission in response to the proposal to realign Central Office to fit the purchaser/provider model.

organisations in the United States. However, Blight directed that the proposed networks that were being discussed by the Health Commission could not be purchasers of services for their communities, but would rather be networks of providers. These debates reflected one of a number of factors that contributed to the creation of the Designing Better Health Care in the South process which is described in Chapter 5, and mirrored national market-oriented policy developments at this time.

In August 1997 Executive agreed to undertake a post-implementation review of the new arrangements. The realignment was described by Ray Blight as:

> … a milestone on the long term reform agenda for the health system and not an isolated management initiative.

Although work commenced to plan the evaluation of the realignment, this process was never followed through because it was overtaken by the creation of the Department of Human Services as part of a major restructuring of the South Australian public sector following the election of the Olsen Liberal Government in October 1997. Possibly as a result of this, the separation of purchasing and providing functions within the SA Health Commission was not implemented to the same extent as has occurred in other states in Australia, such as Western Australia or Victoria.

The purchaser provider split as market-based reform

The introduction of a purchaser/provider model for the management of the health system in South Australia clearly had its origins in the approaches adopted in the United Kingdom and New Zealand. The justification for the implementation of this approach was that health care planning and resource allocation decisions determined by the purchaser would result in service agreements with providers being based on the identified needs of communities and would specify health and service outcomes determined through policy and strategic planning. The separation and clarification of these roles was intended to bring greater accountability and transparency into the health system which would operate through a set of negotiated service agreements. The fact that the evaluation of the realignment of the SA Health Commission Central

Office did not progress was unfortunate because an opportunity to learn from this major organisational change experience was lost.

The separation of purchasing and providing functions within South Australia was finally never implemented in its entirety because this reform process was superseded by the creation of the Department of Human Services and the subsequent preoccupation with establishing an integrated Central Office that would reflect overarching human services priorities rather than health care priorities alone. Despite this, the work to establish a purchaser/provider separation did result in efforts to more clearly define, clarify and articulate desired service delivery outcomes which, it was intended, would be made transparent through the use of negotiated service agreements. Service agreements were developed between the SA Health Commission Central Office and health care agencies as a result of the purchaser/provider split, and continued to be used after the establishment of the Department of Human Services. These agreements specified the services to be provided by the agencies and the funding that would be provided for these services. However, the theoretical prospect that agencies could be de-funded if they were not deemed to be competitive did not eventuate because, in reality, alternatives did not exist. In addition, the consequences of such a decision were not viable and would have been too politically contentious to be acceptable to any government.

Work to identify population health outcomes (as distinct from service delivery outcomes) also commenced, and continued under the new Department of Human Services. However, experience to date has highlighted the difficulties in developing service agreements that can achieve these ends. Information was a basic requirement of the new SA Health Commission Purchasing Office to enable priorities to be set and an effective purchasing strategy to be developed. This proved problematic as such information was patchy at best, or unavailable, making evidence based priority setting difficult. As a result, resource allocation could not necessarily be based on identified and informed priorities. This was further complicated by the reality that political imperatives often override rational resource allocation processes. The

purchasing experience also highlighted the fact that changes to the way resources are allocated can only be made at the margins and that community and political commitment to particular physical infrastructure and services, such as hospitals and acute care services, does not readily allow for rational decisions to be made about the distribution and allocation of resources based on need or equity.

During the short period in which the purchaser/provider separation model was being implemented in its original form, it also became apparent that the separation of purchasing and funding functions contributed to a dislocation and reduction in communication between policy development (a funder role) and service delivery functions (provider roles). Likewise, the centralised Purchasing Office, which did not have access to regional planning units, was separated from the actual service delivery issues. It could be argued that these divisions would have contributed to fragmentation within the system and to increasing the transaction costs of adopting the purchaser/provider separation model. However further dislocation between the Central Office and service providing agencies arising from the creation of the Department of Human Services overshadowed these potential issues and is discussed further later in this thesis.

The investigation and implementation of a purchaser/provider separation model was initiated, following the introduction of the casemix funding system in South Australia, when it became apparent that the Health Commission needed to have a greater understanding of what it should fund. This approach was in line with global trends at this time even though in South Australia the solution was adopted pragmatically without consideration of its ideological underpinnings.

The introduction of the separation of purchasing and providing functions, in order to create what was described in the United Kingdom as an internal or managed market, reflects an increasing tendency for the global search for solutions. Such solutions are often determined by fads and the transplantation of simplified, 'sloganised' approaches through 'one size fits all' policies while the actual experiences and

lessons from other nations are never really taken into consideration (Marmor 2001). Across the developed world, the 1980s and 1990s saw an increase in the focus on global developments providing solutions to health care policy problems, which on occasion resulted in ideological solutions (that often remained unarticulated) being applied to address practical problems. In South Australia, health care decision makers looked to the United Kingdom, New Zealand and the United States for policy directions, including the focus on models of separating purchaser from provider roles and models for managed care. Conscious effort was made to pragmatically pick out and adapt aspects of these models for the South Australian health system.

Human service organisations in the public sector are continually being restructured to produce new service delivery systems to fit new concepts of need. These concepts of need are determined by the ideological perspective of governments as well as by global trends, so that cost efficiency and economic rationalism have resulted in a health system focus on containing costs and controlling expenditure, rather than on more socially oriented goals (Healy 1988). Similarly, a focus on increasing ministerial and bureaucratic control, evidenced in the evolution of the SA Health Commission, can be seen as an attempt to control the agenda and take control away from powerful professional interest groups, such as medical practitioners, in an effort to break down professional hegemony. (This was also a significant motivation for the establishment of the Department of Human Services.) These issues are discussed further in later chapters in this thesis. Ray Blight quite clearly articulated this aim in his statement that separating purchasing and providing functions would lead to a shift in the balance of power in health care away from providers and towards consumers and purchasers. The strategy clearly increased bureaucratic control of decision making about the services that should be provided by health care agencies. However, it is not apparent that consumers would necessarily have benefited from the model implemented in South Australia, particularly as the purchasing role was centralised, and therefore removed from local communities (though this will never be finally known because the model was never fully implemented or evaluated).

This chapter has provided the historical and broader reform context in which the locally based case study, which is described in the next chapter, is situated. It demonstrates the significant recent focus on cost containment, centralising control within the central bureaucracy and shifting the power and influence away from health care providers. The resulting tensions between central bureaucracy and health care agencies, and between managers and individual service providing professionals, particularly medical clinicians, is a key focus of later parts of this thesis. Chapter 5 will follow on from this historical discussion by describing the case study, and through a narrative account, will reflect on its origins, efforts and demise. The themes identified in these earlier chapters will then be used with themes that have emerged from analysis of the case study to draw together a discussion of Designing Better Health Care in the South which, as a case study of attempted organisational change, sheds further light on the nature of the health system and the difficulties in achieving real reform.

Chapter 5

Stories of Designing Better Health Care in the South: Its Rise and Demise

This chapter outlines the history of Designing Better Health Care in the South, and considers the different agendas and perspectives of the key participants and protagonists and how these influenced the development and demise of this regionally initiated and planned integration project.   The stories behind the process of this apparently unsuccessful project provide significant insights into the difficulties of achieving organisational change within a highly contested health system.   Following a brief description of the demographic makeup of the southern metropolitan region of Adelaide, and of the four agencies that participated in Designing Better Health Care in the South, this chapter focuses on telling the story of Designing Better Health Care in the South and considering the perspectives of the actors within it.   Subsequent chapters analyse the case study through a discussion of the key issues that emerge, and through this, develop an understanding of the broader issues within the health system that continue to challenge the system's capacity to reform in order to address endemic structural, political, financial and health care delivery problems that continue to concern government, bureaucracy, service providers and consumers.

The following data sources were used in the preparation of the history of Designing Better Health Care in the South:

- minutes of meetings and related documents, reports and correspondence
- transcripts from phone interviews carried out between 23 March and 30 April 1999 with 29 individuals who had had a significant role in the early planning and consultation for the development of Designing Better Health Care in the South, including senior managers, clinicians, Board members, staff representatives and industrial representatives
- agency annual reports of the four agencies involved for the years 1994 – 2000

- the Interim and Final Reports prepared by the Project Manager of Designing Better Health Care in the South

- the journal which I maintained as a researcher and observer throughout the time of data collection for this study, and the review papers that I prepared every six months based on this journal which provided an opportunity to summarise, reflect on and document my observations of significant events and milestones so that I could discuss them with the project reference group as the data collection process proceeded

- papers that I prepared to present the analysis of and report on the data collected and the findings of the study while undertaking the Australian Research Council Strategic Partnerships with Industry – Research and Training (SPIRT) funded project 'The Health Care Reform in Southern Adelaide Evaluation' within the Department of Public Health, Flinders University, from 1998 – 2001.

The southern metropolitan area of Adelaide – a brief demographic profile

The southern metropolitan area of Adelaide encompasses the Local Government Areas of Holdfast Bay, Onkaparinga, Marion and Mitcham, with a geographical and demographic division between the inner southern (Holdfast Bay, Marion and Mitcham) and the outer southern (Onkaparinga) areas. The inner southern areas, particularly Holdfast Bay, have an older population, while younger families tend to establish themselves in the "newer" outer suburbs where housing is cheaper, with the highest proportion of 0-14 year olds living in the Local Government Area of Onkaparinga. In 1996, when Designing Better Health Care in the South commenced, 303,507 people lived in the southern suburbs. At this time it was predicted that the population of the region would grow to 321,849 by 2006, an anticipated increase of 6.0%, which was greater than that predicted for the whole of Adelaide. Increases were expected in all age groups except among people under the age of 20 years. It was also expected that there would be an increase of 61.4% in the 50-59 year age group. The Local Government Area of Onkaparinga in particular continues to have a

high proportion of unemployed people or people employed in unskilled or semi-skilled occupations.

Four agencies agreed to participate in the Designing Better Health Care in the South project: the Southern Domiciliary Care and Rehabilitation Service, Repatriation General Hospital, Noarlunga Health Services and Flinders Medical Centre. A brief description of each of these agencies at the time of the case study is provided below. (Subsequently, a number of changes have occurred in these agencies, including the amalgamation of Southern Domiciliary Care and Rehabilitation Service into a metropolitan-wide Domiciliary Care Service; and the incorporation of Flinders Medical Centre and Noarlunga Health Services into a southern regional health service as part of a subsequent top down initiated regionalisation initiative. In this later process, the Repatriation General Hospital has continued to maintain its separate independence.) Descriptions are therefore provided of the role and size of the four participating agencies during their involvement in Designing Better Health Care in the South (1996 - 2001).

The participating agencies

Southern Domiciliary Care and Rehabilitation Service

Southern Domiciliary Care and Rehabilitation Service was a small community based agency which provided home and community-based health and supportive care for people of all ages with moderate to severe disability, and to their carers. Services were provided by a coordinated multidisciplinary health team. The agency was collocated with the Royal District Nursing Service, a community based home nursing program, in Marion in the inner southern metropolitan area, and had a branch in Noarlunga, in the outer south. Clients of Southern Domiciliary Care were predominantly aged 70 years or older and also often used the Royal District Nursing Service and the Southern Community Hospice Program (based at the Repatriation General Hospital). Southern Domiciliary Care had regular contact with and provided information to local general practitioners. The Southern Aged Care Assessment

Team, which was administratively supported by Southern Domiciliary Care, was located at the Repatriation General Hospital. Southern Domiciliary Care and Rehabilitation Service also had a liaison officer who worked out of Flinders Medical Centre and a social worker located in the Southern Community Hospice Program. On 30 June 1997, Southern Domiciliary Care had 139.5 FTE (full time equivalent) staff.

Repatriation General Hospital

The Repatriation General Hospital has a 60 year history of providing care for war service veterans and war widows and this group continues to have a strong sense of loyalty to and ownership of the hospital. The Repatriation General Hospital was funded by the Commonwealth government until March 1995 when the hospital was transferred from the Commonwealth to the state government. At the time of this study, it continued to have a primary obligation for the needs of the war veteran population and their beneficiaries but also extended its services to the community in the southern metropolitan area, focusing on geriatric care. It operated a 270 bed acute care general teaching hospital affiliated with Flinders Medical Centre and Flinders University. It had on campus the Artificial Limb Service, the Southern Community Hospice Program and Daw House (the inpatient palliative care facility for the southern region), the International Institute of Hospice Studies (a facility of Flinders University) and the Drug and Therapeutic Information Service. The Repatriation General Hospital had numerous joint academic and clinical staff appointments with Flinders Medical Centre and Flinders University. It had also been involved for some time with Flinders Medical Centre in ongoing efforts to rationalise and increase the collaboration of clinical services for the southern metropolitan area of Adelaide. As a part of these efforts, the Repatriation General Hospital and Flinders Medical Centre worked together to develop a plan to increase their collaborative relationship which resulted in the Repatriation General Hospital taking on a regional responsibility for mental health services for older people. On 30 June 1997, the Repatriation General Hospital had a total of 1,111 FTE staff.

Noarlunga Health Services

Noarlunga Health Services was an integrated health service incorporating a 120 bed Community Hospital and a variety of community health services delivered in a number of locations in the outer southern region, including Noarlunga Centre, Aberfoyle Park, Woodcroft and Seaford. All these locations were also used by other local, regional and statewide agencies and community groups as a strategy to build the coordination of services and encourage community involvement.   Noarlunga Health Services was located in the outer southern region, an area experiencing rapid urban expansion with large numbers of young families. It had a number of links with Flinders Medical Centre, for example through nursing programs, joint appointments and an Interhospital Transfer Scheme.   Mental health services were provided by Southern Mental Health Services, operating across the whole region and administered jointly by Noarlunga Health Services and Flinders Medical Centre. Hospital services within Noarlunga Health Services provided a mix of medical and surgical services, including a private hospital managed by Noarlunga Health Services staff. There were 340 FTE staff at Noarlunga Health Services on 30 June 1997.

Flinders Medical Centre

Flinders Medical Centre was a 430 bed collocated public teaching hospital and university medical school.   Flinders Medical Centre had a number of associated agencies for which it was administratively responsible, including Inner Southern Community Health Service, the Southern Child and Adolescent Mental Health Service, the South Australian Community Health Research Unit, the southern metropolitan Child Protection Service and Southern Mental Health Services (administered jointly with Noarlunga Health Services). It conducted a number of out-posted clinics at Noarlunga Health Services, including for example specialist respiratory services, and had a number of joint appointments with the three other health care agencies described above. Flinders Private, a 100 bed private hospital was opened in January 1999 and collocated with Flinders Medical Centre. It included consulting suites, a surgical facility and a day surgery unit. Collocation of the public

hospital and Flinders University Medical School encouraged innovative approaches to teaching and research in the hospital and university. Flinders Medical Centre also had strong links with the university School of Nursing and other departments such as the Department of Public Health. It had an active Health Promotion Unit and, at the commencement of this study, was the only hospital recognised by the World Health Organization in Australia as a Health Promoting Hospital. The total staff working in Flinders Medical Centre on 30 June 1997 came to 2,068 FTE.

The remainder of this chapter provides a detailed description of Designing Better Health Care in the South, a project initiated by the four agencies described above in order to improve the way that they worked together to provide services to the community in the southern metropolitan region of Adelaide. Although the case study is an example of a locally initiated regionalisation strategy, regionalisation is not assumed within this thesis to be the best or only solution to the complex issues being faced by the South Australian health system, or by other health systems internationally. However, the case study of Designing Better Health Care in the South does provide a number of valuable insights into the challenges of achieving successful reform and the complex relations that are present within the conflictual and contested health system that can support or impede reform.

Table 1 provides an overview of the key milestones in the development and the ultimate disbanding of Designing Better Health Care in the South.

Table 1: Designing Better Health Care in the South – Overview of significant milestones

1995	
Mid 1995	• Chief Executive Officers' Working Group formed to investigate formalising interagency collaboration in the south, developed discussion paper about formalising integration of services in southern metropolitan Adelaide
December	• Discussion paper endorsed, consultation with staff and key stakeholders commences.
1996	
February	• Minister for Health approves proposal to consider options for formalising integration between services
March	• Independent Chair appointed by Minister to chair the Southern Regional Health Service Steering Committee

April	• Memorandum of Understanding signed by Chairs of four agencies' Boards of Management to plan and implement a regional health service model to integrate health services in the southern metropolitan area
Early 1996	• Briefings continue with staff, unions, local Members of Parliament, local government and announcement of intentions to local community through the media
May	• First meeting of the Southern Regional Health Service Steering Committee
August	• Project Manager appointed for Designing Better Health Care in the South
September	• Project Plan endorsed
November	• Visits by Project Manager to investigate interstate regional models in Brisbane, Sydney and Melbourne
Late 1996 – Early 1997	• Consultations with statewide agencies, major stakeholders and union representatives.
1997 Early 1997	• Establishment of Regional Health Service Program Planning Exercise focusing on 4 areas: – Rehabilitation and Aged Care – Primary Health Care – Cardiac Rehabilitation – Emergency Services
May	• Union representatives and Southern Division of General Practice join the Southern Regional Health Service Steering Committee
October	• Steering Committee undertakes study tour of network models in Melbourne • Creation of South Australian Department of Human Services (DHS)
December	• Release of Interim Report by Steering Committee proposing the creation of a single incorporated regional health service in the southern metropolitan area with a regional Board and CEO.
1998 April	• Final meeting of Southern Regional Health Service Steering Committee, which was disbanded having completed its task to develop a model. In its final report the committee proposed a 'loose federation' of agencies with a Regional Council as a committee of each of the Boards of the four agencies to oversee and sponsor the development of regional health programs. (This was their second preference given the lack of DHS support for the interim report proposing a single southern regional health service. Despite approval of the concept, DHS did not support a structural solution and deferred approving the establishment of a regional committee.)
June	• Final report from Steering Committee presented to agency Boards for approval, and then to DHS and Minister for Human Services
July	• DHS holds a Hospital Facilities Workshop between hospital Chief Executive Officers and DHS senior staff to consider future needs and directions for metropolitan hospitals – DHS states that it requires hospital services planning and coordination to occur centrally with networks established around clinical programs and not necessarily around regions

August	• Chief Executive Officers and senior clinicians of the agencies hold a "think tank" to discuss regional program planning. Agree to form the Southern Network Coordinating Committee to develop a regional program of integrated services
	• Exchange of correspondence between DHS and the Chief Executive Officers about the Department's deferral of approval for proposals to establish a Southern Regional Council and a 'formal southern region with amalgamation of key incorporated bodies'. DHS required agencies to relate centrally rather than within the region and stated its intention to incorporate the ideas from Designing Better Health Care in the South into future planning
	• Southern Network Coordinating Committee held its inaugural meeting (membership consisted of Chairs of Boards of Management of the four agencies, the four Chief Executive Officers and a representative from the Southern Division of General Practice). Chair of Repatriation General Hospital appointed as the Southern Network Coordinating Committee Chair, the Committee agreed to establish a 3 year rolling plan to increase collaboration between the agencies through sponsoring collaborative projects
September	• DHS instructs the Chief Executive Officers not to sign Agreement for the establishment of a regional body
	• Southern Network Coordinating Committee prepared a vision statement for Designing Better Health Care in the South
November	• Call for expressions of interest to undertake interagency collaborative projects with support from the Southern Network Coordinating Committee
December	• Resignation of Flinders Medical Centre Chief Executive Officer.

1999 January	• On recommendation from the CEOs and Project Manager, Southern Network Coordinating Committee approves 5 regional demonstration projects to trial interagency collaborative approaches
	  – Regional health information management
	  – Aged-volunteer services
	  – Early childhood intervention
	  – Respiratory services
	  – Human resources

April	• Minister of Human Services met with Noarlunga Health Services Board and CEO and expressed his support for collaborative activities taking place in the south but not for the proposed structural solution
May	• DHS Metropolitan Division consults on their framework and discussion papers on a "primary health care and community support plan for metropolitan Adelaide"
	• Designing Better Health Care in the South Project Manager resigns
June	• New Designing Better Health Care in the South Project Manager appointed with specific task to make recommendations for the future of Designing Better Health Care in the South, and to explore options for an amalgamation between Repatriation General Hospital and Flinders Medical Centre
	• DHS Metropolitan Division presents its model of integrated primary care community based human services

July	• New Flinders Medical Centre Chief Executive Officer commences
	• Project Manager meets with DHS Statewide Division staff to discuss the future of Designing Better Health Care in the South and briefs Southern Network Coordinating Committee
September	• Final meeting of Southern Network Coordinating Committee, presentation of results from regional interagency collaborative projects to the Committee, CEOs agree to dissolve Southern Network Coordinating Committee and announce the dissolution of Designing Better Health Care in the South, agree to establish Southern Health Services Liaison Group in order to continue to exchange regionally relevant information
	• Hospital CEOs met with Executive Director, Statewide Division, DHS to discuss draft "Networks" paper prepared by DHS about establishing acute clinical networks across the metropolitan area
	• Resignation of second Project Manager
October	• DHS Statewide Division distributes its proposal for integrating hospital services across the metropolitan area
	• DHS commences regular Statewide Operations Group meetings with hospital CEOs.
2000 February	• Establishment of Steering Committee by DHS Statewide Division to discuss planning issues for southern metropolitan hospitals
March	• Southern Health Services Liaison Group meets for the first time (membership comprises 4 Chief Executive Officers, Chairs of Boards and a Southern Division of General Practice representative)
	• DHS organises a Strategic Workshop for senior administrators and clinicians with senior DHS Statewide Division staff and other key stakeholders – focus on establishing networks and rationalising without adopting structural solutions. Flinders Medical Centre CEO presented on southern network developments and provided a brief history of collaboration in the south, focusing on hospitals
April	• First meeting of DHS Metropolitan Division Inner Southern Human Services Providers Forum to plan integration of community based human services in the inner southern metropolitan area
June	• Second and final meeting of Southern Health Services Liaison Group
November	• Noarlunga Health Services CEO resigns.
2001 March	• New Noarlunga Health Services CEO commences
	• DHS holds Health System Roundtable with metropolitan hospital CEOs to discuss pressures on the hospitals
May	• DHS Metropolitan Division decides to combine the Inner and Outer Southern Providers Forums to plan integration of community based human services in southern metropolitan Adelaide – implementation of proposed developments are not included in budget but required to be funded through 'slippage'
	• Continuation of DHS work on clinical network planning and discussion of future for hospitals in the south is deferred indefinitely.

Early developments in the south [17]

The southern metropolitan area of Adelaide has had a long history of health workers and agencies working collaboratively both informally through ad hoc and client-specific collaborative strategies, and formally through the creation of joint staff appointments between the agencies, to improve the way that health services were provided to the local communities (South Australian Community Health Research Unit 1994). This history of collaboration commenced in the mid 1970s following the creation of the SA Health Commission and the separate legal incorporation of health units in South Australia (discussed in Chapter 4). The early history includes a number of significant events, such as the establishment of Flinders Medical Centre as a major teaching hospital in 1976 with links to the Repatriation General Hospital to enable academic staff to have access to Repatriation General Hospital patients, and for Repatriation General Hospital staff to take on academic teaching roles; and the funding of Clovelly Park Community Health Centre in 1974 which established academic links to the Flinders University Medical School and fostered general practice exposure among medical students within Flinders Medical Centre[18].

In the inner south, the 1970s and 1980s were a time when academic links and joint appointments between the southern agencies became firmly established as part of a coherent clinical scene. In the outer south during this time the services available to the community were limited and so the local council, local community health centres,

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[17] In conjunction with other data sources listed at the beginning of this chapter, the discussion of the early history of the southern region was informed by interviews with Mr Richard Hicks, Director of Allied Health, Noarlunga Health Services on 9 February 1999, who had a leadership role in that health unit from its establishment in 1985, and Professor John Blandford on 11 February 1999, a former Commissioner of the SA Health Commission and former Administrator of Flinders Medical Centre from its establishment in 1976.

[18] Clovelly Park Community Health Centre was re-named Inner Southern Community Health Service, and in 1997 during early discussions about Designing Better Health Care in the South, agreed to come under the administrative responsibility of Flinders Medical Centre rather than to remain part of the Adelaide Central Community Health Service, a regional structure of community health services in which it had been placed as part of an amalgamation of metropolitan community health centres initiated by the SA Health Commission in 1996. The decision for Inner Southern Community Health Service to be administered by Flinders Medical Centre rather than remain within Adelaide Central Community Health Service was the result of the strong relationships that had developed within the southern region over an extended period between acute and primary health care services and the wish of staff of the community health centre to become part of an integrated regional health service (personal communication, Director, Inner Southern Community Health Service).

the local office of the Department of Community Welfare and the Southern Community Health Research Unit worked together with members of the community to initiate community based social health focused activities. Noarlunga Health Services was established in 1985, having grown from the Christies Beach Community Health Centre (which had been established as part of the national Community Health Program described in Chapter 2), to address the needs of the outer southern population. It provided a different model of health care delivery through integrating community health and acute care services. The community health service was established prior to the establishment of the hospital facility and this had a significant impact on the hospital's acceptance of health promotion and primary health care priorities and made the service unique in South Australia. The Noarlunga Healthy Cities Project began as one of three trial Healthy Cities projects in Australia, with the aim to foster intersectoral collaboration between local government, other agencies and the community in Noarlunga to improve the health and living environment of the local population[19]. This contributed further to the social health and interagency focus of Noarlunga Health Services.

Early focus of interagency collaboration

The original and overarching rationale for increasing collaboration between health care agencies in the southern region was to improve the health of the population by improving the way that services were delivered. As the southern metropolitan area of Adelaide has a clearly delineated population with geographic boundaries that mean that the population predominantly uses health services that are provided by the agencies situated within the region, the agencies saw significant benefit from collaboration for their health care delivery role and for the health of the population of the region. Continuity of care, coordination and collaboration were all understood to

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[19] The Healthy Cities movement is an international movement which was initiated by the World Health Organization to promote intersectoral and community action to improve the health of the community and implement the *Ottawa Charter for Health Promotion* (1986) at the local level. Australia adopted the Healthy Cities strategy in 1987 when three pilot cities (Noarlunga, Canberra and Illawarra) were established and a national office was funded for three years by the Commonwealth Department of Community Services and Health (Cooke 1995).

support patient care within a continuum of care, from acute care in hospital settings through to care within the home and community provided by community based services. These approaches were consistent with coordination and continuity of care strategies increasingly being promoted by the Commonwealth and state governments at the time which represented an expectation that agencies should be responsive to and address the needs of consumers (discussed in Chapter 2).

However, with growing budgetary pressures on the three hospitals in particular, and early discharge increasing pressure on community based services, the four agencies began to explore the potential for making savings and enhancing efficiency by collaborating in a more formalised and strategic fashion. The informal arrangements established during the 1970s and 1980s were breaking down by the late 1980s and early 1990s. This was a result of the increasing number of patients, the availability of new technology, the increasing complexity of care and the increasing prevalence of chronic diseases, which were not reflected in growth in agency budgets. These trends were being experienced by health care agencies across Australia and in many other developed countries, and in many instances resulted in a variety of market-based reforms that were described in Chapter 2, including cost cutting, regionalisation, separating purchasing and providing roles with outputs and outcomes determined by contracts or service agreements, and focusing on short term measurable outcomes. Previous informal arrangements that were in place in the southern metropolitan region also came under threat because of financial pressures on all the agencies, the politics of the different hospitals and the SA Health Commission, and negotiations for the Repatriation General Hospital transfer from Commonwealth to state ownership.

The negotiations between the Commonwealth and state health departments during the early 1990s for the transfer of the Repatriation hospitals throughout Australia were prolonged and difficult, with each Department attempting to ensure the best outcome for themselves. Difficulty with the Department of Veterans Affairs limited the ability of the Repatriation General Hospital to participate in local collaborative exercises until it was transferred to state ownership, and even following its transfer in 1995,

there was a requirement for no changes to the hospital's independent status for three years (preventing for example amalgamation with Flinders Medical Centre or joining a regional health service during this time).

Planning for formalised regional collaboration and coordination

In 1989, Flinders Medical Centre held a Strategic Planning Conference which was attended by over 100 senior staff, many of whom had joint appointments across Flinders Medical Centre, Noarlunga Health Services, Repatriation General Hospital and Southern Domiciliary Care and Rehabilitation Service. One of the main focuses of the conference was to establish a joint development plan for Flinders Medical Centre and the Repatriation General Hospital and other services in the south. Flinders Medical Centre and the Repatriation General Hospital planned, following the transfer of the Repatriation General Hospital to the state, to work towards becoming a two campus institution with shared policy. This also required stronger organisational links with Southern Domiciliary Care and Rehabilitation Service and Noarlunga Health Services to be able to manage the southern caseload more effectively.

The transfer of the Repatriation General Hospital from the Commonwealth to the state government on 9 March 1995 increased opportunities for the pre-existing arrangements between Flinders Medical Centre and the Repatriation General Hospital to be strengthened. It created opportunities for further joint staff appointments and for the transfer of patients between the institutions. At the time of the transfer of the Repatriation General Hospital, Flinders Medical Centre and the Repatriation General Hospital reached agreement on the structure of emergency hospital services in the south. The overload in emergency admissions had become a significant problem for Flinders Medical Centre during the late 1980s and the 1990s. The Flinders Medical Centre Annual Report (1993) emphasised the need for the teaching hospital to be supported in its regional role by Noarlunga Health Services, the Repatriation General Hospital and Southern Domiciliary Care and Rehabilitation Service.

Increasing the collaboration between Flinders Medical Centre and the Repatriation General Hospital had been a key discussion topic for the two agencies since the opening of Flinders Medical Centre. The Repatriation General Hospital Annual Report (1992) stated that:

> Externally changes are occurring politically and economically. The philosophies of both major political parties have running through them an increasing emphasis on competition between hospital services. The imminent prospect of the hospital's integration into the State system looks more likely than it ever has. This brings with it pressures for continuing rationalisation of services with Flinders Medical Centre.

In 1995, physicians from Flinders Medical Centre and the Repatriation General Hospital set up joint working parties to develop principles and plans to maximise collaboration between the two institutions and the integration of some common services. The working parties agreed that there should only be one full Accident and Emergency Department based at Flinders Medical Centre, with the Repatriation General Hospital depending on re-admissions of veterans, arranged admissions and triaging of some acute admissions from the new 48 hour Admissions Ward established at Flinders Medical Centre.

Regionalisation becomes a state and local priority

In February 1994, Flinders Medical Centre organised a second Strategic Planning Conference. This conference endorsed the recommendations of the first conference and emphasised the need for Flinders Medical Centre to work in a regional context with other health care providers, while each agency maintained its own identity. The report from this conference identified regionalisation as one of nine priorities, along with the following strategies to achieve it:

> Regionalisation:
> - maintain momentum on regional discussions
> - develop the concept of a teaching region
> - identify a framework for linking clinical services
> - identify specific tasks that will enhance the development of a regional focus within the next 10 months (Flinders Medical Centre 1994).

The conference agreed that the agencies should develop their interdependency by working in a collaborative fashion. The Southern Regional Liaison Forum was established in November 1994 to follow up on the regionalisation recommendations of the conference and to facilitate a more unified approach to health promotion and health service planning and provision in the south of Adelaide. The membership of the forum consisted of the Chief Executive Officers and Chairs of the Boards of the four partner agencies, representatives from the Southern Division of General Practice, the Flinders University School of Medicine and community health services in the region.

At this time, regionalisation was being promoted as a SA Health Commission policy (described in Chapter 6). This policy supported moving decision making closer to the point of service delivery and closely linking acute and community based care in order to provide more flexible and responsive services. The regionalisation policy agenda of the SA Health Commission contributed significantly to the agencies' consideration of regionalisation as a valid collaborative strategy. The Southern Regional Liaison Forum released a Statement of Intent in early 1995 and made explicit the agencies' commitment to regional health service provision and cooperative planning. The forum concluded its work in 1996 when the Southern Regional Health Service Steering Committee was formed to develop a model for a regional health service in the south. The presence of regionalisation and devolution closer to the point of service delivery as policy directions within the SA Health Commission and among the participating agencies in the south at this time reflects the adoption of a managerialist approach within the health system discussed in Chapter 2. Its intention was to improve flexibility and responsiveness, and to position managerial responsibility for resource allocation and the provision of services closer to the point of service delivery, with the central bureaucracy retaining strategic planning and policy direction and budget allocation responsibility.

Early days of Designing Better Health Care in the South

A discussion paper titled *Toward a Regional Health Service in the South* was released by the Chief Executive Officers of the four agencies in December 1995. The discussion paper acknowledged that only Flinders Medical Centre, Noarlunga Health Services and Southern Domiciliary Care and Rehabilitation Service were in a position to commit fully to integration. (As mentioned previously, the Repatriation General Hospital was obliged to remain freestanding for three years following its transfer to the state.) The discussion paper provided rationales for the importance of integration and suggested a number of safeguards. It also contained an endorsement by the three Boards, committing them in principle to pursuing the development of a regional health service, while the Board of the Repatriation General Hospital gave endorsement to that hospital's participation in the planning and consultation process.

In February 1996, the discussion paper was endorsed by the then Minister of Health, Dr Michael Armitage, who also appointed an independent Chair to chair the Southern Regional Health Service Steering Committee. The four agency Board Chairs and Chief Executive Officers signed a Memorandum of Understanding on 19 April 1996 in which they committed to planning, consulting on and implementing a regional health service model. The Memorandum of Understanding stated:

> The desired outcome of "regionalisation" is:
>> *to achieve the greatest possible health benefit for the people of the southern region by combining the resources of the agencies… and to make it easier for people to get the care they need through better co-ordination.*
>
> This will require moving the focus of operations away from institutionally defined needs (in which each individual service provider has determined what is provided and where) towards a focus on collectively meeting the overall health needs of the regional population and others for whom the project partners have a specific responsibility ((Stratmann 1997 p1), italics in the original).

The Southern Regional Health Service Steering Committee's role was to develop a model and consult on it with relevant stakeholders. In April 1996, the agencies also

jointly submitted a request for funding to the SA Health Commission for a project team to facilitate this process, which was approved.

The Steering Committee met for the first time on 9 May 1996. The Steering Committee Chair, the Chief Executive Officers, Chairs of the agencies' Boards, staff and industrial representatives and a representative of the SA Health Commission were in attendance. A Project Manager was appointed and commenced work in August 1996, based at Southern Domiciliary Care and Rehabilitation Service. At its second meeting on 24 September 1996, the Steering Committee agreed to call the project 'Designing Better Health Care in the South' to reflect the project's objective of improving health care in the region. The Project Manager also developed a communication and consultation strategy which was endorsed by the Steering Committee at this meeting. This strategy was intended to involve and inform as many potential stakeholders about the project as possible. Stakeholders included consumers and consumer representatives; staff of the agencies; union representatives; other health care agencies; other Government Departments, both statewide and based within the south; Members of Parliament and other Government representatives; private health care providers; the SA Health Commission and the Minister of Health. A 'CEOs' Group' also began to meet at this time to implement the actions recommended by the Steering Committee. The CEOs' Group consisted of the four Chief Executive Officers, a SA Health Commission representative, industry and staff representatives from the four agencies as well as the Project Manager from Designing Better Health Care in the South.

The communication strategy developed by the Project Manager proposed a number of strategies, which included briefings for key stakeholders, staff information bulletins for the staff of the four agencies, and media releases at key milestones in the project. From late 1996 to mid-1997, the Project Manager sought numerous opportunities to consult on the project. She attended agency staff meetings to talk about Designing Better Health Care in the South, addressed the agencies' Boards of Management,

consulted with other agencies that were considered to have an interest in the project, and briefed key medical personnel and union officials.

In mid-1996, the Chief Executive Officer of Flinders Medical Centre suggested that the participants in Designing Better Health Care in the South should have an academic partner to the project to record and evaluate the process as it developed. As a result, an application for funding for the evaluation of Designing Better Health Care in the South was made for an ARC SPIRT grant (Australian Research Council Strategic Partnerships with Industry: Research and Training) in May 1997 by the Flinders University Department of Public Health and Health Services Management Development Unit. The SA Health Commission agreed to be an industry partner if the application was approved for funding. The application was successful and the evaluation commenced in July 1998, based at the Department of Public Health, Flinders University.

Developing a model

As part of an extensive consultation process undertaken by the Project Manager of Designing Better Health Care in the South, a series of four focus groups were held across the region to encourage participants to take a regional approach to issues and to examine the ways that a regional approach could be applied to service planning and delivery. The minutes of the Steering Committee of 19 November 1996, explained that these focus groups were intended to "explore the perceptions of the need for change in response to problems of effective service delivery". A total of 71 people participated in the focus groups, comprising 41 staff from the four agencies, 21 staff from outside stakeholder organisations and 9 consumers. Each focus group focused on a particular issue – diabetes, speech pathology services for children, falls prevention, and elective orthopaedic surgery, and was attended by relevant service providers from within the participating agencies, and also by general practitioners, staff from community health agencies from the region, and from relevant statewide organisations. In her report to the CEOs' Group meeting on 21 February 1997, the Project Manager described the focus groups as successful, and said that the

participants were enthusiastic about the potential for working in a regionally integrated fashion.

Between December 1996 and March 1997, at the time that the focus groups were occurring, the Chief Executive Officers of Southern Domiciliary Care and Rehabilitation Service and Repatriation General Hospital resigned. Their replacements continued to support the Designing Better Health Care in the South process.

Following the positive response in the focus groups to the need for change, the CEOs' Group agreed to hold a trial of a regional approach to health service planning and to fund between four and six projects as part of this trial. The Project Manager and CEOs' Group circulated a call for expressions of interest for groups of staff to trial a regional planning approach based on a number of key criteria. These criteria included adopting a primary health care approach to the issue; providing opportunities for staff participation; building on existing networks; and fostering interdisciplinary and interagency collaboration. Four projects were funded as part of this trial in the topic areas of rehabilitation and aged care; emergency services; cardiac services; and primary health care. The projects ran for four months, using funding provided by Designing Better Health Care in the South. They involved a number of regular meetings between participants and regular progress reports were provided by the Project Manager to the CEOs' Group during this time. In July 1997 the four regional planning projects reported to the CEOs' Group and a summary report from the projects was provided to the Steering Committee on 15 August 1997. The Interim Report summarised the outcomes of these projects:

> What were seen by all the program planning groups as necessary organisational elements were:
> - A single regional body able to make high level decisions about the allocation of resources and the array of services offered on the basis of rational regional planning
> - A number of regional "co-ordination" bodies answerable to the overall regional body in relation to particular program areas; these

would have cross-site representation, and would undertake planning and advisory roles and perhaps provide the locus of executive management for that particular area of activity.

This outcome lent support to the concept of a health program approach to the management of integrated service delivery. … The planning groups did not believe it would be worthwhile to pursue any further planning until such an infrastructure was in place to enable their recommendations to be implemented. This reluctance is significant, because it highlights the point at which so many cross-agency collaborative efforts become de-railed, and why the units cannot achieve real co-ordination without a change in corporate structure (Stratmann 1997 p11).

The two key issues for the Steering Committee's consideration that were identified by the projects were: whether the regional body should only act as a purchaser of services or whether it should have a service delivery role; and the extent to which it was possible to cover the full spectrum of service provision using a service planning approach. The Steering Committee agreed that the Project Manager should develop an organisational structure that "addresses issues of regional planning, resource allocation and priority setting" as well as addressing the issues raised by the four regional planning projects (Steering Committee Minutes, 15 August 1997). In October 1997, the Project Manager organised a study tour of the health care networks in Melbourne so that the Steering Committee members could investigate the achievements and potential of the model of regional health care delivery that was in place in Victoria.

The projects proved to be an effective strategy to build a sense of common purpose among the range of key stakeholder groups with an interest in Designing Better Health Care in the South. This strategy, which was supported by the CEOs' Group and resourced by Designing Better Health Care in the South, helped to develop and strengthen the policy community that was supportive of a regional approach to health care provision. The planning groups' consideration of the potential for the region to take on a purchasing role or to combine this with service provision is also significant, and suggests consideration of which model could provide a regional entity with sufficient flexibility and autonomy to be able to respond to locally based service and health issues and needs. The purchaser/provider separation in the health system was

described in Chapter 2 as one example of the adoption of market based approaches to health care, and again in Chapter 4, when the Chief Executive Officer of Flinders Medical Centre unsuccessfully approached the SA Health Commission seeking approval for the southern region to become a sub-purchaser during the separation of purchaser and provider roles in the SA Health Commission. If approved, this role would have given a new southern regional health service significantly more independence and power, with authority for decision making about planning and resource allocation devolved from the centre to the regional level in the southern metropolitan area.

The Flinders Medical Centre Chief Executive Officer's failure to gain Health Commission approval for the southern region to become a purchaser of health care for the population in the south was in part related to Ray Blight's stated belief that separating purchasing and providing functions shifted the balance of power away from health care agencies and towards the central bureaucracy and consumers (via the Purchasing Office) (discussed in Chapter 4). Subsequently, many participants in Designing Better Health Care in the South (including a Department of Human Services representative) believed that this was also a key reason for the lack of support from the Department of Human Services for the southern regional model. The Department was seeking to shift power away from health care agencies (in particular acute care services which drive the health budget) and towards integrated, community based services from across the human service portfolio, not just from the health sector. This view was expressed often in phone interviews and focus groups for this study. This and other reasons for the final lack of support for a locally initiated regional model of service planning and delivery are discussed later in this thesis.

Preparation of the Interim Report

The CEOs' Group held a Planning Day on 14 November 1997 to develop a model that would bring together the results of the extensive consultation process undertaken

by the Project Manager and the deliberations of the Steering Committee and the CEOs' Group. The Planning Day was reported in the minutes of the next Steering Committee meeting on 27 November 1997. Draft recommendations and a proposed organisational structure were presented to the Committee and debated during that meeting. The model that was proposed required that the four agencies should be dissolved and reconstituted under one body with a single board and Chief Executive Officer. The current Chief Executive Officers were to be re-titled General Managers. It was proposed that the new regional body would adopt a program approach to service provision rather than the current institutional focus. These recommendations and the proposed model were then outlined in the *Interim Report on Designing Better Health Care in the South* in December 1997 and presented to the Steering Committee on 18 December 1997 for comment and endorsement. The Interim Report presented the Steering Committee's recommendation:

> After a 16 month process of consultation, exploration, research and development, the Committee has concluded that the most effective way to achieve the project's objectives is for the four organisations to be re-constituted under the South Australian Health Commission Act as one incorporated body – a regional health service network, governed by a regional board and a regional CEO.
>
> The Committee has been concerned throughout the project to ensure that the individual identities and cultures of the existing agencies not be subsumed in the process of "regionalisation". It was pleased to note in its readings and its meetings in Melbourne that even where there is one corporate body and services are managed as streams of care across sites, there is still a strong sense of site identity within the health care networks (Stratmann 1997).

Although liaison between agencies in the southern region and the SA Health Commission had not been successful in gaining Health Commission agreement for the region to become a sub-purchaser of services for their population, the focus of the agencies on integrating at the regional level and adopting a program-based rather than an institution-based approach to planning and service delivery is consistent with the adoption of a managerialist approach in the region. The Chief Executive Officers of the four agencies stated that they sought to have decision making about the services for the southern region devolved to a regional level from the central bureaucracy so that the agencies could be flexible and responsive to the needs of the population and

work together to collectively and collaboratively provide the range of services required. Although the establishment of the region as a sub-purchaser was not approved, functioning as an integrated provider still carried the potential for the agencies to be able to allocate resources efficiently, flexibly and responsively across their organisational boundaries, which continued to be constraints as long as the agencies were legally separately incorporated and the Boards and Chief Executive Officers were responsible to place the interests of their own agency above those of the region.

Creation of the Department of Human Services

In October 1997, the Department of Human Services was established following the re-election of the Liberal Government in South Australia with a significantly reduced majority and changes in ministerial portfolios. A new Minister for Human Services was appointed and a new portfolio was created from the amalgamation of the SA Health Commission and the Departments of Housing, and Family and Community Services. A new Chief Executive was appointed to the Department of Human Services and in the following months a number of Senior Executives of the SA Health Commission who had supported the regionalisation of health services left their positions (and in a number of cases, left the state), either through resignation or because, in the restructure that resulted from the creation of the new Department, their positions were called and new appointments were made, often from outside South Australia as well as outside the previous SA Health Commission Executive.

The Department of Human Services announced its intention to focus on the integration of health, housing and welfare, the new 'human services portfolio', in order to create more efficient, effective and integrated service planning and delivery. There was a delay of some months between the announcement of this intention and the revelation of its implications for health care agencies that were working within the framework of the previous regionalisation policy. As mentioned in Chapter 4, the South Australian Department of Human Services was based on the Victorian model.

The Victorian model was very strongly based on market approaches. In contrast, the South Australian Department was focused on integration between its disparate portfolio parts, rather than solely within the health system.

The Southern Regional Health Service Steering Committee acknowledged that the new Department could have implications for Designing Better Health Care in the South which would need to be considered. The Interim Report was endorsed by the Steering Committee at its December 1997 meeting, and during January and February 1998 was distributed to stakeholders for comment. Responses to the report were mixed and most concern was expressed about the proposed structure of the regional health service rather than about its objectives of improving coordinated planning and service provision. Concern was also expressed by the smaller agencies about the potential for them to have a voice in the proposed new structure.

Responses to the Interim Report

The war veterans community who had a strong sense of attachment to the Repatriation General Hospital and also had significant political influence, were angry and concerned about the proposal for a single southern regional health service. They feared that it would reduce their access to the Repatriation General Hospital. The fact that the proponents of Designing Better Health Care in the South had been unable to engage the Chair of the Repatriation General Hospital Board in discussions about the project, and that he did not attend any of the Steering Committee meetings, is an indication of the significant resistance of the veterans, represented by the Chair, to any proposed changes. This was despite the hospital Chief Executive Officer's positive attitude towards the project, and his recognition of the importance of it for the future of the Repatriation General Hospital.

The four Chief Executive Officers and the Project Manager met with the Chief Executive of the Department of Human Services in early February 1998. Her

response to the proposal was documented in minutes of the CEOs' Group meeting held on 10 February 1998 as:

> …whilst encouraging contact at a regional level, she indicated that the evolutionary phase of the new department should not stand in the way of the Steering Committee's activities (CEOs' Group Minutes, 10 February 1998)

The CEOs' Group met for the last time on 10 February 1998, when they reviewed responses to the Interim Report and agreed that the final version of this report should reflect the reactions to the report of the four Boards of Management and of the Department of Human Services. The four Chief Executive Officers sent a memo to all staff in their agencies in April 1998 outlining the reactions of the Boards and others to the Interim Report and reaffirming their own commitment to Designing Better Health Care in the South. The memo stated:

> The Department of Human Services has confirmed strong support for the service improvement goals of the project and for a regional approach but questions the need for full amalgamation to achieve the strategic direction.

The Southern Regional Health Service Steering Committee met for the last time on 23 April 1998 and, in response to the veterans concerns and the reservations of the Department of Human Services, recommended a 'loose federation model' as the model to be put forward in its Final Report, rather than the establishment of a single integrated regional health service.

The Final Report

The Designing Better Health Care in the South Final Report (Steering Committee to the Boards of Southern Domiciliary Care and Rehabilitation Service et al. 1998) was released in April 1998 and proposed a loose federation of agencies, with a joint Regional Council that would have responsibility to oversee the development of coordinated regional health programs and would be a committee of each of the agency Boards of Management. In this proposed model, the agencies would retain their identities, names and keep separate budgets. The Final Report proposed that the 'loose federation model':

will provide the vehicle by which cross-agency regional health programs can be developed in an incremental fashion. These will enhance continuity of care for the benefit of consumers, and promote efficiency in the use of regional resources. The development of more integrated corporate and clinical support services is also envisaged (in those cases where it can be demonstrated that gains in service quality and/or efficiency can be achieved by doing so) (Steering Committee to the Boards of Southern Domiciliary Care and Rehabilitation Service et al. 1998 p2).

Those specific areas in which the four bodies wish to operate collectively are delegated to a Regional Council, which would be a committee of each of the Boards. Such a delegation would not be irrevocable: the Boards would retain their power to act independently in any and all matters, and they would remain accountable for their respective agencies' responsibilities, outcomes and budgets. An Agreement (in the nature of a "joint venture agreement") would be endorsed by each of the Boards committing each agency to co-operate in the work of the Regional Council for a defined period (Steering Committee to the Boards of Southern Domiciliary Care and Rehabilitation Service et al. 1998 p4).

The four Boards of Management ratified the model proposed in the Final Report and presented it to the Department of Human Services and the Minister of Human Services in July 1998. A submission was also made to the Department of Human Services for funding for the secretariat of the Regional Board. There was no response to the report or the funding submission from the Department. However, at this time the Chief Executive of the Department of Human Services commented on Designing Better Health Care in the South via email, stating that she was:

… a strong supporter of the type of integrated approaches being pursued in the South. A structural approach is not necessarily the best way to pursue it – but the general project approach is extremely good (personal communication via email, 28 April 1998)

Correspondence from this time records that the Chief Executive Officers met with the Chief Executive of the Department of Human Services again on 26 July 1998. She supported the proposals within the Final Report but suggested changes, including that the proposed new coordinating Regional Council should not be called a council, as this suggested structural change, and should not include 'health' in its title, in line with the new broader focus of the Department to integrate health, housing and welfare. The new coordinating council (now called a committee) was due to hold its first formal meeting in August 1998. The four Chief Executive Officers subsequently

met to discuss the outcomes of the meeting with the Chief Executive of the Department. They proposed that the new coordinating committee be called the Southern Network Coordinating Committee and, in light of concerns expressed by the Department of Human Services, agreed to defer the committee's first meeting. The Chief Executive Officers also discussed the launch of the Final Report and the organisation of a 'think tank' meeting to be held in late August or early September 1998 to discuss regional program development that would build on the regional planning work undertaken in 1997. The Department's attempt to control the use of particular language (such as the terms 'council' and 'health' on these occasions), became an apparent strategy to control action and contain interagency processes initiated at the local level. This strategy will be discussed further later in this chapter.

There was no further response to the Final Report from the Department until August when the Executive Director of Statewide Division, which had responsibility for metropolitan hospitals, met separately with the Chief Executive Officers of Noarlunga Health Services and Repatriation General Hospital and expressed concern that the proposed Southern Network Coordinating Committee could be inconsistent with the directions coming out of the Department's Hospital Facilities Workshop, a planning weekend between the metropolitan hospital Chief Executive Officers and the Chief Executive and senior staff of the Department of Human Services held from 31 July to 2 August 1998. At this meeting the Chief Executive of the Department of Human Services had stated that hospital networks would be developed around programs and not necessarily be geographically based, and she had directed that all planning should occur on a metropolitan-wide rather than regional basis with the Statewide Division as the central reference point. This statement was consistent with Departmental attempts to break down the hospital-dominated institutional focus of the health system, while maintaining strong central control of decision making (discussed in Chapter 8). Despite this, the agency Chief Executive Officers believed that they could achieve their aims while working within the Department's directions as outlined at the workshop.

The Chief Executive Officers and key clinicians from the four agencies held a 'think tank' on 10 August 1998. At this meeting they agreed on a process for the Southern Network Coordinating Committee to select a series of ideas or services for action as part of developing a regional planning program. They emphasised the importance of selecting some 'quick strikes' where they could build on existing energy and make gains rapidly. They also discussed whether to invite the Department to join the Southern Network Coordinating Committee (given the SA Health Commission's earlier involvement in the process), but decided that this would not be advisable because of the existing tension between the Department and the Chief Executive Officers around their regional planning activities. An entry from my journal from this time records the Chief Executive Officers' expressions of concern at the lack of clear direction coming out of the Department.

On 12 August 1998, correspondence was received by the Chief Executive Officer of Flinders Medical Centre from the Executive Director, Statewide Division in the Department of Human Services. The letter again referred to the planning weekend and reiterated the Department's messages about requiring planning to be centralised and metropolitan-wide. A similar letter was received on 20 August 1998 stating that hospitals and community services would now be overseen by separate Divisions within the Department and that hospital networks based on clinical programs rather than regions were to be implemented by the Department. The Flinders Medical Centre Chief Executive Officer's letter of response assured the Executive Director that the four agency Chief Executive Officers were aware of the Department's new directions, that they did not believe that their proposal was contrary to these directions and that their focus was now on regional coordination of existing services rather than on planning. She also assured him that no structural change would occur as part of the project.

In retrospect, the message from the Department appears quite clear. It stated that there should be no structural change, the focus of activity should be on integrating health services with housing and community services, and that the Department was

seeking to increase central control of the health system. The Chief Executive Officers received these messages on a number of occasions, but they were not explicitly stated and were generally provided verbally rather than in writing with no clear directive to follow a different course. This, combined with the Chief Executive Officers' reluctance to relinquish a goal in which they had invested significant effort, and that they saw as vital to the future functioning of health care in the south, made them continue to question if this actually was the message coming from the Department. Similarly, the incorporated status and history of relative independence of health care agencies in South Australia did not lead them to expect that they would be required to immediately comply with what appeared to be unclear and contradictory messages (at least in relation to previous policy). My journal documents discussions between the Chief Executive Officers that indicated their determination to continue working on Designing Better Health Care in the South. As messages about the lack of Departmental support were not explicit and occurred at a time when the Department was in the process of determining and clarifying its own policy agenda, the Chief Executive Officers of the four agencies agreed that they should continue with Designing Better Health Care in the South. They believed that there was no explicit Departmental policy directive to the contrary and they hoped that with time, the new Department would settle into its role, and it might yet support their initiative. It took a number of months before they began to understand the full implications of the Department's new direction.

From project to process - Designing Better Health Care in the South goes 'underground'

The Southern Network Coordinating Committee met for the first time on 25 August 1998. The meeting was attended by the four Chief Executive Officers, the four Board Chairs and the Director of the Southern Division of General Practice. The Chair of the Repatriation General Hospital was elected to head the committee and the Chair of Flinders Medical Centre was elected as his deputy. (This was clearly an attempt to engage the Chair of the Repatriation General Hospital in the process). The Chief Executive Officer of Flinders Medical Centre made a presentation to the group about

the new directions of the Department of Human Services as had been presented to the Chief Executive Officers at the Hospital Facilities Workshop earlier that month. The committee members expressed concern that their activities should not be viewed as obstructing the Department's direction of integrating health, housing and welfare services and agreed to avoid developing structures that might be seen to be inconsistent with the Department's integration process. They also discussed the development of a three year rolling plan to build interagency collaboration in the region and agreed to call for expressions of interest within their agencies to undertake projects that could provide opportunities for trialling and learning from regional service coordination.

In late August and early September 1998, the Executive Director of Statewide Division met with each of the four Chief Executive Officers separately and again expressed concern about the Southern Network Coordinating Committee. As a result, the Chief Executive Officers convened a meeting with the four Chairs on 2 September 1998 to review their future directions in the light of the pressure from the Department. They had originally planned to hold a ceremony in which they would sign the Agreement to establish the federated regional body proposed in the Final Report. They now decided to defer the signing ceremony and not to distribute the Final Report any further than had already occurred despite having printed numerous copies. The Chief Executive Officers and Chairs met on 9 September 1998 to revisit the principles and objectives of Designing Better Health Care in the South, and prepared a vision statement for the project and the Southern Network Coordinating Committee. The vision statement is included as Figure 1.

Figure 1: Vision Statement of Designing Better Health Care in the South (30 October 1998)

DESIGNING BETTER HEALTH CARE IN THE SOUTH

JOINT VISION

The Partner agencies work together to improve the health and well-being of the people of southern Adelaide and others for whom the partner agencies have a particular responsibility.

Each member of the community, regardless of entry point and service location, will receive the best possible health care.

We will work closely with local doctors, community health agencies and other community services to promote continuity of care and health advancement.

OBJECTIVES

In pursuing their joint vision, the partner organisations will operate within the planning and service provision aims and guidelines of the Department of Human Services. Our objectives are:

1. to achieve the greatest possible health benefit for the people of the region by more closely integrating the planning and provision of health services by the partners.

2. to make it easier for people of the region to get the care they need through better coordination.

3. to focus on meeting the overall health needs of the regional population and others for whom our services have a specific responsibility.

4. to improve training and research opportunities and establish a teaching region in collaboration with Flinders University of South Australia.

5. to maximise efficiencies through coordination of management support systems including clinical and related information, human resources, material management, financial and information technology systems.

6. to encourage the allocation of resources with reference to the needs of the population served.

7. to take advantage of the increasingly close connections between health and community services as reflected in the Department.

8. to provide access to the region wide array of services from any point of entry and to provide consistent and comprehensive information about the array of services offered.

9. to offer services (and "packages" of services) that are competitive in terms of quality and price.

10. to respond flexibly to changes in demand.

11. to manage services as close as possible to the point of service delivery.

12. to support these objectives by optimal use of information technology and information management strategies.

The four Chief Executive Officers met with the Executive Director of Statewide Division in October 1998. Correspondence from the Project Manager to the Chief Executive Officers about this meeting indicated that she understood that they had been instructed by the Executive Director that the Southern Network Coordinating Committee could not use this name or meet formally. The Chief Executive Officers decided that the committee would continue to meet but would maintain a low profile and not be formalised. They also agreed that they would sponsor a limited number of interagency projects to explore the challenges and opportunities in achieving services that were better coordinated regionally.

The Chief Executive Officers had differing interpretations of the response from the Executive Director of Statewide Division at this meeting, some feeling that he said that the Southern Network Coordinating Committee should be discontinued, while others did not have this impression. They felt that he did not give clear instructions about whether he wanted them to discontinue Designing Better Health Care in the South, despite being asked about this directly. They understood that he suggested that Designing Better Health Care in the South could continue as long as they did not make structural changes, and as long as what they did was consistent with the Department's agenda.

The Chief Executive Officers commented at meetings at this time that negotiating with the Department felt like *"treading on eggshells"*, and that if the agencies could bide their time, the confusion would not last, they just needed to *"keep their heads down"*. The lack of explicit and explained direction from the Department left the Chief Executive Officers second guessing the Department's policy agenda, and contributed to the strong feelings of confusion, insecurity and powerlessness that were very evident. The Chief Executive Officers felt that every proposal to progress Designing Better Health Care in the South was being blocked, constrained or controlled by the Department so that they constantly had to find ways to work around these obstacles while the Department never directly stated that Designing Better Health Care in the South could not proceed.

At their next meeting, on 30 October 1998, the Chief Executive Officers discussed the title of the project and agreed that there were negative associations both with the names "Southern Network Coordinating Committee" and "Designing Better Health Care in the South". It had now become clear to them that regionalisation was no longer part of the State's health policy and that instead, integration of health, housing and welfare services was the Department's primary objective, with an increased shift towards centralisation of decision making about service policy and planning. Despite these concerns, they agreed to continue to use the title Designing Better Health Care in the South because it had significance for staff of the agencies (although they recognised that it was not acceptable to the veterans who saw it as being linked to the original proposed regional health service model, and therefore to the potential reduction or loss of their priority access to the Repatriation General Hospital).

Shifting from a model to a regional collaborative process

At their meeting on 2 November 1998, the Chief Executive Officers agreed to proceed with a call for expressions of interest within their agencies to undertake interagency collaborative projects, but to change the emphasis to coordination and local planning, rather than regional development. They believed that this would be more acceptable to the Department of Human Services.

Given the Department's concern about the use of particular words, the Project Manager struggled to find acceptable words that would convey the meaning of ongoing work on Designing Better Health Care in the South while not raising further concerns within the Department. The result of this was that, apart from the call for expressions of interest, agency staff heard no more about Designing Better Health Care in the South for some time and it was evident from phone interviews undertaken for this study at the time that many believed that it had ceased. Discussions in late 1998 about the possible future directions of Designing Better Health Care in the South with the Chief Executive Officers and the Project Manager made it clear that

there was a shift in this project during this time from being about searching for a particular solution (the implementation of a regional model), to a focus on a fairly disparate process of promoting collaboration across the region while attempting to avoid attracting the ire of the Department.

The Department of Human Services clearly demonstrated some of the trends that have been described in previous discussions in this thesis about the emergence of New Public Management within the South Australian health system, including for example increasing control and accountability through service and performance agreements with agencies within the human service portfolio, integration across the spectrum of health, housing and community services sectors to improve coordination for consumers that used services from across the portfolio (while not supporting intra-sectoral integration such as regionalisation within the health sector), and centralised policy and planning. Tensions were evident in this approach in the Department's efforts to continue to control and direct the interagency planning and activity that was occurring at the regional level.

Sponsoring regional coordination projects to support interagency learning about collaboration

The call for expressions of interest for regional coordination projects as part of Designing Better Health Care in the South was made on 2 November, with a closing date of 4 December 1998. Forty six staff contacted the Project Manager to discuss ideas for projects and thirteen projects were finally submitted. The Project Manager provided advice and support to the agency staff in the preparation and refinement of their project proposals.

The announcement of the resignation of the Chief Executive Officer of Flinders Medical Centre on 7 December 1998 was a significant blow to the key participants in Designing Better Health Care in the South. She had been a strong leader and advocate for regionalisation in the south and her enthusiasm and determination had

been a significant support as the political environment became less supportive. She was described in one phone interview as having *"really led the field like on the white charger"*. Her departure for a senior position in a Melbourne Health Care Network was considered a great loss by the other Chief Executive Officers, the Chairs and staff who were involved in Designing Better Health Care in the South.

On 8 December 1998, the Chief Executive Officers met to determine the criteria they would use in responding to the expressions of interest and agreed that:

- each project should have the potential to achieve its specified outcomes
- its involvement should add value to the health care provided
- it should cover a range of target groups, levels of care and levels of involvement of partner agencies
- it should address an area of strategic importance to the partner agencies and to the Department of Human Services
- they should believe it would work
- the resource requirements should be realistic
- it would not cause resistance from the Department.

The Chief Executive Officers and Project Manager then considered the proposals from the expression of interest process and identified those projects that they would recommend to the Southern Network Coordinating Committee for endorsement. Although the projects would be sponsored by Designing Better Health Care in the South, apart from support provided by the Project Manager, no additional resources were available for them. This contrasts to the first round of projects conducted as part of the development of Designing Better Health Care in the South in early 1997, which received some resources from the Designing Better Health Care in the South project budget.

At its next meeting on 29 January 1999, the Southern Network Coordinating Committee was presented with details of the thirteen expressions of interest and with the recommendations for the projects for their endorsement. Five projects were

recommended and approved from the expressions of interest and were in the areas of aged-volunteer services; early childhood intervention; respiratory services; human resources; and regional health information management. The successful projects were required to produce a progress report for the Southern Network Coordinating Committee after 6 months which:

- explains its immediate objectives and describes progress made in pursuing those objectives
- recommends the optimal means of coordinating service delivery within the region so as to achieve the following outcomes:
  - demonstrable improvements to the health and wellbeing of the community
  - costs are minimised; resources are used effectively and efficiently
  - teaching and research activities are supported
- recommends the next steps to be taken (Minutes of the meeting, 29 January 1999).

The next Southern Network Coordinating Committee meeting was held on 8 April 1999. The Chairs and Chief Executive Officers discussed the need for a communication strategy to inform staff about the progress of Designing Better Health Care in the South. However, concern was expressed, particularly by the Chief Executive Officers, that within any communication strategy there should be no mention of the Southern Network Coordinating Committee or of Designing Better Health Care in the South, as this would antagonise the Department. The Chief Executive Officers were very concerned about the apparent lack of support from the Department and wanted to continue to operate covertly. At this time, two of the agency Board Chairs commented about Designing Better Health Care in the South and the Southern Network Coordinating Committee that they felt that any further effort "*seemed to be a waste of time and energy*", and that there did not seem much point in the committee continuing to meet. The Chairs also saw the role of the Southern Network Coordinating Committee as being much more limited than that of the previous Southern Regional Health Service Steering Committee, which made them feel disgruntled and frustrated. They described the committee as "*more of a rubber stamp*".

During phone interviews for this study, the Chairs and some clinicians expressed frustration about the more constrained and conservative approach that was now being adopted by the Chief Executive Officers, many clinicians believing a lack of courage and "will" on the part of the Chief Executive Officers was the cause for what appeared to be a back-down on their part. A clinician commented that *"there was a bit of hesitancy when the crunch time came"*. It is likely that this misunderstanding was a direct result of a lack of communication about the status of Designing Better Health Care in the South.

On 10 May 1999, the Project Manager tendered her resignation to take up another position within the public sector. She explained that she felt that the Chief Executive Officers would only consider alternative options for this position if she was no longer occupying it. She felt that there was continuing pressure from Senior Executive staff of the Department of Human Services on the Chief Executive Officers to end their alliance and to focus on making agency efficiency gains.

On 11 May 1999, the Chief Executive Officers and Project Manager met with staff from the Statewide Division to discuss appropriate links between the Department and the project. They were informed that there would not be geographic regions for hospitals in the metropolitan area, but that there was merit in investigating a north/south division of the metropolitan area for networks of clinical services.

Prior to her departure on 28 May, the Project Manager distributed a final staff bulletin titled *Whatever happened to Designing Better Health Care in the South?* in which she mentioned the five collaborative projects, the progress of the evaluation and briefly documented the history of Designing Better Health Care in the South. Her position was subsequently filled by a temporary Project Manager who commenced on 15 June 1999. Her brief was to support the five collaborative projects, to further explore the possibility of amalgamation between Flinders Medical Centre and the Repatriation General Hospital, to explore options for Designing Better Health Care in the South,

and to make recommendations concerning its future to the Chief Executive Officers and the Southern Network Coordinating Committee.

The centre develops regional network strategies

The Primary Care Networks paper

On 30 June 1999, the Executive Director of Metropolitan Services (which had responsibility for community based health, housing and community services in the metropolitan area) presented a model of primary care at the state Primary Health Care Research and Evaluation Conference. This model proposed integrated care and planning at a regional level and the development of primary care networks within regions. A draft paper titled *A Framework Paper: a Primary Care and Community Support Plan for Metropolitan Adelaide – a Basis for Integrated Area Planning* (Department of Human Services 1999b) was distributed at the conference for discussion.

In early July 1999, the new Project Manager held meetings with staff and the Executive Director of Statewide Division. She reported the outcomes of these meetings to the next Southern Network Coordinating Committee meeting on 23 July 1999, stating that in her meetings with Departmental staff, it was reiterated that all hospital policy should be determined centrally and that regions, other than a whole-of-metropolitan region, were not part of the Department's policy agenda. She reported that the titles "Designing Better Health Care in the South" and the "Southern Network Coordinating Committee" were now considerably out of favour with the Department and that the title "Designing Better Health Care in the South" also continued to be unacceptable to the veterans. She proposed that the collaborative projects should be completed by the end of 1999; that the agencies should work with the Department to implement the recently initiated Metropolitan Clinical Services Plan for hospitals (which involved planning program-based networks of clinical services across hospitals within the metropolitan area); that the Southern Network Coordinating Committee should be disbanded because of the lack of support for it

from the Department; that the evaluation should continue; and that the existing Designing Better Health Care in the South project office should only continue until the collaborative projects were completed. The Southern Network Coordinating Committee agreed to consider these proposals.

The Hospital Networks paper

In early September 1999, the three hospital Chief Executive Officers met with the Executive Director of Statewide Division to discuss a draft paper about hospital networks in South Australia that had been developed by staff of the Statewide Division. The hospital Chief Executive Officers saw this new direction from the Department as an opportunity to continue their regional focus in a way that was consistent with the Department's policy. One Chief Executive Officer commented that "*this could roll in over the top of what we have been doing in the south*". The paper proposed a 'hub and spoke' model, with the Department at the centre of hospital clinical networks which would be based on services rather than institutions (Department of Human Services 1999a). Because they were asked to ensure that these discussions remained confidential at this time, the hospital Chief Executive Officers did not communicate this new direction to the Chief Executive Officer of Southern Domiciliary Care and Rehabilitation Service or to their Chairs.

Both the Departmental acute care clinical networks and primary care networks proposals were examples of top-down initiated strategies for the integration of services across the metropolitan area (or in the case of the primary care networks, at the regional level), while maintaining central control and direction. The tensions evident here between central control and the devolution of decision making have been found to be fundamental in New Public Management approaches (Peters 2001), resulting in a pendulum swing between the two approaches. This is discussed in detail in Chapter 6, but indicates that to an extent both the Designing Better Health Care in the South model and the aims of the Department of Human Services were consistent with New Public Management approaches, even though the advocates of

these models would have viewed them more pragmatically and would not necessarily have connected them with these ideological origins.

The Southern Network Coordinating Committee next met on 15 September 1999, and at this meeting accepted the Project Manager's recommendations to conclude Designing Better Health Care in the South and the Southern Network Coordinating Committee. The Chief Executive Officers agreed to continue to meet monthly to discuss regional initiatives and changes in the external environment. The group also agreed to form a broader group, which they called the Southern Health Services Liaison Group, in order to continue to exchange information of mutual interest. It was agreed that this group would include the Board Chairs and a member of the Southern Division of General Practice. The Chief Executive Officers agreed to each take responsibility for the organisation of one of these quarterly meetings a year, and the Chief Executive Officer of Noarlunga Health Services agreed to convene the first meeting of the Southern Health Services Liaison Group. The Project Manager resigned on 30 September 1999 and most of the regional collaborative projects continued until the end of 1999.

The partnership unravels

In October 1999, the Statewide Division convened a new metropolitan-wide hospital Chief Executive Officers' group which it called the Statewide Operations Group. This group met monthly in Central Office and the three hospital Chief Executive Officers began to meet together to discuss common issues of concern following these meetings. These regular meetings appeared to signal the beginning of reasonable working relationships between the hospital Chief Executive Officers and the Statewide Division. However, there were no further meetings of the four partner agency Chief Executive Officers for some time, and the Chief Executive Officer of Southern Domiciliary Care and Rehabilitation Service became increasingly excluded, saying at one stage that he felt *"out of the loop"*.

On 2 February 2000, there appeared to be a significant shift forward in the Statewide Division's acceptance of a regional approach between hospitals in the south. After a Statewide Operations Group meeting, the three hospital Chief Executive Officers met with the Executive Director of the Statewide Division who asked them to form a Steering Committee which he would chair, with staff of his Division. The Steering Committee was intended to address the distribution of services between Flinders Medical Centre and Noarlunga Health Services to meet the growing demand in the outer southern metropolitan area, and the distribution of services between Repatriation General Hospital and the other hospitals in the south during the anticipated future decline in veteran numbers. A memo was provided to the hospital Chief Executive Officers which proposed the establishment of a process to develop a:

> Southern Network that supports the integration of delivery of clinical services across Noarlunga Health Services, Flinders Medical Centre and Repatriation General Hospital.

The origin of this proposal was suggested to be the Metropolitan Hospital Facilities Direction Setting Workshop that had been held on 31 July and 1 August 1998 and that the completion of work within the Department on clinical service plans had:

> … resulted in the further development of the service delivery network concept particularly in relation to the north. Most commonly the practical conception is in the form of a Northern and therefore by inference a complimentary Southern Network.

This memo suggests the intention of the Department not to recognise or acknowledge the collaborative processes and planning that had occurred in the south over many years. The hospital Chief Executive Officers agreed to participate in this process, believing that it was a way to achieve their aims while building more positive relationships with the Department.

The first meeting of the Southern Health Services Liaison Group was held on 16 March 2000. The Chief Executive Officers of Flinders Medical Centre and Noarlunga Health Services and the Chair of the Repatriation General Hospital were unable to attend this meeting. The meeting was chaired by the Chief Executive

Officer of Southern Domiciliary Care and Rehabilitation Service. He had not been involved in the hospital Chief Executive Officers' discussions and had seen neither the Statewide Division's hospital network paper nor the Metropolitan Division's community services integrated framework paper until just prior to this meeting. The Chairs also saw the hospital network paper just prior to the meeting and were very upset that they had not known about it before this and that it did not acknowledge the work that had occurred within the southern region. They questioned the purpose of the Southern Health Services Liaison Group and almost decided not to meet again. However, they finally agreed that their role was to maintain the broader perspective, and to ensure there were continued links between community and acute care services in the south, while trying to feed this into the Department's agenda through the Chief Executive Officers. They agreed to meet again in June 2000.

The Department of Human Services held another Strategic Workshop for hospital senior administrators and clinicians, and senior staff of the Statewide Division on 10 – 11 March 2000. The Chief Executive Officer of Flinders Medical Centre was invited to make a presentation on southern network developments at this workshop. She had discussed this presentation with the two other hospital Chief Executive Officers and they had agreed to focus the presentation on activities between the three hospitals. She provided a history of what had happened in the south and summarised the current extent of collaboration between Flinders Medical Centre, Repatriation General Hospital and Noarlunga Health Services.

At this meeting, the Chief Executive of the Department of Human Services made it clear that she did not wish to talk about regional networks, suggesting that networks implied structures, but rather she wanted to talk about *relationships and nodes*". It appeared that the term 'networks' was no longer acceptable within the Department and she suggested that the Statewide Division should consider adopting a model similar to that being developed by the Metropolitan Division (which focused on integrating community based health, housing and welfare services at a regional level). It was apparent that the continuing lack of clarity about the Department's directions,

which was confusing to Departmental staff as well as to those working in human service agencies, contributed to a level of confusion and uncertainty which prevented anyone from effectively taking the initiative. This was reflected in a comment of one of the Chief Executive Officers at this time: *"We don't know how to win anymore"*. The division of hospital and community services into two Departmental Divisions contributed to the break-down in relationships between the Chief Executive Officers, with the hospital Chief Executive Officers working with Statewide Division to advance the clinical networks approach, and the Southern Domiciliary Care and Rehabilitation Service Chief Executive Officer beginning to work with Metropolitan Services Division on their primary care integration exercise, without informing each other that this was occurring.

The Southern Health Services Liaison Group met for the second and last time on 21 June 2000. The Chief Executive Officer and Chair of Southern Domiciliary Care and Rehabilitation Service were unable to attend this meeting. Metropolitan Services Division's primary care initiative, first flagged in the paper presented at the Primary Health Care Research and Evaluation Conference in June 1999, had resulted in the formation of regular forums of community health, housing and welfare managers in the south. This initiative was discussed at this meeting. The hospital Chief Executive Officers had been unaware of its existence. Although the meeting agreed on the importance of the group continuing as a forum for the exchange of information, the Southern Health Services Liaison Group was never reconvened (and never formally closed).

The Chief Executive Officer of Noarlunga Health Services announced his resignation on 3 November 2000 to take up a new position elsewhere in the South Australian health system. By 2000, the Department of Human Services was clearly directing the agenda in the south through its dual and quite separate planning processes for clinical and primary care networks. In March 2001, the Department brought together the hospital Chief Executive Officers in a "Health System Roundtable" to discuss the pressures on the hospitals, which were always particularly acute during the winter

months when there were insufficient beds, and which, in terms of the hospitals' budgets, were an ongoing problem that always resulted in over-expenditure. The Metropolitan Division had previously conducted separate Southern Provider Forums in the inner and outer south but decided to combine these given the number of people that attended both forums. These forums were discussing the creation of regionally integrated community health, housing and community welfare services.

It became apparent in early 2001, that despite plans for integrating primary care services within regions, there would be no new funding to support the implementation of these plans. It was also confirmed in May of that year that the work being led by the Department of Human Services on clinical network planning between metropolitan hospitals would be deferred indefinitely, as would the discussions about the distribution of services between the hospitals in the south. Designing Better Health Care in the South had been overtaken by Departmental initiatives that were themselves stalled as a result of a lack of clear direction and vision for change, and a lack of resources and commitment to implementation.

A lost opportunity?

Designing Better Health Care in the South was seen as a lost opportunity by many of those who participated in its development in the southern metropolitan area. They expressed great frustration and disappointment at its failure to be implemented. These frustrations were articulated during the phone interviews which were conducted for this study in mid 1999, for example:

> *The only other thing is that it would not be so bad, that being rejected, as long as you could understand and know what, how your current status fitted with their vision. I think that is a point that, it's up to you whether it is worth making or not, but I think that is the biggest disappointment is that their vision hasn't been articulated. (Phone interview 11, Senior Manager)*

Another respondent echoed this frustration, saying: *"You don't know what the ground rules are going to be from day to day".* Twenty four of the 29 respondents to phone interviews saw the biggest inhibitor for the implementation of Designing Better

Health Care in the South as being the lack of central support for the project following the establishment of the Department of Human Services. Some respondents believed that the opportunity had now been lost, making comments such as: *"I think for the project it was probably almost too late for its time"; "they may have missed the boat"* and *"a sense that we have missed our window"*. Thirteen respondents believed that structural change was essential to making real change, with a Departmental representative, who had been involved in the development of Designing Better Health Care in the South as a SA Health Commission representative, summarising this view:

> *...ultimately if it is going to be sustainable, I think you do have to make some structural decisions. There still are opportunities. There is nothing to stop for instance "the Repat." and Flinders agreeing on areas of clinical speciality. There is nothing to stop Noarlunga and Flinders agreeing on referral arrangements from lower casemix clients back to Noarlunga from Flinders to take the pressure off. Those sorts of things can be dealt with ... but ultimately if there is a block there in terms of putting in place any structural arrangements to support it, then that is going to be a major impediment (Phone interview 2, Departmental representative).*

As is apparent from the veterans' response to Designing Better Health Care in the South, and was also the case among some of the clinicians, support for the proposed change process was not unanimous and some participants were quite cynical about the intentions of the Chief Executive Officers in proceeding with it, and quite relieved that it did not progress. The perspectives of the participants in Designing Better Health Care in the South and the importance of both trust and power relations in the adoption of these perspectives is discussed in Chapters 7 and 8.

Designing Better Health Care in the South was consistent with both Commonwealth and South Australian health policy of the mid-1990s. For example there is a clear connection between the Designing Better Health Care in the South initiative and the National Health Strategy focus on coordinated care, funds pooling and area health management (a model of regionalisation) discussed in Chapter 2. Similarly, Designing Better Health Care in the South was supported during its early development by a SA Health Commission regionalisation policy (discussed in Chapter 6). However, because the Designing Better Health Care in the South model

emerged from a group of health care agencies rather than from the central bureaucracy, the tendency for the bureaucracy to seek to assimilate and control this agenda is not surprising. This is particularly so given the tensions between the independent incorporated health care agencies and the central bureaucracy. Designing Better Health Care in the South became a contested domain during the debates about the purchaser provider split (described in Chapter 4) when both bureaucracy and agencies sought to position themselves to increase their control of the policy agenda and resource allocation; and also following the establishment of the Department of Human Services, because the policy focus had then shifted to integration across the human services portfolio rather than solely within the health system. The tensions between local and central control, and the focus on coordination and improving efficiencies and responsiveness demonstrate the connections between Designing Better Health Care in the South and the public sector reform processes that have been described in Chapter 2.

The strategy of the Department of Human Services to obstruct the progression of Designing Better Health Care in the South during the time of this study is illuminating when considering the obstacles to organisational change that are revealed through this case study. The Senior Executive of the Department, whether intentionally or unintentionally used strategies which disempowered, confused and obstructed, disallowing the use of certain words, such as 'health' and 'council', but also blocking the use of words such as 'network' within their own planning processes. The control of names and of the use of particular words was an interesting mechanism with which the Department's Senior Executive obstructed the progress of local initiatives, but also obstructed the Department's own processes, possibly unintentionally, resulting in great difficulties in articulating its vision and policy internally as well as to the field.

In a sense Designing Better Health Care in the South missed its opportunity because of the careful and extensive process it went through in order to plan, consult on and develop its model. It was overtaken by major changes in the external political

environment. This was first evident with the establishment of the Department of Human Services which, in amalgamating the SA Health Commission with two other departments, demonstrated an intention to contain the powerful interest groups that dominate the health agenda (particularly hospitals and doctors). The strong expectation that the Department would ensure that its portfolio would remain within budget required efforts to contain the costs of the health system, resulting in the hospitals in particular being a focus for control as they were consistently over-budget. Unsuccessful attempts were then made centrally to replace Designing Better Health Care in the South, which was a local initiative, with centrally derived proposals to achieve integration (although separating these proposals for acute and community based services). However, it was only after a change of Government and the implementation of the Generational Health Review that regionalisation once again became a key policy of the Department in 2002 (discussed later in this thesis).

The following chapters in this study consider the issues of centralisation and regionalisation as the models of governance that were under dispute in this case study, trust and collaboration, and power and control as key themes that have been played out in the case study. These themes are recurring and of major significance in health system reform. They have become more significant with the introduction of market-based approaches within the health system because they illuminate the tensions and difficulties encountered within health care agencies when confronting these major international trends in policy. They result in tensions within the health system and continuous efforts to find solutions to problems through restructuring and organisational change, and demonstrate that constant effort to achieve health system reform is evidence of attempts to resolve 'wicked' policy problems (Rittel and Webber 1973) which are highly complex, multifaceted and challenging and not readily amenable to resolution through simple solutions.

Chapter 6
The Tension Between Centralisation
and Devolution

There is a fundamental tension in New Public Management approaches described in Chapter 2 that on the one hand promote decentralisation in order to foster local flexibility, customer-responsiveness, decision making close to the point of service delivery, and local accountability, while also promoting centralised control to reduce duplication and fragmentation and to increase coordination and integration, coordinated central policy development, system accountability and cost control (Peters and Savoie 1996). This tension was evident in the central bureaucracy's changing stance towards Designing Better Health Care in the South described in the previous chapter, which was a result of a shift in policy from promoting regionalisation to centralisation.

This chapter considers the tensions between the centralisation of control which enables system planning in order to ensure efficiency and the control of costs within the South Australian health system, and the regionalisation of decision making about service delivery, which is a devolved form of centralisation at the regional level. These tensions are further exacerbated by the health care agencies' efforts to maintain the independence of their institutional management from both centralisation and regionalisation efforts. The chapter considers the reasons for the centralisation and regionalisation tensions in South Australia, linking this to a discussion of Designing Better Health Care in the South.

Following a review of the literature on governance, centralisation and decentralisation, this chapter uses official reports to describe the history of centralisation and decentralisation within the South Australian health system before considering the impact of the tensions between the aims of these policy approaches

on Designing Better Health Care in the South. As well as official documents (which included minutes of meetings, internal memoranda, notes from presentations, discussion papers and reports provided by the Department of Human Services), the data sources used in this chapter include:

- transcripts from the phone interviews carried out between 23 March and 30 April 1999 with 29 individuals who had had a significant role in the early planning and consultation for the development of Designing Better Health Care in the South, including senior managers, clinicians, Board members, staff representatives and industrial representatives

- transcripts from 5 focus groups involving 37 people, conducted between August 2000 and January 2001. Three focus groups involved people who were working in the region and who had a significant role in developing and implementing models of interagency collaboration, one involved the Chief Executive Officers of the four agencies and one involved the Senior Executive of the Department of Human Services.

However, given its predominantly historical focus, much of the data for this chapter comes from official reports that were prepared to shape the reform of the South Australian health system from the 1970s onwards.

The tensions that arise as a result of shifts in models of governance towards decentralisation and subsequently towards increased central control, are significant outcomes of New Public Management, and are key to understanding Designing Better Health Care in the South and the motives of the participating agencies and central bureaucracy within this case study. This chapter moves the discussion from the macro level of the earlier theoretical and historical chapters of this thesis into the detail of analysis of the case study, and into consideration of what can be learnt from this case study about the nature of health systems and the challenges of achieving effective health system change. Later chapters address the key major themes of trust, collaboration and power, each of which had clear impacts on the outcomes of Designing Better Health Care in the South, and continue to have a critical role in the

ongoing success or failure of efforts to achieve change within the South Australian health system.

Public sector governance

Governance was a key issue for participants in Designing Better Health Care in the South and for the Department of Human Services. It was the basis for the struggle between central control and accountability and locally based responsiveness and collaboration that underpinned the initiation of Designing Better Health Care in the South and its demise. Both the history of centralisation and regionalisation within the South Australian health system and the experience of Designing Better Health Care in the South demonstrate that differing models of governance and their underlying agendas continue to be fundamental issues within the health system, and give insight into the motivation and direction of organisational and system change. Similarly, the models of governance that are in place have a significant influence on the capacity of agencies to collaborate as parts of a system or to be driven by institutional priorities that result in fragmented and competitive action (Peters 2001).

The literature on public sector administration incorporates a recurring discussion about the role and function of governance in the management of public services. This discussion is also occurring during policy and planning processes of governments as they grapple with the challenge of raising the levels of accountability and responsiveness within the public sector. In this context, the discussion is, in part, a result of the shift away from traditional thinking about the public service which has come about as a result of the rise of New Public Management and the consequent re-thinking of governance that took place during the 1980s and 1990s (Peters 2001). It is also a response to the consequences of the application of New Public Management approaches, discussed in Chapter 2, which include increasing fragmentation and disaggregation that accompanied a move towards "steering not rowing", and attempts to maintain central bureaucratic and ministerial accountability in the context of decentralising the control of agencies (Pierre 2000).

Governance – multiple definitions

Although governance is increasingly being discussed and debated both within government and within academic literature, its definition remains imprecise and its conceptualisation continues to lack clarity (Pierre 2000). Flinders states that:

> Governance is not a synonym for government. It accepts that the relationship between state and society and particularly the successful implementation of public policy is increasingly dependent upon a much wider array of public, private and voluntary organizations than would traditionally be included within the 'governmental' framework (Flinders 2002, p52).

Governance has often been defined in a circular manner by what it does rather than what it is. For example, Kettl (2000) discusses governance in relation to market-style changes that have occurred through public management reform, such as a shift in service orientation to becoming more client-centred, decentralisation of decision making to increase accountability and separation of policy and planning (purchasing) from service delivery (providing) functions to improve efficiency and purchasing capacity, all of which are strategies to address issues of accountability, authority and control and all of which are evident in both the case study and broader public sector reform in Australia described earlier in this thesis.

Flinders (2002) identifies four variables as central aspects of governance theory – control, coordination, accountability and power. Rhodes (1997) refers to governance in the context of decentralised interorganisational networks and the centre's capacity to regulate these self-organising networks. In a variation on this perspective, Feldman and Khademian (2002) describe governance as being about relationships and their management, which involve public managers and other participants in the process of governing, and may be either mandated and formalised, or casual via personal communication. Taylor's discussion of governance is consistent with this definition, stating that governance is 'an independent partnership of leaders' and 'a shared process of top-level organizational leadership, policy making and decision making' (Taylor 2000, p110). This contrasts with the understanding of governance as political control and accountability, and the establishment of governing structures that ensure public managers implement the directions of the government of the day

(Thomas 1998). Pierre brings some clarity to this discussion by providing an overview of the different uses of the term governance:

> Governance has a dual meaning: on the one hand it refers to the empirical manifestations of state adaptation to its external environment as it emerges in the late twentieth century. On the other hand, governance also denotes a conceptual or theoretical representation of co-ordination of social systems and, for the most part, the role of the state in that process. This latter meaning of governance, in turn, can be divided into two categories … In the first category – what Peters refers to as 'old governance' – questions are asked about how and with what conceivable outcomes the state 'steers' society and the economy through political brokerage and by defining goals and making priorities. The other theoretical view on governance looks more generally at the co-ordination and various forms of formal and informal types of public-private interaction, most predominantly on the role of policy networks (Pierre 2000, p3).

He summarises the two different approaches as being 'state-centric', where the focus is on the state's institutional and political capacity to steer and its relationships to other stakeholders in this process (as discussed by Hirst 2000; Peters 2000), and 'society-centred' where the focus is on coordination and self-governance through networks and partnerships (as described by Rhodes 1997). Gamble combines these approaches in his definition of governance:

> Governance denotes the steering capacities of a political system, the ways in which governing is carried out, without making any assumptions as to which institutions or agents do the steering (Gamble 2000, p110).

He explains that the different governance approaches are determined by the extent of the role of the state and that several different modes of governance can operate concurrently, and can include markets, corporate hierarchies, networks and communities. The state's role in these modes of governance can vary from government directly acting and intervening, to government constituting rules and regulations under which modes of governance can operate and be largely self-governing with a minimal further role for government (Gamble 2000). The focus on governance has strongly come to the fore since the arrival of New Public Management, because the focus of New Public Management on decentralisation, competition and consumerism, privatisation, and separating purchaser and provider roles (discussed in Chapter 2) has resulted in the need for mechanisms of monitoring

and regulation, and, as Clarke and Newman suggest, through the ideology of New Public Management:

> … the state is now mainly conceived of as a combination of policy making and financing functions increasingly separated from service delivery. Nevertheless, we think it can be argued that far from being shifts towards a 'rolling back' of the state, these changes involve a 'rolling out' of state power but in new, dispersed forms. These new forms both cross and reorganise the conventional boundaries of public and private (or state and non-state). Dispersal engages more agencies and agents into the field of state power, empowering them through delegatory mechanisms and subjecting them to processes of regulation, surveillance and evaluation (Clarke and Newman 1997, p30).

The dichotomous understanding of state and society-centred governance proposed by Pierre (2000) appears to be overly simplistic when reflected on in relation to the reality of developments within the South Australian health system. During the period when Designing Better Health Care in the South was being developed, the Department of Human Services' approaches to and considerations of governance combined approaches that included both centralised control and accountability, and planning for regional or interagency networks that would determine local needs and services. At that time there were concurrent discussions about centralising control of the health system within the central bureaucracy and creating regions and clinical networks of services across institutions (although these too were to be planned through the central bureaucracy), along with, in the case of Designing Better Health Care in the South, agency-initiated discussions of creating a locality based network of agencies. The combination of these approaches within one system suggests that in reality, governance is currently a vague term which can be defined loosely by governments and agencies and can lack clear theoretical foundations. This may be because the concept is relatively new to governments and therefore public sector thinking on governance issues is at a relatively early stage of development. At least at this early stage in the development of the conceptualisation of governance, it appears that the dichotomous definitions of state and society-centred forms of governance are an artificial division and that they can and do co-exist within the same system. Until there is further clarity, it may be more useful to consider governance in the light of structures and processes as suggested by Flinders (2002).

Reforming the public sector – a shift away from centralised bureaucracy

The traditional understanding of the public service included the view that the public service was apolitical, with no perceptible political allegiances and that it had a focus on serving the government of the day. The public service was perceived to be hierarchical and rule bound and to ensure equality of outcomes for employees and clients through the application of rules without bias. It was also perceived to provide permanence and stability of employment for staff, resulting in promotion through the ranks and the valuing of 'career public servants' with a long history of experience and extensive expertise. Career public servants were seen to contribute to policy development and implementation through bringing a 'neutral competence' to these processes (Peters 2001).

Public sector administrative reform over the last 30 years has had a significant impact on the relationship between public servants and politicians. As discussed in Chapter 2, since the 1970s in Australia, consistent with the origins of managerialism in this country and reinforced by the introduction of New Public Management approaches, politicians have increasingly viewed public servants as part of the problem in reforming the public sector, rather than part of the solution. Career public servants have come to be seen as inflexible and unwilling to change, supportive of the status quo and committed to institutional interests (Wilenski 1986; Orchard 1998).

The traditional model of the public service has been undermined by the implementation of market based reforms, including pressures to accommodate the interests of employees and clients through increasing flexibility and responsiveness, thereby undermining the traditional hierarchical model and its rule-bound approaches (Peters 2001). Efforts to bring in outside expertise and through this to devalue corporate memory, and to adopt managerialist approaches that promoted the value of generalist managers over career public servants with content knowledge and expertise, also undermined the traditional public service approach (Bryson 1987). Internationally, these reforms have led to a reduction in the size of the public sector

and in the number of public sector employees, attempts to reduce the power of the bureaucracy, and pressures on the bureaucracy to be more responsive to the expectations of the community (Peters and Pierre 2001).

Peters (2001) outlines four models of reform that have shifted the emphasis from the traditional hierarchical, centralised and rule bound model of the public service to decentralisation and devolution of decision making. These models are the market models, the participatory model, the flexible government model and the deregulation model. Market models are a result of the creation of competition between agencies, whereas the participatory model promotes shifting control to a different set of bureaucracies at a lower level of the system, and to consumers. The flexible government model is an attempt to address the apparent inflexibility and conservative nature of traditional bureaucracy and to promote more flexible and responsive models of service delivery and employment. The deregulated model may be another version of the market model of governance, as it views the rules and regulations of bureaucracy as inhibiting rapid and creative action and focuses on changing procedures and encouraging risk taking within bureaucracy. However, this model relies on hierarchy, bureaucratic expertise and strong leadership, requiring probity and personal accountability for decisions (Peters 2001).

All of these models have resulted in decentralisation of bureaucratic functions to numerous autonomous or semi-autonomous agencies and the encouragement of increasing autonomy in managers to make decisions for their agencies without the constraints of a bureaucratic hierarchy, even though the rationale for decentralisation differs in each of the models (Braithwaite 1993; Hart 1998). However, as a result of problems with coordination and control, decentralisation has been accompanied by a growing recognition of the need for effective monitoring, performance measurement and evaluation. There has been a subsequent strong counter-pressure to ensure autonomous agencies comply with central policy directions and with the aims and intentions of the responsible ministers and government, resulting in concern over the increasing politicisation of the public service and of its policy role.

The perception that the participatory and the managerialist reform agendas can co-exist has been accepted without question within public administration. However the participatory agenda (which promotes the transfer of power to lower levels of the system and enables consumer participation) is taken more seriously at the regional and provider levels than at the central bureaucratic level, while the managerialist agenda (which picks up on aspects of the market, deregulated and flexible government models) is given dominance within the central bureaucracy (Yeatman 1987). This reflects the different priorities of the bureaucracy and service delivery levels of the public sector[20] and is reflected in the tensions evident in Designing Better Health Care in the South between the bureaucracy and the agencies discussed later in this chapter.

Tensions between centralisation and devolution

Centralisation has been found to lead to inefficiency, a slow pace of change and innovation, a lack of responsiveness to changes in the environmental context and susceptibility to political manipulation (Saltman and Figueras 1997). However, centralisation also enables accountability to government and increases coordination between agencies and services; while decentralisation fosters responsiveness to the community and flexibility, and empowers agency managers to make decisions and to be innovative. This has the potential to lead to a tendency towards reactive politics (for example see the discussion of the attempted closure of the neo-natal unit at Flinders Medical Centre in Chapter 8). As a result of its benefits, there are inherent tensions between decentralisation and achieving a coherent strategic, systemic role at the centre. Decentralisation and devolution lead to problems with coordination and control and to a reduced capacity for central agencies to ensure equality and probity across the system (Clarke and Newman 1997; Rhodes 1997). Decentralisation can

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[20] Also, governments have their own agendas and seek to promote their policies and to maintain popularity. The participatory model can result in government control of the agenda being reduced as other powerful interest groups are given a platform and legitimate voice with which to promote alternative agendas and viewpoints.

lead to internal competition, resulting in agencies having stronger incentives to focus on their own programs and weaker incentives to collaborate with other agencies for the benefit of their common clientele. Decentralisation can also lead to increased bureaucracy, with duplication of administration at central and regional levels (Clarke and Newman 1997; Reverte-Cejudo and Sanchez-Bayle 1999; Kettl 2000).

Decentralisation and the devolution of decision making requires a significant reallocation of organisational authority in government bureaucracies from a highly centralised and controlling central bureaucracy closer to the point of service delivery, exposing the organisation to increased direct feedback from consumers and other interest groups (Hart 1998). The drive to decentralise and devolve resource allocation and service delivery decision making to a regional or even agency level may originate from a number of differing objectives, including the promotion of competition, consumer participation, and/or service flexibility and responsiveness as well as the aim to reduce the influence of traditional bureaucracy (Peters 2001). However, the devolution of responsibility to lower levels of the system can also lead to increased fragmentation and duplication, which can then result in pressure for greater coordination of services, for increased central policy direction and coherence as well as for prioritisation of resource allocation in order to enable cost control (Peters and Savoie 1996). Consequently the aim to adopt an approach which reflects the New Public Management slogan "steering not rowing" (Osborne and Gaebler 1992), often results in the need for an increasing focus on centrally setting standards, monitoring and regulation, a consequence which is in apparent conflict with the spirit of New Public Management approaches (Hart 1998; Pollitt 1998).

As a result, there tends to be a continual process of re-balancing the dominance between models of devolution and regional autonomy and models of central direction and control as the elusive solution to this quandary is sought (Peters and Savoie 1996). Peters states that:

> … the solutions for organizational problems tend to come in opposing pairs, and almost inevitably reformers will argue that organizations have gone too

far in the direction of one end of the continuum and will propose the other end of that dimension as the solution (Peters 2001, p179).

This is a clear example of where a 'wicked' problem within health systems results in an ongoing search for the 'right' solution and as a result, to churning within the system (as discussed in Chapter 3), which in this instance can be represented by a 'pendulum swing' between an opposing pair of possible solutions along a continuum from centralised to regionalised control.

An example of this pendulum swing in the UK is the policy of 'joined up government' which has come out of previous moves towards decentralisation and which has brought with it a shift in policy towards a mix of decentralised and centralised approaches. Decentralisation was introduced during the Thatcher era in the UK to increase local responsiveness and competition. It was subsequently seen to have resulted in a government incapable of functioning as a single entity or of managing effectively, resulting in duplication, and leading to a growing perceived need for coordination and to the re-imposition of direct controls at the individual organisational and interagency levels (Peters 2001; Smith et al. 2001). Ham explains:

> The Labour government that was elected in 1997 has introduced a further set of reforms which claim to be different from both the command and control mechanisms used after the establishment of the NHS and the market oriented policies of this government's immediate Conservative predecessors. Indeed, the government has argued that these reforms represent a "third way" that goes beyond both planning and markets. In reality, the third way comprises a mixture of policy instruments, embracing elements of planning and competition, directives and incentives, and centralisation and devolution (Ham 1999, p1490).

This mixing of aims and approaches, and of models of administration is common in the changes introduced to achieve reform in health systems in developed countries, and is also evident in the South Australian experience, as will be described later in this chapter.

Despite the descriptions of Peters' models as being largely discrete, with differing ideological bases and outcomes, Peters argues that governments tend to select aspects of a number of different models to be combined in their reform efforts. He states:

> Apparently, what often has happened is that governments have selected "off the shelf" reforms derived from one set of assumptions (implicit or explicit) at the same time that they selected others based on quite different, or even directly contradictory, premises. The political and administrative leaders made these selections, expecting all the changes to work well together. It is therefore little wonder perhaps that in practice the sets of reforms have not worked together in a large number of instances and that also at times the interactions have proven to be negative (Peters 2001, p17).

In this statement, Peters confirms the problems with the lack of clarity in definition and understanding of the fundamental premises on which different approaches to governance are based. Thus, governments (particularly of English-speaking countries) have sought to shift public administration towards managerialist approaches – to a more businesslike focus, to customer-responsiveness, to be more flexible, to achieve greater economy and efficiency and to be results-oriented (Pollitt 1998). These approaches reflect market models of governance, but also incorporate attributes from the other models of governing outlined by Peters and summarised above.

The Australian health system is already significantly decentralised, in that it is a federated model where funding is provided by the Commonwealth Government to the states which then provide publicly funded health care services to the community (as described in Chapter 4). The centralisation/decentralisation debate is therefore played out predominantly between the state and regional (intra-state) levels, while there also continue to be debates between the state and Commonwealth levels of government about the use of funds provided to the states. These debates are particularly evident in negotiations around the Australian Health Care Agreement through which funding is allocated from the Commonwealth to the state governments. As a result of the structure of the Australian health system, the tensions between centralised control and decentralised responsiveness are endemic throughout the system.

The experience of reform in the South Australian health system during the period of this study supports Peters' view about the selective application of different aspects of these models without consideration of their rationale or objectives. Examples within the South Australian health system include the introduction of the separation of purchaser/provider functions (as described in Chapter 4), the employment of Executive level staff on contracts, and a growing focus on efficiency (based on the market and, in part, the flexible government models), and efforts to increase consumer participation. In the case of Designing Better Health Care in the South, the initiative to decentralise and to form a locality based network of services came from the health care agencies themselves following a departmental policy shift in this direction, but was subsequently blocked by the Department of Human Services when centralisation of control became a dominant policy focus.

The next section of this chapter describes the centralisation/regionalisation history of South Australia and places Designing Better Health Care in the South in the context of this history.

A brief history of regionalisation in South Australia

South Australia has had a long history of attempting regionalisation without much success. The rationale for attempts to regionalise health care planning was based on assumptions about the value of local responsiveness and decision making occurring as close as possible to the level at which services are provided to the community. The 1973 Bright report (Committee of Enquiry into Health Services in South Australia 1973) discussed in Chapter 4, recommended regionalisation in order to enable local responsiveness to the health needs of the population. In proposing a new structure for the administration of health care in South Australia, the report recommended:

> The organisation (central health authority) should provide for the decentralisation of health services by regionalisation with as much local responsibility as is consistent with good organisational control. The citizen should not be the client of one doctor or one hospital or one power but the client of a regional health system. He should be able to "plug in" to the health

system at the right time, place and level appropriate to his problem. To be accessible and yet comprehensive the regional system must be linked to a population catchment area large enough to support it. It would then permit the amalgamation and teaming of services into economic units and the full potential of modern community based health care can then be realised (Committee of Enquiry into Health Services in South Australia 1973, p311).

Consistent with this recommendation, 'sectorisation' was implemented from 1981 so that central, southern and western sectors were given responsibility for decision making about service delivery across metropolitan and rural areas, and health units were legally incorporated and given greater autonomy. Subsequently, the Taeuber review of 1986, also referred to in Chapter 4, resulted in the abolition of sectorisation and the establishment of three central operational divisions, Metropolitan, Country and Statewide Health Services Divisions as well as central divisions to draw together previously dispersed strategic policy and corporate functions.

No further attempts were made to resolve these issues until the release of a SA Health Commission discussion paper titled *Area Health Service Administration in South Australia* (1991). This document proposed the establishment of Area Health Services and Boards (in line with the National Health Strategy and the model implemented in NSW) that would take responsibility at the regional level for operational decision making about resource allocation and service planning for hospitals and community health services. The response from health care agencies to the discussion paper was overwhelmingly negative, with submissions favouring the retention of individual boards for country hospitals and expressing concerns that metropolitan community health services could be "swamped" by the large hospitals. Submissions also emphasised the importance of community involvement on boards and the necessity to pursue primary health care approaches (a legacy of the Whitlam Government's national Community Health Program initiative discussed in Chapter 2). There was however general support for Area Health Service Associations in the country (voluntary regional associations of separately incorporated units) and for strengthening regional planning initiatives in the metropolitan area. In the Adelaide metropolitan area, the SA Health Commission's commitment to regional planning and priority setting led to the establishment of three Planning Units in 1993 in the

southern, central and northern areas of Adelaide which had a focus on community consultation and participation in health care priority setting and planning processes, consistent with the participatory model of governance described above. The Planning Units were subsequently de-funded in 1996 following a change of government.

At this time (1996), there was continuing debate about the appropriate regional structure for the metropolitan area of Adelaide. Community health centres were amalgamated into regional groupings. There was much discussion within SA Health Commission Central Office about whether the metropolitan area should be treated as a single region, or, if multiple regions were established, about the appropriate number and boundaries for these regions. Before this issue was resolved, the SA Health Commission became involved in an extended process of realignment to a purchaser-provider model of health service funding (discussed in Chapter 4). This process took priority and shifted the focus of the SA Health Commission away from resolution of the metropolitan regionalisation debate. In the next year, and prior to the completion of this process, the Commission was included within the newly created Department of Human Services.

The new Department of Human Services incorporated the publicly funded health, community welfare and housing sectors within South Australian government. Given the intention to build an integrated human services portfolio from these separate sectors, the new Department gave priority to integration across the different sectors, rather than encouraging internal integration within each sector. Consistent with New Public Management rhetoric discussed in Chapter 2, its other clear mandate was to contain costs, and as the health system was seen as the most significant impediment to achieving this goal because of continual hospital budget over-runs, the political nature of the health system and the sheer size of the health budget, the health system was viewed as particularly problematic and requiring significant central control. As a result, the creation of the Department of Human Services led to a strongly centralising tendency not just for policy direction and coordination, although these

were key rationales for this focus, but also for resource allocation decision making, clinical services planning and strategic planning.

Throughout the period from the time of the establishment of the SA Health Commission in 1976, there has been evidence of the tension between the desire to regionalise to achieve the objectives of local community responsiveness and flexibility in service planning and resource allocation, and the contradictory wish to centralise in order to manage a tightening health budget and to improve coordination where fragmentation within the system was consistently identified as a key issue of concern by all stakeholders, from consumers through to politicians.

The aim of centralisation is generally seen as a negative central bureaucratic response, particularly when viewed from a New Public Management perspective. However, it can often be a consequence of decentralisation and the resulting fragmentation and disparity of access to services between different regions, leading to a need for increased central coordination (Peters and Savoie 1996). 'Sectorisation' within the SA Health Commission and its subsequent disbanding are examples of this shift to decentralise decision making and the subsequent reversion to centralised control again. The continuing tensions between these contradictory yet linked policy directions within the South Australian health system have contributed to the ongoing debate about the future organisation of health care in the state. There is not a simple dichotomous 'either/or' answer to this dilemma. Rather, solutions continue to be sought along a continuum of options that seek a balance between centralisation and devolution, even though the reaction often appears to be a 'pendulum swing' between these two approaches. Rhodes explains the relationship basis for this ongoing tension:

> Fragmentation and centralization coexist. There is a persistent tension between the wish for authoritative action and dependence on the compliance and action of others (Rhodes 1997, p15).

Subsequent sections of this chapter, and Chapters 7 and 8, describe the tensions that developed between the central bureaucracy and the participating health care agencies

during the Designing Better Health Care in the South process. It is evident when reflecting on this time, that both the central bureaucracy and the four participating agencies had different understandings about each others' motives and aims, and that this lack of common understanding contributed to the significant tensions that developed between the two groups as each tried to control or direct the agenda. These differing motives and aims are considered in the remainder of this chapter. The final sections of the chapter use data from the case study to consider the implications of the tensions between centralisation and devolution on the outcomes of Designing Better Health Care in the South.

Differing perspectives on Designing Better Health Care in the South

Designing Better Health Care in the South was seen by participating individuals as an opportunity to improve the way that services were provided through improved regional coordination and integration, as well as providing an opportunity for the agencies involved to coordinate and manage their growing workloads and costs in order to keep within budget. The tendency of the newly created Department of Human Services to centralise control over decision making across the human services sectors for which it had responsibility was seen by participants in Designing Better Health Care in the South as a major impediment to the achievement of their goals. This was a commonly cited concern in phone interviews, raised in 24 of the 29 interviews (83%) as a significant impediment to the implementation of Designing Better Health Care in the South (discussed in Chapter 5).

The frustration at the increasing centralisation of control by the Department of Human Services would have been further accentuated by the agencies' history of independence, confirmed in their legal incorporation in the 1970s along with the creation of their separate Boards of Management, which led them to have a strong sense of the importance of their independence over which they perceived that the former SA Health Commission should only have broad policy influence. The Department's approach at this time, which was intended to shift the balance of power from the established powerful medical interest group (demonstrated through the

major focus on hospitals and medical clinicians in the health system) to the central bureaucracy, arose from the Department's lack of confidence in the ability of this powerful interest group to accept a change in focus from health to the broader human services portfolio. This view led it to adopt a strategy of excluding medical clinicians and those involved in acute care from participating in Departmental decision making and planning. This issue is discussed in Chapter 8, and was a significant reason for the lack of Departmental support for the regionalisation proposal put forward by the four agencies, which added to the tensions between the bureaucracy and the health care agencies at this time.

Participants who had contributed to the development of Designing Better Health Care in the South consistently expressed concern about a highly centralised approach to planning. Centralised approaches were seen by those working in the agencies to be slow and out of touch with the issues faced by service providing agencies. This was reflected in a number of comments from individuals who contributed to the development of Designing Better Health Care in the South during phone interviews and focus groups, for example:

> *I think that like with any centralised process it happens slowly and happens in a cumbersome way and is not necessarily in touch with the particulars at the coal face and my concern would be that the things that need to happen may not happen at all because of the sort of unwieldy nature of a highly centralised process. (Phone Interview 1 – Senior Manager)*

Despite this concern, there was also acknowledgment among agency senior managers of the important role that the central bureaucracy played in providing policy direction and '*big picture planning*', particularly given the relatively small size of South Australia's population and the need for coordination across regions and human service providers. For example, a senior manager commented in a focus group that they felt the Department inhibited the implementation of the model of regionalisation proposed through Designing Better Health Care in the South:

> *Inhibitor may be being a little bit too strong, it is definitely not a facilitator and having said that I think it's been trying over recent months to facilitate getting the hospitals together and I think that's an issue on a southern area level, and I don't know how long ago it was that following quite a lot of*

discussions with (a Departmental Executive Director) about – we've got to do some joint planning and some joint work in the south, it doesn't actually make sense not to be doing that, but a very clear view from him that he wanted to be involved and wanted to lead that, but then a problem in terms of time and capacity at their end and competing priorities. ... But I suppose I actually feel that we're trying to drive it and we want to drive it and the Department isn't able to respond and engage itself as quickly and as pro-actively and with the level of resources that, if it wants to be a player, that it needs. ... I think there is a need in a place as small as South Australia not to just let people go off and do, you know, in terms of the big picture planning, just go off and do whatever. I think it has to be done in a context but it's that needing to be involved at more of a managerial decision making level than just the sort of framework and policy level (Focus group – Senior manager).

However, the centralisation of planning within the central bureaucracy without input from service providers caused concern for health care providers who expressed the view that this would result in a separation of planning decisions from the reality of the work of the service providing agencies. (A similar concern had been raised about the purchaser/provider split). This was a commonly recurring theme in both phone interviews and focus group discussions:

I think the idea of health units cooperating in creating the future is a much more productive way to approach problems and issues than allowing either the force of events to push them one way or another, or alternatively to have a central bureaucracy which is yet another step removed from the client, like there are no patients at Citi Centre (the Central Office of the Department), and therefore the people at the centre of the empire want to have large amounts of information coming in, but are not getting the same emotion through that information. A person whose leg's been cut off, bleeding to death on the front doorstep doesn't happen to them and disturb them. ... They are necessarily driven by the budgetary arrangements that the state government entered into with the Commonwealth Government. (Phone Interview 24 - Industrial Representative).

As mentioned in Chapter 5, in both phone interviews and focus groups, agency participants and a representative from the Department suggested that the Departmental view of Designing Better Health Care in the South was that its unstated purpose was to build a power-block in the region which would be able to influence the health agenda and budget decisions of the state to its advantage. For example, respondents explained:

They don't know and I suspect also they don't want certain things. They don't want a powerful board in the south. They don't want something that is going to develop into an organisation with a bit of clout because – and they don't want another layer of control or whatever you like to call it above the existing Boards. And I think they might see Health Care in the South as imposing another level of control. (Phone interview 19, Board member)

That has been a real issue with the south hasn't it? We have been trying to take a metropolitan look at public hospital services and that hasn't fitted in neatly with the aspirations of the southern hospitals. ... The southern alliance was established and attempted to be a formal body whereas the other remainder of the system wasn't that organised. (Focus group, DHS Senior Executive)

Participants in Designing Better Health Care in the South were also seen by Department of Human Services Senior Executive staff as being recalcitrant in appearing not to comply willingly with a strategic system-wide approach to the management of human services (discussed further in Chapters 7 and 8). An extract from the Department of Human Services' focus group discussion illustrates this point:

Executive Director 1: *Flinders is a good example where I think they see themselves still as a fairly independent unit and do their own strategic planning, probably without enough reference to the overall, but that is not unique to Flinders.*

Executive Director 2: *It is probably a bit of an issue about the south, you know, Better Health Care in the South, I think that has been a point of some confusion or contention at various times about the extent to which you, actually in a state like South Australia, you actually have the little groups, south, north, west, east or whatever it might be, and certainly in trying to implement the strategic plan for information management etc, that has been a real issue, so the extent to which you can group people in the south versus having continuity amongst all of the dom. cares (domiciliary care services) or all of the hospitals.*

The Senior Executive of the Department viewed centralisation as a necessity arising from the significant shift in its view of the health system that resulted from the adoption by the Department of a broader human services focus. The predominant view among Departmental Senior Executive staff was that centralisation was necessary in order that this level of change could occur and bring about a more integrated human services system. This consideration, combined with a lack of

confidence in the ability of the hospitals in particular to operate beyond their own institutional self interest, resulted in the creation of a highly centralised and controlling approach from the Department which caused significant concern among the Designing Better Health Care in the South agencies. In describing the Departmental perspective as it was presented to her by a member of the Senior Executive when discussing the lack of Departmental support for Designing Better Health Care in the South, a member of the Designing Better Health Care in the South project team explained:

> *It was interesting in the conversation with (a Senior Executive) last week, he was saying why do you think the centre took the decision it had? His view was that I think, you can't trust hospitals to be responsible for other services. They have such a momentum and self interest in their services that they can't possibly be expected to embrace the full health spectrum. (Phone interview 25, Project manager)*

The different perspectives on the centralisation/devolution debate held by the Department of Human Services and the agencies in the field are apparent from the above discussion. The discussion also highlights the level of anxiety and distrust that was very evident during this time of effort to achieve major transformational change in the health system, both from the central bureaucracy and from the group of agencies who proposed a regional change strategy as a way to address the issues that they held in common and identified as of significance to them as a group.

This divergence of views and interests is in part a result of the different policy agendas being pursued. The Department of Human Services was attempting to meld the differing components of the new human services portfolio which had different philosophical bases and views of their roles. As mentioned previously, concurrently with expounding an integration agenda across the portfolio, the Department of Human Services was also attempting to manage a budget that was consistently over-extended, largely as a result of the hospitals' inability to stay within their budgets. Similarly, the hospitals involved in initiating Designing Better Health Care in the South were struggling to manage within increasingly constraining budgets while responding to the growing day-to-day pressures of health care delivery and also

seeking to achieve their own priority agenda of improving the way that their services were provided.

For both the Department and the health care agencies the aim of integration was central to their approach. However, the Departmental centralising agenda conflicted with that of the agencies which was also in a sense one of centralisation, but at a regional rather than a statewide level. In contrast, the centralising agenda of the Department of Human Services was an effort to control and manage change in order to create an integrated approach from a complex and diverse variety of services and systems, combined with a lack of confidence in the health system itself to support and implement this agenda at the service level. A lack of trust and the increasingly difficult and conflictual relationships between the central bureaucracy and health care agencies were key factors that contributed to this determination to centrally control the highly complex and political health system. These issues are elaborated on further in Chapters 7 and 8.

The centralisation/decentralisation conundrum – a 'wicked' problem

Efforts to improve the performance of the public sector through the implementation of different models of reform seem to continue endlessly through the 'tireless tinkering' of a variety of actors in many countries (Peters 2001, p118). Toonen states:

> Rather than a discrete period of intense, deliberate and well understood 'public sector reform', the period of the past fifteen to twenty years may also be looked upon as an intensified stage of a permanent and continuous reform process (Toonen 2001, p200).

The experience of continuous and permanent reform, a phenomenon described in this thesis as churning, has become a strong feature of the South Australian health system and provides the background to the case study of Designing Better Health Care in the South. When the full picture of reforms are mapped out, as has been done in the history sections of this thesis, it is clear that a large number of changes have been trialled, adopted and adapted, not all of consistent direction, and that the

centralisation/decentralisation conundrum has been an ongoing and underlying dilemma which continues to be unresolved and to create dilemmas in considerations of appropriate models of governance[21].

The centralisation/decentralisation 'pendulum' periodically shifts the focus between 'hands-on' and 'hands-off' government, between centralisation and more autonomous self-steering inter-organisational networks. The tension between centralisation and decentralisation is a result of a dual dilemma – a search for appropriate models of accountability, control and steering for a complex system; and a search for appropriate models of coordination to facilitate interagency collaboration among a complex range of organisations (Flinders 2002). These factors are not necessarily mutually exclusive but contribute to the centralisation/decentralisation conundrum which appears to be an insoluble or 'wicked' problem. 'Wicked' problems are described as such because they are ill defined, complex and subject to conflicting and often competing perspectives, and do not fall within conventional policy divisions or the realm of single organisations to resolve. They are also the domain of multiple, often competing, stakeholder interests (Rittel and Webber 1973). Attempts to address such problems with single or simplistic goals, and without a basis in interagency collaboration, can have unanticipated consequences and can lead to continual change as a result of constant attempts to make adjustments and correct errors as they emerge (McKinley and Scherer 2000; Fougere 2001). This certainly appears to be the experience of reform within the South Australian health system.

Rhodes describes the contexts in which a centralised traditional hierarchical bureaucratic approach is most appropriate:

> If the aim is to experiment with service delivery systems, if there is no correct way to deliver services, it follows that there are conditions under which bureaucracy will be an effective tool. The key question becomes 'What might those conditions be?'. There are at least three possible answers. First, where

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[21] This issue and the resulting considerations of models of governance at both the system-wide and agency levels were dominant concerns of the South Australian Generational Health Review, undertaken in 2002-2003, and resulted in the regionalisation of the health system and the dismantling of the Department of Human Services and re-establishment of a Department of Health on 1 July 2004.

fragmentation produces sub-optimal outcomes, bureaucracy provides central strategic capability and opportunities to integrate policy and implementation. Second, where fragmentation produces independent agencies, poor communications with the centre and reluctance to follow central guidelines, a unified bureaucratic hierarchy reduces such control problems. Finally, where fragmentation diffuses accountability, a unified bureaucracy is a focal point for ministerial accountability to parliament (Rhodes 1997, p109).

As devolution has been found to result in fragmentation and problems of accountability and strategic planning, there will always be a requirement for a central bureaucratic hierarchy to address these issues at a systemic level. However, given the increasing focus on the need for local responsiveness and flexibility, any central hierarchy will also, of necessity, need to be supported by close links to and effective relationships with a level of devolved regional planning and resource allocation. Hence, this is a wicked problem.

Part of the reason for continual efforts to find a solution alternatively between centralised and devolved approaches is that, typically of wicked problems, each change generates unanticipated and unintended consequences that result in the perceived need for further change. Savoie explains:

> … reform is more a continuous than a discrete process. Even if a reform is successfully implemented, it is likely to generate a need for a new round of reform. This outcome appears to be a function of the location of most reforms along a continuum of organizational characteristics, so that moving toward one end or the other soon produces a perceived need to move back again. The current round of reforms, for example, tends to be decentralizing so that before long we should expect a return to more centralized organizations. ... Reformers wishing to "fix" government operations once and for all will invariably be disappointed (Savoie 1998, pp401-2).

This dilemma, together with an understanding of wicked problems, provides some explanation for the apparent churning within the health system, as one health system reform replaces another that has generally not been fully implemented or given adequate time to be consolidated and evaluated. The centralisation and decentralisation dilemma is not a new problem to South Australia and many solutions to this dilemma have been trialled in the past. Understanding this as a wicked

problem helps to explain the pendulum swing phenomenon which is particularly evident in the history of regionalisation/centralisation in South Australia.

The next chapter discusses the issues of trust and collaboration, using Designing Better Health Care in the South to illustrate the impact of trust and mistrust on interagency collaboration for organisational change and health system reform. The development of relationships of trust and collaboration are fundamental to managing a complex system where governance is decentralised and the central bureaucracy has to find ways to guide system development and function without having access to direct management and control.

Chapter 7

Trust and the Management of Organisational Change

Trust and the effective management of mistrust are fundamental to the functioning of interagency collaboration and to successful organisational change. In this study, trust and the management of mistrust were found to be key foundations for the work undertaken by the partner agencies to progress Designing Better Health Care in the South, and the loss of trust, both from the Department of Human Services and between the agencies themselves, was instrumental in the demise of Designing Better Health Care in the South.

This chapter discusses and analyses the important role of trust and mistrust in the efforts to implement Designing Better Health Care in the South. It reviews the literature on trust in and between organisations, in particular in relation to the impact of trust on governance processes and structures and on collaboration, and relates this to an understanding of the processes used to implement Designing Better Health Care in the South. Interagency collaboration is an important mechanism to achieve improvements in health care provision and health service management. Therefore, this chapter discusses the centrality of trust to the successful implementation of activities that build interagency collaboration. It analyses aspects of the history of Designing Better Health Care in the South to illustrate this issue and discusses the importance of managing mistrust effectively in order to both provide the foundations for the development of trust relations between individuals and organisations, and to avoid the negative consequences of unmanaged mistrust on relations within the health system and between its key participants. The chapter concludes with a discussion of the importance of system leadership, trust, shared goals and values and the careful management of mistrust, as the basis for health system reform.

The data sources used in this chapter provide multiple sources of evidence of the role of trust in organisational change and include:

- transcripts from 29 phone interviews carried out between 23 March and 30 April 1999

- transcripts from 5 focus groups involving 37 people conducted between August 2000 and January 2001

- a staff mail survey sent out in early to mid-1999 to a stratified random sample of staff. The sample reflected the occupational profiles (including medical, administrative, nursing and allied health staff), and the relative sizes of the four agencies as well as including a number of smaller agencies for which they had responsibility.

- the journal which I maintained throughout the time of data collection for this study (1998 – 2001), and the review papers that I prepared every six months based on this journal for discussion and reflection with the project reference group.

Each of these data sources provides different perspectives on the issue of trust and organisational change, including perspectives from those individuals who led the Designing Better Health Care in the South process, from Senior Executive staff of the Department of Human Services, from the staff of the agencies who had had varying degrees of contact with Designing Better Health Care in the South but who were experiencing significant ongoing change in the health system, and from the perspective of researcher and observer.

Trust has become recognised as a central requirement for an effectively functioning organisation and for the development of collaboration within and between organisations (Mishra 1996; Rousseau 1998; Bruhn 2001). Trust is a vital component of an effective and well coordinated health system. In the absence of relationships of trust across organisations, a systemic approach requires a strong, hierarchical leadership that actively manages the level of mistrust in the system (Hardy et al. 1998). The effective functioning of organisations where trust relationships are absent

also requires the presence of rules that direct interagency collaboration, and so provide opportunities for the development of trust through the construction of shared meaning and synergies (Forester 1989). The presence of trust enables a system to function more flexibly and responsively and enables interagency and network relationships to be established and developed. At a time when hierarchical structures are increasingly being replaced by flatter more lateral alliances and structures within health systems, reflected in changing governance structures and moves to more fluid network models, effective negotiation skills and skills in managing mistrust and in developing trust are increasingly important (Tyler and Kramer 1996). This situation proved to be the case in the Designing Better Health Care in the South case study.

Defining trust

Over the last decade, trust has become a growing focus for consideration in a number of social sciences, including psychology, sociology, anthropology, political science, economics and history. However, each social science discipline has approached the subject of trust with its own specific lens and attempts to integrate these different perspectives have been limited (Lewicki and Bunker 1996). During this time, the concept of trust has lacked definitional clarity having been given multiple meanings both within and between different social science disciplines (Misztal 1996). This has resulted in significant conceptual confusion in relation to the role of trust in social life (Lewis and Weigert 1985). More recently, the focus has broadened from being solely on trust as the basis of social relationships between individuals and social groups to also include the emerging issue of trust within and between organisations (Creed and Miles 1996).

In bringing together the common elements of a number of definitions of trust from the literature, Misztal explains:

> The main common characteristic of trust, using *Webster's Third New International Dictionary*'s formulation, is its 'dependence on something future or contingent; confident anticipation'. The trust features are thus derived from the contingency of social reality and they require a time lapse between one's expectations and the other's action. What makes trust so

puzzling is that to trust involves more than believing; in fact, to trust is to believe despite uncertainty. Trust always involves an element of risk resulting from our inability to monitor others' behaviour, from our inability to have a complete knowledge about other people's motivations and, generally, from the contingency of social reality. Consequently, one's behaviour is influenced by one's beliefs about the likelihood of others behaving or not behaving in a certain way rather than solely by a cognitive understanding or by firm and certain calculation (Misztal 1996, p18).

Trust is seen as the basis for stable relationships, necessary for the functioning of cooperation and of everyday interactions and transactions (Luhmann 1979). It entails risk and a willingness of the truster to be vulnerable to the trusted other. It is based on the expectation that the trustee will perform actions of importance to the truster without the truster having to control the trustee (Brockner et al. 1997). Trust relations are found where there is risk and uncertainty in decision making, and trust is instrumental in reducing this uncertainty (Luhmann 1979; Das and Teng 1998). Trust relations may also be found where there is little risk. However, in this context, trust is of less critical importance. Positive experiences and contacts between individuals within and across health care organisations can lead to an increase in trust between organisations and across the system. Similarly, as a result of negative experiences, where individuals experience the consequences of misplaced trust, or of a response of mistrust, trust between organisations and across the system is likely to diminish.

Trust in organisations

Trust always has its basis in relationships between individuals. To suggest that organisations can trust each other reifies the organisation and denies the essential role of individuals as the actors within the organisation. However, organisational cultures can promote trust both within and between organisations in the sort of behaviour that is encouraged and deemed acceptable, and the extent and levels of delegation and sharing of responsibility across the organisational hierarchy. Ring and Van de Ven (1994) argue that individuals' roles are defined by the organisations in which they work, although they do have some capacity to perform their assigned role in preferred ways. However, the individual is constrained by the organisational environment.

The organisation can either constrain behaviour that promotes and generates trust or that does not.

Luhmann argues that a lack of trust makes the complexity and sustainability of a system impossible to manage:

> By means of trust, the truster unburdens himself of complexity which he cannot sustain. Anyone who wishes to abuse his trust must take this complexity upon himself. He will have to burden himself with complex demands on behaviour, to ensure the most wide ranging command of the relevant information and complete control of the information available to the truster, with the result that he himself will be in danger of collapsing under the pressure of complexity (Luhmann 1979, p63).

In many instances this trust has been formalised through rules and protocols that determine behaviour and give predictability to intra-organisational arrangements, such as human resource issues. However, in the more changeable nature of daily organisational business, where individuals in different sections of a large organisation must interact, or where functioning requires effective relationships between organisations, relationships of trust are important, or of necessity are replaced by strategies that manage mistrust, such as rules and sanctions. In the case of intersectoral relationships, there are less likely to be rules governing relationships. This can make the management of mistrust and the building of trust more challenging, relying on developing goodwill between individuals in the different sectors, strong collaborative intersectoral leadership and common agreed goals. This was found to be the case in the interagency collaboration being developed between the agencies involved in Designing Better Health Care in the South. Initially, with a strong history of successful collaboration, a committed and supportive leadership and mutually agreed goals, opportunities for interagency collaboration were actively sought and the development of trust between the different agencies was enhanced. Following the cessation of Designing Better Health Care in the South and of the regional Southern Network Coordinating Committee, which comprised the Chief Executive Officers and Chairs of the Boards of the four agencies working together to promote a regional approach to health care delivery issues (described in Chapter 5), the interagency relationships began to breakdown and the focus increasingly returned

to being on the individual institutions. This issue will be discussed further later in this chapter.

Trust in the health system

Succi et al (1998) found that in US community hospitals, trust is a critical factor in effective work relationships between managers and physicians. Trust relationships foster common goals and allow the parties to work together to pursue their mutual interests and align their risks and rewards without fear of betrayal. Succi et al (1998) argue that trust is enhanced when each group obtains greater power in hospital decision making and a greater capacity to ensure that decisions address the interests of both groups. They found that the current health care environment is resulting in trust being eroded between managers and physicians with the increasing focus among managers on priorities of conserving resources and containing costs. These priorities can conflict with clinicians' aims of providing highest quality patient care and best clinical practice, by constraining the clinicians' capacity to achieve these goals (discussed in Chapter 8). This discussion highlights the understanding of the health system as a negotiated order, which requires the negotiation of differing priorities and interests in order for the system to continue to function effectively (described in Chapter 3). Strauss explains that negotiated order:

> … points to the lack of fixity of social order, its temporal, mobile and unstable character, and the flexibility of interactants faced with the need to act through interactional processes in specific localised situations where although rules and regulations exist nevertheless these are not necessarily precisely prescriptive or peremptorily constraining (Strauss 1993, p255)

Understanding the health system as a negotiated order emphasises the important role that trust and mistrust have within the health system. These elements, in combination with power and control (discussed in the next chapter), are fundamental in determining the nature and effectiveness of the ongoing negotiations that occur and their influence on the functioning of the system.

Within an organisation such as a hospital, trust is both a prerequisite and a consequence of responsible clinical autonomy, as Degeling et al explain:

> …relations between clinicians, funders, hospital managers and, ultimately, patients depend, to a significant degree, on a taken for given presence of two related factors: namely that stakeholders (such as patients and funders of care) trust clinicians and secondly a belief that, in keeping with the autonomy which they enjoy, clinicians will act responsibly. What is important here is that 'trust' and 'responsible autonomy' are each a precondition for the other (Degeling et al. 1998b, pp257-258).

This is as true at the system level as it is at the clinician and manager level. Both the relationship between the responsible autonomy of the health care provider and manager, and the central bureaucracy's trust that the health care agency will fulfil its responsibilities, are important for a strategic and coordinated approach to the management of the health system and to the functioning of the health system as a negotiated order. Without trust and respect between bureaucracy and agencies, it is difficult for costs to be controlled, rationalisation and coordination of services to occur, and change to be successfully implemented. Relationships of trust enable these groups to identify and work towards common interests. Where trust is lacking, the struggle for control and for competing interests increases the conflictual, rather than collaborative, relationships between these groups. The playing out of the consequences of relationships of trust and mistrust within the system was evident in the case study of Designing Better Health Care in the South, both between the participating agencies and between the agencies and the Senior Executive of the Department of Human Services.

Trust and mistrust in the case study

In the early development of Designing Better Health Care in the South, when the proposal was supported by the SA Health Commission, a level of trust between the bureaucracy and the agencies was evident. This support was demonstrated by the SA Health Commission having representation on the Southern Regional Health Service Steering Committee which undertook the planning and consultation process from March 1995 until April 1998, prior to Designing Better Health Care in the South, and

disbanded following the submission of the final report to the Department of Human Services. The support of the SA Health Commission was commented on in both phone interviews and focus groups. A focus group participant commented:

> *Looking back on it, it seems that we had a window there where the central authority of the Health Commission was saying "Yes if you'd like to establish collaborations aimed at improving health care delivery and perhaps efficiencies", it was mainly about quality of care, "then we will work with you, we will support that. But the running is up to you, you take the initiatives, we are not going to try and control this. We are here to help and presumably if you do anything that upsets us, we will let you know." (Focus group, Senior Manager)*

In discussing the change of policy that occurred with the establishment of the Department of Human Services, a phone interview respondent explained:

> *I was at a meeting when the representative from the then Health Commission was there and they read out the thing from the Chief Executive Officer of DHS (stating that structural change would not be acceptable) and I said I thought it was absolutely disgraceful that the Health Commission had a representative coming to the meetings most of the time. I don't think there were many apologies. They knew, they had all the minutes. There had been intentions, the background, everything and at no time did they give any indication that it wasn't a goer. There was support all the time, giving people I think false hope. (Phone interview 21, Industrial representative)*

As mentioned in Chapter 6, the data collected for this study indicated that the Department of Human Services had a different view of health care agencies, particularly hospitals, and of the health system from the former SA Health Commission (although there was also evidence of attempts to increase control and accountability by the Health Commission during the separation of purchaser and provider functions for example, as described in Chapter 4). It viewed them with distrust and sought to bring them under central control. This was discussed by 24 phone interview respondents who predominantly expressed their disappointment at the loss of support, with one respondent reflecting a common view by explaining their understanding of the Departmental position: *"You maintain control because you don't trust the hospitals to get it right."* Consistent with this understanding, a Department Senior Executive suggested that the hospitals could not be trusted to

move beyond their own self interest to take responsibility for the full spectrum of care.

The data from this study suggest that the Chief Executive of the Department of Human Services sought to incorporate health services within the broader range of human services, and emphasise community based human services rather than acute hospital care. A focus group participant gave an example of the consequences of this within the Department:

> *The Chief Executive is clearly taking a very strong line about stopping Statewide (the Department of Human Services Division responsible for metropolitan hospitals) going off at what she sees as a tangent, and one of the things that's slowed down a lot of the metropolitan clinical services planning studies is that when they have got to the Chief Executive, and the Obs. and Gynae. one is a perfect example, is that she has said well this is all just totally hospital focused and why isn't it broader than this? And they have done more work across the Department and they have now launched this document called "Healthy Start" which is actually trying to pull together a lot of other work that has been done in terms of trying to support families and parenting and a whole range of other things. And again a couple of the other clinical services reviews that were very much metropolitan hospital focused have got stuck because they want to do lots of work looking at the country-based services. So I think that she is actually trying very hard to stop people working in silos, so we are seeing a change of language ... and a change in terms of this will have to go through this or that will have to go through that, but having said all that, it is still very bureaucratic and from where we actually sit I think it feels that nobody can make a decision. (Focus Group, Senior Manager)*

As discussed in Chapter 6, the effort of the Department of Human Services to centralise control of strategic planning and integration was an indication of the Department's strong perceived need for control of the system and its lack of confidence in the agencies to operate outside of their own interests. Focus group discussions about the relationship between the Department and the agencies suggested that the term 'health' was no longer acceptable within the Department. This was a strong theme in the three service provider focus groups, as well as in the phone interviews. As a focus group participant explained:

> *In the broader sense, we don't have a Health Department, and out of the latest DHS reorganisation, the super-department, you now don't mention the*

"H" word. I mean health in the Department is almost a dirty word and when you look at, there are some excellent people, don't get me wrong by this comment, but when you look at the senior appointees in DHS, they're not health oriented and they have an aversion to talking to clinicians. (Focus group, Senior Manager)

Similarly, a respondent commented in the staff mail survey that they would like to see:

More support for health from the DHS. There appears to be a real anti-health focus by the CEO and delegates. There also appears to be little understanding of bureaucrats regarding primary, secondary and tertiary levels of health and the fact people move across the health continuum constantly and that funding needs to be provided to support the population. (Staff survey, Nurse clinician)

'Health' was perceived by those in the health services as being interpreted narrowly by the Department Senior Executive to mean 'medical', and the sense of exclusion and loss of influence experienced by clinicians and medical practitioners were clear indications of this lack of trust in them and their potential to make a useful contribution to Departmental planning. Focus group comments from the Department of Human Services Senior Executive were consistent with this "anti-health" perception. Department focus group participants seemed to perceive clinicians as having a narrow, territorial focus that resulted in reluctance to accept a broader human services approach. A participant in the Department of Human Services focus group said:

When I talk with clinicians often, and the more senior they are the more I see it, it is that they come from a very narrow perspective and get very frustrated when you try and work and link in some of the other things. (Focus Group, DHS Senior Executive)

In contrast, a focus group participant from a health care agency commented about the perceived lack of understanding about the health system in the Department:

On the broader level, I'd have to say that I quite agree with the principle that good housing is the foundation of health. I don't think anybody would argue about that. But I'm somewhat dismayed at the loss of people who are experienced in providing health services in key positions within the Department and we have seen some rather strange things happen as a result of that. (Focus Group, Nurse clinician)

Mistrust and a 'culture of blame'

Efforts to create top-down integration from within the Department of Human Services in 1999 separated hospital networks from primary care services and consequently were not consistent with the regionalisation aims of Designing Better Health Care in the South. Many respondents from the health care agencies believed that the Department's attempts to instigate central control and to undermine regional initiatives resulted in a break down in relationships between the bureaucracy and their agencies and the development of a culture of blame. In contrast, Department of Human Services focus group participants suggested that people in health care agencies were obstructive to change, territorial and uncooperative. People who participated in the agency-based focus groups suggested that the Department was uninformed, unsupportive of their efforts and 'anti medical model', resulting in a bias against the medical aspects of the health system, particularly hospitals. This resulted in a situation where each saw the other as the 'villain' and as intentionally obstructing positive innovations. These attitudes were apparently equally strongly held on both sides and are discussed further in Chapter 8.

In contrast, some community health service respondents found that their relationships with the bureaucracy had improved with the creation of the Department of Human Services. Two focus group participants discussed this:

> *I think we have got better, much better communication now. I'm from a primary health care agency and we certainly have much better contact, much better lines of communication and things than we ever had before. I would say that, you know, the old Health Commission, no one was really interested in what we did, whereas there is certainly a lot more interest and a lot more focus on what we do now. (Focus group, Allied health clinician)*

> *I think it varies with which primary health care organisation you work for then, because that is not the case for General Practice. (Focus Group, Medical clinician)*

Because the focus of community health services has always been on working across sectors, on working collaboratively and on adopting a primary health care approach, the cross-human services integration being promoted by the Department was perceived by some of the community health players as supportive of their role.

However, for hospitals that consume the majority of health resources, that can be seen as consistently exceeding their budgets and that predominantly operate on a medical model, this shift in focus appeared to have left staff feeling ignored at best, and distrusted and dismissed at worst. Feelings among clinicians that they were viewed negatively and that their opinions were considered invalid added to the resentment that developed towards the Department. A focus group participant commented:

> *Down here we're talking about collaboration but from the Department of Human Services' perspective, we should have FAYS (Family and Youth Services) and DASC (Drug and Alcohol Services Council) and the Housing Trust and everybody else around this table, and that's the way they are going ... I think health has been an enormous loser and people who are dependent on the health system are losing out enormously by what's been happening politically. And I say little "p" political, at the Department level. (Focus Group, Senior Manager)*

Brockner et al (1997) found that where staff trust organisational authorities, they are more likely to be supportive, even if the outcomes of the authorities' decisions appear relatively unfavourable. Therefore the support of managers and clinicians for reform in the health system is vital to the successful implementation of plans for change. Their trust in the decision making authorities, whether they constitute the central bureaucracy or the Government, is likely to increase the capacity of those working in the field to accept change which may lead to outcomes that may not be perceived as entirely favourable to their own agency or their interest areas because of their confidence in the intended goodwill of the decision making authorities (Brockner et al. 1997; Ham 1999; Griffiths 2001; Smith et al. 2001). However, the major challenge in securing this trust and acceptance of change is to address issues of power and professional dominance successfully (discussed in Chapter 8). The evidence from this case study suggests that the Department Senior Executive's attempt to address medical and hospital dominance within the health system through the exclusion of these groups led to a loss of support for the human services integration reform initiative and to a high level of disillusionment and disaffection with the Department of Human Services within many health care agencies.

In contrast, the careful management of trust and mistrust were key roles of the four agency Chief Executive Officers, and their leadership was crucial to the development of Designing Better Health Care in the South. Limerick and Cunnington explain the role of trust in organisational relations:

> The key value in networking, and the one that is most problematic for Western managers, is trust. … High levels of trust help reduce transaction costs. … Trust reduces uncertainty about the future and the necessity for continually making provisions for the possibility of opportunistic behavior among participants. … Trust lubricates the smooth, harmonious functioning of the organization by eliminating friction and minimizing the need for bureaucratic structures that specify the behavior of participants who do not trust each other. But trust does not come naturally. It has to be carefully structured and managed (Limerick and Cunnington 1993, pp. 95-96).

The Chief Executive Officers' leadership role in the development of Designing Better Health Care in the South and their management of trust and mistrust to build collaboration within and between the four agencies was significant. The undermining of this leadership role when Designing Better Health Care in the South became a covert activity affected the levels of confidence and trust of staff who had been involved in the early development of the project. The loss of clear leadership, which was a result of the Chief Executive Officers' increasing uncertainty about the acceptability of the project to the Department, contributed to the failure of Designing Better Health Care in the South to proceed.

Trust, leadership and interagency collaboration

The next section of this chapter discusses the important role of trust in developing interagency collaboration and the influence of trust and mistrust in determining the governance models that are adopted to facilitate or to direct collaborative action.

Gray provides a useful definition of collaboration and its key features:

> Collaboration involves a process of joint decision making among key stakeholders of a problem domain about the future of that domain. Five features are critical to the process: (1) the stakeholders are interdependent, (2) solutions emerge by dealing constructively with differences, (3) joint ownership of decisions is involved, (4) stakeholders assume collective

responsibility for the future direction of the domain, and (5) collaboration is an emergent process (Gray 1989, p11).

Collaboration is a process through which participants can see each other's perspectives on a problem, explore these differences in a constructive manner and search for solutions that are beyond their own vision of what is possible (Gray 1989). Walker argues that trust 'is an important enabling mechanism that makes collaborative action sustainable' (Walker 2001). Collaboration can occur informally or formally. Most collaboration between staff in different health care agencies occurs informally in an effort to meet local needs, or to address specific needs where agencies share common clients. As described in Chapter 5, informal and ad hoc collaboration around the needs of clients was the focus of service provider activity in the southern metropolitan area of Adelaide prior to efforts to formalise this by the Chief Executive Officers of the four agencies.

Collaboration allows agencies to maximise their resources, to integrate and coordinate service delivery and to build supportive relationships that provide a level of protection for all of the agencies in a changing environment because of their capacity to support each other and to find solutions collectively. However, the risks of collaboration for organisations are the loss of resources, autonomy and conflict over their territory, resulting in a need to determine whether the advantages of collaboration justify the risks (Hoatson and Egan 2001). Collaborating organisations need to have an overlap in core organisational objectives in order that a common goal can be defined and agreed upon (Labonte 1997). The decision to collaborate and the extent of any collaboration is inevitably based on the level of trust between the organisations, with a greater level of trust enabling greater risks to be taken in collaborating.

Interagency collaboration requires or results in vulnerability because control and power are shared when organisations work collaboratively. While trust is being developed and to manage mistrust, this vulnerability requires the development of governance structures that enable continuous monitoring and consultation in order to

reduce the risk of opportunism or self interest predominating (Marsden 1998). Regular monitoring can provide a forum for ongoing contact between the different parties and therefore can enable regular adjustment which minimises the possibility of errors and misunderstandings that can cause a breakdown of trust. In this way, consensus can be understood as a by-product of, rather than a precondition for, the success of organisational collaboration (Powell 1996).

The commencement of cooperative interagency relations is dependent both on building a basis of trust, which accommodates the necessary level of vulnerability, and managing the inevitable mistrust, which arises because of differing organisational and professional interests and the resulting power struggles or 'strife of interests' (Sax 1984) which are endemic in health systems internationally. The management of mistrust can be achieved through the use of monitoring and accountability mechanisms which also provide opportunities for increasing trust. This study has produced evidence that the Department of Human Services was perceived to undermine Designing Better Health Care in the South in order to centralise strategic planning. Therefore, the necessary foundation of trust was not present in the relationships between the Department and the agencies, making the development of cooperation and consensus across the health system around agreed goals unlikely at the time of the case study.

Leadership and collaboration

In relation to the early stages of Designing Better Health Care in the South, the development of trust between individual staff of the four agencies (in particular but not only the four Chief Executive Officers) can be seen to have contributed to the development of interagency trust and the building of trust across the region. Leadership is essential for the occurrence of collaboration (Fear and Barnett 2003). During the early development of Designing Better Health Care in the South, this leadership was provided collectively by the Chief Executive Officers to promote and encourage collaboration and joint cross-agency activities. Their leadership was

supported by the SA Health Commission initially, as the Commission endorsed and supported the process in its early development but was not perceived to dominate it.

Consideration of the impact of the development of trust relations between the Chief Executive Officers provides a useful insight into the role and impact that trust had on building opportunities for organisational change. The significance of these relationships was recognised by many of the staff from the four agencies and commonly discussed in both phone interviews and focus group comments. These trust relationships were generally viewed by respondents as something quite unique and surprising. For example, one participant in a phone interview commented:

> *And the way that the CEOs got on, because if you had had rivalry and competition between that group, I think it would have been, the personal survival stuff would have cut across the organisational bits and pieces. (Phone interview 18, Industrial representative)*

In discussing the significance of these relationships at the organisational level, a focus group participant explained:

> *When I got here I thought this is really something quite extraordinary because you've got a big tertiary teaching hospital which has a partnership with three smaller willing collaborators, and in the natural order of the jungle you would expect the three smaller collaborators to be very afraid of the big teaching hospital and it wouldn't be an easy relationship, there would be a lot of defensiveness. And it seemed to me to be something pretty special. (Focus group, Senior Manager)*

The relationships between the Chief Executive Officers were crucial to the progress of Designing Better Health Care in the South and to the agencies' agreement to move towards a regional model of health care delivery. The Chief Executive Officers themselves recognised the importance of regular meetings and dealing with issues as they arose as being crucial to the development of their relationships. In discussing this issue, one Chief Executive Officer said:

For a while there we were meeting about Designing Better Health Care in the South or the Southern Health Information Management Strategic Plan[22]. I was bumping into you guys 2 or 3 times a week. Having projects that bring you together I think has benefits well outside those projects, just the chat, the gossip, the understanding of what's going on, feeling we're in the same boat, we're trying to achieve the same ends. You're dealing with the rumours before they start to affect your thinking. They are particular projects that stand alone and you drive them for their own purpose but they do have beneficial effects in a regional setting. ... That has been lost to some extent now... just because we see each other a bit less frequently. And probably it was inefficient. It's not an efficient way to learn and talk about particular issues, but it helped that understanding. (Focus group, Senior Manager)

The Chief Executive Officers' relationships were based on a number of crucial factors that are evident in the history of Designing Better Health Care in the South described in Chapter 5, including the personalities of the individuals themselves, their history of positive experiences of working together leading to mutually beneficial outcomes, the perceived necessity to collaborate as a result of pressures on their individual agencies which they believed could best be resolved by functioning collectively, and their capacity to look beyond their institutional responsibilities to focus on seeking the most effective health care delivery approaches to improve the health of the population of the region. Most of these key factors were identified by Strauss as essential to the establishment of an effective negotiated order (Strauss 1978) (see Chapter 3). A focus group participant explained:

There was a sort of imprimatur, the permission, support from the four CEOs coming together to be able to say we are supporting working together. Now, I don't think we can ever underestimate what that really meant because what had occurred legitimised a lot of the contacts that were happening at the clinical level between whether it was allied health and nursing or joint projects, and to be able to really get successful collaboration it takes time but it also needs to have permission. I think that was a really important point even though the vision and goals and things and the original direction weren't achieved. (Focus group, Senior Manager)

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[22] A regional Information Management Strategic Plan development project that was funded by the SA Health Commission and the four agencies early in the life of Designing Better Health Care in the South and subsequently sponsored by the Southern Network Coordinating Committee as one of its regional planning projects (see Chapter 5).

These relationships and the factors that supported them were very significant for the development of trust within each agency and for the development of interagency trust. However, without the staff also building interagency relationships and having positive experiences of the outcomes of collaboration, the leadership of the Chief Executive Officers would not have been as effective in building a culture of collaboration across the four agencies[23]. In recognising the significant leadership of the Chief Executive Officers as role models in demonstrating interagency trust, it is therefore also important to acknowledge the role of relationships developing throughout the organisations, leading to a commonly supported readiness among staff to work collaboratively. Phone interview respondents and focus group participants discussed the impact of collaboration on staff. For example, two phone interview respondents explained:

> *There is a good basis, a good foundation, in terms of the relationships that I think exist between the health services that are there to build on. I mean it is sort of like a good faith type relationship. (Phone interview 2 – SAHC representative on Steering Committee)*

> *I think now there is a kind of, there has been cultural change generated in this process that's led to a kind of loyalty more or less strong in different parts amongst the agencies that says we do have common ground and we do identify a bit with each other. So that has been something that has facilitated change because it has been developing over many years rather than just having been imposed. OK so it's that gradual emergence of a sense of common ground over many years, longer than the duration of this project, has helped. (Phone interview 25 – Project Manager)*

With the lack of progress of Designing Better Health Care in the South and the Department's lack of support for the agencies' participation in this process, trust relations between the leadership were undermined. This had a particular impact on the involvement of Southern Domiciliary Care and Rehabilitation Service as the smallest, community based health care agency in the ongoing regional discussions. The Department of Human Services restructured in 1999 so that hospitals and community based services reported to different parts of the Department and were

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[23] The interagency projects initiated by the Chief Executive Officers represented an important strategy which provided practical opportunities for staff across the four agencies to build relationships of trust through working together.

actively discouraged from working together. Clear directions were given to the agencies that all planning should occur through the Department. Before the restructuring of the Department of Human Services, the leadership, long history of collaboration, common agreed goals and goodwill between the agencies was sufficient to build trust between the acute hospital and community based services. However, as described in Chapter 5, the combined impact of the Department's direction that acute and community services were to report to different Executive Directors, the change in two of the leading agency Chief Executive Officers, the regular meetings of the three hospital Chief Executive Officers following meetings within the Department, and the growing pressure from the Department for the agencies to cease collaborative activity, resulted in Southern Domiciliary Care and Rehabilitation Service becoming increasingly marginalised and *"out of the loop"*. The shift in focus and goals that came out of the lack of progress of Designing Better Health Care in the South and the increasing centralising pressures from the Senior Executive of the Department of Human Services were major contributing factors to the break-down of this collaboration.

Applying a model of transitional stages of trust

Lewicki and Bunker (1996) propose a model of transitional stages in which they identify three types of trust that are linked sequentially, so that the achievement of trust at one level is a prerequisite to and enables the development of trust at the next level. The three types of trust that are presented in this model include calculus-based trust, knowledge-based trust and identification-based trust. This typology of trust provides a useful framework for analysing the changing relationships between the leaders of Designing Better Health Care in the South.

At the first level, calculus-based trust is established between two parties who are entering into a new relationship without any prior history or knowledge of each other. Calculus-based trust is based on an economic calculation of rewards for trusting and being trustworthy, weighed against the calculated consequences of the threat of reprisal if the trust is violated, for example through damage to the violating party's

reputation. Therefore the short term gains for being untrustworthy or dishonest are balanced against the longer-term gains of maintaining a good reputation. Deterrence involves ongoing monitoring of the other's behaviour. The control of behaviour is central to this form of trust. At this first level, trust is fragile, partial and easily lost. Trust may not move beyond this level.

The second level of trust is knowledge-based trust which is established on the predictability of the other and the ability to anticipate the behaviour of the other based on knowing them well. This level of trust relies on information rather than deterrence and is based on a long-term relationship where there is a history of interaction which allows the two parties to expect each other's behaviour to be predictable and that each will be trustworthy. Regular and open communication is essential to knowledge-based trust, including the open discussion and resolution of problems between the parties. Trust may not be damaged at this level by occasionally inconsistent behaviour if the instance of inconsistency can be explained and rationalised. The agencies involved in Designing Better Health Care in the South initially were working effectively at this level of trust. Regular meetings between Chief Executive Officers and the Chairs of the agency Boards through the Southern Network Coordinating Committee provided opportunities for exchanging information and discussing problems that could have an impact on the agencies collectively, building on the pre-existing long term relationships and history of interactions between them. The Chief Executive Officers also met together regularly both formally and informally outside this forum.

The third level of trust is identification-based trust. This level is based on the party's identification with the other's wishes and intentions. This form of trust enables a level of understanding so that each party can act on behalf of the other. Identification-based trust is based on the factors described above and also on developing a collective identity, joint goals and shared values. Prior to the cessation of the Southern Network Coordinating Committee in September 1999, the Chief

Executive Officers regularly spoke on behalf of the collective group when attempting to gain Departmental support for their regional planning and activities.

In the evolution of trust through these stages, trust relationships may move through all three levels. However, not all relationships develop fully, most remaining at the first or second level. The movement of relationships from one level of trust to the next is dependent on the need for a greater level of trust between the parties and on the interdependence of the parties (Lewicki and Bunker 1996). For trust to develop through these three stages, organisations need to establish a history that provides a foundation of predictability and goodwill through the experiences of the individuals working within them (Sydow 1998). Violations of trust may damage a trust relationship, resulting either in the withdrawal of trust completely or in the reversion to a more risk averse, lower level of trust, depending on the severity of the violation and the level of trust which is currently shared between the parties.

In following the development of Designing Better Health Care in the South, the movement between these levels of trust is evident, firstly from second to third levels and then, following changes in agency leadership and pressure from the Department of Human Services, a reversion back to calculus-based trust, which requires monitoring and a calculation of risks and benefits for the individual agencies, rather than a collective view of risks and benefits.

Identification-based trust was evident to some extent in the early phase of Designing Better Health Care in the South between the four Chief Executive Officers, but was undermined by the departure of two of these leaders and their replacement by people without the history of these relationships or the collective sense of identity beyond their own agencies[24].

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[24] The earlier loss of two Chief Executive Officers of Southern Domiciliary Care and the Repatriation General Hospital (in early 1997) did not appear to have the same effect. This may have been because at the time that the first two Chief Executive Officers changed, they were not experiencing the pressure of the project not being supported by the Department. At the time the second two Chief Executive Officers changed (in December 1998 and November 2000) there was significant pressure from the Department for the agencies to focus on institutional rather than regional goals, and not to work

For example, when the Chief Executive Officers were working together, they established a number of cross-institutional arrangements for patient care and specialist advice that were not charged for between the institutions, but were provided because there would be a future benefit for the providing agency both in the enhancement of good relationships and good faith, and in the expectation of future reciprocity when it was required. My journal shows that in 1998 and 1999, the Chief Executive Officers were under pressure and experiencing significant criticism from the Department of Human Services both through correspondence to them individually, asking them to explain why they were continuing to discuss regional issues and requiring that they ensure individual agency accountability to the Department, and in individual meetings with Departmental staff when they were told that all planning would occur within the Department. At this time, the individual Chief Executive Officers spoke out on behalf of the four agencies, rather than solely representing their own agencies' interests. However, with a change of the Chief Executive Officer at Flinders Medical Centre, without notice the Repatriation General Hospital began to receive invoices for services that were previously provided reciprocally and without charge. This was a result of the severe budget constraints that all the hospitals, and particularly Flinders Medical Centre, were experiencing at the time, but it could be argued that it was also a result of a change of Chief Executive Officer and consequently a loss of understanding of the history of collaboration and the relationship of trust that had developed over time.

As a result, the relationship between the Chief Executive Officers shifted from being based on identification-based trust where the relationships between them were based on articulated shared goals and values, a history of working together and the preparedness to speak on behalf of the region, rather than solely for their own agency,

together. It is likely that this would have undermined the new Chief Executive Officers' commitment to Designing Better Health Care in the South because they did not share the previous positive experiences of working towards common goals.

back to calculus-based trust, where trust was based on calculations of benefit and institutional interests rather than collective and regional interests.

The data collected for this study suggests that the Department of Human Services played a key role in undermining the trust relationships between the Chief Executive Officers, and also between the Chief Executive Officers and the Chairs of the agency Boards. The Southern Health Services Liaison Group was formed after the decision was made by the Chief Executive Officers and Chairs that the Southern Network Coordinating Committee should be dissolved. As described in Chapter 5, at the first meeting of the Southern Health Services Liaison Group in March 2000, it became apparent to the Chairs and the Chief Executive Officer of Southern Domiciliary Care and Rehabilitation Service that the hospital Chief Executive Officers were meeting separately and making decisions which excluded them. The fact that none of the Chairs or the Chief Executive Officer of Southern Domiciliary Care and Rehabilitation Service were aware of the development of the Statewide Division's hospital clinical networks paper, which the three hospital Chief Executive Officers had received, was a significant indication of the disintegration of communication and collaboration between the Chief Executive Officers and Chairs, and the shift from a regional focus which involved sharing information with the Chairs collectively. At the final meeting of this group in June 2000, it was revealed that the Department of Human Services was progressing plans for the development of regional primary care networks. My journal documents a comment by the Chief Executive Officer of Southern Domiciliary Care and Rehabilitation Service after that meeting where he stated that this was where his agency would now be placing its energy.

At the peak of collaboration to develop Designing Better Health Care in the South, the Chief Executive Officers were clearly functioning at the third, identification-based level of trust. External pressures had a significant impact on these relationships, which reverted back to calculus-based trust, evident in much more fragile trust relationships that were increasingly easily damaged and undermined. The trust relationships within the Southern Health Services Liaison Group, which

included the Chief Executive Officers and Chairs, can be seen to have developed and declined separately from the trust relationships between the Chief Executive Officers. The Southern Health Services Liaison Group met less often (every three months), had less opportunities for informal interaction, and the Chairs were reliant on the Chief Executive Officers to involve them in discussions and decisions, and to share information about developments with them. This process clearly broke down as a result of the significant pressure from the Department of Human Services, resulting in the hospital Chief Executive Officers increasingly operating separately from the rest of the group. Consequently the trust relationships within this group were more severely damaged, to the point where the Chairs were very disillusioned with the process and felt betrayed by the Chief Executive Officers with whom they had previously had close working relationships (discussions between the Chairs reflecting these feelings were documented in my journal). This significant damage to the trust relationships within the group was a major contributor to its rapid demise.

The loss of trust in the leadership of Designing Better Health Care in the South

The Department's strategy to separate community based services from acute care was not necessarily intentionally destructive of Designing Better Health Care in the South, as the Department of Human Services' focus was on the whole metropolitan area rather than just the southern region. However this strategy had the effect of breaking down communication and trust and undermining the shared interest, and common agenda and vision that the group had built and maintained over a number of years. Fuelled by rumours and anxiety which arose from a lack of a formal Departmental response to the Designing Better Health Care in the South proposals, accompanied by many unofficial "corridor conversations" between senior Department Executives and the hospital Chief Executive Officers that appeared to be quite intimidating to the Chief Executive Officers, (reported in my journal), the Chief Executive Officers' capacity to continue to maintain a regional focus and to foster open relationships of trust was significantly weakened. The Chief Executive Officers felt unable to continue to communicate progress of the Designing Better Health Care in the South

proposal openly to the staff of their agencies because they had not had a formal response to the proposal from the Department of Human Services, and the negative messages from the Department were given unofficially. This lack of information undermined the relationships between the Chief Executive Officers and the Chairs of their Boards, as well as undermining the Chief Executive Officers' leadership of Designing Better Health Care in the South. The Chairs felt powerless and excluded as decision making was increasingly centralised and dominated by the Department of Human Services (a deliberate strategy by the Department to gain control of the health system). Staff in the agencies did not know what had happened to the proposal they had worked to support for some years and began to feel disillusioned and to lose their commitment to the process.

This was evident in the phone interviews that were conducted with people who had had significant input into planning Designing Better Health Care in the South and a number of whom were not aware of the reasons for the delay in progressing Designing Better Health Care in the South or of the existence of the Southern Network Coordinating Committee because of the decision by the Chief Executive Officers that it should operate covertly. A phone interview respondent explained:

> *It just feeds the cynicism of people who go along with good hope and enthusiasm that maybe this project will get somewhere and given this was sponsored by the Health Commission for God's sake and it was a long laborious process in the sense of making sure that step by step people were consulted. It was a careful process rather than laborious in that sense. I think some of us - well I know I felt what we needed was a Jeff Kennett almost to come in and say you will be networked and this is what will happen, and get going. But we went through the appropriate consultation stage and nothing has happened nor looks likely to happen with the current regime in power. (Phone interview 7 – Clinician)*

Some phone interview respondents also felt that the lack of progress would make staff more reluctant to become involved again. Two respondents felt that some of the agencies were now turning away from collaboration and towards managing their own budgets and "*looking after themselves*".

This description of one aspect of Designing Better Health Care in the South demonstrates the progressive move from relative trust and collaboration to mistrust, the importance of the environmental context, continuity of leadership and the presence or absence of open communication in building a culture of trust or mistrust within and between organisations. In their leadership capacity, the Chief Executive Officers had been able to articulate a common shared vision which provided the basis for support from the Chairs and the staff of their agencies for collaborative interagency activity and regional planning. The changed external environment undermined the Chief Executive Officers' ability to articulate their collective vision and joint goals and therefore their ability to maintain their agencies' commitment to and focus on regional planning and collaboration.

In a discussion on the findings of international research into business alliances, Kanter identified three foundations for successful alliances which can also be understood to support an effective negotiated order:

> They must yield benefits for the partners, but they are more than just the deal. They are living systems that evolve progressively in their possibilities. Beyond the immediate reasons they have for entering a relationship, the connection offers the parties an option on the future, opening new doors and unforeseen opportunities.
>
> (They) involve collaboration (creating new value together) rather than mere exchange (getting something back for what you put in). Partners value the skills each brings to the alliance.
>
> They cannot be "controlled" by formal systems but require a dense web of interpersonal connections and internal infrastructures that enhance learning (Kanter 1994, p96).

The fundamental paradox within interagency collaboration is that agencies by their nature are expected to pursue their own interests, but are simultaneously expected to restrain their self interest in order to make collaborative partnerships work (Das and Teng 1998), and, in the public health system, to promote the health of the community. This paradox creates tensions for the health system as a negotiated order. Competition between public sector agencies was encouraged with the introduction of economic rationalist approaches (Brown 2000) (discussed in Chapter 2).

Competition has been found to accentuate agency self interest and opportunism and therefore to work against collaboration and trust (Peacock 1997; Hoatson and Egan 2001; Walker 2001). Collaboration requires the surrender of some power in ways that can compromise individual organisational agendas (Charlesworth et al. 1996). In an environment of limited trust this may require taking a substantial risk. Wadsworth (1997, p95) states that the difficulty of working together to achieve change '… is in direct proportion to the level of paradox, contradictions and inequalities of power between the partners'. The challenge for the agencies involved in planning Designing Better Health Care in the South was significant given the power imbalance between the major teaching hospitals and the smaller agencies. However, initially a shared regional vision and positive experiences of collaboration enabled sufficient trust to be established to progress the planned regional model. The establishment of the Department of Human Services, and the involvement of its Senior Executive, which was clearly the most powerful and least trusting party with influence over the outcome of the proposed process and with very different goals from the agencies in the southern region, made the successful achievement of change unlikely.

Trust and control

Lack of certainty in the behaviour of the other agencies and the potential for opportunism to undermine collaborative efforts can be reduced by increasing strategies of control (Das and Teng 1998). Such strategies are consistent with calculus-based trust as discussed by Lewicki and Bunker (1996) and summarised earlier in this chapter. Just as trust enhances the *expected* probability of the trusted other adopting the desired behaviour, control mechanisms are intended to enhance the probability of the desired behaviours being adopted (Das and Teng 1998). This was the strategy adopted by the Senior Executive of the Department of Human Services.

A lack of trust reduces cooperation and increases transaction costs in cooperative efforts (Creed and Miles 1996). Tesoriero explains the challenge of creating new partnerships or collaborations:

Partnerships are the 'different' coming together – different agendas, interests and stakes. With difference and the strange comes the unknown. Here trust may be unrealistic, but excessive levels of mistrust may be destructive to the partnership (Tesoriero 2001, p54).

Consequently, the management of tensions between trust and mistrust is vital to successful collaboration. In new collaborations, trust is calculus-based, and therefore is more fragile or "thin". Expectations are high, as are reservations. A developing history of successes allows the "thickening" of trust over time as the trust is confirmed, the relationship moves into the second, and possibly the third level of trust, and certainty increases (Lewicki and Bunker 1996; Meyerson et al. 1996). Controls then become less important as the negotiated order becomes more stable and functions more effectively. A participant in a focus group highlighted the value of positive experiences of collaboration for the development of trust:

I would say that at a local level, the fact of doing connected things in itself reinforces a change of heart. The doing at a local level and collaboration across agencies in itself changes the agency that you belong to yourself, so that if the other agencies are for it and you are a bit wavery you tend to go for it because the other agencies are for it, so that it definitely seems to me that the whole is more than the sum of the parts. You can have agency 1, agency 2 and agency 3 doing their thing, put them together and something that is more than that comes out of it because of the interaction, and particularly I think because of the effect of the different agencies on each other, like the different silos being brought into conjunction changes the dynamics within them. Yeah, it is a challenge to your own agency's way of being and I have certainly seen it happen quite often, it moves things forward. (Focus group, Nurse clinician)

Collaboration and models of governance

Factors such as the form of collaboration and the extent of control required are significant in the determination of governance structures and the extent of control that these structures entail. For Designing Better Health Care in the South, the presence of close collaborative relations meant that it was acceptable to the agencies to propose the establishment of a single regional health service which would incorporate the four agencies. However, the lack of trust of the Senior Executive of the Department of Human Services demonstrated through concern about the potential

dominance that this model would give to the hospitals in the region and to health over other human services meant that this model, as well as the alternative 'second preference' option of a federated model were unacceptable and were consequently not topics on which the Department would negotiate. The lack of trust of the Departmental bureaucracy in the health care agencies, in particular in the hospitals, meant that the Department instigated a strongly centralised and controlling approach to strategic planning and "siloed" or isolated acute from community based services, which ultimately undermined efforts to establish a regional integrated model of health care delivery in the south at that time[25].

The role of trust in governance

Collaborative interagency relationships can lead to the evolution of new governance structures across organisations. In the case of Designing Better Health Care in the South, the collaboration began with informal arrangements established between clinicians as a result of personal relationships and the desire to meet the needs of clients, as well as informal meetings and discussions between Chief Executive Officers to address the shared needs of their agencies. Collaboration culminated in regular, weekly formalised meetings between the Chief Executive Officers (as well as the ongoing informal meetings continuing), regular formal meetings of the Chief Executive Officers and Chairs of the Boards with other members of the Southern Network Coordinating Committee, and the establishment of and formal support for joint interagency projects that were sponsored by the Southern Network Coordinating Committee. Such structures led to increasing opportunities to resolve differences, share information, identify common solutions to problems and strengthen the shared vision, all of which are consistent with the functioning of an effective, stable negotiated order.

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[25] It is noteworthy that Flinders Medical Centre was consistently over budget during this time, which would have diminished the Department's trust in it as an institution.

In contrast, because the Department actively excluded health care providers, particularly medical clinicians, from their planning processes, the opportunity to find common solutions and resolve differences was perceived to be no longer available. A number of clinicians expressed frustration at their sense of exclusion from Departmental processes in both phone interviews and the focus groups. One respondent explained:

> *And so the edict seems to imply that the people in charge know the answers and are going to tell us what they are, and if they ever do we will all be very happy. If they don't need to employ or harness the synergistic benefit of the collective wisdom then good on them. I think most of us would recognise that there is value in actually getting other people's involvement and building on that, building on the collective wisdom but also on the collective enthusiasm. Because I think one of the things which has really impressed me is the willingness of each of the Boards and CEOs of the relevant institutions to actually put aside their own egotistical desire and actually work towards compromise and building a better system overall. (Phone interview, Board member)*

Trust and control function in parallel and operate in a supplementary fashion as sources of partner cooperation (Das and Teng 1998). All relationships carry features of both trust and power, but if one of these mechanisms becomes dominant within a relationship there can be significant consequences (Bachmann 1998). A system that is over-regulated and centralised as a response to a lack of trust relies on coercion in order to function and tends to focus its efforts and resources on surveillance, control and information gathering, with less incentive to foster cooperation. Mistrust results in fear, suspicion and intolerance and in efforts to reduce responsibility and autonomy through increasing control. Coercion or the threat of coercion can ensure compliance in particular acts, but can be self-defeating in that it also encourages resentment, resistance and defection (Gambetta 1988). Centralised power undermines the norm of cooperation by eliminating negotiation, respect and interdependence (Misztal 1996). Both centralised coercive and cooperative trust-based mechanisms were evident at different levels of the health system during the development of Designing Better Health Care in the South. However, because the centralised coercive mechanism was dominant in the central bureaucracy from 1997 to 2002 (with a

change in state government), it undermined the cooperative trust-based mechanism that was dominant between the partner agencies.

Boundary spanning and the development of interagency trust

In the early phases of Designing Better Health Care in the South, from mid-1995 to mid-1998, the Chief Executive Officers acted as 'boundary spanners' (Sydow 1998), creating and encouraging opportunities for staff to work together across agencies and through this, creating an organisational history of collaborative experience and shared vision in the region. Other key staff also took on this boundary spanning role within their agencies. The Chief Executive Officers provided leadership support for this to occur. During the planning of Designing Better Health Care in the South, the actions of the Chief Executive Officers reflected the principles on which an effectively functioning and collaborative system is based. The interpersonal relationships that they developed with each other and fostered in their staff overlaid the formal inter-organisational network that they were seeking to create through Designing Better Health Care in the South. This was clearly reflected in the phone interviews, focus groups and also in my journal. As an example, a phone interview respondent explained about his early experience with Designing Better Health Care in the South:

> *I always sat there and marvelled at the way the nice talk was going on but I always felt that sooner or later the crunch would come when they would have to address how they were going to do that. I think that it was largely driven by a close cooperation between the four Chief Executive Officers. They had a very important role to play. Whether or not those Chief Executive Officers who had obviously, for reasons that I don't necessarily understand, had achieved a high degree of rapport – how they were going to get that across to the people that made up their subordinate staff, when empires were going to be threatened was to be another issue. (Phone Interview 24 – Industrial representative)*

This process built interagency trust and trust in the change process. There was significant staff concern about the proposal to create a regional health service, which was raised in 14 of the 29 phone interviews (48%). The staff anxiety appeared to be largely a result of concern about change and the unknown, about the implications for individuals' employment and because of a wish to protect their *"territory"*. Several

respondents commented that the modification of the proposed process, which resulted in it changing from a single regional health service to a federated model, was less radical and so staff felt more comfortable with it, probably believing that it would have less impact on them. Despite these staff concerns, the Chief Executive Officers encouraged and sponsored a number of staff consultations in 1996, and interagency planning exercises and projects in 1997 through to 1999 which were viewed by staff as positive and constructive experiences. For example, phone interview respondents commented:

> *I think it was a good process. And I think what came out of it was a real – some people were surprised by it I think, that people became so enthusiastic about it. Going through that process I guess it's like anything. I mean if you get to meet with people often enough you actually become less defensive about your position or you start seeing yourself more as a team rather than as an opponent. So I think it had some real merits in breaking down a lot of psychological barriers between agencies and individuals and departments. (Phone interview 8 - Medical Clinician)*

> *I think I've mentioned to you, even if it stopped today I believe that the amount that the trust and the shift in thinking we would have still have achieved, so I think it has been a success already in that regard. I don't think we can underestimate that but it sounds really trite just saying it. I have been in health for quite a few years now and for the very first time I can remember there is so much cooperation between community health and the hospitals. ... It's a culture change and that sort of thing doesn't happen overnight. But I am amazed at the amount of advances that have actually taken place. ... It's really just the process, I think the process has been very useful even if we just stopped now. (Phone interview 10 - Senior manager)*

These comments provide some insight into the effectiveness of the role-modelling and boundary spanning roles that the Chief Executive Officers adopted. Their "*imprimatur*" and support enabled staff to experience interagency collaboration in a non-threatening context. Despite this, it should be acknowledged that, because participation in these collaboration exercises was voluntary, resistant staff were unlikely to be involved, and had Designing Better Health Care in the South proceeded, mistrust and resistance to the change process are likely to have become more evident.

In contrast, the establishment of the Department of Human Services through bringing together three previously separate Government Departments resulted in an inwardly focused withdrawal as Departmental staff and Senior Executives struggled to integrate the central bureaucracy of the very large and complex Department that had been created. In doing this, there was an exclusion and closing down of a number of previous relationships so that those who were viewed as having 'vested interests' (hospitals and medical practitioners in particular) could not influence the Department's attempts to create significant transformational change, and to reduce medical dominance of the health system (discussed further in Chapter 8). Staff in the health care agencies perceived this period to reflect a lack of openness in the Department of Human Services because the Department was not providing clear policy direction to the field about how agencies should function as part of the new portfolio as it struggled to address its own internal challenges. This resulted in a lack of certainty in the agencies about the intentions of the Department, a lack of understanding of its vision and rationale, and a perception among health care providers that the Department was fragmented and inward looking.

The consequences of unmanaged mistrust – a culture of blame

In their study of continual restructuring within the British National Health Service, Smith, Walshe et al (2001) found that respect is necessary within an organisation for it to be able to manage mistrust and as a foundation for the development of trust, and that a lack of respect leads to the development of a culture of blame. The concerted effort by the Senior Executive of the Department of Human Services to centralise control of the health system and to manage it from the central bureaucracy is both a consequence and strong indication of a lack of trust. The consequences of this strategy in the field were the burgeoning of rumour and gossip (see evidence below) to fill the information vacuum, and the development of a culture of blame (discussed previously in this chapter) both within the bureaucracy and the field as each saw the other as obstructive, uncooperative and difficult. The development of a culture of blame between the agencies and the Department was particularly evident in the focus groups where staff of the agencies and the Senior Executive of the Department were

invited to discuss health system change. It was evident through these focus groups that each held strong views about the other's obstructiveness and lack of collaboration and support.

The influence of rumour and gossip in attempts to address the lack of information and the lack of clarity of response from the Department to the Designing Better Health Care in the South Interim and Final Reports was evident in phone interviews, focus groups and was also documented in my journal. The lack of progress of the Designing Better Health Care in the South proposal was either seen as being the fault of the agency Chief Executive Officers or of the Department. For example, respondents said:

> *To be honest there has been a lack of will to make anything further happen in the alliance in terms of anyone being willing to help develop it and push it further in terms of resources. There's been a lot of talk but no action and the clinicians have really moved ahead much faster than any of the administrators and we are stymied by the fact that to get anything done, we do clinical work, we do teaching, we do research, we do administration, and the administrators, well they do administration, and yet they don't find the time to move any of these administrative things forward. It's the clinicians who find the time to do it, it's ludicrous. (Phone Interview 16, Medical Clinician)*

My journal documents discussions between the Chief Executive Officers about the lack of clarity from the Department about whether the Chief Executive Officers could proceed with Designing Better Health Care in the South. As described in Chapter 5, following a meeting with the Department of Human Services in October 1998, the Chief Executive Officers were unclear about whether the Executive Director of the Statewide Division had directed that Designing Better Health Care in the South and the Southern Network Coordinating Committee should be discontinued. Vague references and a lack of direct response from the Department of Human Services when the Chief Executive Officers asked explicitly about this issue left them feeling confused and exposed and without a common understanding of what the response meant.

Achieving transformational change in the health system

In comparing and contrasting the relationships of participants in Designing Better Health Care in the South with those between health care agency staff and the bureaucracy following the establishment of the Department of Human Services, it is important to recognise that the scale of these changes and their potential transformational impact were very different. Designing Better Health Care in the South challenged service providers within the participating agencies to think beyond their own agency, to consider how to work better together in the first instance, and to commit to forming an integrated regional health service as a formalised outcome of their collaboration. However Designing Better Health Care in the South was focused at a regional level between partners who had a long history of working together and a common focus in that they were all health care agencies and had clearly identified common interests and values. Designing Better Health Care in the South was also never implemented, so that the final outcomes of this organisational change proposal cannot be known.

In contrast, the establishment of the Department of Human Services represented an attempt to bring about a major transformational change that was beyond the scope of the health system alone, that brought together a large number of agencies with very different cultures, philosophies and value systems, and that was being undertaken on a much larger scale for the whole of the state. Although individual agencies within what became known as the human services portfolio had worked collaboratively to achieve outcomes in particular regions or for particular clients, there was no broader previous system-level history of working together collaboratively that enabled knowledge-based trust to be established, either within the different parts of the new, complex bureaucracy of the Department, or between the bureaucracy and the field, although there was evidence of cross-sector collaboration at the local level. It can therefore be argued that the scale of change, the availability of a pre-existing history of successful collaboration and the extent of risk (and consequently the need for control) involved were quite different between the two examples. A collaborative, trust based approach to change may have been much more difficult to initiate and

progress at the human services portfolio level, given the great cultural differences between those involved and the lack of long term history of working together, and also given the Department's intention to control and contain the health system as part of this process.

Trust, control and health system reform

Goodwin (2000) argues that the trend for health systems to become more network-oriented, rather than hierarchical, has resulted in leaders of health care agencies focusing on developing agreements *across* organisational and professional boundaries to support agendas for positive change rather than being inward focused on their own organisation alone. This approach results in inter-organisational networking, achieving change through encouraging and enabling others to take responsibility for change, and, because of a shift to systemic rather than institutionally dominated thinking and planning, balancing local institutional priorities with health system priorities. These aspects of governance have become increasingly important leadership skills in health care agencies and for managing the health system (Hunter 1999), for working within a network model of governance (Rhodes 1997) and with policy communities and networks (Wright 1988; Pross 1992). To provide leadership in this form required the Chief Executive Officers of the four agencies in this case study to demonstrate a significant degree of trust in each other in the face of risk to their personal careers as well as to the agency for which they were responsible. A respondent in a phone interview explained:

> *At the highest level there was an agreement and a commitment which in many ways appeared courageous and brave in the 'Yes Minister' sense, and which amazed people I think. They all said, they're not really going to give up their autonomy, and I think to have reached the stage which was reached at the stage of the Interim Report to suggest that the agencies actually amalgamate was a remarkable indication of commitment at that level. Whether they would have actually seen it through is always difficult to be sure. And even amongst themselves they indicated a sense of relief informally because it was a very hard thing to do, hard both from their personal ambitions perspective of being CEOs, it was hard from being able to envisage what this really would mean if you went ahead with it and what would be the associated impact of undertaking those amalgamations. (Phone interview 25, Project Manager)*

The Chief Executive Officers' roles as boundary spanners and their relationships with each other during the early development of Designing Better Health Care in the South reflect how interpersonal relations overlay and support the developing inter-organisational networks to achieve change and build interagency and intra-agency trust and collaboration. Initially, their roles were underpinned by a history of working together and of regular formal and informal open communication, respect and dialogue, evident in their strong personal relationships and sense of goodwill, and in their shared understandings, values and their shared and clearly articulated vision for the region. With the breakdown of their capacity to continue to communicate their vision to their staff as a result of the lack of formal response from the Department and the pressures towards centralisation within the central bureaucracy, the role of the Chief Executive Officers as boundary spanners was diminished.

It is apparent from this experience that support, trust and the relinquishing of some power from the central bureaucracy as well as the local leadership of health care agencies is essential to bring about change in the health system at a regional level, and consequently, both central bureaucratic and local support, trust and collaboration are fundamental to the successful implementation of change. Leadership and collaboration at both central and local levels is essential to achieve change in the complex health system. Collective system leadership is crucial in the multi-layered health system to achieve systemic change and improvement, involving leadership from administrators, bureaucrats and professionals such as clinicians across the levels of the health system, working if not together, then at least in a coordinated way. In conjunction with strong system leadership, the careful management of mistrust which inevitably exists within a highly contested system such as a health system is crucial to achieving change in a collaborative manner. These are all crucial elements for an effectively functioning negotiated order.

The next chapter describes and discusses the issues of power and control in the health system, and provides an insight into why achieving interagency and systemic trust and collaboration within health systems is such a significant challenge.

Chapter 8

Power and Control in the Health System

The Australian health system, like health systems in all developed countries, is complex, highly political and fraught with competing interests and power bases. This chapter considers the role of some of these competing interests and their impact on the functioning of the health system in South Australia. It commences with a discussion of the literature on the way power affects organisations and considers the tensions between professional and bureaucratic or managerial power, focusing particularly on the ongoing struggle between medical power and administrative control and their conflicting aims and objectives. The chapter uses Designing Better Health Care in the South to illustrate the tensions and challenges experienced by service providing agencies and bureaucracy. It then discusses the role of organisational change and restructuring in the light of bureaucratic efforts to maintain power and control, while minimising the power of competing interest groups, and concludes with consideration of the implications of viewing the health system as a negotiated order.

The chapter uses several data sources to examine the case study of Designing Better Health Care in the South and to consider the role that power and competing interests had in this attempt to achieve organisational change. The data sources used in this chapter include:

- Transcripts of 29 phone interviews with participants involved in the development of Designing Better Health Care in the South
- Transcripts of 5 focus group discussions with service providers and bureaucrats to discuss interagency collaboration and change in the health system
- Key open ended questions from the mail staff survey which highlight the impact of health system change on staff and agencies involved in Designing Better Health Care in the South

- Journal entries and review papers that document my observations of and reflections on events as they unfolded during the period of data collection (from 1998 – 2001).

Each of these data sources provides a different perspective on the issues of power and control in relation to Designing Better Health Care in the South and the South Australian health system. The central role of power and the strong interests of the different, often competing, interest groups within the health system were evident in all of these data sources as a significant emerging theme.

Defining power

The foundations of work on power within organisations can be found in the writings of Marx and Weber, through their focus on the existence of conflictual relationships and the power of relationships of domination based on class structures. Marx argues that class structures and interests are predetermined by society and based on the ownership and control of the means of production (Marx 1976). Weber contributes further to this approach by arguing that power in organisations is not solely reducible to the dichotomy of ownership and non-ownership as Marx proposes, but rather that it is derived from the knowledge of operations as much as from their ownership (Weber 1978). He argues that all members of an organisation have some creativity, discretion and agency to use power, although the extent of this differs. Within this context, the power of the dominant group within the organisation is enforced and legitimated by rules and hierarchical structures.

In considering the development of the analysis of decision making and power within political systems, Lukes (1974) describes the three faces or the 'three dimensional' view of power. His work combines and develops concepts advanced by previous students of power, in particular Dahl, and Bachrach and Baratz. Dahl (1961) developed an understanding of power which focuses on behaviour in decision making about issues over which there is an observable conflict of interest. Lukes calls this the first face of power. Lukes describes the second face of power as the

understanding of power that arose from a critique by Bachrach and Baratz (1970) of the behavioural focus of Dahl's work. The focus of Bachrach and Baratz is on non-decision making, the way decisions are prevented from being taken on potential issues over which there is an observable conflict of interests. Their focus incorporates the issue of control over the agenda, as well as overt observable behaviour in relation to actual decisions, which is the focus of the first face of power. Lukes' (1974) three dimensional view of power was a major contribution to the development and extension of the conceptualisation of power. He considers how potential issues may be excluded from the political decision making agenda through social forces, institutional practices or individual decisions. Observable conflict may not be present, as it may have been averted. Conflict may be latent and may never be actualised because the subjects over whom power is being exercised may not be conscious of their own interests. Lukes describes this as the third face of power (Lukes 1974).

In contrast to the founding sociological analysis of power, mainstream management studies have tended to view the hierarchical power of the dominant group as 'normal' or legitimate power. Hierarchical power is seen as formally prescribed power. It is never questioned but rather is described as authority, while power used outside of the rules and formal structures of the organisation is described as 'illegitimate' or 'actual' power (Hardy and Clegg 1999). This interpretation of power emphasises the power of subordinate groups, such as organised labour, while the dominant hierarchical and therefore more hidden power of management which shapes legitimacy, values and information within an organisation is overlooked, resulting in the depoliticisation of organisational life (Clegg 1989). This interpretation is ideologically conservative, advocating the status quo and ignoring the processes by which the organisational elite maintain their dominance. The health system adds a level of complexity to this interpretation of power because the managerial or administrative power within a health care agency such as a hospital is constrained by medical professionalism, and other significant interest groups such as nurses and other health professionals, consumers, politicians and the central bureaucracy. The dual structure of hospital

authority, which functions through administrative and medical authority structures, means that there are two often competing sets of values functioning within the hospital setting, resulting in an institution which can therefore become highly contested and politicised when these values and goals become unaligned and factionalised (Etzioni 1964). This issue is discussed in detail later in this chapter.

As discussed in the previous chapter on trust and collaboration, Das and Teng (1998) view trust and control mechanisms as operating in a parallel fashion to enable partner cooperation. Das and Teng wrote from a management perspective and did not use the term power but rather defined control as being a regulatory process that enables the elements of a system to be more predictable through standards being established to achieve desired objectives. In defining control mechanisms and level of control, they explain:

> … control mechanisms are the organizational arrangements designed to determine and influence what organization members will do, level of control is the direct outcome of the controlling process – that is, the degree to which one believes that proper behavior of the other party is ensured (Das and Teng 1998, p493).

Das and Teng argue that control mechanisms are established to increase certainty that the goals viewed to be desirable for the organisation are achieved. However they do not discuss who determines the goals that are deemed to be desirable. This issue is fundamental to an analysis of power. This limitation demonstrates that the lack of a clear articulation of power relations within an organisation, or within a network or multi-organisation collaboration, results in the power of organisation management (and medical authority in the case of hospitals) being made invisible, and therefore not open to analysis or critique. When these two dominant power bases come into conflict within the hospital context, the conflictual power structures within the institution are revealed.

Foucault's work on disciplinary power and control provides a significant shift in the focus of discussions of the role of power and power relations. He argues that disciplinary power functions through surveillance and internal training of the subjects

of power to achieve their subjugation and 'docility'. Direct force is not necessary as the subject of surveillance disciplines themselves (Foucault 1977). The hospital is an example of Foucault's 'panopticism', which is a model of total surveillance to control subjects within an institution.

Foucault argues against previous considerations of power where it has been viewed as operating through law and sovereign rule, or through the state apparatus and its ideological expression (McHoul and Grace 1993). He cautions against viewing power as the homogenous domination of the subject by an individual or group, arguing that:

> Power must be analysed as something which circulates, or rather as something which only functions in the form of a chain. It is never localised here or there, never in anybody's hands, never appropriated as a commodity or piece of wealth. Power is employed and exercised through a net-like organisation. And not only do individuals circulate between its threads; they are always in the position of simultaneously undergoing and exercising this power. In other words, individuals are the vehicles of power, not its points of application (Foucault 1980, p98).

Foucault argues that power relations come in different forms and contexts and so should not be interpreted through a general theory, which was the focus of much of the previous literature on power. His particular focus is on institutions, practices and different forms of knowledge that are accepted as taken for granted realities and create a system of relations 'based not on cause and effect, still less on identity, but on conditions' (Kritzman 1990, quoted in McGowen 1994, p96). He cautions against viewing the state as the single or primary focus of power, but rather sees power in numerous occurrences of regulation that take place through 'micropolitics' at the extremities, such as within each health care agency, rather than through the command of the state as central agency (McGowen 1994). Driver explains:

> Rather than seeking the essence of power in some simple theoretical formula, Foucault posed apparently more modest questions about *how* power is exercised in particular sites and settings. … Instead of portraying power as the property of any particular group or institution, Foucault preferred to describe it as a heterogeneous ensemble of strategies and techniques. He was thus sceptical of any approach that mapped power onto an abstract model of class relations. … Rather than confining his analysis to key institutions such

as the state, he emphasized that power took many forms, often at its most effective where it was least visible (Driver 1994, p117).

Power and resistance

Foucault's focus on disciplinary power and surveillance makes it difficult to explain opposition or resistance to dominance because the subjects of power are subjugated and made 'docile' to the extent that they discipline themselves. Similarly, resistance is difficult to explain using Lukes' third face of power, where conflict may remain latent because the subjects of power are not conscious of their own interests. However, Foucault's understanding of power as occurring through a variety of strategies and techniques and not being solely owned by any group or institution, would suggest that resistance, where it occurs, is a form of power in itself which needs to be understood in the context in which it is expressed. Politics includes the struggle for power and also the struggle to limit or resist power (Wrong 1979). This is particularly likely to be the case where the conflict between those with power and those subjected to power is overt, or where there are competing interest groups who are exercising power or resisting each other's power.

The complex scenario of the health system provides a good example of where these conflicts become particularly apparent, resulting in resistance, or the exercise of power at different levels of the system. This can be seen within the organisation of the hospital between administrators and clinicians, and between the hospital as a service providing agency and the central bureaucracy. As discussed previously, at each of these levels of the health system there are different interests. They are most apparent in the tensions between the managerial focus on cost containment and the professional service provider focus on health care delivery as played out in the management of health care agencies and the provision of health services, discussed in more detail in subsequent sections of this chapter.

Barbalet's (1985) analysis of power and resistance highlights the importance of understanding resistance as a distinct phenomenon in the power relation, as the

'efficacious influence of those subordinate to power' (Barbalet 1985, p542). Clegg explains:

> Resistance to power may be of two kinds. Sometimes, under rare conditions of what will be termed 'organizational outflanking', resistance to power may consolidate itself as a new power and thus constitute a new fixity in the representation of power, with a new relational field of force altogether. On the other hand, it may be resistance to the exercise of power which leaves unquestioned the fixity of the terms in which that power is exercised. It merely resists the exercise not the premises that make that exercise possible. In this respect resistance is compatible with reification and the exercise of power (Clegg 1989, p207).

In the case study of Designing Better Health Care in the South, there was evidence of resistance to the increasing efforts of the Department of Human Services Senior Executive to centralise control and decision making and to reduce the capacity of health care agencies to function independently. This could be illustrated by numerous informal and anecdotal examples of resistance revealed during data collection for this study. However, a clear formal example of resistance to the efforts of Senior Executive of the Department to increase their control over the joint activities of the agencies can be seen in the Southern Network Coordinating Committee.

The Southern Network Coordinating Committee was originally intended to be a formal council of the four agency Boards, but following Departmental directives that all planning should be centralised, became an informal committee. This has been described in Chapter 7 in a discussion of trust, collaboration and the breakdown of trust relations. The simple act of the Southern Network Coordinating Committee continuing to meet at a regional level and to work through regional issues of mutual concern collaboratively was interpreted as defiance within senior management of the Department of Human Services. The Southern Network Coordinating Committee was used by the participating agencies from August 1998 to September 1999 as a structure in which they could support each other, exchange information and develop strategies to continue to work together despite directives to the contrary from the Department. However, in all these efforts to resist the centralising force of the

Department, there was an acknowledgment by the members of the committee of the need to comply with Departmental processes and policies. This was inevitable given the Department's control of the agencies' budgets and the legal requirement for the agencies to operate in accordance with Departmental policies. Apart from the functioning of the forum during this time, which was covert because of the pressure from the Department, resistance was not overt and many staff felt frustrated and powerless with no means to openly respond to the Department's attempts at control and coercion (discussed in Chapter 7, and further elaborated on later in this chapter). Even this forum lasted for a relatively brief time, only meeting five times over a period of thirteen months. It experienced significant pressure from the Department to cease, which was expressed through directives given by a Departmental Senior Executive during the latter part of 1998 that there should be no formal structural process, seen as evident in the very existence of the Southern Network Coordinating Committee, and that no planning should occur at a regional level, but only through the Department.

Bureaucratic power has a particular form which is articulated in policies, rules and budgetary control. This example of the Department's efforts to apply pressure to the four agencies to halt their regional activity and to bring them more closely under central direction and control clearly demonstrates the Department's use of power. The agencies' initial response was to attempt to continue covertly, but finally it was apparent to the Chief Executive Officers that this was having negative consequences for their relations with the central bureaucracy and so the decision was taken to cease. A more detailed consideration of the nature of bureaucratic power will help to elucidate analysis of the use of power in the case study.

Power and the bureaucracy

Weber's writings on bureaucracy add further to the understanding of power in organisations. He saw bureaucratic authority as providing the means to manage the administrative requirements of large-scale social systems and developed an ideal type of bureaucracy which included among its key characteristics a clear hierarchy with a

delegation of authority and chain of command, and written rules that govern the conduct of technically qualified career officials and ensure consistent decisions (Weber 1967). The bureaucratic model of administration was adopted by the welfare state, in part because it was the model that was available at the time, but also because it was intended to promote impartial administration of public sector activity, resulting in consistent and predictable outcomes being delivered because of the application of a common set of rules (Clarke and Newman 1997).

Weber's ideal type of bureaucracy embodied for him the rationality of western society applied to the problem of organisation. Weber developed three theories of bureaucracy, the first concerning bureaucracy as a technically efficient instrument of administration. The second theory of bureaucracy depicts bureaucracy as having an inherent tendency to become an independent policy actor, exceeding its instrumental function. This theory incorporates the ideal type characteristics of the role of officials and politicians. Weber's third theory of bureaucracy addresses the way that the class structure of society is reflected in bureaucracy (Matheson 2000).

Weber's second theory of bureaucracy is of particular interest in this study because of its contribution to understanding how bureaucracy plays an independent role in the policy process through its tendency to form a separate interest group within the state, with its own interests, values and power base (Beetham 1985). Weber argued that the attributes of bureaucracy that make it an efficient means of administration with technical expertise and normative ideals also provide the means to usurp political power. This issue is often evident in Government ministers' concerns that the bureaucracy should implement rather than make policy. To avoid this, Weber argued that close parliamentary scrutiny through committees and other mechanisms is essential to ensure bureaucracy is subjected to political control (Matheson 2000). However, even in the implementation of policies, there is the potential for a high degree of bureaucratic discretion when analysing options and interpreting results, just as there is the potential to withhold cooperation through delaying tactics. The Australian Commonwealth Government's attempts to constrain and control its

bureaucracy have been described in the discussion in Chapter 2 on the introduction of New Public Management in Australia.

A less well recognised and often unacknowledged, but very effective means for a Government to maintain control of its bureaucracy is through constant restructuring (Bryson 1987). Control of the bureaucracy through organisational change, justified by a promise of managerial improvement, provides the appearance of achieving change while ensuring an ineffective bureaucracy that is caught in a cycle of introspective chaos while positions are spilled, called and filled, often with different individuals who come from outside the bureaucracy. This strategy contributes to the phenomenon of churning within the health system and was the experience within the Department of Human Services following its establishment. When combined with numerous other concurrently running reform initiatives that originated from Commonwealth and state governments and from the agencies themselves, the resulting churning within the system led to feelings of 'reform fatigue' among staff within the bureaucracy and across the health care system. These feelings were reflected in the focus groups and the mail staff survey in particular, with comments such as:

> *Constant change is very unsettling for staff. The instability in the DHS is not good for the South Australian health system. We did have one of the best health services in the world. This is now put in jeopardy because of a seemingly endless reorganisation. Most disturbingly, there appears to be no attempt to evaluate the changes and reorganisations. (Mail staff survey, Administrative officer)*

> *You never get round to reaping the rewards of the change that you made before and I think that what is constantly happening is that we change for change's sake and then change again on top of that and so nothing actually ever establishes itself. (Focus group, Senior manager)*

> *Stretched resources, continual change for what purpose creates uncertainty, poor morale and decreased efficiency. Generosity of spirit is being replaced by "What's in it for me" by health care workers. People are not valued, only the bottom line and people are responding in kind. Very, very short-sighted. Poor people management. (Mail staff survey, Medical clinician)*

> *Initially I was frustrated at the inertia of the system, you know, how come they won't change? And then I began to think, well if they actually did change*

every time anybody wanted them to change, where would health care be? The only unchanging things in the centre really are there are going to be always people requiring health care and good health carers who are trying to provide it for them, and thank God they are full of inertia and resistance because otherwise they'd ruin the system. (Focus group, Senior manager)

The mail staff survey did not focus directly on Designing Better Health Care in the South but sought information from staff of the four agencies about how changes in the health system were affecting their agencies and their own work. Responses from staff reflected a level of disillusionment and frustration with the extent and pace of change occurring in the health system and with the increased pressure on the workforce as a result of what they perceived to be a continual agenda of cost cutting rather than service improvement, as a staff survey respondent explained, reflecting a commonly held view:

> *It feels that most changes claim to improve services and increase efficiency, but are merely a mechanism to save $$$, therefore placing higher levels of stress and increasing demands on staff, who must perform faster, harder and many more tasks. (Mail staff survey, Nurse clinician)*

Significant change was being experienced at all levels of the health system, from state level bureaucracy down to the way individual clinicians were required to practice, with the introduction of protocols and clinical guidelines through developments such as evidence based medicine. Staff described the consequences of constant change for them, using words such as: "*poor morale*", "*increased fear*", "*unsettled work environment*", and "*uncertainty*". The strength of this response in the mail staff survey indicates the level of 'reform fatigue' that was being experienced across the health system in 1999 at the time the survey was conducted.

Competing interests within the health system

The ongoing pressure for change is clearly related to the shift towards managerialism, discussed in Chapter 2, and the resulting focus on managerial improvement, 'doing more with less', and the appointment of generalist senior managers on contracts who do not have the history or the perceived conflicts of interest arising from having

worked in relevant service providing agencies previously or from having been career public servants within the bureaucracy.

In acknowledging the changing role of bureaucrats with the increasing politicisation of the public service, particularly at its higher echelons, Putnam (1973) identified both the 'classical bureaucrat' who is procedure oriented, and the 'political bureaucrat' who is problem or program oriented and who aligns themselves with the values and objectives of the politicians and party in government. The traditional, classical model of the bureaucrat in the Westminster-style system of government has been progressively eroded in Australia as a result of the abolition of security of tenure through the introduction of contracts, in particular for public servants in the senior echelons of government departments (Matheson 2000). This erosion has contributed significantly to a shift from 'classical' procedure oriented bureaucrat to 'political' bureaucrat at the senior executive level of Australian bureaucracies. This can be seen to have contributed to the extent of change within the system, as each change in Government now appears to be accompanied by a change in Chief Executive and other senior positions within the Department, resulting in a restructure as each new Chief Executive attempts to fulfil the will of the new Government and adjusts the structure of the bureaucracy to achieve this[26].

The politicisation of the public service has occurred to such an extent in South Australia, that the Auditor General warned of its dangers in his annual report to Government, when he stated:

> Political neutrality is of fundamental importance in the impartial administration of the affairs of the State. Similarly, concerns about the independence of the Chief Executive from the influence of Executive Government need to be appraised in the light of actual experience. It is

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[26] This has been the case within the SA Health Commission (and subsequently the Department of Human Services) in South Australia since 1993, when the election of a Liberal Government in December of that year led to the appointment of Ray Blight as the new Chief Executive Officer, and to the previous Chief Executive Officer, David Blaikie resigning in March 1994. After the 1993 election, each change in Government has resulted in a change in Chief Executive (even when this has not involved a change in the political party in power, but only a change in who is leading the Government). The extent of change within the South Australian health system, particularly within Central Office from 1994, was discussed in Chapter 4.

important that the ability of the Chief Executives to disagree with Executive Government on questions of legislative and Constitutional obligation are real and not illusory.

Over the past few years, several Chief Executives have had their contracts terminated at considerable expense to public funds and with no satisfactory explanation for their hasty departures. While their number is small, the pool of Chief Executives in South Australia is itself small. This phenomenon undermines public confidence in the administrative structures of government and gives rise to the obvious question of whether the problem lies with the individual Chief Executive so dismissed or with some more fundamental failure of government policy or infrastructure.

Two issues of immediate concern in terms of audit risk are the vulnerability of Chief Executives to undue influence by Executive Government, and the ability of the Chief Executives to perform their constitutional and statutory duties in situations where they lack the support of the Executive branch of government. Where these situations arise, apart from the heightened audit risk, there is the potential for a weakening of the safeguards surrounding public service expectations and obligations (Auditor General of South Australia 1999, Part A.3).

On the counter side to this concern, the equally significant consequence of bureaucratic usurpation of political decision making and control is that ministers have final responsibility and are held accountable for the actions of departments over which they do not have control. To have the necessary control over a department and portfolio for which they have responsibility, they need to be able to determine policy and its implementation. This is a fundamental tension in Westminster-style systems of government. As one Commonwealth departmental secretary who held office in the 1980s stated:

> … political neutrality is not enough – indeed, the common stereotype, following Max Weber, of rational, formal, deliberate and impersonal officials does not satisfy today's imperatives. Such officials, as Weber saw, were unlikely to initiate or offer dynamism. Governments or potential governments want bureaucracies that are responsive to their political needs and that can be innovative in pursuing them (quoted in Matheson 2000).

The separation of responsibility and accountability is also an issue at multiple levels of the health system. For example, the establishment of the SA Health Commission with an independent arms length relationship from the Minister of Health, described in Chapter 4, resulted in ongoing efforts by a number of subsequent ministers to gain

control and contain this Departmental independence. Similarly, where the central bureaucracy has responsibility for the implementation of government policy, the bureaucracy needs to be able to ensure that implementation of the policy occurs. The legally separately incorporated nature of health care agencies in South Australia made this problematic. Likewise, at the hospital level, through the Chief Executive Officer, the administrative authority structure has responsibility for managing the hospital budget and implementing Government policy. However, the professional autonomy of doctors, the pressures of a multitude of professional and community interest groups, and the pressure of public expectation to provide everything for everyone within the hospital makes this responsibility problematic. There are therefore significant structural obstructions to ensuring accountability in the South Australian health system in response to which numerous change strategies have been initiated, such as the casemix funding model, the separation of purchaser and provider, the introduction of clinical guidelines and models of clinical governance, and the continual efforts to achieve administrative reform in order to increase accountability. These strategies are consistent with New Public Management approaches described in Chapter 2.

An example of the conflict arising from bureaucratic and medical power was played out in mid-March 2003 when a rumour circulated through Flinders Medical Centre that the neonatal intensive care unit would close. This rumour arose as a result of Departmental consideration of this as an option in discussions which were occurring during 2002 and 2003 as part of the South Australian Generational Health Review about restructuring the health system in South Australia, reducing expenditure, and redistributing resources. There was also concern within the Department because numbers of neonatal babies requiring access to intensive care had dropped in South Australia to the point that providing two intensive care services in metropolitan Adelaide meant that the Flinders Medical Centre service in particular was not receiving sufficient patient numbers to maintain clinical skills and ensure quality

standards of care[27].   On hearing that closure of the unit was under consideration, medical specialists, nurses and mothers with children who had used the service rallied and protested publicly outside the hospital.   They were given significant media coverage which resulted in an almost immediate retreat by the Government (within a day of the protest) with a clear declaration that the unit would not be closed despite the fact that the Government was in the midst of a major review of the health system which was explicitly instructed to consider rationalising clinical services and which would report to Government within the next month.

Low neonatal patient numbers and the resulting concern around clinical skills and quality of care were perceived by the bureaucracy to create risks for consumers and to involve unnecessary expense, where funds more usefully could be allocated to alternative areas of need.   In contrast, the closure of the neonatal unit was seen as a threat by the service-providing professionals, who rallied the support of consumers for preservation of the service and successfully used the media to exploit an emotive issue in order to achieve their aim of continuing to offer the service within the region.

This is an example of the power of medical dominance and professionalism within the health system and of the contested power relations between professionals and bureaucracy.   This example demonstrates the struggle between bureaucracy and professionals to achieve different goals and the complex and political nature of health systems. It also demonstrates how resistance can be a form of power, and that both the bureaucracy and clinicians have power and exercise it to attempt to achieve their different, and often unaligned, goals. Similarly, the government has a strong political agenda to keep health issues out of the media spotlight, which gives power to the status quo. This is another pressure that makes constructive reform very hard to bring about.   The medical clinicians in particular form a powerful and influential group within the hospital setting and were consequently key players within the case study of

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[27]   The other neonatal intensive care unit is based at the Women's and Children's Hospital which is very close to the city centre, on its northern side.

Designing Better Health Care in the South. Understanding the role of medical dominance in the health system is important in analysis of the case study.

Power and knowledge – medical dominance in the health system

Professionalism is clearly contrasted with traditional bureaucratic administration. Traditional bureaucracy focuses on predictability and stability (described in Chapter 6), whereas professionalism focuses on the need for expert knowledge and judgement in a complex and uncertain social world (Clarke and Newman 1997). In their ideal types, professionals are guided by an ethos of service (an example of which can be found in the Hippocratic oath for the medical profession) while traditional bureaucratic administrators provide independent 'frank and fearless' advice to the government of the day and implement rules impersonally and equitably. As such, the medical profession can be described as 'street level bureaucrats', having been conferred with the power, by virtue of their medical training and their specialist technical knowledge and skills, to further their interests and to act as policy makers at the service delivery level with the discretion to make resource allocation decisions and to determine which responses and treatments are appropriate for individual patients (Lipsky 1980) (discussed in Chapter 3).

The introduction of New Public Management has shifted the role of both the bureaucracy and the medical profession. In the current context of the South Australian health system, it could not be argued that central bureaucracy continues to be focused on stability and predictability. The more recent focus on continual change in the bureaucracy is consistent with New Public Management approaches (discussed in Chapter 2). Similarly, the introduction of clinical governance in the hospital setting (discussed later in this chapter) has begun to shift the role of the medical clinician, reducing their autonomy and increasing their accountability for clinical decisions.

Professionalisation maintains occupational monopolistic privileges in relation to the market and within society. It is based on the possession of a body of knowledge that

is vital to the exercise of professional power. Where this body of knowledge is not systematised, but relies on a degree of interpretation and independent decision, professional groups are in a privileged position of occupational autonomy and control of the process of service delivery (Southon and Braithwaite 1998). Professionalisation is an occupational strategy that involves social closure through the professional group controlling access to qualification in the profession, for example through examination and registration. The medical profession is a clear example of professionalisation which has resulted in the dominance of medical knowledge and doctors within health systems internationally (Turner 1987).

Freidson (1970) views the health system as being ordered around professional medical authority, whereby the structure of health care agencies is constituted by the dominance of the medical profession over other subordinate professions, such as nursing and allied health. He argues that the fundamental feature of the medical profession as a formal organisation is its legitimated and highly organised autonomy arising from a dual foundation of specialist knowledge and state patronage, and resulting in its dominance as a profession. He argues that the strength of the medical profession is based on a monopoly of practice which is guaranteed by a system of licensing granted by the state (Freidson 1970). Willis identifies three levels of medical dominance: autonomy, authority and sovereignty. Autonomy is defined as medical dominance at the level of control over own work; authority relates to control over other health occupations; and sovereignty relates to authority in the wider society (Willis 1983).

Given that hospitals are the organisational manifestation of medical dominance within the health system, the above definition of medical dominance can be useful in understanding the hospital's dominant position within the health care system. The teaching hospital is symbolic of the social power of the medical profession through its representation of the institutionalisation of specialised medical knowledge. The modern teaching hospital is a complex bureaucratic institution with a central role in training doctors, in medical research as well as in increasingly specialised and

technical clinical treatment. The hospital's administrative authority structure is highly bureaucratic. However, medical staff retain considerable professional power and make decisions which are not necessarily determined by the hospital administrative authority structure, but rather are guided by their own professional codes, knowledge and guidelines (Degeling et al. 1998a). Para-medical professions and occupations, such as nursing, are subject to dual lines of authority which make their roles frustrating, complex to negotiate and difficult. Much of the tension between administrators and doctors within hospitals arises from this dual structure and the differing priorities of these two groups (Etzioni 1964; Abernethy and Stoelwinder 1990). Etzioni explains:

> ... the ultimate justification for a professional act is that it is, to the best of the professional's knowledge, the right act. He might consult his colleagues before he acts, but the decision is his. If he errs, he still will be defended by his peers. The ultimate justification of an administrative act, however, is that it is in line with the organisation's rules and regulations, and that it has been approved – directly or by implication – by a superior rank (Etzioni 1964, p77).

As a result, hospitals are sites of inter-occupational conflict.

While attempting to achieve organisational change through Designing Better Health Care in the South, there was an evident understanding of the significance and power of the medical "*empires*". This was very apparent in the focus groups and phone interviews that were conducted at the time, and was discussed by both administrative and clinical staff within the hospitals. Eight phone interview respondents and two of the five focus groups spoke specifically about the existence of "*fiefdoms*" or "*empires*" within the Flinders Medical Centre and the Repatriation General Hospital, discussing how the organisational structure of the two agencies led to fragmentation of management and decision making between the agency administration and the clinical divisions. This was particularly seen to be the case among senior medical clinicians, within the Divisions of Medicine and Surgery which were considered to be relatively autonomous. One phone interview respondent, an industrial representative involved in developing the model of Designing Better Health Care in the South, explained:

> *By and large at Flinders the professors control the clinical departments because that was the model that was established. There is at Flinders and "the Repat" a management model to some extent which operates by default and there is not a good nexus between the central management, CEO downward, and the coordination between the divisions. Management is fragmented so the CEO might have sub-committees that meet on particular issues but there isn't a group divisional structure which allows broad strategic input and management decision making to take place at that level. (Phone interview 22, Industrial representative)*

The respondent described the management structure that was led by the senior medical clinicians as an "*oligarchy*". Another phone interview respondent (also an industrial representative) had expected the senior clinicians of the two hospitals to be obstructive to Designing Better Health Care in the South because they "*have empires that could be destroyed or taken over and they have a lot of power*". A senior medical clinician also commented on this in a focus group:

> *We do have traditional medical roles, and with those, power. They are power relationships, and we see them medicine versus nursing, we see them medicine versus allied health, and I think there's no doubt those relationships exist and I think they have changed, but they have changed I think more in a place like this than they have in some others, but frankly I suspect they could change some more. (Focus group, Medical clinician)*

This discussion highlights the significance of Foucault's argument that power is not held by any particular group, but rather that power is contested. Each player is in a power/resistance relationship with the other players within the health system even though the levels of power may not be equivalent. This is central to an understanding of the nature of the health system as a negotiated order. Each player seeks to achieve their own goals, which at times may be aligned. For example in the case of the threatened closure of the neonatal intensive care unit at Flinders Medical Centre, medical specialists, nurses and consumers came together to achieve the goal of keeping the unit open even though their underlying motives may have varied, and could have included maintaining control of a clinical empire, preventing the loss of high status services in an institution and ensuring easy access to the neonatal intensive care unit for people who lived in southern metropolitan Adelaide.

Medical dominance is experienced across the health system. However, it is particularly apparent in the hospital setting in the relationships between medical clinicians and administrative managers. In this context, medical clinicians operate with autonomy and discretion as street level bureaucrats in their decision making about patient treatment, and administrators focus on the managerial responsibilities of keeping within budget and applying institutional and government policies in the operation of the hospital.

Accountability and the hospital as street level bureaucracy

As described in Chapter 3, Lipsky (1980) created the term 'street-level bureaucrats' to describe the role of professionals who work within human service bureaucracies and who have the role of translating policy into practice through the decisions they make about their clients and the discretion that they employ in conducting their work. Lipsky explains:

> The essence of street-level bureaucracies is that they require people to make decisions about other people. Street-level bureaucrats have discretion because the nature of service provision calls for human judgement that cannot be programmed and for which machines cannot be substituted (Lipsky 1980, p161).

The medical profession has a relationship with their patients based on a history of clinical freedom and autonomy which is invoked as a key principle of medical legitimacy at times when interference in this relationship is threatened. They have control over the processes of diagnosis, referral, admission and treatment (Sax 1984; Harrison et al. 1992).

As stated previously, hospitals are highly complex organisations with multiple cultures and a dual administrative/clinical hierarchy of authority (Etzioni 1964; Shortell 1991; Succi et al. 1998). This authority structure creates tensions within the hospital institution, resulting in an incentive for both the hospital administration as managers within this street-level bureaucracy, and the central bureaucracy, to seek to increase accountability for medical decision making. As Klein argued in reference to

the UK National Health Service (although he equally could have been referring to the health system in Australia), the continuing paradox within the health system is that the bureaucracy:

> … exercises least control over those who, in theory at least, exercise the greatest influence in determining the demand for health care (Klein 1989, pp222-223).

As a result of the dependence of hospitals on the technical skills and knowledge of medical clinicians and the consequent high level of discretion and autonomy held by doctors, the relationship between hospital administrators and medical clinicians is both one of dependence and one of potential conflict (Harrison et al. 1992). Despite this potential conflict, the interests of doctors and hospital management coincide in relation to the priority of the organisation to provide acute care services for individuals who require them, while medical clinicians seek to provide the treatment options they deem to be appropriate for their individual patients, and hospital management seeks to run the organisation within the budget constraints imposed by the central bureaucracy. In one respect however, the hospital interests, being those of a street-level bureaucracy, reflect the amalgamated interests of all the street-level bureaucrats who work within it, in particular those of the medical clinicians who are the major drivers of treatment choices and consequently, hospital costs.

This complex relationship highlights the tensions which hospital administrators experience in their relationships both with medical clinicians and central bureaucracy and through this, the challenges encountered as a result of the health system functioning as a contested negotiated order. As was clearly articulated by a participant in the development of Designing Better Health Care in the South and quoted earlier in this thesis, the reality of working within a health care organisation that deals with daily crises (eg *"A person whose leg's been cut off, bleeding to death on the front doorstep…"*) is very different from the reality of the central bureaucracy, where the pressures are more likely to come from Government and the responsible minister, and to relate to pressures from Treasury, the public, the Opposition and the media about issues such as waiting lists and hospital budget "blow-outs".

Managers and clinicians – achieving accountability

There is an extensive literature on the changing role of the medical profession and its relationship to management within health care agencies. This literature incorporates consideration of issues such as increased managerialism (Pollitt 1993; Clarke and Newman 1997), de-professionalisation (Southon and Braithwaite 1998), and the conflicts and tensions between managerial and professional structures and cultures (Williams 1991; Degeling et al. 1998b; Thorne 2002). Medical training has not equipped doctors well to work in complex organisations. As Edwards et al explain:

> Medicine has been based on a model in which doctors are trained to deal with individuals, not organisations, to take personal responsibility rather than delegate; and to do their best for each patient rather than make trade-offs in a resource constrained environment. These factors make high workloads and high levels of workplace stress all the harder to deal with. They also create a real problem in that professional values and training based on an individualistic orientation do not prepare doctors to function successfully as members of large, complex organisations. Little training is given to equip doctors for this, and the difficulty that many consequently experience leads to stress and frustration (Edwards et al. 2002, p836).

The medical profession forms a policy monopoly through its institutional structures, its ability to define itself as central to the concept of health and the functioning of health systems and, in this way, to limit access to the policy process (O'Neill 1998). As a result of the expansion of this policy monopoly, the medical profession has sought to affect decisions about the allocation and distribution of resources, an issue that is central to conflicts between medicine and the state; and at the operational level, between the medical profession and management within health care agencies. In relation to the UK National Health Service, (and also relevant to the Australian health system), Hunter notes:

> As one moves from a macro to a micro level in healthcare systems and services, the power of the clinician increases. Whereas the overall resources to be devoted to health care and broad priorities between services are determined by central government and, to a lesser degree, its agents in the field, regional and district health authorities, the precise use of resources in individual cases remains the responsibility of individual doctors (Hunter 1991, p442).

As street level bureaucrats, doctors use their professional judgement when determining the use of resources at the individual patient level and there is strong resistance to any interference in clinical autonomy and the relationship between the doctor and their patient. As a result, the medical profession operates relatively autonomously in order to exercise their independent judgement. Consequently, their expertise is not easily managed by a bureaucracy that is a third party to this process (Hunter 1999).

Countries such as the UK, the US and Australia have responded to the tension between managerial and professional structures and cultures by increasingly involving health care professionals in hospital management. This strategy has the effect of placing clinician managers (from medical, nursing and allied health backgrounds) within dual and conflicting roles of being both practitioners and managers, while increasing their acceptance of and responsibility for the resource allocation dimensions of health care. These individuals are required to work across differing discourses in relation to clinical work where they need to find points of convergence between clinical and managerial perspectives in order to be able to function within their managerial roles as well as with their professional colleagues (Degeling et al. 1998a). In discussing this tension, Abernethy and Stoelwinder explain:

> Professionals are generally placed in managerial positions because of their competence at performing core operating tasks. Their training and socialisation have been primarily professional in orientation and not managerial. This may influence the professional's perception of management and the importance placed on managerial responsibilities *vis-à-vis* other professional-related activities (Abernethy and Stoelwinder 1990, p29).

Across the developed world, there have been significant reductions in medical autonomy, accompanied by increased accountability and a strengthening role of management. The freedom of the medical profession to determine their own priorities for care, to allocate resources and incur expenditure has been challenged as management has sought to gain control (Hunter 1991; Williams 1991). The effort to gain control by hospital management is in part a result of the growing cost of rapidly

developing medical technology, the increasing expectation of and demand for services from the community, and increasing government pressure to control costs. This is consistent with the adoption of New Public Management approaches within the health system.

Efforts to reduce medical autonomy have affected clinicians' morale in developed countries such as Australia, the UK and the US, because doctors' control over their work is important to their job satisfaction (Williams 1991; Southon and Segal 1998; Smith 2001), and is a central component of medical professionalism and power (Willis 1983). This imperative and tension is also reflected at the agency/bureaucracy level where the bureaucracy pressures hospitals to remain within budget and seeks to control resource allocation decision making through a number of strategies. These have including the 'systematisation' of medical knowledge, for example through casemix measures such as diagnostic related groups, and through the introduction of clinical protocols and guidelines to increase the emphasis on evidence based medicine (Davies and Harrison 2003).

The introduction of clinical governance can be understood as a strategy to give doctors managerial responsibility, to place limits on their autonomy and to strengthen their accountability for the quality and cost of their treatment decisions[28]. Clinical governance is a way of sharing power, responsibility and accountability, and maintaining an effective negotiated order within the health system. Both the advantages and disadvantages of this were recognised in the focus group discussion in particular, where clinicians and administrators were brought together to discuss change in the health system, for example:

> *There is no doubt that having clinicians as managers has a lot of advantages because then the resources that you do have can potentially be used sensibly and there is an awful lot to be said for that. (Focus group, Medical clinician)*

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[28] The introduction of managed care in the United States and the introduction of clinical governance in the UK are two examples of other countries' efforts to control and bring accountability into medical decision making.

A lot of clinicians also want to be involved but they don't want to be managers. There have been many experiences where a lot of the clinicians are being forced to go down the path of becoming managers and then when you say well this means you are going to have to learn how to budget and do all these other sorts of things, and how to read balance sheets and so on, they are not interested, and rightly so. But involvement in what is critically important for service provision, as long as that is there, then they are happy. (Focus group, Senior manager)

A senior clinician who had clinical management responsibilities also commented:

I think the problem I see though of course is I've certainly found that I spend more time managing less and less. And that I think is really one of the down sides of clinical management. It really does get very much in the way of my ability to practice, because I am always going to try and manage something, and the response of systems under pressure is for more committees, have more task forces, and more discussion, which takes up huge amounts of time but that is the nature of systems under pressure. (Focus group, Medical clinician)

The involvement of clinicians in decision making about service delivery issues, including taking into account and taking responsibility for the resource implications of their decisions has been a central strategy in attempting to contain medical professional dominance to at least ensure that the managerial objectives of remaining within budget and containing costs are achieved. For health care agencies to function effectively and to meet their goals of improving health and providing quality health care, it is essential that the manager/clinician relationship and the context in which that relationship exists are addressed (Detmer 2000).

The politics of exclusion – managing competing interests

The creation of the Department of Human Services occurred at a time when there had been a long term focus on seeking to increase the coordination of health services and improving links with other interfacing services, such as community and housing services. At this time, there was also a state Liberal Government in power with a political agenda of both building integration and reducing the dominance of the health (or more accurately, the medical) system in the political and financial arenas of the state. It appears that the Department used a form of control which came out of not

providing a response to proposals that it did not wish to see progressing, as evidenced in its lack of response to the Designing Better Health Care in the South Final Report. (For example, my journal describes an incident in October 1998 when directly asked by one of the Chief Executive Officers whether the four agencies should cease work on Designing Better Health Care in the South, a Senior Executive of the Department did not respond directly, but rather focused on the existence of the Southern Network Coordinating Committee, and stated that this was unacceptable to the Department). Consistent with Lukes' second face of power, control over information and non-response to proposals and requests for clarification, and therefore apparent non-decision, were powerful forms of control that the Department exerted over the agencies, although it is not clear if this was an intentional strategy. The Chief Executive Officers were left in doubt as to what was acceptable and were confused about how to proceed in a way that was consistent with the wishes of the Department, leaving them indecisive, unable to act and disempowered.

The Department's lack of support for Designing Better Health Care in the South appears to have been related to the aim to create an integrated human services portfolio and to limit the dominance of the health system within that broader context through increasing central bureaucratic control. To achieve this, medical clinicians and the acute care sector were disempowered by the Department by being isolated from their previous roles in which they could participate actively in health system policy and planning processes. This strategy commenced when the Department was established in 1997 and concluded in 2002 following a change of Government and Chief Executive[29]. The Thatcher-led Conservative Government in Britain used a similar strategy when introducing reforms that re-asserted state control over the health policy agenda while reducing control by the medical profession (O'Neill 1998). This strategy (discussed in Chapter 3) supported the imposition of new neo-liberal policy ideas, such as deregulation, privatisation and contracting out (Richardson 2000). In the UK, this strategy destabilised the previously stable policy communities

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[29]   During the following two years, a number of forums were created which provided opportunities for clinicians to have input into Departmental decision making and priority setting in relation to health and medical research, and clinical service planning.

that dominated the health system and was found to lead to low morale and 'unhappiness' among doctors (Smith 2001; Davies and Harrison 2003). Comments made by clinicians involved in Designing Better Health Care in the South in phone interviews and focus groups suggest a similar response (discussed in Chapter 7).

Taking control of the policy agenda

In relation to Designing Better Health Care in the South, the re-framing of the identified problem from being a focus on each agency being unable to respond to increasing workload and budgetary pressures, and the hospitals in particular needing to offer all acute care to whoever required it, to an agreement to investigate and implement a regional approach where services were available within the southern region rather than within a single institution, was a major shift in the focus of the agencies' policy agendas. It was not a new framing of the problem and solution, as it had already been identified by the central bureaucracy prior to the creation of the Department of Human Services (evident from the history of attempts by the SA Health Commission to regionalise health care described in Chapter 6). However, it was a new initiative from a group of agencies, where the level of resourcing and the power bases of the agencies were very different.

Therefore, the agreement of this group of agencies, expressed in the signing of the Memorandum of Understanding on 19 April 1996 and subsequent interagency collaboration described in Chapters 5, reflected the emergence of a coalition of interest groups to promote a solution to a policy problem that had been promulgated centrally but not previously accepted by or initiated from the field. The identification of a common policy agenda resulted in a 'window of opportunity' for both the bureaucracy (then the SA Health Commission) and the Designing Better Health Care in the South agencies to find a mutually endorsed solution. However, exogenous factors, in this case the developments in the broader political context that resulted in the creation of the Department of Human Services, meant that while this window of opportunity opened on a supportive policy environment, before the agreed policy

solution could be implemented, the policy environment had changed and the window of opportunity had closed (Tuohy 1999b).

It is noteworthy that even before the creation of the Department of Human Services, the SA Health Commission's moves towards separating purchasing and providing functions within the health system represented a shift in the balance of power from the acute care sector of the health system (hospitals and medical clinicians) to the bureaucracy as purchaser. The establishment of the Department of Human Services further shifted the balance of power. It reduced the power and influence of the acute care sector as a key policy network and shifted power towards the central bureaucracy in order to control agenda setting for what was open for consideration, and the initiation of policy change (Richardson 2000). Two Departmental Executive Directors discussed this policy shift during a focus group:

> *Executive Director 1:* The other comment I would make is I think the observation by health care agencies about the role of central bureaucracy is an interesting one. It's one that sort of says you're hands off and you kind of give us broad frameworks and we will just do what we think we are here to do. I suppose if anything, in terms of governance structures, we haven't changed structures. The two things we have actually done is introduce the Minister's powers and changed the delegation arrangements from one that looks at broad based policy controls to one that is working.

> *Executive Director 2:* But I think those things were implicit in the creation of the Department. (Focus group, DHS Senior Executive)

The centralisation of planning and decision making within the central bureaucracy of the Department was in part intended to reduce the influence of hospitals and the medical profession over the determination of the health agenda in South Australia. As discussed previously, this was a result of pressures to contain costs within the South Australian health system and also because of a lack of confidence that the hospitals and the doctors working within them would be able or willing to respond to the new human services agenda initiated through the establishment of the Department. Because hospitals and the medical profession are the dominant interest groups with significant influence on health policy (Sax 1984; Palmer and Short 2000), they were viewed by senior staff within the Department of Human Services as

a major potential stumbling block to the creation of a human services system out of the disparate sectors that pre-dated the establishment of the Department. A discussion between participants in the Department of Human Services Senior Executive focus group illustrates this view:

> Executive Director 3: *You make the point somewhere in here (the preliminary discussion paper provided before the focus group) about the de-medicalisation or taking clinicians out, and I wonder if it is really that they are not comfortable with the broader picture rather than they are actually being taken out of it.*
>
> Facilitator: *I think it is probably fair to say that most of the clinicians we spoke to are very supportive actually of the broader perspective. No one debated that.*
>
> Executive Director 4: *I don't think they debate it until you get to their territory and then they debate it, then it's not in my backyard. (Focus group, DHS Senior Executive)*

This discussion displays the lack of confidence and trust that the Department had in the health system to implement its new policy agenda. Its solution to this mistrust was to gain control of the policy process by excluding the medical interest groups so that alternative voices, such as those of community based services, could be heard, and so that the Department could establish and increase its control of the human services portfolio.

Managing the power imbalance within the health system

Phone interviews and to a lesser extent, focus groups, identified the differing sizes of the organisations involved in Designing Better Health Care in the South as being of concern when they anticipated amalgamating to become a single regional health service. Staff from all partner agencies apart from Flinders Medical Centre, the large regional teaching hospital, expressed concern about being "*swallowed up*" or taken over. This issue was discussed in detail by four phone interview respondents, with comments that reflected a common concern about the dominance of the large teaching hospital as an issue that could have impeded the implementation of Designing Better Health Care in the South. Comments included:

I guess the dominance of Flinders Medical Centre, that was just such a huge body that there was a fear that it would ultimately take over everything, and so I guess when we looked at linking closer with Flinders, because that was the way of the future, we also had to ensure that our interests would also be protected. And when we started talking about management and operational integration that was even more delicate to, I guess, make sure that the Boards of each of the services were convinced that this was still the best way to go. Fear of being taken over, fear of losing the capacity to identify what our priorities were, recognising I suspect that unless we did something, we weren't big enough to influence the decision makers within that health structure. (Phone interview 5, Board member)

People would probably say it's about territory and personal control and those sorts of things, but that's life and those sorts of things can be managed. But in some cases more than others they get in the way. And there are feelings like "the Repat" thinks it's rape and pillage when Flinders thinks it's coming along being helpful. Those sorts of things get in the way too. (Phone interview 25, Project manager)

As leaders of Designing Better Health Care in the South, the Chief Executive Officers recognised these concerns and openly discussed them in planning sessions such as the Regional Planning Think Tank which was held on 10 August 1998 to consider how the participants could jointly progress the federated model within what they understood at that time to be the constraints of the Department's stipulations (described in Chapter 5). At this meeting, each Chief Executive Officer presented their concerns, which included the concern of Southern Domiciliary Care and Rehabilitation Service staff in particular about the potential domination by Flinders Medical Centre, as well as the potential positive outcomes arising from the proposed model. As a solution to this concern and a way forward to achieving a regional approach, they identified and agreed on proceeding with a strategy to undertake the 'quick strike' collaborative projects that would be sponsored by the Southern Network Coordinating Committee when it was convened on 25 August 1998. The Chief Executive Officers intended that this would provide opportunities for them and their staff to learn about and develop models for regional collaboration without moving funds between agencies or altering accountabilities to the Department. This strategy also helped to address and manage the mistrust between the agencies which resulted from institutional and professional loyalties and concern about the dominance of Flinders Medical Centre in the region.

As described in Chapter 7, in their study of chief executive officers and physician leaders in community hospitals in the US, Succi et al (1998) found that trust between hospital managers and clinicians can be enhanced by increasing both groups' power over hospital decision making and their ability to ensure that decisions made benefit the interests of both groups. It could also be argued that similarly, increasing the power of the different interest groups to contribute to decision making about the direction of health care and the health system, including health care agency administrators, bureaucrats, clinicians (of all varieties) and consumers, can contribute to building trust within the health system so that all can work towards the achievement of the commonly supported goals of improving the health of the community. For this to be successful, there needs to be a balancing of medical and other groups' power, a recognition of the health system as an interdependent system, and support for a common aim of improving population health, rather than a driving focus on professional and other conflicting interests.

The recognition that power in the health system resides with multiple groups and that recognising and managing mistrust, and building trust and goodwill is necessary for successful change is fundamental to reforming the highly contested health system. The complexity of the health system requires that an inclusive approach to management that is based on a recognition of mutual dependence should allow for and accommodate professionalism, building partnerships and collaboration to enable an effectively functioning system.

An exclusive, divisive approach, like the one adopted by the Department of Human Services from 1997 to 2002, leads to policy changes being undermined, and to resistance, dissension and a polarisation of views. This was an evident short term outcome of the strategy used by the Department to attempt to shift power away from hospitals and acute care medical interest groups to community based services, resulting in resistance and resentment from the acute care sector of the health system. The strategy used by the Department to control the agenda resulted in a loss of trust

between the central bureaucracy and the acute care sector which was reflected in phone interviews and focus groups and documented in my journal. A division was also created between acute care and community based services following a period in the southern metropolitan area when trust had been developed across these services through the active support of leaders and the collaboration of health care agency staff in the region over a number of years.

The health system as a negotiated order

A hospital can be described as a 'negotiated order' because administrators, professionals and patients are forced to seek compromise in order to maintain daily hospital activities (Strauss et al. 1963; Strauss 1978; Fine 1984). It could equally be argued that the health system should be described as a negotiated order, relying on the negotiation of compromises and decisions between bureaucracy, health care agencies (and their composite parts of administrators and service providers of varying professions, which include medical clinicians, and patients), and the community. Government is a significant actor in this negotiated order as it struggles to maintain financial control of the system as a whole, in all of its complexity and political sensitivity, and with its multitude of different players and interest groups.

The effective functioning of the health system requires that to some extent the goals of all the players are achieved, so that a focus is given to patient health outcomes, cost containment, access and equity, and population health, and that a balanced and therefore necessarily, a negotiated order is achieved. The achievement of this negotiated order requires ongoing negotiation of the power relations between the parties, compromise and trust (and the management of mistrust) so that collaboration can occur. Consistent with this concept, Hunter argues for a 'third way' in health management which focuses on:

> strengthening trust in organisational structures, encourages a government by network approach, and seeks to restore a true sense of public purpose based on improving population health (Hunter 1999, p59).

This requires an approach to and understanding of leadership which is based on shared responsibility rather than dominance and control.

Recognising the health system as a negotiated order relies on the acknowledgement of the mutual dependence of the key groups who have an interest in the functioning of the health system. However, this approach also ensures the continuance of the status quo. Changing power relations within the negotiated order is likely to require different strategies. As a strategy to limit the power of medical dominance within the human services portfolio, the Department's exclusion of clinicians from participating in advisory and planning roles resulted in the alienation of this group of key stakeholders. If the Department's strategy had been continued for a longer period (the Department was only in existence from 1997 – 2004), it may have succeeded in breaking the dominance of this powerful interest group. However this can only be a matter of speculation and, given the role of clinicians as street level bureaucrats and hospitals as street level bureaucracies that therefore function with specialist knowledge, autonomy and discretion, the success of this strategy would not have been assured.

The different approaches to change adopted by the Department of Human Services and the Designing Better Health Care in the South agencies reflect their different aims. The Department sought to shift the balance of power from the dominant medical and acute care interest groups to community based health, housing and welfare services in South Australia, and therefore adopted a strategy of excluding medical interests in order to assert control over the health policy agenda. In contrast, the Designing Better Health Care in the South agencies adopted a consultative conciliatory approach in order to build trust and collaboration between and within their agencies to develop a regional approach to health care planning and delivery. As neither strategy was completely implemented, it is difficult to assess the merit of either, and while the Departmental approach was viewed as hostile and antagonistic by staff of the agencies, given the aims of the Department, and the intentions behind its establishment, the strategy of exclusion needs to be judged in a different light from

the Designing Better Health Care in the South process. The former was focused on shifting power, the latter sought to build trust. Both can be understood as having occurred within the context of the health system as a negotiated order. Therefore, an understanding of the intentions and purposes of the two different approaches helps to shed light on the different strategies and styles adopted and to make sense of a difficult period of unsuccessful health system reform in South Australia.

Chapter 9
Conclusion

This thesis has analysed a case study of unsuccessful organisational change in order to contribute to an understanding of why the South Australian health system, consistent with health systems in developed countries around the world, is experiencing the phenomenon of churning, which results from attempts to reform the health system that are often never fully implemented before the next new idea rolls over and supersedes the attempts at change that went before. In order to understand this phenomenon, the thesis has analysed the case study to develop a systemic understanding of the nature of these changes, their origins and drivers and has identified and reflected on underlying and emerging themes. The study has focused on a number of key issues in relation to the case study, including the roles of and relationships between the bureaucracy and health care agencies; the reasons for and consequences of a clash in policy agendas between these two groups; the reasons for and nature of continuous change within the health system; and the implications of trying to manage change in a complex conflictual system where outcomes are unpredictable. In concluding this thesis, this chapter draws together and summarises the key findings of the study, discusses its limitations and seeks to identify possible ways forward.

Key findings

As a case study of organisational change, Designing Better Health Care in the South was a story of frustration and disappointment, rather than of a successful change experience. Its analysis provides an understanding of the nature of the health system, some of the complex relations that operate within the system which are based on trust and collaboration, and power and control, and the difficulty of achieving successful change within a complex and contested policy environment.

Analysing unsuccessful change is regrettably uncommon, even though change strategies often fail, or are overtaken by other policies and agendas. This is in part because change strategies are usually supported by political agendas that can be undermined by the acknowledgement of the change strategy's failure, and also because the context in which they are situated continues to change and the strategies themselves continue to be adjusted to respond to these changes. This makes the evaluation and analysis of organisational and system change especially problematic, despite the importance for future planning of understanding what has or has not occurred and why.

The consequence of the 'strife of interests' (Sax 1984) that is played out in the case study, and which continues to be evident in the South Australian health system, is the presence of a highly conflictual system with significant structural problems. Attempts to address these structural problems have resulted in the epidemic of organisational and health system change that continues to be the experience of those working within the system, and is evident in the continual efforts to achieve system change and the subsequent ongoing adjustments intended to improve initial reform efforts. Churning is a direct consequence of this search for the ultimate and elusive solution to address intractable structural problems. The thesis argues that churning within the health system is evidence that the structural problems are 'wicked' problems (Rittel and Webber 1973), where there is no common agreement on what constitutes the problem or on how to address it.

Churning can also be a result of reform ideas being adopted from other contexts or countries. These ideas are popular at a particular time but may not be appropriate for the policy context in which they are taken up because they are inconsistent with other approaches adopted in that context and because a 'one size fits all' approach to reform is problematic given the wicked nature of many complex policy problems. In many cases, these reform ideas could be described as solutions looking for a problem. This is a common experience with New Public Management approaches which are

the basis for many recent reforms in the South Australian health system and other health systems in developed countries.

The case study of Designing Better Health Care in the South has provided an opportunity to consider two change strategies – the strategy developed by the four participating agencies to create a model for regional planning and service delivery, and the strategy of the Department of Human Services to achieve transformational change by shifting the dominant power base within the health system away from the medical model towards integrated community based care provided by a range of human services. The changes that are described within the scope of the case study are universally recognisable, and include centralisation, decentralisation, managerialism and integration. Similarly, the experience of unsuccessfully attempting to implement change and being overtaken by other changes is a universal phenomenon within health systems. This thesis has argued that these changes are underpinned by endemic tensions within the system between trust and collaboration, and power and control. These key themes determine the nature of the health system as a negotiated order (Strauss 1978) and whether it is based on processes that maintain stability or lead to conflict and change.

The role of boundary spanning (Sydow 1998) is crucial to the maintenance of a stable negotiated order because ongoing interaction between individuals across the organisations or the system can create sufficient trust to enable problem solving and effective negotiation to occur. Analysis of the case study of Designing Better Health Care in the South highlighted the significance of trust and collaborative leadership in building relationships that provided the foundations for formalised collaboration between health care agencies. Trust was developed by the boundary spanners, who included the Chief Executive Officers as well as a number of key clinical and administrative staff who worked across the agencies' boundaries and developed the agencies' experiences and understanding of regional collaboration. Even at the intra- and interagency levels of collaboration, trust was essential to the maintenance of an

effective negotiated order, and the reduction of that trust finally led the agencies to revert back to activities that were based on institutional self-interest.

This thesis has recognised and discussed the complex power relationships that form the context for many of the structural tensions within the health system. The tensions between professional medical power and bureaucratic managerial power are apparent both within the context of hospitals as institutions, and also within the health system as a whole, reflected in the relationships between health care agencies and the central bureaucracy. It is apparent from the experience of Designing Better Health Care in the South that the central bureaucracy played a key part in shaping and structuring the environment in which interagency collaboration could or could not occur. The supportive policy environment created by the SA Health Commission had a significant role in the agencies coming together and initiating Designing Better Health Care in the South, just as the lack of support from the Department of Human Services was fundamental to the failure of Designing Better Health Care in the South. The Department's lack of confidence in the agencies' ability to function outside their own self interest and the concern over the potential domination of the major hospitals within the regional model that was proposed resulted in the Department obstructing the development of Designing Better Health Care in the South and seeking to centralise and control all strategic planning.

Trust and power, which are at the heart of collaboration, are key parallel elements within the health system that determine the nature of interactions between central bureaucracy and health care agencies, and between administrators and medical clinicians within health care agencies. This thesis argues that the dominance of trust or control influences the governance models that are in place within the health system, which vary according to the level of trust or mistrust that is dominant, and consequently the level of power and control that are perceived as being necessary for the system to function effectively. Where trust and collaboration are strong, governance models are more likely to be decentralised, participative and cooperative, focusing on identifying common problems and jointly negotiating solutions. Where

mistrust and suspicion are dominant, models of governance are more likely to be hierarchical, authoritarian and coercive, focusing on surveillance, monitoring and control. As a result, trust and control are key determining factors for the models of governance that are in place. Consequently the model of governance that is adopted also either inhibits or supports interagency collaboration. Therefore, although Designing Better Health Care in the South became a conflict over different models of governance (centralisation and regionalisation), this conflict was underpinned by differing approaches to change, based on trust and control. The differing approaches to change were determined by the intended outcome of each change strategy, whether to build collaborative planning and service delivery (in the case of the Designing Better Health Care in the South agencies) or to fundamentally shift the dominance of a powerful interest group in the health policy arena (in the case of the Department of Human Services).

In contrast to understanding negotiated order as focusing on stability and maintenance of the status quo, this thesis adopts an approach to the maintenance of negotiated order in relation to complex and contested systems, such as the health system, that recognises the need for ongoing negotiation over time as new issues and challenges emerge that affect the capacity of the system to be responsive to the different needs and priorities of stakeholders. Maintenance of a negotiated order in a complex conflictual system requires the existence of the capacity and structures within the system to support negotiation and review and a recognition of the mutual dependence of stakeholders. In this context, trust is not essential to the negotiated order, and unequal power relations may be present, however the management of mistrust is important in order that negotiation and review can be possible. Thus, the negotiated order concept has the capacity to accommodate and explain policy change that occurs through evolutionary and iterative processes and through interactions that enable the acceptance of new ideas and the reframing of policy problems and solutions.

An effective stable negotiated order is more readily achievable at the organisational level given the key role that individuals have in making negotiations work. However, at the interagency level, achieving and maintaining a negotiated order in order to implement change is more difficult, and it is exceedingly difficult at the system-wide level, particularly where vested interests in the status quo are high, and the change being attempted is transformational in nature (Webb 1991). Significant transformational change requires a period where the negotiated order is broken down in order to undermine the interests of some of the key stakeholders who are dominant within the existing structure. The consequence of breaking down the negotiated order is a chaotic, confused and unpredictable environment which is likely to result in unanticipated and unpredictable outcomes. The case study provides examples of the experiences of unsuccessfully attempting both incremental and transformational change.

Limitations of the study

Two limitations need to be acknowledged in reflecting on this study. Adopting a case study approach has enabled a detailed analysis of the particular case within its historical and policy context, although it also limits the generalisability of this study. However, the study has sought to achieve analytic generalisation (Yin 1994) rather than content generalisation, and through this to broaden the relevance and applicability of the findings from the case study. This has been achieved through reviewing the literature and applying relevant theoretical frameworks to the analysis of the key emerging themes. A comparative analysis of similar change strategies within other health systems may contribute further to the findings of this study.

Chapter 3 of this thesis discussed my role as researcher in undertaking this study while also undertaking the evaluation of Designing Better Health Care in the South and being a seconded employee of the Department of Human Services. The challenge in order to achieve objectivity while functioning as an 'insider' with a detailed knowledge of the system, its culture and politics, is to avoid cooption and bias and to seek an objective perspective by considering alternative interpretations of

this history. This can be difficult to achieve from an insider perspective. In contrast, an 'outsider' perspective can bring alternative interpretations and can have greater capacity to raise sensitive issues and ask different questions. However, an outsider perspective is less likely to have the detailed knowledge or understanding of the cultural and historical context of the study, an important consideration in any qualitative research (Jorgensen 1989; Fraser 1997; Smith et al. 1997). In order to address this limitation in this study, relevant literature was reviewed, a range of alternative perspectives were sought through interviews, focus groups and the mail survey, and the project reference group provided a range of perspectives and interpretations of the data and the events that occurred during the case study.

As the study was situated with the agencies that were participating in Designing Better Health Care in the South and, despite every effort, the Department of Human Services proved very difficult to engage, the viewpoint adopted in the study has been predominantly from the agencies' perspectives. However, reflection on the motives and intentions of the Department, based on analysis of the focus group with the Department Senior Executive, several meetings with the Chief Executive of the Department, and analysis of Departmental documents has been used to redress the imbalance created by the much closer interactions and regular informal discussions that occurred with the Chief Executive Officers and other agency staff than was possible with the Department Executive at this time.

The motives and intentions of all of the participants involved in this case study can be debated and alternative motives proposed, based on an understanding of the culture, history and power relationships within the South Australian health system. The issue of health care reform reflects many different perspectives and values and this thesis has highlighted the tensions and difficulties that can arise from these differences.

Finding a way forward

While the Designing Better Health Care in the South change strategy was one of regionalisation and integration, this thesis does not intend to present regionalised

health care as necessarily the most appropriate structure within which a health system should operate. The outcomes of a regionalised health system can be positive, in that a regionalised health system can be more flexible and responsive to the needs of local populations. However, regionalisation can also lead to a lack of system level strategic planning which can have significant negative consequences, including fragmentation and duplication between regions. In a health system the size of that within South Australia, fragmentation and duplication are considered to be highly undesirable outcomes, and addressing these issues is a common aim of change efforts. It is important to recognise that, given the structure of the Australian health system, the South Australian health system could be considered as a region itself and further regionalisation may therefore increase the potential for fragmentation and duplication within the system.

The challenges for the future are to build and maintain a negotiated order between the key players within the health system, who include consumers, politicians, policy makers, clinicians and administrators. This requires constant and ongoing negotiation, re-negotiation and review to maintain the negotiated order. The further development of this approach would require the development of models of engagement and participation that would need to be supported by Government and involve the central bureaucracy, health care agencies (including key administrators and clinicians), and the community. It would also require the development of new skills in collaboration, negotiation, debate and dialogue to support increased understanding of the differing perspectives and interests of the key stakeholders within the central bureaucracy and in health care agencies (Bell 2004).

Given that the problems being addressed in attempting to design an effective health system are 'wicked' and therefore have no simple, 'off the shelf' solutions, but rather require the involvement of numerous stakeholders in extensive processes of negotiation, it seems that there is no single readily available ideal solution (Rittel and Webber 1973). Such problems cannot be solved definitively or finally, and therefore the focus needs to be on the quality of the problem solving processes, rather than

constantly seeking the currently fashionable 'right answer'. Constant structural change does not allow for organisational learning or the detailed and sophisticated negotiations that are described above and that are essential to addressing wicked policy problems.

An action research approach, such as that adopted for this study, would be beneficial during a process such as that described above. (Feedback from participants about information provided to them during this study demonstrated the value of this approach to them). Through feedback loops, and reflection and learning cycles, action research can help participants to understand the system in which they are engaged. This may reduce some of the anxiety and uncertainty and help to illuminate other perspectives, and through this process, may contribute to building capacity for negotiation and collaboration.

However, the challenges of attempting to reform a system that is fraught with conflict and competing interests must not be underestimated. It was evident from this study that adopting a strategy which excluded clinicians and acute care advocates from decision making, although based on an attempt to shift the medical power base within the health system, was unlikely to succeed. This is largely because the strategy undermined the negotiated order within the system by alienating a key stakeholder group. This strategy therefore reduced the capacity for negotiation to occur, and thus created uncertainty, increased conflict, confusion and resistance to change, which is very inefficient for any health system.

Tuohy (1999a) argues that significant transformational policy change occurs when a policy idea meets a recognised need and sufficient political support to create a window of opportunity. The challenge in achieving successful health system reform is to have sufficient political and system-wide commitment over a sustained period of time to allow the development of collaborative and iterative processes to achieve agreement on and implementation of reform. This would require adoption of an incremental, rather than "big bang" approach to change, and efforts to achieve broad

goals through an evolutionary, consultative process that recognises the mutual dependence of stakeholders in order that jointly negotiated solutions can provide new ways of working. However, this incremental change needs to be based on organisational learning and conscious self-reflection and collaboration across the system, with a focus not on finding the 'right' solution, but on building on what works well. The ongoing, unsuccessful international search for the best model of health care delivery suggests that there is no 'one size fits all' ideal solution and so adjustment and incremental improvement may be preferable to constant attempts to bring about major change. The experience of churning in the health system appears to be most strongly felt when change is constant and never completely implemented. It is not clear whether a more consultative, incremental approach to change would address this phenomenon, but it may provide an alternative approach that at least brings stakeholders along, rather than directing cooperation and compliance at the cost of creating alienation and resistance.

Appendix 1 – Major Events in the Development of the Australian Health System from 1972 – 2000

1972
- Election of the Whitlam Labor government
- Establishment of the Community Health Program

1974
- Establishment of Medibank, Australia's first universal health insurance scheme
- Establishment of the Health Insurance Commission and of special purpose payments to the states to fund free 'standard ward' public hospital care

1975
- Whitlam Labor government brought down by 'constitutional coup'
- Election of the Fraser Liberal/National Party Coalition government commencing efforts to return to the Page plan (which had previously provided a framework for a national health system for disadvantaged members of the community, while the majority of the population were expected to finance their own health care needs through contributory private health insurance)

1976
- Report of the Coombs Royal Commission on Australian Government Administration – largely ignored by Fraser Liberal/National Party Coalition government

1983
- Election of the Hawke Labor government (first Hawke government)
- Introduction of Medicare universal health insurance scheme

1984
- Formation of the Australian Community Health Association
- Establishment of the Home and Community Care Program (HACC)
- Creation of the Senior Executive Service
- Labor re-election (second Hawke government)

1985
- Establishment of the Better Health Commission

1987
- Establishment of the Health Targets and Implementation Committee to develop national goals for achieving Health for All Australians
- Establishment of the Consumers' Health Forum
- Labor re-election (third Hawke government)
- Restructuring of the Commonwealth Public Service into 'mega-departments'

1988
- Establishment of the National Better Health Program

1989
- Establishment of the National Women's Health Program and the National Aboriginal Health Strategy

1990
- Labor re-elected (fourth Hawke government)
- Establishment of the National Health Strategy

1992
- Keating replaces Hawke as Prime Minister
- Launch of the National Mental Health Strategy

1993
- Keating Labor government elected

1994
- Launch of the National Health Policy (Health Ministers' Forum 1994)
- Creation of the Divisions of General Practice
- COAG endorsed the need for reform of health and community services
- Commencement of the Ambulatory Care Reform Program
- Release of *Better Health Outcomes for Australians* report (Commonwealth Department of Human Services and Health 1994)

1995
- Commencement of the National Demonstration Hospitals Program

1996
- Election of the Howard Liberal/National Party Coalition government
- Announcement of up-front accommodation bond for entry into nursing homes

1998
- Signing of the Australian Health Care Agreement (replacing the Medicare Agreement)
- Review of the General Practice Strategy
- De-funding of the Australian Community Health Association

1999
- Introduction of a non-means tested tax rebate for members of private health insurance funds
- Senate Community Affairs Committee inquiry into public hospital funding

2000
- Introduction of 'Lifetime Health Cover'
- De-funding of the Australian Public Health Association

Appendix 2 – Major Events in the Development of the South Australian Health System from 1973 – 2000

1973
- Australian Labor Party in power since 1970 under Premier Don Dunstan; Minister of Health from 1970 to 1973 – Albert James Shard. From 1973 Minister of Health – Donald Hubert Louis Banfield
- Submission of the 'Bright' report – *Health Services in South Australia: Report of the Committee of Enquiry into Health Services in South Australia* (1973)
- Beginning of establishment of Community Health Centres and Women's Community Health Centres in South Australia (using national Community Health Program funding)

1975
- Dunstan Labor government returned; Minister of Health – Donald Hubert Louis Banfield

1976
- Establishment of the SA Health Commission

1977
- Brian Shea appointed as first Chairman of the SA Health Commission

1979
- Resignation of Premier Dunstan for health reasons. J.D Corcoran sworn in as Premier.
- Election of the Liberal government under Premier David Tonkin: Minister of Health – Jennifer Adamson

1981
- Incorporation of the SA Community Health Association
- Establishment of 'sectorisation' of South Australian health services and administration into Central, Southern and Western regions

1982
- Election of the Australian Labor Party to government under Premier John Bannon; Minister of Health – Dr John Cornwall

1985
- Bannon Labor government returned

1986
- *Review of Central Office of the SAHC* (Tauber review) (SA Health Commission 1986a)
- *Review of Metropolitan Hospital Arrangements and Responsibilities* (Uhrig report) (SA Health Commission 1986b)
- Establishment of the Social Health Office, reporting directly to Minister of Health, Dr John Cornwall

1987
- Abolition of sectorisation and establishment of Metropolitan, Country and Statewide Health Services Divisions
- National funding of 3 Healthy Cities projects, one in Noarlunga, South Australia

1988

- *Primary Health Care in South Australia: A Discussion Paper* (SA Health Commission 1988a)
- *Social Health Strategy for South Australia* (remained draft) (SA Health Commission 1988b)
- Establishment of Foundation SA – a grants program to fund health promotion in sports, arts and health development activities, funded through taxation on tobacco
- Establishment of Health and Social Welfare Councils Program – a program to support and promote community participation in health
- Funding of National Better Health Program in South Australia – a joint Commonwealth/state funded program to fund statewide and community based projects in specified priority areas, including nutrition, injury, health of older people, breast and cervical cancer, and hypertension.
- Resignation of Dr Cornwall and replacement by Frank Blevins as Minister of Health

1989

- Bannon Labor government returned.
- Resignation of Frank Blevins and appointment of Dr Don Hopgood as Minister of Health
- *South Australian Social Justice Strategy – Building a Better Future* (Department of Premier and Cabinet 1989)
- *Primary Health Care Policy* (SA Health Commission 1989)

1990

- *A Social Health Atlas for South Australia* (first edition) (Glover and Woollacott 1990)

1991

- Release of the Green Paper – *Area Health Service Administration in South Australia* (SA Health Commission 1991)

1992

- Resignation of Dr Don Hopgood and appointment of Martyn Evans as Minister of Health

1993

- *Strategic Directions for Primary Health Care* (SA Health Commission 1993a)
- SAHC Metropolitan Health Services Division developed *A Strategy for Planning and Management of Metropolitan Health Services* (SA Health Commission 1993b)
- Establishment of 3 regional Health Services Planning Units in the metropolitan area (Southern, Northern and Central) to support regional health services planning and priority setting
- Election of Liberal government under Premier Dean Brown following collapse of the State Bank of South Australia; Minister of Health – Dr Michael Armitage

1994

- South Australian Commission of Audit recommends $65 million cuts to the publicly funded health system over 3 years
- Introduction of Casemix and Contestability Policy

1995

- The state contribution to the National Better Health Program ($500,000) used to establish the Primary Health Care Advancement Program (PHCAP) to provide continued funding for innovative health promotion in South Australia

- $1.5 million provided to the Primary Health Care Initiatives Program (PHCIP) out of anticipated savings from Casemix funding
- Establishment of 3 Metropolitan Regional Health Advisory Panels to be supported by the regional Health Services Planning Units
- Implementation of a regional structure for country health services
- De-funding of the Health and Social Welfare Councils Program
- Establishment of the Aboriginal Health Division in the SA Health Commission
- De-incorporation of the 12 separately incorporated Community Health Centres and Women's Health Centres and their amalgamation into 3 community health services
- Establishment of the North Western Adelaide Health Service (combining the Queen Elizabeth Hospital in the western suburbs and the Lyell McEwin Health Service in the north)

1996
- Premier John Olsen sworn in, replacing Dean Brown as Liberal Premier of South Australia; Minister of Health –Dean Brown
- De-funding of Metropolitan Regional Health Services Advisory Panels and Planning Units
- Re-alignment of the SA Health Commission according to the Funder Owner Purchaser Provider split

1997
- Commencement of implementation of Coordinated Care Trials in South Australia
- Olsen Liberal government returned
- Creation of the Department of Human Services and inclusion of the SA Health Commission within the new department. Minister Brown appointed Minister for Human Services
- Commencement of the DHS re-structuring process combining health, housing and community welfare staff

1998
- Auditor General's report expresses concern about the administrative re-structuring of DHS and the conflict of interest of the CEO

1999
- DHS Metropolitan Services Division produces a paper on its model of primary care
- DHS Statewide Division produces a paper on its networks model
- DHS produces its Strategic Plan for 1999-2002

2000
- Metropolitan Services Division staff begin planning integrated community based human service precincts (to be called Community Link Centres)
- Amendments proclaimed to the SA Health Commission Act to clarify the nature of administrative arrangements between the SAHC and DHS, to validate the appointment of the CEO, and retrospectively, all actions and decisions taken by the current CEO. Amendments were also made in relation to the power of the Minister for Human Services to direct hospitals and health centres incorporated under the SAHC Act.

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