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# Re-orientation of Health Services towards Health Promotion: An Australian Case Study of Aborted Health Service Reform

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*This paper examines a case study of local health care reform in Australia that had as one of its aims the desire to increase the health promotion and partnership work of the region. The case study highlights the pressures contemporary health systems are facing and the challenge of re-orientating health services towards health promotion in this environment. Qualitative research, including interviews, focus groups, a staff survey and policy analysis were used to identify health system professionals' perceptions of the impact of health care reform. The case study portrays a complex system that is subject to frequent change but little reform. Our case study indicates that features of health systems that encourage collaborative partnerships are those where there is: an environment that encourages trust; a common purpose among the key players; a supportive external environment; practical projects to work on; organisational stability; commitment from staff throughout organisations; willingness to commit resources; evidence that change is likely to improve outcomes for users; and an organisational environment in which learning from past experience is encouraged. A number of constraints and tensions that work against introducing a greater emphasis on health promotion and collaboration within the system studied are discussed, including tensions between central funding bureaucracies and health care agencies and the reform fatigue and increasing cynicism among staff resulting from continuous change. The paper concludes that against the chaotic background of contemporary health service reform it is very difficult to bring about genuine reform to achieve a shift to more emphasis on health promotion and partnerships.*

**Key words:** Health service reform, Health promotion, Organisational change

This paper presents data from a case study of an Australian health service organisational change process that included in its aims a re-orientation towards health promotion and better co-ordination of services. The paper uses these data to identify the tensions and conflicts evident in contemporary health systems that appear to mitigate against this re-orientation. Such detailed evaluations of attempts at re-orientation are rare and this case study provides a detailed perspective of why reforming health systems is so hard.

The reasons for the introduction of the reform process analysed in this paper reflect the intractable problems that health systems across Australia are seeking to resolve. They concern the need to contain costs, increase the focus on care in the community and on disease prevention and health promotion, and develop models of governance that are sensitive to changing demands for health care and political and community concerns. The Australian health system has been struggling to

contain costs and improve efficiency. Typically this has been done by controlling supply rather than reducing demand. The system, in common with other OECD countries, has been under pressure to privatise, commercialise and contract out the activities of the health sector. At the same time health systems face contrary pressures to improve co-ordination between tertiary and primary parts of the system and to re-orientate the system towards a greater emphasis on health promotion (World Health Organization [WHO], 1986). The Australian health system has also adopted many of the tenets of the New Public Management (Pollitt, 1995), which has introduced management styles to the public sector that are typical of private enterprise. A further central concern has been with improving the integration and co-ordination of care for users of health services. Professional autonomy has also been eroded (Southon & Braithwaite, 1998; Davis, 1995) and users of health services are demanding more say in the way in which care is delivered and

organised. Health services and health bureaucracies are also the target for frequent organisational reforms and restructures (Braithwaite & Hindle, 2001). In this environment of pressure for many, and often contradictory changes, the prospects for making health promotion an integral part of all health services does not seem great. It is against this background of rapid health system reform that our case study of health service re-organisation took place. The fact that the drivers of health care reform in Australia are remarkably similar to other OECD countries (Organisation for Economic Co-operation and Development [OECD], 1994) means that the lessons may also help inform health care managers and policy-makers in other settings both in Australia and overseas.

### **The Australian and South Australian Health Systems**

Australia spent 9% of GDP on the health care system in 2001 (Australian Institute of Health & Welfare [AIHW], 2002), which puts it in the mid-range of OECD countries. The health system is based on a mix of public and private provision. Primary medical care services are almost entirely private but with the users receiving reimbursement from the federal Medicare scheme, which is a public universal health insurance scheme. Under Medicare, the Federal Government funds the states and territories to provide public hospitals which can be used free of charge by all Australians. South Australia, a state of 1.6 million people, has a reputation for progressive social reform. In particular in the 1980s this was expressed through health. The state bureaucracy translated the Ottawa Charter to a State Primary Health Care Policy and Social Health Strategy. The successful Noarlunga Healthy Cities project started in this period driven by one of the community health centres (Baum & Cooke, 1993). These centres had a tradition of conducting progressive health promotion (Sanderson & Alexander, 1995). This progressive era was followed by a period of neo-liberal government in which the dominant ethos was of cost-cutting and privatisation. It was during this period that the case study health services saw the formation of a regional health service as a means to undertake more progressive reforms despite the political climate. Over the past decade or so the need to improve the integration of health services and conduct more health promotion with a view

to improving population health outcomes has been a continual theme of Australian government policy statements and reviews at both the state and federal levels (see, for example, Macklin, 1991; Department of Health and Ageing, 1999, 2003; South Australian Department of Human Services, 2003). The case study reported in this paper was concerned with an attempt to do both of these things in the southern region of Adelaide, capital city of South Australia.

### **Methodology**

The research commenced in 1998 at the request of four chief executive officers of the separately incorporated health care agencies in this region. They were keen to evaluate the process they had embarked on of establishing a regional health service with a single board of management replacing the existing four boards, a process they called Designing Better Health Care in the South (DBHCS). The original evaluation design was based on action research to enable the agencies to be involved in and shape the nature of the research and to be informed by its findings. This proved to be a wise decision as system-wide reform soon swept over the locally-based reform process we originally set out to evaluate. For instance, as the research started, the SA Health Commission was incorporated into the Department of Human Services (DHS), which combined state health, welfare, housing and selected urban planning functions. The Department's priority was towards the integration and coordination of human services. It gradually became apparent to the CEOs that the regional health service planned by the four health care agencies would not proceed. Despite this, and after much discussion, we decided to continue with the evaluation research on the grounds that these shifts in policy direction and changes resulting from restructuring were not aberrations but part of the environment in which health care agencies now operate. It provided an opportunity to determine some of the reasons why progressive re-orientation of health services towards improved continuity of care and health promotion is so difficult.

From 1998 until early 2001 we collected data on the processes of health service reform in the study region. These data relate to perceptions on the impact of the decision not to proceed with the original planned regional health service, the

subsequent attempts to achieve the same aims through other means and the changes in the relationships between the health care agencies and the central state bureaucracy, the Department of Human Services. This paper draws on four components of the data we collected:

- A policy review paper: prepared in February 1999 as part of the evaluation on the origins and context of DBHCS, which reviewed three decades of health system reform in South Australia.
- Twenty-nine semi-structured telephone interviews: conducted with key individuals who had had a significant role in the development of DBHCS and included individuals from the region and the central bureaucracy. These interviews took place in March and April 1999 and each lasted between 15 and 45 minutes. Respondents were asked about their involvement in the process, the importance they accorded the objectives of DBHCS, how they saw these had changed over time, and the extent to which the process was perceived to have achieved its aims.
- A mailed survey: sent to a random sample of medical, nursing, allied health and administrative

staff working in the four health care agencies. The survey aimed to assess staff perceptions and experiences of health system change taking place within South Australia. The survey was sent out to 768 staff in two mail-outs in March and June 1999, with follow-up reminders. The total response for the survey was 36.6% ( $n=281$ ). We surmise from comments received from a number of staff who did not complete the survey that the low response rate reflected the fact that many staff were not in touch with the changes that were taking place outside of their agency.

- Five focus groups: three were held with service providers and managers from the study region, one with the chief executive officers of the agencies and one with senior executives from DHS, held between August 2000 and January 2001 (a total of 37 participants). Details of the focus group methods have been provided elsewhere (Van Eyk & Baum, 2003).

Table 1 provides a brief summary of the chronology of events in the development and demise of DBHCS, and the concurrent timeline of research activities.

**Table 1: Chronology of DBHCS and concurrent timeline of research activities**

|                     |   |
|---------------------|---|
| 1995 Mid 1995       | <ul style="list-style-type: none"> <li>• Chief Executive Officers' Working Group formed to investigate formalising interagency collaboration in southern metropolitan Adelaide</li> </ul>   |
| 1996 February       | <ul style="list-style-type: none"> <li>• Minister for Health approves proposal to consider options for formalising integration between services in the south and approves establishment of Southern Regional Health Service Steering Committee</li> </ul> |
| April               | <ul style="list-style-type: none"> <li>• Memorandum of Understanding signed by four agencies agreeing to collectively plan and implement a regional health service model</li> </ul>   |
| Late 1996 – late 97 | <ul style="list-style-type: none"> <li>• Extensive consultation with major stakeholders and union representatives and investigation of Australian and international models</li> </ul>   |
| 1997 October        | <ul style="list-style-type: none"> <li>• Creation of South Australian Department of Human Services (DHS).</li> </ul>  |
| 1998 April          | <ul style="list-style-type: none"> <li>• Final meeting of Southern Regional Health Service Steering Committee</li> </ul>  |
| June                | <ul style="list-style-type: none"> <li>• Final report from Steering Committee presented to agency Boards for approval, and then to DHS and Minister for Human Services</li> </ul>   |
| July                | <ul style="list-style-type: none"> <li>• Commencement of evaluation project</li> </ul>  |
| September           | <ul style="list-style-type: none"> <li>• Development of vision statement for Designing Better Health Care in the South (DBHCS)</li> </ul>   |
| 1999 January        | <ul style="list-style-type: none"> <li>• First meeting of Southern Network Coordinating Committee (SNCC) to oversee development of DBHCS; agreed to support 5 demonstration projects to trial interagency collaborative approaches</li> </ul>             |
| February            | <ul style="list-style-type: none"> <li>• Development of policy review paper by evaluation project team to provide a historical context for evaluation of DBHCS</li> </ul>   |
| March - June        | <ul style="list-style-type: none"> <li>• 29 telephone interviews with key stakeholders involved in DBHCS</li> <li>• Random mail survey of 281 staff working in DBHCS agencies</li> </ul>  |
| August              | <ul style="list-style-type: none"> <li>• Due to continuing negative feedback from DHS, SNCC agreed to wind up DBHCS and their committee following receipt of reports on interagency collaboration projects</li> </ul>                                     |
| 2000 March          | <ul style="list-style-type: none"> <li>• Focus groups commenced for evaluation project</li> </ul>   |
| June                | <ul style="list-style-type: none"> <li>• Establishment of Southern Health Services Liaison Group to share information on regional initiatives and issues</li> </ul>   |
| Aug 2000 – Jan 01   | <ul style="list-style-type: none"> <li>• Last meeting of Southern Health Services Liaison Group due to ongoing pressures for agencies to respond to DHS-developed initiatives</li> </ul>  |
| Aug 2000 – Jan 01   | <ul style="list-style-type: none"> <li>• 5 focus groups conducted, 3 with service provides, one with CEOs and one with Executive of DHS (37 participants).</li> </ul>   |
| 2001 November 2001  | <ul style="list-style-type: none"> <li>• Final reporting seminar for evaluation project.</li> </ul>   |

### Description of case study

DBHCS formally began in 1996 but was initiated following a period of almost two years of extensive consultation and negotiation and an even longer period of previous efforts to promote interagency collaboration across the region. It was a collaboration between four health care agencies: a tertiary 430-bed teaching hospital and university medical school with administrative responsibility for a number of community-based health care agencies; an integrated health service incorporating a 120-bed community hospital and a number of community health services for the outer southern metropolitan area; a domiciliary care service providing home and community-based health and supportive care for aged and disabled people and their carers; and a 270-bed hospital that provides acute care and rehabilitation services for war veterans, war widows and community patients (which is also a university teaching hospital). The aims, shown in Box 1, were endorsed by the agencies in 1998. It is worth noting in light of the focus in this paper on health promotion that the southern area of the region in the case study has been the focus of much innovative health promotion work, including a healthy cities project that started in the late 1980s. This means that thinking in the region about health promotion was advanced and key players with an interest in maintaining and extending the health promotion focus worked hard to ensure that it was an important part of the agenda for the proposed regional health service.

These aims particularly reflect two sets of competing pressure within health services. Firstly, to provide better and more co-ordinated services while at the same time improving the efficiency with which services are provided. Secondly, to provide care for individuals while also considering the health of the population of the entire region through "health advancement". Juggling these often conflicting aims is a common feature of health services (Sax, 1984). These complexities were appreciated by the key players who established DBHCS; they intended to use the process of establishing a regional health board to work towards ways of handling these tensions.

Throughout our data it is clear that most respondents perceived the collaboration that led to DBHCS to be remarkable and quite atypical of relationships between health care agencies. A typical comment from the focus groups was:

### Box 1: The aims and objectives of 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.

*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... It seemed to me to be something pretty special... I think that was an aberration because as I say the normal rule of health care politics is: "Don't collaborate. Build your empire, defend your patch and don't give something away unless you get something back".*  
(Senior Health Service Administrator).

Twenty-three of the 29 respondents to the telephone interviews saw the planned regional health service positively; some did express reservations because they knew that some staff felt threatened by the planned change or they feared that a regional health board would become “yet another layer of bureaucracy”. For managers such reservations were acknowledged, as shown by this comment:

*And there was a lot of angst with my staff, especially the staff on the ground, so we had to spend a lot of time convincing them that this was going to be beneficial to clients and that's the crux of the whole thing.*

Despite some negative comments, the telephone interviews and focus groups revealed that the overall reaction from those working in the health care agencies was that they regretted the lack of support from the newly-created department for the formation of the regional health service. This was because most interview respondents felt the project had made some real gains and believed that DBHCS had created a momentum for the development of a regional collaborative approach and had “shifted staff thinking towards co-operating across health units”.

Participants in the Department of Human Services focus group saw the decision not to proceed with DBHCS as one taken because of the department's desire to take a metropolitan-wide view of health and human services. Comments from the DHS executive staff to this effect included:

*We have tried to have common business systems and approaches across public hospitals and other things which is pretty sensible in any enterprise, private or public, but a lot of institutions, and again (names hospital in the study area) perhaps more than the others, has not wanted to join any of those, has not wanted to join in willingly in those systems. And yet as a system to survive we have to do that.*

One of the DHS executives further explained that DBHCS may have created a north-south divide in the city and made rationalisation of medical services in Adelaide more difficult, impeding efforts to achieve integration across the city. Health promotion was not mentioned as a key concern in the DHS executive focus group.

When DBHCS commenced, the plans for the regional health service were strongly supported by the central bureaucracy. Following the formation of DHS this support was withdrawn and the new

executive made it very clear to the health services that the regionalisation was not well-regarded. Once the departmental support was withdrawn from DBHCS the task of achieving integration and a regional approach to health promotion became more difficult. Although players in the south tried to continue the co-operation and co-ordination, the momentum had been lost and the period from 1999 to early 2001 saw a gradual withdrawal from co-operative ventures between the original DBHCS partners. This was not surprising as key players in the region reported that there was very little support for collaboration between the southern units. One reported that “collaboration and especially any sort of structural reorganisation was taboo”.

## Findings and Discussion

Our initial case study was centrally concerned with evaluating a process designed to increase the ability of an urban regional health system to deliver improved integration and co-ordination of care and increase potential for integrated health promotion. From our evaluation we are able to suggest what features of health systems might encourage this. Our first set of findings relates to these. We then consider the prospects for health promotion. Finally, we go on to consider what our study has told us more generally about the potential for a progressive re-orientation of health systems towards a greater focus on health promotion, given the current tensions within a health system as it responds to significant and somewhat chaotic waves of change.

### *Features of collaborative health systems*

Our case study indicates that features of health systems that encourage collaboration in improved care or health promotion are those where there is: an environment that encourages trust; a common purpose among the key players; a supportive external environment; practical projects to work on; organisational stability; commitment from staff throughout organisations; willingness to commit resources; evidence that change is likely to improve outcomes for users; and an organisational environment in which learning from past experience is encouraged.

The respondents to our survey generally agreed that encouraging effective collaboration requires resources. All focus groups supported this, with

one of the departmental executives commenting: “Very few things make people really work well together except a pot of gold”.

A similar view was expressed from a health service perspective:

*I think that what happens is, when there's less money, people will withdraw and protect home base. So the potential for discretionary income that you might give away to someone else or discretionary resource that you might share with someone else, you are more likely to hang on to and make sure it is focused where you want it to be.*

Another interview respondent noted that trying to introduce an innovative project with a focus on health promotion like DBHCS was difficult in a period of resource constraint:

*I think some of the factors that were fairly obvious were the lack of resources for the process. With the cut to health services over the years, there are just fewer and fewer resources to do this kind of stuff because you are almost in competition with direct patient care all the time. How can you put money into these things without it detracting from direct service provision?*

Some members of the DHS focus group suggested that resource constraint might actually encourage people to co-operate. One executive noted in relation to an area where they perceived there to be more effective collaboration, that it was “probably because it is under-resourced relative to the other part of the region, so it is actually having to find creative ways of doing things”. Another one commented: “but certainly the experience of the (named) integration project is that it works best where you've got your least well resourced places, they have to work together”. These views were out of step with those of most people in health care agencies who felt they were already stretched to the limit and could not be asked to take on initiatives that required them to put in more effort. (Thirty-seven per cent of those who provided qualitative comments in response to the mail survey specifically mentioned increasing stress and workloads among staff as issues affecting their work.) Members of one of the focus groups noted in a discussion about the traditional hospital power bases of surgery and medicine that in an environment of economic constraint a lot of energy goes into maintaining those power bases. They also noted that in an environment of resource constraint people are less likely to share. Despite this there was evidence that the positive environment created

by DBHCS did encourage regional collaboration. A nurse in one of the service provider focus groups noted that she had seen “some remarkable changes” resulting from a regional evidence-based fall and osteoporosis prevention strategy. She noted that:

*Now that has actually had an amazing turnaround in that it's got GP acceptance of guidelines...what has emerged is a network in the southern region of clinicians working together at standardising some of the assessment tools. So it's been quite remarkable.*

Another member of the focus group commented that this was because of the “giving it a go” atmosphere created by DBHCS. This project had been developed by a regional community health service and was one to which ongoing resources had been committed and which did provide a good example of the benefits that could result from collaboration when most of the factors assisting collaboration were in place.

### **Prospects for health promotion**

Data from our various sources gave a very clear impression that health promotion is not a central concern of health services. This was despite the fact that “health advancement” was a central aspect of the aims of DBHCS. Overwhelmingly, the concerns were with direct patient care, coping with cost reduction and trying to improve the continuity of care. Some of the initiatives that had been funded under DBHCS had a health promotion component and one of the services involved in DBHCS was doing very innovative health promotion through its Healthy Cities program. Despite these incentives, health promotion did not register as a key concern of either the staff in the staff survey (apart from a handful who were involved in health promotion work) or among the more senior staff involved in the interviews. The focus groups did give some consideration to health promotion, but again, issues of patient care were of much greater concern to participants. The fact that a region with a reputation for progressive health promotion work and a commitment to health promotion within the vision of DBHCS did not put health promotion in a key position indicates that introducing a preventive and health promoting element into health care proves difficult given the pressures faced by contemporary health services.

### **Prospects for re-orientation of contemporary health systems**

The overwhelming impression emerging from our case study is that the health system we studied, like all others, is extraordinarily complex, and that bringing about controlled change within it is difficult. This is especially true of change that will affect patient care directly. The system we have studied appeared to be best characterised as one of constant adaptation and reaction to events. For many of the players this situation was reported as chaos and confusion. Within this environment we identified two key themes that appear to impact on the ability of the health system to effect a re-orientation: the health system is characterised by a series of tensions and the reform fatigue and cynicism among health care professionals are high.

#### **Tension-ridden health system**

The most evident theme emerging from our data was that of tensions between the health care agencies and the central bureaucracy. The literature on the organisation of health care suggests this is a common characteristic of relationships between bureaucracy and service providers (Davis, 1995; Lewis & Walker, 1997). Repeatedly, these tensions were evident. There was little sense of partnership between the two levels of the health system and their relationship and perception of each other appeared to be characterised by mistrust and suspicion (Maddock & Morgan, 1998).

For the people in the health care agencies, this was especially perceived to be the case because of a belief that the new amalgamated department was particularly sceptical of health care agencies. Thus focus group respondents commented:

*There is less communication definitely. There is less contact which allows, and there is a siege mentality, there is almost a siege mentality up there, you know anybody with clinician on their forehead are people you mustn't talk to because it will distort your decision-making.*

The focus groups, interviews and surveys with staff were threaded through with a belief that open debate was not encouraged. The view that conformity was expected was common. Here the comments were reminiscent of the view of modern corporate bureaucracy presented by Saul (1997). He comments that in public and private corporations, conformism, loyalty and silence have come to be

admired and rewarded. Critics are often punished and marginalised. Many of those interviewed in the health care agencies clearly believed in their right and responsibility to speak out against policies or practices with which they disagreed.

The impression from our case study is that the relationship between the health care agencies (hospitals and community-based health services) and the state bureaucracy was predominantly one characterised by blame (Reichers, Wanous, & Austin, 1997). Thus one of the Departmental executives responded to feedback from the focus group of service providers to the effect that the staff found it difficult to understand the complexity of the system:

*I get a bit impatient as you bear with it (sic) because I actually think it is an excuse for people not getting off their backsides and actually doing something and using structures to actually deliver outcomes and I think it is just something that people say when they don't want to understand, are lazy, are protecting territory, or just want to keep on in their own world.*

Clinicians expressed the feeling that they were viewed negatively and that their opinions were considered invalid. A focus group participant reflected a commonly held view: "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".

DHS respondents saw some of the people in the field as obstructive to change, territorial, and unco-operative. Service providers suggested that DHS was uninformed about the details of health policy and practice, not supportive of their efforts and was, at that time, "anti-health". This view from the health services was fairly universal apart from a small number of community-based service providers who felt they were more supported by the new DHS. The kinds of intransigent views and characterisation of one part of the human service system by the other is not, of course, the sort of atmosphere in which transformative change, innovation or service improvement tends to occur. We certainly gained an impression that, in contrast to the days when DBHCS started, where people commented on the "can do" atmosphere that encouraged experimentation, the system now appeared to be more bogged down and stressed, and therefore less likely to lead to innovation or risk-taking.



In terms of the structural shifts, focus group participants described an increasingly politicised style of operation within the public service which has been confirmed by observers from outside government (Altman, 2000). A typical comment was: "We have got a highly politicised Department which basically responds to the Minister directly and Ministerial control and Ministerial aspirations for re-election. It has nothing to do with long term planning".

These perceptions were important in fuelling the lack of trust and the lack of a sense of partnership between the central bureaucracy and the health care agencies. This political orientation of the health bureaucracy means that the chances of progressive reforms that challenge existing resource allocations are much less likely to be realised. Attempts to change the status quo mean pressure groups resisting the change can manipulate agendas through the media by suggesting existing services are threatened.

### ***Reform fatigue and cynicism***

The overwhelming impression from the staff survey, telephone interviews and focus groups was that the staff in the health care agencies perceived their work as becoming more difficult, offering less satisfaction (especially in terms of the quality of care they could offer) and as being far more stressful. In the staff survey, issues of concern were staffing, quality of care, low morale, resource constraint. A typical comment was:

*There is not much positive in our industry. I feel like I am working in a third world country. Staff cutbacks and reduced budgets are making life impossible. Sick leave and exhausted staff are a daily occurrence. The standard of care and service that we once provided has long gone (Hospital, Allied Health).*

Overall the staff survey undertaken in the first half of 1999 indicated a high level of frustration, disillusionment and anxiety about the nature of change in the health system and the apparent lack of positive outcomes from health system developments that had been or were being implemented. Many respondents expressed concerns about their job security, deterioration in the quality of care that they were able to provide, and commented on their increased stress and workloads as a result of funding and staffing cuts. (In the staff survey, 73% of the 199 qualitative

comments on the effects of changes in the health system on the respondent's work referred to these issues.) Our data suggest that the onslaught of changes means most staff experience confusion and difficulty in understanding a highly complex and entangled health system.

This trend has also been noted in other settings. These pressures have had an impact on staff morale and create conflicts with professional values and ethics. In a series of focus groups held with UK National Health Service staff in 1998, Pattison, Manning and Malby (2000) found that staff reported de-personalising relationships between professionals and service users and between managers and workers; mismatched expectations of workers and users; frequent abuse of power—a culture of blame and risk aversion; no recognition for work well done or sense of workers being valued; people not listened to and working life increasingly seen as becoming a process of attrition. Such an environment is not a good atmosphere in which to attempt a transformative reform in a health system.

Additionally, we found that some professional staff believed that professional judgement and the ability to care may be compromised under the pressure of high throughput and barely-adequate resources. Treatment of health care as predominantly an economic, rather than a social good, places unrealistic expectations on consumers to be medically well-informed, and on providers to respond to consumer demand, rather than acting as trusted advocates. This view of health care in predominantly economic terms does not encourage a focus on how the health system can be changed. Workers become defensive of the clinical systems they have and become reluctant to risk more change and disruption to the status quo. This is a very difficult environment in which to try and re-orientate a health system in the way envisaged by the Ottawa Charter for Health Promotion.

### **Conclusion**

Our case study has enabled us to paint the picture of a planned health care reform process that envisaged introducing a greater health promotion and disease prevention focus in the work of regional health services. It appears to have started off with much promise and positive feeling but was eroded by decisions resulting from a departmental

re-organisation overlaid on a period of frequent change and development in many other aspects of health care policy and delivery. Our case study highlighted the complexity of health service reform and that it is impossible to evaluate one area of change without viewing it within the wider set of changes that are affecting health systems around the world. Forms of governance based on the new public management have been introduced to health systems across Australia and our case study area was no exception to this. The successive waves of changes in health service organisation are characteristic of modern systems. Elsewhere one of us (van Eyk, 2005) notes, based on this case study, that the continual cycles of changes that health systems are subject to amount to “churning” in the system which results in significant disruption but little in the way of reform. Reform does not just imply change but a process of improvement and removal of imperfections. Our case study portrayed the health system as being under significant stress with a demoralised, stressed and pessimistic workforce in which a culture of blame and disenchantment with system change appeared widespread. Despite South Australia’s progressive and reformist tradition the potential for transformative reform was slight once there was disagreement between the central funding agency and the health services; the wider system was once again “churning”.

It is apparent from our research that even though the key players in DBHCS were very skilled at change processes they were unable to win over a new bureaucratic structure with new players who wanted to make their own mark and had a different vision for reform. Such problems were anticipated at the conference that drafted

the WHO Ottawa Charter for Health Promotion in which a re-orientation of health services to health promotion was envisaged:

*Reorienting health services involves change and change mobilises resistance among those fearing loss of control, job security and status. The central prerequisite for undertaking change is establishing a working environment which enables and fosters co-operative and participatory problem solving.* (WHO, 1986, p.460)

Our case study highlighted that such a working environment is unlikely in contemporary health services. For a brief period, DBHCS gave hope that this was possible. The reform effort was overwhelmed by a new wave of reform that took the region back to more typical relationships of suspicion and conflict. The failure of the reform process contributed to further disillusioning the workforce. Our case study does not offer much comfort for those wishing to see the WHO’s (1986, p.v) vision of a health system that contributes to the pursuit of health rather than providing for clinical and curative services only. But it does show very clearly that such reform is only likely to result when services and their central bureaucracies are marching to the same tune. A future reform attempt will have to find ways of winning over a workforce that is weary of change and distrustful of bureaucracy. DBHCS did show, however, that when health services and central bureaucracies are in agreement and where there is strong leadership, a well articulated set of aims produced through consultation, which emphasise improved care co-ordination and health promotion—the re-orientation envisaged by the Ottawa Charter—might be possible.

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### **References**

- Altman, C. (2000). *Olsen’s Gang of 10 Cut Down to Three*. The Australian.  
Australian Institute of Health & Welfare, (2002). “Health Expenditure Australia 2000-01”. *Health and Welfare Expenditure Series No. 14*. AIHW Cat. No HWE 20. September.

- Baum, F., & Cooke, R. (1992). The evaluation of the Healthy Cities Noarlunga Project. *Health Promotion International*, 7, 2, 181-193.
- Beresford, Q. (2000). Governments, Markets and Globalisation. St Leonards, New South Wales: Allen and Unwin.
- Braithwaite, J., & Hindle, D. (2001). Acute health sector reform: an analysis of the Australian Senate's proposals. *Australian Health Review*, 24, 3-9.
- Davis, A. (1995). Managerialised Health Care. In S. Rees and R. Gordon, R. (Eds.), *The Human Cost of Managerialism - Advocating the Recovery of Humanity*. Leichhardt: Pluto Press.
- Department of Health and Ageing (1999) *Review of the National Health Priority Areas Initiative* Department of Health and Ageing, Canberra.
- Department of Health and Ageing. (2003). *National Mental Health Plan 2003-2008*. Canberra: Department of Health and Ageing.
- Department of Human Services (South Australia). (2003). *Better Choices, Better Health: Final Report of the South Australian Generational Health Review*. Adelaide: Author.
- Komesaroff, P. A. (1999). Ethical implications of competition policy in healthcare. *Medical Journal of Australia*, 170, 266-268.
- Lewis, B., & Walker, R. (1997). Changing Central-Local Relationships in Health Service Provision. *Health Systems Research Reports*, No. 7, February 1997. Melbourne, School of Public Health, La Trobe University.
- Macklin, J. (1991). The Australian Health Jigsaw - Integration of Health Care Delivery. *National Health Strategy*, Issues Paper No 1.
- Maddock, S., & Morgan, G. (1998). Barriers to transformation: Beyond bureaucracy and the market conditions for collaboration in health and social care. *International Journal of Public Sector Management*, 11, 234-251.
- Organisation of Economic Co-operation and Development (OECD). (1994). *The Reform of Health Care Systems - a Review of Seventeen OECD Countries*. Paris.
- Pattison, S., Manning, S., & Malby, B. (2000). I Want to Tell You a Story. *Health Service Journal*, 25 February.
- Perkins, R. J., Petrie, K.J., Alley, P.G., Barnes, P.C., Fisher, M.F. and Hatfield, P.J. (1997) Health Service Reform: The Perceptions of Medical Specialists in Australia (New South Wales), the United Kingdom and New Zealand, *Medical Journal of Australia*, 167: 201-204.
- Pollitt, C. (1995). Justification by works or by faith? - Evaluating the New Public Management. *Evaluation*, 1, 133-154.
- Reichers, A. E., Wanous, J. P., & Austin, J. T. (1997). Understanding and managing cynicism about organizational change. *The Academy of Management Executive*, 11, 48-59.
- Saul, J. R. (1997). *The Unconscious Civilization*, p 170. Ringwood, Victoria: Penguin Books.
- Sanderson, C., & Alexander, K. (1995). Community health services planning for health, pp. 161-171. In F. Baum (Ed.), *Health for All: the South Australian Experience*. Adelaide: Wakefield Press.
- Sax, S. (1984). *A Strife of Interests - Politics and Policies in Australian Health Services*. Sydney: George Allen & Unwin.
- Southon, G., & Braithwaite, J. (1998). The end of professionalism? *Social Science and Medicine*, 46, 23-28.
- van Eyk, H. & Baum, F. (2003). Evaluating health system change - Using focus groups and a developing discussion paper to compile the "voices from the field". *Qualitative Health Research*, 13(2), February, 281-286
- van Eyk, H. (2005). *Power, Trust and Collaboration: A case study of unsuccessful organisational change in the South Australian health system*. Unpublished PhD thesis, Flinders University.
- World Health Organization (WHO). (1986). Ottawa Charter for Health Promotion, *Health Promotion*, 1(4), i-v, 459-60.

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