

# **Chapter One**

## **Introduction**

### **1.1 Introduction**

This chapter provides an introduction to the study entitled ‘The lived experience of health service managers, their perceptions of the health system and the health management role’. A background to the health management role in the Australian and New Zealand healthcare context is given. The aims of the study are described and, in the tradition of hermeneutical phenomenology, the reader is introduced to the researcher. The limitations and assumptions of the study are identified and the organisation of the thesis is described.

### **1.2 Background to the study**

#### **1.2.1. Introduction to the health management role**

There is no easily discernable definition of what constitutes a health service manager. This gives some credence to the view that health managers are situated in diverse, complex organisations, which constitute a significant human service industry. Health managers operate at differing levels both within and across organisations in what are invariably described as health systems (Lewis 2004) in roles that might be categorized as managing services, units, departments, divisions and facilities; managing programs and services across organizations in networks and/or geographic areas and; corporate managers of support services deployed within the first two categories.

Health managers are often described in terms of what managers do, and health management is a relatively new profession. According to Leggat et al. (2006), the development of the profession as a professional body commenced in the 1930s in Australia, providing an historical time-frame of less than eighty years. While there has been some dispute about the professional definition of the role, it has developed a number of characteristics that give it professional recognition. These characteristics include: a body of health management knowledge, the implementation of formal learning in that knowledge and the development of a professional college, the

Australian College of Health Service Executives (ACHSE). The ACHSE accredits health management programs in association with the tertiary education sector (SHAPE) and provides for continuing professional development, without acquiring government licensure or regulation. These developments commenced, in the Australian context, in the 1930s at the State/Territory level, with the conduct of annual conferences for hospital administrators and the establishment and subsequent incorporation of associations of hospital managers and secretaries, again at the State level, in Victoria and New South Wales in the 1940s. In 1945, this initiative, at the instigation of these two State organisations, became the Australian Institute of Hospital Administrators; the Institute's first formal diploma course in hospital administration began in 1947. The Institute became the ACHSE in 1970 (Leggat, Harris & Legge 2006).

The constitution of the health management role lies in the context of healthcare organisations, described further in the following subsection. Managers, including health managers, are described in the literature in terms of what they do, often in terms of the functions of planning, organising, directing and/or leading and controlling (Fayol 1916; Fulop, Frith & Hayward 1992). Mintzberg (1973) described the role as being interpersonal, informational and decisional. What health managers do varies according to the level of management and the type of health service or industry sector in which they work (Smyth, Legge & Stanton 2006)

There is debate about whether management is generic, that is, whether the same role applies despite industry type or whether it is more specific to the industry context. It has been suggested that the health management role might be unique (Lewis 2004). This latter perspective suggests health managers require contextual technical knowledge, and might need to be adaptable and possess management competencies and capabilities. Management is about the performance of organisations, the leadership of people, and, in healthcare in particular, the responsibility for a diverse highly professionalised workforce. The health professions have always been part of the management of health services and have moved from the clinical arena to clinical management to increasingly becoming central to, and occupying the full range of, health management positions. These perspectives suggest a mediating, collaborative and integrative role for health managers. It would seem to be justifiable to suggest that health systems provide unique

organisations in which health managers operate, based on the complexity of attempting to coordinate competing professional and organisational activities in the production of services rather than products (Lewis 2004).

### **1.2.2 An introduction to health systems**

The historical time-frame, described above, suggests a relatively new profession that has seen health managers, however defined, as moving from managing mostly independent stand-alone health organisations, predominantly hospitals, to management roles within large networked health systems. In that historical time-frame, they have moved from being responsible to a local community representative board to being accountable to a corporate board or directly to a government department. The services are often located within large geographically-based centralised health systems, where managers also have to manage across units and services, being responsible for part of a system or an entire system. In these contexts, health managers have a responsibility to manage upwards to central State-based governance authorities that often have the multiple roles of funder, provider and monitor.

In the Australian context the above developments have been described as government slowly taking control. This description is applied because the philanthropic and beneficial nature of much of the earlier healthcare services has increasingly become dependant on, and a burden to, the taxpayer and State and Commonwealth treasuries (Crichton 1990). The changed circumstances also represent the forces of change (Decter 2000) being experienced by most healthcare systems. These include: the influence of consumerism, new ideas, technology and increasing costs. Other influences include: demographic change, ageing populations, the environment, moral and ethical challenges (Sax 1984; Duckett 2000; Palmer & Short 2000; Walsh 2002), the need to improve horizontal integration of services (Crichton 1990), and the complexity of healthcare and the unpredictability of the future (Leggat, Harris & Legge 2006). In addition, global drivers of change, the advent of performance management, and the application of business practices described as New Public Management (NPM), are also significant influences on change and complexity in healthcare organisations and the health management role (Mickan & Boyce 2006).

Healthcare organisations are now represented as one of the most complex organisations devised (Decter 2000). Although the word *system* is frequently used to describe health organisations, it does not necessarily mean integration or one central controlling authority (WHO 2000). The increased complexity of healthcare and of the systemisation of the organisational arrangements for health service delivery have meant some decades of health service reform, mostly focused on organisational structural change. These changed circumstances are the context in which health managers now reside and in which this study is situated.

### **1.3 Purpose of the study**

The purpose of this study is to explore perceptions from a diverse group of health service managers about the health system, the changed circumstances of that system, and the role of health managers in that context. There is limited research representing the managers' perspectives of the context within which they work and their role in complex organisations experiencing constant change. The research literature for the United Kingdom (UK), National Health Service (NHS) context, suggests that the managers' perspectives have been largely ignored (Preston & Loan-Clarke 2000); in the New Zealand context the complexity and difficulty of the managerial role has not been adequately represented in the literature (McKenna & Richardson 2003).

There has been a significant amount of critical UK research about the effectiveness of management, the management role and the education of managers in the NHS (Fournier & Grey 2000; Cunliffe, Forray & Knights 2002; Elliott & Reynolds 2002; Hewison 2003; Learmonth 2005). In the Australian context, the effectiveness of health service reform, which has mostly been seen as restructure together with the implementation of a performance-based approach to the management of health services, has been criticised as not being effective nor adequately evaluated (Dwyer 2004; Braithwaite 2005, Braithwaite and Westbrook & Iedema 2005).

Harris et al. (1998) in their 1997 study addressed the changing roles of health service managers in Australia and New Zealand. More recent Australian research suggests that the literature lacks any comprehensive description of what constitutes a health service manager, the range of roles and the impact of reform on those roles (Liang, Short &

Lawrence 2005). The study of Liang and colleagues (2005) defined a significant change that became a trend in the employment and accountability of health service managers. This change, which placed many health managers on short-term performance-based contracts directly accountable to the senior health bureaucrat and/or Minister of the day, occurred with the advent of State and Commonwealth-based senior executives services (Liang et al. 2006). This study attempts to respond to the above changing circumstances and the findings of other research involving health managers. It focuses on a qualitative approach in order to provide a greater understanding of the health management role from the perspective of the experience of health service managers.

### **1.3.1 Study aims**

In order to address the purpose of this study – to explore the reality, perceptions and the lived experience of health service managers – the following five aims were developed.

- Examine changes and trends in the description, nature, and role of the health service managers consistent with changes in the evolution of healthcare systems.
- Explore the personal and professional perspectives of health service managers with respect to how change influences them and the healthcare systems in which they work.
- Explore the personal and professional perspectives of health service managers with respect to contemporary management practices.
- Identify the capabilities required of health service managers to manage complexity and uncertainty in the present and future.
- Identify differences (if any) in perceptions and professional practice of health service managers based on their professional and educational backgrounds in management.

An eclectic approach to the Theoretical Framework was developed to address these aims. The Theoretical Framework involved organisational theories of complexity, organisational change, sensemaking and structural interest as described in the following section and more fully in Chapter Two.

### **1.4 Significance of the study**

The findings of this study are significant at a number of levels. The study will add to the limited empirical knowledge about the health management role in health systems from the perspective of health service managers in Australia. It will also add to the existing knowledge about the role of health managers, situated in complex organisations experiencing significant and constant change, by describing their perceptions of the role/their role and the changed circumstances in which they manage. The study describes what motivates and sustains the participants in the health management role and adds to the knowledge about how health managers learn and continue to develop in that role. The perceptions of this diverse group of health service managers has the potential to further inform future strategic approaches to health reform, the structuring of health organisations and the management of strategic change.

The study, at a practical level, first provides greater insights into the perceptions of health managers about the health system and their commitment or otherwise to the objectives of that system and the change agenda. As managers are often considered influential and central to organisational change, these insights will be useful in effectively aligning and committing managers to the organisational change agenda. Second, the study attempts to identify the perceptions of the health manager participants of the capabilities required for the managerial role. These findings will in turn inform health management education curricula and ongoing professional development requirements.

Understanding the perceptions of health managers is also no easy task given the complexity of the role and the unique nature of health organisations. This context suggests that any approach not multi-dimensional in terms of the theoretical constructs used to study the role will have limited usefulness in gaining a deep understanding of the perceived realities of health managers.

### **1.5 Methodology and Theoretical Framework**

This study is situated in the qualitative paradigm and uses a phenomenological design that involved semi-structured interviews of a diverse group of nineteen health service managers. The detailed rationale for the research design is provided in Chapter Three.

In summary, a hermeneutic phenomenological approach is used to examine the phenomenon of the lived experience of health service managers. The experiences described are the subjective experiences of the participants, best expressed through the qualitative paradigm that is more person-centred. This allows the emergence of themes from a collection of experiences interpreted by the researcher, to make explicit both the collective and diverse realities of this group of health service managers (Bassett 2004).

As described by Basset (2004), the experience of a human phenomenon cannot be separated from the experience of that phenomenon and this hermeneutic approach does not just look for new knowledge but also interprets what is already understood. Therefore, the eclectic Theoretical Framework which guided this study allowed comparison of the results with existing theory, and, with the potential of building on that theory following its systematic review and interpretation, linking theory that is already known with what is found in this study (Crookes & Davies 1998).

The framework is fully described in Chapter Two and summarised here. The theoretical concepts that are included in the framework are the understanding of change through: complexity theory as synthesised from the theories by Dann et al. (2006) and applied to healthcare systems by Kernick (2003) and Anderson and McDaniel (2000); neo-institutional theory and the typology of archetypes as adopted by Greenwood et al. (1993); the structural interests theory of Alford (1975); and the sensemaking theory of Weick (1993; 1995).

It is proposed that these multiple perspectives will better describe the multi-dimensional nature of a phenomenon, the lived experience of the health service manager, which is materially influenced and, in part, constituted by the influence of these theoretical influences. The eclectic Theoretical Framework responds to the need for phenomena to be studied contextually rather than in isolation (Omery 1983). The multiple theoretical approach is holistic and is, therefore, considered to be a strength of this study. The approach is also consistent with phenomenological principles. These principles take into account the intentionality and the objective and subjective nature of experience, the application of reductionism to obtain pure and clear phenomena to aid critical examination, to accept the intersubjectivity of experience, and to make experience accessible. A multiple theoretical approach also increases the rigour of this

study in circumstances where the researcher is situated in, and brings pre-understanding to, the study (Bassett 2004).

### **1.6 Researcher's perspective**

The researcher's perspective is presented in keeping with the principles of hermeneutic phenomenology. Martin Heidegger (1889–1976), together with Edmund Husserl (1859–1938), represents the German phase of the development of phenomenology. One of the important distinctions between their respective approaches is that Husserl believed the individual reality of the researcher should be put aside (bracketed) when analysing the data. According to Bassett (2004), Heidegger disagreed with this perspective, believing that we all self-interpret in order to find meaning and significance in our daily lives. Therefore, truth is not objective knowledge but is the subjective reality interpreted, based on our experience. This philosophy suggests that our background presents a way of understanding, giving us pre-understanding that cannot be bracketed or suspended. In fact pre-understanding can inform interpretation. This interpretive or hermeneutical approach also suggests co-constitution of the world from our experience and background (Bassett 2004). This approach, therefore, recognises the situated and interpretative role of the researcher and requires that the perspective of the researcher is acknowledged and presented.

The researcher has had a lifetime career as a health service manager, with nearly four decades of experience in a variety of health management roles and at varying levels of responsibility in mainly public-based health services in Australia. This includes experience in State-based central health department services in public health, the management of psychiatric and disability residential services, and the implementation and development of community-based health services. The researcher has also had experience at the chief executive level in public hospitals, and district health and area health services. This experience was gained in both the management of stand-alone health services governed by a Board of Directors to the more contemporary participation in large centrally-governed health systems. This operational health experience has been further informed by involvement in both industrial and professional associations and colleges, representing health managers at the state, national and international level over that same prolonged period of engagement in the health sector.

The latter decade of experience has seen a move from an operational role to one based on consultancy and academic involvement in health management and gerontology.

The researcher's experience of the health system and of the managerial role has been mostly positive, valuing the role and the public importance of equitable access to high quality healthcare. This study has provided the opportunity for the researcher to make sense of a lifelong career and interest and to align that interest and experience in a theoretical perspective. It has also been an opportunity to better inform a more recent teaching, research and consultancy role in health management and gerontology and the application of policy and practice in these areas.

Having worked in most of the different structural and public policy settings in health services over four decades, and reflecting on that experience and the literature, the researcher brought pre-understanding to this study, expressed in the following perceptions of the health system and the management role.

- Change in healthcare organisations and service delivery is a necessary and enduring reality that can have both a positive and negative influence. Therefore, there needs to be a degree of understanding, certainty and consistency provided to the nature of the change process.
- There needs to be a balanced approach to the engagement of communities, health professionals, and government and its bureaucracy in the planning and the governance of healthcare services and organisations.
- There needs to be clarity of roles and the purpose of the roles of each of these groups to ensure a transparent and balanced approach in meeting competing interests.
- Effective management and governance needs to be accessible to those who deliver healthcare services and to those who are the recipients of those services, implying some geographic division and a level of decentralisation to make that possible.
- In a diverse and geographically varied Australia, there should be potential for health service organisational arrangements to reflect the

variety and diversity of those circumstances and to avoid the extreme consequences of tightly or loosely coupled arrangements.

- There needs to be a balance between the political, technical and socio-cultural perspectives of organisational needs in healthcare reform rather than a reliance on restructuring of organisations as the main approach.
- The importance of quality management for the effective delivery of healthcare needs greater recognition and consideration in public policy

This pre-understanding of the researcher as described in these perceptions is informed by experience and reflection on that experience but remains largely a subjective view that may well be different from that of the participants to the study. However, the pre-understanding does support the need to take into account the diverse realities that may be obtained from the health manager participants in this study.

### **1.7 Limitations and key assumptions**

This research study investigates the lived experience of a diverse group of health service managers. The participants were chosen using a purposive sampling technique. In selecting the sample, every endeavour was made to reflect both what might be described as some of the major characteristics of contemporary health managers and the diversity of the roles of health managers. Therefore, some attempt was made to obtain diversity based on professional background, management qualifications, gender, types and hierarchical levels of roles, and a distribution across State/Territory and national locations. Given the relatively small size of the non-random sample, it was not intended or appropriate that the findings be generalised because the diverse purposive sample would limit any relevance to generalisation. There is also no accepted or clear delineation or categorisation of health management roles that would permit a different approach to this study.

The results of the study are descriptive and represent the reality of the participants as interpreted and made explicit by the researcher. The findings of this study should add to empirical knowledge about health service managers and should be considered in the light of other studies about health service managers. This study presents but one perception of the health system and the health management role, that of those who are health

managers. Furthermore, the power relationship within the role was not specifically addressed, other than as a prompt to gain insights into the health managers' perceptions of their role. Because of financial and candidature time constraints, it also does not represent the perception of those they manage, or those who ultimately deliver or receive the services.

## **1.8 Organisation of thesis**

This thesis consists of six chapters. A brief description of the content of each of the following chapters is provided.

Chapter Two presents the literature review relevant to this study, describing the context of healthcare systems, their historical development and the influence of health reform and restructure. Health managers and the health workforce in Australia and research findings about the managerial role are described and discussed. An eclectic Theoretical Framework is presented to show how it informed and guided the study. This Theoretical Framework addresses complexity and constant change, sensemaking and the impact of structural interests.

Chapter Three describes the research design and methodological approach used to address the research aims of providing greater description and depth of understanding to the health managers' reality of the health system and of their role as health service managers. The paradigm for the research design and methodology adopted in this study is justified. The research setting, sample, interview guide, data collection method and data analysis procedure are described. Rigour, trustworthiness, methodological issues and limitations are also discussed, as are ethical considerations and participant protection.

The results of this study are presented as four themes and nine sub-themes presented in Chapters Four and Five. Chapter Four presents the main themes and sub-themes from the analysis and then provides a detailed account of the justification for the data analysis technique. The profiles of the participants are described. The first two sections of the data analysis are presented as Themes 1 and 2. Theme 1 consists of two sub-themes, 'constant and complex change in a non-adaptive system' and 'bureaucracy and politics – a system of parts', together representing the health managers perceived reality of the

health system. Theme 2 presents the health professions in management as a contested role. This also contains two sub-themes, ‘the importance of sensemaking’ and ‘people, power and politics’, describing how health managers operate in the role.

Chapter Five presents Themes 3 and 4, together with relevant sub-themes. Theme 3 maps the career journey of health service managers. It is further informed by three sub-themes: ‘learning to be a health manager’, ‘role models, mentors and motivation’ and ‘developing and supporting health managers’. Theme 4 represents the health managers’ solutions and is informed by two sub-themes, ‘structuring the health system’ and ‘educating and changing the health workforce’. In both chapters, and for each theme, extracts from the data are presented as narrative that enriches the findings (themes) and portrays accurately the true picture that emerges from the themes. Consistent and divergent perceptions of the participants are presented where relevant. The themes and sub-themes are then linked to appropriate elements of the Theoretical Framework with interpretation and analysis from the theory and research described in Chapter Two.

The thesis concludes with Chapter Six, which presents the researcher’s interpretation of the findings in relation to the purpose and aims of the study and previous research conducted on this topic. The implications of this research study for policy and practice relevant to the health management role and the organisation of healthcare are discussed. The utility of the Theoretical Framework is reviewed and suggestions for further research are provided.

## **1.9 Conclusion**

In summary, this chapter has laid the foundation for the thesis. The background of the study, its purpose and aims are described and the researcher’s perspective is presented. The purpose of the study is to gain a greater understanding of the reality and lived experience of health service managers in respect to their perception of the health system and of their managerial role.

The aims of the study are presented. The significance of the research is discussed with theoretical and practical contributions identified. Specifically, the findings of this study will add to the limited empirical knowledge about the health management role from the

perspective of health service managers within health systems. Chapter Two presents a systematic review of the literature in relation to the study aims.

## **Chapter Two**

### **Literature review and Theoretical Framework**

#### **2.1 Introduction**

This chapter describes the literature that was used to inform the research study. The approach to reviewing the literature and the development of the Theoretical Framework is described in the introduction below. A description of the context of the healthcare system in which the research was conducted, the relevant research about the health management role, and the Theoretical Framework adopted for this study follows.

This research aims to explore the lived experience of health service managers. First, their perceptions of the health system, changes and trends in the health service manager role over time and the influence of change on the system and health managers are examined. Second, an analysis of how managers manage in these circumstances, how they learn and what differences they perceive between the professions in undertaking the health management role is provided.

Healthcare has become a global industry with significant international movement of the health workforce and with formal comparative healthcare performance between and across national health systems. The literature on healthcare managers and healthcare reform in Australia is relatively limited. This chapter, therefore, takes an international perspective drawing on the literature available primarily from the United Kingdom, the United States of America, Canada and New Zealand as well as Australia. The differences in health systems and their relevance to the Australian context are presented where relevant.

The deficit of health management research in the Australian context reinforces the importance of this study. First, the research is important because it is said that health managers face unique challenges (Mintzberg 1979, 1997; McKenna & Richardson 2003). These challenges include achieving dual goals in sustaining financial viability, while delivering high quality care (Schulz 2004), in a context that is different from other industries (McConnell 2000). Second, in the research literature on managers, it is

claimed that the 'voice of the manager has been relatively ignored' (Preston & Loan-Clarke 2000:101), suggesting that a greater understanding of the managers' emotional response to change is required. According to McKenna and Richardson (2003:85), much of the literature fails to represent the 'complexity and difficulty of the managerial experience'. The response to the corporatisation of health structures and the introduction of performance management, such as that of the UK NHS, has led to several authors questioning the priority, relevance and effectiveness of approaches to management and the role of managers and their education in that context (Fournier & Grey 2000; Elliott & Reynolds 2001; Cunliffe Forray & Knights 2002; Hewison 2003; Learmonth 2005). Thus this questioning of the role and the approach to management in national health systems reinforces the need for further research in the Australian context.

Health service managers face constant change and unpredictability in terms of tenure, roles and career direction, requiring them to gain new personal and adaptive skills (Harris et al. 1998; Smyth, Legge & Stanton 2006). Managers are provided with a range of languages (theories) to describe the organisational situation, the problems faced and options for change. However, Smyth et al. (2006:12) emphasised that 'none of these theoretical traditions provides a self-sufficient account of the world as experienced by the manager. They are partial stories which overlap unknowably ... they are incommensurable'. The role is highly contextualised by the history and development of healthcare, the forces of change impacting on contemporary health systems, management and organisational theory and how managers learn and practice their profession. The lack of clear delineation of the role in profession-dominated health organisations also adds to its complexity.

The literature was reviewed by searching national and international sources, utilising the University of New England library catalogue and electronic library resources plus the Health Management and Planning Library of the Australian College of Health Service Executives. Key words and combinations of key words utilised in searches included: health manager, health management, organisational theory, complexity, change theory, health system reform, restructure, health policy, education and professional development, lived experience, interpretative phenomenology. Databases utilised include the ADT program database. Google Scholar and MetaSearch were used

to search for electronic sources primarily through collections, such as Emerald, Expanded Academic, JSTOR and ProQuest. Australian Bureau of Statistics (ABS) data were obtained directly and through the Australian Institute of Health and Welfare (AIHW) electronic resources.

This research describes the lived experience of a sample of health services managers in the Australian and New Zealand healthcare systems. The health systems in which they are engaged are generally well regarded (Blendon et al. 2003; Menadue 2003; Van Der Weyden 2003). However, there have also been consistent calls for reform of health systems and there has been significant criticism of the Australian healthcare system (Gray 2002; Menadue 2003; Van Der Weyden 2003; Martins 2006; Podger 2006), with a number of State-based formal Inquiries (Eager 2004; Wilson 2004; Davies 2005; Forster 2005) around adverse events in specific facilities, as well as unrelenting media coverage of unsatisfactory experiences by the public in their encounters with the health system. The success of reforms in New Zealand has also been the subject of debate (McKenna & Richardson 2003; McKernan 2007; North & Perkins 2007).

This context places the health manager within a complex professionally-dominated, politically-driven system that is experiencing constant change. It reinforces the uniqueness of the role leading this researcher to adopt an eclectic approach to the Theoretical Framework for this study. The theoretical concepts included are the understanding of change through: complexity theory as synthesised from the theories by Dann & Barclay (2006) and applied to healthcare systems by Kernick (2003) and Anderson and McDaniel (2000); neo-institutional theory and the typology of archetypes as adopted by Greenwood et al. (1993); the structural interests theory of Alford (1975); and the sensemaking theory of Weick (1993; 1995).

## **2.2 The context of healthcare in Australia**

This section describes the significant change in healthcare delivery in Australia from one that was predominantly philanthropic and community-based, with reluctant government involvement, to government slowly taking control (Crichton 1990) and the current trend of highly systemised and centrally-controlled, mostly State Government

operated health services (Dwyer 2004). This is the context in which health managers are constituted and perform their role today.

Healthcare organisations, often described as health systems, are represented as amongst the most complex organisations (Decter 2000) because of the comprehensive range and extent of roles and services involved (WHO 2000). The use of the word 'system' does not necessarily imply integration or that there is one controlling authority. Health needs have changed with health services having a broadened role to address wider problems perceived to be within the ambit of health systems (WHO 2000). The increased systemisation in which healthcare resides is also a consequence of the globalisation process and the impact of international organisations, such as WHO and the World Bank. It is also in response to demand for clarity about the major causes of disease and injury, how that might change, and the effect on populations. While the evidence base for setting health priorities is expanding, increased scrutiny will be required as the demand for healthcare grows (Lopez 2003).

### **2.2.1 Historical context of healthcare in Australia**

Healthcare in Australia in the 19–20<sup>th</sup> century was characterised by individual, independent and private medical practice with access to community-developed and community-controlled public hospitals. Direct control by government was initially avoided, but increased through subsequent 'incorporation and regulation' (Sax 1984:22). While governments subsidised individual hospital operations, hospital boards 'aggressively entrenched their independence' (Sax 1984:23). Governments directly provided public health and asylums for the mentally ill.

Progressively, in the 1900s, there was increased funding and control of hospitals, and later health services, by government to the extent that in some cases any sense of community ownership has been removed. Services today are centrally funded and mostly operated by State Government bureaucracies. The Commonwealth Government contributes to those services by way of grants to the States and Territories and directly funds primary healthcare, aged care services and medical and pharmaceutical benefits (Briggs et al. 2004).

The post-second world war period saw the appointment of salaried hospital secretaries, to act in the role of, and subsequently to be described as, Chief Executive Officers. In the larger facilities, a management structure of hospital secretary, matron, and medical superintendent emerged, and even in the smallest hospitals a minimum of a part-time secretary and matron were evident and the emergence of health management as a profession had begun.

The provision of public health and psychiatric hospitals (or asylums) and acute hospitals or institutional care developed from separate directions. Often separate government departments were responsible for elements of what we now regard as a health system. Responsibility for public hospitals was through fairly autonomous and influential community and/or 'not for profit' boards. The 1970s saw the conduct of a number of hospital/health-related government inquiries arising from concerns over cost escalations and increasing demand for government subsidy of predominantly hospital activity. As a result, separate government departments were increasingly merged into single departments or commissions with wider integrative mandates resulting in a broader view of healthcare (Palmer & Short 2000).

### **2.2.2 Health system reform and restructure**

Health system reform and restructure has been a consistent feature for some decades of most national health systems, including those of Australia and New Zealand. Reviews and changes in the way State health services are governed and organised has occurred across most States and Territories in Australia (Dwyer 2004). For example, the NSW reforms implemented area health structures and introduced a new management era with the introduction of a senior executive service and performance agreements (Liang et al. 2005). The New Zealand experience of health reform saw more extensive experimentation in approaches than in Australia; this is described by North and Perkins (2007).

Dwyer (2004) utilised data from published reports of systemic reviews in Australia to conduct an analysis that indicates reviews are prompted by a wider government interest and not just that of the Health Minister of the day. The analysis indicated that reviews sometimes occur because of crisis and the trend is substantially towards a centralised

model of a State-integrated service. This trend has led to a virtual loss of independent stand-alone providers with a disengagement of communities and the loss of boards of governance. According to Dwyer (2004), there was also recognition of the need to move away from micro-management and to better delineate funding, and policy and provider roles. The reality is, however, often closer engagement of government and health bureaucracies in those roles and in the performance management of providers. The analysis indicated that reviews are also notable for being driven from the top down and that they mostly review the lower operational level and often occur in a political context. These reviews are also seen as opportunistic in introducing new measures of efficiency. Dwyer (2004) emphasised the need for innovation in developing models of care, particularly for chronic diseases, but doubted the ability of the system to respond when centralised bureaucratic control and micro-management dominates.

Calls for reform and restructures were also analysed by Rix, Owen and Eagar (2005). These authors identified similar issues to Dwyer (2004) and they concluded that health authorities now have to implement both local and national reforms, while having blurred policy and provider roles as well as investing in crisis management of their service delivery. According to Rix et al. (2005) these circumstances are said to have led previously to a move to decentralised organisational forms. Rathwell and Persuad (2002) indicated that positioning health organisations as centralised or decentralised invokes issues about trust, stewardship, and governance. These authors suggested that the question in health system reform is: does the reform process 'lead to a strengthening or weakening of the relationships between those responsible for the organisation and delivery of services and those who are in receipt of services?' (Rathwell & Persuad 2002:15 ).

The question as to what level of government involvement is required in both resourcing and owning health services has been answered by increased funding, ownership and control of health services by government, at least across the State and Territory jurisdictions in Australia. According to Crichton (1990), while there has been significant reform and change, the system remains one built on politics and negotiated compromise. Despite calls at times for citizens to have active participation in the health system, to increase transparency and accountability through public engagement (Maxwell, Rosell & Forest 2003), citizens remain essentially an external constituency

used by health providers in their interests of maintaining the status quo (Alford 1975). While public participation is always supported as a principle, there is little evidence that it is embraced and applied in health systems (Mooney & Blackwell 2004).

Contemporary debate about the Australian healthcare system continues to call for reform (Menadue 2003, 2006; AHCRA 2006; Podger 2006). The approach behind these calls has been criticised for a continuation of reform based on restructure, with a drive for continued efficiency, effectiveness and improved quality and safety, when reform should start with the patient (Braithwaite 2006). According to Braithwaite (2006), international comparisons of health systems supported no more than a middle range call for reform of the Australian health system and that, rather than restructure, an approach, based on understanding organisational behaviour, culture, power and team-based bottom up methods to reform, might be more appropriate.

According to Decter (2000:4), the four important forces of change in the context of healthcare are ‘powerful new ideas, a consumer revolution, technological transformation, and financial pressure’. The reductionist modern scientific response, together with genetics, new technologies; demographic changes, and particularly an ageing population; the economy and the potential impact of health expenditures; and the environment and moral and ethical challenges, are also proposed as the big drivers of change (Sax 1984; Duckett 2000; Palmer & Short 2000; Walsh 2002). The historical independent development of services in Australia is proposed by Crichton (1990) as requiring reform to improve horizontal coordination of services. These forces are similar to those expressed in the general management literature, although they are generally couched in terms of competitiveness rather than cost control (Cummings & Worley 2001; Stace & Dunphy 2001). Restructuring across national health systems is the universal response to these forces and is both continuous and pervasive (Braithwaite 2005, Braithwaite, Westbrook & Iedema 2005).

Leggat et al. (2006) suggested change influencing factors, such as the complexity of healthcare, the increasing speed of change and the unpredictability of the future and our ability to build capacity to meet that unpredictability, as contributing to change. Mickan and Boyce (2006) suggested the global drivers of change in healthcare include free market economics and small government, the new public management, and the effects

of trade policy on the sovereignty rights of national governments. The World Health Report (2000:231) suggested that the evolution of healthcare has been affected by political and economic changes with transformation from centrally planned economies to market economies with reduced state intervention, less government controls, and greater decentralisation. The calls for reform across healthcare systems have also challenged hospitals and health services to restructure and adopt more commercial business practices. These include the adoption of total quality management (TQM) and approaches such as re-engineering. These, and similar strategies, are adopted and regularly called upon to achieve significant efficiencies (Rathwell & Persuad 2002) but the success of these approaches has been questioned (McConnell 2000; Ferlie & Shortell 2001; Rathwell & Persuad 2002) and there is little central system support for innovation in health services (Dwyer & Leggat 2002).

According to several authors, results of reform, even if deemed successful, invariably represent significant costs in implementation and or lost opportunities, lowered morale, commitment and productivity, and result in increased administration levels and disaffection with management ( Smith, Walshe & Hunter 2001; Fitzgerald & Isaacs 2003; Rondeau & Wagar 2004; Oxman et al. 2005). Equally, change initiatives are said to be the same or similar to those used previously, but are presented and organised as though they are entirely different (Eraut 2004).

In Australia, the tendency is for State health bureaucracies to directly fund and deliver services. There has been a significant move away from the focus on individual care and treatment and facility and service management to a focus on populations and the emergence of health systems, networks of organisations and their management. The latter half of the 1900s through to the present has been characterised by resource constraint, rationalisation of hospitals and continuous restructure of organisational structures with a move to population-based funding models (Dwyer 2004; Rix 2005).

These economic aspects of healthcare reform have increased the interdependencies between administrative and clinical issues (Anderson 2000). While constraining hospitals and their activities and deploying savings and new funding to community-based programs, government has continued to insist on availability, access, and the maintenance of quality care for all. The competing interests between efficiency and

economic reform with that of quality care and good health outcomes has been a feature in the restructuring of delivery systems. There has been some notable system failures and public disquiet over standards and quality of patient care (Eager 2004; Forster 2005). These change influences have also added levels of complexity to the health management role, a role that is described in the following two sections of this chapter.

### **2.2.3 Health managers and the health workforce in Australia**

Health managers are part of, and central to, an industry predominantly dependent on people, the health workforce, for success. This section provides demographic data about health managers and that workforce in Australia. It demonstrates the difficulty in adequately defining and describing the health management workforce.

The pressures on the health manager role, in this case in a hospital context, are said to be enormous and ‘all falling on the shoulders of mere human beings called managers’ (Mintzberg 1997:16). This prompts the assertions that ‘running the most complicated corporation must almost be child’s play compared to managing almost any hospital’ and ‘what is amazing today is not just that hospitals get managed at all but that anyone is willing to do so’ (Mintzberg 1997:16). Healthcare has similarities to other industries and is a significant service industry and employer in its own right, but it is also different. Healthcare is certainly less routinised, less controllable and not dependant on normal economic market signals, and requires a cooperative management system. The context is people-centred and deals with a mobile professional workforce (McConnell 2000).

The monograph *The Changing Roles and Careers of Australian and New Zealand Health Service Managers* (Harris et al. 1998) describes a study that included a survey of health managers in Australia and New Zealand. This study was a stratified randomised survey of seventeen percent of the membership of the Australian College of Health Service Executives (ACHSE) and the New Zealand Institute of Health Management (NZIHM), seeking the views of health managers by a questionnaire and by a structured interview of a subset of non-respondents to the survey/questionnaire. This study described a relatively young workforce, with 70% of those surveyed less than 50 years of age and a reasonably balanced gender profile. The sample consisted of a highly

qualified workforce with a significant component having both clinical qualifications and management qualifications. There was high satisfaction with the type of work, but increasing job turnover (Harris et al. 1998). Validity of the study was increased by the involvement of senior College members in the development and testing of the instruments. However, it must be remembered that the sample was a subset of health managers who demonstrate commitment to the profession by College membership and may not be representative of the larger population of health managers.

According to the ABS and the AIHW, there are 26 722 managers employed in health and community service industries in Australia as at the 2001 Census (AIHW & ABS 2003). This represents a 10.1% increase of 2462 since the 1996 census figure of 24 260. The total number of employed persons in health and community services industries increased by 10.6% to 798 201 in that same period. In the 'other occupations' category, which includes managers, there were notable increases in business and computing professionals (16.9%) and business and computing associate professionals (44.5%). These increases are significant when compared to the increase in registered nurses (6%), medical professionals (11.2%) and allied health professionals (20.4%) (AIHW & ABS 2003). These data demonstrate that health managers have maintained increases equivalent to the average health workforce increase and have well exceeded that average in respect to business and computing professionals. This contradicts assertions made when implementing restructures and reform that the objective is to reduce layers of administration and release administrative resources to clinical services (Hill 2007).

These counts of the number of health service managers need to be treated cautiously because of inconsistencies in definitions and counting utilised at that time. The ABS used the Australian Standard Classification of Occupations (ASCO) Second Edition to assign codes to occupational information obtained from the census (ABS 1997). However, the occupational groups listed under the Unit Group of 'Health Manager' only consisted of two categories, Director of Nursing and Medical Administrator. This restricted description was overcome by a count of those who described themselves as engaged in 'health managers' occupations across industry sectors (ABS 2005). The second problem of not recognising health managers with allied health qualifications was temporarily addressed by counting them into the 'Medical Administrator' code until such time as the new ANZCO classifications were finalised and adopted (Woolley, D. 2005, pers. comm. 24 May). These discrepancies have mostly been addressed in the

ANZSCO –Australian and New Zealand Standard Classification of Occupations – released in 2006 (ABS 2006).

These data, while disclosing discrepancies in the definition and counting of those who might be considered to be health managers, also reinforce the difficulties inherent in being able to adequately, let alone clearly, define what constitutes a health manager. A narrow definition of that role may have been possible in the post-war period when the profession emerged. However, given the diversity of levels of management that now exist, the systemised nature of healthcare organisations, and the general pervasiveness of management practice into the professional role, a simple definition may no longer be possible.

#### **2.2.4 The managerial role and managing healthcare organisations**

In this section, the managerial role and the findings of previous research studies are critically discussed. The role is occupied by health professionals with primary clinical qualifications, with or without health management or management qualifications, and generalist trained health managers, with or without both generic and health management qualifications.

Health service managers are mostly trained in and utilise rational and normative management theory and practice. This approach was reinforced in the Australian context by the implementation of corporatised area health management structures and performance management-based approaches for senior executives (Liang, Short & Lawrence 2005). Therefore, this perspective needs to be critically appraised in this study, as health managers, like management itself, are a relatively new phenomenon. There is a view that ‘uncertainty over the precise nature of management and its effectiveness persists’ (Hewison 2003:123), both in the general management field and particularly so in healthcare (Reedy & Learmonth 2000). Cunliffe et al. (2002) suggest that management practice needs to be redefined as contested terrain, available for critical examination with its political and morally charged nature recognised. According to Fournier and Grey (2000:8) critical management inquiry emerged in the UK in the 1990s, partially as a response, among other things, to the emergence of ‘the New Right, New Labour, managerialisation and the internal crisis of management’. These authors

argued that UK anti-union legislation was meant to ‘restore the managerial right to manage’ and ‘open the way for efficient and innovative management’ (Fournier & Grey 2000:10).

Managerialisation of the UK public sector has been interpreted, amongst other things, as an ‘assault on arenas of professional power’ and to be as much about ‘ideological restructuring as about cost control and, of bringing the market to the public sector’ (Fournier & Grey 2000:10). These statements can also be seen in Alford’s (1975) terms as providing a re-arrangement of structural interests. Management was exalted and managers were seen as having special insights and as having ‘a privileged knowledge of the real world’ (Fournier & Grey 2000:10).

This elevation of management brought closer political alliance and participation in the ‘highly contested change of restructuring, downsizing, and cultural re-engineering’ (Fournier & Grey 2000:11). Management became ‘constituted as the *solution* to a disparate range of problems and issues (Fournier & Grey 2000:11). In this context, management focuses on performativity by subordinating knowledge in the pursuit of efficiency. Critical management inquiry questions the ‘alignment of knowledge, truth, and efficiency’ within ‘notions of power, control, and inequality’ (Fournier & Grey 2000:17). These critical perspectives contrast with the normative, rational view of management and are important to this study in seeking to present the personal perspective of managers about their role, possibly in contrast to that normally presented in the literature.

There are inherent tensions in the managerial role, where managers are seen as both exploitive of others and at the same time victims of the system and are portrayed as constantly in struggle with complex circumstances (Elliott & Reynolds 2001, 2002). Managers have also been described as lacking courage and being without deep conviction (Van Manen 1997). They are also given the immense challenge of still needing to think ‘clearly, rationally and consistently’ (Watson 1996:339). More recent characterisations of managers describe them in terms of Gramsci’s (1971) portrayal of certain roles in society as intellectuals of that society, as active participants, constructors, organisers and persuaders. Here the emphasis is the negotiation of meaning as being central to the role (Elliott & Reynolds 2002). This approach is

important because it allows a move away from characterising individuals based on constituted roles to an emphasis on engagement between them (Elliott & Reynolds 2002). In this context managers are seen as developing social relationships through constructing and reconstructing to achieve order from chaos (Reed & Anthony 1992; Elliott & Reynolds 2002). McConnell (2000) indicated that managers and others who work within the health system could be limited by their dominant paradigm, seeing information that fits the paradigm. They cannot see information and, therefore, possibilities that are inconsistent with their paradigm that is ‘a product of their individual experiences and beliefs’ (McConnell 2000:6). This context can define the negative view of change (McConnell 2000). These approaches are consistent with the call to ‘challenge the dominant ways we think about management’ (Learmonth 2005:186) and are important considerations to this study that attempts to gain the perspectives of health managers about their lived experience in that role.

Learmonth (2005) suggested that management is mostly seen in terms of the technique of control of resources, and management skills are only valued if they increase or improve managerial control. This technical perception, based on performance, needs to be challenged, as it camouflages inappropriate practices in the name of ‘better management’ (Learmonth 2005:186). This again reinforces the need for qualitative research approaches, such as that used in this study, to gain a greater insight from the interpretation of health managers’ perceptions about their role.

In Mintzberg’s (1997) research, he described health managers and health management in hospitals largely from the perspective of the professional backgrounds of the managers. This author utilised a separately developed framework, called ‘four worlds’ and experiential observation techniques and seminars of senior managers and clinicians in England and Canada to determine that hospitals could solve systemic problems, not through structuring and strategic planning, but through tangible change to collective behaviour. Mintzberg (1997) combined the processes of managing *up*, *down*, *in* and *out* with the health manager’s primary profession by indicating that as managers, nurses manage care *in* and *down*, while physicians manage cure by intervention, *down* but *out*. Generalist managers manage *in* but *up* through managing hierarchies; they allocate and restrain the use of resources and are held accountable for the resource decisions of others. Like the physicians, they make periodic corrective interventions. Communities

are said to organise *out* and *up* through boards of directors. According to Mintzberg (1997), these different perspectives of health management make management difficult and require mutual collaboration to address problems. Mintzberg (1997:14) proposed a craft style of management that exhibits deep understanding of context and deep respect for people and, is about ‘facilitating, not directing, inspiring, not empowering’.

Other authors have also suggested that effective managers apply a range of approaches to suit differing situations (Mullally 2003) and operate in organisational contexts by drawing on knowledge to enact action in a unique situation (Schon 1991; Hewison 2004). Important constants and imperatives of the health management role are visibility and availability to staff, a downward management orientation rather than an upward management orientation. Managers also teach, coach, counsel, and facilitate the work of others, while being proficient at managing self, through ‘meaningful, interesting, and challenging work’ (McConnell 2000:16).

Administration as a profession has been demoted in favour of corporate management. This promotion of management and the centrality of management and the manager role in healthcare is recent and also reflects a diminution in the number of Chief Executive Officer (CEO) roles as health services have become systemised. This change in Australia follows a similar demotion of *administration* that occurred in the UK National Health Service (NHS) by 1986, consequent with the ‘lionisation’ of management (Learmonth 2005:183). While managers are portrayed as being in control (Davies 2003; Degeling & Carr 2004), they also have to ‘manage in unique (fast moving) contexts of great uncertainty, with considerable ambiguity and discontinuity’ (McKenna & Richardson 2003:81). The modern health manager is accountable for performance objectives determined by centralised State bureaucracies and (generally) is no longer accountable to communities or Boards. Increasingly, clinically trained health professionals have moved into generic health management roles and research relevant to this trend is important to this study. Managers and clinicians are said to ‘inhabit different assumptive worlds’, but demonstrate sufficient commonality of interest to create synergy in the achievement of those common interests (Sutherland & Dawson 1998:S22).

A consequence of the medical dominance of the health system and the multiplicity of professional roles is that health managers reside in highly professionalised organisations. Healthcare organisations are unique in that they are dependant, not on one profession, but multiple professions contributing to success (Anderson & McDaniel 2000), and there are increasing shortages across the range of health professions (Walsh 2002). The health workforce is segmented and based on professions; there is significant and increased specialisation and training continues to be segmented, reinforcing the occupational and sub-specialisation differences. Occupational groups in healthcare adapt to change and policy differently, with implications for health reform and organisational, management and professional practice (Fitzgerald & Teal 2003).

Previous research studies suggest that managers have difficulty with managing change. This difficulty is described in terms of significant stress, low morale, esteem, loyalty and commitment (Stuart 1995, 1996; Learmonth 2005). Excessive change leads to fatigue, disorientation and dysfunction, disaffection and dissatisfaction (Stensaker et al. 2002; Greener 2004). Unit-based managers assigned leadership in reform processes are limited in their ability to manoeuvre and transform (Degeling & Carr 2004). There is evidence that change management programs do not achieve their objectives (Poole 1998; Beer & Nohria 2000; Cao, Clarke & Lehaney 2004). The perceptions of managers and their role in change have received little attention (Isabella 1990; Stuart 1995; Hartley, Bennington & Binns 1997; Burnes 2000; Doyle, Claydon & Buchanan 2000; Saka 2003).

The reforms of the organisation and management of the UK NHS in the 1980s, arising from the Griffiths Report (Griffiths 1983), occurred in part on the belief that doctors were natural managers and that, as they dictated the use of resources, they should accept management responsibility together with clinical freedom (Bruce & Hill 1994). This perspective about the role of doctors in management prompted research by Bruce and Hill (1994), who aimed to explore relations and roles between doctors and managers in the reformed NHS; the research involved 64 semi-structured interviews with chief executives, general managers, directors of finance, medical and clinical directors, and consultants.

The findings of Bruce and Hill's (1994) research indicated that the doctor–manager relationship was seen more so as containment of opposing forces than promoting harmonious relationships. Management focused on influencing doctors by informing them about financial dynamics; they had limited capacity to achieve more because indicators of medical performance were crude and they did not have legitimate authority to challenge decisions, primarily clinical in character (Bruce & Hill 1994).

The UK NHS study of Bruce and Hill (1994) showed the involvement of doctors in management as evolutionary, long-term and requiring cultural change. Senior managers regarded medical directors as part of the management hierarchy, while others (managers and clinicians) saw them 'as the voice of the medical establishment' and the status of those positions as less than that of a clinical career (Bruce & Hill 1994:54). Clinical directors were seen 'as agents of management' who maintained clinical loads 'to secure trust of colleagues' and consequently they felt pressured by the competing contexts (Bruce & Hill 1994:55). Medical director roles were invariably characterised as *puppet*, *diplomat* or as the *fixer* and *careerist* with strong proactive managerial interest (Bruce & Hill 1994). The authors questioned the use of the medical expertise of this important and influential group in the practice of management as to whether it represented the most 'efficient and effective use of resources' (Bruce & Hill 1994:56). While the findings of the research are important, the research was limited in its application because of the relatively limited number of participants and the limited geographical area within a large national health system that was involved in the study.

The stereotypes of doctors and managers were questioned by Sutherland and Dawson (1998), who proposed that neither group are homogenous. In this study the findings show that medical managerial roles are differentially perceived, with medical directors seen to be part of the management hierarchy by some while others were seen to be largely advisory. Similar to the research of Bruce and Hill (1994), Sutherland and Dawson examined the relationship of doctors and managers through contemporary history, expressed views and through concepts of power, legitimacy, control and autonomy, utilising interview transcripts from three research projects over a six-year period (Sutherland & Dawson 1998:S16). This was secondary research arising from three different research projects with relevant but varying aims conducted over an extended time-frame. These three studies involved personal and organisational

development of senior executives in the NHS; the social and organisational context of translating research into clinical practice; and a policy review of quality initiatives in the NHS.

Thorne (2002) also undertook research located in a UK NHS Trust to explore issues of power and control between doctors and managers through participant observation and in-depth semi-structured interviews. The limitation of this study is that it was based on one case, an NHS Trust within an extensive national health system at one point in time. The findings of this research suggest that the move of doctors into management has created limited change to the profession. While clinical directors have colonised managerialist discourse, medical dominance remains a central tendency and rather than a containment of medicine we may see a re-professionalisation of management or 'management by medicine' (Thorne 2002:22).

This early experience in the UK NHS suggests uncertainty, and reluctance by doctors to become managers, particularly undertaking the role with a lack of experience of managerial issues (Bruce & Hill 1994; Thorne 2002). The rebalancing of power between doctors and managers in the UK experience is not seen as a threat but an increase of power within the profession (Sutherland & Dawson 1998) that has also brought a feeling that power is not the province of these two groups but is held elsewhere within the bureaucratic and political structure (Davies & Harrison 2003).

Management knowledge was primarily experiential through being placed in the role rather than through gaining formally acquired knowledge. This inclusion of doctors into the corporate organisation raised the potential that this 'strategic jurisdiction can create a new and different form of workplace power' (Thorne 2002:20). Strategies to managerialise clinical work are akin to the doctors' strategies to medicalise health, and bring both clinical and managerial expertise to the contested centre of healthcare (Thorne 2002). Generalist 'director general managers' in this study of the UK NHS who became subordinate to clinical directors reacted by meeting apart from their clinical directors. In doing this, they created their own informal parallel organisation, retained their link with senior management and 'kept an eye' on clinical directors for senior managers (Thorne 2002:18). In the Australian context, which is explored more fully later in this chapter, clinical directors questioned the ongoing relevance of some of the

more traditional corporate level positions suggesting redundancy or considerable curtailment of role (Braithwaite 2004). In the UK NHS, the lack of clinical directors' managerial experience meant that they saw budgets and management information as 'manipulative devices to control professional behaviour' (Thorne 2002:20).

Research by Degeling, Hunter and Dowdeswell (2001), on the beliefs and perceptions of medical clinicians, medical managers, lay (generalist trained) managers, nurse managers, and nurse clinicians in six hospitals in Australia and the UK, demonstrated significant profession-based differences in respect to elements of the reform agenda. This research involved 850 participants, in a self-completion survey to elicit beliefs and perceptions around reform and profession-based subcultures. The study involved health professionals from two different and distinct health systems. The study found that the development of a distinct medical managerial perspective remains tenuous; the capacity of hospital managers to effect change in clinical practice remains and managements standing with medical and nursing clinicians are compromised by the need to meet central authority 'financial and activity performance targets' (Degeling, Hunter & Dowdeswell 2001:67).

Other research by Degeling and Carr (2004) involved a survey of the attitudes and values of a random sample of 230 staff in a teaching hospital in Australia; surveyed staff included medical clinicians and managers, nursing managers and clinicians, and general managers. The findings of this study included a finding suggesting that, for reform to be successful, managers of clinical units cannot stray too far from 'the attitudes, values and beliefs of clinical staff, particularly the views of doctors' (Degeling & Carr 2004:403).

Braithwaite (2004) conducted descriptive analytical research over a decade for his three Australian studies. The studies, all part of a program of research, were differently constructed. One study utilised participant-observational work, the second content analysis of 64 clinician managers in four focus groups and the third non-participant observational work of four experienced clinician-managers in two case study hospitals. This analytical research demonstrated that the primary focus of clinician-managers are financial, people, organisational/institutional and customer orientation, which is distinct to that of the literature which suggests a focus on quality management, information systems, clinical pathway management, strategy, and planning. The study also suggested

that work is achieved through conversation, sensemaking, negotiated order, and this occurs within a complex web of stakeholder engagement. The study concluded that the control of clinical work through the appointment of clinically trained managers is problematical and requires a continuous partnership rather than a top-down application. The authors of this study accepted that there is criticism of cross-paradigm or multi-method research by some theorists and researchers. However, they contended that interplay between paradigms allows fertilisation of ideas without integration of paradigms. The research could also be criticised as being influenced by the effect of participants behaving on the basis of knowing they are under observation. The authors suggested in this case that that influence would have been minimal because of the triangulated evidence of the data sets and the longitudinal nature of the study.

This research study by Braithwaite (2004:249) suggested that, while clinical directors are in a position of power over subordinates, this latter group has an expectation that the former are to 'represent them and their interests'; suspicion between the two groups was present. At the same time, senior executives expected effective and efficient control of clinical work and reserved power to themselves for larger and strategic decisions. Despite the expectation that clinician-managers might control the work of clinicians, this does not appear to have been achieved. Another Australian study by Degeling and Carr (2004), described earlier, indicated that general managers located in clinical units within a hospital doubted the integrity of senior management commitment to reform in the face of senior clinician resistance and felt their authority was denied by their lack of support. These managers are, therefore, managing the disjunctions and containing potential public fall out from the contested issues. This reduces the role to mobilising and maintaining resources, protecting the unit from outside interference by satisfying upwards performance-reporting requirements. This outcome assists the erosion and denial of the reform agenda from within (Degeling & Carr 2004).

Medically trained managers are increasingly used to both contain costs and improve care (Schulz 2004). A research study to assess the difference in performance between medically qualified and managerially qualified senior managers by Schulz (2004) involved 38 medically or managerially qualified senior managers who undertook a computer-based simulation model to make resource allocation decisions for a hypothetical integrated healthcare organisation. The study found that, while there were

differences in the ability of senior managers, there was no significant difference in strategic decision-making ability or in the longevity of healthcare organisations based on the educational degree of the participants. It suggested that ‘discussion over the advantages of one type of educational background versus another may be misguided’ (Schulz 2004:114). The limitations of this research include the small sample size, which influenced the statistical power of the ANOVA tests. Another limitation is that the use of simulation in experimental situations; while having benefits, use of simulation makes the results ‘suspect to artificiality’ (Schulz 2004:113). Further studies to examine real-world decision-making using surveys and observational techniques were suggested by the authors of this study.

In the US, physician executives (medically trained managers) are said to have a unique perspective, combining knowledge of healthcare and medicine and being motivated to serve and advocate for patients (Sherer 1993). They exhibit diverse approaches to management and important insights in developing opportunities for the organisation (Brown, Larson & McCool 1988) and physician-led organisations have performed well (Weber 1995). However, they lack business and financial expertise (Sherer 1993), which is considered by several authors to be the most important management capability (Sieveking & Wood 1992; Parsons Gustafson & Murray 1997), and this lack of expertise is seen as a disadvantage to the organisation (Sherer 1993; Belfiglio 2000).

There has been an increasing move over the last three decades to, first establish clinical teams and directorates and then to stream clinical services across hospital boundaries to a geographic area or a State jurisdiction. This reinforces the managed approach to clinical services and the inclusion of clinicians into more central managerial roles (Degeling & Carr 2004). Control still requires cooperation through delicate diplomacy of clinicians who remain relatively autonomous. This suggests that a continuous engagement and inclusion of clinicians in ‘managerial processes, activity, and decision making’ might be more beneficial than top-down control and that ‘partnership, rather than instruction’ might be more conducive to professional-managerial relations (Braithwaite 2004:255).

Generalist managers in hospitals studied in the research conducted by Degeling and Carr (2004) had stories of betrayal and lack of support. Nurse clinician stories were of lateral

and horizontal professional violence and being located at the bottom of the system that is under the pressure of contested reform. General managers based in clinical units described the experience of pressure of reform rhetoric from the centre and senior hospital management and the resistance of the medical clinicians with whom they work. Medical managers saw their role as temporary and looked to a return to a clinical role. Doctors saw nurses as attempting to extend their professional place and role in both the organisation and in clinical care, a perception shared by general managers who saw the role of nurse managers as close observers, so marginalising nursing. Generalist managers saw their role as containment and managing the organisational impacts of 'medical individualism' (Degeling & Carr 2004:408). Alliances between the professions did not appear to be possible, reinforcing the contested nature of the professions in healthcare and in management.

Research by Davies and Harrison (2003), in the UK NHS, involved an historical review of doctor–management relationships in the context of changing structural arrangements and the international forces for change. This was secondary research utilising the published results of a range of relevant but varying research that suggests differences between lay (generalist trained) managers and clinicians. The former are said to favour rationality and transparency in organisation work more than the latter, demonstrating the difficulty and tensions in combining both roles, while reinforcing the importance of involving doctors in management. The post-modernist application of logics and hegemony also indicates that separate identities will remain despite integrative attempts in respect of those identities (Harding 2005). The evolving research of Harding (2005) is a theoretically-based analysis of organisations using ontological critiques and discourse theory of political action of the status of organisations and managers. The author recognised the limitation of this research as 'a work in progress' that utilises for the first time the work of Laclau and Mouffe's (1985) discourse theory of political action to understand health management. However, it is still considered important to move clinicians beyond individualised patient care to give them 'authority to engineer change and shape system reform to which they would otherwise be subjected' (Braithwaite & Goulston 2004:399).

Conflict between management and clinical identities is an issue for nurse managers because the identities are distinct and there are difficulties in moving between them;

there has been inadequate training provided for these roles (Edmonstone 1997; Reedy & Learmonth 2000; Hewison 2001). The variety of managers – medical, nursing, and general – have ‘different minds’ and lead in ‘different directions’ when it comes to reform agendas (Degeling & Carr 2004:405). While some contend that the management identity is single and fixed, managers have multiple identities that are increased when they have a clinical professional identity (McConnell 2000). There is movement between the identities and a duality of views that can be opposite (Harding 2005). An adherence to a single identity of being efficient, in control and busy can present a stressful outcome when the objectives of that identity are not achieved. Inconsistency between our ‘ethics, values and moral work’, our self-esteem with our work identity can also create conflict and stress (Mischenko 2005). These contributions suggest profound differences between the professions that imply they bring different perspectives to the management role and those differences need to be understood, respected and valued. In a complex health system, where interdisciplinary team-based management is increasingly the norm, the challenge for health managers is to engage and harness that diversity to meet organisational and care delivery objectives.

The independent standing afforded the professions is sedimentised into medicine, nursing, allied health and administration in most health structures, as described in the research of Degeling and Carr (2004) in this chapter. Professional values are entrenched in training and professional associations and are properties of the larger society, not of individual organisations (Anderson & McDaniel 2000). People also espouse competing values, and the conflicts that arise are resolved by compromise that can become embedded in practice. This suggests that the emphasis needs to be on mediating the conflicts rather than attempting to change values (Eraut 2004). In the health sector, the expertise and values component of professionalism are said to be ‘strong and well’ (Anderson & McDaniel 2000:84). It not only remains a powerful force, it is ‘one of the defining issues in the relationship between managers and professionals’ (Sutherland & Dawson 1998:S18).

Developing further expertise in the professional role can be limited by the extension into the administrative role (Eraut 2005). Likewise, managers, who are not members of a profession, encounter ‘vastly different mind-sets (in managing professionals) than would be the case in managing workers in non-professional settings’ (Schulz 2004:104). The

move of clinical professionals into management has been accentuated by the move to clinical directorates in hospitals and might be seen as ‘a longitudinal move away from the managerial-clinical dichotomy, despite its longstanding nature’ (Braithwaite 2006 et al: 2).

It is common for a number of subcultures to exist within an organisation and individuals can simultaneously be members of a number of these nested cultures, including some that extend beyond the organisation. Professional cultures are accommodated as subcultures within organisations (Bloor & Dawson 1994). A Home Care Service in Australia was utilised as a case study in research by Bloor and Dawson (1994) to examine professional subcultures. They described the dominance of the medical staff. Physiotherapists and occupational therapists existed in what was described as orthogonal subcultures, which accepted the primary structure and valued high standards of professional practice, while having some conflicting positions to that of the dominant medical subculture. Social workers were seen more as a counter-culture, valuing professional standards but having an advocacy–empowering role on behalf of clients, presenting a dissenting professional subculture. The administrative occupational group formed an orthogonal subculture supporting the dominant medical subculture while the paramedical aides formed a differential subculture (Bloor & Dawson 1994). New entrants to organisations progress through stages of learning the interpretative scheme through signification, legitimation, and domination. Professional subcultures are major determinates of an organisation’s culture (Bloor & Dawson 1994). The authors of this study recognised the limitations of a single case study of one sector in the health system but regarded ‘it as a first attempt to recognise the significance of professional subculture as a major determinant of an organisation’s cultural system’ (Bloor & Dawson 1994:292).

Research by Forbes and Prime (1999), undertaken in the NHS UK context, investigated the move of radiographers into managerial roles, in charge of professional colleagues. This was a comparative study, using semi-structured interviews with 25 radiography managers in Scotland and London. This study’s limitation is reflected by the small number of participants across a range of institutional settings in two distinct geographical areas of a national health system. This limitation was recognised in the claim that it sought to contribute to the emerging literature examining the move of

clinical professionals into management. Domain theory was used to understand the role transition from clinician to manager. The findings demonstrated that domains developed internal mechanisms to legitimate their purpose, creating tensions between the domains of policy, management, and service in the absence of any shared reality or vision. This led to feelings of isolation as health professionals moved from service to management domains, where they were then viewed by former colleagues as a manager.

This study showed that radiography managers viewed themselves both as professionals and managers with a strong attachment to their clinical roots. They felt professionals should be in control and considered professional autonomy important. While their primary socialisation was to their professional background, they developed into and identified with the managerial role, while suggesting that the professional background provided an advantage in promoting clinical issues. The duality was not without role tension and ambiguity and they saw this as making their role more difficult than that of generalist managers. Their role required a broader perspective of organisational issues and a blurring of the professional perspective. A further finding was that clinical radiographers were said to have contributed to feelings of isolation of the radiographer manager by perceiving them in a different role with a different agenda (Forbes & Prime 1999).

Professional subcultures, as they relate to the allied health professions experiencing change within five different organisational models, were described in research by Law and Boyce (2003). The research of Boyce represented a longitudinal review of a decade of developments of the restructuring of public allied health services and a case study of one Australian tertiary medical centre; Law (1999) conducted case studies in Australia, Canada and the United Kingdom. Some of these models were critiqued as 'antithetical to core professional values' that reduce positional power and, give it to other professions, even though that might be to another allied health profession (Law & Boyce 2003:177). The challenges were seen to be how to create a structure that 'preserved attributes valued by the professions' (Law & Boyce 2003:178), to adapt to more collaborative practices, and to accept a loosening of the sovereignty of the professional discipline as the mainstay of organisation' (Law & Boyce 2003:184). The strength of the dominant view of the profession in the organisation of professions was best described as a change in culture from 'an "allied health" subculture structured around the notion of "allied to

each other” ’ as compared to the approach of ‘allied to medicine’ (Law & Boyce 2003:179).

Radiographers are referred to as ‘members of Professions Allied to Medicine (PAM)’ (Forbes & Prime 1999:106). Nursing is represented as the ‘enduring and central feature of health care’ and the nursing perspective on matters such as quality is different to that of chief executives, medical staff and politicians (Hewison 2001:187). Nursing identity is also characterised as feminised, while the managerial identity is masculinised. The clinical identity is also said to provide a strong discursive resource for the resistance of the managerial identity (Reedy & Learmonth 2000).

Fitzgerald and Teal (2003) reported on part of their larger study that used quantitative and qualitative approaches to collect data on six different occupational groupings. Ethnographic evidence was obtained from participant observation, questionnaires were utilised, and interviews and eight focus groups were conducted, the focus groups consisting of six to twelve members. This research identified subcultural differences within a single profession such as medicine. Organisational commitment was influenced by perceptions of status and educational experience, the degree of reverence to other professional managers, and the extent of engagement within and by the organisation. Advances in professional sub-group approaches to teamwork were also described and nurses were seen as a powerful resource in facilitating boundary crossing and the change progress. These authors all contended that the perceptions of the professions about their respective roles, and their relationships to each other and to the managerial roles all bring differing dynamics to organisational culture and how health professionals manage and might be managed and are, therefore, important perspectives to this study.

The discussion of health service reform is often about flattening structures, delayering levels of management and getting rid of managers. Delayering, achieved through the removal of middle management, does not necessarily mean a lessening of the number of managers but a displacement often to lower levels and an increased level of responsibility and span of control to those who remain (McConnell 2000). Research into the UK NHS changes by Dopson and Stewart (1990), investigating the effects of structural change on middle managers, suggested the opposite occurs, with an increase in middle management roles and a move from maintenance roles to more challenging

roles at that level. This research was part of a larger study that involved five comparative case studies in the public and private sector, including the NHS. The changed role created tension with the participants' primary clinical background, and required a change in attitudes and a need to become more flexible and adaptable, and to acquire new skills, including a wider appreciation of the organisation. The inability to provide a good service because of resource constraints was a source of stress for middle managers and there were excessive constraints on the actions of middle managers in the public sector (Dopson & Stewart 1990). This was a small-scale study that does not permit generalisation, but the findings add to the literature and reinforce the need for further similar studies.

Research by McConville and Holden (1999) involved a case study utilising structured and semi-structured interviews of 14 middle managers at two acute service hospitals in the UK NHS. At the same time, both facilities and the participants in the study were facing change and uncertainty. This research demonstrates that, while the managers wanted to be proactive in their role, they were constrained because financing decisions were taken at another higher level and they were isolated from others in the hierarchy, leading them to feel they had contradictory roles. This study was limited by being restricted to middle managers from only two acute hospitals in a large national health system, serving different geographic areas with different competitive circumstances as providers.

A research study by Preston and Loan-Clarke (2000) involved a case study of a UK NHS Community Trust as part of a larger longitudinal study. This part of the study involved 39 interviews of managers, mostly middle managers, to gain perceptions of the Trust and their role in that organisation. The findings indicated that the managers had difficult and stressful jobs, were negatively viewed by others, and were perceived as inadequately informing staff about change. Many of these managers had moved from clinical roles because they believed they could make a difference. They also felt their contributions as middle managers were useful, challenging the accepted negative view of the role (Preston & Loan-Clarke 2000:106). The limitation of this research is that it was restricted to one organisation in a large national health system and the findings cannot be generalised either within that health system or across the public sector.

However, it does provide a useful contribution to empirical data on managers' personal responses to changes in role and status.

Research into New Zealand health managers by McKenna and Richardson (2003) involved interviewing 17 health managers at the service/team leader first line management level. This study utilised an unstructured, complexity mapping methodology to investigate the experiences of the health managers in a changing environment. Eight interpretive devices were defined as attributions – motive, causal connection, credit and blame, unity, fixed qualities, emotions, agency and providential significance – of the experience of these health managers. The findings showed that managers saw themselves as both victims and survivors, whereas in a UK study by Greener (2004), described later in this chapter, managers were portrayed as heroes and villains. Both of these studies reinforce the importance of values, self-worth and purpose to the identity of health managers. In the New Zealand study by McKenna and Richardson (2003), nearest managers, those closest in reporting arrangements to their senior manager, held positive views of bosses who had been introduced into the health service to provide professional management skills, but who consequently depended on the participants for operational expertise. This study also found that constant and uncertain changes were the result of government policy. Nurses, who were promoted into management, became service leaders by default with significant roles, large budgets, but without clarity of purpose or management training. Blame was attributed to politicians and senior civil servants, while strong bonds emerged between service leaders and staff. Attribution of fixed qualities, predominantly negative, were reserved for politicians and senior civil servants (McKenna & Richardson 2003).

McKenna and Richardson's (2003:85) study suggests that managers make sense of their role by 'ordering the ambiguous, stabilising the unpredictable, simplifying the complex, and giving some continuity to the discontinuous'. They do this in a narrative sense by 'giving themselves a sense of purpose, a feeling of "moral goodness", self efficacy, and self-worth' and these attributions and narrative meanings are coping mechanisms in a stressful environment (McKenna & Richardson 2003:85-86). This study, while also adding to available empirical data about health managers, was restricted to one health organisation within a regional health authority that was one part

of a national health system. It represents the perspectives of 17 participants so the findings are not generalisable.

Research by Greener (2004) involved interviews of 40 senior health managers in two UK NHS Trusts and the interview data were thematically analysed. This research identified managers' cynicism, viewing the system in terms of 'disorganisation', seeing management in health as being different and difficult for an 'outsider' to undertake, while they were confident about their own ability to work outside of health. It was also suggested that health managers increasingly look for quick solutions and the use of consultants to achieve those solutions. The study showed that NHS managers were portrayed as being both 'heroes and villains' (Greener 2004:328), providing similarities to 'victims' and 'survivors' of the New Zealand study by McKenna and Richardson; victims in that, despite the negative impact of the system on them, they were resolute in their determination to succeed and achieve outcomes in what was seen as a morally positive role. Again the limitation of this study is that, apart from the broader review of policy documents and research by others, it is limited to a relatively small sample of managers within two Trusts in a large national health system. Again, the strength of the study is that, like many of those reported herein, it builds on and adds to the available empirical data.

A research study by Liang et al. (2006) examined the impact of an area health management reform implementation on a group of senior health executives in an Australian jurisdiction, the NSW health system. The study identified a number of shortcomings in the reform agenda from the executives' perspectives, including a lack of proper engagement in the reform process, a centralisation of authority, and greater exposure to the political process. The consequences of this approach to reform are that innovation and community engagement are further restricted, with no improved outcomes for staff and patients. The barriers to success in the achievement of roles were in fact because of requirements to comply with the central policy of those introducing the reforms (Liang et al. 2006). This study as reported by Liang et al. (2006) also described how roles have shifted from the traditional functional perspectives to a broader role, including leading and motivating change management; financial management; coaching and mentoring; liaison and networking; and strategic decision-making and planning. This study sought participation from 60 out of a possible

population of 71 senior health executives. Of the 22 who agreed to participate, 13 were randomly selected for participation. The majority were supportive of reform aims but said that they were also expected to accept blame for the Department of Health and the Ministerial office when expectations were not met, even though financial constraints meant achievement was impossible. This brought a level of insecurity and instability, which the authors suggested leads to high turnover and burn out of senior health executives, to those executives (Liang et al. 2006).

Part of the rationale for the need for health service managers with health management, business, or commercial skills arises from the application of business and commercial managerial practices and processes to healthcare, following the broad adoption of the new public management (NPM) approach to the public sector. This paradigm involves 'hands on' professional management, explicit standards and measures of performance, emphasis on output controls, disaggregation of units, greater competition, private sector styles, and greater discipline in resource use (Hood 1991; Hewison 2003, 2004). Healthcare reforms in Australia in the last few decades have been, in part, predicated on performance management approaches and they are, therefore, relevant to this study.

Quality improvement is also central to performance management systems, with the emphasis increasingly placed on standardised outcomes providing a further means of control. Managers exert control through controlling the skill of the workforce; defining and standardising outcomes; and defining monitoring and regulating work process. Clinical governance provides legitimacy to managers over quality of clinical services; this imperative does not mean that managers require clinical knowledge, 'but need to be assured that clinical services are appropriate and effectively delivered' (Sutherland & Dawson 1998:S22).

Adoption of business processes has become standard operating procedure in hospitals and health systems. There is an untested affirmation that their adoption will address some problem, but the reality suggests that this is not the case. The ready acceptance is based on the assumption that these practices are 'inherently superior and appropriate for hospitals' (Bigelow & Arndt 2000:69), in an environment where there is little confirming or disconfirming evidence of their effectiveness. The research of Lozeau Langley and Denis (2002:537) explored the 'misfit between the theories underlying two

widely adopted managerial techniques', utilising data collected over 15 years from four different studies to examine the application of strategic planning and quality management, involving 12–33 hospitals in Montreal, Canada. These studies were mostly qualitative, involving interviews, document analysis, and direct observation and built on earlier work by these same researchers and others mostly in the Canadian context (Lamothe 1996; Denis et al. 19990).

The findings of this study by Lozeau and colleagues (2002:555), suggest that these techniques 'appear to be blunt instruments for change', that organisations are pressured to adopt, consume considerable resources and the implementation is corrupted as the techniques are 'captured by the very dynamics that they were intended to change'. These techniques fail because they are inappropriately transferred and implemented from another sector or because of the lack of understanding and commitment from management, and are often most successful in contexts where they are least required. A further finding of the study by Lozeau, Langley and Denis (2002:560) is that their implementation was seen as a process of social construction inconsistent with the positioned practices in professional health organisations, consuming 'resources for marginal benefit'.

The research study of Lozeau, Langley and Denis (2002) demonstrated that strategic planning does not meet the objectives or theoretical constructs of its supporters but is readily adopted and utilised in negotiation with government and internally within an organisation. The authors suggested that professional opinion was more highly regarded than analysis and that planning became another tool for power and influence rather than an approach to rational and strategic choice. These authors indicated that for planning to be successful power must be harnessed and management must become more forceful (Lozeau, Langley & Denis 2002:551).

Similar results to that of strategic planning research were observed for the application of quality management within the study (Lozeau, Langley and Denis 2002). These findings are supported by an analysis of Total Quality Management (TQM) in the NHS by Nwabueze and Kanji (1997). Institutional constraints seem to force acceptance and compliance by individuals to the application of these managerial processes, often with rapid turnover of techniques. This creates cynicism, de-motivates staff, and reduces

collaboration. Lozeau Langley and Denis (2002:558) argued that their observations are 'generalisable across a variety of managerial innovations'. They indicated that attempts at change must be negotiated through the existing positioned practices, as described by Reed (2001) in his theoretical analysis of trust and control, or through sedimentation, described by Cooper et al. (1996) as adding new layers of ideas and values onto older organisational forms.

The study of Lozeau, Langley and Denis (2002) was a comprehensive study in one Canadian city over a significant time-frame, providing relative consistency in the environment in which the hospitals were situated. Three of the four studies involved had a focus on management tools being formal analysis, strategic planning, and quality management and the fourth study was about strategic change. Therefore, there were different foci in the individual studies, with data in some cases collected over different time-frames between two of the studies. Different research personnel were involved in each study, with one consistent member and common research questions across the studies. There is a high degree of commonality in the hospitals included in the strategic planning and quality samples. Some of the hospitals selected in the planning and quality samples had positive involvement in implementation of these techniques, therefore giving potential positive bias to the techniques. The study relied on previous theoretical work to explain the difference between the theoretical context of the techniques and the context in which they were deployed.

Gollop et al. (2004) in their research indicated that health professionals resist change in the organisational context because of both poor past and continuing experience. The actual way programs were promoted increased scepticism and resistance, challenged professional autonomy and increased the view that power resided elsewhere, with the participants disempowered (Gollop et al. 2004). The analysis by Gollop et al. is from their research, which used semi-structured qualitative interviews with 19 clinicians and 19 managers holding senior roles within the UK NHS. This research was based on a small sample, which was narrowly focused in terms of the selection of participants; although they were senior in their organisations, they were considered key informants and were consistent in their responses.

The ready adoption of these practices demonstrates the institutional perspective influence in the adoption and diffusion of managerial techniques (DiMaggio & Powell 1983; Lozeau, Langley and Denis 2002) Therefore, institutional theory perspectives and theory around health system archetypes are central to the Theoretical Framework of this study. This influence takes on greater importance in pluralistic and professional-dominated organisations and in the public sector, where the market influence is diminished but where conflict over values and interests are more evident (Greenwood & Hinings 1996; Lozeau, Langley and Denis 2002; Hewison 2003). Supervision of professionals is a paradox, and excessive supervision is said to lead to lower quality performance (Anderson & McDaniel 2000). A move away from blind acceptance of the value of business practice, to an examination of the contribution to knowledge of how health managers manage in turbulent circumstances and also begin to learn from all experiences, including failures and successes, is also suggested (Bigelow & Arndt 2000) as a more appropriate approach than an over reliance on performance techniques.

Management of health services through performance management is, therefore, difficult. Health managers already work in complex circumstances because highly qualified experts play important roles (Mintzberg 1979). Patients lack power and knowledge, while hospital autonomy is highly circumscribed because external professional, industrial and accreditation agencies are influential (Lozeau, Langley and Denis 2002) and, to a large extent, determine what a hospital or health service can and cannot do because of the application of these agencies' processes. Hospital governance structures add to this complexity. In most cases they are part of professional-dominated public bureaucracies that generally have governance structures reflecting the main professional groups and, in some cases, the community, as well as the political bureaucratic interests. Accommodating these differences in governance structures has been described as dual hierarchies (Friedson 1970), three-legged stools (Johnson, 1979) and four worlds (Mintzberg 1997). In the Australian context of this study, most, but not all, governance structures have subsequently been overtaken by area organisational structures and State-wide health system imperatives.

Issues of governance and accountability are important in the current evolution of systemic health structures. Mechanic (1981:5) stressed that, at the institutional level, attention to issues of quality and access are seen as being given 'lip service' because

‘when budgets get tight, costs replaces competing concerns’. A natural consequence of these events is the ‘displacement game’, played by service providers, health bureaucracies, and governments alike. ‘Each unit is concerned with its own costs and not about aggregate expenditures’ (Mechanic 1981:6). In structural interest terms, physicians and health institutions are adaptable, resourced and have requisite expertise and considerable public support to ‘play the game well’ (Mechanic 1981:7). The ‘focus on targets reflects a belief in the benefits of centralisation and a lack of trust in those at the coalface’ (Jamrozik, Heller & Weller 2003:575), and the public are believed to have little understanding of the issues. Accusations of manipulating activity and fiddling figures (Jamrozik 2003; Learmonth, 2005; Ball 2007) and that organisations become proficient at manipulating data and results (Mechanic 1981) are common, and not necessarily new.

Furthermore, the central authority response to clinician resistance to reform is to impose further top-down performative reporting requirements on hospitals (Degeling & Carr 2004). As described in the Degeling and Carr (2004:406) study, the psychological impact of reform in terms of anxiety and depression indicates stress to be significantly higher in general managers (from one hospital study) than that of the general community and the ‘anxiety among general managers and amongst nurses is of particular concern’.

Managers, in addition to learning from past managers, good or bad, indicate that they need to develop emotional resilience, set boundaries, develop personal support structures and understand the formal and informal sides of the organisation (Boucher 2001). These findings from Boucher’s study (2001) involving four new health managers from a health facility in Melbourne, Australia, utilised cooperative enquiry in reflective practice groups as well as informal discussions with other health managers. The aim of the research was to describe the experience of moving from a clinical to a management role, the competencies required to make the transition and identifying the helpful and hindering personal and organisational factors to successful transition. This study did not intend to generalise the results but was instead focused on the experience of those involved.

Research into managers’ perceptions was conducted at the Organization Development and Change Research Group at De Montfort University (Shanley 2005) and the findings

suggested the management of continuing change now plays a significant role, being seen as an add-on to the normal role. Doyle and colleagues conducted a survey of 92 managers in the public and private sector. Their findings suggested that an adequate theory of change must address 'the lived experience of those involved in progressing change initiatives and the pressure, tensions, contradictions and constraints under which they function' (Doyle, Claydon & Buchanan 2000:S72). Shanley (2005) conducted semi-structured interviews of 20 facility managers of aged care residential facilities and 19 stakeholders in the aged care industry in Australia to better understand the perceptions and understanding of facility managers to change in that industry. He/she found differing levels of understanding between aged care managers and the industry stakeholders about managers' understanding of managing change. The findings also indicated a lack of appreciation of the lived experience of facility managers in these understandings of the change management role (Shanley 2005). This research was again limited to a relatively small sample of facility managers in the Australian aged care industry. It does have an added advantage of including a further sample of industry stakeholders to give a perspective greater than just that of the facility managers.

Fulop et al. (2005) undertook research into the context and processes of UK NHS Trust mergers that analysed drivers of mergers. The research examined nine Trusts and four in-depth case studies in the second and third year of the mergers. The findings demonstrated the presence of stated and unstated drivers of change and that simplistic notions of organisational change do not take into account dynamic relationships between organisation context and the people engaged within those organisations. The stated drivers included: management cost savings, closer community cooperation, safeguarding the future of specialist units, ensuring quality and service, improved career directions, and meeting political imperatives. The unstated drivers were identified as addressing managerial and financial deficits. Negative and positive findings of the case studies included: the impact of differences in organisational culture, opportunities for shared learning, and a loss of managerial focus and control. There was a lowering of service delivery, a delay in service development and both positive and negative impacts on staff. This study commenced after the merger had occurred, but early on in the merger process, so the findings reflect circumstances at a particular point in time.

A number of studies Anderson & McDaniel (2000); Eraut et al. (2000); Kernick (2003); Cooper, Braye & Geyer (2004); Dann & Barclay (2006), addressed the importance of learning from experience through the change process as an important aspect of accomplishing the managerial role. Eraut (2000) and his colleagues undertook a study, which included healthcare organisations and people in health management positions, into the development of knowledge and skills at work across three occupational sectors, in both the public and private sector in the UK. This study involved 120 respondents from 12 different organisations. Participants in this study described learning from the challenge of work itself and from other people. The study also found that confidence, challenge and support are central to learning.

Eraut (2004:111) subsequently stated that learning is often one off, sporadic, often focused on new practices, and involving engagement and disengagement, rather than professionals and ‘managers learning how to facilitate change through clustered activities’. Learning needs to be based in the workplace and in education settings with interaction between those settings seen as being vitally important (Eraut 2004:115). Informal learning is emphasised because it is the predominant form of learning in the workplace (Eraut 2006). Learning is from people, in and around the job, and is dependant on good relationships and the climate and culture of the workplace. This prompts questions about how organisations interact to facilitate and support learning and raises the question of the extent of government and organisational commitment to education and development, particularly, of the health management workforce. Adversity in these contexts suggests that individuals will emphasise ‘prioritisation and encourage coping behaviour rather than quality improvement’ (Eraut 2004).

Greener (2004:325), in a study described earlier in this chapter, indicated that managers learn from ‘experience’ and from formal academic courses, although the latter were not highly valued or used in the work setting, but gave credibility, assisted career achievement and were more valued for ‘the chance to discuss problems with peers and extract knowledge from their knowing’. The explicit knowledge from courses was of secondary value, while contextual knowledge was regarded as valuable. Mintzberg (1997:14) suggested management and leadership cannot be picked up in the classroom, but that it grows out of experience and, out ‘of a deep understanding of the situation being managed’. Change is generally considered as a political and administrative

process, focused on decision-making and persuasion rather than being seen as a learning process (Eraut 2004).

Engestrom et al. (2003) conducted research into a single case of patient care across the acute and primary care services to develop a negotiated way of delivering care across boundaries. This study found that tensions and inconsistencies in complex situations are triggers to new knowledge. They suggested that boundary crossing across professions and types of service providers to engage in joint problem solving are required but not often utilised (Engestrom, Engestrom & Kerosuo 2003). This research reinforces the importance of primary care and perhaps the need for a greater emphasis on interprofessional practice and learning across both institutional and service type boundaries (Braithwaite & Travaglia 2005). The need for co-operation, partnership, and improved work practices across professional and organisational boundaries are the main drivers for its adoption. This approach is also seen as de-valuing difference, promoting cost containment, efficiency, and central control, or a move to blur boundaries and identities (Doel 2002), while others emphasise the importance of mentoring within professions (Sibson & Machen 2003). Resistance is also about loss of autonomy and responsibility and power differences (Cooper et al. 2004). The UK NHS has called for the development of common foundation programs for healthcare professionals as a response for a need for greater interprofessional understanding and practice; in some professions interprofessional learning is identified as a component of pre-registration training (Hewison 2001).

To remain competent and relevant, managers must also possess competencies of 'learning, changing, adapting, forecasting, anticipating and creating change' (Burgoyne 1990). Australian research, described in this chapter, that reviewed international research about health managers identified a move from the functional perspectives of the competencies required of health managers to a broader range of competencies similar to those just described (Liang, Short & Brown 2006). These authors suggested that the new manager in healthcare will require specialist healthcare knowledge and knowledge in non-health specialities found in healthcare, such as finance, as well as graduate education in health administration. It is also anticipated that experience in the ranks and in management at departmental levels will be prerequisites for a health management career (McConnell 2000).

Kolb's (1984) experiential learning cycle (action learning) is considered useful in helping managers 'make meaning from experience, raise their awareness of their theories-in-use and help them develop, test and continually refine subjective theories of action that will facilitate their becoming and remaining competent' (Hayes, Rose-Quire & Allinson 2000:100). These authors' research examined the universality of senior management competencies within one multi-site service organisation, with a manager population of 159. They examined job descriptions, and elicited the managers' self-perceptions of job demands, utilising repertory grids developed from organisation documents and questionnaires. They found that there was no general agreement about what competencies apply at what level of management. Competency approaches in the UK NHS are described as transforming clinical professionals into managers through forming an entirely new identity (Reedy & Learmonth 2000).

In research by Eraut et al. (2000), previously described in this chapter, knowledge is defined in two distinct ways: *codified* that is propositional, codified, and stored, and *personal*, knowledge which individuals bring from personal experience and reflection. The *personal* knowledge includes knowledge that is propositional, procedural and processual, tacit and experiential. The two definitions are not mutually exclusive. This research included participants from UK NHS, including managers. It demonstrated that, while respondents expected formal training, there was also some preference for learning by doing and practice. Learning was mostly organisationally situated, derived from the challenge of work itself; learning from others was also important to most respondents (Eraut et al. 2000).

Respondents in leadership and/or management roles have to contend with the complexity of issues they deal with on a daily basis, while responding to the dictum to increase the work unit efficiency and improve the quality of the work. In the health sector, this often means a reduced workforce without any reduction in work, which suggests a specific skills set in 'managing change, consulting and using all the resources of their work group' (Eraut et al. 2000:244). Factors important to learning at work include: the potential to increase confidence, self-efficacy through self-evaluation in terms of capability, achievement, and motivation, and 'the workplace microculture and how the person is managed' (Eraut et al. 2000:250). This research established that 'a

virtuous circle of positive development is established' based on the considered application of confidence, challenge and support to learning (Eraut et al. 2000:251).

Heavy workloads, low skill mix, falling standards, and declining morale increase the negativity of the learning context and may require significant cultural reform to redress them. Learning resources for managers in times of change were least available when investment in this area should be seen as important (Eraut 2006). Learning is facilitated through a combination of the knowledge forms – explicit, tacit, group and individual – in a focused education setting (Greener 2004).

In summary, the historical context and the forces of change influencing the delivery of healthcare in Australia, and the development of the managerial role, have been reviewed. Contemporary international research that examines the health management role has been described and analysed. The conclusions to be drawn, thus far, are that there are profound differences between the professions that bring different perspectives to the management role. The health management role is increasingly being described as requiring active participation as constructors and negotiators of meaning, in other words a sensemaking role, which demands a reconsideration of the traditional rationalist normative view held of the role. Change in professional health organisations is complicated by positioned practices of health professionals that reflect the dominant archetype where change is layered on existing practice. This suggests that neo-institutional theory and the typology of archetypes (Greenwood 1993) are relevant to understanding change in professional organisations or systems, such as healthcare.

This view is supported by the research of Macintosh and McLean (1999), who suggested that the archetype theory described and used in health research by Greenwood and Hinings (1993, 1996) is useful. This is because it describes change along the two dimensions of pace and nature of change, combined with the application of the archetype with its interpretative framework that takes into account 'the cognitive dimension of archetypal behaviour' (Macintosh & McLean 1999:299). This perspective is also relevant to the theory of structural interests, the application of complexity theory and the sensemaking nature of the health management role and is further explored in the context of the constant complex change of healthcare systems.

### **2.3 The application of organisational theories to the health management role and the development of the Theoretical Framework.**

This section describes and defines the theories used for this study, including the origins, and strengths and weaknesses of the theories and contemporary research that utilises those theories. This study is predicated on the assumption from the literature (Mintzberg 1997; McKenna 2003) and from the authors experience that the health management role might be unique. It is multi-dimensional and situated in a complex changing health system. This study is also based on the researchers' personal view that the lived experience of health service managers cannot be described or interpreted from the basis of one theoretical concept but requires an eclectic approach utilising multiple theoretical perspectives in its analysis and interpretation.

This study uses organisational theory to develop the following eclectic Theoretical Framework to study health managers in complex healthcare systems facing constant change. The theoretical concepts that are included in the Theoretical Framework are the understanding of change through: complexity theory as synthesised from the theory by Dann et al. (2006) and applied to healthcare systems by Kernick (2003); neo-institutional theory and the typology of archetypes as adopted by Greenwood et al. (1993); the structural interests theory of Alford (1975); and the sensemaking theory of Weick (1993; 1995). This researcher used the concept of power during the individual interviews as a prompt to gain insights into the health managers' perceptions of their role and the motivation for entering the health management role. The power relationship within the role was not specifically addressed in the study, where individual perceptions of the role are explored rather than relationships to other organisational actors.

The term organisational theory as used in this study represents knowledge gained from broad and diverse discipline studies, such as economics, sociology, psychology, political science, to name a few, These diverse studies have gained acceptance in differing organisational theories over time and might bring both similar and distinctive theoretical perspectives to management and organisational theory. This approach recognises the relatively recent nature of management and organisation theory and that the acceptance of theories from other perspectives into management theory is evolving and contested (Rosenhead 1998). However, this inclusive approach of utilising differing perspectives within organisational theory is supported by a number of organisation

theorists because organisations and their management ‘cannot be explained by any single theory’ and the approach needs to be ‘multiplicitous [sic] because of the variety of other fields of study that it draws on for inspiration’ (Hatch 1997:4). This view is supported by Clegg et al. (1999:5), who indicated that, in the study of managing organisations, traditional demarcations of topics are no longer sufficient and ‘current inquiry demands more flexible conceptualisation’. In the health context, Blaauw et al. (2003) argued that health reform is often preoccupied with narrow perspectives of economic and technical structuralism and called for greater consideration of social theory and organisational and institutional studies. Mark (2006:863) also argued for a broader context of researching and understanding organisations and their management, and suggested an approach that requires an inclusive and not hierarchical sensemaking framework that provides an opportunity for ‘the transfer of theory across sectors and cultures’.

It needs to be emphasised here that this study is concerned with the perceived reality of a group of health services managers of the health system in which they are engaged and how they managed. The researcher was not concerned about their knowledge of management and organisational theory or how they used it, or if they considered it relevant to their reality of the system or their role. However, the eclectic framework was adopted to frame their perceptions of the health system role and their role in an organisational theory framework most appropriate as a unit of analysis for interpretation of their shared reality.

The selection of organisational theory for the framework was guided by debate about strategies for studying organisations that portrays organisations as either closed or open systems, where in the former, certainty and rationality within a determinate system are characterised as normal. These characteristics are evident in the scientific and administrative management schools or theoretical approaches that are also consistent with bureaucracy theory and the bureaucratic organisation structure of most health services and health systems. In open systems there is more of a position that systems are not determinate and that uncertainty is to be expected; a complex organisation consists of interdependent parts that are engaged both internally and externally in a larger interdependent environment. Therefore, the open systems perspective does not see organisations as autonomous but as complex, and accepts uncertainty and unintended

consequences as normal (Thompson 2003). The literature reviewed in section one of this chapter describes health service organisations as both dynamic and unique. They are situated within interdependent systems that are invariably described as complex and experiencing constant change.

Organisations structure and develop management systems to reflect the complexity caused by an unpredictable environment and, thereby, attempt to be isomorphic with that environment. The enactment view of theorists, such as Karl Weick (1979), suggests that the complex and changing environment is a consequence of the experience and uncertainty of decision-makers seeking more information and certainty as they construct the environment. In either perspective, the environment is present, as well as the actors within the organisation. In the theories comparing organisational and environment relations, institutional theory is most relevant because it is formulated at, and focuses on, the influence of the environment and on the isomorphic nature of organisations, and is situated at the system level (DiMaggio & Powell 1991b; Hatch 1997).

### **2.3.1 Constant change and the application of complexity theory**

Complexity theory was adopted as part of the Theoretical Framework to respond to the reasonably commonly held perceptions that health systems are complex. Healthcare organisations are both complex and adaptive (Anderson, Issel & McDaniel 2003; Crabtree 2003; Plesk & Wilson 2001) and managers are increasingly operating within elements of healthcare systems at a time when it is said that the complexity of healthcare is increasing (Plesk & Greenhalgh 2001). Braithwaite (1998) however, suggests that change or reform is slower than that prescribed, can be generational and tends to move towards stability and, despite attempts at standardisation variability will occur. According to Anderson and McDaniel (2000), the greater our understanding of the complexity of the human condition the more we desire to coordinate the effort of professional expertise in addressing issues arising from that condition.

The above authors utilise complexity theory, sometimes described as a group of theories, where organisations are described as complex self-organising systems (Reason & Goodwin 1999) and where order emerges from the interactions of the elements of the system (Anderson & McDaniel 2000; Tosey 2002). Some regard this approach, of considering organisations as complex adaptive systems, as the emergence of a new

scientific paradigm (Macintosh & MacLean 1999). Complexity theories provide a stimulus to question existing beliefs and provide a new and ‘refreshing lens through which to view healthcare organisations’ (Anderson et al. 2005:672).

Dann and Barclay (2006) and Rosenhead (1998) reviewed the theories that together are described as complexity theory. The development of complexity theory is recent and is attributed to the Santa Fe Institute, an independent research centre established in 1984, and in particular to the work of Kaufmann (1993). Mitleton-Kelly (2003) is attributed with combining findings from the natural and social sciences and describing Complex Evolving Systems (CES), and Holbrook (2003) with describing Dynamic Open Complex Adaptive Systems (DOCAS). The key contribution of complexity theory is the recognition of ‘the non-linearity of complex social and natural systems to enable new views on social organisational processes’ (Styhre 2002:343). This concept builds on a history of theorists and researchers moving away from a Cartesian-Newtonian tradition, although the literature still remains mostly rationalistic. Complexity theory applied to change also challenges Lewins’ model of change because the latter does not recognise changing environmental contexts, assumes a static context and a linear concept of organisations (Styhre 2002).

Complexity theory is not a unified theory and is sometimes referred to as a science, given that it has emerged from and within a number of scientific disciplines, and is of particular interest in systems that are dynamic and where predictability of behaviour is the concern. Systems can exhibit both predictability and instability and the term chaos is used to describe behaviour that has some regularity but that can also defy prediction. Change at the edge of the stable and instable zones of the system provides a transition phase at the edge of chaos, generating the unpredictable divergence, while the system attempts to return to stability. As discussed above, healthcare systems have been described as complex systems and the concept has also been adapted into general management theory (Rosenhead 1998).

Complexity theory has been adopted in theories around organisational activities, with its acceptance in management theory given different perspectives by various authors and researchers, but it is nonetheless justified in part by the limitations of the utility of pre-existing management theory and its rationalist traditions and a realisation that the

natural world, humanity and systems do not operate consistently in logical predetermined ways (Stacey 1996; Rosenhead 1998; Styhre 2002; Dann & Barclay 2006). Complexity theory has been used in studies into organisational transformation, organisational culture, and organisational design and research in healthcare described in this section (Styhre 2002).

Rosenhead (1998) provided a critical analysis of the adoption of complexity theory with organisational and management theory, based on the support to the application of complexity theory to management by Stacey (1996) suggesting that, if accepted, it turns much of the organisational theory on its head. However, Rosenhead (1998) conceded that complexity theory provides a focus on the importance of learning and how it can be fostered in organisations and that manager's control, based on feedback, requires reflection and agility in respect to unfolding events. These imperatives place senior managers at the boundary of the ordinary and extraordinary boundaries of management, requiring them: to ensure that there is not a single homogeneous organisational culture; to promote an active and democratic internal politic; and to promote an emergent, evolving agenda of aspirations and strategic issues. Stacey (1996) also supported complexity theory by describing the similar outputs of others from more conventional management schools.

Rosenhead (1998) doubted the claims for complexity theory in organisations, based on the view that claims of success are hard to evaluate because they are about long-term initiatives and/or are based on examples of failure of more formal accepted methods, and that the mantle of science has been placed on the theory to give it authority in the absence of empirical evidence. The inconsistency in an organisation's tendency to isomorphism in the face of the complexity theory perspective need to operate at the edge of chaos is also presented as an inconsistency of the theory. Positioning complexity theory as a metaphor or an analogy is also suggested as weakening its theoretical validity, although the analysis does suggest that complexity theory does provide thought provoking insights into organisational issues.

Dann and Barclay (2006) have synthesised the characteristics of complexity from the theorists into groups described as: organisations, interactions, random events, adaptation and evolution. From this they have proposed a complexity representation model (CRM)

based on organisational learning and redesign to make sense of all of the theory around complexity and to produce application outputs. They have combined the CRM with two aspects of management, described as knowledge accumulation and dissemination and learning capacity and application, to develop a complexity application model (CAM). The two aspects of management utilised in the model are based on the premise that management is based on ‘the gathering and transforming [of] knowledge into marketable products and services’. The second aspect emphasises that ‘the ability to learn, self-organise and adapt are key elements of complexity’ (Dann 2006:24). Kernick (2003) similarly proposed a framework based on complexity theory that he applied to the UK NHS to provide insights about how that health system might develop and move forward.

In this complex systems approach, the paradigm of managers needs to change from knowing to making sense of the world; from forecasting to designing the future; from a fixed to fluid structure; and from overcoming system limits to unleashing the system potential. This requires an organisation or system perception of fluidity with linkages, rather than being concerned with mechanistic organisational approaches. It also suggests inclusive decision-making and the learning organisation concept (Anderson & McDaniel 2000).

This synthesis of the theory and the perspectives of the major theorists provided by Dann and Barclay (2006) produced a framework that, together with the application of a similar approach by Kernick (2003) and Anderson and McDaniel (2000) in healthcare, is used in this study. Research in healthcare relevant to this study and the use of this theory includes that of Zimmerman (1999), Papadopoulos et al. (2001), Plesk and Wilson (2001), Wilson and Holt (2001) Kernick (2003, 2006) Anderson Issel & McDaniel (2003), Anderson Corrazzini & McDaniel (2004) and Matlow et al. (2006).

Kernick (2003, 2006) stated that complexity theory provides a framework to allow the articulation and exploration of intuitive insights, an approach that is consistent with the phenomenological approach of this research. He also emphasised that there is no Theoretical Framework unique to healthcare and that we draw on a range of disciplines or theories that do not provide a convergence of themes but provide contested models, most of which reinforce a world-view (2003:3). Health systems cannot be understood

through ‘the application of analytical rule-based frameworks’ and that the focus needs to change ‘from predictability to an emphasis on local interaction and the emergence of order’ (Kernick 2003:2). Kernick (2003:2) used models and metaphors to make sense of organisations and suggested that ‘the edge of ‘chaos’ describes the interplay between the formal and informal components and is the ‘transition zone between chaos and predictable stability’. He suggested that health organisations adopt coping mechanisms when faced with the ‘ambiguities of organisational life’ (2003:4).

The framework developed by Kernick (2003) suggests that organisations consist of both formal and informal elements and the interplay between them is characterised by the influence of the application of predictability and power. The application of complexity theory to this framework recognises that health systems have large numbers of rich, diverse components, where information is distributed across the system and, where feedback loops give rise to non-linear behaviour, which means that the future cannot be predicted with any certainty or the system manipulated to meet desired ends. Emergence is the evolving nature arising from interactions at a local level that allows adaptation and self-organisation in response to external challenge.

In applying his framework to the NHS, Kernick (2003:9) suggested that historically the NHS could be seen ‘as a search for the right organisational solution and a failure to find one’. He suggested the NHS needed to be seen as ‘a hierarchy of inter-related systems that interact in a complex, non-linear manner’ (Kernick, 2003:9) that is stable but can explore boundaries, where policy provides guiding principles and the future emerges from interaction at the local level. In the case of the NHS, this proposes a move from managing to overseeing the system, while recognising the importance of managing networks not just hierarchies.

Kernick (2003) proposed this approach as the ‘fourth way’ for managing the UK NHS. The fourth way proposed by Kernick (2003) promotes an approach that, to make sense at the edge of chaos or the zone of complexity, government must provide a stable linear element to prevent chaos, but not to the extent that it might restrict system creativity. The constitutive elements of this approach are a hierarchy of interrelated systems that require the management of networks. The system is stable, but explores boundaries and accepts that the future is emergent and is situated in related networks where interaction

is non-linear. The focus is on dynamic relationships, based on vision and values in a flexible, loosely-coupled learning-focused system. In this context policy provides guiding principles. Mark (2006) recognised Kernick's contribution as progress amongst that of others in research in organisational behaviour in the UK NHS.

The application of complexity theory in healthcare systems has been used in research to analyse waiting list data from over 20 000 patients across England in the UK NHS; the NHS at that time was described as being at the edge of chaos (Papadopoulos 2001). Complexity theory has also been used to explore new approaches to issues in clinical practice, organisational leadership, governance and education in healthcare (Plesk & Greenhalgh 2001; Kernick 2006). The use of complexity theory was described by Zimmerman (1999), in a series of process reforms in a US hospital, and by Matlow et al. (2006) in examining the coordination of paediatric care. Anderson et al. (2004) utilised complexity theory to study staff turnover in US nursing homes and Wilson and Holt (2001) described its application to the management of diabetes, clinical encounters and health promotion in the UK.

In support of the complex systems perspective, Braithwaite et al. (2002:191) suggested unresolved issues in healthcare are 'complex, deep seated systems problems' and that health systems are in fact moving from machine to complex adaptive systems. The future state of complex systems is *unknowable* and, while patterns emerge, predictable and contemporary management tactics are less than satisfactory responses (Anderson & McDaniel 2000).

The implication of the complex adaptive systems approach, in what are professional-dominated organisations, is that managers must focus on 'relationship building and less on role defining, traditional bureaucratic approaches to management, which often treat organisations as collections of roles' (Anderson & McDaniel 2000:87). Complexity theory places the need for learning at the centre of organisational priorities because of the principle of unknowability about the future and the need to bring informal learning within formal organisational learning structures (Rosenhead 1998; Dann & Barclay 2006). In multidisciplinary team-based health systems, it also brings into context interprofessional education (Cooper, Braye & Geyer 2004) and how we learn at work and from the change process itself (Eraut et al.2000).

In the complex adaptive systems approach, key managerial tasks, defined as leadership tasks, are described in Table 2.1 and compared with those in the more traditional professional bureaucratic system approach (Anderson & McDaniel 2000). These tasks are compared with tasks that are described by participants in this study and are described in the final chapter.

**Table 2.1:** Managerial approaches in professional-based organisations

<b>Complex Adaptive Systems Approaches</b>	<b>Bureaucratic Approaches</b>
Relationship building	Role defining
Loose coupling	Tight structuring
Complicating	Simplifying
Diversifying	Socialising
Sensemaking	Decision-making
Learning	Knowing
Improvising	Controlling
Thinking about the future	Planning based on forecasting

Source: Adapted from Anderson and McDaniel (2000)

Complexity theory does recognise that uncertainty and unpredictability is a normal function of complex systems and allows an acceptance that not all things are controllable. It proposes a shift in thinking from the traditional linear approach to an ‘adaptive framework, emphasising emergence and interpretation’ (Cooper, Braye & Geyer 2004:186). It also holds the potential to share ideas, methods, and experiences in changing contexts across systems and has had some application in health systems and healthcare. Such an approach values diversity and is limited where there is an overemphasis on equilibrium and stability. It also raises the issue about how organisations, and those within them, might adapt and innovate and that organisational contexts need to be conducive for adaptation and innovation to occur (Glor 2002).

### **2.3.2 Constant change and the application of neo-institutional theory and the typology of institutional archetypes**

Health systems in Australia have been, for more than a decade, experiencing regular, if not continuous, change and the influence of that change on health service managers and their role. This role and the effects of change on that role are central to the research aims of this study. Therefore, the inclusion of change theory in the Theoretical Framework of this research is important. The effectiveness of healthcare change, described as reform or restructure, is questioned by the literature (Decter 2000; Dwyer 2004; Braithwaite 2005; Menadue 2006). This questioning, suggesting a lack of success or attainment of desired outcomes, is not restricted to hospitals but to the evaluation of the effectiveness of health systems as well (OECD 2004; Braithwaite 2005). For example, in ‘some cases [Griffith proposals in UK NHS] outcomes were the very reverse of the objectives set out in the report’ (Hewison 2003:128). This section introduces the theoretical concept of neo-institutionalism and the typology of archetypes and interpretative frameworks, as elements of the Theoretical Framework of this study, to describe change in healthcare systems and its influence on health managers. These approaches are described as being a ‘robust sociological perspective within organisational theory’ (Perrow 1979; Greenwood 1996:1022)

Archetypes are used as a typology to describe ‘a set of structures and systems that reflects a single interpretive scheme’ (Greenwood & Hinings 1993:1052). Greenwood and Hinings (1993) suggested that it is important to distinguish between the values and beliefs described as the interpretive scheme, embodied in the organisation, and the extent to which organisational actors are committed to them at a particular time. Archetypes, the descriptor of the structure, are said to be institutionally specific, and values and ideas within a sector limit the variety of organisational designs. The need to conform to sectoral rules and requirements are institutional norms to gain legitimacy, resource requirements, and to enhance survival. While complexity may lead to multiple forms, only a few archetypes are legitimated (Greenwood & Hinings 1993). This approach derives to some extent from earlier analysis of organisational structuring and its analysis (Ransom, Hinings & Greenwood 1980:981).

The typology of archetypes is derived from neo-institutional theory, which is an appropriate framework for this study because health managers operate in institutions

described as organisations and neo-institutional theory is focused at the society sector level that is equivalent to the systemised nature of the health field. Durkheim (1950) is said to have called sociology the 'science of institutions' (Jepperson 1991). DiMaggio and Powell (1991:1) presented institutionalism as 'a distinctive approach to the study of social, economic and political phenomena' but that its definition varies across its use in different disciplines and, 'there are as many "new institutionalisms" as there are social science disciplines'. These authors suggested this theory could be traced from a 1977, beginning with John Myer, with substantive neo-institutional theory and interest developed by 1985 (Powell & DiMaggio 1991).

Major foundation work is ascribed to: Meyer and Rowan (1991) with respect to theory about formal structure as myth and ceremony and the adoption of loose coupling as a buffer between structures and work processes; DiMaggio and Powell (1991) with respect to institutional isomorphism and collective rationality; Zucker (1991) for theory about the influence and extent of cultural persistence in institutionalism; and Scott and Meyer (1991) for placing neo-institutional theory at the society sector level of analysis rather than at an organisational level. In fact, it is this raising of the focus away from local organisations to organisational sectors and an interorganisational locus that represents some of the distinguishing features between the old and new institutionalism. This focus and these loci are consistent with current and historical development of organisations into more systemised structures consisting of nested organisations within wider fields.

Neo-institutional theory attempts to move beyond the recognition of institutional cultural and social foundations, to describe how practices and organisations become institutions and are institutionalised. Meaning is given to institutions through repeated actions and shared conceptions of reality. Institutional sectors are distinguished from technical sectors that have a focus on technology, exchange and markets, whereas the institutional sector is concerned with rules and process and legitimacy, and means and ends. Notwithstanding these differences, they are not mutually exclusive and have relative strengths to each other. Institutional pressures are seen as responses to uncertainty and have been defined by Powell and DiMaggio (1991) as coercive, normative and mimetic that, in that order, describe the influence on organisations of government and regulation, cultural/professional influences, and the tendency towards isomorphism respectively. Importantly, in this theory, organisations seek social

legitimacy from important constituencies in their environment, and this is said to provide a useful starting point for analysing an organisation's structures in terms of sources and types of pressures and how decision-making processes might shape institutional beliefs ahead of rational choice (Bryman 1996; Hatch 1997). Institutional theory in considering structures sees the State as coercive rationalisers, favouring centralised discretion held at the top of bureaucracies, as opposed to professionals who favour decentralised forms with discretion in the hands of practitioners (Scott & Meyer 1991). This approach also presents a move to consistent and similar organisational forms in health jurisdictions, reinforcing a desire for sameness and uniformity across jurisdictions that reinforce the isomorphic character of institutionalism (Brint & Karabel 1991).

DiMaggio and Powell (1991), in traversing the move of institutionalism in new directions, referred to Greenwood and Hinings' (1988) archetype typology as emerging from the early work of Selznick (1949), from one of the original institutional schools of organisational study in the United States. The work of Greenwood and Hinings (1988, 1993), amongst others, is said to have 'made great strides in developing the conceptual framework necessary to describe the momentum of change, transition and adaptation in organisations' (Whipp 1996:19). The Selznick tradition is also credited, along with others, of having determined that 'organisations have distinct interests of their own, which can take on an autonomous logic capable of diverting organisations from their original goal' (Brint & Karabel 1991:344).

The neo-institutional organisation theory, institutional fields, archetypes, and interpretative frameworks, as espoused by Ransom, Hinings and Greenwood (1980), Greenwood and Hinings (1993; 1996) and Brock (1999; 2006) and was selected for this study because, in examining change in organisations, they take into account both the values and beliefs that reflect the interpretative framework of organisational members and the institutional and structural perspectives of the organisation. The existing and emergent archetypes are influenced by the members' interpretative framework. This approach was selected because the recognition of the interpretative framework reinforces the phenomenological underpinning of the study.

The above approach was selected ahead of other more recognised approaches to change that are based on the work of Lewin (1951). These represent the organisational development approach of planned, rational change (Johnstone, Dwyer & Lloyd 2006; Palmer & Hardy 2000). They stand in contrast to current realities of constant change and turbulence described by Dunphy and Stace (1990) and Kanter et al. (1992). Others suggest that there are similarities between Lewin's theory and that of complexity theories, and that a case can be made to return to Lewin's work to implement the complexity approach (Burnes 2004). Change has increasingly been seen as complex and unpredictable, rather than linear and something that approaches normalcy, rather than occurring at intervals (Pettigrew & Whipp 1991). This promotes the view that change is emergent and brings a resonance to the complex adaptive systems (CAS) theory also utilised in this study, as described earlier in section 2.3.1. The CAS theory sees unpredictability as the norm with events and actions emerging in a future context that is unknowable.

Organisational change management theory mostly appears to be focused on change implemented within organisations, often in response to external pressures (Edwards & Roemer 1996; Aitken et al. 2002), but nonetheless an essentially internal response. It is said to reflect the influence of life cycle and population ecology and dialectical theories (Palmer & Hardy 2000). Organisational and professional change studies indicate that change is detached from the practitioner–client interaction level, which represents the actual purpose of the organisation (Engestrom et al. 2003) Most theoretical approaches to change go some way to attempting to make sense of change but they 'cannot reflect the complexity and diversity of what actually happens in organisational change' (Shanley 2005:20). These approaches bring into question: whose agenda is being served; the politics of change; the process and direction of change and prescriptive approaches; the role of leadership and management; and the importance of emotional and social contents (Shanley 2005). In addition, these approaches do not adequately reflect the reality of change in the health context, a reality that is focused at the system level rather than within individual health organisations.

Change in healthcare appears continuous and is system wide. According to Greenwood and Hinings (1996) and Perrow (1979), neo-institutional theory is not a formal theory of change but it has been used to explain the similarity and stability of organisational

arrangements in a given field or population of organisations. Institutional pressures act against change and neo-institutional theory provides a model of change that links organisational context with intraorganisational dynamics. It emphasises the normative embeddedness of organisations, the place for the agency of actors, recognises structural differences within and between sectors and the political nature and influence of organisational dynamics. It is also recognised for its robustness in sociological perspectives and in organisation theory (Perrow 1979; Greenwood & Hinings 1996:964).

Critics argue that neo-institutional theory is not normally a theory of organisational change but a descriptor of organisational arrangements (Ledford 1989) and that institutional forces resist transformational change (Buchko 1994:1146). However, Greenwood and Hinings (1993:892; 1996) are supported by the view that the neo-institutional theory provides a good definitional basis of change and its accounting (Dougherty 1994), and signals the dynamics of organisational adaptation (Leblebici et al. 1991). This perspective is considered appropriate to this researcher's objective of understanding the influence and dynamics of change on health managers and their role.

The context of this study requires an understanding of the existence of different patterns of change, particularly those that take into account members' meanings, and values their interpretative framework described in terms of archetypes in a range of organisational settings within the institutional health sector. Given that most health services, facilities and organisations are situated within networks or other health systems, the neo-institutional theory is relevant because it does not focus on an organisation but a category or network of organisations (Greenwood & Hinings 1993). For all of these reasons, this study utilises neo-institutional theory as a theoretical context to examine the organisational change described by the participants, utilising the typology of archetypes described and used by Greenwood and Hinings (1993, 1996).

In this theoretical approach, values in organisational change are seen as important because there has been little emphasis on examining 'the attitudes, values, and beliefs of those subject to reform' (Degeling & Carr 2004:403). Values in organisational change are important and facilitate change, where there is congruence between values and the reasons for change. Values provide meaning and interpretation in organisations and

‘underpin the way in which organisations are designed and operate’ (Amis, Slack & Hinings 2002:437). Organisational members create provinces of meaning, incorporating interpretive schemes, which articulate values and interests that orientate and give them purpose within organisations (Amis, Slack & Hinings 2002). Organisational structures are shaped by members, their understandings, interpretations, meanings, values and interests, and structuring is the privilege of some actors, or in other terms an organisation ‘is composed of a number of groups divided by alternative conceptions, value preferences, and sectional interests’ (Amis, Slack & Hinings 2002:7).

Amis, Slack and Hinings (2002) conducted a longitudinal study of an entire population of 35 national Olympic sporting organisations in Canada, using retrospective data utilising the notion of archetypes. The study attempted to investigate how values might affect the processes of change and why some organisations are successful at change attempts and some are not. The research examined reports and research documents and included interviews with prominent sports individuals to determine organisational values. A questionnaire was developed from this first stage, piloted and sent to 616 individuals across the organisations with an 81% response rate. Collection of data extended over 12 years. The study of Amis et al. (2002) was limited to a particular institutional field and requires caution in any attempt to extend the findings past that field. However, it did demonstrate that values play an important part in the effectiveness of change processes.

Greenwood and Hinings’ research involved selected municipal governments in England and Wales. They researched the municipal government area, partly because the organisations had ‘discretion to organise as they wished’ (1993:1060). However, this discretion is not available to the Australian healthcare sector, where there has been systemic integration of organisations to the extent of prescriptive and commonly applied structures, roles, and titles. The study sought to define the concept of archetype, the underlying interpretative scheme and the value of this typology in understanding organisational change, and to review theoretical and methodological issues involved with the study. Greenwood and Hinings’ (1993) study involved a two-stage research design; the first stage involved the identification of archetypes through documentary analysis and unstructured interviews, structured questionnaires and the analysis of academic research on local government. The second stage was a longitudinal study of

24 organisations with semi-structured interviews, documentary analysis and structured questionnaires. The findings of the study supported the existence of archetypes within organisations and that they tend to move towards archetype coherence and stability ahead of change. The study also explored the importance of institutional and temporal contexts.

Kirkpatrick and Ackroyd (2003) provided a critique of this archetype theory indicating difficulties with its use because of the continued legacy of functionalism and assumptions about professional organisations, its relevance in the public institutional domain, and management change. These authors, while recognising the value of archetype theory, supported an alternative approach based on social theory and the sociology of professions. However, Brock (2006), in his contemporary analysis of the archetype concept, described a number of relevant studies in the health field, for example, the autonomy and discretion in decision-making of professionals in American hospitals (Scott 1965); the fluidity and role creation by professionals within large healthcare organisations and the increased corporatisation of medicine (Starr 1982); and the professional dominance of health professionals, particularly that of physicians (Freidson 1970). In a case study involving a UK Hospital Trust, Mueller et al. (2003) identified three interpretive schemes demonstrating change to a more corporate structure. Dent et al. (2004) undertook a qualitative case study involving interviews with a range of participants within a public sector hospital group in Germany to describe an archetype change from a public sector hospital archetype to a public hospital corporation archetype, following the application of New Public Management and German corporatism to the public hospital sector.

Brock (2006) proposed an emergent Global Professional Network (GPN) archetype that has six important characteristics of: managerialism; greater reliance on formal networks as opposed to informal networks; more individualised reward systems; increased corporate governance; increased global reach; and movement towards multidisciplinary practice. This author further described a typology of professional organisations, based on size (local through to global), and strategy, based on being generalist, specialist or multidisciplinary perspectives. While this archetype was developed primarily from the perspective of commercial professional firms, Brock draws on American healthcare models as examples of its emergence in the health sector, suggesting technology allows

new small, localised, professional practices to be established. Technology, complexity and information allow specialist medium-sized operations at the State and national level, leading to multidisciplinary practices at the regional and global level. Brock (2006) further suggested that alternative competing archetypes coexist during change and transition, and that values of old professional interpretive schemes remain sedimentised in the new emergent archetype. Based on the analysis of Australian health reform by Dwyer (2004), the Australian archetype could be described as ‘integrated systemic’, with key features of having a centralised governance authority with radical change designed to achieve sustainable spending levels. These archetypes and interpretative frameworks are used in this study to enable this study to consider their applicability to the lived experience of the participants of this study.

Ransom and Hinings and Greenwood (1980:8) stated that ‘power is most effective when it is unnecessary’ and where power holders ‘institutionalise their province of meaning to become the interpretive frame of organisational members’. This treatment of power and its outcome is also consistent with its use in the structural interests’ approach of Alford, which is discussed later and represents what Weber (1949) has conceptualised as an order of domination (Ransom et al. 1980). These authors also argued, as described by Luckman (1975), that the modern individual is ‘entrapped by his institutional and organisational systems in that they are less open to social reconstruction’ (Ransom Hinings & Greenwood. 1980:9) and that organisational arrangements are contingent, based on situational circumstances as described by contingency theory (Lawrence & Lorsch 1967).

Ransom et al. (1980), in their analysis of organisational structures, suggested that a more unified Theoretical Framework is required to provide an adequate analysis of organisational structuring. The adequacy includes a phenomenological perspective of an interpretation of the meaning that those engaged in the organisation bring to the structuring process because structuring is the act of generating and recreating meaning. While there are competing provinces of meaning within organisations, power holders act to ensure their values and interests are, or remain, dominant (Ransom et al. 1980). Organisations are embedded in the wider societal context and influenced by it; they continue to ‘generate and re-enact the contextual order of domination’ (Ransom et al. 1980:12). This conceptual framework is consistent with neo-institutional theory and

archetype typology, and involves provinces of meaning, dependencies of power, and contextual constraints, as they intend to analyse the ability of organisational members to construct and change structures. These authors suggested, among other things, that their Theoretical Framework is useful in the analysis of meaning and causation at the level of seeking to understand the purpose to which actors attach to their conduct, bringing disparate perspectives together, including phenomenological perspectives of constructions of meanings (Ransom Hinings & Greenwood 1980).

### **2.3.3 Structural interests in healthcare systems**

The systemisation of healthcare, and the constant change through reform and restructure, leads to an examination of whose interests are being served by these approaches. As described throughout this chapter, the structural interests theory about healthcare organisations is relevant to how health managers operate and how their reality of the health system is constructed. The theoretical perspective of Alford (1975, 1998) is used in this study.

In 1975, Robert Alford (1975:xi) published *Health Care Politics*, which commenced with the statement that ‘health care in the United States is allegedly in a state of crisis’. He then went on to observe that this ‘crisis’ had been a regular occurrence in past history and it was a manifestation of specific interest groups seeking to make political capital, presumably to serve the self interests of that group. This view was reported as a reason for the inevitability of continuing strife in the Australian health system (Sax 1984) and is mentioned in the policy analysis by Duckett (2000) and others in Australia and internationally (Hessler 1986; Hancock 1999; Cho 2000; Palmer & Short 2000; Gibson 2003; Hunter 2004).

The structural interest theory is defined as ‘those interests served or not served by the way they “fit” into basic logic and principles by which the institutions of a society operate’ and those interests are classified as ‘dominant, challenging, and repressed’ (Alford 1975:14). It suggests that ‘powerful interests benefit from the health care system precisely as it is. These interests do not have to exert “power” to influence particular “decisions,” except to block proposals for change’ (Alford 1975:6). Attempts at reform are made in the face of a system highly resistant to change. While reforms

favour one or more interests above others, they do not seriously damage interests but represent a rebalancing of those interests ‘against any basic structural change’ (Alford 1975:6). In fact State-based hierarchical systems with collegial mechanisms demonstrate an implicit accommodation between the State and doctors, have parallel authority structures, and practice consensus management (Tuohy 1999). Clinicians and non-clinicians are said to have ‘entrenched notions’ of what a healthcare organisation is and, have ‘deep vested interests in the present way of doing things’ (Anderson & McDaniel 2000:84).

Dominant coalitions within professional-based organisations are said to be based on the expertise, values and positional power of its members and they set the tone and character of that organisation (Anderson & McDaniel 2000). Policy formulation is seen as the purview of politicians, bureaucrats, and professional and industry interest groups and is politically contested. At the same time Lipsky’s (1980) term *street level bureaucrats* is used to confirm ‘the discretion and relative autonomy of professionals in re-constructing and applying policy at the local level’ (Braithwaite et al. 2002:191).

Repressed structural interests are described as the community population and are defined as marginalised groups, such as the poor, black and the middle class rendered indigent by escalating medical costs. They are ‘repressed because no social institutions or political mechanisms in society insure that these interests are served’ (Alford 1975:15). In Australia, these groups are represented by ‘social movements’, which have some limited impact on social policy (Willis 2002:193). The key difference between the dominant and repressed structural interests is the ‘enormous political and organisational energies’ (Alford 1975:16) required to offset the extent of disadvantage, compared to the need to do nothing by the dominant interests. The terms dominant and repressed also do not imply that they are always in opposition to each other. Often, both benefit from the healthcare system as demonstrated in Australia by Medicare and the safety net provisions to ensure some limits on personal expenditure. A further structural interest is the equal-health advocates who seek free, accessible healthcare for all (Alford 1975:191).

Alford (1975) hypothesised that crises are used as political weapons by interest groups. Sociological theory supports the view that powerful and strategically located interests

within the system effectively resist change and those studies, investigations and inquiries into the 'crises' become part of the system and form part of the barriers to significant structural change (Alford 1975; Sax 1984). The findings from Alford's examination of his hypothesis surrounding the influence of structural interests remain relevant and contemporary.

... the first response to periodic 'crises' take the form of symbolically reassuring investigations, whose reports call for new administrative devices to 'coordinate' and 'integrate' the health care delivery system and thus heal the deep – seated disease of fragmentation.

(Alford 1975: xiv)

The opposite view to that of Alford is, he suggested, a societal values view that affords power and privilege to groups, such as doctors, because they are held in high esteem and this affords them professional monopoly. Alford (1975:17), however, argued the reverse is the case in that 'it is the doctors' power which generates the societal consensus'. It is also recognition that this is the only way in which health services might be delivered. In other words, what is inevitable becomes what is right (Alford 1975; Willis 2002). There are some opposite views to Alford who adopts a structuralist approach compared to those who propose a pluralist or post-structuralist theoretical approach (Addicott & Ferlie 2007). However, Alford (1975) is widely cited in health service research and, apart from redefinition as to what groups constitute his designated structural interests in the Australian context, his theoretical approach is relevant to this study (Willis 2002).

Alford's (1975) theory has been used through a review of policy and research documents to analyse medical dominance in the various reforms of the UK NHS (Harrison 1999). Addicott and Ferlie (2007) used five case studies with triangulated methods of medical care networks for cancer in London to demonstrate that the power relationships of these networked organisations were still subject to top-down central managerial control that restricted the bounded pluralism of the medical elite. Limitations to this study included the fact that it was restricted to a study of London-based centres that were considered more complex than similar centres across the country. These centres were also more formalised structural services than other elements of the UK NHS and the authors recommended further studies before claiming

the results to be generalisable. Evans Han and Madison (2006) utilised structural interest theory in a case study of an Australian rural health service to suggest that a community empowered model of healthcare delivery was required to address the structural imbalance of communities in respect to the dominant forces. This research involved a case study of a single rural health service in one state health jurisdiction in Australia and the lead researcher acknowledged his close personal and professional involvement in that community and health service.

The British NHS is evidenced as a state-hierarchical system accommodating a central role to physicians and the collegial mechanisms that are resistant to market reforms (Tuohy 1999). The divide in structural interests in the United States is between market reformers and bureaucratic reformers (Alford 1975). In the Australian context, Willis (2002) suggested that the conflict over health policy and funding comes down to the tensions between those who support the welfare state or the market approach, and the bureaucratic reformers are mostly found in government in Australia, rather than in the hospitals and medical schools as in the United States (Crichton 1990).

Alford's (1975) perspective on the bureaucratic focus and its perceived relationship to the community it is meant to serve is also illuminative to the Australian context. The community population is seen as an external constituency of the health providers to be used in the interests of the latter in maintaining equilibrium (Alford 1975). There have been a number of inquiries into aspects of healthcare performance within State health jurisdictions. The most recent and most comprehensive has been the Inquiry into the Queensland health system, suggesting that it was not serving the public interest (Davies 2005). This finding tends to reinforce the view that the community and public interest is external and not integral to the functioning of health systems. Public inquiries are held to make sense and re-establish the legitimacy of the organisation and to situate blame and responsibility (Allard-Poesi 2005). Despite the Queensland experience, other State jurisdictions are moving increasingly to the deletion of formal engagement of the community in the management of healthcare at the governance level. The main exception to this is the current district board structure in New Zealand, which has a focus on local governance engagement by a mix of appointed and elected local board representatives (McKernan 2007).

According to Willis (2002), four groups influence Australian healthcare policy; these are citizens, health professionals, the State, which includes politicians and bureaucrats, and the private sector. The players in these structural interests groups are viewed, 'not as individuals and not anymore rapacious or venal than any other community group, but as individuals adopting social roles within diverse organisational and professional contexts' (Alford 1975:18). This perspective explains how individuals might and do play contradictory roles 'since we all know of the "distance" between ourselves and our roles' (Alford 1975:19).

In the structural interest context, decision-making dimensions between market and hierarchical health systems were reviewed by Tuohy (1999) to suggest a balancing of the politico-economic structure of interests across State, private finance and healthcare professions and providing mechanisms of social control that systemise and legitimise relationships. The three main mechanisms are seen as the market with voluntary exchange, hierarchy based on obedience to structure, and rules and professional collegiality subscribing to a set of norms (Tuohy 1999). The research of Tuohy (1999) utilised a framework of analysis of two key dimensions of decision-making to analyse and compare the distinctive logic of the US, Canadian and British health systems. The strength of this research is its comparative nature between three distinct health systems, while the limitation of the comparison is that each system differs in terms of its own dynamics and logic.

A recent critique of the failures of the Australian healthcare system suggests that, 'major institutions have lost touch with their natural constituencies' (Menadue 2003:367). These are described as a failure of Commonwealth and State cooperation; lack of government honesty; an inward-looking health system; resource waste; and an institutionalised, medicalised and hospital-centric system with issues around the quality of healthcare. These criticisms extend to a lack of clarity of roles across the full range of participants; micromanagement of healthcare systems by Ministers; emphasis on media management; reluctance to make decisions by senior executives; managing upwards and determining the Minister, not the public, is the client; closeness of central departments to the Minister; and the political agenda (Menadue 2003). Threats to universality and access, workforce shortages, poor performance measures, poor community care and the breakdown of social networks are also raised as criticisms (Van Der Weyden 2003).

Alford (1975) suggested that attempts at central planning, including the objective of avoiding the duplication of services, have had limited success.

These perspectives of the Australian health system also need to be seen in comparative terms. Research conducted by Blendon et al. (2003) reported the result of a survey, the fifth in a series since 1998, of adults who met one of the criteria of poor health, serious illness, injury or disability requiring intensive medical care, major surgery or hospitalisation in the past two years. The random sample was drawn from screening interviews of nearly 3000 people for a final sample of 750 in each of the five countries. The perceptions of these patients were from the five health systems of Australia, the United States, United Kingdom, Canada, and New Zealand. The results suggest that Australia in particular compares well by being in the mid-range of the patients perceptions of their satisfaction with the system. The common areas of concern across the system were associated with medical error, inadequate communication between patient and physician, and insufficient coordination of care. Thirty five percent of the sample in Australia and 48% in New Zealand were dissatisfied with the system, with those very satisfied at 15% in Australia and 14% in New Zealand. In Australia, shortages of health professionals and waiting times were identified as the main problems. This latter issue was also identified as the major problem in New Zealand (Blendon et al. 2003).

Participants from both countries saw increased spending as a solution, followed by increasing the number of health professionals for Australia and reduction of waste as a second solution for New Zealand. Lack of coordination of care and breakdown of organised healthcare systems were also notable perceptions in both countries. Again, satisfaction with physicians was rated highly across all countries, particularly Australia and New Zealand. In the latter, this rating coexisted with a high dissatisfaction with the health system. The authors asserted that the New Zealand result might reflect the impact of a series of major health reforms and capacity constraints. Australia was neither the best nor the worst on any measure (Blendon et al. 2003).

The dynamics of healthcare systems are seen as having their own powerful logic that rests at the intersection ‘between the balance of influence and the mix of instruments in the system, a logic with particular implications for the pattern and pace of change’

(Tuohy 1999:129). State-based hierarchical health systems with collegial mechanisms are characterised by the implicit bargain and second level agency relationships with the medical profession as exhibited in Britain, Canada (Tuohy 1999) and Australia. Implementation of reform has to 'respect the need for state actors to maintain coalitions of support [with] a central role for the medical profession' (Tuohy 1999:131). These coalitions of support are evidenced as moderating change in Britain and retaining basic features of the system in place in Canada. Government has increasingly intervened in professional-dominated organisations and this has had the effect of diminishing professional dominance through the adoption of more corporate and managerial models in the quest for greater efficiency (Powell, Brock & Hinings 1999).

Various structural interests are at work in a health system but it is primarily seen as a medical system, because most human conditions are seen as an illness or disability requiring intervention, particularly by the medical profession, to effect treatment, cure, or maintenance. While Illich (1976) is remembered for his view that the medical establishment was a major threat, the illness or medical model that he criticised, does advantage a wide range of interest groups. For example, patients gain from being diagnosed as ill or diseased, and pharmaceutical and diagnostic companies depend on it. Governments, insurers, and employers have unsuccessfully challenged the increased spending that results from an ageing population and technology that allows more to be done. These events have continued to lead to a questioning of the value of the investment in healthcare. This is particularly so when the increased spending in the more educated and developed countries leads to higher incidence of reporting of illness and disease rather than a reduction. Calls are increasingly being made for developing ability for mutual self care, a shift in power from doctors to people and a better distribution of simple effective healthcare (Moynihan & Smith 2002; Sen 2002).

The acute care and primary care sectors are dominated by medicine, but medicalisation is often viewed as a pejorative and its extension to 'old age' has been resisted in favour of social care. However, this resistance has belied the potential for treatment, cure and maintenance of this older age group. The resistance to medicalisation in aged care has also been seen as a convenient excuse to reduce costs by excluding appropriate access to acute care and medical treatment to older age groups. This occurs when other pre-occupations with youth and beauty are unencumbered, prompting the view that the older

generation would benefit from medicalisation (Ebrahim 2002). The medical dominance of the health system has both positive and negative influences on the health system and is an important influence on the health managerial role and, therefore, central to this study.

In summary, this section has described the influence of structural interests in a highly systemised health system and the relevance of Alford's theory to the Theoretical Framework of this study. The next section explores the value of sensemaking theory to the framework given the central role of health managers in the management of organisations and in managing change.

#### **2.3.4 Making sense of managing in healthcare systems**

In this section Weick's (1993; 1995) sensemaking theory is added to the Theoretical Framework in this study. Sensemaking in organisations provides a phenomenological perspective because it looks at explanations and answers based on how people see things, that is, their interpretations, rather than being concerned with the structures or systems involved. Daily organisational life influences not only how people feel about their role but how they perceive the organisation, its culture and how people communicate through making sense of their experience (Leeuwijn 2006). Sensemaking allows an individual to locate themselves within a constructed reality and to deal with uncertainty if they are to remain effective and participate in decision-making (Wright 2004).

The approach of Weick (1993; 1995) is explored together with perspectives from other authors that bring a health context to sensemaking, including the phenomenological sensemaking research of Parry (2003). Change creates uncertainty and, where the trajectory (in complex adaptive systems – CAS) is unknown, 'sensemaking becomes more important than decision making' (Anderson & McDaniel 2000:89). Complexity can increase 'perceived uncertainty because of the greater number of diverse elements that can interact in a greater variety of ways' (Anderson & McDaniel 2000:83).

Sensemaking theory has been under development since 1972 and has been used in healthcare settings. Sensemaking theory derives from a social constructionist approach

that followed on from Berger and Luckmann (1966), Blumer (1969) and Schwandt (1994). Weick (1995) takes a more internal view that focuses on enactment by those engaged, applies his theory and research to organisations. In referring to the historical development of sensemaking, Weick (1995) provided an extensive list of chronological references that have some relevance to the development of sensemaking theory over the period of 1890–1994.

Sensemaking is an activity or process that involves the placing of stimuli into a framework to enable interpretation, so that, in this case, organisational members can have shared meaning about the organisation and the interactions and processes of the organisation. Sensemaking is literal and is about constructing, filtering, framing and creating facticity that creates and sustains a wider reality that rationalises events, and should be seen as an ongoing process (Weick 1995). It is social, involving activities of identity construction, requiring retrospection and enactment, perception and believing, interpretation and explanation and enactment, both as an individual and with others (Weick 1995; Cecez-Kecmanovic & Dalmaris 2000).

The core assumptions or properties of Weick's (1993; 1995, 2001) sensemaking theory are that it is an iterative process of constant redefinition of self, that is: retrospective based on experience; enactive in the construction of reality, social and contingent and defining of the organisation; ongoing, moving from the familiar to the general; and based on plausible, socially acceptable, pragmatic and credible representations rather than accurate representation. This framework of Weick (1993) has gained general acceptance in the literature, although he does not suggest that it is definitive and it has been questioned in terms of theory about power, the situation of sensemaking in terms of organisational, individual or cultural levels, gender and in terms of articulation, temporality and meaning (Parry 2003).

According to Weick (2001:136), 'organisations are built, maintained, and activated through the medium of communication'. This enables coordination of actions, prediction of behaviours, and the creation of meanings that allow decisions and coordination of action (Weick 1995; Allard-Poesi 2005). Sensemaking 'activates and re-enacts society and the "organisation" within which the interactions are taking place' (Allard-Poesi 2005:175). Organisations are viewed as collections of people trying to

‘make sense of what is happening about them’ (Weick 2001:5), the greater the complexity of the organisation, the greater dependence given to habit and routine (Weick 1995).

Environmental uncertainty predisposes sensemaking through managing information load to deal with complexity and turbulence. Increased information load implies management of it and the seeking of cues to determine what is noticed and used. Effective use of sensemaking in management implies practices such as ‘walk the talk, being an author and using rich vocabularies, providing historical context, making meaning through meetings, sensemaking through verb use, shared experience ahead of shared meaning and crafting reality from expectations’ (Weick 1995:182). Sensemaking allows organisations and the actors within to create a shared meaning. It requires paying attention and alertness for organisational survival. In bureaucracies effort is often focused on the decision-making process, whereas in professional complex adaptive systems the focus is also on ‘strategies for making sense as well’ (Anderson & McDaniel 2000:89).

Decision-making is seen as critical to the health management role. The increased interdependency between clinical and administrative issues and the impact of non-clinical decision-makers on clinicians is increased conflict, ‘in part driven by different norms of rationality’ (Anderson & McDaniel 2000:83). Managers are seen as negotiating meaning between contradictory influences (Elliott & Reynolds 2001). The degree of an individual’s willingness to participate in decision-making varies with the degree of comfort or confidence in which they view their life balance, work, community, and family. These contrasting states are seen as the emotional dimensions of change with comfort leading to the status quo, while confident suggests the taking up of new challenges (Eraut 2004).

In a discussion of logic, dialectics and trialectics, frameworks are presented as logics, paradigms, interpretive schemes, worldviews, and deep structures that ‘are fundamental and coherent sets of organising principles that are unquestioned and unexamined assumptions about the nature of reality’, providing people with their reality (Ford & Ford 1994:758). Logic gives people their understanding of change and, if they have more than one logic, they have alternative ways of making sense and can move between

differing points of view. Those that have only one view can be trapped by that limitation; that in itself can exacerbate the problem and the ability of people to respond effectively (Ford 1994). The rules that define organisations are conveyed in diffuse contradictory terms; managers try to make sense of these circumstances and, are active participants in constituting themselves and organisations (Harding 2005).

Allard-Poesi utilised Weick's theory of sensemaking to analyse the approaches to research in the area she describes as seeking an objective science of subjectivity, that allows us 'to make sense differently of sensemaking processes in organisations' (Allard-Poesi 2005:169). Social reality is an 'ongoing construction elaborated through interactions' (Allard-Poesi 2005:174), with definition and redefinition through action and experiences – defined as the interaction hypothesis by Schwandt (1994:554). The sensemaking perspective suggests that meanings are 'fluid, unstable, and idiosyncratic with no common, unified, or shared representation in organisations' (Allard-Poesi 2005:172). Attempts are made to structure self, others, and the world around them. This process is taken to achieve both a personal and social identity to project an appropriate self that is redefined and re-enacted in the outcome of its contact with the environment. In organisations, sensemaking focuses on interdependent acts that influence people's abilities to achieve their objectives (Allard-Poesi 2005:548).

Sensemaking is seen as a tensional dynamic, where divergent views may lead to innovation if held norms and values are compatible, but which may mean less social order and more confusion if it calls into question the dominant social structure. If circumstances are deemed normal, people will leave the institutional rules, policies and procedures, which impede divergent viewpoints, to deal with a problem. In these circumstances, generic subjectivity, the majority answer, or consensus compromise produce the groupthink of Janis (1972), without necessarily adherence and at the expense of innovation (Doise & Moscovici 1994; Nemeth 1997; Allard-Poesi 2005). The constituents of sensemaking can also 'deny and destroy each other' and give rise to a 'complex, precariously balanced and highly tensional conception of collective sensemaking in organisations' (Allard-Poesi 2005:176).

Managers need to find ways of personally dealing with the contradictions and conflicts in their roles through sensemaking and to have the potential through writing and

teaching to both stay engaged with practice and encourage new ways of thinking (Learmonth 2005). Managers are seen as negotiators of meaning, no longer definitive authors of meaning and knowledge but as boundary workers where 'the title of manager confers an editorship role' (Elliott & Reynolds 2001:9). Sensemaking is about plausibility rather than accuracy and involves being 'pragmatic, coherent, reasonable, creative, inventive and instrumental' (Weick 1995:55).

There is considerable use of sensemaking theory in health research. In a research study, 'making sense of executive sensemaking' in a UK NHS Trust, Parry (2003) used an idiographic, phenomenological ethnographic approach, using grounded theory and semi-structured interviews of ten executive directors of the Trust of which he was the Chief Executive. Seven themes of executive sensemaking were derived from this research. In summary these were: sensemaking was value driven; culturally biased; experiential; strategic; reflective; story telling and action orientated; and potentially influenced by gender. The data in that study evidenced Weick's themes of 'action, reflection and experience' (Parry 2003:254) and the first two themes of 'value driven and culturally driven could be subsumed in the first characteristic, grounded in identity construction' (Parry 2003:255).

This research of Parry (2003) critiqued Weick's (1995) sensemaking research as secondary research because it is based on prior research, books and reports. It is also in an area where there has been no inductive research since 1995 but it is regarded as the standard reference point for deductive research. Parry (2003) described his phenomenological sensemaking research as following the naturalist paradigm, being interpretist and constructionist. Parry (2003) is located in the study both as the researcher and, because the study is located in an organisation where he is the chief executive, he has a network of relationships and is interested in how others construct their world differently from how he has constructed his world. Parry (2003:241) sought inductive theory from the data and 'only at the end of the process are the results compared to established theory'. However, Parry (2003) also cited Blaikie (1993) to suggest that deductive and inductive research as pure models do not exist and that a third abductive reasoning approach of theory, data generation and analysis occurring dialectically and simultaneously is a reasonable approach. Parry (2003) rigorously addressed the validity and reliability of his research against recognised qualitative measures. However, the main limitation is in effect the small size of the sample from

one UK NHS Trust that means the findings cannot be generalised and its use as a critique of Weick's sensemaking is limited. However, the purpose of his approach was to seek explanation rather than generalising or comparing.

Choo (2001) utilised a framework of the 'knowing organisation' that incorporated sensemaking, knowledge creation and decision-making to analyse its application and to demonstrate its effectiveness in the success of the WHO smallpox eradication program. Lindberg and Rosenqvist (2003:1204) utilised sensemaking in a study that researched how Intensive Care Unit (ICU) staff in a Swedish hospital understood their work at a time of major restructuring, and to test the applicability of a quality system model. The study involved semi-structured interviews of 14 ICU staff members. The results indicated that all participants viewed ICU and their tasks in terms of their dichotomous nature, and in terms of turbulence and ambiguity, and as both highly efficient but also threatening. The authors found that health professionals act through interpreting meaning, which becomes the foundation for daily organisational life. While the authors addressed methodological considerations and emphasised the strengths of the study, they did not identify the small sample or the selection of the ICU, a unique unit within hospitals as potential limitations but described the latter as a strength. This study followed earlier work of Lindberg (2002) that took into account the complex nature of healthcare in developing a quality system. Lingberg (2002) proposed that the system should consist of two dimensions, one that recognises the sensemaking process and the other that deals with methods and apparatus.

Fitzgerald et al. (2002) also utilised sensemaking theory along with others to examine the diffusion of innovation in healthcare. These researchers used comparative case studies in two health regions in the UK NHS, involving in-depth interviews and micro-analysis of identified innovations. While the analysis was multi-dimensional, one conclusion was that Weick's concept of thinking in terms of circles and loops needed to be adopted to understand the diffusion processes. A later analysis of adoption of innovation of information technology (IT) in respect to innovation decision models was conducted by Seligman (2006) in a US context. He selected a sensemaking-based perspective for his analysis for studying IT innovation and utilised the seven properties of sensemaking in the analysis, comparing those approaches with an innovation development-process model (IDPM). He described the use of Weick's theory as an

adopter-centred model used to explore behavioural processes of the adoption of technology. The findings suggested further research is required because the sensemaking-based model does not provide complete answers to many questions surrounding the adoption of technology.

McKenna et al. (2003) undertook research into the interpretation of experience in managing in the New Zealand health service. This study was explored in more detail earlier in this chapter. The study of 17 participants, using a complexity mapping methodology, found that managers use sensemaking to maintain a strong sense of self-identity in difficult complex circumstances. Apker (2004:1207) utilised sensemaking theory to explore nurses' interpretations of managed care in the US context. This involved a study in one large hospital in the mid-west, with semi-structured interviews of 24 nurses who were organisational members. The study found that the nurses' sensemaking indicated ambiguities of identity that extended beyond role uncertainty or conflict relative to the change to managed care. The limitations of the study included the selection of the hospital as being distinct in size, location and role suggesting that results may not be broadly inclusive and that the interview data reflected a managerial perspective. Braithwaite (2004), in his descriptive analytical model of the behavioural routines of clinician managers, discussed more fully earlier in this chapter, described clinician managers' behaviour in terms of Weick's sensemaking theory as constantly sensemaking in a complex world by attempting to decide what to do, with whom, and what was and was not possible. This occurred through discourse, justifying decisions that were based on feasible options ahead of those based on available data.

Parris and Vickers (2005) undertook a study in Australia to examine the experience of people who work in teams across public administration organisations. They conducted in-depth interviews with a purposive sample of eight people who worked in teams in differing organisations. The research examined rhetoric and sensemaking around the concept of team-based work, where organisational rhetoric situates teamwork as a positive attribute to organisational success. The interpretive findings of the study suggest that, when uncertainty arose, the respondents worked to make sense of their situation. They experienced discomfort and dissonance, as the rhetoric about the team did not match their expectations, where the expected experience of belonging and support did not occur and instead a sense of isolation, disconnection and alienation was experienced. This was a small study of team members from different organisations and

the authors concluded that further study of the experience of working in teams within organisations needs to be undertaken.

Mark (2006), in a review of research into organisational behaviour in healthcare within the UK healthcare system, defined the need to allow the alignment and use of conflicting epistemologies and ontologies to make sense of circumstances under scrutiny, as existing approaches in health organisation research rarely reflect organisational complexity. Her perspective placed an emphasis in health research in organisational behaviour on what is known, what is knowable, and what is complex or chaotic, and proposed the use of a framework based on sensemaking to proceed in this direction. Sambrook (2007) drew on sensemaking theory to explore the discourse of senior managers in two Welsh NHS Trusts to examine how they make sense of human resource development (HRD). There were 25 participants across the range of senior managers, and the study involved in-depth interviews. The findings reflected the different discourses used by these managers to describe HRD and their experience of their own development and the impact of that experience on their own sense of identity. This research is limited in that it is situated in only one of the countries of the UK NHS and in a country that is culturally different in its traditions and in the use of two languages where the interpretation is focused on narrative discourse.

The above perspectives suggest that sensemaking is both continuous and an ongoing learning process, making it important in this study to address how managers manage and how they learn their role.

## **2.4 Conclusion**

In this chapter the relevant literature has been reviewed, including that of the Australian health system, the historical perspectives, the constant reform and restructures, health managers and the health workforce in Australia. A review of research-based literature relevant to the health management role in a number of national health systems, each of which have experienced the challenges of change, was then presented. The chapter then addressed the Theoretical Framework adopted for this study.

The literature describes a health system that has developed from relatively autonomous, loosely coupled, community-based providers with local governance and without much

State intervention to a contemporary structure that has become highly systemised. The systemised structure consists of collections of health service providers mostly directly controlled by centralised State health bureaucracies. This change has occurred in response to concerns about burgeoning healthcare demand and costs and a move away from an emphasis on acute care to primary care and population health to help manage demand, improve health outcomes, and, at the same time, improve efficiency. This change has had a significant impact on how services are delivered and on how health professionals engage with the health system. Health management has emerged, during this significant change, as a relatively new profession. In the current circumstances, management has become pervasive across the health system, not only impacting on how clinicians undertake their role but engaging health professionals directly in the health management role.

Given the enormity of this change to the health system and to those who are engaged in it, an eclectic Theoretical Framework was developed from the literature to guide the thesis and the analysis and interpretation of the lived experience of health service managers. A number of the theorists utilised in the Theoretical Framework suggest relevance to the phenomenological approach and make claims of relevance in their theoretical approach to change and to understanding the complexity of systems change. These theorists also claim relevance of their theories to research within systems as opposed to organisations. They point to the institutional isomorphic characteristics of organisations and the emergent, as opposed to planned, change within systems and many suggest sensemaking as an element of their approach.

This literature and theory describes the expansion of management in health services, suggests a highly contested approach to the role by the health professions and a domination of the system by political and bureaucratic interests ahead of other interests. The literature suggests that the management role is diluted by institutional, structural and professional cultural influences and that power, normally resident in management, now firmly resides in the bureaucratic and political interests. These factors have implications as to how managers learn to manage, and how they adapt to change and to their changing role.

In the next chapter, the methodology of the study is outlined, and the research design justified. This next chapter also describes the study procedures, the data collection method and the interview schedule.

## **Chapter Three**

### **Methodology**

#### **3.1 Introduction**

This chapter describes the research design and methodological approach used in this study. The purpose was to explore the perceptions of a diverse group of health service managers about the health system, the changed circumstances of that system, and the role of health managers in that context. Initially the research design and methodology adopted in this study are justified. The research setting, sample selection, interview schedule and data collection method are described. Rigour, trustworthiness, methodological issues and limitations are also discussed, as are ethical considerations and participant protection.

#### **3.2 Justification for the research design and methodology**

This study utilises a hermeneutic, phenomenological approach because it provides the most appropriate design to research the lived experience from the unique perspective of the individual, at a particular point in time. The researcher wanted to provide a more complete qualitative description of health managers – their role, and their sense and understanding of that world in which they operate, i.e. their reality – than is presently available. Phenomenology is not used to necessarily provide an answer, because ‘there may not be an answer’, but it is used to ‘provide a greater level of understanding of those issues to begin to understand the intensely personal issues surrounding complex subjective occupation’ (Bassett 2004:163).

Derived from the early work of Immanuel Kant in 1764, this philosophy and design is often described as having developed in stages. The stages include the preparatory phase of Brentano and Stumpf, the German phase of Husserl, and, importantly in terms of this research, Martin Heidegger’s hermeneutic approach, and the subsequent French phase of the late 19<sup>th</sup> and early 20<sup>th</sup> centuries (Bassett 2004). Phenomenology, according to Patton (2002), can be viewed as a philosophy, an inquiry paradigm, an interpretive theory, a social science analytical perspective or orientation, a major qualitative tradition or a research framework. Patton further indicated that ‘what these various phenomenological and phenomenographic approaches share in common is a focus on exploring how human

beings make sense of experience and transform experience into consciousness, both individually and as shared meaning' (Patton 2002:104).

The positivist paradigm was rejected in favour of an interpretive paradigm in this research because little research is available in an interpretive qualitative paradigm that focuses on the lived experience of health service managers. The role requires 'understanding, rather than explanation' and the qualitative paradigm allows the utilisation of 'knowledge embedded in experience' (Mackey 2004:179). Studies have focused on what managers do, the desired competencies of managers, and learning pathways. They adopt an approach of determining where managers' views congregate, in the range of choices provided and developed from aspects of management theory or practices and using the languages of management theory (Smyth, Legge & Stanton 2006), and are aimed at determining a consensus view(s). None of the management or organisational literature adequately describes the world-view(s) as perceived by health managers. Therefore, the objective of this study is to provide a more complete and deeper understanding and description of the perception of health managers about their role and the 'world' in which they operate. This contention is supported by Smyth, Legge and Stanton (2006:12), who in discussing the access to and use of theory by managers, stated:

None of these theoretical traditions provides a self-sufficient account of the world as experienced by the manager. They are partial stories which overlap unknowably. Most of these different theories are constructed within different frames, and while they overlap they do not articulate with each other. They provide different pictures of the same reality but they cannot be translated into each other. They are incommensurable.

An interpretative qualitative paradigm is a better-placed approach for this study rather than a traditional positivist approach because health management is practiced within a number of different theoretical frames that are not necessarily connected (Smyth, Legge & Stanton 2006). Health management has an important sensemaking role and, is situated (Lewis 2004) and is contingent on environmental and operating circumstances (Shortell & Kaluzny 2006). These circumstances strongly reflect Heidegger's ontological approach of understanding *Being* through philosophical concepts of 'being in-the-world,

forestructures, time and space' (Mackey 2004:181). This requires the researcher to be 'alert to those things which stand out in [participants] descriptions, which situate their experience in time in order to enhance understanding of the experience of time and the nature of Being' (Mackey 2004:184) and to provide explicated text that describes the emerging themes (Diekemann 2001).

When developing a research design, the researcher needs to consider the relationships between ideas, theory, concepts and the 'operationalisation' of research (Berg 2004:15). In an applied context, Berg (2004:15) defines theory 'as interrelated ideas about various patterns, concepts, processes, relationships or events [and] as a system of logical statements or propositions that explains the relationship between two or more objects, concepts, phenomena, or characteristics of humans'. The health service manager is surrounded by distinct theoretical constructs, within which the practice of health management occurs; that practice is often seen as contingent or situational (Shortell & Kalunzy 2006). This again emphasises the complexity of the system in which they operate and of the role they perform. This poses a challenge to the researcher, to select a research design that situates it within these multiple theoretical constructs (Guber 1994:27).

In discussing the contribution of anthropology to health research, Lambert and McKevitt (2002:212) suggested that many approaches rarely produce genuine new insights 'because this approach ... fails to incorporate a central feature of social science research – that of reconfiguring the boundaries of the problem'. Therefore, and in keeping with a phenomenological interpretative approach, this researcher was drawn to a method that allows individual managers to speak in their own voice, outside the organisational context in which they are situated and for the meanings to emerge from the data (Guber & Lincoln 1994). This puts the research into the context of Guba's (1978) discovery-orientated definition of naturalistic inquiry. This qualitative approach attempts to reveal the health managers' understanding of the nature of their industry, their role, the issues and challenges, and how they operate and how they learn (Berg 2004). Utilising such an approach assists the researcher to meet the following aims, previously described in Chapter One.

- Examine changes and trends in the description, nature, and role of the health service managers over time, consistent with changes in the evolution of healthcare systems.
- Explore the personal and, professional perspectives of health service managers with respect to how change influences them and the healthcare systems in which they work.
- Explore the personal and professional perspectives of health service managers with respect to contemporary management practices.
- Identify capabilities required of health managers to manage complexity and uncertainty in the present and future.
- Identify differences (if any) in perceptions and professional practice of health service managers based on professional and management education backgrounds.

The methodology for this research is considered within the four crucial points of disagreement within the qualitative tradition. These are described by Murphy et al. (1998) and relate to ontology and epistemology, and the need to provide justification for selecting this approach. The four crucial points of disagreement are: our understanding of the real world or the question of social constructionism; the degree of emphasis on induction and deduction; the place and approach to values; and how does a researcher adequately present ‘the motives, intentions, or thought processes of the people being studied’ (Murphy 1998:3). These disagreements are exemplified by perspectives, such as reality being socially constructed, a social artefact or ‘a product of mind and language’ (Knight 2002:24). Conversely, Hacking (1999) argued that some things, such as objects, could be seen as real while others, such as ideas, can be seen as social constructions. Knight (2002:26-27) proposed a pragmatic, critical realist position that ‘holds that realism is a fair description of some aspects of the world and says that the rest is observer related’. Bhaskar (1986) suggested that reality exists and our understanding is a social construct, continually tested against the real. Berg (2004:9) suggested meaning is given to ‘objects, people, situations, and events ... by and through human interaction ...’ and that this is the source of data, the participants’ perspectives and ‘their ability to take the roles of others’. These perspectives are central to a study of health managers who are influenced by a wide diversity of health professions, stakeholders, and interest groups.

In contrast to positivism and functionalism, social construction suggests that there can be a number of views that are valid and it is possible to have different perspectives (Alderson 1998). Phenomenology ‘takes the view of a questioning outsider rather than an accustomed insider’ (Alderson 1998:1009), and social construction theories see the relationship of researcher and practitioner as worthy of research in its own right, taking into ‘account the expectations and values, backgrounds and roles of the main groups’ concerned (Alderson 1998:1009). Approaches, such as post-modernism, break down the barriers and are sceptical of what is truth, while critical theory demonstrates that people make different, but valid, sense of experience with groups competing for power and resources (Alderson 1998). All of these approaches are valid and have varying strengths and limitations. They also bring a requirement that makes clear the impact of those strengths and limitations to the research design. In essence, Knight suggested that ‘research becomes inquiry into the ways in which social constructs are formed, operated and sustained, and for whose benefit and to whose detriment’ (Knight 2002:22). The healthcare context of complexity and competing professional and stakeholder interests reinforces the need for an interpretive phenomenological approach.

The hermeneutic phenomenological tradition accepts that the researcher is not alone or neutral in the research process. This implies that a variety of understandings can emerge and withstand scrutiny (Knight 2002:34). This distinguishes this study from the earlier view and work of Edmund Husserl, who proposed that the ‘personal and individual reality of the researcher could be put aside when analyzing the data by bracketing or holding it in suspension ...’ (Bassett 2004:157).

Discussion of the four crucial points referred to above also brings into question the importance of the role of the researcher in this research. By definition, this study requires a Heideggerian view in that ‘things cannot be separated from the experience of them, and interpretation can only make explicit what is already understood’ (Bassett 2004:158). The researcher comes to this research with some forty-years experience of the NSW public health system, mostly in senior operational management positions, with health management qualifications and having held leadership positions and had experience at the national and international level in professional and industry health management organisations. This reflects the major feature of ‘ontological hermeneutic philosophy, the hermeneutical circle’, which recognises ‘background pre-understanding and co-

constitution' (Bassett 2004:158). The pre-understanding of the researcher also comes predominately from 'access via personal involvement', while accepting that over time this understanding has been influenced by the collegiate access of 'experience of others', coupled with more recent understanding derived as a student and academic (Gummesson 2000:71).

The third and fourth crucial points of disagreement within the qualitative tradition are concerned with values. They bring into issue the question of how the researcher adequately represents 'the motives, intentions, or thought processes of the people being studied' (Murphy et al. 1998:3). It also raises the issue of the role of the researcher in the research, given the significant 'pre-understanding' involved. The Heideggerian view is that prior understanding is about knowing, not about being or just about acquiring new knowledge. This implies that that which is already understood comes to be interpreted and our presuppositions help with the interpretation of meaning of the phenomenon (Bassett 2004). Drawing on Omery (1983), Bassett (2004:159) suggested that the participation of the researcher is both important and essential because it is about 'interpreting frequently taken-for-granted shared practices and common meanings'. In phenomenology, descriptions can be both multiple and challenged by other descriptions (Van Der Zalm & Bergum 2000). Understanding, using Thibodeaus' (1993) term of 'simultaneity', is, according to Bassett (2004:160), 'the sensation [that occurs] when the streams of consciousness of both the researcher and the researched flow along a temporarily parallel path'.

Gummesson (2000) asserted that qualitative methodology has had slow acceptance in university management programs and business schools, while Palmer and Hardy (2000:1) indicated that the management literature is 'replete with many good theories' but that its use by 'reducing management to a series of simple solutions reflects neither managers' lived experiences nor the wealth of research about management' (2000:9). Palmer and Hardy (2000) presented management theory as contested and requiring debate to make sense in its relevance and application, while others have suggested that management theory is both contingent (Shortell & Kaluzny 2006) and situational (Lewis 2004).

In applying the above paradigms, Gummerson (2000:35) went on to suggest that survey techniques and questionnaires, at best, complement the analysis of processes within a company, while qualitative interviews and observation 'provide the best opportunity for the study of processes'. The qualitative nature of this research required the use of semi-structured interviews that were conducive to determining understanding and meaning from a diverse range of participants (Polit, Beck & Hungler 2001). Focus groups may have been an acceptable approach to this study but were rejected by the researcher because of the logistics involved in gathering a group of managers together from across Australian health jurisdictions. More importantly, the researcher was concerned that focus groups might provide a broader but consensus-achieved view, as opposed to the potential diversity of views from single semi-structured interviews. Furthermore, group dynamics, particularly in grouping together peers from differing levels of management hierarchy and professional sub-groups might hinder the expression of the individual view (Polit, Beck & Hungler 2001; Bassett 2004).

### **3.3 Setting**

The diversity of the setting for this study is exemplified by the fact that at the time of the 2001 Census there were some 26 722 managers employed in health and community service industries in Australia (AIHW& ABS 2003). In this study the participants came from two national organisations, four State health jurisdictions, and two State-based organisations and from New Zealand. At the time of this study, they occupied a diverse range of health management positions, in small rural health services, rural and urban area/network organisations, teaching hospitals, and aged care providers, as well as those in national and state organisations.

Priority was given to obtaining a diverse purposeful sample (Barbour 2001). Health managers practice in what are considered to be complex adaptive systems (Plesk 2001), so every effort was made to address the full range of that diversity within complex health systems in the broad, essentially Australian, healthcare system and its various subsystems. This was not an attempt at representativeness because an interpretative phenomenological approach is not meant to be representative of a population nor is it proposed to generalise from the data but rather to obtain 'the range of responses and ideas that people have' (de Vaus 1995:77). The focus was on providing opportunity to

discover that diversity. For example, the invitation to participate through the official publication of the Australian College of Health Service Executives was neither exclusive to the membership of the ACHSE nor exclusive to Australian health jurisdictions. The researcher included participation from New Zealand because the College has international membership and because some of the recent qualitative research about health service managers is in the New Zealand context (McKenna 2003).

The researcher, while having predominantly been employed in the NSW public health sector, has engaged in consultancy work and professional association work that has provided personal exposure to the range of diverse industry settings, across States and Territories in Australia, in New Zealand, and the Asia Pacific.

### **3.4 Sampling procedure**

To address the complexity and diversity of health management roles and to attempt to adequately reflect this in the sample population, a purposive sample of health service managers was obtained. Purposeful sampling has key principles, developed by Morse and Field (1996), of ‘appropriateness and adequacy’, that is, appropriate in the sense that ‘the participants chosen have relevant knowledge and experience to inform the study’ (Bassett 2004:12) and, adequate in ‘that sufficient, relevant data should be generated through the participants’ (Bassett 2004:13). Recruitment of participants was by both public and private invitation, achieved through a combination of a published invitation through professional college publications, as well as a direct approach to those known professionally to the researcher. While there are dangers inherent in recruiting acquaintances, given the profile of the researcher within the industry it was not realistic to only recruit participants not known to the researcher. Where those selected were known to the researcher, the familiarity was not personal and was mostly, distant and professional (Bassett 2004).

Barbour (2001:1115-1116), in discussing the ‘complex dilemmas in research design’, appraised a range of current approaches, including purposive sampling, and suggested that ‘purposive (or theoretical) sampling offers the researcher a degree of control rather than being at the mercy of any selection bias inherent in pre-existing groups’. This approach also allows deliberate inclusion of outliers and deviant cases where the

exception may prove the rule. In this study, the selection of a purposive sample allowed the researcher to be strategic, ensuring the selection of people relevant to the research purpose (Bryman 2004). The approach was to ensure selection of health managers from different health professional backgrounds and public and private sector organisations across a range of health jurisdictions. This approach allowed diversity in the sample to gain a wider appreciation of the differing perceptions of health managers (Bryman 2004). Subject to proper analysis, purposive sampling addresses concerns of bias, enhances sample coverage and provides a framework for analysis; as a result it may 'illuminate subtle but potentially important differences' (Barbour 2001:1115-1116). This purposive sampling strategy is congruent with qualitative research and is commonly used in phenomenological studies (Bryman 2004). This approach was also taken because the purpose of the study was to add to empirical knowledge about a group that is diverse and not easily classified or described. Adequate classification, therefore, was not available to allow effective probability sampling and the research could not and was not intended to be representative. For these reasons probability sampling using randomisation was rejected.

For the purposes of this research, the ABS (1997) statistical definitions of health service managers, at the time of the study, were inadequate in their definition of the diversity of roles of health service managers. Therefore, the researcher was provided with access to the membership database of the ACHSE (Appendix 8). This college is the only Australian professional college whose membership criteria allow membership across the whole potential diversity of health managers from the full range of both clinical and non-clinical health service managers. The ACHSE membership database was used as a general guide to assist in the recruitment of the diverse range of health professionals who occupy health management roles. In addition, managers operate at the technical, interpersonal and conceptual levels of organisations (Davidson 2006) and the inclusion of managers at each of those levels in this study was also a consideration when recruiting the sample.

Participants were selected from those who responded to public and private invitations and who reflected a range of professional and educational backgrounds and a range of the other selection criteria, such as the possession or otherwise of management and other qualifications, roles, industry sector, age and gender, as described in this chapter. The

major inclusion criteria were service type (industry) and professional qualifications. Exclusion criteria were not developed nor required, allowing those who defined themselves as health managers the opportunity to respond and participate. In total, nineteen participants self-nominated and they reflected the diversity of characteristics of the sampling frame without the researcher having to select participants based on those characteristics. To achieve these objectives, a pilot sample of four health management colleagues was selected by personal invitation and interviewed. Data collection commenced with the pilot study, followed by a public invitation, issued to all members of the Australian College of Health Service Executives (ACHSE) by the National Director of the College in the official journal of the College, the *Health Manager*, Winter Edition, to participate in the research. At the same time, the National President of the ACHSE extended an invitation in his electronic newsletter to members. Personal invitations were also made by the researcher, following the release of the public invitation, at regional seminars and the National Congress of ACHSE held in Adelaide in 2005. As a result of this recruitment strategy a further fifteen interviews were scheduled throughout 2005.

This qualitative study is concerned with representing the diversity of roles rather than representing the frequency of the representation of those roles. The sample size was determined by attempting to provide coverage of the sampling considerations described above. The adequacy of the sample size was determined at the point where data saturation was reached. Following the analysis of the data, and reflection on that data and the emerging themes, it became evident that 'recurrent preoccupations' (Coffey & Atkinson 1996:5) emerged consistently across the data from the group of nineteen respondents, demonstrating that saturation had been reached.

### **3.5 Pilot study**

The four pilot interviews were conducted in 2004. Pilot studies can be used to test the potential of a larger study and to ensure that interpretation of questions is appropriate and consistent (O'Brien 2003; Schneider 2004), to identify problems (Knight 2002), and add to reliability through pre-testing (Silverman 2001:229). The participants, two male and two female managers known to the researcher, were selected because of their appropriateness in meeting the sample criteria and the convenience of access to them by

the researcher. These four interviews were conducted in person and were recorded using a portable digital voice recorder. The pilot interviews were conducted to test the interview schedule, that is, to determine the appropriateness of the semi-structured questions plus refine the interview skills of the researcher. The digital recordings were downloaded to the researcher's computer as sound files and duplicated on a separate PC laptop, as well as a separate external hard drive to ensure the safety and security of data. Some material was transcribed by the researcher and some by a separate external transcriber employed for that purpose. Copies of the typed transcripts were forwarded to the participants and feedback encouraged. The nature of feedback was editorial and there were no requests for major change or disagreement about content. After the pilot study, changes were made to the interview schedule, which are fully described in the following section.

### **3.6 Interview schedule**

A semi-structured interview schedule, together with a recursive conversational style of interviewing, was adopted as the major source of data collection. The three iterations of the interview schedule helped ensure that the interview schedule would allow the appropriate collection of 'detailed and richly textured person-centred information' that 'gives access to subjective perceptions, meaning and understandings' (Minichiello et al. 2004:412).

The first iteration of the interview schedule focused on the issues and challenges faced by health services managers, and what managers do, that is, the functions of the manager, all derived from contemporary health management literature, as described in Chapters One and Two. This iteration was trialed in the four interviews of the pilot study. It was considered by the researcher to produce significant, but often confirmatory, data about what managers do rather than what they think and perceive to be the reality of their role and what they see as the issues and challenges of that role. A second iteration was prepared but not used or trialed because the questions, when reviewed and discussed with the researcher's supervisors, were considered too directional. A refined third iteration was utilised effectively in the study following the pilot study. This third iteration proved effective because the questions were broad and did not limit the participants' capacity to respond, and it more accurately reflected the research purpose

and aims and design of the study. This staged approach to the development of the interview schedule and the inclusion of pilot interviews helped to develop rigour and is also consistent with a hermeneutic – phenomenological approach (Crotty 1998). The iterations of the interview schedules are Appendices 1, 2 and 3. The third or final iteration is listed below, along with prompts and amplifications that were used to stimulate discussion.

### 3.6.1 Interview schedule – questions and prompts

<p><i>1. What are your perceptions and views of the health service/system, both positive and negative? What are your perceptions about your role as a health manager?</i></p> <p>Prompt: This can be as broad as you like and doesn't necessarily require you to talk about your current circumstances, but more about your 'lived experience' so far.</p>
<p>2. What do you see as the central problems/challenges of a health service manager in managing in the health system?</p>
<p>3. The health system involves multiple stakeholders, government, the professions, and the community to name a few. Can you discuss this context and perhaps comment on who are the dominating forces?</p>
<p>4. (Researchers talk about healthcare delivery in terms of 'complex adaptive systems'). What are your views in this area, how do you manage in these circumstances?</p> <p>Prompt: What is your advice to other less experienced managers? Is the integration of health services working?</p>
<p>5. What is it that health managers have to learn to successfully manage health services?</p> <p>Prompts: How did you learn to be a manager? Is the learning that is provided in the health system adequate? Did that learning equip you adequately for the role? Where is the emphasis required?</p>
<p><i>6. How and why did you become a health manager?</i></p> <p>Prompts: Would you encourage others to consider a health management career? What is it that attracted you to this role? The power, glory or the challenges?</p>
<p>7. In your experience what has been the most negative and/or frustrating aspect/issue experienced in your health management role?</p>

8. In your experience what is the most positive and/or rewarding aspect or issue experienced in that role?

9. What demonstrates the essence of a health system?

Prompts: That is, what is it about a health system, a characteristic or value, or self-evident truth, which some call axioms, that are an essential element of a good health system? Can I ask you to make the statement short and if you wish, you can make more than one?

Throughout the interviews, additional questions ‘emerged through the dialogue’ and allowed the interviewer to ‘alter the line of questioning’ (Minichiello 2004:413). These were generally prompting questions to elicit a deeper response or to clarify responses to the questions contained in the guide. For example a prompting question that became a consistent part of the interview schedule arose from the discussion of the ‘how and why’ of the participants becoming health service managers and why they held a mostly positive view of the role, despite exhibiting frustration with the role and the health system. This question was generally stated: ‘What is it about the role that attracts you, the power, glory or challenges?’

Demographic data, collected in writing prior to the interview using the Interviewee Demographic Data Sheet (Appendix 4) completed by the participant, was reviewed at the interview to confirm and clarify accuracy. Data collected in addition to name and personal contact details included: current title, role and employing organisation; primary clinical, technical or management qualifications; secondary management qualifications; and professional memberships. In addition, participants indicated if they worked full-time or part-time; the numbers of staff who reported directly to them; gender; and their age group in five-year ranges. This information was important in terms of the purposive sampling objective of obtaining a range of participants across the sampling frame and in gaining participants across the technical, interpersonal and conceptual levels of management, or in management hierarchical terms across junior, middle and senior levels of management.

### **3.7 Data collection procedure**

Data were collected from 2004 to 2006. The researcher followed up, by telephone or email, those who agreed to participate to confirm their agreement. They were provided with either a 'hard copy' or electronic version of an Information Sheet for Research Participants (Appendix 5), a Participant Demographic Data Sheet (Appendix 4) and a Consent Form (Appendix 6). The information sheet described the aims and significance of the study, and the options for managers to participate, either in person or by telephone interview. The right to withdraw consent at any time, the intention to audiotape, and measures to provide security of confidentiality of the data were also described. Details of the University of New England Human Research Ethics Committee approval and contact details of the researcher, the two supervisors and the Research Office of UNE were included. The demographic data sheet and two consent forms were completed by participants prior to the interview. One copy of the consent form was either given to the researcher at interview or was emailed to the researcher prior to the interview, while the second copy was retained by the participant. On two occasions participants requested copies of the questions prior to interview and these were provided to them. The remaining participants were satisfied to participate based on the content of the information sheet provided previously.

The researcher utilised a combination of face-to-face and telephone interviews with the nineteen health managers who participated in the study. Arrangements were made by email, telephone contact or a combination of both for a suitable time and date for the interview to occur. These approaches had the advantage of convenience for the researcher and participant to meet through attendance at conferences and seminars. Six of the nineteen interviews, including the four pilot interviews, were conducted face-to-face, while thirteen were conducted by telephone. The use of the telephone increased the potential diversity of the sample by making it cost-effective to include participants occupying roles in national health organisations from four State health jurisdictions and from New Zealand. Telephone interviews are considered to be as honest and the factual information as valid as that obtained by face-to-face interviews (Denscombe 2003). While it has been suggested that answers to open-ended questions over the telephone should be less complex and shorter than those answered face-to-face (Knight 2002), this did not prove to be the experience of this researcher. The duration of the interview for all participants was approximately one hour and the in-person and telephone interviews

were of similar duration. The use of telephone interviews allowed the participants the choice of time and location, often at evenings and weekends, and it also allowed them a more relaxed and informal setting. This proved less disruptive to holding the interview in person in office or conference ante-room locations. Telephone interviews have the disadvantage of not being able to observe body language or other visual clues (O'Brien 2003) that occur in face-to-face interviews, but verbal signals were still recorded.

The approach to each interview was dependant on how well known the researcher was to the participant. At the commencement of each interview the participants' demographic data and work history were reviewed. Where there had been little or no prior contact, additional effort was made to ensure that the purpose about the research was clear and to ensure a relaxed interview environment and to establish trust. Where there was a prior collegiate relationship with the researcher, the emphasis was on clarity about the research purpose and process, because rapport between the researcher and participant already existed. The interviews with all the participants were approximately one hour. At the conclusion of each interview, participants were invited to make further comment, or provide additional information of their own volition. In a few cases, participants took the opportunity to provide some additional information. They were also given the opportunity to ask for further clarification around the research purpose or process that might have arisen during the interview, but no participants sought additional clarification. They were then advised that they would receive an emailed typed transcription of the interview and were welcome to change/delete material or to provide additional comment to the transcription as necessary.

As previously described, the digital voice recorder was used to record the interviews. The interviews were transcribed by a paid transcriber, due to the time constraints of the researcher and the quantity of material to be typed. On each occasion, the transcribed material was checked by the researcher against the relevant sound file and corrected for obvious errors. A copy of the relevant transcript was emailed to each participant, with a request that they check it to ensure that they were satisfied it was a fair transcription of what they had said and to allow them to make corrections, request omissions or seek additions or clarifications to their material. The email message to which the transcribed interview was attached advised participants that if they did not reply to the researcher it was assumed that they were satisfied with the transcript. Of those who responded only

one requested corrections be made. This respondent requested changes to ensure that the spoken word was consistent with correctly written English expression.

### **3.8 Ethical considerations**

The University of New England Human Research Ethics Committee granted permission for the study to take place under Approval Number HE03/205, valid until 15/6/05 (Appendix 7). The Committee approved an extension of the study until June 2006 on 23 June 2005. As previously mentioned, all potential participants were provided with an Information Sheet for Research Participants (Appendix 5), an Interviewee Demographic Data Sheet (Appendix 4), and a Consent Form (Appendix 6). The participants' willingness to participate was indicated by their return of the completed Demographic Data Sheet and signed Consent Form, either in hard copy or scanned electronic copy by email. The recording of the interview was advised in the information sheet, acknowledged in the signed consent form and also confirmed at interview. Each participant was advised in the information sheet that they could withdraw from the study at any time without prejudice or penalty. They were also individually informed in the information sheet where counselling would be available should participants become distressed, even though the interview questions were not considered to be of a sensitive nature.

Each participant was allocated an identifying code that was used to de-identify the participant in the transcription from the digital sound file. In addition, place and organisational names that might identify the participant were deleted from the transcriptions to further ensure the privacy of the participant. The identification codes were kept separately in a locked cupboard in the researcher's office, as were transcribed 'hard' copies of the interviews. Sound files were maintained in the researcher's personal computer with secure password access and backed up to an external hard drive for security purposes and located within the researcher's locked office. Only the researcher and his supervisors had access to the data. Sound files and transcripts will be retained for five years after which they will be destroyed, consistent with UNE Human Research Ethics Committee approval and the National Health and Medical Research Council Guidelines (NHMRC 2007). The hired transcriber was also required to complete a

confidentiality agreement with the researcher to maintain the confidentiality of the transcribed data and the participants (Appendix (9)).

### **3.9 Rigour and trustworthiness of the study**

The application of rigour and trustworthiness to this study is presented as being consistent with the approach agreed by the British Sociological Association Medical Sociology Group of 1996 (Silverman 2001). This approach provides ten criteria for the evaluation of research that together inform the rigour and trustworthiness of this study. These criteria include: the appropriateness of the method; the connection to existing knowledge and theory; clarity in the selection of cases, data collection and analysis; sensitivity of methods to the needs of the research question; systematic data collection and record keeping; the use of accepted methods of analysis and how systematic the analyses were; the descriptive adequacy of how themes were derived; adequate discussion of evidence around the researcher's arguments; and clarity of distinction between the data and their interpretation. Denzin and Lincoln (1998:277) suggested that the constructivist's perspective of the postpositivist view argues for quality criteria 'that translate internal and external validity, reliability and objectivity into trustworthiness and authenticity'. Trustworthiness is defined as consisting of credibility, transferability, dependability and confirmability (Polit et al. 2001). Rigour is defined in terms of clear and strict process and attention to detail (Roberts 2002).

According to Knight (2002), the above criteria add to the quality of the research and trustworthiness, transparency, credibility and appropriateness are measures of that quality. The researcher developed the research purpose and aims and the hermeneutic phenomenological approach as appropriate because of a desire to achieve sensemaking from a career as a health manager, but has made no prior claims about that career or the phenomenon under study. The considerable experience of the researcher, as a health manager, is used in the study to assist with the interpretation of the meaning of participants and is consistent with the hermeneutic-phenomenological approach of Heidegger (Dreyfus 1991). That participation is made credible by the carefully developed research purpose and aims and the testing of the Interview Schedule through the use of pilot interviews and by the use of health management literature (addressed in Chapter Two). The health management literature supports the need for better description

and understanding of the health manager. The quality of the study was further enhanced by the use of a purposive sample, which aimed at achieving the views of a diversity of health managers and presenting these views fairly.

Trustworthiness in qualitative research, developed by Guba and Lincoln (1994), has criteria of credibility, transferability, dependability and confirmability. Credibility is the acceptability of the research findings, firstly, through ensuring that the study was conducted through adopting good research practice and, secondly, through submitting the findings to those in the social world that was studied – described as respondent or member validation (Bryman 2004). The first criterion of credibility was addressed by the adoption and application of the Sociological Association Medical Sociology Group of 1996 approach, described earlier. It was further addressed by ‘prolonged engagement’ in the development of the interview schedule over a period of time with three iterations following periods of reflective consideration and discussion with supervisors and utilising a journal to describe that reflection. The engagement of the participants in interviews also averaged approximately one hour. Trustworthiness is a dimension of methodological rigour that goes to the trustworthiness of the person collecting and analysing the data and the competence demonstrated in that process. This requires the researcher to be balanced, fair and conscientious (Patton 2002), as distinct from attempting to be objective rather than subjective.

The second criterion of respondent validation was addressed by providing respondents with an account of what they said to the researcher, with an invitation to seek clarification and/or change to the written transcript. This approach demonstrates engagement, ‘persistent observation’ and member checks in ensuring rigour and credibility (Polit et al. 2001:313). One of the researcher’s supervisors assessed themes independently to those developed by the researcher. Rigour and trustworthiness were further addressed by presentation of data at two seminars of academics and practicing health managers during the study and to an industry seminar of health managers (described in Chapter Four). The audit trail approach increased the credibility and confirmability and internal logic of the study. It also added to the transparency of the study. Audit trials that occurred in this study are also evidence of the systematic collection, coding and analysis of data using the computer software Nvivo 7.

Transferability is a direct function of the similarity of the contextual nature of the research to the social world being studied, that there is fittingness or congruence in the receiving and sending contexts (Patton 2002). In this research, literature relevant to the research purpose and aims and the Theoretical Framework, using four theoretical perspectives in which to situate the research, were presented in Chapter Two. This allowed the researcher to identify similarities and differences in that literature to the perceptions of the respondents described in the data and their analysis (Chapters Four and Five) and to the findings and conclusions (Chapter Six).

The findings of previous research, described in Chapter Two, also confirmed the appropriateness and fittingness of findings of this study. Silverman (2001:225) described this approach as taking into account Hamersleys' (1990, 1992) 'three elements of realism of identifying validity through our confidence in our knowledge, but not certainty of its truth; that reality is independent of the claims we make about it; and that we view it from perspectives that represent reality but that do not reproduce it'. The initial feedback of the supervisors, with independent assessment of themes and then with respect to the detailed analysis, also added assurance that the research was contextually situated and that the differing perspectives of the respondents were presented in context. The presentation of themes and the data at industry and academic seminars also provided opportunity for feedback from those involved in the social world being studied.

Dependability relates to the criterion of trustworthiness in establishing the merit of the research through ensuring the completeness and accuracy of records so that they are accessible (Bryman 2004). Copies of all records of this study have been kept in both printed and electronic form, with secondary storage of the latter also maintained for enhanced security. Sound files of interviews were also retained, as were iterations of chapters of the thesis. A system of coding was utilised to link data back to interview narratives, and to demonstrate similarity and differences expressed by respondents based on their differing professional backgrounds. This systematic approach and coding of the data to the narratives of the respondents provides an audit trail. The tabulation of data around themes to ensure the appropriateness of the fit of the data within themes also reinforces the richness of the data in those themes.

Confirmability brings to examination the fairness of the researcher in acting in good faith in presenting the data, their analysis and the findings. The researcher clearly stated his pre-understanding of the topic in Chapter One to ensure that the reader was aware of that perspective. An independent assessment of some of the transcripts in terms of emerging themes was made by one of the supervisors. The researcher maintained a journal throughout the study to allow, amongst other things, reflection on issues that arose during the study. On two occasions, typed extracts in the form of a memo were made from the journal to discuss issues with supervisors around theme development and the data analysis. Iterations of the data analysis chapters were made available for review by supervisors to ensure accurate and fair presentation through to the findings. Data were coded and tabulated around the themes as part of the audit process and to demonstrate fairness in presentation. Data analysis was presented to peers in the health industry and at research seminars to demonstrate the link between the data and the themes and to receive feedback in that respect.

Given that the research aimed to allow the meaning to emerge from the data, multiple theoretical perspectives were applied at the interpretation and discussion stage to confirm or disconfirm the findings that emerged in that context. Disconfirmatory evidence was sought by ensuring the diversity of participants' professional qualifications and industry background, ensuring that they came from a range of management levels and from across a number of health service jurisdictions. Disconfirmatory evidence within and between participants is discussed in the subsequent data analysis and discussion chapters. The diversity of the purposive sample of health management participants and the socially constructed nature of their role, together with the situated and contingent nature of their reality, places this study in the context of adding to empirical knowledge.

### **3.9.1 Researcher's journal**

The researcher maintained a journal throughout the study. This journal was used to record reflexive thinking about the research approach, conceptual development of ideas about the research phenomenon, iterations of the interview guide, issues arising at different stages of the research and notes of relevant research and theory applicable to the research. This approach adds to the credibility of the study.

The keeping of a journal is an accepted practice in qualitative research, particularly around the interview phase of data collection and its analysis. Others have suggested that keeping a journal frees up writing (Richardson 1998) and provides insights and clarity of ideas (Koch 2004). The researcher found that keeping a journal throughout the entire research process was a useful reflective practice that enhanced the Heidegger phenomenological approach of being descriptive and interpretive. It also enhanced the engagement of the researcher's prior awareness and the context dependant knowledge of the researcher and the participants and allowed reflection on meanings that needed to be made explicit. The use of the journal enhanced the use of the hermeneutic circle (Mackey 2004). The researcher does not suggest an ordered diary but a collection of notes, handwritten and typed in narrative plus conceptual maps representing mental models or frames of reference described by the researcher as thoughts, ideas and questions as they arose throughout the study. At times the journal was more formalised in the format of typed memos to discuss progress and ideas with the researcher's supervisors. This was the case particularly at times when themes were being developed from the data and discussed with the supervisors. These various items, described above as forming the journal, were collated and maintained in a folder for continued reference and reflection as well as some elements being maintained as memos and notes in Nvivo 7.

### **3.10 Methodological issues and limitations**

There are a number of methodological issues and potential limitations that were considered in this study. These include the sample size, the role of the researcher and the issue of generalisability. However, given that this study proposed an ontological Heideggerian approach that sought to understand the participants' experiences in a contextualised world, these issues and limitations are of less significance. Phenomenology is meant to find meaning in a given situation rather than to make inferences from that situation (O'Brien 2003).

The sample size was purposive rather than randomised. A probability sampling strategy was not appropriate for this study because the study does not attempt representativeness in the sample or generalisability of the findings. The phenomenon of health managers is also not amenable to precise definition and categorisation that randomness and representation imply. Care was taken to ensure variety through the sampling process to

increase the potential diversity and richness of the data. The participants were recruited 'because of their experience of the phenomena (and) their ability to articulate that experience' (O'Brien 2003:197). While accepting that the experience of the phenomena is infinite, the number of participants was determined by the logistical and pragmatic considerations of a study of this type and by an attempt to achieve 'maximum variation' (Llewellyn 2004:227). This variation was achieved by utilising a range of characteristics as inclusion criteria, such as professional background, organisation type, and management level, to construct the sample and allow patterns to emerge; data collection was concluded when saturation had been achieved (Bassett 2004).

The role of the researcher has been addressed by establishing the centrality of that role in hermeneutic phenomenology as presenting and interpreting the discourse of the participants. The experience of the researcher as a health service manager was disclosed at the outset, as was the desire to bring a greater sense and personal understanding of that career through this study. In terms of the hermeneutic circle the researcher's experience brings considerable pre-understanding to the study, also disclosed in Chapter One. The research purpose and aims of the study were developed to provide greater depth of understanding to the role of the health manager, the diversity of that role and its contexts. Therefore, the purpose and aims and method of the study preclude any claims to generalisability of the findings. The multiplicity of aims of the study and the diversity of the background of the participants, purposively selected, also preclude the researcher offering a single view of the health manager role or of the phenomenon (O'Brien 2003; Bassett 2004).

### **3.11 Conclusions**

This chapter commenced with a justification of the qualitative hermeneutic, phenomenological approach as the research design. Within the justification it was demonstrated how the design fits in with the purpose and aims of the study. The chapter then addressed the research methodology, including the setting, sample, pilot study, interview schedule, data collection and the role of the researcher. Ethical issues and rigour and trustworthiness were also discussed and finally methodological issues and limitations were identified and addressed. The following chapter presents the data analysis and identifies the relevant emergent themes arising from the data.

## **Chapter Four**

### **Analysis of data: Themes 1 and 2**

#### **4.1 Introduction**

In the previous chapter, the research design and methodology were described. The analysis of the data is presented in Chapters Four and Five. In this chapter the justification for the data analysis technique is presented and then the profiles of the participants described. The first two sections of the data analysis are presented as Themes 1 and 2. Each of these two themes has two sub-themes. In the following chapter the other two themes that emerged from the data are presented and discussed. The themes are described with supportive quotes from the respondents in the study and linked to the context of the Theoretical Framework described in Chapter Two. In summary the themes and sub-themes that emerged are presented.

##### **4.1.1 The study themes**

The study themes are:

##### **Theme 1: The health managers' perceived reality of the health system**

**Sub-theme 1.1:** Constant and complex change in a non-adaptive system

**Sub-theme 1.2:** Bureaucracy and politics - a system of parts

##### **Theme 2: The health professions in management: contested roles**

**Sub-theme 2.1:** The importance of sensemaking

**Sub-theme 2.2:** People, power and performance

##### **Theme 3: The career journey of health service managers**

**Sub-theme 3.1:** Learning to be a health manager

**Sub-theme 3.2:** Role models, mentors, and motivation

**Sub-theme 3.3:** Developing and supporting health service managers

##### **Theme 4: The health managers' solutions**

**Sub-theme 4.1:** Structuring the health system

**Sub-theme 4.2:** Educating and changing the health workforce

There are five major research aims in this study. The overall research purpose is to explore the reality, perceptions and the lived experience of health service managers. Theme 1, the health managers' perceived reality of the health system, addresses that broad research aim, by examining changes and trends in the description, nature, and role of the health service managers, consistent with changes in the evolution of healthcare systems. This aim is addressed throughout the four themes.

The second research aim, addressed in Theme 1, is to explore the health managers' perceptions of the health system and the influence of change on them and their role. These experiences have been organised into two sub-themes which describe these experiences in terms of a health system that exhibits constant complex change, is non-adaptive and bureaucratic, a system of parts that is focused on both illness and performance. The respondents perceive the influence as substantially negative, both on themselves and their role.

Theme 2, the health professions in management: contested roles, also addresses the second research aim as well as the third, which is to seek health service managers' perspectives on how they manage and on their perceptions of management practice. Theme 2 responds to the research aims by presenting perceptions and interpretations relevant to the role, the capabilities required and how the role is performed. It describes the impact of the professions and the structural interests on that role. This theme has two sub-themes that describe how health managers perform the role in terms of sensemaking and, people, power and performance.

The fourth aim is to identify the capabilities of health service managers to manage in complex and uncertain contexts. This aim, partly addressed in Theme 2 and also addressed in Theme 3, describes the career journey and goes on to present three sub-themes concerned with learning, role models, mentors and motivation and how health managers are developed and supported. The final aim is to identify differences, if any, in the perceptions and practices of health service managers based on their professional educational background. This aim is embedded in all the themes but particularly in Theme 2, which addresses the role of the professions in health management. Theme 4 presents the respondents' solutions to the issues and challenges they have described in

the previous three themes and how the profession and the health system might move forward.

#### **4.2 Justification for data analysis technique**

Qualitative research generates large amounts of data, the collection of which begins in the field, and continues in the transcription and analysis and coding of the text into categories (Berg 2004). In hermeneutic phenomenology, the analysis and interpretation of meaning continues into the writing and rewriting around the categories and themes that make explicit the meaning of the subject and of the structures within which the subject or phenomenon exists (Van Manen 1997).

The purpose of hermeneutical research is to provide explicated text in the form of themes that represent the shared experiences (Knight 2002; Bassett 2004) and, also sometimes, the diversity of experience (Diekelmann 2001). This is done while remembering that that experience is situated in the understandings of those involved and the circumstances of the research encounters (Silverman 2001). The researcher needs to be alert to those things that stand out and those things that are normal in the participants' descriptions as well as understanding the situated context (Mackey 2004). Therefore, all descriptions can be challenged by other descriptions and multiple descriptions can exist (Zalm & Bergum 2000), and a number of interpretations can be generated and survive (Knight 2002).

The approach in this data analysis utilised thematic analysis, consistent with that described by Pope and colleagues (2000), and further informed by Colaizzi (1978) and Miles and Huberman (1984). While substantially utilising this approach, the researcher was mindful of the diversity of approaches and adapted those approaches where appropriate into this study. Colaizzi (1978) suggested stages of data analysis that consist of: reading and rereading the transcripts; the extraction of significant statements with meaning established and noted for each statement; themes established and clustered with references back to the original description to ensure validation; and description of the phenomenon from the integration of themes. Finally, the themes are validated with the respondents to the research (Colaizzi 1978). This researcher did not seek validation

from the respondents other than earlier seeking confirmation of the authenticity of the transcribed interview; reasons are described below, in this section.

Data analysis commenced during data collection, which allowed the researcher to refine and develop the approach, refine interview questions and to pursue emerging issues (Pope et al. 2000). This provided the basis of a continuous process of analysis and allowed the themes to emerge from the data. The approach continued throughout collection, analysis, evaluation and interpretation, until saturation was reached (Sarantakos 1998). The analysis involved identifying what the researcher perceived to be meaningful phrases or passages of interview content, extracting sufficient text to retain the meaning and to provisionally code or index the section of text (Pope et al. 2000). This approach of identifying meaningful data is consistent with hermeneutic phenomenology, where the process is repeated a number of times and adjustment of the amount of text around the meaningful data occurs to ensure adequate context (Jones & Borbasi 2003).

The data were categorised into like groups, where themes and sub-themes began to develop inductively from the data (Pope et al. 2000). This process was achieved by using printed Nvivo 7 abstracts, this computer program aiding the analysis through the management of a large amount of data (Coffey & Atkinson 1996). It was further informed by placing the data into tables of identified themes to clarify the relevance and consistency of the data with the theme or to detect differences or inconsistencies that might arise from an individual participant. Miles and Huberman (1984) suggested this approach amongst a range of approaches to analysing, interpreting and displaying data. An independent analysis of some of the transcribed interviews was undertaken by one of the researcher's supervisors. This occurred before the researcher's analysis was discussed with, or provided to, the supervisors. This approach is seen as a core activity of supervision sessions (Barbour 2001) and improvement in consistency or reliability of the analysis can be achieved by the use of more than one analyst (Pope et al. 2000). There was a high degree of consistency in the analysis and the determination of themes through these two independent processes.

The initial level of analysis was first attempted with the four pilot interviews. This assisted the researcher in further refining the interview guide into the format used for the remaining fifteen interviews. The first level analysis occurred in a continuous

pattern as transcripts were confirmed by participants and returned to the researcher. The initial codes included descriptors, for example, codes such as ‘stakeholders’ and these were further described as consumers/community, politicians, and bureaucracy as examples. In the latter case, the data suggested ‘blurred boundaries, adding layers, time wasting, red tape, keeping the minister happy’. Therefore, under the code ‘stakeholders bureaucracy’ relevant data were manually aggregated and marked with the participant’s unique identifier and a paragraph number back to the Nvivo 7 transcript to provide an audit trail to all the data. This aggregation identified the strength of the data around a particular code. It also indicated where there were shared perceptions and where differing views were held. Following completion of this level one analysis for all nineteen interviews, the coded data from each of the interviews were aggregated under the twenty codes and printed out for further higher-level thematic analysis.

A further example of the analysis process is provided in the case of the participants’ perception of the health system. The data were grouped into some eight subsections - power; politics; bureaucracy; public good; hospital illness system; complex, non-adaptive; constant change and the challenges and problems. This process of analysis was repeated until the groups emerged into initial themes of like data. In addition to the ‘perceptions of the health system’, described above, the initial themes that were developed were ‘the role of the health service manager’, ‘stakeholders’ and, ‘the health management career’. Each of these initial themes contained a number of sub themes, for example, the stakeholders’ initial theme extended from three to five sub themes because of the second level of analysis. After further analysis, Theme 1 ‘perception of the health system’ reduced to five sub-themes, then down to two. Subsequent iterations of the data in narrative form changed and re-ordered these initial themes into the themes and sub-themes described in this and the following chapter.

This process helped identify the relative strength of the participants’ discourse around a theme and further confirmed the relevance of the theme to the data. Recourse to both the sound files of the participants’ interviews and the transcribed versions occurred throughout to reinforce the link between context and meaning. The process was both recursive and reflective, continuing through to the writing and rewriting of emergent themes, to adjust and refine the iterations (Coffey & Atkinson 1996). The researcher’s supervisors provided feedback on some of these iterations. Initially all data relevant to a

theme were included to ensure fairness and accuracy of representation. These data were retained until both the shared and disparate experiences of the participants around the theme were interpreted by the researcher using the relevant theory and literature.

The status of the data, therefore, has an aspect of authentic experiences of the respondents, while being part of representations of shared experiences constructed between the researcher and each respondent that is then presented as shared experiences within the themes. This approach is consistent with reservations that individual respondents may not have understanding of, or interest in, sociological contexts (Bloor 1978) and that respondent validation may only be possible when the analytical results are compatible with the self-image of each respondent (Abrams 1984). This would seem particularly apt where the interpretation represents shared experiences above that of the individual respondent's perspectives. The strong linkage of the themes to the theory and literature provided a form of validation of the appropriateness of the themes, as did the public presentation of those themes, as described earlier (Silverman 2001). In validating the analysis, Miles and Huberman (1984) suggested data analysis as three linked processes of data reduction, display and conclusion drawing and verification (Coffey & Atkinson 1996).

Miles and Huberman (1984) proposed some thirteen tactics, which were adopted for this research, for generating meaning. The plausibility of the fit and logic of patterns, themes, and conclusions were tested with the supervisors and in presentations to experienced health professionals and academic colleagues. Identification of consistencies and differences, or clustering by actors, circumstances, and processes were detected, for example, within the differences of the actors' views about who should be health managers. The use of metaphors are said to lead to a higher level of abstraction and to facilitate conclusions. Metaphors that powerfully described the participants' shared feelings emerged naturally from the participants' narratives; these were examined in both a metaphorical and semantic context to consider meaning (Coffey & Atkinson 1996).

The researcher attempted to avoid anecdotalism (Mehan 1979) by including the full array of data in early drafts to allow judgement and critical comment from the supervisors, until final drafts refined the extent of data content. This also assisted the

demonstration of representativeness and diversity within instances and findings and helped avoid fitting data to preconceived ideals or selecting conspicuous data ahead of less dramatic but indicative data (Fielding & Fielding 1986; Bryman 1988).

Tabulation or counting is not a consideration of qualitative research but it is of value in identifying the strength of trends, the comparison of events and the meaning of relationships. It was valuable in validating the robustness of the researcher's interpretation and insights, and recognised by Miles and Huberman (1984) as an appropriate approach for generating meaning. Comparing and contrasting of similarities and differences was achieved with the use of sub-themes within the major themes. At times during the analysis, data were also partitioned into different and multiple themes and sub-themes to aid analysis in testing fit, diversity, and coherence of meaning. This partitioning progressed to subsuming the particular into the general to assist analysis and to validate legitimate conclusions. The relationship of data was refined using sub-themes. The themes suggest a logical chain of evidence within and across the data that is demonstrated in the analysis and discussion in this and the following chapter. These approaches effectively demonstrate the move from data to constructs and then theory (Miles 1984; Sarantakos 1998)

In summary, the stages of the thematic analysis were:

1. Each interview was digitally recorded and sent to a professional transcriber for transcription.
2. The transcribed interview was sent to respective participants with a request that they provide feedback as to the accuracy of the transcription and the identification of errors together with advice regarding clarifications and amendments required by the participant.
3. The researcher read each interview in its entirety through a combination of reading the transcript from the computer screen while listening to the actual voice of the respondent on the sound file.
4. The transcripts were read and re-read in this manner with the researcher highlighting sections of narrative that addressed the study aims.
5. A further reading of the transcript occurred where a descriptive code was applied to the highlighted narrative that, in the researcher's view, typified the meaning of the data within the text.

6. Typed transcripts of some of the interviews were provided to one supervisor to provide an independent analysis of emerging themes to that of the researcher.
7. Journal entries were made at two stages of this process to document progress, reflections and emerging themes and these journal entries were shared with the supervisors.
8. Coded data were thematically analysed in a reflective recursive and iterative process by extracting the data in hard copy from Nvivo 7.
9. An audit trail was established using Nvivo 7, with paragraph numbers and participants' codes utilised on all occasions to verify the location of the data in the text of each interview and on all analysed documents produced and retained in folders.
10. After 19 interviews the researcher agreed with the supervisors that saturation had been achieved and data collection was deemed to have ceased.

### **4.3 Participant profile**

Nineteen respondents, eleven female and eight male, were interviewed in this study. At the time of the study the respondents worked in a variety of public/private and non-government health organisations in four different states, two national health organisations and New Zealand.

Table 4.1 presents details of the respondents. Their names have been replaced by a code that designates the professional background of each respondent, together with an identifying number to ensure linkage to the transcript and data abstracted from their transcript for audit trail purposes. To protect anonymity, the demographic details of respondents include: clinical/generalist background, health management or other management qualifications plus approximate title and role.

**Table 4.1:** Demographic and code detail of respondents

Respondent code	Background	Qualification	Title/role	Organisation/department/role
HMA1	Allied health	Health management	Director	Network/area organisation
HMA2	Allied health	Health management	Director	Network/area organisation
HMA3	Allied health	Health management	Consultant/ Project Officer	Health department
HMA4	Allied health	Management	Manager	Health department
HMA5	Allied health	Health management	Manager	Teaching hospital
HMG1	Generalist	Health management	Director	National role
HMG2	Generalist	Health management	Director	State role
HMG3	Generalist	Business and health management	Manager	Teaching hospital role
HMG4	Generalist	Business and health management	Director	State role
HMM1	Medical	Health management	Director	Teaching hospital
HMM2	Medical	Health management	Director	Network/area, regional/rural organisation
HMM3	Medical	Health management	Director	Network/area/rural organisation
HMN1	Nursing	Health management	Manager	Rural hospital role
HMN2	Nursing	Health management	Manager	Teaching hospital role
HMN3	Nursing	Health management	Manager	Aged care role
HMN4	Nursing	Management and health management	Manager	National role
HMN5	Nursing	No formal management qualification	Chief Executive Officer	Not for profit provider
HMN6	Nursing	No formal management qualification	Manager	Rural hospital
HMO1	Other health discipline	Management and health management	Coordinator	Network/area organisation

### **Legend to Codes**

HMA – Health manager with allied health qualification and professional background

HMG – Health manager with generalist health management and/or management qualifications with health system experience

HMM – Health manager with medical qualifications and professional background

HMN – Health Manager with nursing qualifications and professional background

HMO – Health manager with health profession qualifications other than those described in the above categories

## **4.4 Theme 1: The health managers' perceived reality of the health system**

### **4.4.1 Introduction**

Theme 1 describes two sub-themes that constitute the health managers' perceived reality of the health system. Collectively, the two sub-themes, constant and complex change in a non-adaptive system (Sub-theme 1.1), and bureaucracy and politics – a system of parts (Sub-theme 1.2), represent the theme and a reality that the components of the health system are just that, that they do not operate effectively in a systemised fashion. The shared perception of the respondents is that the healthcare system is pre-occupied with constant bureaucratic and politically-motivated change, while the system is not particularly adaptive and responsive. This context creates both problems and challenges for health service managers in performing their role. The change is typified by constant restructures into predominantly larger health systems perceived by the participants as having been ineffective in developing an integrated and effective healthcare system, suggesting that the system is non-adaptive. The respondents believed the system is still focused on illness and hospitals and this is inconsistent with what the respondents consider should be the purpose of a health system.

This collective perception of the participants is recognised in these sub-themes:

- Sub-theme 1.1     Constant and complex change in a non-adaptive system
- Sub-theme 1.2     Bureaucracy and politics – a system of parts

#### 4.4.2 Sub-theme 2.1: Constant and complex change in a non-adaptive system

There was an almost overwhelming sense among the respondents that change is constant. *'I think one of the biggest things has been that there is constant change'* (HMA3). The respondents described change in similar terms to earlier research of Eraut and colleagues (2000) and colleagues about workplace learning, where managers have to deal with the constancy of change, its competing demands, and its continuous nature. Their perceptions are also consistent with Decter's (2000) description of the forces of change. A generalist health manager described the system as: *'You are dealing in a very dynamic and complex environment'* (HMG3). The constancy and continuity of change and its dynamic nature, as described by the respondents, is consistent with the view that reform has been occurring in health systems for some four decades (Bigelow & Arndt 2000) and that the change is both dynamic and cumulative (Lozeau et al. 2002).

Some allied health qualified respondents described the change in terms of its enormity. One respondent suggested: *'there have been enormous changes. All of them have been significant'* (HMA5). Another said: *'the way that patients are managed has changed enormously'* (HMA4). The changes were also described as having *'become more complex. It is a very complex system'* (HMA5), a view shared by a number of the respondents; *'yes, they are extremely complex'* (HMA4). These statements of the respondents indicate that the emerging interest in the application of complexity theory to healthcare is appropriate.

Consistent with the above view of allied health qualified respondents about complexity, a medically qualified health manager believed: *'the whole system likes complexity, because it maintains the status quo'* (HMM3). This respondent believed that 'the system' likes the fact that complexity impedes the impact of change. This perspective is consistent with the theoretical perspective proposed by Alford (1975). The capacity of the system to not accept or to resist change and to attempt to maintain the status quo position is also consistent with a number of theoretical concepts in the literature. Consistent with the literature complexity is described as a possible inhibitor by research findings around power structures, interpretive frameworks and institutional values (Ransom et al. 1980; Amis et al. 2002) and the tendency of organisations to move towards isomorphism (Powell & DiMaggio 1991), a characteristic of neo-institutional theory. Part of the reason for this perception of complexity inhibiting change is that the

dominant, systemic integrated archetype (generally large centrally-run health organisations that have been established in the last decade) has not displaced or replaced the previous provider-driven archetype, but coexists with it. This is consistent with the research of Denis et al. (1999), where reform was seen to involve compromise and is often layered on and coexists with existing structures.

Some allied health qualified health managers described the increased complexity in terms of becoming more specialised, pressured and requiring more skills. The respondents suggested: *'we've got more and more specialist in some ways; it means that the teams caring for patients have become larger and larger'* (HMA5) *'and the health services has become more, pressured, more highly skilled'* (HMA3). These perceptions are consistent with the position put by Eraut (2005) that we are seeing the emergence of new roles and sub-specialism within roles and this has, as a consequence, the narrowing of the knowledge base of experts within the sub-specialism domains.

One of the generalist health managers described the health system complexity as complicated:

*So there is a very large complicated system, run by a funny set of rules, highly regulated, that creates market distortions and because of the emotional situations, particularly in the acute care environment, it can end with all sorts of funny kind of perverse outcomes* (HMG4).

This perception is consistent with the theory of Alford (1975), who described 'innovations', as being designed to integrate and coordinate, but having the opposite effect of further complicating and fragmenting the system. The system is seen as having *'multiple funding streams, multiple providers [and] a primary health focus, public health focus and the tertiary settings'* (HMA5). This perception raises the question as to whether one integrated health system can respond to these multiple and somewhat competing settings? It is seen as a people dependant system where *'people are complicated and particularly human relationships are very complicated.'* (HMG4).

One participant used the metaphors of a frog and a bike to put the health system, its complexity, and the impact of change into context:

*In a sense of thinking about the system, you know, you have to think of it like a "FROG". You know if a frog is just put in water, (laughter) if the water is gradually heated it's nice and content there but it dies.*

*I just wonder sometimes about the complex nature of the health system, some people are quite content to sit in the boiling water, not quite realising they are actually in boiling water. Some people approach it as if it is a bike. The idea of a bike is that you can take its parts, cut it, join it, weld it back together and it will still be a bike.*

*You can't do that with a frog! People expect that they can dissect the health system and cut bits of it off and join bits to it, and join it in different ways. Somehow, they still expect it to be functioning! (HMG4).*

The same respondent stated: *'it's a very organic system that has to constantly change and evolve'* (HMG4).

One medically qualified respondent suggested: *'people accept it [problems with the system, adverse events] because of the complexity, because everyone is so busy, stressed, you know, we try to build up systems to make it safer all the time'* (HMM2). This discourse suggests resigned acceptance of the dysfunctional impact of some of that change and the reality that no matter how much reform or control is applied, variability and failure will occur (Braithwaite 1998).

The complexity, for other participants, is linked to size: *'because of the huge complexity and scale you are not afraid of size when you are working in health, you know what I mean. The scale of the organisation just dwarfs most others'* (HMG4). This generalist health manager's perception of the institutional scale and size of the health system reinforces the description of health systems as Denis et al.'s (1999) proposed integrated systemic archetype.

Some participants further reinforced the perception that *'we are terrifically slow to change'* (HMA5). This is consistent with the perspective of Braithwaite (1998) that change is slow, generational and balanced by counterbalancing forces. The effectiveness of change is also questioned. There is *'change for change sake, sometimes*

*it seems that, we've been doing this for a while now, lets move on and do it a different way'* (HMA2). A nursing qualified manager perceived restructuring as not well considered, being reactive rather than proactive.

*The solution seems to be 'oh, let's restructure' without actually taking it any further to fully understand the issues and the causes and really putting the effort and the resources in to changing some of those systemic problems* (HMN4).

One of the medically qualified respondents suggested that the more we change the more we remain the same:

*We have changed a whole lot of things, but the ultimate model of care is very similar, changes are actually blunted around the edges. We don't adapt what we don't change; complexity is one of the reasons for it* (HMM3).

Another participant suggested that the change is different: *'The change is different each time, as so, that we don't ever go back'* (HMA3). Change initiatives can be similar to those used in the past, but can also be presented as though they are entirely different (Eraut 2004). Change is often focused on the organisation and its structure and goes on around the recipient of care where the change makes little impact on caregivers (Braithwaite 2005). This latter aspect was reinforced by a medically qualified health manager: *'From the doctors point of view very little has changed. The amalgamation has had no impact on their practice'* (HMM3). An allied health qualified health manager suggested: *'the patients still stayed the same'* (HMA3).

While these two respondents suggested change had limited impact on practice, this same claim is also often proffered by those implementing change, to reassure patients, staff, and communities alike, that the change will have minimal impact and not affect key groups. The irony of this claim is seen in the challenge by a nursing qualified health manager respondent, when a chief executive (CE) of a health organisation undergoing amalgamation and restructure made that claim.

*So as (CE) said you know it should be business as usual at the clinical level. It should make no difference to how care is delivered. I wanted to say to him well if that's the case why are we doing it. Really, I had to ask, if we are not making any difference to people or people's experience for the outcomes of care or for the clinicians, why continue to do this?* (HMN6).

The perception of this nurse qualified manager demonstrates that the purpose of change is focused on the organisation, not on improving the delivery or outcomes of care or at least not having an impact on outcomes of care; the purpose of the change is not clear (Braithwaite 2005).

Reductions in the numbers of managers and levels of administration to free resources for clinical services are often quoted publicly as the reasons for restructures (Hill 2007). However, the reality for these participants is that the changed structure actually increases the complexity of making decisions and managing a service, as indicated by a nursing qualified health manager:

*I have to go through, four (4) or five (5) layers of people and it might take a, a week to get up to the one person, then it might take two weeks up to the next person, and then you know, whatever (HMN6).*

A further perception in the context of change for the respondents is that the experience is substantially negative. The following allied health and medically qualified health managers described that negative view:

*I think there has been some change for the positive. And some of it has been appalling. I hate to say it; I think it was working better before we made some of the changes we have made (HMA5).*

*Right now with our amalgamation, you can do amalgamations well or we can do them badly, now there is a category worse than badly (HMM3).*

The negative perception of change also suggests that this is because it is imposed.

*These thoughts are from some conversations the day before the interview, where some very negative thoughts were expressed as to the current changes to health in this State. You know change usually is the top-down approach any way, well its impact, inflicted, if you like, on the health services (HMA3).*

The top-down approach suggested by this respondent is described as a common feature of health system reform (Dwyer 2004). According to the research of Denis et al. (1999), centralised systematic integration can, as a consequence, demoralise unit management

and health professionals. The uncertainty and confusion around change was given by a health manager with nursing qualifications, HMN6, as a reason for leaving the industry or a particular jurisdiction.

*I've made a decision partly in the current climate of enormous change around this restructure. I don't want to be trapped out here ... there is so much confusion around it, and it is so unsettled and they tell us that the next level down is probably another six (6) months away. I've chosen to step out of it during the upheaval (HMN6).*

This perception of the nurse qualified health manager was reinforced by the experiences of a medically qualified health manager when describing the impact of change on health managers:

*When, when you look at the number of really badly hurt people, who are unsupported, unprotected, don't even know if they've got a future and now we're well over 12 months into it. People who are good managers leaving the system to find another job not just in (State). Looking interstate because the system is just so awful. There are people who have decided to just throw it in completely. Leave the whole idea of management behind and do something completely different (HMM3).*

According to research conducted by Smith et al. (2001), constant reform leads to a sense of helplessness and reform fatigue among managers. The negative perception of change is an important issue; it was expressed by managers who have the roles of both implementing and making sense of change, to their staff, communities, and other stakeholders. Little was said by the respondents as to the necessity, focus, or purpose of this constant change. The exceptions were from allied health qualified managers who mentioned a focus on performance management and community expectations.

*What's changed in the health system in 20 years is all this stuff about reduced length of stay, environments (HMA1).*

*The way that patients are managed has changed enormously. There's this overriding focus on length of stay (HMA4).*

While the discourse of the respondents about the extent and nature of change was substantially negative, there were some positive views; such as by a nursing qualified health manager:

*I was fortunate to be part of the department of health clinical service working party. The thing that has made a difference has been the GMTF [General Metropolitan Task Force]. It actually has got an awful lot of things done. We have ended up with case managers who have just been outstanding, and I think we have moved forward (HMN2).*

The above perspective is an example of research that suggests that, where the focus goes beyond organisational barriers with stakeholder involvement and takes into account the complex system view providing a focus on soft systems and engagement of people, change might be more effective (Braithwaite 2005). Notwithstanding the concerns about change, a generalist qualified health manager acknowledged the impact of community expectation as requiring a more immediate response:

*Changes seem to happen very quickly now in the industry, new procedures come in very quickly and then almost accepted as being everyone's got to have it and its like zip its always been there within about six months you know (HMG2).*

Some researchers draw on complexity science to consider healthcare in terms of complex adaptive systems (Plesk & Greenhalgh 2001; Kernick 2006). The participants' provided a shared view suggesting that, while the respondents recognised its complex nature, they did not perceive the health system as adaptive. One of the nursing qualified health managers reinforced this view because the system '*is too unwieldy to be adaptable*' (HMN6). A nurse qualified health manager suggested a lot more could be achieved: '*I think there could be a hell of a lot more integration. I don't think there is any at the moment*' (HMN3). This perception was previously quoted and supported by an allied health qualified health manager who stated: '*we're terrifically slow to adapt*' (HMA5).

One medically qualified respondent indicated that some innovation does occur: '*you know, there are good systems in these more isolated areas*' (HMM2), while a nursing qualified health manager commented that innovation described in entrepreneurial terms is not sufficient: '*there are some great pockets of entrepreneurial spirit and entrepreneurs, there are not enough to actually make a difference to the system*' (HMN6). These statements imply that innovation comes from individuals, groups or from necessity because of distance or isolation, rather than being a guiding principle or

characteristic of the system. While the case can be argued that innovation has and does occur, there is also evidence to suggest that current structures, governance and public policy mitigates against innovation. Support for developing innovation at the central level is not adequate (Dwyer & Leggat 2002). It reinforces research with an institutional perspective, which states organisations and actors are resistant to change because of the dominance of existing stakeholders and their interpretative frameworks and because of the tendency towards organisational isomorphism (Ransom et al. 1980; Greenwood & Hinings 1993; Brock et al.1999).

One allied health qualified manager provided qualified support to the contention that the system is:

*Adaptive, well yes I suppose they are adaptive, they adapt to changes in funding, to changes in policy, and those sorts of things. I just don't know if they are particularly quickly adaptive. I think that is kind of the nature of the beast because they are so complex; it is actually very hard to change these things in a short period of time (HMA4).*

While this participant suggested that funding is one of the factors that causes the system to adapt, the following nursing qualified health managers saw funding as an impediment to adaptation:

*I am being nailed for my budget; they are being nailed for theirs. Everybody is worried about what is going to be costed to whom? It is just a barrier [to] integration (HMN6).*

*Clearly, any clinical change needs to have some funding behind it to allow it to happen. I think that the way our funding is provided is not based around what is the most effective way to get a good outcome for people (HMN4).*

*The small dollars that everybody gets they hang onto and they do not, will not, share that with anybody else. I think that is all money driven. I think as professionals we would dearly love to integrate but I do not think we can get our heads around where am I going to get the money to do that (HMN3).*

The perception that the funding considerations are paramount over service provision, as described by these respondents, is not new (Mechanic 1981). Even at the public policy

level, where services are subject to major reviews, one respondent pointed out that significant long-term recommendations are overlooked.

*They will pick on some of the recommendations emanating from those reviews, but they are usually the ones that are the most expedient and are going to cost the least (HMN5).*

One of the generalist qualified health managers reinforced the importance of the people aspect of the ability of health systems to adapt:

*We are probably not adaptive enough; this comes back to the human frailty again. Some people do it better than others; it is so people dependant as a system. (HMG4)*

A nursing qualified health manager considered that staff like to operate within a comfort zone:

*People seem to feel, within their own comfort zone, why create waves, why look at doing things differently or just the mentality of treating the person when they are sick and forgetting about, preventative health (HMN5).*

According to a medically qualified health manager, the resistance to adaptation continues to be reinforced by the complexity of the system: *'And to change one small thing, means that the whole pile of other things that flow on from it have to be changed too. So, we don't adapt what we don't change'* (HMM3).

Integration is considered to be a desirable attribute sought by health systems. However, a nurse qualified health manager suggested that this is difficult to achieve because *'structurally it's difficult to achieve because of professional structures'* (HMN6). The difficulty in patient transfers within and between area and networked health structures was evidenced as a lack of adaptation by an allied health qualified health manager who said:

*It's extremely difficult to get them [patients] from our health service over to somewhere close to home. It is kind of breaking down the silos in other health services as well as dealing with the silos that exist here (HMA4).*

The difficulties presented by 'silos' have been evidenced as being a negative in the recent *Review of the Queensland Health System* where the 'silos' are described as the

tribal behaviour of the professions (Forster 2005). Finally, the slowness in adapting to best practice demonstrates a reluctance to utilise available knowledge.

*It was sound evidence that what we were doing did not work. There was a way to make it work, but we had to change what we were doing. The old way of doing it is still in place in some places ... You know, 20 years to get a change in clinical practice (HMA5).*

*You see someone reinventing the wheel ... for some reason they haven't been able to access what either you've done in the past or what others have done ... It is the waste of time and resources, particularly when it was proved last time to be not workable. (HMA3).*

These two perspectives of the respondents about adaptation are also supported in the literature, usefully summarised by Dwyer and Leggat (2002). These authors suggested traditional roles and practices needed to change and be redefined, with new roles developed, requiring a greater emphasis on team-based approaches, with greater use of knowledge- and learning-based approaches.

Sub-theme 1.1 clearly indicates that the respondents see the health system in terms of constant change, that they hold negative views about the value and effectiveness of that change. This perspective is consistent with the literature and research that indicates change often occurs for reasons other than improved healthcare outcomes. For example, change is often centrally imposed and focused on the overarching organisational structures without consideration of its impact on the delivery system. The mostly negative view of these health managers from across different health jurisdictions in Australia and New Zealand should be of concern to policy makers, funders and providers, given the assumed central importance of health managers to the effective implementation of change.

Sub-theme 1.1 further indicates that the participants believe health services are slow to adapt. Health systems are human dependant systems; they are complex and the structural barriers around funding, the lack of support for innovation, and the negative influence of professional cultures contribute to that complexity. The respondents' perception that a technologically-based, knowledge-rich system populated by diverse

highly skilled health professionals is not capable of more adaptive behaviour is an area that requires more detailed examination, particularly when complexity theory suggests that complex organisations become adaptive when operating at the edge of chaos (Kernick 2003). The factors that inhibit adaptation and innovation include the highly centralised control, the continued application of bureaucratic hierarchical structures and the continued traditional professional cultural influences that are further examined in Sub-theme 1.2 and the other themes discussed in this and the next chapter.

#### **4.4.3 Sub-theme 1.2: Bureaucracy and politics – a system of parts**

The respondents' view of the health system, as one of constant change and being non-adaptive, is further reinforced by their perception that it is dominated and directly controlled by political/bureaucratic interests, and that it is not coordinated nor integrated, but a system of parts. The respondents perceived this dominant interest as a close alignment between the political and bureaucratic structural interests, as described by a medically qualified respondent:

*The politicians are driving the agenda and asking for input from fairly low down in the system that the decisions are being made by managers all the way through, based on what the political impact will be, rather than what is best for the patient. I think that can be quite harmful (HMM2).*

The media and the professions, in particular the medical profession, are perceived to be the other forces that have influence with the dominant political bureaucratic structural interest. Some allied health qualified respondents generally considered that the interests of patients, consumers, and communities are repressed: *'It really is the more community-based sectors that lose out and the consumers who often aren't heard (HMA4); 'We have some consumer representation but it is not comprehensive (HMA5).* A generalist qualified health manager stated that groups, such as patients, did not have sufficient influence or the means to be effectively engaged in the policy, planning, or delivery of healthcare and were in effect used to advance the claims of other interest groups. *'It all comes down to the political environment, because anyone can use the benefit of patients as a justification to push forward their own viewpoints' (HMG3).* These perspectives are consistent with Alford's (1975) structural interest theory, where the community population is often repressed and seen as an external constituency of

providers to be used by them to maintain the interests of providers. These various alliances also reinforce the feeling of a lack of power and an inability to make a difference, as expressed by respondent managers and further described in Sub-theme 2.2. The respondents invariably saw the difficulties of the health system as emanating from health departments that are central to the delivery of significant portions of healthcare. This concern was expressed in terms of a lack of clarity in roles, the increasing size of the bureaucracy and its relevance to healthcare delivery and its politicalisation. These perceptions are consistent across the respondents and in most cases represent strongly held views of the majority of respondents. The political control of the health system is extensively described.

The following nursing qualified health managers think that: *'as far as the health system goes, it is extremely bureaucratic and political'* (HMN3) and it *'is a large, unwieldy organisation'* (HMN6). A generalist health manager was more emphatic: *'It's bloody big. It is a people system, and it's a service system. Health is really managed, as I see it, by media, political environment, and power groups'* (HMG4). This approach was seen by another nursing qualified health manager as being *'driven by treasuries'* (HMN5) and that the health system is placed in a reactive position of *'always responding, whether it be, the governing bodies or accreditation bodies or funding bodies'* (HMN3).

The impact of *'resource distribution decisions, basically made from a political perspective'* (HMG4) has created *'a blame situation with the State blaming the Commonwealth, for not enough money to deliver those aged care services to the public hospital system'* (HMN5). The political/bureaucratic approach makes difficult the process of care and devalues the role of staff.

*The actual process of care is overtaken by documenting the stuff around it. Therefore, you do not have the time to engage. I think people don't feel as cared for and nurses don't feel as satisfied with what they do* (HMN6).

These bureaucratic and political influences are also seen as constraining purpose because the fundamental purpose of a health service is lost in responding to those requirements. A nursing qualified manager believed: *'well I think a lot of time, we lose sight of what we are actually doing, and that it's for the benefit of the actual community as such'* (HMN3).

A generalist qualified health manager indicated: *'there are a lot of political pressures, and that's how people get funding, that's how people get services developed, that's how the whole thing works'* (HMG4). Similarly, another generalist qualified health manager stated:

*There is just going to be more political interference. We've seen progressively over the last 20 years greater and greater political interference to the extent that the Minister is almost the CEO of the health system. I think that creates significant difficulties for people operating in management levels in health services* (HMG2).

The above perception about the close interest of the Health Minister also supports the view that there is wider government interest in healthcare reform (Dwyer 2004). The respondents' perceptions were that the increased bureaucratic and political control has been at the expense of those who provide and those who utilise the services, and that this approach has also resulted in reduced engagement of communities. In examining health system reform, Rathwell and Persuad (2002) suggested that the key issue in determining the success of reform is the extent that the reform weakens or strengthens the link between the providers and recipients of care. The respondents' perception is that the link has been weakened, so limiting the effectiveness of reform. The circumstances of reform in the Australian context can be contrasted with reform in similarly constructed jurisdictions, such as Canada, where reform heightened political interest in closer community engagement with the health system (Maxwell, Rosell & Forest 2003).

While respondents were fairly consistent in their view about the dominant bureaucratic and political influence on the system, their perceptions of the health system varied. The system was described by a medically qualified health manager in terms of the type of service provided: *'It is a number of discreet entities in terms of community care, hospital care, aged care, acute but non-hospital care'* (HMM1). One of the allied health qualified managers described it as: *'the whole continuum of care, plus the (State Health Department) as the overarching funding and governing body'* (HMA4). It was also described by another respondent as consisting of different sectors. *'You have the private sector, the NGO sector and the public sector and all the other aspects'* (HMO1). This

following generalist health manager questioned the differences in terms of how services are funded and delivered: *'A population basis or do you deliver it on an individual-by-individual basis'* (HMG4)?

The majority of respondents believed that hospitals and illness still dominate the system; *'It is really an illness system; it's a focus on acute illness generally'* (HMN4). One allied health qualified health manager thought: *'we're still dealing with that perception, that a hospital is a health system'* (HMA5). *'Generally speaking in health, we are just about patching up sickness'* (HM01). A generalist qualified health manager suggested: *'I think it is always going to be hospitals'* (HMG2). Respondents also suggested that their view is also reflective of, and shared by, the wider community. According to the following generalist health manager: *'people engage in all sorts of risky (health) behaviours in their day-to-day life'* (HMG4). These perceptions confirm the central importance of hospitals in the health system (Decter 2000; Dwyer 2004). The recognition that the focus is still on hospitals and acute care also implies that the reform agenda of shifting the emphasis to primary care, wellness and population health (Dwyer 2004) have been less than effective.

The continued perceived focus on illness, and the influence of the over-arching organisational arrangements described by the respondents as health systems, indicates that the objective to integrate and provide more effective coordination of care remains a yet-to-be-achieved policy direction. The respondents, as evidenced by a medically qualified health manager, an allied health manager and a nurse qualified manager, suggested that these potential benefits of the system have not been achieved.

*What the hospital provides is very specific and our attempts to link with outside providers is difficult because you cross boundaries of professional interest and discipline, as well as the funding boundaries, and all of a sudden the barriers to actually having smooth transitions for patients is quite difficult* (HMM1).

*In terms of trying to get integration of care and so forth, it still is siloed so although we have this fabulous program structure, it still is very much siloed into acute, subacute, community, sort of thing* (HMA4).

*We operate almost exclusively, in our own domains without any real cooperation, and where there is cooperation, it is usually on a local level rather*

*than being driven, through either a State Government or through the Federal Government (HMN5).*

The WHO (2000) suggested that a system does not necessarily imply integration or that there is necessarily one controlling authority, but these circumstances might influence how well the system performs. The effectiveness of the system, particularly its restructuring, is questioned by the respondents in this theme. This questioning applies to both the effectiveness and the purpose of restructure (Alford 1975). The dominant political bureaucratic interest also does not provide clarity about respective roles. Attempts to 'be all' and 'do all' by state bureaucracies were described in terms of conflict between the political and management role by the following nursing qualified health manager:

*The central bureaucracies like the State Departments of Health they are all variations on a theme. I don't think they themselves have clarity about what their role is. They are trying to do everything; they are trying to create the policy as well as fund, as well as operate. I think that lack of clarity means that there's a lot of people running around being very busy but not necessarily being terribly effective. I think that is because there is that lack of clarity at that central level, at the State level (HMN4).*

These perceptions suggest that contemporary claims for health reform to address fragmented service delivery and to better integrate service to improve access to, and movement through, health systems are not being satisfactorily achieved. The implications for health managers of this lack of clarity of roles and the close influence of bureaucratic and political structural interests on the health system was described by a generalist health manager:

*At the moment, we have our managers working in contexts where there are some fairly close political involvements and the managing up phenomenon in that context takes a lot of time. The political imperatives can sometimes be in conflict with some of the service imperatives and the issues of the distribution and equitable use of resources (HMG1).*

This same respondent went on to indicate that the nature of these arrangements created 'pressures and difficulties, challenges and tension around the health service manager' (HMG1). The nexus between the bureaucratic and political levels of the health system

was described by HMM3, a medically qualified health manager, as working effectively for the benefit of both.

*I think they have very much got an agenda that is in the bureaucrats running at a political level, support the political masters or you don't have a job, the politicians don't look at the big picture because they only have a short-term thing, the two work together very neatly (HMM3).*

Another allied health qualified respondent suggested that the political aims are often inconsistent with those delivering the services and as a result, this creates structural dysfunction.

*The interface between the political aims and the health services in particular, the people on the working floor, should be, but are not always, in parallel. The structure had built up over time with the boundaries becoming very blurred (HMA3).*

This conflict was perceived by a medically qualified respondent as politically-based, with short-term aims rather than decisions being made based on needs.

*The next major influence is the whole political thing, the fight between the major political parties in any given state and then across jurisdictions and even at a local level. They often make decisions that are around short-term vote getting but not the logical things that you would see happening in the long-term (HMM1).*

Another nursing qualified health manager supported the above views of primarily State health-based manager respondents, by contrasting those views with experience of working in aged care, which is a direct Commonwealth Government responsibility.

*The health system is extremely bureaucratic and political and I think public health more so than aged care. I think because in aged care there is one layer that we do not have to deal with. I think in aged care, we generally have much less political interference and much less bureaucracy and that is refreshing as far as coming out of public health and going into aged care (HMN3).*

This view was supported by another nursing qualified respondent.

*I often look at people working in the public hospital system and feel sorry for them because, you know, what, you only have to see the constant change in,*

*political thinking and bureaucratic thinking in the public sector, which doesn't happen in our sector (HMN5).*

An allied health qualified respondent also contrasted perceptions gained from having worked at a more local service level compared with her experience gained in a central State health department as increasing her cynicism about the value of the central role.

*I've become a bit more cynical in terms of the significant disconnect between certainly the health department and the health services. Really, its policies are very much set in the vacuum and then it is essentially left up to the health services to implement said policy. The health department really does not want to know if there are any problems. Like here is the policy, you sort it out (HMA4).*

One of the generalist qualified respondents suggested that the health department and the political level exercise tight central control of the local services:

*Health has a massive organisational structure around it so there should be considerable planning done in both the long-term and short-term. The people who decide what is going to happen almost on a daily basis are the health department and more increasing the political level (HMG2).*

A medical qualified respondent also suggested that there is a disconnection between the centrally determined direction of health departments and the reality of implementation at a local level.

*It comes all the way down through the Department of Health. They keep coming up with all these grand ideas, that look great on paper, but when you actually think about it, they do not work; I think that is the biggest frustration. It is not based in reality; it is based in some political fantasy (HMM3).*

An allied health qualified respondent suggested: '[the] changes seems to be adding layers and layers of bureaucracy. I don't understand that they add any value at all' (HMA5). Another nursing qualified respondent also questioned the value of current centralised approaches:

*I think it is self-interest and self-sustaining. I think those departments are huge and trying to justify their own existence and therefore centralise a lot of things that could be decentralised and was many years ago decentralised out to communities (HMN3).*

The impact of the centralised bureaucratic approach was described by a medically qualified respondent in terms of the difficulty in understanding and interpreting requests.

*I got an email this morning, asking for input to something in a parliamentary folder. Now I do not even know what the issue was, I have one line that I cannot interpret, that tells me what the politician wants to know. I am removed from the politician by about five or six layers. It says that the political side of it is being driven down too low (HMM3).*

The close engagement of the bureaucratic and political structural interest, and the consequent micro-management that the respondents suggested, supports the contention that these contexts are an outcome of current reform across Australian health jurisdictions. The centralised bureaucratic political approach has developed a sense of mistrust and doubt amongst health managers about how to respond, as described by a medically qualified respondent (HMM3):

*Never trust your boss? (Laughs). This is because you need to second-guess the Minister and his minions. You need to work out what the Department of Health really want. If you do not trust them, you think it through if you are trying to cover all the bases (HMM3).*

A lack of trust was further demonstrated by a nursing qualified respondent:

*A high frustration was the expectation to present a particular perspective to the State. At the State level in terms of ministerials, you had to present a picture and really create letters or stories about what was happening which was very, very different to reality. That is a huge frustration. Its game playing and lack of, I suppose, lack of, desire at the top, at the State level to really acknowledge reality and what was happening at the coalface (HMN4).*

*We were doing some great work but the role that I was doing was exactly like Yes Minister ( ... laughter ... ) paper shuffling and writing ministerials to say 'no we are not closing beds', and at the same time having discussions with staff about 'yes we are closing beds' (HMN4).*

The manipulation of events dependant on the audience and the circumstances at the time place managers in tenuous positions that dilute values and trust within health systems. These circumstances reported by the respondents are consistent with findings in other research, including research conducted in Australia and New Zealand (Mechanic 1981; Jamrozik 2003; McKenna 2003; Learmonth 2005; Liang, Short & Lawrence 2005). This lack of trust is also demonstrated when political announcements about increased funding for healthcare are made.

*I hear the health minister say, he's put another 6 or 8 % into the system, by the time you look at wage rises and other costs, he puts a very small amount in, dresses it up nicely (HMM3).*

Another nursing qualified respondent was mistrustful of how funds are spent:

*So the health system's spending, you know, a lot of money and I think a lot of it goes in bureaucratic, big tower things, particularly for (State Health Department), and it doesn't actually evolve down to the community level and maintaining health (HMN3).*

A generalist health manager suggested that the priorities of the health system have been focused on 'budgetary integrity':

*We have had eight years where budgeting integrity has been the prime goal of the organisation. Ultimately, we are simply delaying the inevitable kind of increase of funds that are required (HMG4).*

Some of the nursing qualified health managers suggested that change and restructure have resulted in reactive and short-term approaches that are not in the best interest of communities or the attainment of longer-term objectives.

*It's not rational; it seems to be more reactive rather than planning for what is most effective, and what's best for each community (HMN5).*

*I think that the restructures in health do not provide enough time for long-term planning. That leads to a fragmentation and great frustration (HMN1).*

The differing perception of health managers regarding the relevance of central bureaucracy interventions is explained in terms of managers and their central bureaucracies having different agendas. It is also consistent with research that resistance

to reform (in that case from clinicians) prompted the imposition of further top-down performative reporting requirements, as described in the research of Degeling and Carr (2004).

*Central agencies have an imperative to try to drive problems out of the system. The local management people have a straight up professional interest and responsibility in terms of running the organisations. The manager is caught in a bit of a vice between central reporting arrangements and local practices and expectations of communities and boards (HMG1).*

*Unfortunately, the main management approach at the top level is directive and interventionist. Approaches that are more modern require less intervention, more delegation and to be more inclusive (HMG2).*

*The restructuring, I think, devalues the role of rural managers. They get so frustrated that they cannot actually do things for their community that they decide to move on (HMN1).*

*It seems to me that it takes a long time for things to reach, you know from the high organisational levels down to where it actually makes a difference to people's experience and outcomes in receiving healthcare or accessing healthcare (HMN6).*

HMG4, a generalist health manager saw the system as closely connected to the political system:

*So tied up with government and therefore ultimately politics and the political system that what we have is very much adversarial, and as such a bad instinct can be a bit of a free kick to the opposition (HMG4).*

A medically qualified manager concluded: *'at the top end where the health management and the health delivery happen, it's not working (HMM1)*. The respondents across the range of professional backgrounds commented extensively on this adversarial issue.

*As I said earlier, the relationship issue of senior managers and in turn, unit managers in area health service, to political processes means that this whole performance management issue has an edge to it (HMG1).*

*It actually says the organisation is sort of forgetting its people, particularly after this amalgamation. They're angry, they're not doing their job adequately, they're, doing just what's necessary, they're looking for ways out, they're looking for people to blame (HMM3).*

*You kind of get hauled over the coals and it's very much that (State Health Department) wants to have no responsibility. Its kind of very much about keeping things out of the headlines, keeping the minister happy and making sure that anything that is going on is kind of not highlighted (HMA4).*

*I think the reins are too tight for otherwise experienced professionals in being able to be accountable for overall budget, rather than being directed and micro-managed by a State system that does not really acknowledge the quite significant differences in area health services (HMN1).*

These views about health departments go across jurisdictions. The view was also expressed that, while some change has been for the good, it is not often perceived that way and is seen to create 'red tape'.

*The most awful bit about it, is actually the people I'm dealing with are looking at it from a completely theoretical perspective. So they're not even thinking that we're talking about a real situation (HMA5).*

This interaction was seen as wasteful, time consuming and with no real purpose.

*They have been debating what a new definition of (public policy area) would be. I think well how much more discussion can there be. It should be self-evident and the system should be in place shouldn't it? I have concluded that it has been made difficult to give the people something to do with their work. The only good I can see it adds is it slows down the spending of the money. (Laughs), I do not know if that is the reason to do it (HMA5).*

Even where decision-making was seen to be appropriate, it was considered by a generalist health manager that political considerations would be the determining factor if the issue becomes a public issue.

*You need to have an understanding of the political environment because a lot of the decisions, even though they may be appropriate decisions, if it ends up on the front page of any paper, it's going to end up a political decision. (HMG3).*

Another senior generalist health manager described the impact of pending major change:

*So we do feel our direction, our control is a little bit out of our hands. We are going to be told to do something. We are still in that phase where we still do not know exactly what we have to do. It is a bit frustrating. We have gone through the acceptance, you know, the denial and anger phase, now we are waiting for what it is going to be and then we will have to do something (HMG4).*

The monitoring of health service activity by health departments was seen by one nursing qualified respondent to be variable and inconsistent:

*In some areas, they're watching very closely what happens at an operational level but not necessarily across the board, so there's mixed messages and again an absolute lack of clarity (HMN4).*

This political bureaucratic nexus is encapsulated in the following generalist qualified managers response: *'If there is a bit of bad press the politicians cannot help but intervene. They evaluate you on the press'* (HMG4). When prompted about how this situation might be better addressed, the same respondent replied: *'I suppose I'm a little bit of an advocate for something like, you get the government you deserve'* (HMG4).

The adversarial nature of the relationship between the central bureaucrats and the political level with managers and other staff, as perceived by these respondents, suggests a disconnect between the values of the respondents and the reasons for the change being imposed, making its acceptance and implementation more difficult (Amis et al. 2002). The research of Amis and colleagues (2002) suggested that structuring of organisations rests with some privileged members, amongst a range of members with differing values, but that an organisation's structures are shaped by members' understandings, interpretations, meanings, values and interests. The negative perceptions of the respondents suggest the need for a greater alignment of, and with, managers' values to those ascribed in support of the need for reform, if it is to be effective. The perceptions of the respondents are also consistent with some of the findings of Liang and colleagues (2005) in their research involving senior executives in the New South Wales health system. The research described inadequate resourcing of

change, centrally imposed goals, insecurity and instability amongst senior managers and increased political intervention creating reform ambiguity.

There were some contrasting views from different jurisdictions and operational perspectives about how well the system operates. For example, one respondent suggested that: *'Well I see it as chaos at the moment. Ah, and crisis, it's not really a system, or it's not at all a functioning system, they are not really working well together'* (HMO1). Alford (1975) also reminds us that the term crises is said to be used often to engender reform in the interest of a particular interest group. Another generalist qualified health manager was somewhat more positive:

*I say, Australia's health system is pretty successful ... you will find disadvantage ... And obviously, there is indigenous health. So in a global sense it's quite good, but it does have pockets of under achievement, even failure (HMG4).*

This mostly negative view of the impact of the increased political bureaucratic control of healthcare is reported at a time when Australian healthcare jurisdictions have moved towards large centrally-controlled health organisations and systems over the last three decades. This has had a consequence of a blurring of the funder, provider, and accountability roles and a closer engagement of government with all three roles through micro-management utilising regulation, standards setting and performance management (Crichton 1990; Dwyer 2004; Rix 2005).

There is a lack of evaluative research of the relative merit/s of the different health system organisational structures that have been implemented over time. The effectiveness of these successive structures have not been critically analysed from a health management perspective. However, the negative view of most respondents suggests that in their lived experience the changes do not meet their view of what the health system might be and how it might be operated. The negative view of the respondents is significant in terms of Greenwood and Hinings' (1993) proposition that, in analysing the effectiveness of change, it is important to understand the degree to which organisational actors are committed to the values and beliefs of the current systemic organisational archetype.

The negative perceptions reinforce the position put by North and Perkins (2007) that the impact of paradigm shifts in healthcare structuring often fails to take into account the impact that change has on the capacity of managers to manage in those changing contexts. Secondly, we are reminded that the reasons for reform are the oft-quoted failures of the previous reform (Dwyer 2004). Another analysis does suggest that the Australian health system has a large number of strengths and only requires minor structural change (Duckett 2000).

The respondents, like the policy analysts, considered that healthcare is an important community service.

*Probably the most important thing alongside, you know your other social, your education and your social welfare programs, certainly its one of those essential services (HMA3).*

*The health system is there to treat patients; it is there to actually do a job for the patients' (HMA2).*

*It is the community's health system the public health services of Australia' (HMG1).*

The central importance of health services is described by an allied health qualified manager:

*The health system is still perceived as a public good and a public right; people mostly see the health system as a public good (HMA5).*

These statements by the respondents suggest underlying positive personal and professional values and commitment on their part to the importance of the health system, as compared to their negative perceptions of how that health system is perceived and how it functions. These perceptions are further emphasised in the following themes that describe the health management role.

## **4.5 Theme 2: The health professions in management: contested roles**

### **4.5.1 Introduction**

The perceptions of the respondents of the health system as bureaucratic, complex, non-adaptive and driven by political considerations suggest that the health managers' role

might be unique. The literature also supports the contention that the health system and the management role are different and perhaps unique (Decter 2000; McConnell 2000; McKenna 2003). This is particularly so in professionally-dominated organisations, where multiple diverse professions are situated (Mintzberg 1997) and where health professionals, with and without management and/or health management qualifications, are assuming management roles. These contexts suggest particular and industry specific challenges, such as how managers respond to distant governance and address complexity, and professional subcultural differences and sedimented practices, and the application of market and business practices in a system that does not respond in a linear fashion (Anderson & McDaniel 2000; Lozeau et al. 2002). The response of respondents to this study suggests that the role is a contested role, more so than being seen as a unique role. This is because of the impact of the professions on, and within, the management role and a focus of management on sensemaking and managing people, power and performance. These perspectives are described in the following two sub-themes:

Sub-theme 2.1: The importance of sensemaking

Sub-theme 2.2: People, power and performance

When participants were asked to comment on the management of stakeholders and the professions, significant discourse occurred, from which emerged the main theme of the contested role of the health professions in management. The responses described in this theme produced the most contested views of the respondents in this study. Activities and processes that constitute sensemaking became the dominant discourse, when respondents were asked how they managed. Their responses are explored in Sub-theme 2.1. The respondents also clearly emphasised that the focus of their management role was on the people employed in the system, and that their ability to effectively manage was dependant on the limiting nature of power relationships and the impact of performance management, as demonstrated in Sub-theme 2.2.

A number of respondents suggested that managing in healthcare is different and unique. One generalist qualified health manager had this perspective:

*I think managing in a health service, is different [because] you will get very strong egos. You need to have faith in your own ability, and need to have strong basis for your decisions (HMG3).*

An allied health manager suggested that the health management role required *'that ability to put your own aside and be able to look across the professions'* (HMA6). A nursing qualified health manager, described why the role is different and perhaps unique, by confirming the view in the literature that normal managerial and business practices do not necessarily apply or work effectively in the management of healthcare (Lozeau et al. 2002).

*The people, the power, the politics is very much a huge component of working in the health system, so common sense, logic and business practices don't necessarily abide all of the time* (HMN4).

This perspective of this nursing qualified health manager, HMN4, that the role might be unique because of the belief that logic and business practices don't necessarily apply in healthcare, was supported by another of the generalist health managers.

*The system [doesn't] respond to those, what I call, logical signals, or commercial type signals. This didn't make sense to me [but] I was interested enough in the system to try and understand it* (HMG4).

A generalist qualified health manager, described the difficulty of not being able to define health outcomes, *'the inability to quantify health outcomes'*, and of the difficulty of explaining decisions to people who are *'focused on individual patient outcomes'* ahead of wider organisational considerations (HMG3). This same manager went on to describes economic differences, knowledge asymmetry and the humanistic environment as further explanations as to why the role is unique.

*An environment where consumers don't have complete knowledge and they don't bear the cost just sort of intrigued me, I guess. How we can measure the outcomes and how different health is in terms of an economic modelling exercise, how different it is. You are dealing with people and not figures. It is very challenging, very complex and you have a lot of different things that you need to consider. It's an exciting place to work; you are dealing in a very dynamic and complex environment'* (HMG3).

Another generalist health manager, in a discussion over the chief executive role in healthcare, concluded that occupants of CEO roles could not expect to last more than five years because *'it is almost an impossible job'* (HMG4). The literature and research described in Chapter Two also suggested difficulty in the managerial role because of a

perception that power resides elsewhere (Davies & Harrison 2003). This is because the upward reporting imperative makes engagement with clinicians more difficult and constraining financial circumstances mean objectives cannot be achieved (Liang, Short & Lawrence 2005). The reform process itself also adds to the sense of hopelessness in the managerial role (Smith, Walshe & Hunter 2001). This perception of the generalist health manager, about the near impossibility of the role, is also consistent with the view of Greener (2004) that managers are held accountable for a significant portion of matters that are not within their control.

The respondents in this study had a focus on the contested nature of the role ahead of any view about its uniqueness. Despite some support for the uniqueness of the role, the dominant discourse occurred around issues of who should manage and about the involvement of the health professions in the managerial role, and how they manage through making sense, engaging people and dealing with issues of power and performance management. Participants were asked to comment on the multiple stakeholders, including the professions, and who are the dominating forces. These prompts and probes provided considerable discourse on the relative merits of the contribution of the range of professions to the health management role. The different perspectives demonstrate divergent views, that the role is contested territory based around the central and dominant role of the medical profession in healthcare.

A nursing qualified health manager respondent emphasised the importance of the diverse nature of the health workforce:

*One of the huge skills that a health service manager needs to have is to really be effective in bringing diverse groups together and working across the system. The ability to work across all of those different groups rather than working within a particular group (HMN4).*

These views emphasise the need for, amongst other things, a greater understanding of a broader range of professional disciplines (Eraut 2005:840). While there was a clear divergence of views about the merits of the various professions in health management, one medical and health management qualified health manager placed the debate in terms of credibility with colleagues, and in the context of teamwork (Mintzberg 1997; Forbes & Prime 1999).

*It depends on which bits you are looking to manage. Given that most things are managed by a team, I think that some clinical experience in the team is useful just to maintain, one, a bit more credibility with the people you are trying to manage and two, to provide a sort of, if not, at least an historical view of what it is like to be on the floor (HMM1).*

This medically and health management qualified respondent saw clinical professional background in the team as important for credibility but also stated the following:

*I do not think you have to be clinical to be a good health manager. I've worked for people in the past who haven't been clinical at all, but have been some of the better managers, but they've usually been highlighted, by individuals who were clearly capable managers; they were capable listeners and could understand it from someone else's point of view (HMM1).*

This perspective emphasises that the individual capability of a manager, particularly being able to demonstrate empathy to others, is more important than a specific clinical background. Acknowledging the differences between the professions and the complex nature of health organisations determines how a manager might guide the system (Anderson & McDaniel 2000).

*Yes, I think having doctors, nurses, allied health involved in the overall management is important but I don't think they necessarily, the managers necessarily, have to have that background to be managers, if that makes sense (HMM1).*

A generalist health manager considered that more than a clinical background is required:

*I think that people in health management positions will probably come as they are now from a variety of backgrounds. Clinical backgrounds are starting to be fashionable, clinical backgrounds are also narrow backgrounds, in many ways the broadening process is important (HMG1).*

This is an important perspective in that previous research suggests that managers are limited by their dominant paradigm, not seeing information and therefore possibilities beyond that paradigm, which is a consequence of their personal experiences and beliefs (McConnell 2000). This perspective also places less emphasis on constituted roles and,

presumably professional and educational backgrounds to an emphasis on engagement between those involved (Elliott & Reynolds 2002). This perspective also reinforces the view of the respondents, discussed in the Sub-theme 2.1, where they emphasised the need for understanding the big picture and the context of healthcare as being central to the success of their role.

Another medically and health management qualified respondent questioned the appropriateness of a health manager undertaking both clinical and managerial roles:

*The surgical ward at (hospital), I think the budget is \$3 000 000. Now is it appropriate to have a nurse who may not have done a lot of management training, managing that sort of budget, and trying to supervise clinical stuff at the same time (HMM2).*

This questioning of the appropriateness of dual clinical and management roles is consistent with questioning in other research studies (Bruce & Hill 1994; Thorne 2002). The post-modernist application of logics and hegemony also indicates that separate identities will remain despite integrative attempts in respect to those identities (Harding 2005). One of the medically qualified respondents felt that the following approach might be appropriate:

*I think I'd like to see more generic managers in the system. They bring a business focus and business skills. Writing business plans, ah, you know managing the people (HMM2).*

This perspective stands in contrast to other research discussed earlier, which suggests that normal business approaches are not necessarily effective in healthcare organisations. The same respondent stated that management skills really determine the capability of the health manager, and suggest a degree of comfort in these circumstances if you are a doctor.

*I haven't worked for a medical CEO directly. I've always worked for non-medical. There's no problem you know, dealing with them if you're a doctor. As long as they've got the management skills. I've worked with other people that don't have good management skills and they're the worst ones (HMM2).*

A generalist health manager emphasised the differences in clinical and managerial roles, the importance of teamwork in healthcare, the importance of communication and the need for management training, which is consistent with research described in Chapter Two (Bruce & Hill 1994; Thorne 2002).

*...I think the big issue in health organisations is that people have got to be able to work in teams. The majority of people who work in health are from a clinical background, those people quite often are trained as individual operators, dealing with an individual patient one at a time. I'm talking about doctors and nursing particularly well basically all of them really. Most people quite often don't come into managerial situations with good training in terms of how to operate as a good manager. Their communication skills are quite often on a one to one basis and their method of operations the same (HMG2).*

The clinical background was seen as providing value and credibility. *'It gives me credibility with the doctors. It just eases the relationship building. It's not a hindrance. But as far as dealing with the non-medical managers, they value my input'* (HMM2). The credibility emphasis was also expressed by a speech pathology and management qualified respondent:

*I still keep up to date with my clinical reading. So it means that I can actually join in clinical conversations. And that gives me credibility. You can't underestimate the credibility either (HMA5).*

This emphasis on clinical credibility as being important might also be a justification of the rebalancing and realignment of clinical power into managerial roles, a re-assertion of the profession's self-regulating role, through forging new roles, that has place in both service and management domains (Sutherland & Dawson 1998; Thorne 2002). Research into medical managerial roles suggests senior management and the medical establishment perceive these domains differentially (Bruce & Hill 1994; Thorne 2002; Braithwaite 2004). The maintenance of a clinical identity into management adds to the multiple identities of managers (McConnell 2000), providing for a duality of views that can be opposite (Harding 2005). Individuals adopt social roles in diverse organisational and professional contexts that explain how they might and do play contradictory roles.

One of the nursing and health management qualified participants had a different perspective:

*That structure now is certainly flattened and doesn't exist as it used to, whereas some of those people are now heading up clinical arms aren't clinicians, I think that structure will struggle with the doctors. The doctors will be ever so powerful again (HMN3).*

Another nursing and health management qualified respondent emphasised the importance of broad experience:

*I believe very much in having a broad experience, and I don't believe that necessarily a clinical background or a non-clinical background either makes or breaks a person. I do believe that it can be easier for someone with a clinical background to progress through the system because there is a bit of a culture of 'well you're not clinical so what would you know?' (HMN4).*

This statement is qualified by the requirement that *'there is very much the need to understand the perspective of all of the different professional groups that are involved in the health system'* (HMN4).

One generalist health manager with business and health management qualifications was of the view that: *'at the moment management in health is dominated by people with clinical expertise rather than management expertise, and that clinical qualifications of any kind are valued more than managerial qualifications, particularly with senior management positions'* (HMG3). This same manager suggested clinicians are promoted into management positions while not having had:

*That foundation in management, they have not had their education, the education management, or just the experience in management. They have reached a senior management position by being a good clinician (HMG3).*

This respondent's concern with doctors as clinicians impeding career prospects is further heightened because a preference for nursing qualifications may also be a barrier to a career as a health manager.

*I know it will be more difficult for me to get into a general manager position without a nursing degree, however I don't see that as a major barrier and I think*

*if I keep on working and proving myself, I'll be able to change those perceptions*  
(HMG3).

This generalist-trained manager with business and health management qualifications was of the view: *'there is no single natural leader, there has to be a very collegiate linked in approach. It's a very collaborative structure, because of the collegiate nature; a multiplicity of skills is required in the health service for that complexity'* (HMG3).

However, a participant with allied health and management qualifications supported the value of the need for a clinical background:

*Look I think it is important to have had that hands on experience, knowing how to try and navigate your way around the health services. What the obstacles and blockages are but also the good things, what parts of the health service work well. So I think that having had that experience is really crucial* (HMA4)

A physiotherapist and health management qualified health manager reinforced the dominance of the medical profession, suggesting that success depends on gaining the acceptance of medical staff. This manager confirmed other research findings that managers of clinical units cannot depart too far from the *'attitudes values and beliefs of clinical staff, particularly the views of doctors'* (Degeling & Carr 2004:403).

*We certainly have to be able to articulate what we're doing to the medical staff if we want to change what we're doing or we need their support to get additional staffing or anything like that; they have to understand what value that we might add. Generally, if I can't get buy in from medical staff then even if I've got a terrific case I might not get it any further* (HMA5).

The following comment from an allied health respondent demonstrates effective inter-professional skills in working with nurses: *'I went and worked with the nurses, and I had to laugh when the news got back to me, that they thought that I was a nurse'* (HMA3). A nursing and health management qualified participant made an important point in respect to the transient nature of management appointments compared with the tenure of the clinicians with whom they work.

*I think the senior medical staff are major, major driving forces. I frequently say to my guys that they are here for the duration, we administrators are in and out,*

*we are transient. We give five, ten years, whatever, whereas senior medical staff, it is a lifetime appointment (HMN2).*

A medically qualified respondent with health management qualifications pointed out that the hierarchical nature of nursing provides a structured opportunity for nurses to move into management positions and gain management experience. This opportunity does not exist in the same way for medical practitioners because *'you either choose without necessarily a lot of broad-based healthcare delivery experience to become a medical administrator or you become a clinician'* (HMM1). There are also barriers to clinicians moving to administration because *'you have been paid as a senior clinician and you are asked to take a substantial pay cut to then take more responsibility to be an administrator'* (HMM1).

Another medically and health management qualified respondent said: *'you need people who have got that expertise. Yes, a clinician can pick it up, there are some who do it very well, but you need both [and] the benefits of someone who, who can be hard headed'* (HMM3). Caution was also expressed: *'I can look at a number of managers who have come from outside health and the further into health they come, into the actual clinical side, the greater the need you can see in them to understand the system'* (HMM3).

This respondent went on to suggest a difference within medically qualified administrators between those who have gained little clinical experience beyond their training and those who come to management with considerable clinical experience.

*There are several I can think of just quickly who have basically done a minimal amount of clinical work as an intern or a resident and then you're administrators from then on. I think that any, anyone who's got a major clinical chunk of their life first, actually does the job differently, I'm not going to say better (HMM3).*

Another generalist health manager, with business and health management qualifications, posed an interesting question, brought about by the differences in training, purpose, and education.

*I think doctors, if I use doctors as an example. They are almost, they just can't be good managers because they are so kind of myopic in their focus. Very few of them are strategic. But you don't want strategic doctors, do you? The guy operating on you, you want him to be totally focused on that little piece of tissue that he's found. You don't want him to be instructed with the big idea and the big picture of where we are going in ten years time (HMG4).*

However, in raising this perspective he saw a role in management at an appropriate time.

*Maybe, more senior clinicians are kind of retreating maybe from the clinical interface because, you know, it's the hand/eye coordination and those sorts of things. Maybe those sorts of guys might be better because they often then start taking a bigger picture (HMG4).*

One respondent, who holds a senior health management position with nursing qualifications, reflected on the impact of the lack of formal management qualifications:

*I have probably developed my skills and success as a manager in having worked with a variety of people and being mentored by a variety of people. In fact some of those people that I have often admired as managers, have come from a total non-clinical background. I've worked outside of health in management positions as well (HMN5).*

This respondent also commented on the value of the nursing background:

*I guess the only thing that I would see is that I can focus on having been a nurse working at the coalface, that I can see the benefits of being in a position of influence on the end result on the person you are caring for (HMN5).*

Another nursing qualified respondent was more emphatic about the value of that background. This respondent suggested a place in health management has more to do with the centrality of the medical profession and the need to utilise clinical knowledge than management skills and knowledge to negotiate with them.

*I think that it is a huge advantage if you are a clinician, because you can argue, barge, and argue with the doctors. And I think because they are ever so powerful, if you can't do that, then you are behind the eight ball. I really believe*

*that. If you are not a clinician, your 2IC should be, so they can go into bat (HMN3).*

However, not only does previous research suggest that the professions have ‘different minds’ but that an alliance between the professions in management was not possible (Degeling & Carr 2004). Another respondent with clinical and management qualifications had a different perspective about the same issue:

*I actually feel that the medical and nursing are far too dominant. I think there are often positions that do not need to be nursing positions, but are nursing positions. We do not have the flexibility that we need to have. We need to look at the skills mix, not necessarily the qualifications of the person (HMO1).*

A speech pathologist and health management qualified respondent saw clinical experience as important in the management role:

*I think it is always useful to have had that clinical experience in terms of really knowing how the system works and what some of the challenges are, what the key issues are and how it actually feels to be delivering services to patients and, you know, those sorts of things’ (HMA4).*

Again previous research suggests that alliances of health professions are unlikely because of the contested nature of the role of each profession and that of the generalist health manager, and the differing perspectives they all hold about their respective place in that role (Degeling & Carr 2004). However, another nurse and health management qualified respondent provided a different perspective:

*I think they are a group [admin. officers] we need to develop more and work with because the day of the clinician doing everything is gone, and it needs to go because the clinician’s are actually very expensive (HMN2).*

Concern was expressed by a nursing qualified health manager about preparedness for the health management role:

*As a novice manager who came from managing a ward, and doing after hours managing and then doing strategic management for nursing, [and] to come out to a place like this [to manage a hospital], is that largely you are unprepared for the level of responsibility and accountability that you have in these places (HMN6).*

A nurse and health management qualified respondent saw a move outside nursing as important:

*I thought, the best way to assist the nursing profession was to get out of the nursing profession. A bit ironic, so I wanted to like work outside of nursing to help to be a positive role model, I wanted to be a good role model to both nurses and other health services managers (HMN4).*

Management skills are also seen as a natural consequence of clinical practice. One respondent, for example, made the following comment:

*As a sole practitioner, anyway, I always had that, management of a service, so I think management starts very early when you are a clinician. I've also been a private practitioner as well, so setting up that business, of bringing those skills in has always been very useful (HMA3).*

The discourse around the relative merits of clinically qualified health managers, besides being emphatically positive from most of those with professional qualifications, also brought some doubt from the respondents. In contesting who should be a health manager some respondents expressed duality in their individual views:

*Does it need to be a health professional doing that management. I would say yes, but you know it needs a good argument behind that (HMA3).*

*In terms of health I actually do believe you need, health managers need to have a clinical background, and I can't prove that (laughs) that's just a gut feel (HMA5).*

*I think it's something one of the doctor's said to me when I first came out here and they said 'oh only failed clinicians do management' and I said 'oh no I'm a hot clinician I'm just vain'. In a way that's true, I mean, I think you always think that you can do better (HMN6).*

Disparaging clinicians in management roles extends across professions.

*You get a few knocks, you know. As a doctor in management and even from non-medical managers, you know. You never know exactly how they regard you; you*

*know whether they see you as threatening or whether they see you as a failure ah, because you have ended up in medical administration. I think it is a perception. Yeah, colleagues. Some doctors try that on. And ah, some nurses; senior managers try it on. It is a real thing. But it's not common (HMM1).*

Contestability was raised in terms of professional silos by questioning if management has to be discipline specific. One allied health manager, for example, questioned if this would be acceptable in the Physiotherapy department:

*Does the physio department need to be run by a physio, can there be a general manager there? The physios would scream at that suggestion, but ... (HMA3).*

A manager in a mixed discipline department also made the following comment:

*Unfortunately everybody knows that I'm from a physio background and some of the team leaders are too. And so, even though we work very hard to be completely fair, people's perceptions are that we might be different and that's because of our own profession backgrounds (HMA5).*

These perceptions demonstrate that in an advanced healthcare system there are still demarcations around the professional role.

*The demarcations that are there, nursing versus medicine versus administrators versus allied health, you know (HMG4).*

*I've got a new boss, who's a clinician who is now the director for X who has no respect for me because I'm not a clinician. Senior managers are promoted on their clinical ability rather than the fact that they actually have any aptitude for management. This person has no management competence, no management education, has never been a manager before. (HMG3).*

Previous research suggests that management experience of clinically qualified managers is primarily experiential after having been cast into the role (Thorne 2002). Managers and others who work in healthcare are also limited by their dominant paradigm and, if they have not developed context and an understanding of the 'big picture', then the dominant clinical paradigm can be just as limiting to successful change and management practice (McConnell 2000).

The duality of views on the relative merits of clinical versus non-clinical backgrounds was demonstrated by an allied health qualified manager, who supported the need for clinical qualifications:

*My other very strong role model was a man I reported to who was an accountant. But he's the exception that proves the rule. With my clinical background I think it means that I never lose sight of why we're here, I think if I hadn't ever worked with the accountant I would have said they have to have a clinical background.*

*So there are, there are exceptions. Actually thinking about it, the other very good example I observed was the general manager when I worked at the X Hospital. Really fine manager never lost sight of the patient.*

*I have to backtrack and say no you don't need a clinical background. If I think about it some of the, the very best managers I've worked with haven't had a clinical background. I do think you need to know both. It's no good if you just were a very good clinician and now you're actually a no good manager (HMA5).*

Perhaps, the answer to entrenched views on who should manage might be seen in the following comment by a generalist health manager:

*You see some great clinical teams but everyone in that team has put aside their clinical qualification or their clinical background and obviously just work as a team. I would say we need to institutionalise that across the whole system and we need to move away from what you are called to what you are actually qualified to do (HMG4).*

The contested nature of the health management roles is linked to strategies to managerialise clinical work and is akin to the doctors' strategy to medicalise health, bringing both clinical and managerial expertise to the contested centre of healthcare (Thorne 2002). While not disputing the value and merit of engaging clinicians in management, research suggests that the capacity to effect change in clinical practice is tenuous, and managers standing with clinicians are compromised by their need to meet central authority performance reporting requirements (Degeling et al. 2001).

To gauge their feelings as to how they view themselves, either as a clinician or as a health manager, clinically trained health professionals were prompted with the question:

‘so do you regard yourself as a manager or a clinician?’ or ‘do you regard yourself as a health manager or as a (specific discipline)?’

An allied health manager was emphatic in being seen as a clinician:

*A clinician. If you ask, or if I go overseas as much as I possibly can then I write on my immigration card, what's my occupation I put a physiotherapist. And if anyone asks me when I'm outside work what I do, I am a physiotherapist. Because, that is really what I am. I'm not the least bit fussed about status and power. That doesn't bother me in the least if people don't know that I'm in the role I'm in (HMA5).*

A nursing qualified health manager suggested that the importance of the clinical background is to do with monitoring the doctors and advocating for patients.

*My clinical background, being able to negotiate with doctors at a clinical level. You do that, all day, everyday. Having the experience of being, the patients' advocate (HMN3)*

The duality around how clinically trained health managers perceive themselves extends across clinical disciplines.

*I regard myself as a manager now. ... I think what it means is that I am a manager but I have, I still have, a very strong attachment to my clinical roots (HMM2).*

*Both within the organisation that we worked for as well as in the industry. I see myself now as a healthcare manager, um, but still with, with some traditional roots (HMN5).*

Some respondents put their preference for a clinical role in terms of how adverse the management role is at any particular point in time. For example, one manager said: ‘particularly when I'm having a bad management day. I think I just want to go out and look after people’ (HMN3).

The nursing qualified participant had stepped past the clinical role into general management, but recognised the value of that nursing background in the current role.

*Well it's interesting because I take my nursing hat on and off ... (laughter), when it suits me. I don't feel that I am a nurse and I don't label myself a nurse.*

*However, it's interesting that I've reregistered and I've actually rejoined the College of Nursing. I went through a stage where I felt that I wanted to just get rid of that label, step away from it, but now I embrace the fact that I have a nursing background. I don't call myself a nurse, no but, I'm enjoying, in my work talking with people like the chief nurse and directors of nursing at area health services and the chief executive of nurses registration board, so they're the sorts of people I deal with in my current role (HMN4).*

Previous research, described in Chapter Two, demonstrates that the maintenance of a clinical load by clinically qualified health managers is also about ensuring the trust of clinical colleagues (Bruce & Hill 1994; Thorne 2002; Braithwaite 2004). Degeling et al. (2001) in their research, see Chapter Two, indicated that the full range of clinical and non-clinical managers and medical and nursing clinicians demonstrate profession-based differences to health reform.

One respondent pointed to the diversity of health management roles and suggested that those in a clinical management role are disadvantaged in resources compared to health managers. This comment also reflects the difficulty in neatly defining the health management role.

*When they think health managers, and they are important managers, very important managers, health unit managers, political managers, they have a role, they have a budget, they have numbers and they have got all the stuff. However, I think, you know, the organisation forgets about clinical managers. (HMA1).*

The medical profession is the most dominant of all the professions in healthcare and exerts most influence on the major dominating political and bureaucratic structural interests. It was suggested by a generalist health manager that clinically qualified health professionals have a dominating influence: *'Health is dominated by people with clinical expertise rather than management expertise'* (HMG3). Another generalist health manager confirmed the dominance of the medical profession by stating: *'I would have to say the medical workforce is totally dominant, it's a key part, and it's the hub in the wheel type thing'* (HMG4).

Nursing qualified health manager respondents see the medical profession as very protective of its own interests:

*They have a vested interest in keeping people coming to them (HMN3).*

*I think that a lot of what happens in the health system is determined from a political level and doctors influence that more than anything (HMN6).*

The medically qualified health manager was open in his criticism of his own profession.

*It is more about getting more for doctors rather than more for the health system.*

*I find that frustrating because I find that as a public health doctor, you are paid pretty well and you are OK (HMM1).*

A generalist health manager also supported these views: *'They are the biggest vested interest, particularly with remuneration and incomes. They are the most biased party in the whole equation'* (HMG4). However, one of the other medically qualified respondents did not necessarily share these views:

*Doctors, they work hard to get to medical school, they do their training, and they all believe they are going to make a lot of money when they come out. They go for it. Now, you cannot blame them for doing that (HMM2).*

Another medically qualified health manager had a different perspective to contribute in linking the patient and doctor together:

*The other major stakeholder is the combination of the doctor/patient where if you look at the average doctor, he has forgotten the cost to the system of what he does. The patient never sees that and both of them in a very real and proper sense want to get the absolute best outcome (HMM3).*

Health managers with an allied health background also commented on the role of the medical profession: *'Particularly the medical workforce being such a powerful group'* (HMA3); *'I think it is still very much medically dominated. They're not the dominant group in terms of numbers, but I certainly see them as having the most power'* (HMA4).

This same respondent with an allied health background believed that there are differing levels of influence:

*We don't have as strong a voice as medical staff. I certainly think within the acute sector it is very much medically driven (HMA4).*

One of the generalist health management qualified respondent proposed differing emphasis to patient care:

*We both have the patients at heart, but, there is a different perspective. I am looking at more community focus, where the doctor is looking at more of a patient focus. They want to provide as many resources as they possibly can, to do the absolute best for that patient. They know what's best; there is no one else that knows as well as they do what needs to happen (HMG3).*

However, the importance of senior medical staff was recognised by one nursing qualified health manager:

*The senior medical staff, they are the ones that attract the patients; they are the ones that are the clinical leaders. If you have a good surgical department with research and development, teaching and education that is what creates a profile for the hospital. So certainly, I think the Senior Medical staff is the major, major driving force (HMN2).*

The ability of the medical profession to positively influence outcomes in their successful participation in public health campaigns was also raised.

*Surveys demonstrate that general practitioner advice was the most powerful point of getting women to take up breast screening. That really struck me as evidence of the power (HMG4).*

The power to influence also extends past consumers to the health bureaucracies.

*Certainly from a departmental perspective that's whom they tend to listen to. You know the medical groups (HMA4).*

Another nursing qualified health manager, who subsequently moved into a general management roles, saw disadvantages in having a nursing background because of power imbalances with the medical profession and the subservient nature of the nursing role.

*There is a power imbalance and I used to look sometimes at the nurses in senior roles, where, I think, very much some were in subservient positions (HMN4).*

Another nursing qualified health manager also saw the other professions being in a marginalised position compared to the medical profession: *'The other professions tend to become a little bit marginalised'* (HMN5). An allied health qualified manager respondent also raised this issue of differences within the professions under the group title of allied health.

*One of the things that I have worked hard to do is to emphasise the equality that we all bring the same value of whatever discipline we are in.*

*When we have full allied health meetings, there are a lot of white shirts from the physios. It is quite, whether you like it or not, it is a very visual sort of statement.*

(HMA5).

A generalist health manager believed that this group has to meet higher expectations in a health management role than the clinically qualified.

*I feel that being a manager who has come from a management background rather than a clinical background, I feel that the expectation on me is a lot more than it is with my clinical colleagues* (HMG3).

One of the nursing qualified health managers was emphatic that the differences are still entrenched:

*This is all turf war. Doctors, nurses, allied health, I mean, the game has gone on forever. Everybody is very protective of their little patch and expertise. They do not want to give it up to anybody else, even though they might not provide it themselves. A lot of professional protection is not in the best interest of the patient* (HMN6).

This discourse effectively reinforces the central dominance of the medical profession in the healthcare system. Respondents justify their profession and role in health management around that centrality of the medical profession (Degeling et al. 2001). The respondents also demonstrated differences within the broad professional categories as well as differences between professions (Sutherland 1998; Degeling & Carr 2004). The clinical professions make a claim for the management role based on their professional background and clinical experience as providing the contextual knowledge to reinforce that claim.

Most respondents, clinically qualified and generalists, stressed the importance of broad contextual knowledge to the management role. That some respondents saw a specific clinical mind as providing a narrow contextual experience and research, described in Chapter Two, confirms that clinicians come from different domains (Sutherland & Dawson 1998; Forbes & Prime 1999) and speak with different voices. Clinical and managerial roles are different and demonstrate tensions when brought together (Bruce & Hill 1994; Thorne 2002; Braithwaite 2004). They have differing perspectives of reform (Degeling et al. 2001). Some literature suggests that bringing the two roles together is a re-professionalising of the management role by the clinical role (Thorne 2002), increasing the power of the profession. Research with a post-modernist perspective, described in Chapter Two, also suggests that the hegemony of logics preclude the successful integration of differing identities (Harding 2005).

The research described above reinforces the contested nature of the role as described by the respondents. The strength of the contested nature cannot be ignored in any consideration about how best to organise and manage health services and perhaps the way forward is, as suggested by Braithwaite and colleagues who suggest a continuous engagement of clinicians in partnership, through conducive professional – managerial relations (Braithwaite 2004). The respondents' suggestions about how the contested nature of the managerial role might be addressed are further explored in Theme 4. After the respondents were asked to describe their reality of the health system, they were asked how they managed in the circumstances that they had described. The responses to this questioning led to the two following sub-themes about the management role and were developed around sensemaking, and people, power and performance. Both sub-themes appear to be central to the perception of the respondents about how they accomplish the role

#### **4.5.3 Sub-theme 2.1: The importance of sensemaking**

In the discussion with participants in their semi-structured interviews, the researcher did not raise the theory of sensemaking in organisations (Weick 1995), nor did the respondents use that term or directly refer to sensemaking theory in their discourse. A number did talk about having to make sense of circumstances and events to themselves and to their staff. The participants were asked what their perceptions about their role

were, what challenges they faced and how they managed in complex organisations. Very early in the analysis of data, the researcher interpreted the respondents' responses as suggesting they have a sensemaking role because they spoke in terms of looking for cues amongst competing interests and priorities to make sense of their circumstances (Weick 1995). This was evidenced in statements by a number of respondents. Some allied health qualified managers spoke of how staff were engaged in the change process:

*Motivating staff into seeing change as a positive thing. Filtering back to staff because it is important that they get straight information. Being able to pick up what is important and then link that through to where it needs to go (HMA3).*

*Helping staff realise they are part of a broader system by helping them realign with the change of focus (HMA4).*

This initial interpretation led to a more critical analysis of the data and further interpretation based on the sensemaking role described by Weick (1995), which was included in the Theoretical Framework described in Chapter Two. It became evident during the data analysis that sensemaking was the major discourse of the respondents in describing how they manage, particularly in changing circumstances. This is consistent with the approach required in complex adaptive systems where 'sensemaking becomes more important than decision making' (Anderson & McDaniel 2000).

The emphasis in the interpretation on the importance of sensemaking was reinforced by one respondent commenting on the skills required in the role:

*A significant kind of intellectual gymnastics to take opposing ideas and somehow convert them into something that you want to do, and bring those opposing or those opponents with you (HMG4).*

This context was further expressed by an allied health participant as: '*trying to find out what are the key things for the other people involved and looking to find your common ground, and moving forward from that*' (HMA4). These approaches suggest managers attempt to negotiate meaning between contradictory influences (Elliott & Reynolds 2001), 'in part driven by different norms of rationality' (Anderson & McDaniel 2000:83).

An allied health qualified respondent, in describing how staff were dealt with, took the following approach:

*I try and make sure I understand the changes that are occurring and then I make sure that they're part of everybody's orientation so that we at least try and get staff to understand (HMA5).*

This approach involves enactment (Weick 1995) as the respondent is dealing with ambiguity about change to deal with problems, 'to make sense of uncertain situations' (Weick 1995:9). The respondent was also trying to create a coherent structure both by acting individually and collectively within an organisation (Weick 1995).

One of the generalist health managers described the difficulty in achieving clinician understanding of management decision-making, indicating that it requires explanation. *'It's very difficult to explain decisions to people that are very focused on individual patient outcomes'* (HMG3). Another generalist qualified health manager had a similar view *'that thinking [budget accountability] doesn't even just compute with a clinician. I had to find ways of explaining what were the impacts on treatment, on services'* (HMG4). These approaches of 'explaining' are examples of interpreting events or circumstances to achieve shared meaning, a sensemaking activity.

A medically qualified health manager demonstrated the sensemaking role by stating: *'the trick is to try and get management to demonstrate the benefits to doctors; to the patients and to the doctors'* (HMM2). Sensemaking needs to be applied in differing contexts to accommodate different perspectives of care. According to the medically qualified health manager there are different understandings between managers and clinicians, as demonstrated in the following statement. In this example interpretation of meaning is required to ensure understanding.

*The quantity of care is a different thing to a physician, or surgical nurse than the activity that the hospital managers view. The quantity of care is more people-based, so you have to try to turn it into patient-based stuff. I think some people do that better than others'* (HMM1).

These generalist health managers and the medically qualified health managers views demonstrate that meaning in sensemaking is achieved through incorporating stimuli into frameworks that are perceived differently by differing professions (Weick 1995). In

addition to making sense to clinicians, the respondents themselves had to make sense about this phenomenon.

*I thought as a finance person, it was very straightforward. You do something because you do have money or you do not do something because you do not have money. Then realising that the system did not respond to those logical signals, or commercial type signals, I said this does not make sense to me, this is crazy. I was interested enough in the system to try to understand it, and so I looked for ways to do that (HMG4).*

The manager above is contradicting the view that normal business practices might apply to healthcare organisations. The respondent also accepted the situation as given and different from his logic and paradigm or interpretative framework (Ford & Ford 1994); he then moved to make sense of that collective structure. In doing this, he 'is constituting' himself (Harding 2005), engaging in his identity construction within the organisation (Parry 2003), consistent with the iterative process described by Weick (1995).

A medically qualified health manager expressed both frustration and resigned acceptance by stating: 'does *anybody know what we are actually doing? There's that frustration I suppose that's where you use your retrospect view to say look, this is just the way it works, it's up and it's down and you have got to, sort of, cope*' (HMM1). This demonstrates the retrospective nature of sensemaking to make plausible, pragmatic and credible explanations sufficient to enable others to achieve objectives (Weick 1995; Parry 2003). This same respondent explained how he dealt with the personal frustrations of the system:

*I actually try to use the other clinical managers for a sound off and a whinge and try to keep the staff stuff off that, so that you do not betray that frustration onto the people that are actually just doing the work. There is enough negativity around without adding to it yourself (HMM1).*

In the above quote the medically qualified health manager is describing a dualism approach of dealing with inconsistencies and hence frustrations in the role by 'normalising' these issues and frustrations to staff, while being more critical and demonstrative to managerial colleagues (Allard-Poesi 2005). The following example

reinforces the complexity of the sensemaking role and the need to be flexible in that role:

*You need to be able to be flexible in your thinking to deal with what you've said today that may be quite contrary to what is said next week or the month afterwards, six months time. A lot of things happen that are complex in the way they are controlled (HMM1).*

The above example demonstrates that sensemaking is both enacted and retrospective and therefore requires paying attention and being alert to changing circumstances. What is said today may not be supportable into the future because the future is unpredictable and unknowable, which is why closer attention is required to sensemaking than decision-making. Sensemaking also recognises that social reality is an 'ongoing construction' (Allard-Poesi 2005:174).

The following comments, by a health manager with a clinical background, were made in the context of dealing with health professional colleagues. It demonstrates that the participation of clinicians in decision-making and the inherent tensions between the different perceptions of the professions are seen as both positive and important (Anderson & McDaniel 2000).

*The hardest personal management issue to develop is about trying to manage a range of independently trained professionals who all both know and believe they are correct in their thinking and trying then to manage their thoughts towards the collective goal (HMM1).*

The following medically qualified health manager respondent described the role in terms of juggling between competing interests.

*Juggle competing interests to ensure that things that really matter can get through that juggling. You need to pick out what matters, you need to work out who the important people are, or work out what their take on the whole thing is. Sometimes you'll tread on one set of toes, sometimes on another set of toes. You have to work out which toes matter for this one (HMM3).*

Again this same respondent indicated that these competing interests in sensemaking require you to 'work out whether the patient actually is the most important person on this one or whether you need to take into account the surgeon, or the nurse unit manager or whoever comes into it' (HMM3). This example demonstrates that

sensemaking, as described by Weick (1995), involves looking for cues about competing interests, priorities, and the relative importance of the various actors in dealing with a contingent situation, to make sense and perhaps make a decision.

Another nursing qualified respondent saw the health management role as being able to *'understand where they're coming from and therefore be effective to do your best to work with diverse groups clinical/non-clinical, all the different groups, to work with them and bring them together'* (HMN4). This understanding of diverse groups suggests social contact and ongoing events as attributes of sensemaking (Weick 1995) and is further explained by the same respondent:

*Understanding organisations, the culture of nurses, the culture of doctors, and the demands at the coalface. Especially understanding how hospitals run and understanding the pressures of the nursing and medical groups. Understanding how they think and how they operate* (HMN4).

According to this nurse qualified health manager, the role requires a critical approach that requires making sense and assessing value creation.

*Really coming back to fundamentals. To say what are we trying to do here? Does this make sense and how much value does this create, having that critical thinking which is so important. It is that critical thinking and the ability to challenge and think outside the square and the ability to just not take things, the status quo as is.* (HMN4).

The above example in an organisational context describes the characteristics of sensemaking of 'perceiving, believing, interpreting, explaining, predicting, and acting' by an individual within that organisation (Weick 1995:934). Another respondent reflected on the past to suggest that sensemaking was always an important ingredient of the role: *'It was always a problem even back then to keep staff always motivated into seeing change and movement as a positive thing'* (HMA3).

Weick (1995:17) described sensemaking as a process that involves 'grounding in identity construction, retrospective, enactive, social, ongoing, focused on and extracted by cues and driven by plausibility rather than accuracy'. The respondents actively engage in their identity construction. This involves personal flexibility and visioning

and is described as understanding the big picture. An allied health qualified health manager suggested: *'you do need to be flexible and you do need to always have your eye on that bigger picture as to what is happening'* (HMA4). This same allied health qualified manager went on to say: *'flexibility is the key and having that broader picture focus as well, because you don't operate in isolation'* (HMA4). This latter statement demonstrates that constructing self is grounded in the social context of the organisation, a further characteristic of the sensemaking process. According to a nursing qualified health manager, it requires *'the ability to change and be flexible and accommodating in different situations'* (HMN4). The last respondent is describing both the ongoing and cue-seeking characteristics of the sensemaking process.

The need to have broad view was also seen in a self-defensive perspective by the general qualified health manager, *'you definitely have to have that idea of broad vision otherwise it becomes very disheartening at times'* (HMG4). The respondents talked in terms of vision, broad view and big picture, which for this same generalist qualified health manager meant that *'you have to be very long-term focused, and strategic, you always have to have the big picture, have a very big view of the world and be very strategic, because you have to have ideas about the directions, and taking things forward'* (HMG4). This respondent is placing emphasis on the ongoing and enactive characteristics of sensemaking.

This use of 'visioning and the big picture or broad view' is consistent with theoretical concepts from the literature. These concepts suggest that understanding and explanation of change is derived from the presentation of logics that can be described as frameworks, paradigms, interpretative schemes, and worldviews. If, as the respondents have suggested, they have a vision and develop a 'big picture' they are in effect acquiring more than one logic, allowing alternative ways of making sense and enabling them to move between differing views, that is, being flexible. This reinforces the interpretative aspects of sensemaking based on interpretation from experience (Cecez-Kecmanovic 2000; Parry 2003).

The construction of self is further described by the respondents as understanding about self. This gaining a sense of self, according to the respondents, requires processes of stepping back, having self-doubt, possessing self-faith and self-belief and being self-confident. They suggested that understanding self is about being positive, and being

able to manage yourself in order to make a difference. As an example, an allied health qualified health manager stated: *'I think you also have to learn how to manage yourself. I don't think you can actually manage people unless you kind of know how to manage yourself as well'* (HMA4).

The following generalist qualified health manager believed: *'[you also] need to have faith in your own ability'* (HMG3). Another generalist qualified health manager reinforced this view when he said: *'Certainly a lot of self-belief would actually be critical'* and, *'to be personally self-motivated and to work in that environment requires a lot of mental strength'* (HMG4). The following generalist health manager described self-confidence in these terms:

*Even though the people that I'm working with don't have an appreciation for the issues, I feel that I have an appreciation for the issues, I can perform my role regardless of how they are impacting on it* (HMG3).

Self-confidence was seen as important by one medically qualified respondent: *'you have to develop the sense of positivity and belief that you are actually doing some good'* (HMM1). A nursing qualified health manager also believed that you need a *'personal belief that you can make a difference'* (HMN4). This same respondent also suggested that this personal belief is couched in *'very, very high levels of self-ethics'* (HMN4).

Self-belief is important in order to resist the doubts of others. One of the medically qualified health managers saw it as requiring courage:

*The system needs us. You know you have to believe that. About yourself. You get a few knocks, you know. More so from your colleagues. It is a real thing. But it's not common and I mean it's like anybody who's in management, God you've got to have a bravado about you, you've got to have guts and courage. Yeah. (Laughs) In yourself, and ... You know, stuff 'em* (HMM2).

The above attributes are seen as important to an individual's willingness to participate in decision-making. This willingness is described as the degree of comfort or confidence in which individuals view their life balance, work, community, and family. These emotional dimensions of change are described as *comfort* leading to maintenance

of the status quo, while *confidence* leads to the taking up of new challenges (Eraut 2004).

The importance of understanding self in identity construction is further explained by the respondents in terms of resilience. For example, a nursing qualified health manager believed: *'to be an effective manager you have got to have a very high level of resilience'* (HMN4). According to a generalist qualified health manager, resilience also allows you to be opportunistic: *'I think the key thing then, is that resilience that requires you to be, you almost have to be an opportunist in some respect'* (HMG4). Resilience in the role of health manager was also demonstrated by this same generalist health manager in how to approach change: *'I suppose the way we deal with that is that, we started to think about, how do we respond, where do we want to go, how do we use this change in a positive way'* (HMG4). This same manager described resilience in terms of determination: *'People will tell you it can't be done, but you find ways, don't you?'* (HMG4). Resilience is also described metaphorically, again from a professional development learning opportunity:

*Like trimming away at a hedge, and what she does is that, she keeps trimming away at this huge hedge, right, and eventually she find a way of actually, trimming right through the whole hedge and create the thing that you need to get through. Snip by snip, and then eventually you get an opportunity where you can kind of crash through* (HMG4).

According to an allied health qualified health manager, in the management role you also learn *'to step back and try that whole thing around emotional resilience, [and] not to take people's outbursts personally but realise it was related to the changing circumstances they were finding themselves in'* (HMA4).

Sensemaking involves engagement of people who work for and with managers. This generalist health manager provided an example: *'From a collegiate basis I engaged a lot more with a range of clinicians that really broadened my thinking. I had to engage to be effective. It was a very, very valuable lesson about, how to deal with clinicians,'* (HMG4). Engagement with stakeholders was also seen as an important skill for managers.

*There are a multitude of stakeholders, and we have to manage them all, you have to be aware of how they interact with us, you know, which ones are our customers, and which ones are stakeholders ... stakeholder management is very important (HMM2).*

*I think health managers have to be more aware. We keep saying this. You know they have to engage with the community. They have to be able to get their stakeholders. I think this is one of the critical skills of a health services manager (HMG4).*

The importance of skills in community engagement was reinforced by one respondent, who described the skills required to turn around negativity and uncertainty between a health service, its community and its doctors and the local media. The context of the health service and the health manager in that community was described by the respondent as: *'they were under a state of siege, attacked from everywhere'* (HMG4).

*He [the health manager] just worked away at the chair [Board Chairman], who is connected with the opposition party. He worked away on him and got him on side. He worked away with the clinicians, developed plans and engaged them as part of the change process rather than kind of telling them, what we have to do. He gradually started to swing people around, you know, worked on the local paper, which is like the official opposition up there in (Place). He is a very good example of what we have been talking about with this engagement, the need for engagement (HMG4).*

Communication was regarded as an important skill by a nursing qualified health manager: *'I think effective communication is absolutely fundamental'* (HMN4). One of the generalist health managers also emphasised the importance of communication:

*I suppose you have to tell everybody what you think should be done. Therefore, it is sharing that with everybody else, particularly those people who can be influential. You know, they have to be great communicators. They have to have considerable empathy and a great ability to listen. Obviously then explain ideas, the communication skills, you know, I think it is the same with any, senior manager, in any organisation today, communication is just critical. (HMG4).*

In the above example, sensemaking is occurring through the use of language, creating meaning with others from cues they provide through this engagement and social

activity. This represents the process in sensemaking of being thrown into ongoing situations (Weick 1995). The placement of sensemaking as central to the health management role through this researcher's interpretation of the respondents' discourse further confirms that healthcare organisations are complex and in complex organisations sensemaking is said to be more important than decision-making (Anderson & McDaniel 2000). Sub-theme 2.1 suggests that health managers primarily negotiate meaning between contradictory influences and differing rationalities ahead of being directive in their engagement with staff and stakeholders (Anderson & McDaniel 2000; Elliott & Reynolds 2001).

The discourse of the respondents is readily identified in Sub-theme 2.1 and is allied with the range of characteristics of sensemaking, as proposed by Weick (1995), Cecez-Kecmanovic and Dalmaris (2000) and Allard-Poesi (2005). The discourse of the respondents also demonstrates the constitutive nature of sensemaking of self and of the collective structure that provides meaning to the actions of a group of people (Ford & Ford 1994; Weick 1995; Parry 2003; Allard-Poesi 2005; Harding 2005). Sub-theme 2.1 affirms the importance to the respondents of visioning, context, self-belief and resilience to their ability to undertake the managerial role. These characteristics and sensemaking are central to the role, which they described as primarily being about and for people; this is further described in Sub-theme 2.2.

#### **4.5.4 Sub-theme 2.2: People, power and performance**

This sub-theme represents the third element of the respondents' perceptions of the managerial role. The first perspective described in Theme 2 refers to the role as 'contested'. The two sub-themes describe how the respondents manage in that contested role. They do this by sensemaking as described in Sub-theme 2.1 above and by working with people and dealing with issues of power and performance. Underpinning the centrality of the sensemaking role is the importance to managers of having 'good' (capable) people to be successful in the management role. The effectiveness in managing people is constrained by issues of power and the influence of performance management, what this generalist health manager described as '*a conundrum*' (HMG4).

*What is more important, the money, having the money or having the people? We came up with the answer, 'it's the people because if you've got good people,*

*they'll get you the money'. I think too, if you have good people, they will get you the outcomes (HMG4).*

Some of the allied health qualified health managers indicated that people management is a more complex function and more important than managing budgets.

*A key thing in health management is actually, you know, is managing people. That is probably more difficult than learning how to balance cost centre budgets and those sorts of things. Certainly, the people management is more challenging (HMA4).*

*They have to learn to manage people, that is, the dollars are important but it is actually, my dollars are spent on people ... 90% of the budget is spent on people (HMA5).*

A medically qualified health manager also supported these views: *'I think in some ways that the personnel management issues, are, the hardest ones to develop about trying to manage a range of independently trained professionals'* (HMM1). This view was similar to that of one of the allied health qualified health managers: *'I think managing people is actually very hard and certainly, it does depend a lot on the personalities involved as well'* (HMA4). One of the nursing qualified health managers suggested: *'the clinicians are actually very easy to manage and people are easy to manage, it's their personalities that are always the challenge'* (HMN2).

The personalities are not just seen in terms of professional differences. One generalist health manager suggested: *'there is a very real need to be able to relate and build relationships with people from different industrial backgrounds'* (HMG3). A nurse qualified health manager agreed: *'I see a big role in managing the non-clinicians, you know having a relationship with the admin officers, who are paid a very small amount of money, but if they are not there, the place doesn't run'* (HMN2).

In addition to being more important than budgets and financial management, it was also suggested that *'system design and sense of organisational structure is just so relatively unimportant compared to having good people. Your good people will find networks and find ways to get things done'* (HMG4). This view of a generalist health manager was

supported by a nursing qualified health manager: *'It's all about working effectively with people, getting efficiencies and providing a good quality service'* (HMN4). A medically qualified health manager was seen to be protective of staff: *'so that you don't betray that frustration onto the people that are actually just doing the work'* (HMM1).

There was also an underlying perception that health managers lack power. This is in contrast to the public perception that power rests with the managers. This feeling of not having power was described by an allied health qualified health manager: *'I probably can't put my finger on what, on the big difference I make now'* (HMA5). A generalist qualified health manager also stated: *'I need to find a way to communicate my frustration about not being able to influence things'* (HMG4).

A medically qualified respondent described circumstances that suggest health managers are implementing someone else's policy or directions without being able to have influence: *'You're part of delivering it rather than necessarily setting the agenda so to speak'* (HMM1). This view was reinforced by a nurse qualified health manager:

*As a manager, you are thwarted because you do not actually have the power to do that, because other people above you are saying 'no'. Just do what you have got to do, keep doing what we said you're going to do, but, you know, save that million if you could. Unrealistic expectations. And no delegation or authority. All accountability and responsibility but no real delegation or authority.*  
(HMN6).

Other respondents described passive acceptance as a means of dealing with policy or direction that limits capacity to act.

*I have kind of termed the phrase, passive acceptance. Therefore, we go through these hoops. We agree to everything, but we obviously actively work on those things, which are going to give us the best value, we believe* (HMG4).

*Find a way to live with the structure that, has always been my philosophy. Find the best way to live with it. And it is up to your ability to negotiate an outcome*  
(HMA1).

The above perceptions also demonstrate that the actors engaged in reform respond to a degree they deem necessary, while positioning themselves to take a path they consider

more appropriate or to look for subsequent opportunities (Cooper et al. 1996; Reed 2001; Lozeau et al. 2002). Some medically qualified respondents attributed the feeling of lack of power to make a difference to a forced narrow focus on budget accountability and an emphasis on resource efficiency that demonstrates the tensions inherent in the managerial role, particularly for those with a clinical background (Bruce & Hill 1994; Braithwaite 2004).

*I think as a manager you become accountable to your budget, the people who report to you, so I find that you are pushed all the time to become more narrow, perhaps I've got it wrong, but, that's the way I feel about it (HMM2).*

*The manager is always caught between a rock and a hard place, being driven to do things that are incompatible. Now I think that one of the basic causes of stress is when you have goals that you can't reach. The system is not prepared to accept that it just pushes and pushes (HMM3).*

A generalist qualified health manager suggested the bureaucratic nature of the organisation contributes to the feeling of a lack of empowerment: *'I do not feel that I am that empowered. In my level of the organisation'*. (HMG4).

Another nursing qualified health manager saw the lack of power in the context of a stressful system:

*The system is under stress it is under-resourced, and as a manager in that system, it is almost impossible to function effectively and to do what you believe you should be doing. I have heard people, even recently, say, you know, and this is postgrad nurses, I want to be a manager, so I can tell people what to do. I say, well funnily enough, as a manager, most of the time you spend being told what to do (HMN6).*

The limitations of not being able to implement change in stressful situations are dealt with as follows by one nursing qualified health manager who said: *'I'm not as doggedly passionate about particular things as I used to be, because I sometimes think there is wasted energy in that and you can't change it. I don't get stressed about it any more'* (HMN3).

The lack of power was also expressed by a medically qualified health manager in the context of will decisions be accepted, implemented and remain in place? *'It's fine to put it on paper and send it to someone but will they actually take notice of it and will they actually do it. And if you actually make it happen, will it stay happened?'* (HMM3). The enormity of health need versus the individual effort of a health professional or a team was also expressed in these terms by a health discipline qualified respondent: *'I felt like I was the 'princess of the pond,' with spoon with all the holes in it, to empty the pond and there were these enormous tankers down the other end filling it up'* (HMO1).

The lack of power described by these respondents is an important issue if they are meant to carry, implement, and defend reform. Invariably, reforms can add a further layer of bureaucracy without giving the power and authority to those who are meant to achieve its purpose (Alford 1975). Given the dominance of the political bureaucratic structural interest, Walsh (2002:40) considered reform might be more about the continuing re-alignment of 'the balance of power between politicians and bureaucracies'.

Apart from the importance of sensemaking, the centrality of people and the illusory perception of power, the respondents only briefly mentioned other contemporary management practices. Overall, there was a negative view about performance management and the use of information. For example, one health manager observed that it is *'the inability to quantify health outcomes'* (HMG3).

*It's very hard to measure whether it is performing well. There is no consensus into outcomes* (HMG4).

*I think the funding system needs to be changed so it actually is more linked with outcome of the patients as opposed to just churning them through the system* (HMA4).

*The one way that the managers of health services often get managed, is about meeting short-term targets, both in activity and financial terms* (HMM1).

*We never apply long-term strategic thinking to health services and keep evaluating them on the next disaster rather than how they are achieving and delivering health outcomes.* (HMG4).

A medically qualified health manager suggested: *'it is almost impossible to have a good quality transfer of information'* (HMM3).

Performance management is now a feature of most healthcare reform internationally. This makes the decision-making processes for health managers untenable because they are held accountable for what is outside their control (Greener 2004). These perspectives reflect research findings from Liang et al. (2006) that the instability and distraction of reform in the Australian context has led to high turnover and burn out of senior executives. The short-term nature of CEO appointments and turnover affects financial performance and the change process (Greiner 1972; Palmer & Hardy 2000; Liang et al. 2006). Performance measurement, while important, has also been criticised for having a focus on performance ahead of strategy, being too extensive and being used to micro-manage (Lozeau, Langley & Denis 2002:962). Despite these criticisms, the respondents' perceptions demonstrate that the new public management and the application of market and business principles to healthcare remain pervasive (Rathwell & Persuad 2002; Micken & Boyce 2006).

The discourse of the respondents also raises the question as to whether we are using the valuable and expensive time of health managers appropriately. For example, one health manager made the following comment: *'And see we've stripped out nearly all the clerical support. I do not have a PA. Which is fine, but I do all sorts of things. (Laughs) You know, Friday afternoons I file'* (HMA5). This situation is also experienced by other respondents: *'I type my own agendas, I do my own minutes. I photocopy my own stuff'* (HMN6).

Finally, there was a view from medically qualified health managers that the importance of management and administration is devalued and diminished in terms of its importance to the health system by the constant restructuring of the system.

*The Minister has said that the amalgamation will save one hundred million dollars and get rid of hundreds of administrative jobs. If we are going to continue to improve that takes administrative capacity* (HMM3).

*I do not get the impression that at the CEO, general manager level that I have worked for, any have a particular impression of longevity in their roles (HMM1).*

The devaluing of management and administration was not supported by the respondents, one of whom suggested: *'I would like to see more generic managers in the system. They bring a business focus and business skills'* (HMM2).

When discussing the concept of leadership there were various views amongst the respondents, for example, *'I think it comes back to the leadership of those teams'* (HMG4). A medically qualified health manager suggested: *'it is also to try and be that public face that keeps the workforce coming to your place to work'* (HMM1). Another medically qualified health manager believed: *'to accomplish it, I think genuinely visionary leadership is required at the top'* (HMM3).

Decision-making was also addressed by some respondents. *'Once you make a decision you've basically got to find a way to make it happen'* (HMM3). A nursing qualified health manager stated: *'you have to be able to make decisions on your feet. And justify them. I think, in this day and age you have to be able to make a quick decision'* (HMN3).

Financial management and budgets were also briefly discussed as *'the funding boundaries'* (HMM1), *'driven by the almighty dollar'* (HMN5), *'multiple funding streams'* (HMA5), *'as a manager you are conscious of activity and budget and get hounded about that on a regular basis'* (HMM1). Finances were seen to be something to work with.

*Finances that is something we have to live with and manage. In addition, manage it, not be dictated to by the budget. Working proactively within it. They need to know their business, know their portfolios, know their priorities, and certainly know their budget (HMN2).*

*Therefore, you make your plans of how you are going to try to stay within your budget, which is often about vacancy managing. Then you have to manage the fallout from that, because the staff can become quite angry about that (HMO1).*

One important aspect of understanding finances was expressed by a nursing qualified health manager:

*I always believed I could not effectively talk to a health services manager or a CEO unless I understood the finances, and a spreadsheet and the figures (HMN4).*

Despite organisational design, strategy, quality, and safety being central concerns of most health organisations, these areas were only given brief mention by participants.

*System design and sense of organisational structure is just so relatively unimportant compared to having good people (HMG4).*

*Strategic planning and concise business planning, ah, is an absolute' (HMN5).*

*I think the, one of the other big issues is the medico legal and clinical governance area problem in health (HMA3).*

The relatively scant attention paid to these areas in the discourse around how respondents manage, further reinforced the centrality given to the importance of sensemaking in this interpretation of the role. Sub-theme 2.2 emphasises the importance of people within the healthcare system. It further describes the respondents' perceptions. Despite their managerial role, the respondents feel relatively powerless within that role, a perception supported by other research findings, described in Chapter Two, and reinforced by the respondents' perceptions of the health system as described in Theme 1. Despite their lack of power, the respondents were positive about entering and staying in the health management role, as described in the following chapter.

## **4.6 Conclusion**

This chapter has presented the first two themes to emerge from the data analysis of the discourse of the respondents to this study. Theme 1 described the health managers' perceived reality of the health system through two sub-themes, as one of constant change within a complex system that is not particularly adaptive, and one that responds primarily to the bureaucratic and political structural interests and continues to operate as a system of parts, despite claims to be integrative. The second theme emphasises the involvement of the health professions in the management role and the contested nature

of that involvement. The theme includes two sub-themes both focused on the health management role. They demonstrate the importance of sensemaking and a role that is focused on the management of people in circumstances constrained by influences of power and performance management.

The next chapter describes the career journey of health managers (Theme 3). This theme describes how the respondents became health managers, how they learnt the role and were developed and supported in that role. Theme 4, the final theme, describes the solutions the respondents offered to the issues and challenges faced by the health system and their managerial role.

## Chapter 5

### Analysis of data – Themes 3 and 4

#### 5.1 Introduction

In the previous chapter, the data analysis approach was justified and the first two themes presented. Theme 1 addressed the health managers' perceived reality of the health system, the constant and complex change in a non-adaptive system that is seen as a system of parts emphasising political and bureaucratic structural interests. Theme 2 addressed the professions in health management as representing contested roles, which have an emphasis on sensemaking, people power and performance. In this chapter, the two remaining themes are presented here.

##### 5.1.1 The study themes

The second two study themes are:

##### **Theme 3: The career journey of health service managers**

**Sub-theme 3.1:** Learning to be a health manager

**Sub-theme 3.2:** Role models, mentors and motivation

**Sub-theme 3.3:** Developing and supporting health service managers

##### **Theme four: The health managers' solutions**

**Sub-theme 4.1:** Structuring the health system

**Sub-theme 4.2:** Educating and changing the health workforce

#### 5.2 Theme 3: The career journey of health service managers

The respondents were asked to discuss their career, including how they became health managers, if they would encourage others to consider a health management career, and how the role and associated skills of health management were learnt. This resulted in a theme about their career journey and the three sub-themes described above.

For some respondents their career started in a small service or facility and sometimes in rural health services. The perceptions of those experiences were positive and seen by the respondents as a valuable approach to learning and gaining experience. Those

experiences, which often occurred early in the respondents' careers, were common to a number of the respondents.

*I started off ... very early, well I was managing a small service, and did the management courses that were available at the time. (HMA3).*

*Well I think the smaller organisation gives you a good grasp (HMN1).*

*The first toe into management was working in a private hospital, so I had responsibility for the day-to-day co-ordination of a small number of other staff (HMA6).*

A variety of learning and experiential work contexts, including early and challenging roles in smaller to medium size country hospitals, was seen as valuable.

*I was given some accelerated learning opportunities for both formal and informal education experiences at a relatively young age, and was given the opportunity of being a chief executive officer of a medium range country base hospital at a relatively young age (HGM1).*

The impact of working in a smaller hospital also provided further incentive to adopt a management career because it provided an environment that developed the respondents' interests.

*The department manager I had at the time was involved in the hospital executive and in seeing his role and subbing in for him when he was away. I think working in a smaller hospital made it easier because there were very few full-time people within the organisation and the roles needed to be filled and so by both mentoring necessity you got involved (HMM1).*

The career of a generalist health manager was started through the availability of a formal health management-training program.

*I was picked to do formal education on a full time basis as a Health Commission Cadet. I came in at that level and I think that probably my longer-term adherence to the system was probably pretty well guaranteed (HMG1).*

Another respondent indicated that these types of career opportunities are no longer available:

*There used to be some sort of career structure previously where people could get trained up for higher positions. I came through the old administrative management career structure, which almost doesn't exist any more (HMG2).*

The value of starting and working in rural health services was further emphasised by other respondents from differing professional backgrounds. A health manager, who was nursing qualified, saw rural experience as valuable and rewarding.

*Particularly rural health service management, because I think it gives you such a broad view. I actually think that anyone who has been through rural health service management can actually do anything. I think professionally, it's extremely rewarding because you are very close to the interface with the community and you can actually see the difference you make and that in itself is very rewarding (HMN1).*

A medically qualified health manager reinforced the value of rural experience by making the following comment:

*It is a shame more people don't come out here [regional rural centres], because I think you just learn to think in a different way (HMM2).*

This feature of starting a health management career in smaller scale hospitals or departments and in rural settings was a reasonably common experience to the range of professional and health management backgrounds of the respondents. This view of the value of structured experiential development across a range of organisational levels is consistent with that described in the literature as prerequisites for a health management career (McConnell 2000).

Some respondents saw limitations in their clinical role as a reason to move into management roles.

*My personal interest was (clinical discipline), quite limiting in some ways, as you provide the short-term care to one patient and then the next patient and your influence is quite small (HMM1).*

*There was only so far you could go in the nursing profession. There were not many opportunities to progress beyond being a ward sister in those days (HMN5).*

*The only career path at that time, which is why I'm doing the job that I am doing now, was to go back into the big hospitals and, you know, become a head of department (HMA3).*

*The majority of my clinical time was spent in (clinical department) and that was great because you were dealing with the people on a one-on-one', but 'I wanted to have more inputs over what was going on. The big picture of things (HMN3).*

Having 'input to the big picture' was also seen as having greater capacity to influence patient care.

*You would look around and you would see that there was not enough staff to do what you wanted to do. I then thought, well the only way I could influence that is to, become the manager, and then you would be able to influence that level of care, not just for one person, but to everybody who's in your unit (HMN3).*

The above perspective, from a nursing qualified health manager, was shared by respondents from other professional health disciplines.

*I wanted to contribute in a different way. I think management lets you contribute to the improvement of people's lives, patient's well-being and the system (HMM2).*

*I think because I felt that I would have more influence and be more able to make things happen where I thought they should be happening (HM01).*

The ability to influence the wider health system in a positive way was also proffered as motivation to move to a health management career.

*I enjoyed being in a position where you could influence decision-making, that you could influence professionally where you wanted to see, not only your own career path but what you thought was best for the industry and the end delivery of care to people that you wanted to ensure had a good health system behind them. (HMN5).*

Other nursing, allied health and generalist qualified respondents saw their entry into management as opportunistic: 'it just happened' (HMN3, HMN5).

*I had not ever seen myself as heading towards a full management role (HMA6).*

*I was never trained, as a manager, I was trained as a clinician and that was my first interest, it was just something that happens along the way (HMA2).*

*I nearly fell off my chair when I found out I had the position. It was almost as if I'll throw my hat into the ring and see what happens but once I got into the position, it was fairly clear that it was something that I did really enjoy doing. I was extremely glad that I had made that decision (HMA4).*

Challenge and an opportunity to learn were also offered as reasons for pursuing a health management career. A generalist qualified health manager, was attracted to the complexity and challenge found in healthcare.

*I kind of liked health, and found myself, kind of, trying to understand its complexities. I found it a challenge. I found it incredibly stimulating, I would say it was probably one of my best jobs I ever had (HMG4).*

Intrigue, asymmetry of knowledge, economics and dealing with people also motivated another generalist health manager.

*I took an interest in health economics. An environment where consumers don't have complete knowledge and they don't bear the cost of, and it just sort of intrigued me, that was exciting to me, and through that I sort of got involved with health services and providers in a hospital environment was interesting. It is a very exciting role. It is a role where you are dealing with a lot of people; it is a humanistic environment (HMG3).*

A nursing qualified health manager saw the career move as a further opportunity to learn: 'I've just got a basic desire to learn and have new experiences' (HMN4). The motivation to learn was also described by one of the medically qualified health managers:

*Some of it was out of interest working on the board, not as a former board member but as the medical input and wanted to be active in that and actually learn some of the process; then I was formally employed (HMM3).*

The learning opportunity as motivation for a move to a management career is consistent with learning being a consequence of social action and of making sense of circumstances through ongoing learning and interpretation processes. In this context

status becomes a function of what you learn and how you apply that knowledge to the benefit of the system (Anderson & McDaniel 2000).

The following allied health and nursing qualified respondents demonstrated self-confidence and the desire to make a difference as motivation.

*I identified myself as being a potential leader (HMN5).*

*Believing I could do it. Believing that it would be interesting and believing that it would make at least as much difference as working hands-on (HMA6).*

*To be honest with you, I used to look at the people around me and my managers and I'd think, I'd see their deficits and what they were good at and I'd think, I can do a better job than that! (Laughter). To be honest with you, I could see what needed to be done and I'm thinking, you should be doing this, this, this and this, so I suppose it was my desire to make a difference to have an impact, so I thought yep, I can do this (HMN4).*

Research suggests that managers learn about management from past managers, good or bad (Boucher 2001). Challenge and confidence are seen as also being important to learning and the development of capability (Eraut 2004). Family background made some respondents feel predestined to become a health manager.

*Predominantly family background (HMN2).*

*I've always had an interest in management and my father was a manager. I've always tried to fit lots in my life and you just have to learn to manage. Then into health and I had to manage projects (HMO1).*

*I had an interest in health as an area of society, there was some family background of hospital management on my mother's side (HMG1).*

*I demonstrated signs of working towards that very early on in my career. I'm a systems thinker, I'm organised, I get things done. I actually quite like management, even though I love being a clinician and I stayed at the bedside for an extended period of time, but the skills I have now, were skills that I learnt at the bedside, and you know I just evolved into that management role (HMN2).*

Family considerations can also influence career changes, as demonstrated by one of the nursing qualified health managers:

*I thought there are times when you get a bit bored and you have more to offer. I reached that conclusion and integrated with your professional career is the time to move forward with your domestic family situation and in my case (children) were old enough for me to be able to go back to university and to be able to work full time (HMN1).*

One generalist qualified respondent always wanted to be a health manager, despite having no prior or explicit motivation.

*Well believe it or not, at some period of my early teens I actually just thought I would like to be a health manager (laugh). I have no idea as to why I thought of that because no one in our family had any health background, they didn't even work in health; I have always wanted to be a health manager. Extraordinary isn't it? I really can't put my finger on it (HMG2).*

Respondents were reasonably clear about potential career aspirations and directions. One nursing qualified respondent, however, placed a caveat on a future career direction that reflects very much the impact of constant change described in Theme 1.

*I don't know where I see myself in five years time because what I do now didn't exist five years ago (HMN2).*

There was aspiration for specific and in some cases newly created roles for some of the generalist, nursing and medically qualified respondents.

*I want to stay in the operational management of a hospital. I see myself as one day becoming a general manager of a hospital, and working my way up that way (HMG3).*

*I see the new positions of director of operations or clinical operations, whatever, being absolutely fantastic. Giving you a great overview of the whole hospital and you are out there in an operations capacity. Yes, I would personally like that sort of role next (HMN2).*

*I wouldn't mind being like a director of clinical operations or a director of clinical governance. I think they're big challenges, managing big teams of people. I'd like to sort of get into that level (HMM2).*

*I feel now I'm ready to be more responsible. Take on more of that CEO-type responsibility. I feel that I have good ability to deal with human services-type organisations. (HMG4).*

An allied health qualified respondent has taken a more structured approach:

*So I currently have an external mentor, we're kind of working through the whole career directions and what I want to do [because] I had outgrown my previous role. So I certainly know that I want to step up to that next level. It's kind of finding the position that's suitable (HMA4).*

Another allied health qualified respondent was concerned to maintain a proximity to the professional role:

*I can't imagine myself [becoming a generalist manager]. I don't think I've got the capacity actually to move to general management, I feel as I'm, though I'm as far from the patient as I want to be (HMA6).*

This response from a clinically qualified respondent is partly explained by research, which indicates that the measure of self-concept gained from belonging to a profession is important in influencing the career preference (Braithwaite & Travaglia 2005). Some respondents were reflective about their future career or expressed self-doubt about continuing in that role.

*I have found the last few months incredibly frustrating. But I don't know if that's forever. But I'd say we certainly are, I think most people here in [State health jurisdiction] are at a real low. I'm still optimistic. But, I suppose to be honest; if somebody offered me a job somewhere else I would probably be interested in it. Probably outside health [laughter] would be more appealing at the moment. It's quite possible too that I'm just entering that, 'well should I be doing something different' phase as well (HMG4).*

The reflections of the respondent above are reinforced by previous research that describes the negativity felt by managers in a context of constant change (Smith, Walshe & Hunter 2001). That same respondent, while expressing confidence in a potential CEO role, also reflected on other career considerations.

*Once you have tackled the challenges in health you can tackle anything. It's a very demanding job, hugely demanding. Everything else is almost too tidy. Do you look to go maybe backward where what you are saying is I want to consolidate now, I just want something with a little less hassle in the work life, and more in the private life or something. I suppose it is all about not taking ourselves too seriously at the end of the day. (HMG4).*

One respondent reflected on the commitment required for a health management career:

*The other problem with management is that you can't be a part-time manager. You either have to be a manager right up till you retire, and then what do you do? There is a lot of very damn good managers out there, they just hit a brick wall and stop (HMN3).*

Other respondents suggested some uncertainty about future career directions:

*I'd probably go into the private sector (laughs) but I'd probably stay in health, I don't know. Where would I go, I would probably go into some of that personal development area or the academic area. I really like all that personal development area (HMO1).*

*I think still a manager. I don't know. I haven't thought that far (HMA2).*

HMN6, a nursing qualified respondent almost reluctantly accepted that: *'the day will come, when I realise that someone could manage my organisation better than I can. I've then got to accept that that's the case and step aside'* (HMN5). Another nursing qualified respondent had taken the decision to go back to a clinical career.

*Not wanting to go to the next level of management when there is so much confusion around it, and it's so unsettled. I've chosen to step out of it during the upheaval (HMN6).*

A medically qualified health manager respondent was determined to stay in a health management role.

*When I am given that choice I am still making a conscious choice to stay in this role. I have a significant commitment to what I'm doing and to the organisation. I'm staying and will say that the people who are prepared to wear the mess, that*

*there's still a place and a worthwhile and potentially more important job than a clinician (HMM3).*

An allied health qualified respondent pointed out that, with health workforce shortages, the move of health professionals into management can be counter-productive.

*The only issue with that [encouraging people into a health management career] is, with what I'm doing at the moment, is trying to keep people in their own professions. What I do see people having the opportunity to do is to step outside of their own, just go on secondments for a short while, to go and do some management project-type things, and then go back. So, I think that's a very good cross-fertilisation of clinical and management (HMA3).*

The emphasis of many of the respondents on the value gained from experience in small hospitals and health services and from experience gained in rural settings is important in any consideration of how best to develop health service managers. As described by the respondents, many of these opportunities are no longer available because of the flattening of management structures and the centralisation of management control. This brings people into senior management positions without the experience and learning that comes from that experience. The importance of work-based experiential learning and of the importance of the challenge provided from that experience to learning is emphasised in research described in Chapter Two (Eraut et al. 2000).

The motivation of clinically trained respondents to move into management roles 'to make a difference' or 'to have a greater influence' is consistent with the view that they should be engaged beyond individual patient care, in system reform rather than just being subjected to that change (Braithwaite & Goulston 2004). In the process of describing why respondents had chosen or entered health management careers, three sub-themes emerged from the respondents' discourse. These were focused on how the respondents learned to become health managers, the importance of mentoring, role models and motivation, and the need for more support and development of health service managers.

### 5.2.1 Sub-theme 3.1– Learning to be a health manager

Participants were asked to describe how you learn to successfully manage health services. The following discourse describes how they learned, the adequacy of that learning, and where the emphasis on learning was placed. Respondents had a broad view of learning and the skills, competencies and capabilities required of health managers. They also reinforced research findings described in Chapter Two, about the importance of informal experiential workplace-based learning (Eraut 2006) and structured experience (McConnell 2000).

*So it's been a gradual development of those kind of hands-on experience, but complimented by structured development and learning along the way. None in itself was critical but together they make it work. I do not think you could do it just by one approach (HMG4).*

*On the job learning, I think is really important as well as the formal qualifications (HMN4).*

Structured levels of experiential learning were described as a positive way to learn, available to some professions, but generally not available to the medically qualified health managers.

*On the nursing and the allied health side, mentored by their seniors, certainly taking the allied health and nursing hierarchy, there's assistant department heads and then department heads and then program heads and then hospital, after hours administrators. There are levels of management that people slowly build up if they're mentored well, get trained in all of those things, each step along the way (HMM1).*

Respondents who were generalist trained health managers with health management qualifications suggested that the deficit in structured experiential training is more widespread and affects a wider range of health management aspirants. *'I think organisations work better if they are flatter but the negative is it has taken all the training positions out of management (HMG2).* Another of the generalist qualified health managers suggested that the lack of adequate professional development opportunities has long-term negative consequences for the health system.

*The absence of those two approaches [professional opportunities and planned experience] will produce a health service management workforce that has come*

*through without a high degree of education, training, and experience. It will probably end up being a weaker force in terms of trying to keep the public health system forward thinking and responsive (HMG1).*

A nursing and health management qualified respondent also stressed the value of structured experiential learning in terms of apprenticeships, an approach consistent with findings about organised learning support identified in earlier research involving participants from the health system (Eraut et al. 2000).

*Where does the emphasis in learning need to be? Actually, apprenticeship, I use that word apprenticeship, as I was second in charge of a busy ward, so I really was the apprentice for the next management position. Apprenticeship is actually working one-on-one with somebody, so you are part of that team. Yeah, but not only as a trainee, but maybe as a deputy. Unfortunately, there is no apprenticeship role for someone like me, to go into a general management position (HMN2).*

These generalist health management qualified respondents emphasised the need for and important of structured diverse broad experience in an adult learning context.

*A lot of the senior health managers say to me there's just too big a gap between people starting or thinking about becoming a manager and what that first position might be. They have had no opportunity to be trained in assistant to deputy-type positions. That is obviously a major issue (HMG2).*

*People who come in for management roles without (health context) being offered to them can work narrowly and simplistically. I would support formal education but at the same time, you have to support the whole concept of adult learning and people seeking out professional and personal avenues for ongoing understandings and knowledge. They need intersections with people who have difficult experiences, who can add to their backgrounds. The sorts of materials they can draw upon for application in their day-by-day environments (HMG1).*

Consistent with the research findings of Eraut et al. (2000), the respondents to this study expressed a strong preference for work-based experiential learning. The value of formal management training programs was also seen as a good approach to learning. *'That kind of hands-on training, like the ACHSE program gives you, is probably a really good*

*grounding'* (HMN6). However, some caution was expressed in the selection process for these programs.

*There is always the issue of the capabilities and personal qualities that people have when they come into management. If you accelerate a donkey into a thoroughbred horse race, it is always going to perform like a donkey. You have to be very careful how you select people for those sorts of programs (HMG1).*

This same generalist qualified health manager described the personal experience of a formal management training program.

*I was given the opportunity of having academic courses that were attuned and developed some skills and practical material that is relevant intellectually in the health system. There was also four university terms given to planned exposure to various health contexts so that there was in some settings a 24-hour-a-day attachment to health institutions. This was to understand its workings from the cleaning and kitchen and boiler room right through to the highest levels of clinical performance in operating theatres. It included an opportunity to intersect with the Chief Executive Officer on a weekly basis and discuss the things that you had been observing and learning (HMG1).*

The structured experiential opportunities, starting small and working in rural areas, were also described earlier in Sub-theme 3.1, as to how managers got started, albeit mostly in an earlier era (HMG1, HMG2, and HMN1) and are consistent with contemporary approaches to learning identified in research involving healthcare professionals and health managers (Eraut et al. 2000).

Informal and work-based learning and learning by trial and error were seen to be important learning processes to these clinically qualified health manager respondents.

*Learning to manage the technical parts of managing, the budget and the roster, was just the direct mentoring. I do it, take it to the boss, where have I got it right, where have I got it wrong? and so on. Personnel management, I have found it harder, I think that is a lot more haphazard, there are times when you need to act and sometimes it goes wrong and sometimes it goes badly, and you learn by the bad ones. I think the informal learning has been much more useful on the day-to-day management of the people (HMM1).*

*Management experience was going through working with medical administrators. I've learnt some things the hard way. I've done the wrong thing and then found out the right way to do it (HMM2).*

*I think most of it is actually learned by doing it (HMM3).*

*You learn as you go. Stuff up along the way (HMN6).*

*I had worked my way up to manager through ability and through small hospitals into a large hospital, then Area Allied Health manager's role. I learnt on the job. What I learnt on the job was the game rules, I also learnt a lot about staff management. I made mistakes, and I went from being a clinician to being management. You make many mistakes, but as a small department manager it was a process of being linked in a sort of a network with your supervisors (HMA1).*

A nursing and health management qualified respondent emphasised the value of learning on the job.

*I think there is immense value in just starting at the bottom, really, getting your hands dirty, understand, literally and figuratively, I think that coming through and having experience at the coalface is absolutely essential (HMN4).*

Another nursing qualified health manager suggested: *'that some kind of on the ground, traineeship is necessary and then maybe doing tertiary stuff'* (HMN6). This variety of learning experiences and opportunities was placed in a structured experiential context by a generalist trained health manager.

*I guess giving people educational opportunities outside the square a little bit. Building on their primary backgrounds but giving them some very accelerated opportunities for learning the environment. Giving them some career experiences, planned for them in terms of the sorts of roles they undertake. I do not know that that sort of thing is as well done now as it might have been back in the sort of 30-year period (HMG1).*

Informal learning occurred in a number of different ways. Discourse with others and networking was seen as learning.

*Like what you [the researcher] are doing, talking with other people, getting all that qualitative information which is so valuable and adding to the wealth of knowledge (HMA3).*

*ACHSE, the networking that I think we talked about. I tried to talk to people from different backgrounds, so we would understand things better (HMG4).*

*Experience as an executive has been valuable because it opened my eyes to the pressures at various levels (HMA1).*

Despite a range of clinical and higher degree health management and management qualifications, a nursing qualified respondent, saw informal learning through networking as very important.

*Informal learning, I think again the College was a big part of that, only looking back now even when I joined the College, early in my career when I was still doing nursing, just coming along to some sessions, in-service, and just having a conversation with others, I think that networking is very helpful (HMN4).*

Informal learning through and with others was also seen as important learning.

*We don't get the sharing, and so on that you get when you are working with a group. Whether it is informal or formal postgraduate studies or attending a seminar with other people, so probably being able to work with others is probably one of the big things, that opportunity to investigate, a work area (HMA3).*

*I've taken advantage of working with people that I find very competent managers and I've used them and watched what they did, and how they managed situations. I guess that is how I have learnt (HMG3).*

Learning outside of work and in different contexts was also supported. '*Informal learning also just by friends and colleagues who are outside of the health system and talking about how things do or do not apply*' (HMN4). One experienced health manager, with a nursing background but without formal management qualifications, described skill acquisition as learning from other people.

*I guess that a lot of the skills that I've developed have been through perception, learning from other people who may well be more academically skilled as a manager (HMN5).*

Reflection was also mentioned by some respondents as an important learning process.

*I think that the things I've thought through and done for myself have ended up probably more useful than the things that were offered from outside (HMM3).*

*My team have portfolios where they put reflections on their practice of them, of the team. Everybody does the clinicians and the team leaders. If people learn to reflect on their practice, then they'll actually learn they'll actually develop it into a learning environment (HMA6).*

*I have learnt from watching other people. However, I've also learnt a lot from reading, and critically reflecting on what I've read (HMA6).*

Informal work-based and social learning, and learning by doing and from mistakes is strongly supported, highly valued and regarded as highly important by the respondents. Experiential learning is ranked ahead of formal learning by the respondents and this is consistent with and supported by earlier relevant research (Eraut, 2000:255). The discourse around learning led some respondents to link the informal learning to the need for formal learning.

*I needed the formal. That's exactly my learning style anyway. I needed the discipline of having lectures to go to and I needed the discipline of having to hand assignments in (HMA6).*

*You have to have a theoretical context to explain how you are observing the world. It gives you ways to explain alternatives, to negotiate and articulate your ideas (HMG4).*

One medically qualified respondent received advice that: *'if you actually want to take a broader role in hospitals and have a better understanding, you probably should do some formal study as well'* (HMM1).

An allied health qualified respondent suggested that informal learning should receive greater recognition as formal learning.

*Some of the informal learning has to be more transparently recognised as learning. If we can get away from the sense that you have to be sitting in a room somewhere before you are learning (HMA6).*

Another medically qualified respondent suggested: ‘*I personally felt that my training in both (clinical discipline) and medical school had not delivered me any [management] background with which to work, it is not anything you get trained in as a doctor*’ (HMM1).

A medically and health management qualified health manager suggested that there is a lack of management understanding and skills among some health managers.

*I see a lot of evidence in health that those skills are not well developed in many managers. Managers, some higher-level managers, and this causes unsatisfactory outcomes. I just wonder if perhaps they have not had the right training and do they know what management is about? I think formal training is important for management. I regard management as harder work than clinical work (HMM2).*

Another medical and health management qualified health manager was not as confident of the value of formal health management learning.

*I’m not sure that the (health management qualification) gave an enormous amount. I found it was very academically-based, without any attempt to connect back to the reality. There was never an adequate connection because it was historical to what was happening now. The only way to get from the theory to the practice was to go and work it out yourself (HMM3).*

While this view was perhaps about a particular program and qualification, it was not consistent with the view of many about the value of formal learning.

*I think the formal learning has been more important in the broader sense of understanding the whole system (HMM1).*

*It just gives you such a far more global perspective of where you sit in the general scheme of things, and, it is our history and stuff (HMN6).*

*I think they provide me with a good foundation of the theories and how to think through issues and a way of looking at how to make decisions (HMG3).*

There were a number of reasons why health managers saw value in their formal learning. These included a better understanding of the healthcare context and its complexity and it provided a comparative analysis of different national health systems from which they gained a better perspective of their own health system. On a personal basis, formal learning provided critical analytical skills, credibility and increased self-confidence.

*I feel the course I did helped, exactly as it was put to me by the people I asked about, not necessarily on a day-to-day basis. It would give you a good background and understanding without necessarily giving you the answer on how to deal with the immediate problem in front of you. It highlighted how complex our own system is, and that it is similar to what most other parts of the developed world deal with. I think those more broad-based subjects helped me have an insight into the fact that acute hospital care is not the be all and end all of healthcare. The other thing was that, those other subjects helped to deal with some of the frustration around the funding and the fluctuations of what you are asked to do or not to do (HMM1).*

*I would not have been able to do it without having done my Masters and all my other studies. Because that opens you up to networking, to really drilling down into information and time management and certainly report writing. I find that the education side is very, very empowering (HMN2).*

This last respondent also felt that the formal learning had ‘sustained me as a person going through that complex journey [career change and reapplying for own job]’ (HMN2). This sustaining value of formal learning is also seen as providing confidence in self.

*They gave you the confidence to make the decisions, to go into bat and know that you knew what you were talking about. I don’t think that I could be, the manager that I am today, if I hadn’t done any study (HMN3).*

*I got good grades and I wasn’t expecting to, so I was astonished that I could do it. It certainly helped with confidence. I prepare myself properly because I learnt to do that when I was doing my Masters (HMA6).*

Another respondent who lacked formal management qualifications suggested: *'I'm disappointed that I probably didn't grasp the opportunities when I had them, and as I said earlier I certainly probably don't have some of the analytical skills'* (HMN5).

This perceived lack of analytical skills through not undertaking formal learning is the precise value that an allied health qualified health manager felt was achieved from formal learning.

*It made me a critical thinker. I think it made a huge difference. It's made me much better at analysing what comes to me and work out whether it has a sound basis or not. That's the biggest difference. I don't think I learnt stuff, I think I learnt how to critically appraise. I think that has to be taught in a robust academic way* (HMA6).

A nursing qualified manager, with health management qualifications and a higher in degree management, reinforced the importance of learning analytical skills from both informal and formal sources: *'It's that critical thinking and the ability to challenge and think outside the square and the ability to just not take things, the status quo as is'* (HMN4).

The discourse on learning suggests that formal learning provides context, understanding, confidence, credibility and critical analytical skills. These views of the respondents are consistent with research, which has indicated that formal learning is not so much valued as experience but because it gives credibility and improves networking; the contextual knowledge gained is valued ahead of explicit knowledge (Greener 2004).

Respondents also suggested that learning, both formal and informal, is about *'the people management that is more challenging'* (HMG4).

*That's probably more difficult than learning how to balance cost centre budgets and those sorts of things. I think you also have to learn how to manage yourself. I think as we progress into postgraduate qualifications, I think the emphasis should be a lot more on communication and problem solving* (HMG4).

*They need to be able to look at the big picture. They need to be good strategic thinkers. They need to have good time management skills and be able to prioritise, both resource allocation and tasks. I think a good manager is*

*someone who can manage people well and have good insight into how people work. It's taken me a long time to feel a bit more confident about that. We need to know about finance. I think we need to understand better population health (HMM2).*

One respondent cautioned that the learning needs to incorporate *'the simple approaches because I think, effective communication is absolutely fundamental it's really coming back to fundamentals* (HMN4). The respondents emphasised working with people and understanding individual differences as important to the delivery of efficient, quality services.

*I think some of it needs to be focused on getting people to understand individual differences (HMA6).*

*It's all about working effectively with people, getting efficiencies and providing a good quality service (HMN4).*

The respondents also emphasised that time and experience, not just qualifications, were important considerations in developing good managers.

*I think time makes the best manager. I don't think anybody that comes out with a bit of paper is automatically a manager (HMN3).*

*It's not necessarily whether they have the qualifications; it's whether they have the experience and whether they have the ability (HMG3).*

A generalist health manager suggested that the skills and behaviours required of health managers should be of a high order.

*I guess that the sorts of skills required are ones that enable people to gain confidence and trust and have a clear head in terms of the sorts of issues they are facing. To be able to manage both up and down effectively. You have to have the capacity to work meaningfully with a wide variety of stakeholder groups. To be able to distil the essence of what their needs are into an agenda that is capable of being delivered. Those sorts of competencies are high-level intellectual and interpersonal skills and require a high level of personal behaviour (HMG1).*

Some respondents commented on the positive value of learning in the workplace itself.

*We are obviously dealing with adult education and adult learning and there's no doubt, just in fact over my own career, the things you learn best are the things you do. The learning should be incorporated into what they are doing in the workplace (HMG2).*

Most participants had postgraduate management qualifications that were health context specific and they valued and supported the importance of health context in those management qualifications.

*I think some of the traditional health management programs do provide a broadening, a perspective, systemic understanding, and some clear skills acquisition (HMG1).*

*Doing the Bachelor of Health Administration at the time really broadened my view on health services and management in health services (HGM2).*

Some participants chose postgraduate management programs that did not contain specific health context material. One such participant with an allied health background justified this choice:

*It was actually a little bit more broad, which in hindsight, that was really good at giving me exposure to managers from other organisations and totally different backgrounds to my own, in terms of enriching the learning that I took out of that (HMA4).*

In this respondent's case, the health context 'was in terms of how I applied it to my workplace, what you were doing was actually going to challenge you and meet your learning needs' (HMA4). Another generalist manager saw the value of undertaking qualifications that provided health context to previously acquired generic management qualifications.

*I have done postgraduate health and policy, to give me that health background. Because health doesn't make sense to a person who is just not used to it. (HMG4).*

Another perspective from a medically qualified health manager with health management qualifications was: 'some doctors are more focused directly on the high

*management jobs so they'll go the MBA. And then you know they want to be a CEO the next day sort of thing' (HMM2). When questioned on the relative merits of these choices the response was equivocal:*

*That's a tough one too (laughs) because sometimes I think I should have done an MBA. I think I would have a more detailed knowledge of organisational structures and management and have more in-depth knowledge. (If you did your MBA?) Yeah. I think with a degree, three (3) years out, it gets a bit irrelevant. Personal skills, personality and how you interact with people and how good you are at politics prevail (HMM2).*

The same respondent then confirmed that:

*... if they're going to work in health they'd need some exposure to the health management-type subjects most definitely. Yes, the context is different (HMM2).*

*Look if you are a star performer you could do anything. However, if you're working your way up and you're getting a career, then you've got to have some understanding of the environment. It's not a straight business environment we operate in (HMM2).*

One respondent with a nursing background discussed the diverse management qualifications acquired:

*The MBA, I think was especially helpful to compliment my clinical background. So that was both through the health administration degree and an MBA. It has broadened my approach, broadened my thinking, really given me the diversity or the ability to change and be flexible and accommodating in different situations (HMN4).*

A generalist health manager suggested that there is enough differentiation between generic management and health management roles to warrant health service managers seeking a specific health management qualification.

*I do not think that everyone who comes into health management these days from a general management background is going to have a health management degree. If they are looking for a career in health management then they should have a health management qualification (HMG2).*

Circumstances at the time of embarking on a career influence career choices. A generalist qualified health manager, described the paucity of degree qualified health managers at a particular point in time and that availability of scholarships was influential to his career choice.

*I wanted to move out of the health department environment into acute healthcare management. In those days there were not a lot of people with degrees in management. I saw that as the best method of getting into acute healthcare management. The other reason was purely monetary; there were scholarships to go to university full time for a year.*

*If I had done a straight management degree and then tried to get into acute healthcare, I do not think I would have been looked on as favourably in those days. Health administration qualifications were looked on as being more appropriate. If I had of done it when I was working in health management directly I probably would have done an MBA or something of that nature more of a straight masters in management type qualifications because I already had a health management qualification.*

*If I was to do it now I would either do a master of health administration or health management to further increase my knowledge or health management education. I would even be interested in an adult education-type degree (HMG2).*

This sub-theme emphasised the importance respondents placed on work-based experiential learning and, for some of them, the value of structured opportunities to gain that experience. The respondents who had had those opportunities emphasised that those programs are not as readily available as they once were, but that they should be. Some respondents suggested that the lack of structured experiential programs would limit the quality and effectiveness of health managers who had not had those opportunities. While emphasising the importance of informal learning, they also described the value of formal learning, mostly through formal postgraduate health management programs, as valuable in understanding health system context and its complexity and providing critical analysis skills. They also saw these formal programs as providing credibility and building their self-confidence.

There were some diverse views about the relative merits of formal generic management programs, as opposed to those with a specific health management focus. However, the

respondents generally agreed the learning in formal programs needed to be relevant and applicable to the work situation, providing broad health context as being important content for learning programs and experience.

Sub-theme 3.2 continues the respondents' career journey by describing their experience in terms of role models, mentors and motivation.

### **5.2.2 Sub-theme 3.2: Role models, mentors, and motivation**

The health managers in this study were motivated in their career by altruism and personal values. The challenge of the role was also valued, as was to some extent the power and influence of the role. One of the major influences on respondents entering a health management career was both the positive and negative influence of other managers as role models and the value of formal and informal mentors. The influence of other managers was significant. An emphatically negative experience of a nursing qualified health manager was described as follows:

*I was managed so appallingly by another manager – I thought I could do better than that so that encouraged me to actually do some tertiary qualifications in management, and then I moved into the site role, and then I moved into the management role of one facility and there I am currently managing two facilities (HMN1).*

Some respondents experienced both positive and negative influences from these role models and mentors. *'I was actually very lucky when I first started my management position and my manager was great, I got a lot of mentoring from her'* (HMA4). The negative experience of a previous manager is described as: *'I didn't particularly enjoy the way he'd managed the department'* (HMA4). Another allied health manager had experienced both good and bad managers: *'My very first manager was the model of how I wouldn't do it. Then later on, 10 years later, I had the person who I would do it like. Had both'* (HMA6).

One respondent presented a positive experience of working with a previous manager as the reason for moving into management.

*The reason that I've ended up heading into management is because the person that managed me was very inclusive and she insured that we really worked as a*

*team to set the direction of the place. I hadn't ever seen myself as heading towards a full management role (HMA6).*

Another respondent spoke of *'working and being mentored by people in a more senior position than me over my entire working career, being mentored in such a way that you picked up on all the positives and tried to remove the negatives'* (HMN5). All of the respondents described positive and negative experiences with role models and mentors, who they had either formally or informally acquired and some of these are described here.

*I learnt a lot in the mentoring (HMO1).*

*I feel that a lot of the senior managers did not have the appropriate skills to lead and to inspire. But I also worked with a number of really inspiring leaders, and I've taken advantage of working with people that I find very competent managers and I've used them and watched what they did, and how they managed situations. I guess that is how I have learnt (HMG3).*

*I was fortunate enough to work with both a direct clinical manager, when I first started and also a hospital manager who, again I was fortunate, [was] a mentor that showed that, you know, if you have the right skills you can actually have an influence across the broader range of patients (HMM1).*

*You have your mentors, you have people who you see and you think I really like the way that they did that. That's the way I'm going to handle that situation from now on because I can see that it really works. So you take pieces from people. From managers that you have had in the past or managers that you might not have worked under, but you've worked alongside them or they've been in another division and you have seen the way that they have managed something and the way they conduct themselves, that sort of thing (HMN3).*

The above views of the respondents are consistent with UK and Australian research that demonstrated learning from others is important (Eraut et al. 2000; Eraut 2004; Greener 2004) and managers learn from other managers, good and bad (Boucher 2001). Most of the role models and mentoring of participants occurred by chance rather than being a

planned experience. The lack of any formal and systematic mentoring programs is demonstrated by the experiences of the following respondents.

*You know there is very little mentoring for these roles, in fact there is (expletive) mentoring into these roles, so you find yourself sitting at a desk in a hospital one day, and then things just kind of happen and then, its like well I didn't know that, nobody told me that. It didn't take me long to realise that the level of the accountability is, I find, crushing and there is little preparation for that and there is very little support for that (HMN6).*

*I think there is a need to develop, almost mentor managers, learning to be a new manager from whatever you were, being a manager, and it's quite difficult (HMA3).*

The respondents views about the value of role models and mentors is supported by research which suggests that learning is both an individual and a group activity, involving coaching, working with experts, sharing practice, teamwork and learning from others to develop a wider personal perspective (Eraut 2004). Learning is said to be facilitated through a combination of knowledge forms, being explicit, and tacit, group and individual knowledge in a focused education setting (Greener 2004). Research about the education of nurses and doctors supports the important impact of mentors, as presented in a meta-analysis of the literature by Braithwaite and Travaglia (2005). In that analysis, it was suggested that senior nurses, as mentors, have a greater impact on nurses on their professional identity than did their undergraduate training. Sibson and Machen (2003) indicated that doctors, particularly residents, are influenced by their senior colleagues as mentors. The perceptions of the respondents in this study suggested that the influence of other managers as mentors is consistent with these discipline specific findings and is an important contribution in the socialisation of these respondents into the health management profession. In Theme 2, which described the contested nature of the role, the respondents were prepared to recognise, some more readily than others, that the influence of role models and mentors extends both across the professions and includes the influence of those with generalist health management qualifications.

Participants were prompted during the interview with the question ‘*what is it about the role, the power, challenge, or the glory?*’ in an attempt to gain a description of what the respondents thought it was that motivated and sustained them in their role. Many gave multiple reasons, such as these examples from medically qualified health managers, one of whom said: ‘*there is a whole pile of things*’ (HMM3). A second medically qualified respondent suggested:

*Look, it is a bit of everything. I think you do have a bit of power. You have recognition of your skills. So that is important to me. The fact that you get well remunerated ah, that you’re recognised for, you know your skills. That you can influence things, that’s all-important to me* (HMM2).

The major motivators were around the theme of personal professional values followed by the challenge of the role: ‘*part of it is altruism, wanting to see the right thing done*’ (HMM3).

*It was my desire to make a difference to have an impact* (HMN4).

*I work in it because I believe in, that it is a public good. I want to make a lasting difference actually* (HMA6).

One allied health respondent thought that the role is worthwhile: ‘*I think it comes down to my whole value system. It is making a difference within the system, even if it’s only to a small degree. What motivates me is that really intrinsic drive to social reasons*’ (HMA4).

Similar value-based reasons were offered by many respondents as motivating their adoption of the management role.

*I do have a fundamental belief in the system you know. I have a lesser belief now, in the system, but a desire to make people’s experience better* (HMN6).

*The thing that keeps me interested is that little bit of influence across a broader range of patients. You can actually feel like you’re contributing to something and even though at times you might feel like you are contributing to very little* (HMM1).

*There's an essential value in health management in a human sense and in the societal sense both in the public and the private sectors. It's a worthy thing to try to protect, maintain or restore health to people or to provide care to people whose health has become a problem to them. The altruisms are inherent in most people who have gone to any senior role in health management and probably without it the perseverance factors may not be so great because what you say is exactly right, you know, there's all sorts of capricious acts taken against managers to protect other interests (HMG1).*

In addition to a strong sense of values and purpose, some respondents also perceived that it was the challenge of the role that motivated them (HMA6, HMG4, HMN4, HMG3, HMM3, HMN6), as confirmed by this respondent:

*I think it's challenge and influence, because, I do think you have more influence to make things happen and you've certainly got a lot of influence over how you behave. As a role model for people (HMO1).*

A number of respondents were prepared to admit that power was also a motivation for them to adopt the managerial role (HMG3, HMM2), with one respondent suggesting that power was a general motivator for wanting to be a manager: *'Power and influence, same as everybody'* (HMN6). Others refuted any sense of power being a motivator, *'there's no power and glory in it'* (HMM3). This view was supported by other respondents, *'I'm not the least bit fussed about status and power'* (HMA6). A generalist health manager reflected the feeling of a lack of power described in earlier themes: *'It's not the power, because I don't feel that I'm that empowered'* (HMG4). A nursing qualified manager suggested the organisational hierarchy dilutes managerial power:

*I think the reporting lines were such that you could only influence rather than having the power to change. I think that that is a very high frustration (HMN4).*

One participant saw *'stability'* in the management role (HMM3), when compared to clinical practice, while others thought that management was *'exciting'* (HMN4) and *'really thrilling, like intellectually and personally'* (HMG4). The shared experience of the respondents about their careers was mostly positive.

*I enjoy my management role more than I have enjoyed any other role. If it fits you, it's a great career (HMA1).*

The main motivation of respondents for adopting the management role was value driven, a desire to make a difference, to have influence and because of the challenge the role presented. The latter motivation is also consistent with findings from other relevant research into motivators for learning (Eraut et al. 2000); this research emphasised the importance of confidence, challenge and support to learning. The almost diffident perceptions about power also need to be considered with the perception of feeling powerless within the health system, described in Themes 1 and 2. These perceptions reflect the constraining nature of organisational, functional and institutional perspectives and the domination of existing power holders. The constraints themselves reflect the institutional theory perspectives of this study's Theoretical Framework (Greenwood & Hinings 1993).

Sub-theme 3.2 presented the respondent health managers as having a mostly positive view of the role, despite negative perceptions of the health system (described in Theme 1) and the contested nature of the role between the professions (described in Theme 2). While presenting a positive view of the role, they also generally acknowledged that their power in the role is constrained. Sub-theme 3.3 continues the career journey theme by describing the perceptions of respondents about the need to support and develop people in that role.

### **5.2.3 Sub-theme 3.3: Developing and supporting health service managers**

In Sub-theme 3.3 the majority of respondents present the view that there is inadequate provision and/or support for management training in the health system. This view extended to the development of individuals generally in the health system and about the need to have an adequate health management workforce. Offering support to individuals leads to greater confidence in their capabilities and improves their capacity to undertake challenging work (Eraut et al. 2000). The respondents were confident of their capabilities in undertaking the role despite their misgivings about the level of support they are afforded. The perspectives of the respondents firstly described a lack of organisational support for their development. The following respondent stated: '*No learning or support?*' (HMN6). This view is supported by other respondents.

*There is a lot of ongoing special development for clinical issues, but there is not a lot around on the ongoing seminar basis for management issues (HMA3).*

*I don't think that that is happening, certainly within the government health system, in a structured manner that's going to ensure that we have got capable managers, and even the workforce. The planning for the future demand and what's required is totally inadequate (HMN5).*

*I actually don't think the health service does that particularly well. The focus really is around clinical development as opposed to developing managers and leaders of the future (HMA4).*

*There seems to be focus on training for clinical skills rather than management skills. I personally do not find my job training and learning to be adequate (HMG3).*

*Organisation has done nothing. I might be being unfair here but I don't think there was really much as far as professional development is concerned (HMM2).*

*We have a system that doesn't look after us, doesn't train us, doesn't support us (HMM1).*

*I don't think we are training people up enough for senior positions. Then people get into them and they struggle. In addition, they struggle because of isolation (HMN2).*

In the following quote, a generalist qualified health manager respondent considered the inadequate organisational support in terms of the constant change and turnover of managers.

*This context of turnover has bedevilled the whole idea of developing people. I think the hard-nosed bureaucrats would say that well the half-life is say five years or whatever in a career. The half-life of a chief executive might be two years. So what do we expect of them and what should we invest in them? (HMG1).*

This generalist qualified health manager makes an important point about the ability to learn and to develop people in the change context of short-term appointments and high turnover, particularly of senior people. The environment provides little opportunity and time for reflection and learning (Harris et al. 1998; Greener 2004). This suggests that

health managers, with little commitment from employers and less easily discernable career paths, will need to be more assertive and flexible in developing their careers than has been the case in the past (Harris 1998). They might also need to focus on capabilities of managing change, consultation and properly utilising the full resources of their workforce (Eraut et al. 2000).

One of the nursing qualified respondents suggested that the lack of preparedness of people for management roles is the appropriateness of training to particular roles.

*Probably more in that strategic rather than operational role, I was very good at that. I was on the board of a professional college; I was in state working parties but none of that actually prepared me to be a manager here (HMN6).*

One generalist trained health manager reinforced the need to broaden and ensure the appropriateness of education and experience, even where there is prior clinical training and experience. This perspective reinforces the uniqueness and contextualised nature of the health management role.

*To bring people in to manage in the health sector requires the broadening of their intellectual base and the diversity of experience that they are given. This is important in terms of understanding the mechanics of the health system, it's just an extraordinarily valuable thing. To keep them in a very narrow confine, even albeit in the professional setting of say nursing or medicine, and then expect them to work through the broader activities of a health organisation probably doesn't equip them ideally for the task (HMG1).*

The lack of adequate organisational support to the education and development of health service managers stands in stark contrast to government-sponsored programs of the past, described earlier in this Theme 3 by some of the respondents. Organisations have passed on both the cost and initiative for education and development to the managers, as described by this allied health qualified respondent:

*On a personal level, I think I have been phenomenally lucky actually. Lots of it I have self-funded. Some of it I have fundraised. I think I have not expected that it would be funded for me (HMA6).*

Others, such as the following medically qualified health manager, have also made their own opportunities.

*Well I have my own professional development. I'm part of a learning set. I attend that every few months. I think you need to step out of it. I attend in person. I negotiated it as part of my contract. I really do enjoy that. I have my college professional development stuff as well as learning management skills (HMM2).*

It was also suggested by the following generalist qualified respondent that health managers have some personal professional responsibility.

*You would hope that the emerging health manager has done enough personal work and has enough personal perspective developed to seek out those sorts of supporting things from employers. It is not likely to be provided, given the economic imperative and constraint of the day. Without people really wanting to develop themselves you get an emerging health manager that may not ultimately make the difference that perhaps health services require (HMG1).*

The following generalist health management qualified respondent demonstrated that undertaking a health management degree encouraged personal professional interest and a different role perspective.

*Doing the BHA [Bachelor of Health Administration] pushed me into thinking in terms of being a college member, a member of a college group that was interested and responsible for professional development in health management. I did not actually think that way when I worked in the health department and I thought of myself more as a public servant (HMG2).*

There was also some evidence from one generalist qualified health manager of some organisational support for learning.

*I went onto the Leadership Program. Did tours of various jurisdictions, saw different ways, talked to interesting people and so forth, and learnt about things, like the frog and bike analogy (HMG4).*

One allied health qualified respondent suggested that the investment in training is understated.

*We have quite a small budget for external training opportunities so we have about \$300 a person for external training opportunities. People were very disgruntled about that. I did a review of how much time we spent on training and*

*how, what the actual dollar cost of that was and 10% of people's time is in some training or other, which is quite significant (HMA6).*

One generalist trained health manager with health management qualifications emphasised the impact of current approaches that do not adequately invest in developing health managers.

*The weakness of current approaches has been that the sorts of money that is required to establish educational professional development and ongoing training-type activities for a wide variety of staff including managers is seen as peripheral to the essential provision of services.*

*Budgets are tight; those developing, nurturing and learning-type activities tend to be at the edge of budget trimming. A lot of the talent that is potentially available to be nurtured in a professional context in the development of leaders and the development of managers is unfortunately lost. The essential paradox comes with a less equipped organisation with less money to try to cope with some of the pressures that are around (HMG1).*

The discourse about learning for health managers broadened to include the respondents' views about the development of the health workforce.

*I am talking about workforce now as the health services has become more pressured, more highly skilled and so on. That means there is a bigger gap between what the education facilities are producing as graduates, because they have all got their pressures, so that gap of having workforce ready, new graduates is widening. I see that as a big, big problem (HMA4).*

The respondents also identified a number of problems with current health workforce development. A generalist trained health manager suggested that the skills gained in nurse training are not adequately recognised.

*We have a nurse studying for three years, undergraduate, maybe ten years of practical experience, has done a two-year full-time-equivalent Masters degree in a specific type of healthcare specialty. How that person could be less equipped to deal with patients, who front to her on a day-to-day basis with very similar conditions, how could she be less equipped than a junior doctor? We all know that junior doctors are trained by senior nurses in their first two years in ward rounds (HMG4).*

A medically qualified health manager suggested that another problem is that we are training health professionals to become more specialised, when that is not necessarily the way we are attempting to deliver services.

*We need the workforce to come on and not expect to do only the sub-speciality, be that nursing or medical, in which they have trained. They need to be prepared to be a little bit flexible. They need to go with the flow if the work requirements change. That is quite difficult because that is not the way we are training people anymore. Twenty years ago a nurse, was a nurse and would look after anyone. Medicine is the same, once you are a surgeon you will not ever look after a medical patient (HMM1).*

The above comments of the respondents reflect the narrowing of the knowledge base of professions and the extensive move to sub-specialism (Eraut 2005). While this sub-specialism may increase the skills and knowledge of a health professional, albeit in a narrower speciality, and may improve the quality of care, it also reduces the flexibility of health professionals to work in a broader context. This lack of flexibility is further compounded by increasing shortages of health professionals in most health systems.

Another medically qualified health manager suggested: ‘*a lot of the system is almost self-replicating*’ (HMM3). This same respondent commented further on this issue:

*The training of health professionals is by the same people and to some extent very much in the same way. You can change a university course and make it problem-based, you can change some of the training for specialists, you can take nurses out of the hospitals. All of those things are significant changes, but if the job itself is still very similar, no matter how you train them they are moulded back into doing something in a very similar way (HMM3).*

A nursing qualified health manager expressed similar concerns:

*The way that healthcare people, the clinical people, the health professionals, and the health managers are educated reinforces the status quo, absolutely (HMN4).*

*I think even before people start to work in the field, it creates barriers. In terms of being able to work effectively together, it creates different mindsets and*

*different approaches. It does not create an environment where all of the different healthcare providers can work effectively as a team with the one goal (HMN4).*

The status quo self-replicating nature of training and learning and the influence of mentors in the workplace reflects the view that professional values and expertise, which are part of a person's self-concept, inhibit reform and innovation (Anderson & McDaniel 2000; Eraut 2004; Braithwaite & Travaglia 2005). The mention of training and learning experience being a barrier to teamwork demonstrates the importance ascribed to teamwork in healthcare and the difficulties of achieving effective teamwork in an inherently complex system. This highlights the need for more collaborative approaches in the management and delivery of healthcare (Braithwaite & Travaglia 2005).

A respondent with an occupational therapy professional background indicated concern about the lack of attention to clinical managers.

*They have forgotten the huge layers of clinical managers who are managing very important teams who have ended up like nursing unit managers without any management training and they are real key managers in an organisation. There is no formal foot to developing and supporting them (HMA1).*

Again, a medically qualified health manager suggested that current training is narrow and too discipline specific.

*The impression I get is there is nothing in their training about health system-wide issues. The form of the health system, interlinks between various groups, the actual patient movement between the groups, the funding. My impression is that that general overview is not there in the training (HMM1).*

Advice to those seeking a career in health management suggests that career paths have changed and are less determinate than in the past, highlighting the significant change to health management in one career lifetime.

*Keep options as broad as possible. Do not be thinking of a particular career path because the chances are no one is going to be able to determine a career path at the starting point. There is no set career path, move around move sideways. There is probably going to be more sideways moves, that is already the case, get as broad a range of experience in as many different settings as you*

*can. Unless you get into positions where you have staff responsibility and preferably service responsibility you are going nowhere. You get so specialised into only being able to look after budgets or something. A lot more people get employed on contractual arrangements for 12 months, two years or something, to do a particular project. It probably fits with the thinking of many young people these days who do not look for long-term careers. They seem reasonably comfortable about far more temporary work arrangements than perhaps you and I. We had it drummed into us to get a good steady job and stay in that job (HMG2).*

The respondents mostly believed that there is inadequate support for their education and development as health managers. One respondent suggested that this in part reflects a system view about how much organisations are prepared to invest in people in roles that have become, by definition, of relatively short tenure. The same respondent also suggested that investment in education and training are often the first areas to be divested in cost-constrained circumstances. These perceptions and developments confirm earlier research of Harris et al. (1998), which suggests managers may have to take greater initiative and responsibility for their own development. Some of the respondents supported the idea/concept that managers have personal responsibility for their own development.

A narrow discipline-based experience or experience in a narrow range of healthcare settings does not equip managers with sufficient context to adequately manage broader organisational settings; some respondents expressed caution about this. There was also concern that education and development of the health workforce is self-replicating of the existing roles and practices and that this undervalues the skills and potential of some professions. Also, that an emphasis on sub-specialism with a continuation and narrowing of roles does not effectively address the need for greater teamwork that is said to be required in healthcare delivery and its management.

Theme 3 has addressed the respondents' perceptions about their career journey as health managers. Despite negative views about the health system they work in, they are positive about their roles, although holding a perception that they have limited power to influence and be effective in the role. They have learned to become health managers

through both informal and formal learning. They emphasised the value of informal work-based learning, while suggesting that the formal learning has given them broad health and organisational context understanding, critical analysis skills, confidence in their ability and credibility in their role. They were positive about the influence of role models and mentors on their career selection and progress, while critical of organisational support for their education and training. In their discourse, the respondents offered solutions to the challenges facing the health system and to the health management role; these are described in Theme 4.

### **5.3 Theme 4: The health managers' solutions**

In this final theme the respondents' proposed solutions to some of the challenges they identified in the other three themes are addressed. In those three themes, the respondents' perceptions of their reality of the health system, their role, and their career journey, the respondents have identified challenges they and the system need to address. Theme 4, the health managers' solutions, draws on the respondents' discourse to suggest approaches to meet the challenges described and suggest alternative approaches to how health services might be organised, managed and delivered and the workforce developed. The solutions emerge into two sub-themes that together represent this theme. The first sub-theme addresses the structuring of the health system. The second addresses challenges to do with educating and developing the health workforce. The two sub-themes are:

Sub-theme 4.1: Structuring the health system

Sub-theme 4.2: Educating and changing the health workforce

#### **5.3.1 Sub-theme 4.1: Structuring the health system**

The respondents, in discussing structural issues, suggested that there was a need to clarify roles and responsibilities, particularly in respect to the differing levels of government involvement. The following respondent proposed that government has a funding role and should not be involved in the delivery of services while maintaining responsibility for evaluation of service delivery.

*In an ideal world, the role of government would be a funding body and not be too involved in the delivery of healthcare. I guess the role of government is to keep a monitoring arm over the health service (HMG3).*

An allied health respondent suggested that funding needed to be targeted to those who are meant to be recipients of health service delivery and improved health outcomes.

*I think, hopefully that the health dollar will go to the consumer, the patient, where it is supposed to go and that the outcomes are best for that person or the best that can be hoped for in the situation. I think that it means that health service managers have to be professional managers with an awareness of the health system, and the context in which they are working (HMA2).*

This clarification of roles and targeting of funding may encourage an approach that ‘ultimately is to think about the population and the broader community’ (HMG4). A nursing qualified health manager supported the view that a single source of funding would clarify roles and relationships.

*The major area that needs to be changed is along the funding lines, so that there is a single source of funding. I just know from my experience, that people are employed quite literally, to look at the rules and to look at the regulations between State and Federal and look at ways that we can overcome and cost shift. The cost shifting goes both ways. It is a game of distraction, that is very expensive and it detracts from the service that we are trying to provide (HMN4).*

A medically qualified health manager, HMM1, suggested that the removal of one level of government from responsibility for healthcare is required.

*A level less of health management, I think that one less layer of government would make it clear about what was happening and would, by necessity, bring all the various aspects of health under the one umbrella. I think that it would be advantageous (HMM1).*

Another respondent supported: ‘a national approach not a state-by-state approach’ (HMO1). A medically qualified health manager suggested: ‘[an] ideal would be to have health almost as a statutory body which was run by a central bureaucracy without political influence’ (HMM1).

One of the nursing qualified health managers agreed that the suggestion for health to become entirely a Federal responsibility is '*not such a bad idea*' (NM05). This respondent also cautioned:

*If one central body was responsible for health and aged care, we would have to ensure that the level of funding in real terms doesn't drop, for aged care in preference to acute health (HMN5).*

The health department role would then be '*to achieve equity, they would be looking at equity for the members of the community so ensuring that there is some appropriate distribution of resources*' (HMG3). This approach, one respondent suggested, might lead to a return of the situation that used to exist where the aim is '*to separate the public servant from the political side of things*' (HMM3).

An allied health qualified health manager suggested that, however structured, there needs to be '*general agreement at the top level, but then [the system needs to] be able to pick up on the individual differences for that state and recognise the differences, like particularly between metropolitan services and rural services, rural and remote services*' (HMA3).

If there is a role at the State level, it would be very much about '*quality regulations and oversight*' (HMN4). This same nursing qualified health manager further explored this favoured approach:

*I reckon they are the ones who should be monitoring. Making sure that the overall policies are appropriate, they are implemented appropriately, that they are really looking at key indicators or key benchmarks across the system to make sure that what they want to happen at the policy level is actually happening (HMN4).*

In addition to reducing the levels of government involvement in healthcare and clarifying roles, the respondents expressed views about how services might be delivered.

*I am a great believer in developing services that are more independent that removes itself somewhat from the political arena. Services could be contracted out to the provider in regional communities that has the best resources and*

*capability of delivering a whole range of services. This would take them out of that government domain to a proficient provider (HMN5).*

This same nursing qualified respondent suggested that this approach is needed to 'pull it all together' (HMN5).

*You would have only one entity in each community that is seen to be that deliverer of care. Now you have a host of, any number of providers who are out there, often services overlapping. The person that you need to care for is so damn confused about where they go to for a specific service; they do not even know where to start (HMN5).*

A generalist health manager suggested a similar approach by utilising geographically-based areas that in many states had been the method of delivery, at least until the most recent times.

*Area health-based services is appropriate in the sense that there is going to be variations in need, in various communities based on the demographics, based on the social environment or the social demographics. There are also going to be different services already provided, different access to private facilities and things like that. I guess there needs to be some consideration in an area health environment of those types of factors. It gives you a chance to build the service based on the individual requirements of the area health service. (HMG3).*

Another generalist health manager also supported a geographic population-based approach to the organisation of health services.

*In an ideal world, you might look for something that was created on a population base and funded directly to have a more overarching responsibility for health. Managers would have a clear arena for the sorts of activities that they were governing and being active in a more regionalised health service with individual organisations within the region given clear funding from an agreed formula basis (HMG1).*

This view was supported by another respondent with a health profession background: 'It would make sense to have entities smaller than State governments' (HMO1). Another generalist health manager provided a different view that sees the states as being more appropriately responsible for health services.

*I'd like to see the Commonwealth get out of the provision of health services and leave the provision of all health services at the point of delivery to the states (HMG2).*

The solution proposed is also meant to change the focus of care delivery and to mitigate the political and bureaucratic influence.

*Providing, care in a community setting rather than waiting for a crisis to occur has to be economically beneficial and better than having people in beds. It becomes a revolving door (HMN5).*

The respondent also emphasised the need to separate out the close bureaucratic, political direct control of the health system.

*The health system has to be de-politicised and de-bureaucratised to a certain extent. That allows the freedom of an agency to deliver services at the grass roots level with the intention of preventative health, maintenance of well-being and avoidance of either institutionalisation or hospitalisation (HMN5).*

A generalist health management respondent also supported the need to disengage somewhat from the bureaucratic political structural interests.

*We have moved into this more direct relationship of government and service provision in the public sector. It may well be that that close relationship between government and service provision in those sectors is just too politically difficult for government not to act against the interests of the community in some ways by trying to have a system that presents as little problem as it can to government. It may well be better, given those pressures to think about some commission-type structures again (HMG1).*

A nursing qualified health manager suggested a much more grass roots approach.

*I think in Australia we can do that a lot better than what we are now. Not just, having token community forums where the communities give views, but actually having quite a degree of autonomy with the financial planning and being able to market that to their own community. That would make a significant difference. Not just health bureaucrats saying that, but people who actually live and work in that community and they have not got a vested interest and not employed by the health service (HMN1).*

Another nursing qualified health manager also supported greater community decision-making ahead of that undertaken by clinicians and funders.

*I think the community have to engage far more in decision-making around health, what it is that's important, what it is that they want to spend their money on. You know there's a lot of decisions made in health by clinicians and funders (HMN6).*

A generalist health manager considered that, at the actual service delivery level, you need competent people exercising the roles for which their experience, training and qualifications have prepared them.

*You need to have a clear purpose of what you are trying to accomplish. You need to have very skilled, competent people doing what they have been trained to do. That means that you need to have clinicians providing clinical expertise, and you need managers that have management experience and expertise, providing management and senior leadership.*

*I think you have to take some of the control from clinicians that do not have an understanding, or the skills in a management environment and hand it to managers that actually have the qualifications, skills, and ability to effectively manage (HMG3).*

A generalist health manager suggested a greater emphasis on preventing illness and maximising health.

*I would say, people should know if you are hospitalised for asthma the system has failed you. What I am trying to emphasise there is that that admission is totally preventable. The system should be focused about avoiding illness and obviously maximising health (HMG4).*

A nursing qualified health manager suggested that the structure and service delivery should be designed to meet local needs.

*It has to be based on the culture of the country you work in, of the state that you work in, of the local government area and the community that you work in, so it cannot be a one size fits all. It has to be with the key people in those communities from a grass roots up approach so that you are meeting the targets, but not at the expense of quite different health outcomes that need to take place in that particular community (HMN1).*

A nursing qualified health manager suggested that the model of care needed to be changed.

*I would probably try to change the model of care, obviously, the doctors would be part of that, but they would not be running it. They would be an equal partner. I think that has to happen. It has to be a collaborative thing, a team approach. It cannot just be around a doctor because they are not going to be there (HMN3).*

A medically qualified health manager also agreed that change is beginning to occur.

*'I think that the other healthcare groups are starting to gather more momentum, I think we are starting to see that with the nurse practitioners role being developed'* (HMM1).

This medically qualified respondent also supported the move to increased independent practice that is occurring in private practice but not evident in the public sector.

*Certainly, already in the private sector, there is more independent care delivered by allied health practitioners. At the minute, I have not seen that translate into public hospital practice (HMM1).*

In this sub-theme about the structuring of health services, the respondents suggested a clarification of roles with government having a funding and evaluation role but not a provider role. There was a distinct preference for having responsibility for healthcare located at one level of government with some preference for that being at the Commonwealth level and, some support for a separate agency, a 'commission' as the responsible authority. The respondents mostly supported a geographic population-based area structure as appropriate for the delivery of services, with an increased focus on wellness and community care. A number of the respondents recognised the need for greater community engagement in the management and delivery of health services. Some of the respondents also suggested that consideration needed to be given for the differences between geographic areas, such as urban and rural differences, thereby cautioning against a 'one size fits all' solution.

The respondents also suggested greater acceptance of potentially new and wider roles for the professions, increased teamwork and recognition that people need to be appropriately experienced and qualified for the role that they are occupying. Issues about workforce training and development are more fully explored in Sub-theme 4.2.

### 5.3.2 Sub-theme 4.2: Educating and changing the health workforce

Sub-theme 4.2 of the health managers' solutions addresses the respondents' perceptions about requirements needed to change and enhance the healthcare workforce. The respondents were of the view that any change to the structure and care delivery approaches also requires changes to the human resource capacity of the health system. One medically qualified health manager suggested that the shortage in the numbers of doctors will force change, and there is a need to increase flexibility within the workforce and to re-examine how we train health professionals.

*The medical profession have maintained their dominance by maintaining a short supply. They have now started to open up gaps in what the number of doctors available can provide. By necessity, the politicians and the community will start to demand that somebody fill those gaps (HMM1).*

*It is a challenge to have the workforce expecting to do only the sub-speciality. We need them to be prepared to be a little bit flexible to go with the flow if the work requirements change. That's quite difficult because that is not the way we are training people anymore, to be general health providers. The more you specialise, you can deliver things that are more complex. The challenge is how you maintain a base ability to work across specialities that is important (HMM1).*

*There is nothing in their training about health system-wide issues, the form of a health system, the interlinks between the various groups, the actual patient movement between the groups, the funding. People need to have an understanding of the issues in which they are involved. I do not think that the health professionals get much of that at all. (HMM1).*

The following respondents took the issue of health professional training further:

*We come from a model where there are different schools, where the doctors are trained very separately from the nurses, who are trained very separately from the allied health, who are trained very separately from the health managers (HMN4).*

*I think, even before people start to work in the field, it creates barriers in terms of being able to work together effectively. It also creates different mindsets and different approaches and does not create an environment where all of the*

*different healthcare providers can work effectively as a team with the one goal. There is very much the need to understand the perspective of all of the different professional groups (HMN4).*

*That it is a question going back to where people get their initial training and maybe training all the different professions together, in at least part of their training, so they do not think they are so different from each other (HMO1).*

*We need to look at the skills mix, not necessarily the qualifications of the person. It's about deciding not to make a position, not to classify as medical unless it needs to be medical and not to classify it as nursing unless it needs to be nursing. (HMO1).*

*It is about training to work in the multi-disciplinary teams. Because there are times when you need doctors, and you do need nurses, but, but you need them to be able to work together (HMO1).*

A nursing qualified health manager also supported the need for more common training within the professions.

*I'm very passionate about nursing and nurses, but the health system shouldn't really be about the professions. You know, the professions need to get out of their corners sometimes and stop being caught up in role protection and co-function a little bit better, to provide care (HMN6).*

*I think that there needs to be, um, almost a combined degree. The first year or two of any health professional degree is spent together. You learn the same and you work together. Because from an organisational level, it is very difficult to legislate or make that happen because it is about how the professions relate (HMN6).*

A generalist trained health manager had a more revolutionary solution:

*Well I just think we should abolish medical school and nursing school and just be a health university or a health school. It is a competency-based system. Now people say it's not competency based, but it is, we all know that medicine is an apprentice system. You learn by your master.*

*They should just be certificate one, certificate two nurses or levels and as people become more and more specialised they become a certificate ten. That is what they are, a health worker certificate ten. That might be the equivalent of a brain surgeon, but we do not call them brain surgeons we just call them health workers certificate ten. I know that sounds very Soviet Union (HMG4).*

A nursing qualified respondent also challenged the discipline-based training: ‘*formal training is segregated for professional groups, that’s a barrier, so I’d like to bring all of those together*’ (HMN4).

*You would have a basic health degree as your primary degree, and most of your health professionals would come out of some sort of postgraduate degree. You pool your healthcare deliverers in a common training scheme. At least for say two years, or whatever that might be. That way there is a more common understanding of what everyone else knows at a basic science level. It is hard to apply for something you do not understand when you are 18. I think that probably goes for some of the other nursing and allied health disciplines. The competition can begin a little bit later about who would get into medical school (HMM1).*

These respondents supported the view that there is a need for increased inter-professional practice and a greater understanding of and between the roles, the values and perspectives of the professions, and that this needs to be reflected in the education, training and practice of health professionals (Cooper et al. 2004). Willingness to learn is influenced by the agency of practitioners, groups and organisations, which suggests that learning and managing change requires partnership and support and cannot be left to managers and health professionals alone, that it should be a shared responsibility (Eraut 2006). Providing integrated complex care for chronic and often multiple conditions also suggests collaboration across agencies and inter-professional practice (Cooper et al. 2004; Braithwaite 2005).

Prompted about solutions the following generalist health manager suggested:

*The solution is some kind of enlightenment in terms of the mismanagement approach in the health sector and in the public sector. In terms of saying sure, we are up against tough times in the service in terms of the measurements of demand and things like waiting times, waiting lists. However, there will be no*

*improvement in those measurements unless we have a continually skill trained educated and enlightened workforce.*

*It may be more advantageous for people to starting thinking that it may well be better to look for the selection, development, training and education of people who are going to actually last longer in a health system (HMG1).*

When suggesting how to develop and support new managers, one generalist qualified respondent presented some wisdom that might be applied to the wider health workforce and quality and safety issues.

*It is not just when there is a problem you can pin an individual and then the problem goes away. The problem does not go away. It may well be that a group of better developed, educated, trained and supported people should be allowed to work through difficult areas where mistakes are potentially damaging. Arguably, this approach with some loyalty of and to the system may well mean that the health system has a better overall outcome (HMG1).*

In this sub-theme respondents emphasised the difficulty created in the separate education and training of health professionals, when attempting to deliver services in a more integrated and coordinated manner. They indicated that the separate development of health professionals makes the much desired approach of team-based care difficult. The increased focus on sub-specialist training amongst the professions also detracts from the flexibility of health professionals to work across the range of health services and to respond effectively to changing service needs. A number of respondents pointed to the need for some commonality in health undergraduate programs, to engender greater understanding and teamwork before moving on to specific profession-based programs.

It was also suggested that greater emphasis on the development and support of the range of health professionals might provide a capacity within that workforce to be more enduring and committed to the health system. It was further considered that this type of approach might develop capacity in health professionals to work together to address system-wide problems more effectively.

In summary, in Theme 4 the respondents' solutions to challenges they perceived the health system to be facing involved moving to a single level of government responsibility. They also suggested that government should have a funding rather than a service delivery role. They considered that, in addition to a greater clarification of roles, the delivery of healthcare should be regionalised. The respondents also proposed a greater engagement with communities and better workforce planning. The respondents suggested an emphasis on enhancing the human resource capacity of the workforce. They indicated that this requires a lesser emphasis on education and training within professional disciplines to a greater emphasis being placed on collaborative team-based healthcare education and service delivery.

## 5.4 Conclusion

In this chapter Themes 3 and 4 were presented. Theme 3 presented the respondents' perceptions about the career journey of health managers, a mostly positive view. The theme had three sub-themes that describe how the respondents learned to become managers and the mostly positive influence of role models and the use of mentors. Sub-theme 3.3 described their perceptions around their development and the support they felt they needed as health managers.

In Theme 4, under two sub-themes, the respondents offered solutions to the challenges that they see the health system and they face as health managers. Sub-theme 4.1 essentially proposed structural change to the health system. Sub-theme 4.2 described the need to enhance the human resource capacity of the health system. This would require reform to undergraduate and postgraduate training and education. That reform is needed to enhance the capacity of health professions to be able to address and solve system-wide problems.

The respondents' solutions in this study reflect in part the claims for reform proposed by various structural interests (described in Chapter Two) and in particular those of the health professions in management. The position put by the respondents is consistent with the perspective in Theme 1 that the bureaucratic political structural interests are too dominant in the health system. The respondents suggested a greater balance between structural interests is required. The solutions are also consistent with an attempt to

address the contested nature of the professions in the health system and in health management (described in Theme 2). The respondents' solutions are also consistent with Alford's (1975) theoretical approach, where structural interests also purport to represent the community interest in that solution.

In Chapter Six the major findings and conclusions of the study are presented. These are then discussed in the context of the Theoretical Framework. The implications for policy and practice are then addressed together with the utility of the Theoretical Framework and recommendations for further research.

## **Chapter Six**

### **Discussion and conclusions**

#### **6.1 Introduction**

The preceding two chapters described the four major themes and seven sub-themes that emerged from interviews with a diverse group of health managers in Australia and New Zealand. The respondents described their perceived reality of the healthcare system, their role and career journey, how they learned to become health service managers, and how they managed the challenges faced by the health system and the managerial role. The participants also suggested solutions to the health system challenges they face in that role.

In this study the experiences of the participants are described and interpreted utilising phenomenological principles. This chapter presents the relationship of the findings to the research aims of the study and the theoretical constructs relevant to understanding the lived experience of health service managers (described in Chapter Two). The major conclusions and the findings of the study are also discussed from the researcher's perspective. A discussion follows on the compatibility of the theoretical constructs to the reality of the health management role, followed by the implications of the findings to policy and practice. Finally, recommendations are made for further research arising from the findings of this study.

#### **6.2 Overview of major findings and conclusions**

The four major findings drawn from this study are described below and linked to the purpose and research aims. The purpose of the study was to explore the perceptions of a diverse group of health service managers about the health system, the changed circumstances of that system, and the role of health managers in that context. The research aims, summarised here, were to:

1. Examine changes and trends in the description, nature, and role of the health service managers consistent with changes in healthcare systems.

2. Explore the personal and professional perspectives of health service managers with respect to how change influences them and the systems in which they work.
3. Explore the personal and professional perspectives of health service managers with respect to contemporary management practices.
4. Identify the capabilities required of health service managers to manage complexity and uncertainty.
5. Identify differences (if any) in perceptions and professional practice of health service managers based on their professional and educational backgrounds in management.

The first finding, which addresses the purpose of the study and the first two research aims, is that, collectively, the respondents viewed the health system as one of constant complex change, often lacking clarity of purpose. From their perspective, the purpose of change was focused on the organisation, not on improving the delivery or outcomes of care or at least not having a significant impact on those outcomes. The system was seen as complex and not particularly adaptive, directly controlled by political/bureaucratic interests and limited in effectiveness by the impact of professional subcultures. It was perceived as being a system of non-coordinated and non-integrated parts.

The second finding, which continues to address the first two research aims and also addresses the third, fourth and fifth research aims, is that respondents were positively motivated towards the health management role. They described the role as contested, because of professional differences, and where they, the respondents, demonstrated duality in their views about who should manage. The accomplishment of the role in this study is described mostly in terms of sensemaking and demonstrates that respondents were motivated in the role by professional and personal values, the desire to influence and the challenge of the role. At the same time, they expressed feelings of lacking influence, control and having a lack of power in that role, being participants in change that is imposed, rather than being in active control of the change process. As stated in Chapters One and Two, the degree of power inherent in the health managers' role was not specifically explored in this study.

The third finding reflects the third and fourth research aims. The health managers identified the value of role models, the use of mentors and the importance of work-

based, informal and experiential learning, and tacit knowledge ahead of codified knowledge and formal learning. They valued opportunities for structured learning experience and felt that their learning and development was not supported at the organisation or health system level.

The fourth finding reflects the responses of the respondents to the challenges of the health system and their role in that system across the collective research aims of the study. The health manager respondents proposed solutions that require a more transparent health system with clarity of purpose and responsibility. This solution requires structural changes to clarify roles and to provide geographic region-based healthcare delivery. Funding and monitoring should be provided by one level of government, with service delivery through entities distinct from government and engaged with communities. They also suggested a need to increase the health system human resource capacity, through health workforce education and training reform, with an emphasis on contextualised health system knowledge and collaborative inter-professional practice, to enable more effective teamwork and coordination of care delivery.

### **6.3 Major conclusions**

The abovementioned findings led to four major conclusions. The first conclusion is that the proffered objectives of the emergent systemic archetype are not being achieved. The objectives of the emergent archetype are described fully in Table 6.1. They are characterised by a health system focused on population health, community and integrated care, program management, reduction in resource waste. While having democratic citizen control, the health system is under increased bureaucratic control and political engagement.

The perceived archetype of this study's respondents, their reality of the health system, is not consistent with the claimed characteristics of the emergent systemic archetype, except for acknowledging the increased bureaucratic control and increased political engagement of what is described as the systemic integrated health system (Denis et al. 1999). While the health manager respondents supported most of those characteristics of the emergent systemic archetype, there are inconsistencies between their reality of the

health system and those characteristics. The respondents' perceptions suggest that the dominant political/bureaucratic influence over the structural arrangements constrains the achievement of the archetype's implementation, providing a system that is still illness/hospital-focused, a system of parts that is slow to adapt and integrate and that is beset with constraints imposed by multiple funding streams and the impact of professional subcultures. The respondents' realities also indicate an inability on their part to have influence on the change process and the successful adoption of the preferred characteristics of the emergent archetype within the system.

The second conclusion is that to be effective in the health management role requires broad contextual knowledge of health systems and the policy and political contexts of those systems. This contextual knowledge and understanding is important in responding to the challenges described by the respondents. The need for broad contextual knowledge is described by the respondents and is also necessary for health managers in being able to manage what the respondents in this study described as constant change, contested roles and close bureaucratic and political engagement within the health system.

The third conclusion is that there needs to be better recognition, support and coordination of the education and professional development of health service managers by health providers, government, professional colleges and education providers to enable more effective implementation of health reform. The respondents in this study described how they are not central to the implementation of reform and believed they were not adequately supported in their education, training and development. Consequently, they are limited to an increased sensemaking role.

The final conclusion is that for health reform to be effective organisational and management approaches that provide a balanced and inclusive approach of structural interests are required. The respondents described a system that is overly influenced by bureaucratic and political interests and they suggested the need for greater community engagement and a separation and clarity of the roles of government, health departments and providers. This conclusion suggests a need for greater debate about the appropriate scale (size) of health providers and their relationship to government and the communities they are meant to serve. It also suggests more detailed consideration of

how best to provide adequate stewardship of health services and governance of health systems.

In this study the findings and conclusions represent a reasonable degree of consistency of views amongst the respondents, despite the diverse range of health professions and differing experience levels of the participants. These findings and conclusions are discussed in the following section

### **6.3 The findings and conclusions within the context of the Theoretical Framework and previous research**

The findings and conclusions of the study are discussed within the context of the Theoretical Framework that represents an eclectic approach utilising a range of appropriate theories drawn broadly from organisational theory, described in Chapter Two. This framework recognises the influence of the institutional theory perspective on change. Previous research, on the influence of archetypes and interpretative frameworks derived from neo-institutional theory and theories of complex adaptive systems in relation to change on the health management role and the influence of structural interests, was utilised. These theoretical approaches indicate the primary importance of sensemaking, so the theoretical concept of sensemaking is included in the framework. Sensemaking theory and complexity theory both recognise the importance of organisational learning as a component of change management and of the effective development of health managers. The findings and conclusions are discussed within the context of the Theoretical Framework and previous relevant research (described in Chapter Two).

#### **6.3.1 Finding 1 – A system of constant complex change, lacking clarity of purpose**

The first finding of this study indicates that the respondent health managers' perceived the health system as experiencing constant, complex change that lacks clarity of purpose and is focused on organisational arrangements rather than on the effective delivery of appropriate healthcare. This finding led to the conclusion that this perceived reality is inconsistent with the claimed characteristics of the emergent systemic archetype that has been implemented or is being implemented in most health systems (see Table 6.1). The respondents' archetype, constructed through their discourse and interpreted by this researcher, has similarities, differences, and inconsistencies with the emergent archetype of health systems described in the literature (Ransom Hinings & Greenwood

1980; Greenwood & Hinings 1993; Denis et al. 1999; Brock 2006). Table 6.1 provides a comparison between the respondents' archetype and an archetype constructed by this researcher from the work of Denis et al. (1999) and Brock (2006), and from the policy analysis of the Australian healthcare system by Dwyer (2004). This comparison indicates that the respondents' perceptions of some of the objectives of the emergent characteristics of the archetype are not being achieved and are inconsistent with the claims of their proponents. This is a significant conclusion from the first finding, given the proposed importance of these characteristics in justifying the need for change and to the success of reform. It should be of particular concern given that managers are central to, and charged with, the responsibility for implementing reform.

**Table 6.1:** Contrasting the characteristics of the emergent health system archetype with that described by the respondents to the study

<b>Emergent health system archetype <sup>1</sup></b>	<b>Respondents perceived health system archetype <sup>2</sup></b>
Population health driven	Illness/hospital system focus
Community care and integrated systems, continuity of care, increased role of primary care. Multidisciplinary practice	Non-adaptive, system of parts that is complex and slow to change
Democratic citizen control, accountable to government and community	Repressed patient and community interest
Growing bureaucracy and bureaucrats in control. Closely engaged, politically sensitive and complex	Highly bureaucratic and political top-down control
Questioning of boundaries. Radical change	Constant, complex and conflicting change based on restructure
Co-existing archetypes	Co-existing competing archetypes with silos of care, such as primary healthcare, public health and acute services
Program funding	Multiple funding streams and responsibilities
Reduction of waste and duplication. Sustainable spending, cost and activity constraint	Ineffective finance/budgeting and performance management systems
Global reach	Global comparison
Innovation through technology	Limited innovation and knowledge use

Notes: <sup>1</sup> The emergent health system archetype was constructed from the work of Denis et al. (1999), Brock (2006) and from the policy analysis of the Australian healthcare system by Dwyer (2004).

<sup>2</sup> The perceived health system archetype was developed from the perceptions of the health manager respondents to this study.

Overall, the respondents in this study accepted the need for change but were negative about the change experience because it has been constant and significant, though sometimes having little effect or value. These findings are consistent with Alford's (1975) structural interest perspective that questioned the purpose, value and effectiveness of change. The respondents' interpretative framework demonstrates strong values and a strong commitment to the public importance of the health system (public good), to their contribution to that system and to the managerial role. However, it should be of concern to policy makers, given the central role of managers in the change process, that the respondents' perception of the emergent archetype was not consistent with the characteristics claimed of the archetype by its proponents, the bureaucratic and political structural interests,

As previously mentioned, the distinctions drawn by the respondents are summarised in Table 6.1. They saw the system as substantially hospital and illness focused, despite their and the system's desire for a population-based wellness health system. They described a system that is not particularly adaptive to change and, despite integrative approaches, remains a system of parts, described by them as 'silos' within their networked organisations. This is in contrast with the emergent archetype that the proponents described as having characteristics based on community care with integration and continuity of care. The emergent archetype calls for democratic citizen control or at least accountability to community and government, whereas the findings of this study suggest minimal community engagement occurs. The respondents spoke of the impact of performance management and the constancy of change, while the emergent archetype claims integrated management structures. The one characteristic of the emergent archetype, where the respondents and the proponents of the archetype both agree, is the close engagement of the bureaucratic and political structural interests that demonstrates political sensitivity in the management role; the respondents, however, saw this in mostly negative terms.

It is likely that the espoused personal and professional values of these health managers are what sustain them in a system in which their perspective is reasonably negative. The respondents, as effective change agents, are most likely limited by the inconsistencies and contradictions between their values and interests and the structural features of the health system (Powell & DiMaggio 1991). These circumstances are consistent with the

findings of earlier research (Amis et al. 2002) that described organisational structures as shaped by members' understandings, interpretations, meanings and values, which give them purpose, and that within organisations there may be groups with differing conceptions, values and sectional interests. Given the intensity and duration of health system reform around structuring and the negative perceptions of the respondents about that reform, it would seem that the respondents have adapted their role to meet the situational exigencies without necessarily fully adopting the changed structural arrangements. This is consistent with the findings of Lozeau et al. (2002) that the positioned practice of professionals in health organisations is capable of corrupting the successful implementation of managerial techniques and is also capable of utilising the techniques for their purposes, which may not be consistent with the intended purpose. It is also consistent with the findings of Greenwood & Hinings (1993) that archetypes tend to move towards coherence and stability ahead of change.

The need to meet situational exigencies and adapt to limiting structural arrangements perhaps also explains the respondents' perception of being part of, rather than central to, reform. These perceptions are consistent with the findings of Ransom et al. (1980) that power holders institutionalise their power position through an order of domination (Weber 1949). It explains the increased sensemaking role, interpreted by this researcher as dominating the respondents' discourse about how they manage, because sensemaking is enacted in uncertain changed circumstances (Weick 1995). Health managers cannot substantially influence the reform or change process but to be successful in the role they need to make sense of it for themselves and for those whom they manage. These circumstances reinforce their negative perception of change as not being adaptive. This interpretation is consistent with research findings where management control is said to be diluted (weakened), irrespective of the formal structures that may be arranged, by the influence of the professions and their endeavours to cooperate with each other in enabling each other to operate effectively (Denis et al. 1999). This study demonstrates that those responsible for health system change at the systemic structural level may not have adequately engaged an important group, the health managers within the system, to the reform process.

The respondents also presented a negative view of the extent of the political/bureaucratic engagement and the control that entails. They accepted the

centralised, managerialist characteristic of the emergent archetype but expressed a belief that it is not effective in its performance, delivering inadequate funding and financing mechanisms. This requires the respondents to engage in a process of interpretation and sensemaking, mostly to their staff and, in some cases, their communities. The centralised nature of the archetype and change imposed is perceived as constant, complex, and conflictive and imposed.

The respondents' experience of reform confirms previous research findings that reform is often layered on existing structures. This results in some level of compromise, with solutions captured by the 'same dynamics that caused the problems they were intended to solve' (Denis et al. 1999:108). The dominance of the political/bureaucratic structural interests and of the professional subcultural influence, particularly that of the dominant medical profession, led respondents to express feelings of being constrained in their ability to influence and manage the change process. This is consistent with the theory of Ransom et al. (1980:8) that those in control 'institutionalise their province of meaning to become the interpretative frame of organisational members'. This perspective is also consistent with the findings and theoretical perspective of Lamothe (1996) and Denis et al. (1999:108) that 'emergent operating units, differentiated professional influence and diluted managerial control' are central to 'understanding the fate of boundary redefinition initiatives'.

The respondents also expressed these constraints on their ability to manage in terms of central organisational contexts, as being top-down, imposed and creating negative perceptions of the change and the constancy of its imposition. The central top-down approach to change suggests a sense of demoralisation at the management level that should also be a concern to those proponents of change where the manager is entrusted with the task of implementation. The reality of the respondents is consistent with previous research findings (Smith et al. 2001; Fitzgerald & Isaacs 2003; Rondeau & Wagner 2004). This 'demoralisation' was evident amongst a number of the respondents. The diluted managerial control perspective was described by a number of respondents, including a health manager with nursing qualifications who said that in reality health managers spend a lot of their time being told what to do rather than exercising a directing role.

The respondents' reality regarding a lack of influence and control is consistent with the structural interests theory of Alford (1975) and represents what Weber (1949) conceptualised as an order of domination (Ransom 1980:598). The emphasis on control is ineffective in complex adaptive systems (CAS), where managers should 'search for improvisational behaviour that enables innovation and creativity at all levels' (Anderson & McDaniel 2000:89). It also suggests that, at an organisational level, the emphasis in health systems is on formal systems rather than giving sufficient emphasis to informal systems, considered important in the complexity application model (CAM) of Dann and Barclay (2006), if change is to be successful. In this context, the respondents suggested that the bureaucracy is in the ascendancy and managers are not in a position to improvise, innovate, and be creative; this may also explain why what are considered complex systems are not seen to be adaptive by the respondents.

Earlier contexts of chief executive roles in public hospitals focused in part on coordinating, mediating and supporting the health professions and managing the organisation. The move of clinical professions into management places them in a position to implement change and shape reform, and allows them to move beyond issues of individual patient care and being subjected to change (Braithwaite & Goulston 2004). However, the perception of the respondents about their lack of influence and ability to control situations was relatively consistent across the clinically qualified health managers, including the generalist qualified health management respondents. This suggests that their perceptions have more to do with the structural systemic tight coupling, described in the previous paragraph, and this affects the health professions and generalists' managers in management equally.

These perceptions accord with previous research on the impact of change that suggests impacts of lost opportunity, lowered morale, commitment and productivity and disaffection with management (Smith et al. 2001; Rondeau & Wagar 2004; Oxman et al. 2005). The emphasis on performance management is also said to contribute to negative environments (Learmonth 2005). This provides difficult contexts for managers, who have to proclaim comprehensive benefit for their initiatives, while implementing restrictive measures over access (Rathwell & Persuad 2002). Recent Australian research by Liang et al. (2006) showed that, while health managers were supportive of reform aims, the necessity to accept blame on behalf of others, when expectations were not met

because of financial constraints, led to levels of insecurity, high turnover and burn out amongst that group.

In this study, the respondents believed that the health system is not particularly adaptive. The emergent systemic archetype has not been successful at integrating or providing continuity of care; it is slow to adapt and is resistant to change. Therefore, characteristics that suggest improvements in efficiency, effectiveness, and improved clinical outcomes of the emergent archetype are disputed by the respondents' archetype described in Table 6.1 and by the literature (Bigelow & Arndt 2000; Braithwaite et al. 2006). The literature suggests that reform actually increases administration levels and dissatisfaction with management (McConnell, 2000; Smith et al. 2001; Fitzgerald & Isaacs 2003; Hewison 2003; Rondeau & Wagar 2004). The respondents' perspectives also confirmed the layering or sedimentation of layers over existing structures because of restructure, as described by Cooper et al. (1996) and Lozeau (2002).

The perception of the respondents that change was focused on the organisation and did not impact on or make any difference to care has been described in Chapter Four and is consistent with previous research (Braithwaite 2005; Braithwaite et al. 2005). This study also reinforces earlier research that change is detached from the practitioner–client operational level and resides at the central policy level (Engestrom, Engestrom & Kerosuo 2003).

One of the respondents described health systems as organic and evolving; this description raises a number of issues relevant to the complexity of healthcare and the nature and direction of healthcare reform. The metaphorical description of the health system as a 'bike' reinforces the view of the health system as mechanistic and that reform is about restructuring the organisation, not the delivery of healthcare. This perception was also reinforced by many of the other respondents.

The ability to adapt, integrate and provide continuity, which are desirable attributes long sought by the health system, were seen by the respondents as difficult to achieve. The respondents described the limiting influence of the professions and the need to address inter-professional differences, if teamwork and integrative service delivery were to be achieved. The application of institutional theory and the typology of archetypes

underpinned by interpretative frameworks suggest that the values of organisational members underpin the organic nature of organisations. The respondents' perspective also supports the view that reform with an emphasis on these areas might be more productive (Braithwaite et al. 2005).

The lack of adaptation perceived by respondents at the unit and service delivery level reflects the negative impact of tightly-controlled coupling of organisations within highly centralised healthcare systems, rather than the managers' lack of willingness and capacity to innovate and adapt (Kernick 2003). Systemic integration, which crosses organisational boundaries, is said to increase the potential for intersectorial approaches, while diminishing organisational autonomy (Denis et al. 1999). Dwyer's (2004) review of health policy in Australia suggested that innovation might be more difficult in centralised bureaucratic organisations where control through micro-management dominates. However, one respondent discussed the potential for change to occur where stakeholders are engaged in the process when she described involvement with the General Metropolitan Task Force (GMTF), an initiative in one State health jurisdiction. The respondent believed this initiative demonstrated progress and described how it occurred across organisational boundaries (Braithwaite & Goulston 2004).

### **6.3.2 Finding 2 – Respondents were positively motivated towards the health management role, a contested role because of professional differences**

The respondents were mostly motivated to the health management role because of altruism, a desire to serve, positive professional and personal values, and the challenge of the role. They expressed these positive values and reasons for becoming health managers whilst having negative perceptions of being engaged in highly centralised bureaucratic health systems with tight coupling of provider units/services within those systems. The respondents' perspectives about their role support research findings that suggest the managerial role in healthcare is diluted (Denis et al. 1999).

The perceptions of the respondents about their role and the place of others as health managers are contested. Some respondents indicated that there was a need to put aside the differences and be able to look across the professions. This view is supported by the literature, which calls for a greater understanding of a broader range of professional

disciplines (Eraut 2005). The overriding discourse of the participants emphasised the importance of understanding differences in professional cultures and their impact on the management of health services. The professions represent a significant structural interest in the health system. The discourse of the respondents suggests that the professions are a dominating influence in how the health system functions. The medical profession exerts the most influence of all the professions on the major dominating political and bureaucratic structural interests (Alford 1975; Bloor & Dawson 1994; Thorne 2002; Degeling & Carr 2004).

The health manager respondents who were also clinically qualified felt strongly that their clinical experience was important to the role and gave them credibility with those they manage and with others with whom they engage. While their perceptions can be used as a justification for undertaking the management role, it does not reflect the findings of the literature (Bruce & Hill 1994; Forbes & Prime 1999; McConnell 2000; Degeling et al. 2001; Thorne 2002; Braithwaite 2004; Degeling & Carr 2004). The reality, as described in this study, is that there are differences and a duality in the views of and between the professions as managers, and between managers. This duality of views is about who should manage healthcare services. These differences in perceptions require a system response to emphasise the need for greater understanding of the influence of professional subcultures and the need for inter-professional learning for those who might aspire to the management role. This finding led to the second conclusion of the study that to be effective in the health management role requires a broad contextual knowledge of health systems and the policy and political contexts of those systems.

Health manager respondents, who had a prior clinical role, continued to profess a strong continuing attachment to that role ahead of the managerial role, or utilised their prior role as required in advancing their managerial role, or maintained some adherence to their traditional clinical roots, while being a manager. While these perceptions are strongly held, the literature suggests that managers are in fact limited by their dominant paradigm (McConnell 2000). While the perspective of the respondents was focused on the constituted role and their professional and educational backgrounds, the literature suggests the emphasis should be on engagement between those involved (Elliott & Reynolds 2002) and also indicates that separate identities will be retained despite

integrative attempts in respect to those identities (Harding 2005). These circumstances reinforce the need for health managers to have a detailed understanding of the various clinical professions and the contribution they bring to the delivery and management of healthcare and how they might best be managed.

This emphasis on the importance of clinical credibility might also be a justification for the rebalancing and realignment of clinical power into managerial roles, which is a re-assertion of the professions' self-regulating role through forging new roles that have a place in both service and management domains (Sutherland & Dawson 1998; Thorne 2002). Previous research into medical–managerial roles suggests that the roles are differentially perceived by senior management and the medical establishment (Bruce & Hill 1994; Thorne 2002; Braithwaite 2004) and similar differential perceptions are described for and within other professions, such as radiographers and the allied health professions in management (Forbes & Prime 1999; Law & Boyce 2003).

A number of respondents, both clinically and non-clinically trained, stressed the importance in health management of broad experience, and collegiate and collaborative approaches and teamwork in undertaking the health management role. Some of the clinically qualified respondents held this perspective but at the same time held the view that their clinical background provided an advantage. Some of the generalist health manager respondents suggested that a specific clinical background might in itself be limiting, given the need for a broad health context requirement to successfully undertake the role. Another generalist health manager was critical of the acceptance of clinical qualifications without management ability, experience and/or qualifications as being a requirement to fulfil the role. Again, these views are represented in the literature (McConnell 2000; Thorne 2002).

As described in Chapter Four, these mixed, differing and sometimes contradictory views of the health management respondents provide a finding that health managers not only have doubts about who should manage but express duality in those views and see the role as contested territory. This finding is consistent with the literature, which describes the professions as having 'different minds'; this means alliance between the professions is difficult (Degeling & Carr 2004:405). The contested nature of the roles

was also demonstrated by the respondents within their profession, between the professions and between the different possible combinations and levels of management.

The researcher, reflecting on personal experience, the perspectives of the respondents and the literature described in Chapter Two, agrees that healthcare is highly contextualised. This led to the conclusion that health managers require broad understanding of the nature of healthcare, the professions, and organisations. This leads the researcher to believe that a single clinical background, with or without health management qualifications and without broad health industry experience, is not sufficient in itself to claim adequate contextual knowledge and sovereignty in the health management role. This is particularly so where the objectives for education and development for the clinical role and the management role are opposite. Likewise, management qualifications of the non-clinician manager, without health management and health industry experience and knowledge, are similarly limiting. Therefore, this researcher concludes that the health management role requires a variety of skills, backgrounds, and disciplines to provide effective teamwork, with an objective to improve integration, continuity of care and intersectorial collaboration and this will be further discussed in 6.4 Implications for policy and practice.

The majority of the respondents were mostly motivated in their career by altruism and personal values and the challenge of the role. The clinically qualified health manager respondents indicated that they were motivated towards a management career because of limited clinical career opportunities and a desire to influence care across a greater number of people together with the challenge of the role. The move to a management career was also partly in response to either satisfaction or dissatisfaction with existing and prior management and a confidence in the latter case that they could do better. Generalist qualified health manager respondents were attracted to the role because of the uniqueness, the complexity and challenge of the role.

The concept of sensemaking became the major thread of the respondents' discourse, when asked to describe how they manage in the context of their perception of the health system. Sensemaking is social, and involves interaction with others to create shared meaning. This implies engagement and the respondents demonstrated the importance they place on the engagement of the full range of stakeholders, staff, colleagues,

patients, and communities, in order to make sense of and accomplish their role. Some of the generalist health managers demonstrated the importance of sensemaking by considering that health organisations are unique because they do not respond logically to normal market and economic signals. This distinction, and the need to make sense of it, was what drew them into the health system and the health management role.

The example, from two of the generalist health managers, described in Chapter Five, and briefly described in the above paragraph, demonstrates that organisations are created to justify the collective structure that gives meaning to the interdependent actions of people; an understanding of that meaning is influential in the ability of health managers to achieve their management objectives (Allard-Poesi 2005). These two respondents accepted the situation as given and different from their logic and paradigm or interpretative framework (Ford & Ford 1994) and they moved to make sense of that collective structure. In doing this, they are constituting themselves (Harding 2005) and are engaged in their identity construction within the organisation (Parry 2003), consistent with the iterative process described by Weick (1995).

The visioning and big picture view of the respondents is consistent with the presentation of logics, involving frameworks, paradigms, interpretative schemes, and worldviews, as the logic that gives understanding to change. If, as the respondents suggested, they have a vision and develop a 'big picture', they are in effect acquiring more than one logic, allowing alternative ways of making sense and enabling them to move between differing views, that is, being flexible (Ford & Ford 1994). This reinforces the interpretative aspects of sensemaking based on interpretation from experience (Cecez-Kecmanovic & Dalmaris 2000; Parry 2003). Evidence of sensemaking in the respondents' narratives can be seen in their discussion of the big picture and visioning, which reinforces both the uniqueness of the role and the importance of managers in healthcare having an understanding of the broad context of healthcare.

The emphasis of the study respondents on the importance of self-belief and self-confidence is also described in the literature (Eraut et al. 2000) in the context of an individual's willingness to participate in decision-making. This willingness is described as the degree of comfort or confidence with which individuals view their life balance, work, community, and family. These emotional dimensions of change, described as

*comfort* leading to maintenance of the status quo and *confidence* leading to the taking up of new challenges, and the perceptions of the respondents about the importance of self-confidence in undertaking their role are consistent with the literature (Eraut 2004), and consistent with the importance of identity and identity construction in sensemaking theory (Weick 1995; Parry 2003).

Resilience was described by the respondents as important for the fulfilment of their health management role, described in the literature as organisational resilience. This resilience is sourced from the improvisation and bricolage of those engaged with a readiness to assume roles, to achieve objectives, the application of wisdom and respectful interaction with others (Weick 2001). The importance of resilience is underscored by the challenge of constant complex change, which is the perceived reality of the respondents' health system, and by the constant, continuous, and conflicting demands of undertaking a sensemaking role. Resilience is an underpinning requirement of sensemaking because rules that define organisations are conveyed in diffuse contradictory terms (Harding 2005).

The respondents recognised that to be successful in the managerial role, they need to have a highly contextualised understanding of health. In the contested nature of the role between the professions, some respondents used their clinical background to demonstrate that having a clinical background advantaged them by providing that contextual health knowledge. Other respondents suggested that the requisite health contextual knowledge is in effect limited by a single and perhaps narrow clinical professional background. They, nonetheless, indicated the need to have a good understanding of self, to be flexible and resilient. They demonstrated high altruism, and stated they enjoy the challenge of the role with a desire to make a difference for people.

The respondents' views regarding the health management role are summarised in Table 6.2 and are compared to the roles described in a review of 14 prior studies carried out since the 1980s (Liang, Short & Brown 2006). Managing change was not described as part of the role by participants of this study, despite it being an enduring aspect of the respondents' perceived reality of the health system. The emphasis of the respondents suggests that they made sense of the change, rather than managing the change. These differences in terminology used by the respondents and that summarised from the

literature may be semantic. The different responses might reflect the varying composition of the groups and the purposes of the different studies. The inclusion of clinical governance and quality properly reflects the current emphasis in healthcare systems. The differences between the previous studies and this study may reflect that this is a more diverse group of respondents than those represented in the previous studies. This study generally confirms the findings of the past two decades of studies reported on by Liang, Short & Brown (2006), with the exception of the emphasis placed on sensemaking by the respondents in this study.

**Table 6.2:** Comparison of roles and responsibilities of health service managers (1980s to current)

Most important roles senior health managers – 1980s <sup>1</sup>	Most important roles senior health managers – 1990s– early 2000s <sup>1</sup>	Roles perceived by respondents in this study <sup>2</sup>
Organising	Leader	Leadership
Planning	Financial management	Financial management
Directing	Managing change	Making sense, filtering, creating understanding, converting ideas, finding common ground, orientating, explaining, demonstrating benefit, using retrospective view, flexible thinking, juggling competing interests and priorities, big picture, broad vision
Controlling	Coaching and mentoring	Managing people, managing self
Staffing	Motivating others	Communication, motivating,
	Liaising and networking	Decision-making
	Strategic decision-making and strategic planning	Strategic and business planning
		Clinical governance, quality service

<sup>1</sup> Adapted from Liang, Short & Brown (2006).

<sup>2</sup> Activities that suggest sensemaking are highlighted.

The extent of the respondents' data that describe a sensemaking role contrasts with the lack of discussion by the respondents around the other management roles described in Table 6.2. During the interviews, the health managers were asked about their role; the central problems and challenges and the positive aspects and frustrations of managing in a complex health system; the advice they might offer to less experienced managers; and what they, as managers, needed to learn to manage effectively. Despite these opportunities for the participants to address the wider range of management competencies and capabilities or to address organisational design issues or the functions of management, issues of sensemaking predominated and the other issues above were either absent from the discourse or only lightly traversed.

Table 6.3 summarises managerial approaches from the literature described by Anderson & McDaniel (2000) as key leadership tasks in professional bureaucracies and professional complex adaptive systems. These two approaches are compared to that described by the respondents as the major characteristics or activities of their role. While there are differences in the terminology used by the respondents, there is greater similarity in their terminology with that of approaches adopted to manage in a professional complex adaptive system than to those suggested as used in professional bureaucratic approaches. The perceptions of the respondents were also consistent with previous research that suggests health managers must become proficient at managing self and being self-motivated (McConnell 2000).

**Table 6.3:** Comparison of health management role approaches described by respondents to this study to managerial approaches in professional-based organisations described by Anderson and McDaniel 2000.

<b>Professional bureaucratic approaches<sup>1</sup></b>	<b>Professional complex adaptive systems approaches<sup>1</sup></b>	<b>Characteristics of a sensemaking role described by respondents in this study</b>
Role defining	Relationship building	Engagement Communication
Tight structuring	Loose coupling	Interpretation and understanding
Simplifying	Complicating	Flexible thinking
Socialising	Diversifying	Managing competing interests
Decision-making	Sensemaking	Critical thinking
Knowing	Learning	Big picture visioning
Controlling	Improvising	Understanding and managing self
Planning based on forecasting	Thinking about the future	Resilience and self-confidence

<sup>1</sup> Adapted from Anderson & McDaniel 2000:88.

The bureaucratic approach is inconsistent with the managerial approaches to complex adaptive systems (Anderson & McDaniel 2000), which includes sensemaking and the characteristics of the role described by the respondents in Table 6.3, that are consistent with the sensemaking role described by Weick (1993; 1995). These contrasted approaches most likely demonstrate why the respondents expressed a negative view of the health system, which is structurally bureaucratic and dominated by bureaucratic and political interests. This finding supports the view that healthcare organisations are complex and require a different organisational approach, as suggested by Kernick (2003). The ‘fourth way’, described by Kernick (2003), recognises the complexity view that organisations need to be managed at the edge of chaos rather than being tightly controlled and that the government role should be to provide a stable linear element, with policy making providing guiding principles. This approach allows hierarchies of interrelated networks, boundary exploration and non-linear interaction. It recognises the dynamic nature of organisations that emphasises vision and values, the importance of learning and the ability of managers to apply the managerial and sensemaking approaches (described in Table 6.3).

While the focus of the respondents was predominantly on the sensemaking role, they also indicated throughout the discourse what they thought to be important in accomplishing the managerial role. The respondents exhibited a high degree of cohesion about their perceptions of the health system. There was also consistency about how they perform the managerial role, despite differences in professional and educational backgrounds. This homogeneity did not extend to perceptions about who should perform that role. The literature also does not adequately describe or define the role and who might best occupy that role.

However, general assumptions supported by some recent Australian research (Liang, Short & Lawrence 2005), suggest that the impact of three decades of restructure/reform has seen a significant reduction in chief executive positions of stand-alone hospitals and health services. There has been a high turnover and a continued reduction of chief executive positions in area/district and network organisations and, although not quantified, a significant increase in the number of health professionals in health management roles, particularly nursing professionals. There is a perception, fostered by the political/bureaucratic structural interests to justify restructures at management levels, implying that the reduction of middle management levels will provide more resources for clinical services (Hill 2007).

The literature, however, does demonstrate that in Australia, in the inter-census period of 1996–2001, there was a 10.1% increase in management positions compared to an overall increase of the health and community workforce of 10.6%; this is far from a diminution of management positions in health and community service industries. There were also notable increases within health systems of business and computing professionals and business and computing associate professionals (44.5%) (AIHW 2003:673). These data demonstrate that over that period the growth in the health management workforce has mirrored the growth in the overall health workforce, but does not adequately describe where these positions may be situated in the health systems. This most probably reflects growth in the corporate areas within health systems, possibly at the expense of positions that previously managed health services and facilities. This finding is consistent with international research (Dopson & Stewart 1990; McConnell 2000; Hewison 2003) where the outcome of a compression, reduction, or delayering, particularly of middle management positions, often leads to displacement

to other, often lower, levels, rather than the proposed reduction being achieved. These strategies suggest that the role of middle managers is undervalued even when the changed role is often important and challenging.

The complex constantly changing nature of health systems, which are people dependant and which do not respond well to normal market, economic and commercial prescriptions, contributes to the view that the health management role might be unique. The claim to uniqueness is further reinforced by professional organisations being located within a centralised bureaucratic system with multiple professional disciplines involved in both the delivery and management of healthcare. The findings of this study suggest that the contested nature of the professions in health management might also contribute to the view that the role might be unique. The structural interests, described by Alford (1975), and the implications of professional subcultures (Friedson 1970) also point to a complex role, where the manager is often required to defend the system in the context of competing stakeholder and community interests (Rathwell & Persuad 2002). The literature, in supporting the above finding, also suggests that healthcare is a difficult concept, with widely shared responsibilities; both the art and science of healthcare are ‘critical to our well being’ (Anderson & McDaniel 2000:84).

The respondents described an inability to make a difference and to have influence, and being part of the delivery process rather than setting the agenda. These perceptions further inform the previous findings about the influence of structural interests and the constraining influence of institutional form and the professions within organisations. They also reflect the literature that suggests actors participate in reform to the extent necessary to position themselves appropriately to take particular directions or opportunities (Cooper et al. 1996; Reed 2001; Lozeau, Langley & Denis 2002).

### **6.3.3 Finding Three – the value of role models, the use of mentors and the importance of learning**

The respondents’ views about the value of role models and mentors is supported by the literature, which suggests that learning is both an individual and group activity, involving coaching, working with experts, sharing practice, teamwork and learning from others to develop a wider personal perspective (Eraut 2004). According to Eraut

(2004), organisational learning tends to focus on learning by the members of the workgroup rather than from them. Learning at work and from others is important and valued, but the effective use of knowledge already held by members of the organisation is limited (Eraut 2006). Learning is said to be facilitated through a combination of the knowledge forms, explicit, tacit, group and individual, in a focused education setting (Greener 2004). Previous research about the education of nurses and doctors supports the important impact of mentors on that learning (Braithwaite & Travaglia 2005).

Despite the emphasis placed on the value of work-based learning and the use of mentors and role models by the respondents, these approaches were mostly self-initiated practices of the respondents rather than strategic organisational practices. This lack of connection between the education and development needs of health managers and organisational practices to support that learning and development led to the third conclusion that there needs to be better recognition, support and coordination of the education and professional development of health service managers by health providers, government, professional colleges and education providers to enable more effective implementation of health reform.

One of the major influences on the respondents entering a health management career and the success of that career was the positive and/or negative influence of other managers as role models. The respondents were positive about the value of both formal and informal mentors. The influence of other managers was significant to the respondents both when they entered a management career and how they learnt the management role. Some of the respondents also saw the learning opportunity as motivation for a move to a management career. This is consistent with learning being a consequence of social action and of making sense of circumstances through ongoing learning and interpretation processes. In this context, status becomes a function of what you learn and how you apply that knowledge to the benefit of the system (Anderson & McDaniel 2000).

The respondents had a broad view of learning and the skills, competencies and capabilities required of health managers. They also reinforced the importance of informal experiential workplace-based learning, as described by Eraut (2006), and structured experience, described by McConnell (2000). This view is consistent with the

central place of both formal and informal learning in the complexity application model of Dann and Barclay (2006). The respondents strongly supported the need for structured experiential development of managers across a range of organisational levels. This is also consistent with the literature about prerequisites for a health management career (McConnell 2000).

Having confidence and being challenged were also seen as important by the respondents and are recognised in the literature as being important to learning and in the development of capability (Eraut 2004). The discourse on learning suggests that formal learning provides context, understanding, confidence, credibility, and critical analytical skills. The views of the respondents are consistent with previous research by Greener (2004), who indicated formal learning was not as valued as experience but it did provide credibility, improved networking; the contextual knowledge gained was valued ahead of explicit knowledge.

Respondents entered the health management role because of positive professional and personal values to serve, a desire to make a difference and influence care, and because of the challenge of the role. These findings are consistent with findings from other relevant research into motivators for learning (Eraut et al. 2000). The respondents were strongly of the view that there was a lack of adequate organisational support to the education and development of health service managers and that this stands in stark contrast to government-sponsored programs of the past, described by some of the respondents in Chapter Five.

For example, a generalist qualified health manager respondent made an important point about the effect on the ability to learn and to develop people as managers, when organisations are focused on strategies not conducive to this approach, such as short-term appointments and high turnover of managers, particularly senior people. Such an environment provides little opportunity and time for reflection and learning (Harris et al. 1998; Greener 2004). Willingness to learn is influenced by the agency or relationship of practitioners, groups and organisations, which suggests that learning and managing change requires partnership and support and cannot be left to managers and health professionals alone; rather it should be a shared responsibility (Eraut 2006). Otherwise health managers, with little commitment from employers and less easily discernable

career paths, will need to be more assertive and flexible in developing their careers than has been the case in the past (Harris et al. 1998). They might need to focus on capabilities of managing change, consultation and properly utilising the full resources of their workforce (Eraut et al. 2000).

The status quo self-replicating nature of training and learning perspectives of the respondents reflect the view that professional values and expertise, which are part of a person's self-concept, inhibit reform and innovation (Anderson & McDaniel 2000; Eraut 2004; Braithwaite & Travaglia 2005). The respondents' beliefs that prior clinical specific discipline training and learning experience is a barrier to multidisciplinary teamwork demonstrates the importance ascribed to a broader contextual understanding of healthcare and the difficulties of achieving effective multidisciplinary teamwork.

Importantly, respondents highlighted the need for more collaborative approaches to the management and delivery of healthcare (Braithwaite & Travaglia 2005) and not just in health management. The respondents believed that there is a need for increased inter-professional practice and a greater understanding of and between the roles, values and perspectives of the professions; this needs to be reflected in the education, training and practice of all health professionals (Cooper et al. 2004). Providing integrated complex care for chronic and often multiple conditions also suggests that collaboration is needed across agencies and inter-professional practice (Cooper et al. 2004; Braithwaite & Travaglia 2005).

#### **6.3.4 Finding four – Clarity of roles and responsibilities**

The respondents' solutions to the challenges they perceived the health system to be facing involved increased clarity of roles and responsibilities between funders and providers with a single level of government involvement and an enhanced human resource capacity for the health system. This led to the final conclusion that there needs to be a better balanced and more inclusive approach to what are currently competing structural interests. To achieve that balance, and to ensure a more community- and patient-centred approach to the organisation and delivery of health services, will require a greater engagement of the community in the governance of health services. The respondents proposed moving to a single level of government responsibility, with government having a funding role not a service delivery role. In addition to greater clarification of roles the respondents suggested regionalised delivery of healthcare.

Improved workforce planning and a greater emphasis on improving the human resource capacity are also supported by the respondents. The respondents' solutions reflect in part the claims for reform proposed by various structural interests (Dwyer 2004). These solutions and the potential for improved health reform they suggest are further discussed in the following section.

#### **6.4 Implications for policy and practice**

This section addresses the implications of the findings of this study for policy and practice in relation to health managers. The immense difficulty in achieving healthcare reform is recognised in this study and in these implications. The findings show that reform has not provided a system that is effectively integrated or that is particularly adaptive. The unrealistic limits placed on management effectiveness by the continued application of bureaucratic organisational and management structures and practices needs to be acknowledged as a limiting factor in healthcare reform.

The respondents confirmed their negative view of the health system bureaucratized and political focus and questioned if the reform of health systems into large, centrally controlled organisations has achieved integration and better coordination of healthcare services and more effective resource utilisation. The respondents called for clarity of roles, the removal of the provider role from government, and the placing of an entity, such as a health commission, between government and providers to be accountable for meeting government objectives. The respondents indicated that the engagement of communities in the management of health services was important.

The views of these respondents are consistent with the findings of other studies described in the literature and will need to be tested to see if they are consistent with and supported by the wider community and health industry stakeholder interests. This will require a process of public debate about the need for more appropriate health policy that involves governments, health departments, health professionals, industry associations, the general public and community advocacy groups, health researchers and academics.

Government at the State/Territory and National level should welcome and support a period of public debate before implementing changes to public policy. If government is not willing to respond, community groups, health researchers and industry stakeholders should increase public advocacy of the need for this debate. The following issues need to be addressed in the debate and should be developed as key objectives to be achieved in future healthcare reform:

1. Public policy needs to be about improving health outcomes and providing guidance (Kernick 2003) rather than detailed prescription to, and micromanagement of, providers in the delivery of health services. Therefore, public policy should establish frameworks of responsibility and cooperation at the program delivery level.
2. Effective models of community engagement need to be incorporated into agreed health policy frameworks. Better engagement of community interest in the governance of health services is necessary to reduce the adversarial position sometimes taken by and between structural interests and to improve community understanding and acceptance of the complex nature of health policy. Engagement with community interests in most Australian health jurisdictions at the present can only be described as advisory rather than direct engagement in governance.
3. Healthcare reform should be focused on the healthcare needs of communities and populations and the structural arrangements should be considered in the light of that focus. In the debate this will require agreement about which policy and practice is best delivered and managed at central and regional levels and that which is best left to more localised providers.
4. If public policy is focused on principles and guidance (Kernick 2003) rather than prescription and control this would then allow greater focus by organisations and management on governance and service delivery. Organisations would then need to be restructured to a scale that allows effective engagement of structural interests, stewardship of services and resources and

trust between stakeholders. This comprehensive approach suggests good governance.

5. Successful implementation of reform is more likely to be effective if it is delivered through organisations that have quality localised management and authority. The debate about what constitutes appropriate organisational structures needs to consider the following parameters:

- A need for alternative organisational arrangements that recognise one solution does not fit all circumstances because of diversity in the geographic location of populations as well as differences in culture, healthcare needs and a need to achieve inter-sectoral collaboration.
- Based on the findings of this study, the organisational arrangements should take into account how adequate levels of trust, stewardship and governance (Rathwell & Persuad 2002) can be restored to the health system.
- This debate needs to have a focus on how far those responsible for the delivery of care can be situated from the recipients of that care (Rathwell & Persuad 2002). The debate about the level of centralisation and decentralisation also needs to take into account that for managers to be effective they need to be able to manage down and out as well as up.

6. The inherent tensions between competing organisations and roles, according to the findings of this study, have not been satisfactorily addressed by their incorporation into large systemic organisations. To implement reform that achieves integration and adaptation requires debate to address changes to public policy that:

- Provide incentives for providers to change current practice and to allow them to form new organisational relationships with other providers to deliver new services or programs.
- Ensure that any additional or new funding at any level of government provision should be conditional on providers moving towards new organisational arrangements that improve the integration and delivery of care services.

This approach suggests a transitional approach model to reform based on partnerships and joint ventures of healthcare delivery organisations. Such an organisational arrangement would be encouraged to engage with other intersectorial agencies to improve service delivery locally through collaborative arrangements and to act as an agent for delivery of State and Commonwealth programs that have may have State and national application. This would allow existing services and facilities to be maintained while and until there has been transition into more appropriate and diverse organisational relationships. For this approach to be successful it will require an investment in highly qualified and competent managers.

In the context of a health system/industry that is highly regulated, where it is considered appropriate for health professionals to be registered, licensed and required to provide evidence of continuing professional development, it would also seem reasonable to suggest that those entrusted with the management of those health professionals and the stewardship of health resources should be required to meet similar standards. Professional health management colleges, educational organisations and health industry organisations should actively advocate for the registration of health managers that prescribes minimum standards of health management education, structured health system experience and continuing professional development.

Health managers have become accountable to the central systemic organisation and are required by that accountability and performance management regimes to manage up rather than down and out. There is a misalignment of vision and values between the systemic integration proponents and health managers. As a consequence of this approach, and consistent with the findings of this study, managers feel that they are part of but not central to reform, devaluing the importance of management. Managers have become passive participants in the change process rather than being in control or central to its implementation. Health policy and organisational reform implications already described in this section return health managers to a more central role in the reform and management of health services. Positioning health organisations as centralised or decentralised invokes issues about trust, stewardship, and governance (Rathwell & Persuad 2002) and the lack of recognition of and response to this issue place health

service managers in uncertain roles with unattainable and competing goals and objectives.

Systemic health systems require managers who are skilled to manage in a variety of health management contexts. The first context requires health managers to manage units, hospitals, health centres and services or operational departments. The second context requires managers who are skilled and have the capacity to manage in networks, partnerships, programs and alliances across organisational or health unit boundaries, implying more responsibility and seniority and, differing skills to the first group. The third context is for managers who are skilled in corporate and support services and, this group is required across both health unit and systemic systems roles at differing levels of responsibility and seniority. Health managers in each of these categorisations might aspire to senior health management career opportunities across those categories.

This preliminary categorisation of health management contexts is offered by the researcher based on the demographic characteristics of the respondents and their perceived reality of the management role, as described in this study. It is proposed as a starting point to address implications from this study regarding the education and development of health service managers to appropriately undertake health management roles within systemic health systems. According to the findings, these roles require:

- Greater contextual understanding, increased sensemaking, and a continuation of the important role of mediating professional and structural interests and boundary riding in these contexts. This approach places emphasis and importance on health managers' negotiating meaning, being active participants, constructors, organisers, and persuaders within health systems (Elliott & Reynolds 2002).
- Increased understanding of the powerful influence of professional subcultures and the constraining nature of that influence on healthcare reform. This influence is demonstrated in the contested nature of the professions in the management role and the respondents' recognition of the constraining influence of professional silos in delivering effective healthcare.
- Recognition that education of health managers and health professionals generally needs to extend beyond individual professional discipline-based backgrounds at the undergraduate and postgraduate level. Health managers need

to develop more than one logic (Ford & Ford 1994), so that they have a greater understanding of healthcare challenges that increase their sensemaking capacity, allowing them acceptance of and movement between differing points of view.

There will need to be greater emphasis in health management education on team-based, work-situated and collaborative learning that needs to more formally recognise both the value and contribution of informal and formal contexts of learning. This education will require greater engagement between professional colleges, health organisations and education and training institutions than is currently the case. It will also require a greater emphasis on continuing professional development to sustain improved collaborative practice.

Different contextual health experiences in the training of health managers are required to ensure that a health manager's learning broadens their understanding and provides greater appreciation of the complex health context. These approaches could best be achieved through a cooperative partnership of industry providers, professional colleges and education providers. The implication in this approach is that the health system requires an experiential training program for health managers to provide access to these varying contexts of experience. Selection of managers should require evidence of experiential learning in these different contexts. This experiential learning should be linked to the use of mentors and role models and should be recognised as part of the health manager's formal learning. Given the increasing global nature of healthcare and the health workforce, the learning should preferably be across national health system boundaries.

Government and health departments should invest in and support such an approach because short-term performance-based contractual relationships with health service managers and a lack of investment in their development are counter productive to long-term sustainable health system reform. Irrespective of government and health department commitment or otherwise, an alliance of key stakeholders could demonstrate to government, over time, the value of such an approach. This partnership could take a central leadership role in brokering training and education, together with work-based experience for health managers across organisational and system barriers.

This approach suggests the development of a cadre of highly skilled competent health managers, an approach that already exists to a limited extent in the approach to management training programs of organisations such as the ACHSE.

The strategies suggested will require the engagement of managers as learners, teachers, mentors and role models in which they would all be more effectively engaged in managing the constant change through learning (Eraut 2004). This will require a significant change in context to allow learning to occur and be effective. It will also require an environment different to that described by the respondents and by Liang et al. (2006) (described in more detail in Chapters Two, Four and Five). The practice of management of these services will require this cadre of well trained competent managers who, because they have been supported in their education and development, will hopefully, have a long-term commitment and loyalty to the health system and the achievement of its objectives. The implications are reliant on an enlightened approach to public policy, an appropriate organisational scale and a significant emphasis and investment in health management education to effect an improvement in health management practice.

### **6.5 The utility of the Theoretical Framework using an eclectic approach**

This research drew on a number of theoretical perspectives in the researcher's belief that an adequate understanding and interpretation of the lived experience of health service managers could not be obtained from the use of a single theoretical concept. This section describes the researcher's perspective of the utility of the Theoretical Framework to the study.

Building on the methodological approach of Heidegger's interpretative phenomenology, the Theoretical Framework utilised an eclectic approach using a number of theoretical perspectives to research the lived experiences of health managers. This eclectic approach was deemed necessary by the researcher because health managers are not uni-dimensional and their being is constituted and situated in a dynamic context, invariably described as a health system. The eclectic Theoretical Framework was developed from what the researcher believed were four broad theoretical influences on the health management role. These four broad areas included: organisational change within

systems; complexity theory and change in complex systems; theoretical perspectives of sensemaking; and structural interests.

The Theoretical Framework drew on neo-institutional organisation theory to describe change. Even though it is not regarded as a change theory, many researchers and theorists have used it to describe change and to develop archetype typology to describe change in system settings. These researchers include: Ransom et al. (1980), Greenwood & Hinings (1993), Amis et al. (2002), Brock et al. (1999, 2006) and Denis et al. (1999). Much of the research from which the archetype typology emerged also arose in the study of organisations dominated by professionals, including healthcare organisations. Institutional theory emphasises legitimacy and embeddedness, the regulative nature applied to organisations, and the influence of values and power. Neo-institutional theory extends this approach to networks of organisations within an organisational field, the influence of persistence in organisations and how change occurs. This then places the centre of interest on understanding change through the contribution of archetypes that focus on organisational dynamics (Greenwood & Hinings 1996). This theory demonstrates utility in this study because it takes into account both the organic and mechanistic nature of organisations, necessary in an analysis of a human phenomenon situated in a system structure.

The representation of organisations in terms of archetypes is also useful because it takes into account the institutionalised nature of the structure, its embeddedness and resistance to change, together with the interpretative framework of organisational actors that represent their preferences, values and actions within the organisational context. Greenwood and Hinings (1993) described archetype theory as based on two statements: organisational structures and management systems are best understood by analysis of overall patterns rather than narrowly defined organisational structures, and these patterns of ideas, beliefs and values provide the interpretative scheme that together with the structures and the systems defines the archetype. The value of neo-institutional theory and the typology of archetypes in healthcare research have also been demonstrated by Denis et al. (1999) and by Lamothe (1996). This theory and typology provided useful comparison with the archetype described by the respondents and informed the analysis of their discourse.

In the phenomenological nature of this study, this organisational perspective is important because it takes into account that health managers are situated in and constituted by the structure and the agency of the actors within the organisation. These theoretical approaches are interpretative. They are consistent with the theory of sensemaking in organisations and by the actors within organisations, justifying the inclusion of sensemaking theory in this study (Weick 1993:936). Sensemaking theory is relevant because in neo-institutional theory the organisations and actors are involved in constituting themselves through making sense of their circumstances. The application of sensemaking theory is very relevant because of the extensive discourse of the respondents trying to understand the system, describing how they managed in the system, including understanding themselves in these contexts.

The Theoretical Framework was further informed by the influence of the structural interests theory espoused by Alford (1975). Changes to the research study setting can be described over time by the position and influence of the various structural interests and how they have changed as health services developed. The theory, adapted to the Australian context, remains as relevant a descriptor of structural interests as it did when first developed. One of the major structural influences in health organisations is that of the professions, particularly the medical profession. The respondents effectively highlighted that interest and the close structural alignment of the political/bureaucratic interests.

The claim that healthcare organisations are also complex led to complexity theory being incorporated into the Theoretical Framework. This was adopted because of its application to health systems at the organisation level by Kernick (2003, 2006) and Anderson et al. (2000). The approach proposed by Dann & Barclay (2006) to organisational learning was utilised in this study to compare those approaches to the respondents' perceptions of the health system, how they manage and how they learn. The respondents described a number of characteristics of complex systems, while identifying that the characteristic of being adaptive was not particularly effective. This reflected the domination of central systemic bureaucratic approaches, also described by the respondents and consistent with the findings of Kernick (2003) and Anderson and McDaniel (2000). The value of the complexity application model (CAM) of Dann & Barclay (2006) clearly reflects the high value respondents placed on informal learning

as being important to organisational learning. The lack of emphasis placed on informal systems by the systemic archetype proponents suggests that to them learning and informal systems are not highly valued in the current systemic system.

Weick's (1993, 1995, 2001) sensemaking theory, given the analysis of the discourse as having a sensemaking role, was also effective in defining the health manager's role and describing how health managers manage in complex systems. The finding from the study about sensemaking also reinforced the consideration of complexity theory as proposed by Kernick (2003, 2006) and Anderson and McDaniel (2000), which helped demonstrate that health organisations are perceived by respondents as complex but not necessarily adaptive. Alford's (1975) structural interest theory, adapted to the Australian context for this study, remains consistent with the perceptions of the respondents and presents a constraining influence on change that emphasises a participative rather than central role for managers.

The utility of the Theoretical Framework and the emergent archetype concept supports Silverman's (2001:285) contention that accounts are situated, and that there are 'dangers in seeking to identify phenomena apart from these practices and the forms of representation which they embody'. The thematic analysis in Chapters Four and Five presented aspects of meanings of the respondents and the consistencies and differences in meanings between respondents, while the use of the emergent archetype allows those meanings to be described from an institutional perspective and compared and contrasted with the systemic emergent archetype described by previous research. Therefore, the respondents' perceptions are situated in the institutional perspective from which they derive their meaning and existence. This is also consistent with the post-modernist view that managers are active participants in constituting self and organisations (Harding 2005).

The utility of the Theoretical Framework is further supported by another conception of Silverman (2001:290) that through the treatment of the data we have to demonstrate how the 'elements we have identified are assembled or mutually laminated'. The Theoretical Framework and emergent archetype concept places the data into the social organisation in which the respondents reside and describes their perception of that reality. This approach demonstrates linkages between the archetype characteristics and

frames and the meanings of the respondents. The centralised tightly-coupled and political/bureaucratic conception of the health system is a frame described by the respondents. This frame can be linked to their feelings that their managerial role is contested and that they are participants in the change process, rather than being agents of change. This reality of the impact of that frame gives impetus to the promotion of the sensemaking role as a major focus of the managerial role, and the perception that the system is non-adaptive.

The use of this Theoretical Framework has enabled the researcher to demonstrate that the emphasis of health sector reform 'remains as Weber expressed it, to achieve more calculable and predictable control of organisational performance' (Weber year cited in Ransom et al. 1980:2). This approach has demonstrated it is consistent with research that members' actions can be inconsistent with the systemic emergent archetype, through the displacement of goals, subversion of roles and by amplification of rules that are seen as sensemaking by the respondent members. The use of the framework substantially demonstrated how the respondents accomplished their managerial role (Greenwood & Hinings 1993; Brock 2006).

The value of complex systems theory (Reason & Goodwin 1999; Kernick 2003) to this research is limited to its utility in providing different perceptions to how those engaged in complex organisations manage compared to the normative rationalist and functional approach to management described through the dominant bureaucratic model. The respondents did not agree with the perception in the literature that, if healthcare systems are complex, by definition, they are capable of adaptation (Plesk & Greenhalgh 2001). This perception is reinforced by their view that health systems are tightly-coupled and centrally-controlled, characteristics that are seen to limit innovation (Dwyer & Leggat 2002) while allowing reform (Denis et al. 1999).

This then brings into discussion Weick's (1993,1995, 2001) sensemaking component of the Theoretical Framework. Reason and Goodwin (1999) put the context as a science of qualities, where they see intuition and participation as central to knowing in complex systems, including organisations. They also suggested this is consistent with the phenomenological tradition of perception, understanding, and interpretation of meaning. Anderson and Mc Daniel (2000) put sensemaking into context in management practice

in complex organisations. Kernick (2003) called for vision and discourse within complex systems. The significant discourse of the respondents, described in Theme 2, is consistent with Weick's (1995) description and typology of sensemaking in organisations and the importance of this role in managerial practices in complex organisations. Dann et al. (2006) reinforced the central importance the respondents placed on learning, particularly informal learning.

## **6.6 Future research**

There has been little research in the Australian context that describes the perceptions, understandings, and interpretations of health service managers about the health system in which they are situated. Healthcare has been significantly changed and systemised, over the past three decades, and this change has materially affected the managerial role and those who practise that role. Given the centrality of health managers to the success of change and reform, it is suggested that further research in this area is required to confirm, extend or disconfirm the findings of this study in relation to other groups of health managers. This is important to improve understanding about how managers might be effective in managing within large centrally-controlled health systems. Any such research should include consideration of the short-term contracted tenure of managers and the application of performance management practices on effective long-term reform.

This study questions the effectiveness of current systemic reform and the efficacy of highly centralised health organisations, where government has become the funder, provider, and controller of healthcare delivery. The respondents in this study raised concerns over the value of this highly centralised, political/bureaucratic approach and further evaluative research might suggest other approaches to healthcare delivery and management. Such research needs to explore if one integrated health system can appropriately respond to multiple, competing needs, demands, and interests in the Australian context.

Research is also required to assess how best to bring diverse and important perspectives of the health professions into better alignment, to also broaden the contextual knowledge of health systems beyond that derived from a single discipline education and

experience to make more effective the contribution of the respective professions to both the delivery and management of healthcare. Such research should include how to utilise learning from the contributions of health professionals and their interactions as an approach to effective reform. This suggests a greater emphasis on collaborative action research to look at the effectiveness of that approach to learning by addressing common challenges.

There have been significant negative human resource consequences described in this study and other previously mentioned Australian research that suggests further wider research is important. The cost of the disengagement of management from initiating change and reform, the reported high turnover of management positions and the impact this might have on effective healthcare delivery reflects a financial cost to the system that means resources are not effectively utilised. It would be appropriate to extend the empirical base provided by this study and other contemporary Australian research (Liang et al. 2005, 2006). The perceptions of health managers gained from these initial studies might inform a larger study of health managers across Australia to enable greater generalisation of findings.

## **6.7 Conclusions**

In this chapter, the findings and conclusions of the respondent health managers have been presented and then discussed in the context of the Theoretical Framework used in this study. The implications of these findings for both health management practice and effective public health policy have been discussed. The chapter concludes with a recommendation for further research in this area.

A hermeneutic phenomenological approach was used to investigate the phenomenon of the lived experience of health service managers in a wide range of institutional and jurisdictional settings in Australia and New Zealand. The Theoretical Framework deliberately took into account a broad perspective of institutional theory, archetypes, and interpretative frameworks, change and learning theory and complexity and sensemaking in recognition of the major multidimensional influences on the health management role. Given the centralised and systemic organisational arrangement of

contemporary health services, this approach was considered necessary, appropriate, and effective in meeting the aims of this study.

In this context, the study was motivated by the researcher's long-term engagement as a health manager and commitment to the health industry and the profession of health management. That engagement and experience, described in Chapter One, was situated in three decades of reform to healthcare in the Australian context. The perspective of the researcher in this study reflects the approach of the Heidegger hermeneutic school of phenomenology.

For those who aspire to be health managers, this study demonstrates that they will require openness to opportunity to allow advancement in that career, based on merit, not by profession alone. They will need to demonstrate broad contextual health knowledge and understanding obtained through a variety of health service experiences, and preferably based on structured and supported opportunities to learn.

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## Appendices

## Appendix 1 – Interview schedule 1

1a). What do you consider to be the major drivers or forces of change that are impacting on the health system?
Prompts if required: Ageing population
<i>Technology</i>
<i>Capped finances</i>
<i>Increased demand</i>
<i>Consumerism</i>
1 b). What do you consider to be the implications of these changes for the health system and the role of health service manager?
2a). What do you consider to be the main management approaches utilised in health systems these days?
<i>Prompts if required: Organisational design</i>
<i>Strategy</i>
<i>Performance management</i>
<i>Improving performance/quality</i>
<i>Clinical governance/Risk management</i>
<i>Human resource development/Leadership</i>
<i>Knowledge/Learning organisation</i>
2b). What are the relative merits, strengths and weaknesses of these approaches?
3a). Can you discuss with me the relative merits, strengths and weaknesses of your professional and educational background in equipping you for a role/career of health service manager.
3b). Why and how did you become a health service manager?
3c). What are the key skills, capabilities and competencies to enable a health service manager to succeed in the current health system?
4a). What different skills, capabilities and competencies will be needed in the future for health service managers?
4b). How can future managers be supported and developed?
4c). What sort of services and organisations will they be managing?
4d). Given your health management experience and background what sort of advice would you be giving to the emerging managers?
4e). Would you encourage young people to pursue a career in health management?

## Appendix 2 – Interview schedule 2

Health services/systems as social constructs:
1. We all have different perceptions/views about what a health service/system is. Can you describe your perceptions and views (positive and negative) about what our/your health system is and how it works? In other words, what is your reality of the system you work in and your management role?
2. What do you see as the central problems of a health service manager in managing in the health system? (Lambert & McKeivitt 2002:210-213)
Culture and the Professions:
1. The professions have in the past dominated health care. It now seems that government policy and ‘managerialism’ dominates. What are your views? (Degeling et al. 2001: 36-48)
2. Managing health care is largely about engaging health professionals and about the community having confidence in the health care system. Can you comment? (Schneller & Ott 1996:121-136,)
Context and complexity – Managing complex adaptive systems:
1. Some researchers talk of health care as being ‘complex adaptive systems’ that are constantly evolving. What are your views? Is it possible to achieve certainty of structure, management and delivery of services into the future? (Plesk & Wilson 2001:746-749)
2. How do you manage in these circumstances? What is your advice to other managers, particularly those less experienced than you?
3. ‘Is the integration of health services working? What are its early consequences for patients? For providers, for communities? (Decter 2000:2).
Learning
1. What is it that managers have to learn to successfully manage health services?
2. Are we providing that learning and is it adequate?
3. Where is the emphasis required? Competencies, capability, teamwork, leadership, or followship?
4. How did you learn to be a manager? Did that adequately equip you for the role? (Eraut et al. 2000:231-262)
Personal context
1. How and why did you become a health service manager?
2. Would you encourage younger people to consider health management as a career?
3. In your experience as a health service manager, what has been the most negative and frustrating aspect or issue experienced in that role?
4. Again, in your experience as a health service manager, what has been the most positive and rewarding aspect or issue experienced in that role?

### Appendix 3 – Final interview schedule

<p><i>1. What are your perceptions and views of the health service/system (positive and negative). What are your perceptions about your role as a health manager?</i></p> <p>Prompt: This can be as broad as you like and doesn't necessarily require you to talk about your current circumstances, but more about your 'lived experience' so far.</p>
<p><i>2. What do you see as the central problems/challenges of a health service manager in managing in the health system?</i></p>
<p><i>3. The health system involves multiple stakeholders, government, the professions, and the community to name a few. Can you discuss this context and perhaps comment on who are the dominating forces?</i></p>
<p><i>4. (Researchers talk about health care delivery in terms of 'complex adaptive systems'). What are your views in this area, how do you manage in these circumstances?</i></p> <p>Prompt: What is your advice to other less experienced managers? Is the integration of health services working?</p>
<p><i>5. What is it that health managers have to learn to successfully manage health services?</i></p> <p>Prompts: How did you learn to be a manager? Is the learning provided in the health system adequate? Did that learning adequately equip you for the role? Where is the emphasis required?</p>
<p><i>6. How and why did you become a health manager?</i></p> <p>Prompts: Would you encourage others to consider a health management career? What is it that attracted you to this role, the power, glory or the challenges?</p>
<p><i>7. In your experience what has been the most negative and/or frustrating aspect/issue experienced in your health management role?</i></p>
<p><i>8. In your experience what is the most positive and/or rewarding aspect or issue experienced in that role?</i></p>
<p><i>9. What demonstrates the essence of a health system?</i></p> <p>Prompts: That is, what is it about a health system, a characteristic or value, or</p>

self-evident truth which some call axioms that are an essential element of a good health system? Can I ask that you make the statement short and if you wish, you can make more than one?

## Appendix 4 – Interviewee demographic data sheet

### Interviewee Demographic Data

To be completed at and prior to the interview. Please return to David Briggs at 7 Lawrence Avenue Tamworth, or by facsimile to 02 67655561

Your full name: .....

Your contact details:

Phone: .....Facsimile: .....

Mobile: .....Email: .....

Your current title/role and employing organisation:.....  
 .....  
 .....

Your primary clinical, technical or management qualifications:.....  
 .....  
 .....  
 (Qualification and awarding organisation)

Your secondary management qualifications.....  
 .....  
 .....  
 (Qualification and awarding organisation)

Please list the professional organisations, associations or colleges to which you belong and your level of membership.....  
 .....  
 .....

Are you working full-time ( ) part-time ( )

What are the total numbers of staff who report to you directly .....

Your age group:

Under 30 ( ) 31–35 ( ) 36–40 ( ) 41–45 ( ) 46–50 ( ) 51–55 ( )

56–60 ( ) 61–65 ( ) 66+ ( )

Sex: Male ( ) Female ( )

Thank you for your participation

David Briggs, Senior Lecturer  
 School of Health, UNE, Armidale  
 Phone: 02 67655398, Facsimile : 02 67655561, Mobile : 0411471203 Email: [dsbriggs@northnet.com.au](mailto:dsbriggs@northnet.com.au)

## Appendix 5 - Information sheet for research participants

**Research Title: To explore and analyse the lived experience of health service managers**

**Persons responsible:** David Briggs – PhD candidate.  
Contact: School of Health, UNE  
Phone: 02 67655398.  
Email: [dsbriggs@northnet.com.au](mailto:dsbriggs@northnet.com.au)

Dr. Lyn Irwin – Supervisor. Contact: School of Health,  
UNE. Phone: 02 67733679  
Email: [lirwin@metz.une.edu.au](mailto:lirwin@metz.une.edu.au)

Dr. Mary Cruickshank – Supervisor. Contact: School of  
Health, UNE. Phone: 67733640  
Email: [mmcarty@metz.une.edu.au](mailto:mmcarty@metz.une.edu.au)

**Dear Colleague,**

I am inviting you to assist me in undertaking the above research by voluntarily participating in an interview with me. The purpose of the research being undertaken, as part of study towards a PhD, is to explore the following issues from the personal professional perspective of health service managers. The specific aims of the research are to:

- Gain greater description and depth of understanding to the role of the health service manager.
- Examine changes and trends in the description, nature and role of the health service manager over time, consistent with changes in the evolution of the health care systems.
- Explore the personal professional perspectives of health service managers in respect to the major change influences impacting on health care systems.
- Explore the personal professional perspectives of health service managers in respect to contemporary management practices.
- Identify capabilities required for health service managers to manage complexity and uncertainty into the future.
- Identify (if any) differences in perceptions and professional practice of health service managers on the basis of professional and management education backgrounds

The research involves interviews with a sample of health service managers. The interviews will consist of semi-structured questions that will address the purpose of the research as described above and will involve questions that will focus on your perceptions of:

- The health system and forces of change that are impacting on health systems
- The role of professions, managers and government in health systems
- Managing in complex health systems
- Your experience and views about 'learning health management'
- Your personal experiences and views about your role as a health manager

### **Participation**

You are invited to participate in this research **to present your own personal and professional views** on the research topic outside of your organisational context. Your participation is entirely voluntary and you are entitled to withdraw from participation at any time, without penalty. The results of the research will ultimately be published and made available to you and colleagues through publication in professional journals and at appropriate conferences.

With your approval, it is proposed to audiotape the interview. The purpose is to enable your interview to be transcribed and analysed. Your personal details will not be disclosed and the transcription of the interview will only identify you by a code number. It is anticipated that the interview/discussion may take an hour of your time. It can be conducted in a place and at a time that is suitable and convenient to you personally. All data from interviews will be de-identified and aggregated for analysis and subsequent publication and there will be no linkage of data to any individual interviewed. All transcription and tapes will be retained in a locked cupboard in the researcher's office until the research is completed and will be retained in that manner for up to five years when it will be destroyed.

Given the nature of this research and the fact that it is collegiate and of mutual professional interest, it is not anticipated that it will raise any personal or upsetting issues, but if it does you may wish to contact your local Community Health Centre.

From the commencement of this research it is anticipated that it may take some three years to complete and publish. If you have any questions regarding this project at any time during the research my supervisors and I remain available to answer your questions.

This project has been approved by the Human Research Ethics Committee of the University of New England (Approval No HE03/205, valid to 15/6/05)

Should you have any complaints concerning the manner in which this research is conducted, please contact the Research Ethics Officer at the following address:

Research Services  
University of New England  
Armidale, NSW 2351.  
Telephone: (02) 6773 3449 Facsimile (02) 6773 3543  
Email: [Ethics@metz.une.edu.au](mailto:Ethics@metz.une.edu.au)

Thank you for your willingness to consider participating in this research.

David Briggs  
Senior Lecturer  
School of Health  
University of New England  
Phone: 02 67655398  
Mobile: 0411 471 203  
Facsimile: 02 67655561  
Email: [dsbriggs@northnet.com.au](mailto:dsbriggs@northnet.com.au)

## Appendix 6 – Consent form



### School of Health

Armidale, NSW 2351 Australia

Head of School: Dr Jeanne Madison

#### Research Proposal: The Lived Experience of Health Service Managers

**Persons Responsible:** David Briggs – PhD candidate. Contact: School of Health, UNE. Phone 02 67655398.  
Email [dsbriggs@northnet.com.au](mailto:dsbriggs@northnet.com.au)

Dr. Lyn Irwin – Supervisor. Contact: School of Health, UNE. Phone 02 67733679  
Email: [lirwin@metz.une.edu.au](mailto:lirwin@metz.une.edu.au)

Dr. Mary Cruickshank – Supervisor. Contact: School of Health, UNE. Phone: 67733640  
Email: [mmcarty@metz.une.edu.au](mailto:mmcarty@metz.une.edu.au)

#### Consent

*I ..... have read the information contained in the Information Sheet for Research participants and any questions that I have asked have been answered to my satisfaction. I agree to participate in this activity, realising that I may withdraw at any time. I am also giving my consent to the audio taping of my interview and I agree that research data gathered for the study may be published, provided my name is not used. I agree to provide the following personal information which I understand is only to be used to correctly identify which sub-set of health service managers, I should correctly be allocated to for the purpose of this research and which will not otherwise be disclosed or used. I further confirm that I'm over the age of 18 years.*

.....

.....

*Participant or Authorised representative*

*Date*

.....

.....

*Investigator*

*Date*

***Please complete and return this form to David Briggs 7 Lawrence Avenue Tamworth NSW 2340 or facsimile: 02 6765556. You will subsequently be contacted by David Briggs to arrange a mutually satisfactory time and place for the interview. Thank you for agreeing to participate.***

***David Briggs***

## Appendix 7 – UNE Human research ethics committee approval

Fiona Prater [Ethics@pobox.une.edu.au](mailto:Ethics@pobox.une.edu.au)

Monday, 15 December 2003 10:23 AM

David Briggs [dsbriggs@northnet.com.au](mailto:dsbriggs@northnet.com.au)

RE: Ethics approval

Dear David,

Thank you for your response to the HREC conditions of approval.

You have met the conditions of approval in full. Your approval number is: HE03/205, valid until 15/6/05.

The Human Research Ethics Committee may grant approval for up to a maximum of three years.

For approval periods greater than 12 months, researchers are required to submit an application for renewal at each twelve-month period. All researchers are required to submit a Final Report at the completion of their project. The Renewal/Final Report Form is available at the following web address: [http://rs-nt-10.une.edu.au/Home/V\\_2\\_1/ecforms.html](http://rs-nt-10.une.edu.au/Home/V_2_1/ecforms.html)

The *NHMRC National Statement on Ethical Conduct in Research Involving Humans* requires that researchers must report immediately to the Human Research Ethics Committee anything that might affect ethical acceptance of the protocol. This includes adverse reactions of participants, proposed changes in the protocol, and any other unforeseen events that might affect the continued ethical acceptability of the project.

Good luck with your research.

Regards, Fiona.

Fiona Prater  
Research Ethics Officer  
University of New England  
Armidale NSW 2351  
Ph: 02 6773 3449  
Fax: 02 6773 3543  
E-mail: [Ethics@pobox.une.edu.au](mailto:Ethics@pobox.une.edu.au)

**Extension Approval**

<b>6</b>	<b>Dr L Irwin/Dr M Cruickshank/Mr D Briggs</b>	<b>To explore and analyse the educational and professional development of health service managers</b> <b>Extension Application- HE03/205</b>	
<b>Extension Application- HE03/205 - Approved</b>			

## **Appendix 8 – ACHSE approval**



Australian College of Health Services Executives  
PO Box 34 North Ryde NSW 1570 Australia  
Telephone: 61 2 9673 5052 Facsimile: 61 2 9673 2172 www.achse.org.au

7 August, 2003

Mr D Briggs FCHSE  
"HAKEA"  
TAMWORTH NSW 2340

### Research Proposal

Dear David,

Thank you for your recent letter outlining your proposed PhD research protocol and requesting access to certain ACHSE member information.


Federal Council has considered your request and has agreed for you to have access to the College Membership data base for your research.

Such access would limit you to drawing information that does not contain member identity or contact details. Federal Council also would require that any subsequent research undertaken in terms of any personal contacts, initiated by you, with persons whose information is on the College data base, is not facilitated by your access to ACHSE information.

The College is delighted that you are undertaking your research and will assist along the lines above. Should you require any other assistance, this can be discussed in the context of ACHSE policy on facilitating health management research.

Federal Council wishes you every success.

Yours sincerely,  
*Bill Lawrence*  
Bill Lawrence  
National Director

Supplied to  
  
for research

## Appendix 9 – Transcriber confidentiality form



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### School of Health

Armidale, NSW 2351 Australia

Head of School: Dr Jeanne Madison

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#### Confidentiality Agreement

I ..... of ..... Secretarial Services understand that material being transcribed for David Briggs is research material being gathered as part of PhD research and as such is provided to the researcher on a confidential basis.

In undertaking transcription of this material, I hereby agree to maintain confidentiality about the individuals involved and named in the documents as well as the contents of the matters disclosed in the transcription. I further agree to maintain that material whilst in my possession in a secure environment and not provide access to other persons.

.....  
Signature

.....  
Date