

# The lived experience of health reform in rural New South Wales during the 1990s

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## Introduction

During the 1980s and 1990s governments in Australia and globally were concerned about the escalation of health costs.<sup>1</sup> Governments adopted a number of strategies to reduce the rise in health expenditure including the repeated restructures of health services. This research looks at the health reform process which occurred in a rural setting involving three organisational models over a three year period.

In the mid 1980s the NSW Department of Health restructured metropolitan health services.<sup>2</sup> The model across the rural areas of the State was organised around six regions with hospital having a governance structure of individual hospital boards until 1993.<sup>3</sup> In 1993 the government announced a new organisational structure of twenty three District Health Services.<sup>4,5</sup> The goal was to achieve thirty million dollars in administrative savings which was to be redirected into clinical care.

Three years later in 1996 following a change of government the District health model was dissolved and an Area health service model of eight areas implemented across rural NSW.<sup>6</sup> The reforms were designed to reduce operational costs associated with delivering health care and directing the savings into improved clinical services. During the period of the restructuring recognition was being given to the socioeconomic determinants of health and the implications of geography on health outcomes.<sup>7,8,9</sup>

## Methods

The intent of the study was to reveal the experiences of the participants who worked in the context and timeframe (1990-2000). The data collection was undertaken using oral history methodology.<sup>10</sup> Oral histories complement existing documentary sources but contribute a unique and authentic perspective to the historical record in their own right.<sup>11</sup>

The use of primary and secondary historical sources were used to reveal multiple realities: the history from the documents outlined decisions by government, professional groups, unions, and community groups; the oral histories collected from participants were linked to a chronology informed by the documents; the recording of the participants' experiences preserved the memories of those who had lived and worked through the rural health restructures.

Ethical approval was obtained from the Charles Sturt University Ethics in Human Research Committee. Nine people were recruited to participate in the study. The participants included senior executives who met the criteria for inclusion, which was that participants were to have been employed in the rural health system in a senior managerial role during the 1990s.

The researcher collected the oral histories from the participants, one face to face and the remaining eight by telephone. The oral histories were transcribed by the researcher.

Following each interview the completed transcript was read several times using margins to note anything of significance or of interest. Potential themes were isolated so that each theme stood alone. The themes in each transcript were listed and then, following the same process for each of the additional transcripts, the identified themes were examined in detail. The process of identifying similarities between the themes in the different transcripts was undertaken.

In contrast, there were other experiences described by perhaps only one or two of the participants which were considered to be worthy of consideration and incorporated into the final findings. The number of themes was expanded and changed as more of the transcripts were analysed. The aim was to pull together a number of themes that were common in several of the participant’s experiences. New themes began to emerge in the later interviews and, while similar, these themes emerged or were identified in material previously overlooked.

The thematic analysis followed five months of collection and transcription. Themes were identified by ‘bringing together components or fragments of ideas or experiences, which often are meaningless when viewed alone’.<sup>12</sup> The identification of themes took place over the 12 months after the oral histories were collected. The text was analysed using a thematic process informed by Foucault<sup>13</sup>, Lukes<sup>14</sup> and Bourdieu.<sup>15</sup>

## Results

1	Cluster	Themes
	Theme 1—The general agreement that a move to a geographic model of health care	
2	Theme 2—The Political Influence during the Rural Health Reforms	Theme 3: Politicisation of the Change Management Process Theme 4: Assumptions that financial savings occurred Theme 5: Assumption that metro-centric model of health care would work in rural areas
3	Theme 6—The lack of regard for people	Theme 7: Loss of people, expertise and knowledge from rural health services Theme 8: Loss of capacity within rural health services

The thematic analysis identified eight common themes. The eight themes have been further clustered around three main findings from the participants’ experience. The first cluster and theme which stood alone was the general agreement that a move to a geographic model of health care was needed.

The second cluster of themes was around the highly political environment in which the participants worked. Themes included the strong political influences operating, the government’s justification of the health reforms, and the rhetoric surrounding cost savings being redirected back to rural health services. A third cluster of themes related to the lack of regard for people, poor treatment of staff during the change management processes leading to loss of expertise from the rural health workforce.

The first theme was the agreement that a change to an organisational model of health care across geographic areas was an appropriate action for government to take at the time. Participants believed that the Area Health Service model had been operating in metropolitan areas since 1986 should be adopted.

The second major cluster of themes was the highly political nature of rural health practice during the period under investigation. Health care and the political environment are intertwined. The level of health services provided in an area is dependent on government’s capacity to pay. Participants identified that the political nature of their practice and recognised the influence of global and economic rationalisation on the NSW government agendas.

Continuing in this cluster of themes is around the highly political environment of the rural health reforms. The change management approach employed by government raised concerns with participants. The fourth theme was around the justification used by government of the first restructure, where significant administrative

savings were to be achieved and redirected into increased clinical services in rural areas.<sup>16,17</sup> The participants identified the savings being achieved but limited evidence of the funds being redirected back into rural areas.

The final theme as part of the highly political environment of health relates to the political influences of the metropolitan health services on models of health care operating across the State. The ever increasing financial pressure on all health services increased political imperatives to identify savings, which resulted according to participants of the redirection of resources from rural health services to the metropolitan health services.

The third cluster of themes common throughout the participants' experiences was the lack of regard for people. The sixth theme related to the poor treatment of staff and community representatives. It included both senior people working in the health system and the community members who had contributed to community through membership of the hospital boards.

Theme seven was the loss of people, expertise and knowledge from rural health services.

The successive nature of the changes following the announcement in 1993 of the District Health Services resulted in a loss of significant numbers of health staff from rural health services. Initially it related to staff from the former Regional offices through to the high turnover of staff as the boundaries and service restructured again in 1996 moving from three Districts to eight rural Area health services. Government offers of redundancy to reduce staff numbers resulted in a further loss of people and services from the rural health services. The final theme identified the loss of capacity of the rural health services to effectively deliver the outcomes expected from the reforms.

The 1990s was a time of rural health activism where clinical workforce issues dominated the national rural health agenda. During the same period in rural NSW while clinical workforce issues were prominent there was a lack of awareness by government that health service management was also a scarce commodity for rural health services. Despite the need for skills managers to progress a health reform agenda, the participants' stories from this study identify that the high turnover of these health professionals impacted upon the government's ability to deliver on its health reform agenda.

The voices from the participants of the study give strength to the study as they articulate the challenges senior managers faced as they implemented the governments of the days health reform agenda. The participants maintained that they implemented strategies in accord with policy directives to reduce expenditure. Overwhelmingly they were disenfranchised as they believe the reinvestments of savings were not prioritised.

## Discussion

The 1990s in Australia Braithwaite<sup>18</sup> described as the health service management revolution was an attempt by as governments trying to addressing the escalation of health costs reaching Australian governments in the 1990s. This period of change occurred concurrently with global reform of the public sector as a result of a change in political thinking which has been titled the 'New Public Management'.<sup>19</sup>

Political ideologies in western liberal democracies shifted towards free market economies and small governments.<sup>20</sup> It was an environment where economic rationalists dominated and competitive reform challenged the traditional managerial and professional cultures on which the traditional health services had operated for many years.<sup>21,22</sup>

Health care and the political environment are intertwined. The level of health services provided in an area is dependent on government's capacity to pay. Participants identified that the political nature of their practice and recognised the influence of global and economic rationalisation on the NSW government agendas. The participants related an escalation of political interference and management from the Health Ministers' office and the Department of Health during the periods of organisational change.

The literature on effective organisational change<sup>23</sup> describes the types of change management strategies are dependant on the organisational circumstances. The model used by the NSW health system in both the restructures from health Regions to Districts and then to Areas was one described as 'change by decree'.<sup>24</sup> These models are often ineffective. While there may be circumstances for organisation that it may be necessary to apply these methods, Dunphy and Dick<sup>25</sup> acknowledge that such action is often taken in the naïve belief that re-drawing the organisational structure can change organisational culture. These wrong

assumptions result in confusion, conflict, and low morale, rather than more effective performance. The participants provided evidence that the authors were accurate in their theorising.

The change approach by edict was one which usually worked well in the past in traditional and authoritarian societies when organisations were smaller than most government departments and companies today. The manager of today must coordinate or reconcile the differing and conflicting interests of various stakeholders. The highly professionalised nature of the health workforce is one which also makes the change by edict a difficult approach to achieve. Hastings<sup>26</sup> has described the challenges of the health workforce as the tensions between the various levels of management between those responsible for control and the staff working within the health service.

The huge disruption for health staff working through organisational reforms and the limited evidence of the achievement of financial gain has been identified in recent work by organisational scholars.<sup>27,28,29,30</sup> Braithwaite argued that health authorities should look beyond the structure at what really matters 'the way in which people provide the services to patients, how they relate to each other and their clients, and how teams work. Money spent on restructuring could be turned into investment in people delivering care'.<sup>31</sup>

The experiences of the participants of the study describe the difficulties of meeting the stated health reforms goals of improving health outcomes through the redirection of savings into clinical services. The research of the time was identifying that people in rural areas were experiencing poorer health outcomes. Improved health for these people would be obtained by addressing the socioeconomic determinants of health and improving access and not alone by an increase and access to clinical services. The lack of equity for rural health services has been drawn to the attention of health researchers and policy makers.<sup>32</sup>

## Conclusion

The findings from this study identified that in an environment of health disadvantage that organisational restructure aimed at improving delivery of health services failed to achieve the desired outcomes. The managers charged with the implementation of the reforms were able to make administrative savings but these were not incorporated back into the future budgetary allocation for the rural health service but allegedly redirected to the central agency.

The limitations this study relate to the use of oral history methodology as an approach to research. The subjective nature of historical memory however does not detract from its value. Portelli<sup>33</sup> states that oral histories are more than eye witness accounts that are either true or false but it is important to look for the themes and structures of the stories. A further limitation of the study is the number of participants.

The lessons from this study relate to the approach taken by governments and senior health bureaucracies in important resources of the whole health workforce both clinical and managerial in working in a consultative manner in the implementation of health reforms in an environment of health disadvantage and workforce shortage.

Gleeson clearly articulates the disparity between urban and rural services<sup>34</sup> and Humphreys<sup>35</sup> while the findings from the participants' experiences sustain the argument. These are powerful voices clearly and consistently revealing how centralised health and centralised policy failed to deliver the promise of improved health outcomes for rural people through health reforms during the 1990s.

The participants of this study, senior managers, and their community representatives have identified that this is an area for further investigation and research. Their views will remain unheard while a centralised bureaucracy a thousand kilometres or more away making decisions on rural health. Health needs of a population have been shown to be expendable when the decision-making processes are driven by the most politically acceptable solution for the government of the day.

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