Healthcare reform in New South Wales 1986–1999: using the literature to predict the impact on senior health executives

Zhan Ming Liang, Stephanie D Short and Bill Lawrence

Abstract

While numerous reviews have examined the changing roles, skills, competencies, and educational needs of health service managers as the result of health care reforms, no study has focused specifically on the impact of New South Wales health reforms on the roles, responsibilities and behaviours of senior health executives in the public health sector. This paper briefly illustrates the significant changes in New South Wales health management since 1986. It also examines the forces behind these changes and predicts their impact on NSW Senior Health Executives based on national and international literature, and provides a foundation for further empirical research.

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What is known about the topic?

The literature suggests senior managers in health care systems around the world have experienced changing roles, responsibilities, accountabilities and required competencies.

What does this study add?

This paper outlines the health sector reforms in NSW since 1986 and relates the findings of an international literature review to these reforms, with the suggestion that NSW senior health managers would experience high turnover and burn-out, changes in career paths, convergence of new roles, skills and competencies and the need for higher educational qualifications.

What are the implications for practice?

The authors have identified the need for further study to confirm the impact of the NSW system reforms on senior health executives.

THIS PAPER EXPLORES THE CHANGES to the senior health executive workforce in the public sector since 1986 brought about by health reforms in New South Wales. Most notable was the introduction of the area health service model to the Sydney metropolitan area in 1986 and to regional areas in 1993. The study builds on relevant previous research conducted internationally, nationally and in NSW.

Zhan Ming Liang, MB BS, MSc, Lecturer
Stephanie D Short, PhD, MSC, BA, Head
School of Public Health, Griffith University, Brisbane, QLD.
Bill Lawrence, BA, MHA, National Director
Australian College of Health Service Executives, Northern Sydney Education Centre, Sydney, NSW.
Correspondence: Ms Zhan Ming Liang, School of Public Health, Griffith University, L05, 4.61, Logan Campus, University Drive, Meadowbrook, Brisbane, QLD 4134.
ming.liang@griffith.edu.au

There is considerable literature examining the necessary skills, competencies and educational needs of senior health managers, but limited literature on the Australian experience of what these managers really do. Moreover, no paper has comprehensively addressed the impact of health care reforms. This paper, from a broad perspective, aims to provide an overview of the NSW reforms, forces behind the reforms, and the effects the reforms may have had on senior health managers as predicted by national and international literature.

New South Wales health service management 1986–1999

The structural reform in the New South Wales health system was marked by the introduction of the area management model in 1986.[1] This model is a refined version of the regionalised

health service administration model first put forward in the 1960s in the Starr Committee Reports. The early stage (since the early 1970s) of the area management model was the emergence of regions under individual regional offices with delegated powers.

Implementation of the area management model proved difficult in some regions, especially within the large Sydney metropolitan region. The size of these regions made the estimation of local needs and local planning extremely difficult. This brought about the need for a further tier of "areas",[2] creating a simpler, more efficient organisational structure for administration and planning purposes.[3] Following the establishment of the Department of Health under the *Health Administration Act* (NSW) in 1982, four Area Health Boards covering 15 areas were soon piloted and then examined. A review of the four pilot Area Health Boards, commissioned by the Deputy Premier and Minister for Health in July 1985, regarded "area" as the most appropriate level to meet the various criteria for comprehensive high quality services provision, cost efficiency, coordination and responsiveness to local communities.[4]

In May 1986, the *Area Health Services Act* (NSW) was passed to provide the legislative basis for the establishment of Area Health Services (AHSs) in Sydney, the Central Coast, Illawarra and the Hunter from October 1986.[5] Initially, 23 Area Health Boards, replacing all individual hospital boards, were established to be responsible for the day-to-day management of all public hospitals and community health services.[6] In June 1988 the boundaries of AHSs were redrawn and the number of Areas was reduced to ten.

The five regional offices — the three Sydney Metropolitan Regions, the Hunter and the Illawarra Regions — were not abolished until 2 years after the establishment of the Area Health Boards. The elimination of the regional offices removed one "unnecessary" administrative layer.[7] In 1995, Eastern Sydney and Southern Sydney AHSs were amalgamated to form the new South Eastern Sydney AHS, reducing the number of metropolitan AHSs to nine, to further streamline the administrative structure.[8]

The management structure of non-metropolitan health regions remained unchanged until the reorganisation of Rural Health Services became effective on 1 July 1993. The new structure expanded the six non-metropolitan regions into 23 District Health Services with the aim of reducing bureaucracy and administrative overhead costs and consequently allowing better administration and better networking of support services in the local communities.[9] These 23 District Health Services were reduced to eight rural AHSs following a 1995 review of the NSW Health Department's organisational structure, commissioned by the Director-General, John Wyn Owen. NSW Health comprised 17 AHSs, including nine Sydney metropolitan and eight regional AHSs, until further restructuring was announced in July 2004.

The restructuring also affected the Health Department's Central Administration. The pressure for cost containment and for the improvement of quality of care and accessibility brought enormous pressure to the departmental head.[10] The Health Minister announced a major reorganisation of the Department's senior management structure following the implementation of the AHS structure in August 1987. The changes included the creation of a new divisional structure for the Department's central administration that reflected the recommendations of an independent management and strategy review.[6] Since then, the number of divisions and corresponding senior executive positions within the Department has varied from four to eight.

The most important changes, which heralded a new era in management responsibility and accountability, were the introduction of the Senior Executive Service (SES) in 1989 and the performance agreements for senior health executives in 1990. For the first time, health plans and budgets were directly linked to the performance of the organisation and its senior management, and the goals, key initiatives and targets for the senior health executives for the next financial year were detailed in the agreement. This is the first study to identify this important policy reform and to examine its consequences for the health administration workforce.

Forces behind NSW health reform

A number of forces have shaped the health care system, yet the effects of these forces are hard to predict and vary from time to time. These major forces include increasing health expenditure and changing health needs of the population, the changing population distribution,[1,11,12] advancement of information and medical technology,[13-15] governmental control and politics in health, and interference by powerful pressure groups. Two forces have been identified as distinct to NSW health systems.

The changing pattern of population redistribution and the inefficiency of a regionalised structure

Australia has a largely urbanised population with the greatest proportion of health facilities and resources being injected in the urban areas.[16] Rapid population growth in the outer suburbs, together with increasing local demands of health care services, has brought to light the significant differences in the complexity and level of health care between urban and rural areas across the states and territories, and the oversupply of centralised health care in inner city areas. These imbalances are desperately in need of immediate alteration.[11,17] In NSW, this imbalance has further exaggerated the inefficiency of the regionalisation structure.

After the NSW Regionalisation Structure had been fully implemented in 1975, problems soon emerged as health regions varied enormously in size, ranging from the population of 1.2 million for the western Metropolitan Region to 96 000 for the Murray Region. The difficulties in estimating local needs and developing plans based on the needs in the large Sydney Metropolitan Regions led to the development of a further tier of "areas" for administration and planning purposes as recommended by The Task Force on Regionalisation and the Management Structure of the Health Commission of NSW 1977.[2]

The Task Force (1977) also identified a number of major problems which were still affecting NSW health care, including the unsatisfactory health status of the Australian community; the fragmentation and maldistribution of services; and the need for more efficient utilisation of scarce resources against a background of rapidly escalating and inadequately controlled costs.

The Task Force highlighted that the full economic benefits of regional administration would not be realised without the improvement of public hospital expenditure. Doctor control over hospital expenditure without consideration of efficient resources utilisation and the lack of hospital board control were identified as obstacles to achieving public hospital expenditure improvement.[2,18] Therefore, the Task Force recommended the establishment of Area Boards to provide community participation in the management of community health services and hospitals in each area. This marked the beginning of the development of the Area Health Management Model in NSW.

Public sector reforms

Another significant change worldwide is the reform of the public sector in the last 2 decades, which has had tremendous influence on how health care systems are managed. It has been long argued that the traditional bureaucratic approach to public sector management is not working[19] and public sectors are under constant and increasing pressure to improve performance and demonstrate greater transparency and accountability.[20] As a result, various corporate change strategies and private sector managerial models such as decentralisation, downsizing, delayering, reengineering, and privatisation[19] have been adopted by public sectors to develop a "new public management" paradigm aiming at strengthening management capacity in government operations.[21] The significant changes to NSW Health management as a response to the public sector reform were the introduction of the Senior Executive Service (SES) in 1989 and the performance agreements for senior health executives in 1990.

The impact of health reforms on health services managers

No study has been conducted examining the impact of the extensive reforms on NSW health

care managers. However, the impact of health care reform on health care managers elsewhere has been reviewed and also identified in the literature by a number of studies of daily life on the job, uncertainty about the future and strong feelings of insecurity.[22-24] The significant findings identified by these studies could highlight the need for further investigation of the senior health management workforce in NSW. The literature suggested four phenomena, which are discussed below.

High turnover and high burn-out

High turnover and burn-out among senior health executives have been commonly identified in relation to health system reform. Studies carried out in the United States[22] and Canada[23] confirmed that the major reasons for high turnover among health executives were: the unstable health care system; conflict with Board members and medical staff; and deficiencies in leadership, financial and conflict-management skills. Nordhaus-Bike's 1995 study[24] of middle and upper level managers in the USA identified that increased stress and job pressure were the main contributors to high turnover and burn-out, but suggested that the impact of other major factors, such as increased competition, higher complexity and intensity of work, faster pace, and constant layoffs and consolidations, should not be underestimated. Another USA study on burn-out, targeting a group of organisations serving people with severe and persistent mental illness, found a strong link between staff burn-out and organisational structures and management processes. These findings were also supported by a number of other reviews.[25-27] A study carried out in the NSW New England AHS examined the impact of the establishment of Rural Health Services in NSW in 1996 on their staff and reported the loss of morale, the feeling of stress and "cultural shock".[28]

The change in managers' career path

In Australia, the highly educated, labour intensive workforce accounts for 70% of total health care costs.[29] The workforce became the logical target for cost saving under the constant pressure of cost reduction.[30] As a result, many senior health executives have left the system and found their way into related fields.[22,31]

"Delayering" has also affected the middle-level managers, as this is often the level of management no longer required. Middle managers sometimes either lose their positions or remain within the structure but at a lower level, becoming first-line managers.[32] While middle-level managers are losing their managerial roles, clinicians and nursing executives are offered opportunities to take up roles which may ultimately redirect them to alternative career paths.[33-36] However, these clinician-turned-managers are often not prepared for the managerial role. This puts unexpected pressures on managers at the senior level as they are required to supervise and mentor these new managers.[32]

Convergence of new roles, skills and competencies

A number of studies stated that reform of the health care system required new skill sets, competencies, and knowledge. Senior health executives were expected to achieve new levels of performance to build and support professional teams, understand the influences of changing technologies on clinical processes, create and use information and knowledge more effectively, and identify and implement improvement.[17,37-40] The role of the senior health executives also included an enhanced span of control and increased authority and responsibility, and thus greater accountability.[32]

Empirical evidence gathered in the 1990s and early 21st century also pointed to the need for senior health executives to not only possess excellent skills and competencies identified as important in the 1980s, but to also acquire skills and competencies distinct to later years. The skills consistently viewed as important to health care managers since the 1980s included interpersonal and decision-making skills.[41-45] Health care managers in the late 1990s and early 21st century are required to acquire personal qualities of initiative, self-reliance and risk-taking; to be adaptive and flexible; [32] to have the ability to motivate and

mentor their colleagues; [46] and to manage and lead organisational change.[47-49] They also need to demonstrate the qualities of good leadership skills, the ability to manage change, and mentoring.[50-52] Furthermore, financial management, such as control of budgets, forward planning, contracting and tendering, and cost and quality performance monitoring,[51] has also been identified as one of the key components of successful health service management, especially among the most senior positions such as Chief Executive Officers.[39,53,54]

No previous studies have clearly examined the direct linkage of health care reforms with changes for health care managers, therefore further investigation into the relationship between the NSW health reforms and changed roles and responsibilities of NSW Senior Health Managers is necessary.

Higher educational qualifications

Recent studies carried out in the USA, Canada and Australia[39,50,55] found that today's senior health managers possess much higher educational qualifications. Education is the most significant predictor of being a senior manager.[55] A typical profile of a CEO, drawn from Dalston and Bishop's study,[39] is a 42-year-old male with 1 to10 years experience and a Master's degree. It is unclear whether the possession of higher educational qualifications among senior health managers is a response to health care reforms; or whether health care reform has led to the changed requirement and expectations for senior health managers.

Overview

Structural reforms in health care have been a common phenomenon worldwide since the early 1980s. In NSW, the most significant reforms included the implementation of the Area Health Management Model; establishment of Area Health Boards replacing individual hospital boards and taking responsibility for the day-to-day management of both public hospitals and community health services; and the introduction of the Senior Executive Service and performance agreement for senior health executives. The reforms have heralded a new era in management responsibility and accountability. A number of forces driving health sector reforms have been well discussed and recognised in the international literature, with two factors being identified as distinct to the NSW context; they are the population redistribution which exaggerated the inefficiency of the regionalised structure, and the general public sector reforms.

Given the significance of the health system reforms, studies have been conducted examining the impact of reforms on various aspects of senior health care management. There is consensus that reform affects senior health care managers significantly, such as higher turnover and burn-out among these groups, and the change of their career path. At the same time, it is also acknowledged that senior health care managers are required to take up new and complex roles and responsibilities and demonstrate a new set of skills and competencies in order to achieve new levels of performance and to meet the managerial needs of constantly changing health care systems.

However, this critical analysis of recent studies since the 1980s has not identified any studies examining changes in the main duties of senior health executives, the competencies required to perform the duties, and the obstacles to effective performance. Furthermore, no study on senior health care managers has placed specific focus on NSW since the late 1980s, after the major reforms were implemented, and no previous study has acknowledged the significance of the public sector reforms in health and the introduction of Senior Executive Service and performance agreements in NSW. This analysis of the literature and identification of the research gaps and questions has provided a foundation for empirical study on the impact of health care reforms on the roles and responsibilities of senior health executives in NSW between 1990 and 1999.

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Competing interests

None identified.

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