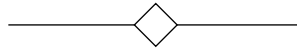


COMMENTARY



Bureaucracy to adhocracy

A possible structure for the Department of Health and Family Services

ANNE CAHILL, JAMES BIRCH AND GARETH GOODIER

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Background

At a meeting on Friday, 7 June 1996, the Minister for Health and Family Services, The Hon. Michael Wooldridge MP, asked the authors to prepare a paper on a possible structure for the Department of Health and Family Services. This followed our explanation to him of navigating women's and children's health service issues through the existing departmental structure. We had explained that such navigation included nearly all of the divisions within the department; and then within those divisions there were different branches responsible for different activities. It has been our experience that rarely do the different divisions, branches or sections exchange ideas, views or policies that might affect women and children. The result is a fragmented approach to this important group of the population. We know that this same approach exists for other key population groups.

This paper has been prepared at the request of the Minister, and follows an approach based on population and outcome.

Introduction

The traditional bureaucratic model has served the antecedents of the Department of Health and Family Services reasonably well since health was established as a separate portfolio. However, the election of the Coalition Government on 2 March 1996 has seen different interest groups, including some within the department, questioning its current structure and its effectiveness. An analysis of organisational barriers to effective community interface with the department was undertaken by Professor Fran Baum and a team of consultants in 1995 (Baum 1995). That analysis identified centralisation and the lack of devolved decision-making, structural constraints, staff stability and continuity as major obstacles.

The new Government requires a number of initiatives of the Department of Health and Family Services to meet its economic commitments and public sector commitments. In addition, the environment in which the department now exists is vastly different from that of even 10 years ago.

The population is ageing and becoming more vocal about its requirements. Technology has leapt ahead, and it could be suggested that the department has not kept abreast of the changing trends in the population and in technology.

This paper will examine the current structure of the department, and the reasons for an alternative structure, and make some concrete suggestions for that alternative structure.

The current structure

The current bureaucratic structure is reasonably traditional (if not larger than average), comprising some 12 divisions reporting through Section, Branch and Division Heads and then Deputy Secretaries to the Secretary of the Department. While the department apparently embraces the concepts of modern management such as total quality management and devolution of decision-making, there is little evidence of a 'team approach' across sections and branches or a recognition of local expertise which can be incorporated into decision-making, which is so central to this management approach.

Bureaucratic departments working as unrelated silos and lack of broader participation of the field in planning mean that the department's consumers experience slow, rigid and unresponsive approaches. This is completely out of step with the rapid changes of the nineties.

Although it is true that the department has attempted to devolve decision-making within the program areas (sections and branches), this seems to be in the absence of agreed strategic directions for the whole department. This has

resulted in unrelated and sometimes inconsistent programs. Inappropriate rules and regulations related to a range of issues, including research and financing, are major features. Importantly, there has been little cross-fertilisation between divisions and branches. For example, women's health issues are contained within a women's section in the Primary Care Branch. However, other areas make decisions that significantly affect those providing women's health services, including the Health Benefits Division, the Health Services Development Division, the NHMRC, the Office for Aboriginal & Torres Strait Islander Health Services, the Disability Programs Division, the Aged and Community Care Division, the Family & Children's Services Division, and the Therapeutic Goods Administration. In addition, the Portfolio Strategies Group will also draft proposals, for example coordinated care, and make decisions that significantly affect women's health services. The Office of the Status of Women must also have some role here, yet this is denied by both that office and staff of the department.

While nearly all of the key divisions of the department have some input to women's health issues, rarely is there evidence that they have spoken to one another and coordinated their decisions. So, for example, we have the NHMRC making pronouncements about the target rate for breastfeeding by the year 2000, yet decisions in the Primary Care Branch and the Classifications and Payments Branch actively discourage that objective while in pursuit of other competing objectives. This is not a criticism of individual staff working in those various areas, as examples can be found of similar inconsistencies right across the population being served. Rather, it highlights the way that the traditional bureaucratic model works. Managers are being allowed to manage, but of necessity they are managing their own projects rather than population-based programs of care.

It is interesting to note that a previous Secretary of the Department was concerned about the structure that had been introduced following the amalgamation of the health portfolio with community services (Hamilton 1993, pp 73–87). His particular concern was that a non-traditional structure (which the then new department was perceived to have) would allow sections of the population to fall into cracks. He outlined strategies to overcome this significant shortcoming, such as:

- an integrated computerised information system
- regular corporate meetings
- central program support and development
- an enhanced research base
- funding of national secretariats of community groups
- introduction of business rules.

It is our contention that the bureaucratic structure that 'overhung' the department did not enable the subtle and effective linkages between programs that Hamilton was looking for. Rather, arenas of competence and lines of authority and accountability were reinforced.

Key environmental trends

It is worth focusing on the Government's imperatives for a moment. The economic situation is that major reductions in financial and staffing resources will be made to the department. At the same time, significant activities are to be handed back to the States and Territories. The health portfolio is seen as one of the major portfolios for reinstating State/Territory 'rights' and responsibilities. Thus, the obvious situation will be that significantly fewer staff will be left in the department to manage whatever is to remain under federal control.

Rapidly developing technology in both service delivery and information is another major reason for change. On the service delivery side, the structure of the department has prevented it from retaining an up-to-date view of treatment regimes. The cause of this lack of current viewpoint is partly to do with the department's reliance on a very small section of the community for advice. This, in turn, has led to questionable decisions across all divisions relating to resource allocation issues, and it is the authors' view that examples of such decisions are to be found in women's and children's health services. A key issue is that communities of interest want to participate in policy but, as Baum's group determined (1995), there are major obstacles. On the information side, the department tends to obtain information from traditional sources, including internal sources as well as tried and true sources. There have been a plethora of special interest health issues groups established at a national level over the last five to ten years. Their establishment has been mainly to 'combat' the use of inappropriate or outdated sources of information. These include groups related to women's health, children's health, men's health, aged care, health of the rural community, Aboriginal health, and so on. These groups are some of the key clients of the department. The department needs to streamline and ensure that it is more accessible to communities of interest.

There are other lifestyle changes that will have an impact on the department's structure. These relate to issues such as improved education and knowledge of the health system by consumers, as well as workforce participation issues. This gives added impetus and importance to the issue of accessibility to the department by communities of interest.

The focus of the department has also changed, particularly as States and Territories have insisted on their service provision obligations. The noble objective of assisting the Australian community to maximise its health and quality of life may not be the main objective of the department. Rather, it might be *ensuring* that the health and quality of life for the Australian community is maximised. That is, the department might provide the policy context, the incentives and monitoring and evaluation of progress in relation to key outcomes.

As technology has developed and the expectations of clients have increased, the ability of the department to be 'all things to all people' has dwindled. Again, this is not a criticism but a fact of life. For example, the department has managed best practice initiatives and casemix initiatives. However, its ability to successfully manage these initiatives must be questioned. Could they be contracted out to service providers or interest groups such as those mentioned above, with the department keeping a 'watching brief' on the outcome? The department might, in such a circumstance, facilitate the initiatives but not manage them.

The need to be flexible and innovative has already been mentioned, but is also a key issue. Bureaucratic structures traditionally do not encourage flexibility or innovation. Bureaucratic structures can be useful for 'steady state' environments but the 'task force' approach is what is required to develop quick responses within a culture of service and an environment of change (Handy 1985, pp 190–2; Robbins & Barnwell 1989, pp 206–7; Wanna, O'Faircheallaigh & Weller 1992, p 27).

Another structure

Hospitals in Australia are increasingly moving towards a patient- or population-focused structure where management decisions are made closer to the bedside. Smaller units are established within the structures and managers of those units are empowered to make decisions about those units. The collegiate nature of work in hospitals means that those managers frequently consult with their colleagues, who will also affect the work of their own unit. Common units, predominantly resource units, are established to service these small units. In most hospital settings, this structure has supported flexibility, innovation and enthusiasm of the staff, even though they have been confronted with significant budgetary cuts. One of the main reasons for the success of such a structure in the hospital setting relates to cultural development. There is a 'service orientation' or output-based culture that exists in the hospital setting that facilitates communication, flexibility, innovation and change.

Would this work at a federal departmental level? Our proposal focuses on population groups but allows projects to cut through a range of population

groups. The projects, or task groups, can be developed and concluded quickly, as required. The population approach has been endorsed as recently as 14 June 1996 by the Council of Australian Governments (1996).

The textbook description of the matrix design (our model) is that it enables the traditional functional divisions, but allows a focus on projects (Robbins & Barnwell 1989, p 222). It also allows resources to be used and controlled by two opposing sets of managers (Jackson & Morgan 1982, p 149). So, for example, if women's health was seen as a project, then we might see the public health people supporting that project as well as the NHMRC, the Case Payments Branch, the Hospitals Branch, and so on. Using children's health as another example, the issues related to child care are paramount to the health and well-being of children, and those issues would be integrated with a project that might be entitled 'Children's health'.

Figure 1 shows various population groups as the project groups. These are just a few suggestions and not necessarily exhaustive. Some of the population groups can be grouped together, such as women's health and children's health. However, we would prefer that they remain separate as the agendas are the same but the detail is different. The population groups we have focused on are:

- women's health
- children's health
- men's health
- Aboriginal and Torres Strait Islander health
- health of the elderly
- rural health
- migrant health
- mental health
- health of the disabled.

There would be a need to set priorities within and between groups. The supporting services would come from some of the existing services, but would take an 'across portfolio' view, namely:

- portfolio strategies
- health benefits
- financing
- research (including the NHMRC)
- the Therapeutic Goods Administration.

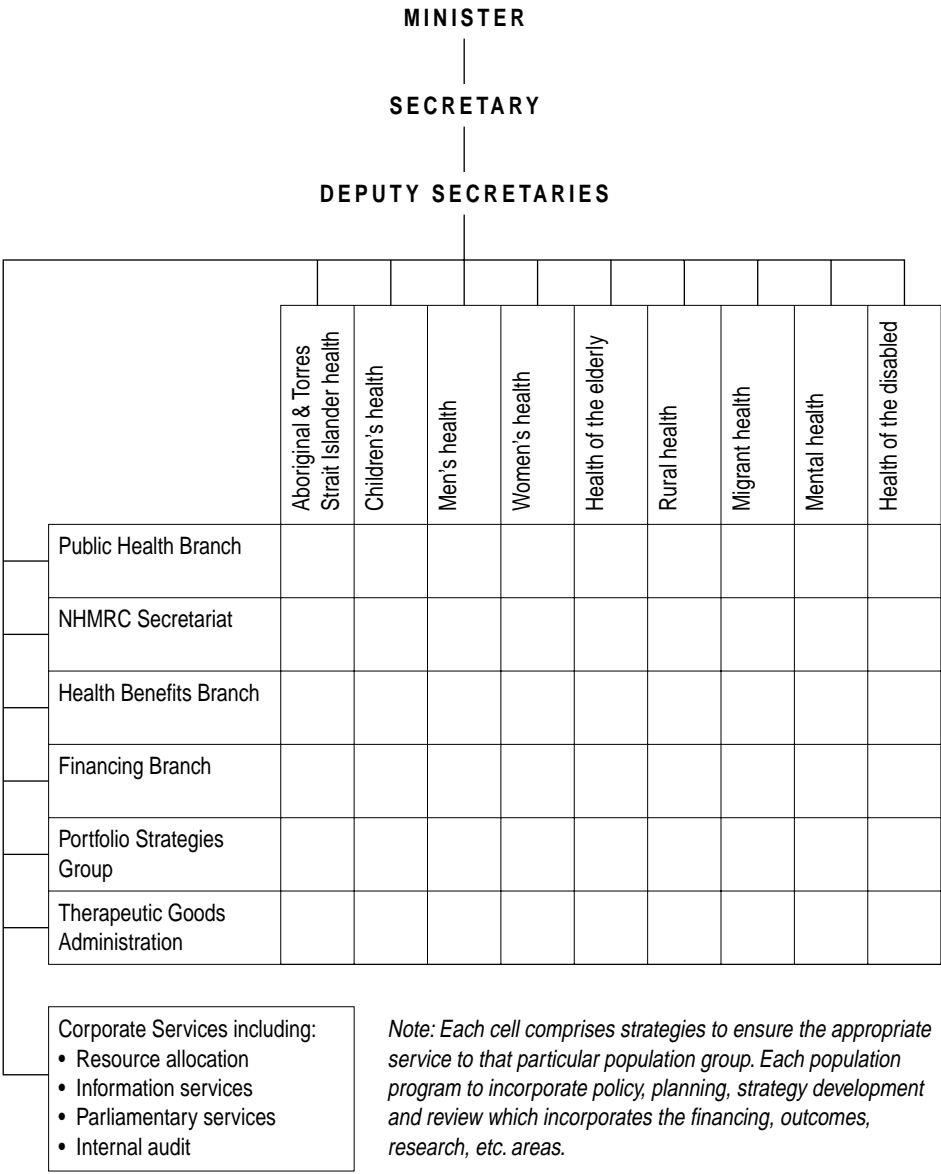


Figure 1: Possible structure for the Department of Health and Family Services

It could be argued that some of the population groups could and should be moved to the service group area. If that was to occur, then there might be just three population groups, namely, men, women and children. The remaining special interest groups could be moved to the service area, but would be

represented in each of the population areas. Such a decision is a political one, but is one that may be open to a community participation exercise.

The only area that might stand out on its own is Corporate Services (including information technology and a separate internal audit arrangement). The Legal Services Branch would need to justify its existence to prove that it is cheaper to have an in-house service, rather than a service that is contracted out, either to government (Attorney-General's) or to the private sector.

The Portfolio Strategies Group would encompass policy development, and evaluative and quality assurance issues that are currently fragmented amongst various branches throughout the department.

There are areas of the department that have not been included on the organisation chart, for example, the Australian Government Health Service and the Commonwealth Rehabilitation Service. It is our contention that these services ought to be contracted out or privatised, provided, of course, that appropriate outcome agreements can be put in place.

The State/Territory office structure has not been incorporated in this initial proposal either, as it will entirely depend upon the view taken centrally. Our own view is that State/Territory offices should be small and reflect the flavour of this matrix design.

A key component of such a restructure relates not to the lines and directions on an organisation chart, but to the vision and values which pull the department together. A planning framework is necessary that clarifies objectives and strategies by which these objectives might be best met and evaluated. Our proposed restructure would provide a facility for this.

One other issue that has not been addressed relates to the plethora of committees, statutory or otherwise, that exist within the health portfolio. It is our view that all of these ought to be abolished initially. New committees, with consumer and service provider representation, might be established in the future for consultative purposes. Some of the committees, however, have outrun their usefulness and their work could be better performed by other organisations in the community. For example, casemix issues for women's and children's health might be better undertaken by the national associations that have been established to provide a national voice for women's and children's health, with representation from the Commonwealth and other interested groups. Thus, the department might oversight the work of such a committee, but not manage it. This would be a money-saver for the Commonwealth, as much of the work is now done anyway by special interest groups.

The statutory authorities that fall within the portfolio of the department have not been addressed in this paper. Their structures will develop once the department's focus has again been honed, particularly the structures of the Australian Institute of Health & Welfare and the Health Insurance Commission.

Another issue for consideration relates to the statutory obligations of the department in relation to a Chief Medical Advisor. In days gone by, the department was always headed by a medical practitioner and there was a legal or statutory requirement for such an appointment. Nowadays, a Chief Medical Advisor is in place, presumably to fulfil those legal and statutory obligations. There is no reason why a Chief Medical Advisor's office could not be incorporated within the service structure, to ensure that each of the specific health areas receives the attention of the Chief Medical Advisor. It is our view, however, that with multi-skilling, medical managers might comprise part of those service units, thus ensuring an appropriate incorporation of medical advice.

Finally

This is a radical step in proposing a matrix structure for a traditional bureaucracy. However, radical steps are needed to address the economic reality, the desire of Australian Governments to reform their responsibilities and commitments, and the changing nature of the business of the Department of Health and Family Services.

While this is not proclaimed as the panacea for the department, it is a model that might go some way to addressing the needs of the population of Australia and the necessity of the Federal Government's role of insisting on an outcomes approach. It is a model which can be built upon and developed, as circumstances change. That is, it embraces the concepts of the population as a whole, flexibility and innovation. It is a model that can be adapted as the population changes and as the economic and political circumstances warrant.

In conclusion, the direction of this paper is one of a 'broad picture' approach. The authors do not claim to have the answers to all of the details. Some of those details will only be resolved once the big picture is resolved and the issue of what the department will do in the immediate future has been addressed.

Acknowledgement

The authors are grateful to Dr Kathy Alexander, Assistant Chief Executive Officer, Women's & Children's Hospital (Adelaide), who provided valuable guidance and assistance in finalising the paper.

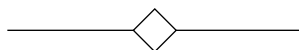
24 June 1996

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REJOINDERS

Australian Health Review sought the following replies
to the commentary, 'Bureaucracy to adhocracy',
by A Cahill, J Birch and G Goodier.



No matrix magic

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While no doubt Cahill, Birch and Goodier do understand the complexities of organisational change, their proposal does not really reflect this. It appears to reflect a common form of response: a neat textbook solution, chosen from a menu of organisational types. Such an approach is a seductive way to try to solve tough problems. This involves an element of unjustified optimism, which bubbles to the surface in the section on the state of hospitals. They tell us that hospitals now have 'a "service orientation" or output-based culture...that facilitates communication, flexibility, innovation and change'. Is this a realistic view of the effects of a financial squeeze and years of rampant managerialism on the health system? Some management changes have delivered some improvements in some places, but such a blanket and uncritical statement would hardly ever be justified, let alone in a period of crisis in many hospitals and in the public service more generally.

Let us take just one hospital to both illustrate the problems that can occur from applying a matrix model and question the authors' blanket enthusiasm for what has happened in hospitals. The new John Hunter Hospital, in the Hunter region of New South Wales, tried a matrix model for its structure, with very unhappy consequences. These have left a legacy of problems for the hospital, which now has a more traditional structure. This example should give pause to enthusiastic

supporters of the model. This does not mean a matrix model cannot have some uses or inspire some innovative hybrid approaches. There is, however, no matrix magic.

A proposal such as this takes a blanket approach when what we need is a detailed assessment or evaluation of different sections of the organisation's current arrangements and how effective they are. The current hard won, and admittedly far from perfect, consultative arrangements are seen as dispensable, without giving us any evidence as to why. The 'plethora of committees' is to be abolished and new ones 'might' be established. No doubt some committees will have outlived their usefulness. But blanket abolition, in the absence a detailed evaluation of current arrangements and a discussion of alternative arrangements, raises grave concerns.

The proposal suggests that this restructure will have flexibility and that it is not restricted to lines on an organisational chart 'but to visions and values which pull the department together'. But we are never told who will be able to have input into these visions and values. The only area identified as gaining an increased role is that of the Chief Medical Advisor. Towards the end of the paper we find that the Chief Medical Advisor's office is to be 'incorporated within the service structure, to ensure that each of the specific health areas receives the attention of the Chief Medical Advisor'. It appears that community influence is to be abolished but internal medical influence is to be enhanced.

The proposal implies that there should be a uniform approach across a range of areas, yet no case is actually made for this. Variety may be preferable, however, and it is concerning that the paper projects similar interests even when this seems obviously to be a questionable assumption. In rejecting the idea of combining women's health with children's health, the authors justify keeping this division by saying 'their agendas are the same but the detail is different'. I feel sure that many would question the 'same agendas' proposition, unless that merely implies better health, which clearly applies to everyone.

If we move beyond the issue of change often providing a cover, intentionally or unintentionally, for redirecting power and resources, we find that the proposal poses perennial problems associated with organisational structural change. It tends to focus virtually exclusively on the structure and this is understandable because this is a line of less resistance. Bureaucrats have direct power to change structures and often lots of experience in doing this. What sociological analysis points us to, however, is that we not only have to keep in mind social structures, but also the 'agency' of staff in these structures, that is, what people do. Staff are obviously never empty vessels on which structures can be imposed.

Many of the attempted 'revolutionary' changes of public management over recent decades have foundered because they relied too heavily on structural change. Many government (and private) organisations have structured and restructured without noticeable improvements to the quality of their 'public (or private) service'. This, in turn, leads to major and unacceptable costs. In the long run, as in any organisation, it is the staff of the Department of Health and Family Services, in partnership with all the levels of its constituency, its stakeholders, who will determine outcomes.

Structures are not irrelevant though they are far less important than is often assumed. Consistently encouraging flexibility and responsiveness may create a more salutary effect than major structural change. The changes almost invariably bring their own problems which, in turn, can only effectively be dealt with through flexible and responsive reactions. The seductiveness of structural change lies in the ready manipulability of structures (assuming that, in itself, it is not a cynical exercise, masking other motives). Changing structures is something bureaucrats can deliver and they are the experts in this. Changing structures allows us to feel as if we are doing something positive; it keeps us busy and puts off the very hard and intractable problems such as making an impression on the health of Aboriginal Australians. Structural change is particularly attractive to politicians as they can offer, and to an extent ensure, the delivery of promises. This, in turn, sounds good and tends to avoid the worst conflicts of values inherent in aiming for change to outcomes.

However, we might ask, even if the deck chairs on the Titanic had finished up in a more attractive and user-friendly order after their restructuring, would it have been an appropriate priority to which to deploy resources at the time the boat was sinking? Plans for organisational restructuring must initially be subject to the key question: Will the benefit be worth the cost? We have seen in the recent managerial 'revolution' (both in public and private organisations) a disproportionate effort going into organisational structural change, much of which would have been better directed to outputs, especially when there are also staff reductions to cope with.

Research in a range of areas has demonstrated that the enthusiasm and commitment of staff is probably the key ingredient in any effective organisational change, and that this holds regardless of organisational structural form. Yet this key issue is not addressed in this proposal. How are those in the Department of Health and Family Services who need to focus more effectively on Aboriginal people, women, men, children, the aged and people in rural areas to be enthused to put these issues on the main agenda in the future? This is the people question which should be at the front of all proposals. Structural change can probably

facilitate this but, unless there is evidence that it will, organisational change can, at best, be a waste of time and effort. At worst, it can be a mere political cover, a way of cutting expenditure under cover of a claim to be improving a department's functioning.

Reorganising health

DON HINDLE

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The authors claim that the department of Health and Family Services has many types of weaknesses. It has poor internal communications, lacks knowledge about the current health system, is unable or unwilling to consult with others (experts, people with local health knowledge, community advocates, etc), responds too slowly to problems and opportunities, cannot manage new ideas, and has no corporate strategy.

They argue that the weaknesses could be alleviated by making two main types of changes in management structure. First, the department should adopt a matrix organisation. One dimension would involve splitting work according to population groups (women, children, migrants, the elderly, etc) and the other would divide tasks according to function (financing, health benefits, research, etc). Second, the management structure should be more flexible. In particular, it should support the formation of project teams to suit current challenges.

I have several minor concerns about their thesis. First, they may be correct about the department's sins, but I would have been more comfortable if they had compared it with its peers. The department might actually look good relative to the United Kingdom (Best, Knowles & Matthew 1994), Cuba (Nayeri 1995), South Africa (Pillay & Bond 1995) or the United States (Srivastava 1995). Health care is hard to manage, and these kinds of weaknesses are common in any large organisation that deals with difficult matters.

Second, I doubt whether population group and topic are the best dimensions if only two are allowed in the matrix. I am also worried about the categories on each dimension. Moreover, it is unclear how the model would handle

intersections like elderly migrants, or topics which cross all population groups (for example, illness prevention or oncology).

Third, the authors may be confusing bureaucracy with maladministration or abuse of influence. Weber's model of bureaucracy is imperfect, but I agree with Perrow (1972): it is better than flower power for some purposes, if only because there are some continuing tasks in health care. The authors are dismissive of the department's committees, but I have found them often to be effective in facilitating new perspectives which cross the normal boundaries of responsibility.

This said, the authors' views about health care strategies make sense: care coordination, health gain for the population, and so on. The specific proposals about departmental structure are sensible too, even if they are a generation out of date. It is surely useful to have more than one view of the system (Galbraith 1971), and to be able easily to adjust resources to meet new challenges (Peters & Waterman 1982).

My main concern is the implication that a new structure will deliver significant benefits, even if it merely rearranges the same old people. Reorganisation has been common in large enterprises, and it has some advantages. For example, it requires little more than a whiteboard and a powerful chief executive.

However, the evidence shows that it can contribute little by itself, especially in systems as complicated as health care (Szeinbach 1992; White 1993; Burns & Wholey 1993; Mularz et al. 1995; Arndt & Bigelow 1996). One factor is that, if you simply combine functions A and B to overcome weaknesses of coordination, discontinuities of equivalent magnitude will emerge between C and D (in another part of the system which is not currently under observation).

Drucker (1974) and many others have argued that organisation designs are rarely good or bad, and success depends on attention to detail. The recent trend has been towards the establishment of management models which have been deliberately designed to handle complicating factors like conflict and uncertainty (Rosenhead 1980; Friend & Hickling 1987). Several similar approaches are now widely used such as soft systems methods (Checkland 1993), qualitative system dynamics, strategic choice analysis, and meta-gaming.

The common theme is that you cannot change organisational culture top-down or from the outside. Beer (1965) notes that the cybernetician's answer to how the system should be organised is that '...it ought to organise itself'. There must be an internal change program '...from which structure, system and policy will emerge in due course'.

Ackoff (1975) describes the same ideas under the heading of purposeful systems. If an enterprise's management structure is less than optimal, one could choose to change it by direction from above. It will, however, drift out of optimal over time. If the people are the same, they will again be unable to adjust. In contrast, purposeful systems contain people who have the power to change their methods where they appear to be sub-optimal on the basis of the latest knowledge. In short, more will be gained by building people than by re-drawing the organisation chart.

The health care sector is frequently presented with simple solutions: centralise for economies of scale or decentralise for problem ownership and local knowledge, compete to encourage efficiency or collaborate for effectiveness, and so on. I suspect that we need more centralisation, carefully targeted, together with more decentralisation of functions best handled that way. I am sure we need both more competition and more collaboration. There is even a place for Weber's four principles of bureaucracy, with extensions.

In summary, my main concern is that the authors present a simple model directed at reducing the complexity. In contrast, the purposeful systems approach is based on the idea that operational complexity is essential, and therefore you must have staff who are capable of handling it.

There are opportunities to improve the department's performance, as there are in other similar enterprises. However, it would be unwise to attempt another reorganisation. Rather, I would encourage it to continue to build its people, and to make use of modern techniques when doing so.

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Political before bureaucratic reform

PETER BAULDERSTONE

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Most of Cahill et al's criticisms of the Commonwealth Department of Health and Family Services are fair comment, but their resolution lies more in political policy than in bureaucratic reorganisation. As health care has moved from cottage medicine to big business over the past 30 years, Australia has never logically established the roles of Commonwealth and State government; public and private sectors.

Those unresolved conflicts are reflected in the unbalanced structure of the federal department. It has considerable annual expenditure of over \$20 billion (45 per cent of all health spending) but provides few direct services to patients. That expenditure is mostly (85 per cent) tied up in the policy formulation of four large entitlement programs: Medicare benefits; pharmaceutical benefits; public hospital services; nursing homes and aged care.

This level of funding gives the department a considerable influence, but it has traditionally remained at a distant arm's length in using this power to shape care delivery. States are the major shapers of hospital policy; drug companies and prescribers of the use of pharmaceuticals; and independent medical practice was largely unchallenged until the Federal Budget limitation over future provider numbers. Only aged care service delivery has been overtly shaped through Commonwealth initiatives like the Home and Community Care (HACC) Program.

This approach has created a culture of program administration rather than active management within the department. Program staff have been thrice removed from the service delivery implications of the funding programs they administer: by geographic remoteness; by a lack of specific service expertise; and by the expectation that patient outcomes are the provider's responsibility and not that of the funder.

Cahill et al's prescription is for greater consultation and devolution of responsibilities to provider and client organisations. This would be accompanied by a matrix management approach that builds the department's structure around client population groups. This approach works well in the management of new, expansive projects where client and departmental interests are aligned. A recent example is the General Practice Development Program.

But the department's current and future agenda is a much more contractionary one. The first nine months of the new government were largely involved in planning and

implementing the \$4.4 billion in budget cuts over the next four years. Neither clients nor providers could be expected to constructively contribute to planning the reduction of their own entitlements.

The longer term looks little different as the department's strategic priorities are the transfer of programs (particularly aged care) to the States under the COAG process; further staff reductions; and the commercialisation of the department's remaining few service responsibilities (for example, the Commonwealth Rehabilitation Service). These initiatives are mostly opposed by clients and viewed with some diffidence by provider groups. Hardly fertile territory for consultation and cooperation.

Accountability requirements inevitably link the department's staffing and structure closely with the major funding programs they administer. Linking structure to client population groups is intuitively appealing, but this is not the basis on which the Parliament has structured the funding programs. The client population responsibility for over \$6 billion in Medicare benefits expenditure could not be clearly identified, when most of that expenditure is not treatment- or diagnosis-specific.

The department's recently released corporate plan (which was not available to the article's authors at their time of writing) probably makes the best fist of implementing the current contractionary policy agenda. It adopts a matrix management approach (as the authors suggest), but internally within the department (not reaching out to client groups as proposed). This approach gives single point accountability to one area of the department for the implementation of each strategic priority across all affected programs.

This is a sensible, pragmatic use of matrix management, but there seems little scope for its wider external application. Only one of the department's four strategic priorities – the creation of a leadership role in information and research management covering evidence-based medicine, best practice health care and public health – is likely to be strongly supported by client groups.

The Commonwealth Government is unlikely to retain its current influence if it devolves its funding responsibility and takes mostly a public health leadership role.

Responding to Cahill et al's valid criticisms of management remoteness within the department will require a political agenda rather than an administrative one. Most countries are looking toward geographic regional responsibility for all health services, or an enrolled population choice between insurers (United States) or fund-holding general practitioners (United Kingdom) for management of their total health care needs. The key elements of these strategies are devolved local resource allocation, and integration of funding programs to encourage substitution of cost-effective services.

Until that political agenda is adopted, the pragmatic medium-term approach embodied in the Department of Health and Family Services' Corporate Plan probably has more to commend it than the authors' altruistic proposal.