Beyond organisational design: moving from structure to service enhancement

DEBBIE LAW AND ROSALIE A BOYCE

Debbie Law is Director of Allied Health & Community Health Services Division, Flinders Medical Centre, South Australia. Rosalie Boyce is an ARC Research Fellow, UQ Business School, University of Queensland.

Abstract

The Australian health care industry prior to the 1990s was notable for its relative stability and uniformity in relation to organisational design. Since then, new organisational designs have proliferated and a diversity of approaches is evident. The new fluidity in organisational design is particularly evident amongst the allied health professions. The aim of this paper is two-fold. Firstly, to summarise recent changes in organisational design as they relate to the allied health professions and secondly, to move beyond design issues to focus on service level enhancement in an organisational change context. This later aim is achieved by presenting data from an in-depth study of one institution's experience with wide-ranging organisational reforms. The recent formation of the National Allied Health Organisational Structures Network (NAHOSN) has given energy to the impetus of placing a research-based framework around the change experiences reported by Allied Health groups. An objective of the network is to foster research, rather than rely on commentary and anecdote, in the often highly contested arena of organisational design and reform.

Organisational design and allied health: a brief history

Prior to the 1990s the governance structures affecting public sector allied health services were remarkably uniform. Departmental managers of professional disciplines typically reported to a medical administrator within a medical division. Institutions typically organised internally around medical, nursing and administrative divisions (Duckett et al., 1981). The 1990s have been marked by the restructuring of governance arrangements for medical and nursing services within public hospitals and agencies. Restructuring has revolved around concepts of decentralisation, greater financial and professional accountability, new clinician management roles and clinical sub-unit structures with features drawing on patient focused care, program management and clinical directorate philosophies.

Whilst allied health professions and services were not directly targeted in the initial wave of restructuring, their close traditional structural relationships with medical services inevitably created a flow-on questioning about appropriate and possible structural change capable of fitting the new organisational milieu. The organisational outcomes for allied health during the predominantly managerialist ('devolution') restructuring period of the late-1980s and the 1990s have been varied, and not well documented at a clinical institutional level. The opportunity cost of change demands that the experience of "street-level" professionals is systematically and comprehensively recorded in a way that informs allied health, hospital management and service decision-makers. This approach would alleviate in part, some of the negative outcomes associated with the adoption of well-marketed intuitively appealing and politically palatable organisational models which are implemented without adequate appreciation of the complexity of the modern health service (Anderson & McDaniel 2000).

This concern for a more research-focused approach to organisational design was echoed at the 4th National Allied Health Conference in 2001. Post-conference meetings led to the formation of the National Allied Health Organisation Structures Network. The objectives of the network are to gather evidence of key

professional management issues and the impact on staff as a result of re-organisation, develop evaluation models for program evaluation and cross site comparisons, and provide a support network for allied health professionals undergoing change.

A critical factor in the formation of the network was the desire to move away from the obsession with structures and to gather data at the level of professional practitioners experiencing change. Several recent allied health re-organisation experiments in hospitals have used critical success factors to focus on service enhancement underpinned by a direct role in hospital decision making and service planning.

The purpose of this paper is two-fold, and reveals both academic and practitioner viewpoints. The first aim is to review developments over the past ten years in the restructuring of allied health services in public sector acute care hospitals. This objective is pursued by reference to a large body of work undertaken by Boyce (1991-2001). The research has a longitudinal dimension covering the organisation and management of allied health professionals, as well as current projects in the context of internal market reforms, the emergence of enterprising professional behaviour, and the development of "allied health" as a distinct organisational subculture (Boyce & Shepherd, 2000; Boyce, et al., 2000; Rowe & Boyce, 2000). This section of the paper draws significantly on the review of a decade of change in governance structures for allied health presented in Boyce (2001)1.

The second purpose of this paper is to review the practical implications of those changes. It draws on studies from the workplace level and the experiences of practitioners in the acute public sector hospital arena. It is concerned with the grass roots 'generative' learning from these changes (Argyris 1992), and the justification for an allied health role in hospital business. The more recent development in thinking, away from the obsession with structures, to that of critical success factors in developing good organisational governance for allied health will be reviewed, and the aims of the NAHOSN described, in building an evidence-based repository of these experiences.

Pushing and pulling allied health reform

Australian public hospitals, influenced by New Public Management (NPM) policies of managerialism and marketisation, experienced sustained policy and financial pressures in the late 1980s and early 1990s which resulted in a wave of internal organisational restructuring and new inter-agency relationships (Boyce 1993; Harris 1999; National Health Strategy Unit 1991; National Health Strategy Unit 1993).

Several common themes were evident in the impact on individual agencies, despite their utilisation of a wide variety of local drivers effecting the precise organisational restructuring prescriptions adopted. These common approaches included the recommendation that management and financial control be decentralised to clinical units and that services and resources should be organised around patients rather than providers (National Health Strategy Unit 1993; Charns & Tewksbury 1993; Hunter 1996).

Rarely the direct target of reformist objectives, the allied health professions have nonetheless been drawn along with change. The feature that most shaped the change trajectory of allied health in the past decade was the devolution of centralised professional hierarchical structures to divisional clinical unit models. This structural change created the new role of medical clinician manager and a range of shared medical and nursing governance models at the operational level. Until the late 1980s medical directors were the traditional and largely unchallenged operational supervisor-managers of allied health departments in public hospitals (Duckett, et al., 1981). That role was now frequently transformed to a non-operational corporate level position. This shift inevitably raised the question, "who should manage allied health?"

It is argued that there are two distinct domains in the governance structures of allied health services that require compatible structural outcomes, if stakeholder needs are to be met: a *resource management domain and a service delivery domain*. The need to manage this duality has implications for health service executives in terms of how they might structure allied health services in an operational and policy environment, which increasingly stresses cost minimisation, greater provider accountability for service quality and cost and flexible client-centred oriented service delivery. In the following sections, an abridged history of change in allied health is presented in order to contextually ground the workplace level data that follows.

Emergent diversity — Late-1980s to mid-1990s

The emergence of new models of Australian allied health organisation were mapped as follows (Boyce 1991):

1 *Traditional (classical) medical model* (individual profession-managed departments reporting to a medical director)
2 *Allied Health division model* (representative / rotating chair of allied health, located within a larger medical division consisting of individual profession-managed allied health departments)
3 *Allied health division model* (appointed director of allied health located within a medical division consisting of individual profession-managed allied health departments)
4 *Allied health division model* (appointed director of allied health in a freestanding division reporting to a Chief Executive Officer or Clinical Services Manager position, consisting of individual profession-managed allied health departments), and
5 *Unit dispersement model* (individual professionals are dispersed amongst clinical units. Profession management is eliminated although notional professional leadership positions acting in an advisory capacity may be retained).

The earliest case of a fully implemented *unit dispersement* model operating for allied health services, in a public sector acute care Australia hospital, was the John Hunter Hospital in Newcastle. The model was negatively critiqued as antithetical to core professional values by profession and union bodies. These core values were operationalised as management principles based on the need to retain management responsibility over personnel and budget. Loss of budget and management were factors which they argued would reduce their positional power, give control of their services to other professions with little knowledge of their services, and further reduce already limited financial support for professional development, student training and service development.

Coincidently, the independent development of a rival model, the *division of allied health* model, provided a countervailing argument about the direction of change for the allied health professions. Within this structural option, the freestanding version (see model 4 above), was favoured by the professional associations and unions that had criticised the *unit dispersement* model. Although several of the allied health professions saw the *division of allied health* model as a threat because the director of allied health position was open to competition from all allied health disciplines, it was regarded as less of a threat than the *unit dispersement* model (Boyce 1996a). The primary advantage of the divisional approach was the retention of profession management of professional resources, and the ability to coordinate and develop organisational wide service priorities and systems. It increased positional power in the organisation through the director of allied health's membership of the corporate executive (Australian Physiotherapy Association 1994).

The findings of British research based on the transformational change being experienced by professionals in the NHS strengthened support for the *division of allied health* model amongst Australian professionals. The British organisational equivalent, the Therapy Directorate, was associated with "business autonomy" a new form of professional autonomy, which accrued from generating organisationally-valued revenues through internal and external contracts or service agreements (Cook 1994; Øvretveit 1992; Øvretveit 1994; Pringle 1996).

Within this period of emergent diversity, the Chief Executive Officers of several influential hospitals publicly recorded their reservations about *division of allied health* models. Allied health professionals were labelled as "the most resistant group" to restructuring (Catchlove 1991, p. 86). Another predicted that the divisional model would only be a transitional step to decentralisation and *unit dispersement* (Scarf 1991).

Established diversity, mid- to late-1990s

A second wave of reform within allied health was driven by the introduction of local forms of the purchaser-provider split, where service agreements or internal contracts were contemplated. Theoretically, under such an operational approach, allied health services had access to several structural options ranging from:

1 Loss of departmental budget and staff to a clinical unit (unit dispersement model);
2 Budget holding with 'soft' service agreements or contracts (zero based budgets within a division of allied health model);
3 Contestability with external competitions (outsourcing);
4 Privatisation.

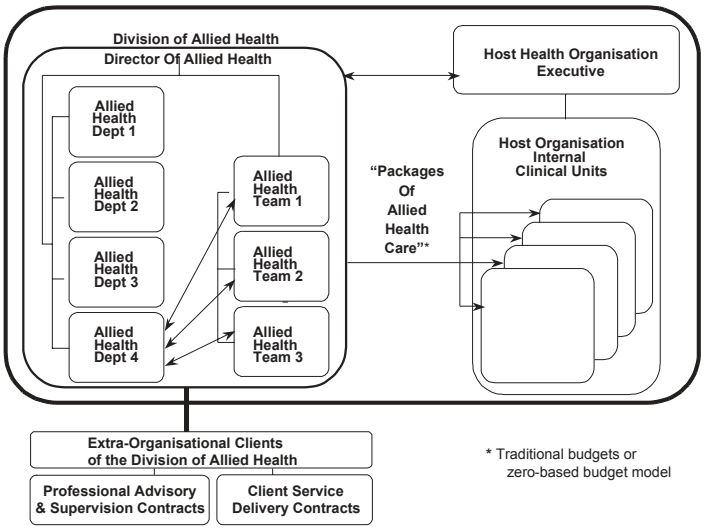
The prospect of an internal purchaser-provider operating model renewed the attraction of the *unit dispersement* model of allied health organisation in many hospitals (option 1 above). However, the potential for this approach was severely limited by the availability of allied health information systems, and by clinical unit manager's knowledge of allied health utilisation and cost profiles in their clinical unit. As the reforms played out it became clear that the most favoured model of the four above would in practice be number two (Boyce 2001). In this option, service agreements were designed to clarify mutual expectations, process flows and staffing arrangements with little systematic delineation of costs, volumes, performance benchmarking or penalties for non-performance.

By the late 1990s a key challenge to the allied health professions was to create new approaches to organisation, which preserved attributes valued by the professions, but which were capable of contributing to organisational objectives and customer (internal purchasers) needs in the context of market-like operational conditions. The *"Integrated decentralisation"* model (see Figure 1) was developed to respond to these needs and to acknowledge the complexity of the duality of a resource management domain and a service delivery domain inherent in allied health practice (Boyce 1996b).

The *"Integrated decentralisation"* model is founded on an intra-divisional matrix of co-existing profession management structures and team management structures. This approach supported the principle of profession-management (strategic and managerial arm devoted to resource management). It also promoted responsiveness to the needs of clinical units through a team-based service delivery design ("allied health team") structured as the operational arm. The close integration of the two dimensions of the matrix suggests that developmental initiatives could be efficiently operationalised into the service delivery domain. However, *"Integrated decentralisation"* was markedly different to typical patterns of professional hierarchical organisation because it challenged allied health professionals to adapt to more collaborative practices, and accept a loosening of the sovereignty of the professional discipline as the mainstay of organisation.

Figure 1 shows the resource management arm of the model on the left as the Division of Allied Health and its array of individual professional departments (1-4), for example, physiotherapy, occupational therapy and so on. The service delivery component of the internal matrix is shown by an array of allied health teams (1-4). On the right is the larger organisation, for example a hospital, with its constituent clinical units, for example, obstetrics, surgery and so on. The existence of internal soft contracts between the division of allied health and the hospital's clinical units in a purchaser-provider environment is illustrated by the "packages of allied health care" shown in the diagram. Amplifying this to the external environment, the possibility of the division of allied health having formal contracts with a range of external clients is shown.

Figure 1. Integrated decentralisation: a model for allied health services



Source: Adapted from Boyce (1996b)

The findings of a national survey of organisational approaches to allied health in 107 Australian public sector hospitals with more than 100 beds (total beds in the sample = 35,936, 94% participation rate), confirms the growing importance of models based around the *division of allied health* ((see models 2, 3 and 4 above) (Boyce 2001). The data shows that whilst the *traditional or classical medical* model (see model 1 of 5 listed above) continues to be important as a governance system with 47% of the total beds under survey, the *division of allied health* model accounts for 37%, or 45% when adjusted to account for its presence in mixed models.

The unit dispersement model (see model 5 above) is relatively rare with only 6 sites identified from the total sample of 107 hospitals. The *division of allied health* model has gained a central place in health services management in Australia as a viable model of organisation. The particular dynamics of the divisional model that leads to a more collaborative managerial focus on the "business of allied health" has driven clinical level operational reforms, with greater expectations of collaboration, accountability and service outcome.

From allied health professions to "allied health": tribes and nations

Closely following the period of implementing new organisational models for allied health in Australian public hospitals, there was a rise in targeted strategic activity by senior allied health professionals who organised under the banner of "allied health" at regional, state and national levels (Boyce 1997). This drive towards appropriating "allied health" as a professional, cultural and managerial vehicle was reflected in the emergence of new national groups. This dynamic reflected the observations of Blayney & Fitz (1999 p. 8) who called for a shift in focus from "tribes to nations". This period of transition in Australian allied health is reflected in the emergence of an "allied health" subculture structured around the notion of "allied to each other" rather than received understandings of the traditional approach of "allied to medicine" (Boyce 1996a; Boyce 1998).

The experiences of allied health in the field: a case study

How is this history of governance change reflected in the experiences of allied health in the field?

The outcomes for allied health associated with restructuring to clinically devolved management units during the 1980s and 1990s have been varied, and not well documented by practitioners. It is argued that the opportunity cost of change demands that we comprehensively record those experiences, in an evidence-based manner, to inform allied health, hospital executives and service planning decision-makers. This would avoid the frequently experienced application of external models as a 'management for all seasons' (Hood 1991), with weaknesses or problems revealed all too late. More optimistically 'getting it right' first time would be a much less costly experience. However, the question still remains whether the outcomes of such restructures result in more effective health provision.

The impact of change, negatively or positively, has been anecdotally reported by allied health in a variety of forums in terms of the following areas:

- Management responsibility, and control of a budget
- Efficiencies and economies of scale
- Organisational integration and continuity of care
- Professional management of professional issues
- Collegiality
- Human resources support and development
- Role in organisational policy and decision making
- Creating functional partnerships
- Accountability for performance
- Service resources - service equipment, training and development
- Recognition of sound and often innovative management and service delivery practices.

The following report of the restructuring of Flinders Medical Centre allied health services illuminates many of the issues underpinning these factors. The restructure was planned in the late 1990s. The initial phases of the restructure involved a stakeholder analysis. This was complimented by a series of case studies of overseas and

Australian allied health governance and operational models (Law 1999), highlighting the typical issues and concerns practitioners were experiencing from organisational governance restructures.

The focus of Law's study was to understand the functional issues for allied health in a unit dispersement model (see model 5 listed above), as opposed to allied health professional autonomy in a clinical devolution structure as at Flinders Medical Centre. The rationale of restructuring allied health to a *unit dispersement model* generally seemed to focus on separating professional issues from operational management of services. This traditional nexus was seen as the barrier to breaking down professional role demarcation, being able to shift resources across allied health disciplines, and being more cost effective. It was also seen as a barrier to innovative and flexible responses to the medical staff's requirements for services, which they perceive to be provider-need driven (built on the basis of individual specialist interest areas) as opposed to integrated patient focused driven. The Patient Care Units or Divisions were seeking allied health to work more closely with them, creating a customer focus.

The rationale for such a restructure appeared logical at first pass, but was the evidence clear? The vulnerability of restructuring allied health into Patient Care Divisions (ie. Unit dispersement – model 5) *may* be that it institutes a hierarchy of ownership, rather than changing behaviours to those of negotiation for work practice changes with an accountability framework. Simply redefining the organisational landscape may not achieve break down of professional barriers in favour of cooperative practices and value for money or, deliver better outcomes. The responses of allied health professionals to this structural approach indicated clearly that they perceived that it is not likely to address aspects of teaching, professional development and professional autonomy or effectively address the question of who is the allied health customer.

The Canadian, United Kingdom and Australian case studies undertaken by Law (1999) explored the above issues and revealed that restructuring allied health to a *unit dispersement model* was based on a series of informal assumptions. Table 1 lists seven assumptions identified from the international study conducted as part of the restructure exercise at Flinders Medical Centre. The assumptions will be discussed in turn below.

Table 1. Assumptions underpinning unit dispersement model

1	New structures will drive change in professional behaviours for improved care and better allocation of resources
2	A 'committee' approach to management would deliver fair or at least appropriate access to resources around the patient focus
3	Control of allied health would align clinical practice and operational systems and processes more efficiently
4	Professional groups are full participants in health service delivery when they have the capacity to manage their own professional growth and contribute directly to hospital policy, decision-making and service planning did not apply to allied health
5	The needs of medical and nursing teams are the same as those of allied health in the desire for team integration and allied health control
6	Provider-driven development of services can be reversed by focusing on health unit needs
7	Structural change, in itself, will drive achievement of all the required outcomes

Source: Adapted from Law (1999)

1. New structures will drive change in professional behaviours for improved care and better allocation of resources

An overriding assumption was that devolution of allied health to Patient Care Units along with their medical and nursing colleagues, and control of allied health staff and budget, would drive the desired teamwork, partnerships in care, meeting consumer needs (internal and external) and more efficient operation. The team integration and allied health visibility as part of unit teams was impressive, and recognition of innovative practices often came about as a consequence of interdisciplinary team membership. However, greater operational efficiency was not evident. This finding was consistent with Boyce's (1998 p. 400) conclusion that 'removing profession-centred structures does not (of itself) remove profession-centred behaviour'.

Unit directors were frustrated at being unable to achieve internal reform for allocative efficiency, once they had control of the allied health budget. These comments reflected a lack of understanding of the competence that allied health departmental managers traditionally demonstrate in providing as much flexibility as possible, through daily movement of a low volume of staff across unit boundaries, to meet the peaks and troughs of demand.

2. A committee approach to management would deliver fair or at least appropriate access to resources around the patient focus.

Allied health reported that access to equipment, conference attendance and continuing education did not happen in many cases, or happened unequally from unit to unit, based on historical relationships with, or biases of, the Unit Director. Whilst restructuring provided medical staff with the full 'control' of allied health that they seemed to wish, the responsibility for good allied health staff management in exchange for authority over allied health was not generally fulfilled.

3. Control of allied health would align clinical practice with operational systems and processes more efficiently.

With few allied health resources, trading across units proved to be extremely difficult and the operational response at a hospital-wide level was lost. The flexibility to deliver a wide range of services across the hospital, manage leave cover and deliver both specialist and generalist services and training opportunities were also severely restricted. Allied health often constructed informal ways around devolved structures, despite the Patient Services Managers not favouring this approach. This informal approach alleviated, to some extent, the lack of trading between units, and the professional and organisational isolation, which had lead to lowered work standards and competencies. Allied health staff consistently claimed that their new (non-allied health) managers did not understand their recruitment and resource needs. In fact Unit Managers often handed this responsibility back to a new position – a Profession Practice Leader - but usually without the budget.

4. Professional groups are full participants in health service delivery when they have the capacity to manage their own professional growth and contribute directly to hospital policy, decision-making and service planning.

Support for allied health professional growth seemed to be inconsistently applied across units and was in competition with the 'bigger players' from other professional groups. Whilst medical and nursing staff expected to be able to contribute to hospital planning, policy and decision making, allied health did not enjoy structural support to achieve this outcome. Allied health seemed to have no natural advocate, and the previous collegiality that promoted learning about strategic thinking, was lost due to the dispersal of staff into devolved units. Consequently an allied health voice was not developed or lost. This observation gives weight to Boyce's (1991) argument that a 'lack of attention to strategic issues has made allied health vulnerable to adverse outcomes'.

It was noted that overseas colleagues for this reason envied the Australian model of Allied Health Divisions and its structural support for an executive-level presence.

5. The needs of medical and nursing teams are the same as those of allied health in the desire for team integration through allied health control.

The goals of integration and control can be in conflict when weighed against operational flexibility, cost effectiveness, professional growth and cross-Patient Care Unit planning. The existence of numerous variations of the unit dispersement model combined in a matrix with informal-formal professional leadership / management approaches highlighted the difficulties in making this model work effectively for both allied health and the Patient Care Units.

6. Provider-driven development of services can be reversed by focusing on health unit needs.

Generally this appeared to be unsuccessful, and in reality this phenomenon may not have existed. The lack of success was possibly related to poor communication of needs, an absence of cross-hospital trading of resources and a lack of understanding that services had developed in response to demand. Where a restructure took place to achieve desired outcomes, these outcomes were not always clearly articulated nor consistently agreed to across the stakeholders. The design had often not achieved 'form follows function', and a balance of needs did not appear to be met.

7. Structural change, in itself, will drive achievement of all the required outcomes.

There was little evidence in the study settings for this assumption. However, service agreements between organisational units had been used successfully to negotiate and review the services provided. The "success" rested in the attempt to define user needs and allied health services more accurately, to introduce accountability through performance measures, and to drive opportunities to influence specific clinical areas, as well as to be "customer focused". The service agreement process also provided an opportunity for allied health to be able to educate the key groups of purchasers about service rationale, allied health needs, and to market new and innovative practices that were often subsequently taken up by the user unit.

The triangulation approach to the international case studies, where a variety of stakeholders were invited to comment on the same issues, revealed interesting conundrums; such as doctors and administrators were unclear why the restructure had not achieved what they expected. A sense prevailed of "the jury is out on whether the matrix model improves outcomes" (Law 1999, p. 4). Dissatisfaction expressed by more than one group of stakeholders, clearly indicated an imbalance between expected function and what the structure actually delivered.

Case studies of sites with an allied health divisional structure revealed evidence of a highly supportive model, which maximised attention to multidisciplinary service improvement, research, education and teaching. The model in action showed the development of cooperative processes between allied health for resource allocation to service priorities, and an increased focus on health outcomes. It also provided a focal point for coordination of responses, an increased ability to attract project funding, and an articulation of common goals rather than a focus on the underlying differences between the professions. Its strength was the distinctive organisational capability to add value, improved accountability, and the corporate memory it held. These findings support the early propositions and research data reported respectively in Boyce (1991, 1996a) and the conclusions of National Allied Health Best Practice Industry Report (Compton & Robinson, 1997).

Moving from assumptions to actions: structure and service enhancement

Moving away from the obsession with structures a number of recent allied health re-organisation experiments in hospitals have used *critical* success factors to shape the change process. This methodology ensures that the values and features prized by allied health are preserved whilst incorporating the needs of other stakeholders. Of particular utility is the ability of the *critical success factors* approach to deflect the argument over the pros and cons of a particular structural model, to the needs of the resource and service delivery domains for patient outcomes. The approach was an important tool used in finding common ground in the restructuring process at Flinders Medical Centre.

The use of *critical success factors* is predicated on a 'form follows function' general approach to restructuring and might include:

1 Agreement to learn from the pitfalls and mistakes of other organisations' change experiences to drive critical adjustments

2 Agreement on the expected outcomes of restructure, incorporating what both users and providers need

3 Team articulation of outcomes and evaluation

4 Determination of common goals for allied health group identification

5 Alliances required for strategic contribution to service planning and policy decision making input, and appropriate resources and communication

6 Collaboration with referrer units to recruit staff with the right skill and experience sets to match the jobs available and to provide better performance appraisal

7 Retaining the strengths of the current operational model

8 Decreased allied health duplications in service in exchange for focusing on opportunities for critical roles

9 Formalised negotiation and review through service agreements with customers

10 Valuing allied health services and excellence in practice and innovation

11 Optimal allocation of allied health resources to clinical units

12 Negotiation and review of service provision to meet a balance of stakeholder needs

This approach enabled Flinders Medical Centre to achieve agreement for a model of multi-disciplinary allied health clinical teams for service delivery and retention of allied health departments for professional issues under the governance of an allied health division.

National Allied Health Organisation Structures Network (NAHOSN)

Following the 4th National Allied Health Conference in March 2001 a *National Allied Health Organisation Structures Network* (NAHOSN) was formed, with the objective of gathering evidence of key professional management and service issues, as a result of re-organisation. The work of this group is relatively new and has been planned through several approaches. The first is developing a data repository on allied health structural change and their histories. The purpose is to identify examples of best practice in restructuring, to identify what met expectations and what did not, and to provide a reference point for exploring local issues.

A further step in NAHOSN activities is to support the development of suitable models for program evaluation. Evaluation techniques and tools will be used, which focus on needs and impact analysis, as well as the effectiveness and efficiency of organisational changes (Owen and Rogers, 1999). Collaboration with university health service management units is being pursued to achieve this. Any evaluation process will need to utilise a framework capable of cross service comparisons in order to increase the validity of the local findings and to ensure the development of a body of generalisable results.

The members of NAHOSN will provide a support network for allied health professionals undergoing organisational change. It has already identified a number of appropriate references relating to allied health organisational change so that information or advice may be provided on managing the context, in particular the political environment. It will continue to build this expertise.

Lastly, NAHOSN's brief is to collaborate across health and education sectors. The network will target venues, conferences and organisations to disseminate the findings of the evaluations of the impact upon allied health, and to form partnerships with which to continually build a body of appropriate evidence.

Conclusions

The reforms of New Public Management associated with managerialism and restructuring have forged opportunities for allied health to create new directions. Whilst the transition of allied health services over the last decade has been most profound at workplace level, national bodies are now also supporting the vision (Boyce 2001). The National Allied Health Organisation Structures Network intends to add value to professional practice by supporting the type of change, which promotes interdisciplinary integration and cooperation for the benefit of quality patient care. Without an evidence-based approach to restructuring, organisational change efforts will remain centred on polarised debates about competing structural models rather than grappling with how structures can be utilised to enhance service provision.

Endnote

The current paper is a revised version of a conference paper presented at the *Workplace Reform In the Health Sector Conference*, co-organised by the School of Public Health at La Trobe University and the Victorian Healthcare Association, November 21, 2001. Sections of this paper are adapted from an earlier Australian Health Review paper (Boyce 2001). For a more comprehensive analysis of change in allied health over the past decade, please refer to this original source article.

References

Anderson E & McDaniel RR Jr 2000, 'Managing health care organizations: Where professionalism meets complexity science', *Health Care Management Review,* vol 25, no 1, pp 83-92.

Argyris C 1992, *On organizational learning*, Blackwell Publishing, Oxford.

Australian Physiotherapy Association 1994, *Position statement and discussion paper on hospital restructuring,* Australian Physiotherapy Association, Melbourne.

Blayney KD & Fitz PA 1990, 'The allied health professions: a critical resource in the future of health care', in Perspectives on the Health Professions. Report of the Pew Health Professions Programs, Duke University, Durham. NC.

Boyce RA 1991, 'Hospital restructuring: The implications for allied health professions', *Australian Health Review*, vol 14, no 2, pp 147-154.

Boyce RA 1993, *The organisational design of hospitals — A critical review: A report on the 1992 Australian College of Health Service Executives Overseas Study Award,* Australian College of Health Service Executives, North Ryde, Australia.

Boyce RA 1996a, 'The organisation of allied health professions in Australian general hospitals', Unpublished PhD Thesis, Queensland University of Technology, Brisbane, Australia.

Boyce RA 1996b, 'Researching the organisation of allied health professions: Sorting fact from fiction' *Proceedings of the 2nd National allied health conference*, Division of Allied Health, Central Sydney Area Health Service, Sydney.

Boyce RA 1997,'Heath sector reform and profession power, autonomy and culture: the case of Australian allied health professions', in R Hugman, M Peelo & K Soothill (eds) *Concepts of care: Developments in health and social welfare,* Arnold, London.

Boyce RA 1998, 'The allied health professions', in M Clinton & D Scheiwe (eds) *Management in the Australian health care industry*, 2nd Edition, Longman, Melbourne.

Boyce RA & Shepherd N 2000, 'Entrepreneurship as a dimension of professional culture'. Proceedings of the Annual Conference of the Australian Sociological Association, Adelaide.

Boyce RA, Shepherd N & Mickan S 2000, 'Restructuring professional culture: The impact of "enterprising" management ideologies and entrepreneurship on public sector professionals.' Paper presented to State, Political Power and Professional Structures: New Patterns and New Challenges, Conference of the International Sociological Association. Lisbon, Portugal.

Boyce RA 2001, 'Organisational governance structures in allied health services: A decade of change.' *Australian Health Review,* vol 24, no 1, pp 22-36.

Catchlove B 1991, 'Changing the management structure at the Royal Children's Hospital', *Australian Health Review*, vol 14, pp 86-88.

Charns MP & Tewksbury LJS 1993, *Collaborative management in health care: Implementing the integrative organization*, Jossey-Bass, San Francisco.

Compton J & Robinson M (Consultative team) 1997, '*The national allied health best practice industry report',* Final Report to the Commonwealth Department of Health & Family Services.

Duckett SJ, Scarf CG, Schmiede AM & Weaver C J 1981, *The organisation of medical staff in Australian hospitals*, Longman Cheshire, Melbourne.

Harris P 1999, 'Changing patterns of governance: developments in Australian public hospitals and universities', *Policy Studies*, vol 20, no 4, pp 255-272.

Hood C 1991, 'A public management for all seasons?', *Public Administration* ,vol 69, Spring, pp 3-19.

Hunter DJ 1996,'The changing roles of health care personnel in health and health care management', *Social Science & Medicine*, vol 43, no 5, pp 799-808.

Law DS 1999, 'Allied health organisation; A study of Australian and overseas models.' Unpublished Report, Flinders Medical Centre, Adelaide.

National Health Strategy Unit 1991, *Hospital services in Australia — Access and financing*, National Health Strategy Unit, Melbourne.

National Health Strategy Unit 1993, *Health that works: Reform and best practice in the Australian health industry*, National Health Strategy Unit, Melbourne.

Rowe P & Boyce RA 2000, 'Macro structures and micro mechanisms: modelling uncertainty' *Proceedings of the Annual Conference of the Australian and New Zealand Academy of Management*, Sydney.

Øvretveit JA 1992, *Therapy services: Organisation, management and autonomy,* Harwood Academic Publishers, Chur, Switzerland.

Øvretveit JA 1994, 'Changes in profession-management, autonomy and accountability in physiotherapy', *Physiotherapy*, vol 80, pp 605-608.

Owens JM & Rogers PJ 1999, *Program evaluation: Forms and approaches*. 2nd Edition. Allen & Unwin. St. Leonards NSW.

Pringle E 1996, 'Occupational therapy in the reformed NHS: the views of therapists and therapy managers', *British Journal of Occupational Therapy*, vol 59, no 9, pp 401-406.

Scarf CJ 1991, 'Clinical management structure: The Royal Prince Alfred Hospital experience', *Australian Health Review*, vol 14, pp 83-85.