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Tensions around introducing co-ordinated care:  
A case study of a co-ordinated care trial

Submitted by

Hannah Piterman  
M Ec (Monash); B. Ec Honours (Monash); Graduate Diploma  
Organisation Behaviour (Swinburne)

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Doctor of Philosophy  
Australian Graduate School of Entrepreneurship

Swinburne University  
Hawthorn, Victoria 3122  

Australia

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Statement of Authorship

Except where reference is made in the main text of the thesis, this thesis contains no material published elsewhere or extracted in whole or part from a thesis by which I have qualified for or been awarded another degree or diploma.

No other person’s work has been used without due acknowledgement in the main text of the thesis.

This thesis has not been submitted for the award of any degree or diploma in any other tertiary institution.
**Ethics approval**

The Swinburne University of Technology Human Research Ethics Committee approved the research procedures in the thesis.

Permission to use material to undertake the doctoral research was obtained from the Southern Health Care Network Co-ordinated Care Trial (the transitory organisation formed to undertake the Southern Health Care Network Co-ordinated Care Trial) and from the Commonwealth Department of Health and Aged Care. Consent was also obtained from participants to use data obtained during the Trial process for purposes of the doctoral research.

**De-identification**

All names of individuals used in the thesis are fictitious.
Below is a glossary of some of the more technical terms used in the thesis. The Southern Health Care Network Co-ordinated Care Trial is referred to as ‘the Trial’ throughout the thesis.

**Brokerage funds** in the context of the Trial Model of Co-ordinated Care refer to discretionary funding provided out of the funding pool to the case manager or service provider to purchase a range of services.

**Budget holders** (see fund holders)

**Budget neutrality** in the context of the Commonwealth co-ordinated care trials requires total service use and associated expenditure of Trial participants to be equivalent to what expenditure would have been had there been no Trial. The requirement of budget neutrality is not intrinsic to the concept of co-ordinated care. However, it was a requirement of the Commonwealth Co-Ordinated Care Trials, and hence this Care Network’s Co-ordinated Care Trial Model.

**Co-ordinated care trials** refer to the nine pilot studies, which are designed to test alternative funding and delivery modalities for patients with ongoing and complex needs (COAG, 1995, 1996 in Donato & Scotton, 1998). The aim of co-ordinated care is to provide a framework which will improve integration of services between patients, general practitioners, and other health care providers.

**Care co-ordinators** are general practitioners who have consented to take on the care co-ordination function as part of the Southern Health Care Network Co-ordinated Care Trial. More detail about this role can be found in Appendix 1.

**Capitation** involves payment of a fixed fee to a single care giver or group of care givers or health care organisations to provide care for a defined group of patients. Capitation contract arrangements involve capitation rates, the amount paid per patient per month
for health care. Simply put, the doctor receives X dollars for which they treat Y number of patients per year, for those conditions covered by the contract (Halasz, 1999).

**Case management** constitutes the Trial intervention applied to clients assessed at risk Level 3 (high risk). These are clients whose health needs are complex, who are socially and/or emotionally disadvantaged and whose ability to manage an agreed care plan without substantial and active support and supervision is limited. More detail about this role can be found in Appendix 1.

**Competition policy** involves a Government initiative that establishes structures in which market incentives are used to drive and regulate economic relations. In Australia a national competition policy was introduced in 1995 with bilateral support, establishing competition and cost consideration as the guiding principal of public policy at every level of government. The policy is enforced through a framework of law, including the Trade Practices Act 1973, the Competition Policy Reform Act 1995, and the Prices Surveillance Act 1983 as well as two regulatory bodies: the Australian Competition and Consumer Commission and the National Competition Council (Komesaroff, 1999, p. 170). The rationale of competition policy with regard to health policy is that market incentives can increase economic efficiency and make better use of resources to improve health outcomes and consumer wants.

**Divisions of General Practice (Divisions)** are local networks of general practitioners working within defined geographical areas. Divisions form a representative body for general practitioners and are structured to enable GPs to work together and within the wider health system to improve quality and continuity of care, meet local health needs, promote preventative care, involve GPs in continuing medical education and respond rapidly to changing community health needs. Divisions also provide general practitioners with a corporate identity, a method of influencing the organisation of health care delivery, a chance to utilise a broader range of skills, knowledge and expertise, and an opportunity to work with other stakeholders on issues of common interest (McNally et. al., 1995, in Rudd & Steed, 2000). By the end of 1999 there were 123 divisions throughout Australia (Power, P. & Aloizos, 2000).
**Fund holders or budget holders** are central to a managed competition, managed care, or purchaser/provider regimen. Budget holders are funded on a capitation basis, an amount per head of enrolled population, and are at risk for costs incurred by their enrolled populations. The budget holder enters into contracts with those who provide services, health and hospital care for the enrolled population, aiming to obtain maximum service for least cost.

**Fund pooling** describes a process of several agencies effectively transferring funding from their control to a centralised account or ‘basket of funds’ to be managed by an organisation (funds manager/funds holder) whose role is to address the health care needs of a target population. The primary purpose of fund pooling is to provide greater flexibility in addressing the needs of clients. This is achieved by the ‘removal’ of conditions normally attached to use of the funds by the originating funder (Pilla, 2000).

**Funders** are providers of the funding, in the case of the Trial it is the Victorian State Government, the Department of Human Services and the Federal Government, the Federal Department of Health and Aged Care.

**GP** general practitioner, a medical practitioner involved in what is referred to as family medicine or community medicine.

**KPI** Key performance indicator is an evaluative measure of performance

**Managed care** is an organised system of health care delivery, which aims to reduce costs and improve quality of health care. Managed care models are underpinned by competition policy, which relies on market principles to achieve efficiency in health care delivery and cost containment, while improving (or at least maintaining) individual health outcomes (Segal et. al., 1997).

**Network** represents a network of providers from which the Victorian Department of Human Services purchases health care. The networks are regional groupings of hospitals reporting to a board. The Southern Health Care Network constitutes a group of
hospital and community health service providers located in the south-east corridor of metropolitan Melbourne.

**Purchaser-provider model/split** aims to introduce market incentives into publicly financed systems. To achieve this distinct institutions are assigned managerial responsibility for the functions of supply and demand such that there exists a separation of government as purchaser of goods and services from the public and private agencies that provide them. Under this model small core government agencies, ‘purchasers’, purchase services from non public sector organisations, which are contracted to be providers. Providers depend on their revenue for contracts awarded to the ‘purchasers’, who are not consumers or patients, but purchasers commissioned to secure health improvements for their resident population by buying health services (Street, 1994, p. 370). The model involves setting up a market, in which potential providers compete for contracts from government and where the contracts specify exactly what goods or services are to be provided and on what terms.

**Service co-ordination** is the Trial intervention applied to clients who have been assessed as Level 2 (medium risk) clients. Service co-ordination involves linking clients to the health and community services recommended in the care plan and then following up to ensure that services are received by clients. The Southern Health Care Network Co-ordinated Care Trial Model defines this role as a ‘clerical, telephone-based booking and scheduling function’ and does not involve face to face contact between client and service co-ordinator. More detail about this role can be found in Appendix 1.

**Unplanned admissions** are ‘unexpected’ admissions into the acute (accident and emergency) sector, which may be preventable if there was more effective co-ordination between general practitioners and medical staff in the acute sector. One of the aims of the Trial was to achieve substitution of high cost acute care by community based service provision, by improving the co-ordination of clinical practice and improving the referral and administrative process to optimise communication and the flow of information between service providers.
Chapter 1

Introduction

1.1 Aims

The overarching aim of this thesis is to observe, examine and analyse the organisational dynamics of an implementation process within the health sector. The thesis examines organisational dynamics associated with the introduction of the Southern Health Network Co-ordinated Care Trial, referred to in the thesis as the Trial. This will be done through an intensive case study design described in Chapter 6.

Given the study has been undertaken in the context of an environment in which market principles are increasingly determining the allocation of the health dollar, a number of questions arise which the thesis explores. Has the market model impacted on the way stakeholders have experienced the implementation process? Does a market orientation have implications for the way a program is managed? Are there aspects of the health care sector that are intrinsically unique and hence require a management approach that reflects the needs inherent in Health?

In the research, the dynamics of an implementation team are studied over a period of two and a half years. Such an intensive case study provides an opportunity to learn about medium term organisational change. An opportunity to refine and clarify current thinking and assumptions about the management of change is created through the analysis of successes and failures in the process. Such knowledge can assist:

- the development of theories;
- extrapolation of successes to future program development;
- more effective program implementation and policy making; and,
- the expansion of the body of knowledge about change management and health care reform.

From an analysis of this study, the author argues from two major conclusions:
1. Failure by management to accommodate tensions that exist between providing care and managing cost led to a split in these functions, which impacted on the effective facilitation of the change process and capacity of stakeholders to embrace the model.

2. Clarity around the primary task is one of the key determinants of an effective change management strategy, particularly when the task is complex and the environment uncertain.

These arguments will be established and discussed in the thesis.

1.2 Note on Style

In order to facilitate discussion, the author will write in the first person. This style also underpins the tenor of the thesis in so far as the research reports on a method employing participant observation of organisational change. Throughout the thesis citations to Chapters and sections will be denoted by ‘c’ and ‘s’ respectively, so for example, Chapters 6 Section 2, will be cited as ‘C.6: S.2’.

1.3 The Case Study Organisation: The Southern Health Care Network Co-ordinated Care Trial

The Southern Health Care Network Co-ordinated Care Trial (the Trial) is a demonstration project established to explore changes to the financing and delivery of health care in a local geographical setting. The Trial is the transient organisation formed to undertake the implementation process of the Southern Health Care Network Co-ordinated Care Trial Model. It has occurred in response to cost and resource allocation pressures, and an increasing demand on the primary health and community support services sector to take a more active role in the provision of health care (Aged, Community and Mental Health, June 1998). It is part of a broader set of trials held in different regional areas. This thesis seeks to learn about the Trial implementation process through an exploration of its organisational dynamics. This includes how relationships emerged and operated throughout the Trial process from its beginnings to its winding down phases.
The establishment and ongoing conduct of all the trials has involved a complex set of arrangements between organisations and individuals. Included are interrelationships between the Trial sponsor (the Commonwealth), Trial management, local evaluator, patients and the myriad of agencies, institutions, and practitioners involved in the provision of services, including hospitals, divisions of general practice and community service agencies (Leigh et. al., 1999, p.7). In undertaking the thesis, I have needed to establish an arbitrary boundary around the Trial organisation to focus the study and contain the data. I have limited the presentation of the findings to the experiences and observed interaction of those who are most closely aligned with the organisation of the Trial. Members of the Trial organisation have included those directly involved in the care co-ordination process, including the Trial management and administrative support, the Executive Director of the Division of General Practice, service co-ordinators and case managers and the care co-ordinators they interact with.

1.4 The nature of the research, its demands on theory and methods

The operationalisation of the Trial Model has involved a series of interventions, bounded by guidelines and protocols developed by the Commonwealth of Australia. These are set out in Chapter 2. Within those boundaries the Southern Health Care Network Co-ordinated Care Trial Model has been shaped through its definition, interpretation and internalisation by role-holders (actors) and how they took up their roles and responsibilities.

The implementation process is an exercise in change management in the context of a complex and changing health and community care environment. The Trial’s actions and characteristics are informed and influenced by wider organisation linkages as well as the aspirations of stakeholders within. Hence the study of the Trial implementation process needs to be viewed in the context of a broader health reform agenda, which has social, political and economic dimensions and impacts on the agendas of the stakeholders. Studying an implementation process over time will be aided by a theoretical framework able to transcend a single account of change and to accommodate the experience of participants in a way that brings out complexities, competing perspectives and unconscious motivations.
One way of studying an implementation process is to explore the subjective accounts and experiences of stakeholders and their observed interactions. This way of analysing organisational dynamics involves the exploration of what Patton refers to as the ‘day to day, incrementalist, and conflict laden realities of program implementation’ (Patton, 1979, p. 328). It involves an exploration of the things people experience that makes the program what it is (Patton, 1990, p.95).

Organisational dynamics, including unconscious processes, can potentially facilitate or inhibit a change process (Czander, 1993; Stapley, 1996). An exploration in the case study of the dynamics that have occurred between individuals and groups during the two and a half-year implementation process provides a window for the exploration of change. This has required examining the ways groups and individuals have interpreted, internalised and operationalised the Trial Model of Co-ordinated Care over the two and a half years. It has involved an examination of the values and assumptions held by individuals and groups about co-ordinated care, how they internalised this understanding, and negotiated, constructed and enacted their roles. It has also involved an exploration of the impact of authority relations on role conception and role enactment and how stakeholders understood and interpreted the systems and structures that underpinned the Trial Model, the decision making processes, as well as interpersonal and inter group relations. It has involved understanding the difficulties and conflicts that have ensued in the process by investigating the relationships both within the Trial, and between the Trial and those interacting with it.

1.5 Overview of the Thesis

The introductory Chapter outlines the aims of the study, and sets the context for the theoretical approach, methodology and methods which are elaborated in more detail in further Chapters. Chapter 2 sets the scene in which the Trial Model implementation process occurs. The Chapter discusses the background to the health care reform debate, in light of current gaps in the Australian health care system. It discusses the rationale behind the introduction of co-ordinated care and the co-ordinated care trials, and introduces the Trial organisation and a brief overview of the Trial Model.
Chapters 3 and 4 set out the theoretical orientation underlying the thesis and the development of a conceptual framework appropriate to the study of the Trial implementation process. Chapter 3 argues that the theoretical framework needs to accommodate the study of the Trial in the context of broader systems, structures and power bases. A number of analytical perspectives are introduced and analysed, including planned and contingency models of change. A model conducive to the study of an implementation process over time is then described. A contextual/processual framework (Dawson, 1994; Pettigrew, 1990, 1985a, 1985b; Pettigrew et. al., 1988a, 1988b) enables the study of an implementation process, as an open system operating in the context of other systems, in a way that is neither causal nor linear and hence can accommodate complexity in relationships. However, the contextual approach, while acknowledging some irrational aspects of behaviour does not countenance unconscious dynamics, which can contribute to an understanding of observed individual and group anxiety. Chapter 4 introduces a psychodynamic frame to explore organisational dynamics, and presents the Tavistock sociotechnical systems approach (Miller & Rice, 1967) as a frame with which to explore the unconscious dynamics of a change process. Psychoanalytic theory provides an added dimension to the understanding of both data collection and analysis by offering a lens for the development of hypotheses regarding observed behaviour.

Chapter 5 sets out the research approach, the methodology and methods appropriate to the study of the Trial implementation process. Qualitative methodologies are conducive to a research process that seeks to understand an implementation process through the inter-subjective accounts and experiences of stakeholders. A complex case study method has been chosen to capture the implementation process. This method has been influenced by the work of Dawson’s ‘processual approach’ (1994) and Pettigrew’s ‘contextual approach’ (1985a, 1985b, 1990). These approaches centre on the importance of context in examining how change unfolds over time. The approach to research has also been informed by Shapiro’s ‘interpretive stance’ (Shapiro & Carr, 1991) which acknowledges research as an interpretive enterprise mediated by the subjective experience of both the researcher and the subjects. The interpretive stance makes room for both conscious and unconscious processes involved in a research endeavour.
Chapter 6 presents the findings derived from the interviews and qualified by my observations as a researcher. While patterns, themes and categories emanate from the data during the course of the research, they are guided by what Dawson (1994, 1997) following Polanyi (1983) refers to as ‘tacit knowledge’. This is the knowledge gained through experience and involvement, ‘a form of inarticulate intelligence’ (Gray & Pratt, 1991 in Dawson, 1997). The data presented are organised around the Trial trajectory over time from the developmental phase to its winding down in the context of a conflicted partnership arrangement, and a vociferous debate around the allocation of the health care dollar. It is segmented around beginning, middle and winding down phases. The beginning and preparatory phase is characterised by a drive for recruitment, (also referred to as a time of ‘confusion’). The middle is the live phase of the Trial, when the implementation process is activated, referred to as ‘the drive to cut costs’ (also referred to as ‘the dark ages’); and, the winding down phase is referred to as ‘the learning’ (also referred to as ‘the divorce’).

Chapter 7 discusses and interprets the findings in the context of theory and aspects of the health care reform debate. This thesis argues that ambiguity and confusion around the primary task of the Southern Health Care Network Co-ordinated Care Trial Model has led to anxiety expressed in conflicted, difficult and ambiguous intra- and inter-organisational dynamics. Failure by management to accommodate the tension that exists between providing care and managing cost has led to a split in these functions, which has impacted on the effective facilitation of the change process and capacity by stakeholders to embrace the model.

Chapter 8 provides some concluding comments regarding the management of a change process, arguing that clarity around the primary task is one of the key determinants of an effective change management strategy, particularly when the task is complex and the environment uncertain.
Chapter 2

Context

2.1 Introduction

This chapter sets the background to the Southern Health Care Network Co-ordinated Care Trial Model implementation process. Section 2.2 discusses the background to the health care reform debate in light of current gaps in the Australian health care system. Section 2.3 presents the rationale behind the introduction of co-ordinated care. Section 2.4 explains the features of generic care co-ordination models and introduces the population-based model of co-ordinated care. This is the model of co-ordinated care that underpins the Southern Health Care Network Co-ordinated Care Trial Model. Section 2.5 introduces the reader to the co-ordinated care trials and presents the guidelines and basic features of the evaluation required for the trials. Section 2.6 discusses the Southern Health Care Network Co-ordinated Care Trial organisation and the Trial model. Section 2.7 presents the design features of the evaluation of the Southern Health Care Network Co-ordinated Care Trial.

2.2 Background issues facing the Australian health system: The health care reform debate

Debate exists about the directions the health system should take. Central to the debate are issues around cost, purpose, control, efficiency and effectiveness of the current system of health care (Swerissen & Duckett, 1997). The potential for rising costs associated with an ageing population, changes in technology of care, and increased consumer expectations has created concerns among developed nations regarding the allocation of the health dollar (OECD, 1992; Patterson, 1996; Swerissen & Duckett, 1997; Donato & Scotton, 1998). Demographic and other trends in Australia have resulted in an increased level of demand for health and support services. The role of institutional based care is also changing so that people, who were previously institutionalised, are now living in the community. Values are also changing in response
to the pressure on resources, such that there is an expectation that the frail, or disabled with chronic illness should be supported, so that they can live in the community (Aged, Community and Mental Health, June 1998).

Health resources allocation is understandably contentious and issues associated with health are emotional and value laden. Choices that need to be made at a public level cannot realistically be divorced from underlying value systems and ethical imperatives around what constitutes social justice (Mooney, 1998; Richardson, 1998).

Authors who assert that real health care costs are increasing, cite the progressive growth of GDP devoted to health services over the last fifty years (from 3 percent to 8-9 percent in developed countries), combined with the fact that real costs of health care have risen faster than the rate of growth in the economy (Mooney, 1997, 1998; Butler, 1998; Swerissen & Duckett, 1997; Richardson, 1998).

The fundamental choice in health care decision making is accepting the message of resource scarcity, and thus the need for specific agreed objectives for rationing these resources and believing that everything is possible, with high expectations that will inevitably be thwarted (Mooney, 1997, p. 575).

Others contend that Australia does not have a health expenditure problem at present. Buchanen (1999) cites health expenditure in Australia as about 8.5 per cent of GDP, which is in the middle of the OECD countries, and less than the United States, which is 14 per cent of GDP (Productivity Commission Report, No. 57, 1997, into Private Health Insurance p. 291 in Buchanen, 1999, p. 29). Rosenthal (1999) asserts that the scarcity phenomenon is a myth, arguing that there is a deliberate skew in the way facts are presented, so as to obscure the distribution of wealth away from the low socio-economic groups in society (Grant & Anaf, 1999). She argues that society has more than enough resources to provide top quality health care services to everyone, but chooses to reward the few at the expense of the many by opting for a health care system that is driven by privatisation, industrialisation and rationing of health care (Rosenthal, 1999).

The current Liberal Coalition Government’s approach to health care reform is informed by much of the recent health economics literature (Mooney, 1997, 1998; Butler, 1998;
Scotton, 1998; Richardson, 1998), which treats health care as a scarce resource that requires rationing. To the extent that the market decides the way the health care dollar is allocated, issues of equity, fairness and universal access to health services are not necessarily guaranteed (Hancock & Mackey, 1999; Duckett, 1999).

At the centre of the Government’s approach to health care is an increasing emphasis on the role of the market in regulating decision making. Underpinning a major aspect of the reform agenda impacting on the Australian health care system is cost rationalisation. In the two decades since the introduction of Medibank by the Whitlam Labour government, Australian health policy makers have shifted their concern from equity and social justice to cost containment and now cost effectiveness. These trends are not unique to Australia or to the management of the health system (Swerissen & Duckett, 1997, p.33).

Soon after taking office in May 1996, the Minister for Health, Dr Michael Wooldridge, presented the Government’s commitment to promoting competition in the health care sector (Komesaroff, 1999).

One fundamental of micro-economic reform has been the application of competition principles to industry, including those where public sector funding and provision has been significant, as it is in the health sector (Wooldridge, 1996 in Komesaroff, 1999, p. 266)

Issues around financing are compounded by institutional and structural characteristics that are peculiar to the Australian health system. The complex division of powers and responsibilities for the financing, provision and regulation of health care services between Commonwealth and State governments remains a dominant feature of the Australian health system. The jurisdictional overlap is further compounded by a multiplicity of different programs at both Commonwealth and State level. The result is a highly complex, fragmented and uncoordinated system, which lacks the flexibility and responsiveness to meet the demands of individuals and communities, particularly those with chronic illnesses and complex health care requirements (Donato & Scotton, 1998; Council of Australian Government Communiqué. Canberra, 11 April 1995, in Segal et. al., 1999).

In addition to the duplication and overlap of programs and poor integration of services, there have been problems in cost shifting from capped budgets to uncapped areas under
Commonwealth control, such as the Medical Benefits Schedule and the Pharmaceutical Benefits Schedule programs. There is a concern that the current system of Medicare enables providers, such as medical professionals and other health workers, to drive up the cost of health care in their own interests (Donato & Scotton, 1998; Swerissen & Duckett, 1997).

Under the Medicare Agreement the Commonwealth places pressure on the States to achieve efficiency improvements or reduce hospital budgets through other strategies (Duckett, 1998). Given the pressures imposed by the Commonwealth, State governments facing budgetary constraints have an incentive to place increasing pressure on the primary health and community support services sector, to take a more active role in the provision of health care (Donato & Scotton, 1998).

2.3 Introduction of co-ordinated care

Concerns raised by the Council of Australian Governments (COAG) regarding current health funding and service delivery arrangements led to the establishment in 1995 of a blueprint for a reform process of the Australian health system. The reforms were aimed at realigning fundamental responsibilities in financing, planning, organising and managing health and community services. On the agenda were proposals to explore ways of clarifying the funding and service responsibilities across all levels of government in order to improve the integration of the array of health service programs and to eliminate duplication and cost shifting (Donato & Scotton, 1998; Segal et. al., 1999).

One such initiative has been the introduction of co-ordinated care. The introduction of co-ordinated care to the funding and delivery of health care has attempted to address some of the current problems in service co-ordination within the public system, and to integrate the health of the patient through a more effective and systemic approach to health care delivery. This model involves structural changes to address the widely documented failures of current health funding and delivery arrangements (Segal et. al., 1999). This will be discussed in more detail below.
The implementation of co-ordinated care has not occurred in a vacuum. Tensions occurring in the broader health system have impacted on the introduction of co-ordinated care. The financing and delivering of health care are complex issues, and reform has persistently been on the political agenda (Richardson, 1998). Not surprisingly there have been significant disputes between key stakeholders about the development of co-ordinated care (Swerissen & Duckett, 1997). Whilst the idea of care co-ordination has gained increasing prominence in recent years both conceptually and in practice, its meaning has remained somewhat contested, mainly because shared understanding about what it can and should involve is limited (Dawson et al., 1999).

Decisions regarding the allocation of responsibilities in the funding of the model of co-ordinated care cannot be divorced from the historical tensions between Commonwealth and States. The States and the Commonwealth contested the extent to which various funding sources, such as Medicare and the Pharmaceutical Benefits Scheme, were to be included in the funding pool. There was contention around how the fund pool would be allocated, the scope of services to be included, the extent to which user and provider participation would be voluntary, and which level of government should be responsible for start up costs, Commonwealth or State. Consumers wanted assurances that participation would be voluntary, Medicare would not be undermined, quality and diversity would be protected, and funding would not be reduced. There were also concerns that the model of co-ordinated care, as conceptualised by the Commonwealth, was too medically dominated (Swerissen & Duckett, 1997).

2.4 Models of co-ordinated care

In response to the increasing pressure on health funding and delivery arrangements, various models of co-ordinated care are being introduced across Europe, North America, and New Zealand, and international ideas about the funding, planning and management of the health system have been intensely scrutinised since 1993 (Swerissen & Duckett, 1997).

There exist a number of models of co-ordinated care, and opinions vary about its form. The diversity in care co-ordination models reflects differences in objectives and client
group. Models range from population-based system-wide responses, such as the General Practitioner Fund Holding Scheme in the United Kingdom and the Managed Care Plans of Health Maintenance Organisations in the USA, to targeted case management services for specified eligible groups with highly complex care needs (Segal et. al., 1997).

There exist common elements in these models. Models of co-ordinated care are underpinned by a market paradigm, in which market incentives guide resource allocation in a way that is thought to increase economic efficiency. Proponents of this approach argue that economic efficiency leads to a better use of resources, improved health outcomes, and satisfied consumer wants (Scotton, 1998). The aim of co-ordinated care models is to reduce costs by expanding and improving community based services, and reducing the number of people in residential and acute care facilities (Fine & Thomson, 1995).

Typical elements of co-ordinated care models are set out as follows:

- An enrolled population of patients defined by geographic area and/or disease health needs;
- Fund holding arrangements where the size of the pool is capitated and the basis for establishing the size of the pool is determined by a population risk adjustment formula, historic service use, and individual needs assessment. Co-ordinated care models vary in size of budget, the level at which funds are pooled, mechanisms for drawing on funds and characteristics of the fund holder;
- Use of service delivery and clinical protocols to determine health care needs and service access;
- Cost containment through selective contracting and managed care (e.g. competing health plans and packages based on lowest costs), that limit the panel of specialists and choice of hospital available to those who have enrolled in the care plan.
2.4.1 Population-based co-ordinated care models

During the 1990’s there has been an introduction of what are referred to as population-based models of co-ordinated care. A population-based model of co-ordinated care is often referred to as a ‘managed care’ model (Segal et. al., 1997).

Managed care models are underpinned by competition policy, which relies on market principles to achieve efficiency in health care delivery and cost containment, while improving (or at least maintaining) individual health outcomes. The focus involves the processing of an episode of care with the major aim to substitute less expensive for more expensive services wherever possible, and to minimise costly events such as hospital admissions. The managed care plan is responsible for providing all health services to those enrolled, who negotiate with a set of preferred providers on price, quality, clinical management protocols and access. Strategies for cost control occur through the development of centralised care plans and protocols. A single funder is central to these schemes, with a single administrative structure, which has clearly defined responsibilities for the management of episodes of care. Generally a case manager takes on the administration of the care plan. (Segal et. al., 1997).

One of the premises of the managed care model is that there exists potential for improvements to the efficient allocation of health services, by ensuring that clinicians follow best practice protocols. Weinberg (1988 in Richardson, 1998 p. 210) argues that clinicians are resistant to best practice guidelines and do not follow best practice initiatives. He refers to ‘an intellectual crisis’ in the scientific basis of clinical practice, a situation in which clinicians commonly do not know the best treatment regimen, and in which clinical decisions are based on personal preferences or inadequately justified judgements. Hence managed care generally involves the contracting out of health care to a third party, who assumes full responsibility for the provision of health services for its members (Richardson, 1998).

Managed care has been hotly contested by medical practitioners, ethicists and consumers of the health system. Medical practitioners oppose the idea of managers directing clinicians to manage health care in a way that manages cost. Moreover concerns have been expressed at the potential for managed care models to tamper with
the doctor-patient relationship. At a more general level those who eschew a market model argue that applying competition principles to the regulation of health care policy is neither ethical nor economically beneficial to society. They contend that certain services including education and health care have social value and are community rights and therefore their provision is the responsibility of governments to provide (Komesaroff, 1999; Hancock, 1999a; Brand, 1997).

Managed care models are not new to Australia. Australia has effectively had capitation arrangements operating for a number of years to finance public hospitals. Governments are outsourcing services, previously provided by government employees, to regional groupings of hospitals, referred to as networks, which are effectively fund holding entities. The process of outsourcing is referred to as the purchaser-provider split, which involves a split between the purchasers and providers of health care. In Victoria, public health care has been outsourced to networks of providers from which the Department of Human Services purchases health care. In this model health services are provided by hospitals, nursing homes and community health centres which do not have a budget but depend for their revenue on tendering for contracts awarded by the purchaser or ‘budget holder’. These are the third parties commissioned to secure health improvements for their resident population.

2.5 Establishment of Co-ordinated Care Trials

The co-ordinated care trials were pilot studies designed to test the application of a co-ordinated care alternative to the funding and delivery of health care. Co-ordinated care is defined for the purpose of the trials as follows:

The explicit process of planning and organising the provision of services through the pooling of funds (within current resource levels) and the development of agreed individual care plans for people who have difficulty accessing appropriate services and/or self managing their care needs over a long period of time (Leigh, et. al., 1999, p. 8).

Nine co-ordinated care trials were conducted in Australia, of which the Southern Health Care Network Co-ordinated Care Trial was one. The features of the trials were diverse. There were differences in the size of the target populations, the method for allocating
clients to the intervention or control groups, eligibility criteria, role and function of personnel involved in care co-ordination activities, the care planning process, and development and distribution of their funds pool (Leigh, et. al., 1999). However, all trials were expected to follow the same Government guidelines and test the primary hypothesis that:

Co-ordination of care for people with multiple service needs where care is accessed through individual care plans and funds pooled from existing Commonwealth, state and joint programs, will result in improved individual client health and well-being within existing resources (Leigh, et. al., 1999, p. 5).

An additional 8 secondary hypotheses were developed to test a range of issues including substitution; fund pooling; administrative arrangements; aspects of care co-ordination, and client characteristics (National Evaluation Team of the Co-ordinated Care Trials, 1999). In developing a methodological approach the national evaluation established a plan which comprised the requirements of three types of data. This included:

- Descriptive and contextual information about the establishment and operational features of each trial;
- Quantitative data about clients, their use of services, health status and outcomes, level of satisfaction, and progress;
- Qualitative information on the impact of the trials on clients, service providers and the health and community services system generally (Leigh et. al., 1999).

Except for the requirements that evaluators should use an experimental epidemiological methodology for the quantitative analysis, other aspects of the methodology have not been prescribed and each of the nine Local Evaluators were free to choose a methodology appropriate to exploration within these parameters.

The publication of the Commonwealth’s guidelines on the ‘Role of GPs in Co-ordinated Care trials in 1996’ (Commonwealth Department of Health and Family Services, 1996) has impacted on the development of the local care co-ordination models. The document described the general practitioner as ‘the central focus of primary health care…’ and provided for a number of guidelines to assist trial sponsors in developing an appropriate
role for general practitioners within their proposal. The targeting of general practitioners as care co-ordinators is based on the evidence that a strong gate keeper role for general practitioners leads to a strong primary health care system (Starfield, 1996 in Report of the General practice Strategy Review Group, 1998). In their role as gatekeepers to the rest of the medical system, general practitioners have a profound influence on health outcomes and health expenditures and hence have been targeted as care co-ordinators, in the co-ordinated care trials.

By October 1997, nine of the twelve trials that submitted protocols were proceeding, with parameters being broad enough so that each trial could develop a design that was contextually specific (Leigh et. al., 1999).

2.6 Southern Health Care Network Co-ordinated Care Trial (SHCN CCT)

2.6.1 Southern Health Care Network Co-ordinated Care Trial Model

The Southern Health Care Network Co-ordinated Care Trial was one of nine trials established to test co-ordinated care. Its design was heavily influenced, although not prescribed, by the Commonwealth guidelines referred to above, hence the focus on the role of the general practitioner in the Southern Health Care Network Co-ordinated Care Trial Model. The stated primary objective of the Southern Health Care Network Trial Model of Co-ordinated Care was to improve the health outcome of an identified target group, who were previously high cost users of the Network’s acute care facilities (Ross et. al., 1999). One of the assumptions underpinning the Southern Health Care Network Co-ordinated Care Trial was that care could be co-ordinated more effectively with current resources by formally managing the total range of health services. The model involved a series of interventions provided to individuals based on an assessment of their health needs. The components of the model were:

- Care co-ordination and care planning available to all Trial participants and provided by the general practitioner, who is referred to in the model as the care co-ordinator;
- Service co-ordination for those with moderate needs;
Case management for those requiring intensive intervention (Ross et. al., 1999).

A more detailed presentation of the roles and responsibilities associated with these interventions can be found in Appendix 1.

These interventions were aimed to assist ‘clients’ navigate a system characterised by:

- Fragmentation, in which there existed a diverse number of providers, with few formal co-ordinating mechanisms between them;
- Rigid eligibility criteria making it difficult to place clients;
- Narrowly focussed purchasing arrangements placing inflexible conditions on service providers; and
- Service gaps due to a situation where the demand for services exceeds available supply.

No additional funding was made available and the care co-ordination team was required to navigate within the existing system to co-ordinate care and hence facilitate systemic reform. New services were to be financed from any savings arising out of reduced hospitalisation, from better monitoring of pharmaceutical use, and from improved patient health (Ross et. al., 1999).

‘High cost’ or ‘at risk’ participants have been identified as those costing the acute sector more than $4,000 between 1994 and 1997, in two main regional hospitals (the Southern Medical Centre and the Dandenong District Hospital) and residing within a defined catchment area, with all ages and diseases represented. High cost acute care was chosen as the focus, because the Southern Health Care Network wished to test the hypothesis that recent high cost hospital use is a predictor of future high cost use, which could be mitigated by effective care co-ordination (Ross et. al., 1999).

The Southern Health Care Network Co-ordinated Care Trial has been designed to test whether a generically applied intervention of care co-ordination, operating within a framework of existing services, could make a difference to the health and well-being of a group of ‘at-risk’ people in a defined population… The Southern Health Care Co-ordinated Care Trial sought to substitute appropriate community care, for expensive acute care...
care based on the belief that clients with multiple needs could have their care better managed through a more integrated service system that transcended the traditional constraints of the State and Commonwealth funded programs... A major focus was to establish and maintain improved communication and referral patterns for health service providers in the designated geographic area of the Trial. This will encompass all health service providers; from general practitioners, medical specialists, hospitals, through organisations such as the Royal District Nursing Service and community health providers (Ross et. al., 1999, pp. 149-150)

In addition the Southern Health Care Network Co-ordinated Care Trial sought to examine:

- The emerging role of the general practitioner as care co-ordinator;
- The extent of patient involvement in the development of individual care plans;
- The scope of the funds pool;
- The nature and size of any shift in health service mix;
- The level of patient contributions;
- The interface between the acute and primary sectors and the way these relationships facilitate or adversely impact on client care (Ross et. al., 1999).

### 2.6.2 The Southern Health Care Network Co-ordinated Care Trial Organisation: Structure

The Southern Health Care Network Co-ordinated Care Trial was auspiced and initiated by the Southern Health Care Network. The Network is the main provider of tertiary and secondary health services in the region. The Trial was established by an agreement between the Commonwealth of Australia and state of Victoria and the Southern Health Care Network, with the intention that the Government and the Southern Health Care Network participate as partners in the Trial. A Memorandum of Understanding between the Southern Health Care Network and the Dandenong Division of General Practice set out the partnership arrangements between the Divisions of General Practice and the Southern Health Care Network (Southern Health Care Network and the Dandenong District Division of General Practice and the Sherbrooke and Pakenham Division of General Practice. 1997a). It was seen to be the mechanism for ensuring the objectives of the Trial were met and that collaboration between practitioners was enhanced. It set
out each Trial partner’s role, responsibilities, outcome expectations and performance indicators, funding and expenditure frameworks, communication and reporting requirements, which relate specifically to care co-ordination (Ross, 1999).

**Southern Health Care Network Co-ordinated Care Trial Organisational Structure**

The Trial organisation constituted a transitory partnership between the Divisions of General Practice and the Southern Health Care Network for the duration of the trial period. The partnership involved the Southern Health Care Network and the Dandenong District and Sherbrooke and Pakenham Divisions of General Practice, together with Springvale, Berwickwide, Cranbourne, Dandenong and Cardinia Community Health Centres (Community Health Centres were brought in under the umbrella of the Southern Health Care Network). The Southern Health Care Network largely represented the interests of the acute sector, while the Divisions represented general practitioners and were linked to the community through their constituent general practitioners.
The driving force behind the Trial and prime sponsor was the then CEO of the Southern Health Care Network. The Trial was seen as a potential contribution to the Southern Health Care Network’s key strategic objectives, which included:

- The development of more appropriate ways of providing health care services;
- Better access to a range of health care services for the target population group
- Improved quality of care;
- Enhanced efficiency (Southern Health Care Network (1996a) (Vic) original submission: Commonwealth Department of Health and Family Services, p.3).

The Southern Health Care Network, as the Trial sponsor, held overall responsibility, devolving the operational elements of care co-ordination to the Dandenong District Division of General Practice. The Division was responsible for the management of the care co-ordination function of the Trial, while the Network was held responsibility for managing the funding and information technology process and tracking client usage and costs.

The Trial was headed by the Project Manager, who was accountable to the Southern Health Care Network and Dandenong District Division of General Practice. The care co-ordination team was headed by the Division Director, Dandenong District Division of General Practice. The Trial was accountable to the Monitoring and the Management Committees and the National Evaluators. It also had responsibilities to the Local Evaluators, the Consumer Reference Group, the General Practitioner Reference Group, the Acute Sector, the Community Health Centres (now part of Network), as well as a number of local agencies including the Royal District Nursing Service, Windermere Child and Family Services, Kingston Centre, Dandenong Psychiatric Hospital, and others represented at the Service Co-ordination Reference Group.

A care co-ordination manager headed the care co-ordination function. The position reported to the Division of General Practice and had accountability to the Network. The case managers and the service co-ordinators reported to this position. Case managers from other agencies had accountabilities to this position in terms of the reports they provided.
Links to the care co-ordinators (general practitioners, who participated in the Trial) occurred through the Division and the General Practice Reference Group, whose role was to guide the implementation of the Trial Model and to provide advice to Trial management on all aspects of care planning for clients.

Physically the Trial offices were located in the premises of the Dandenong District Hospital, part of this Health Care Network. The Trial manager and her administrative and management support staff were housed in these offices. Those involved in providing patient services were not located at the Trial premises. The case managers and service co-ordinators were located at the Community Health Centres from where they were contracted. The care co-ordinators were located in the geographical region of the Greater Dandenong Area, where their general practices were situated. The Divisional management was housed at the Division premises, which were also located on the grounds of the Dandenong District Hospital.

2.6.2.1 The Monitoring Committee

The Trial management reported to the Monitoring Committee, which represented the interests of the funders, the state and Commonwealth Governments. Given the Network’s role as Trial sponsor, it attended Monitoring Committee meetings ‘to present reports, raise issues and to provide explanatory information on issues of importance’ (Southern Health Care Network Coordinated Care Trial Monitoring Committee, 1996a). In effect the Southern Health Care Network, as Trial sponsor, reported to the funders, the State and Commonwealth Governments.

The main objectives of the Monitoring Committee were to:

- Monitor financial performance and viability, including the assessment of the level of funding to be provided to the pool in accordance with agreed funding parameters;
- Monitor the progress of the Trial in terms of client involvement and satisfaction;
- Ensure the Trials were evaluable; and
• Inform strategic decision making (Southern Health Care Network Coordinated Care Trial (1996b)).

2.6.2.2 The Management Committee

A Management Committee made up of representatives of the Divisions of General Practice and the Southern Health Care Network, which included the Community Health Centres, oversaw the management of the Trial.

The role of the Management Committee was to oversee the Network’s obligations contained within the Agreement for Co-ordinated Care Trials. The obligations outlined the deliverables, time frames and payments from commencement of Stage 1 of the Trial to the time when the Trial went ‘live’ (Southern Health Care Network Coordinated Care Trial, (1997)).

2.6.2.3 Other Groups

The Trial also had accountabilities to:

• The Consumer Reference Group, which was an advisory body to the Trial and linked the Trial with organisations representing consumers (Southern Health Care Network Coordinated Care Trial, 1997c);
• The General Practitioner Reference Group, which linked the Trial to the community of general practitioners in the area. It also acted as an advisory body to the Trial, providing input into decisions impacting on the general practice community (Southern Health Care Network Coordinated Care Trial, 1997d);
• The Service Provider Reference Group, which linked the Trial with the broader community of service providers. Although this group was not formally established as part of the Trial support structure, it developed as a response to the need for improved communication with the broader health system;
• The National and Local Evaluators, who were responsible for the national and local evaluations respectively.
2.7 The Local Evaluation of the Southern Health Care Network Co-ordinated Care Trial

Each trial was funded to conduct a local evaluation, responsive to local circumstances, while also meeting the requirements of the national evaluation. Each trial was assessed against the national hypotheses (primary and secondary) and any additional hypotheses established at the Trial level (Leigh et. al., 1999).

The Southern Health Care Network contracted the Centre for Health Program Evaluation to conduct the local evaluation of the Trial. The Centre is part of the Department of Economics, Faculty of Business and Economics at Monash University. It is located at the Austin & Repatriation Medical Centre in West Heidelberg, Victoria. Ethics approval was gained from the Monash Medical Centre Research and Ethics Committee to conduct the Trial.

The chosen methodology was an experimental epidemiological methodology. The study design was a randomised control trial whose aim was to test the primary hypothesis outlined in Section 2.6.1. Other requirements of the local evaluation were embodied in secondary hypotheses, which sought to explore characteristics of the care co-ordination function, administrative arrangements, and client characteristics. The secondary hypotheses were addressed through qualitative research methods comprising interviews and focus groups with stakeholders.

The membership of the evaluation team was diverse with members focusing on different aspects of the Trial evaluation. The evaluation team comprised an epidemiologist, statisticians and data processors, a health economist and a qualitative researcher. I was employed as a member of an evaluation team to conduct the qualitative research.
CHAPTER 3

CONCEPTUAL FRAMEWORK:
A CONTEXTUAL APPROACH

3.1 Introduction

A theoretical framework, able to transcend a single account of change, is appropriate to the study of the Trial implementation process over time. A framework is required that accommodates the many contexts and meanings people use to govern their behaviour. It needs to accommodate the experience of participants in the Trial, in a way that brings out the ongoing interplay of political agendas of the vested interest groups. The framework needs to be able to accommodate the study of the Trial in the context of other stakeholders and hence needs to accommodate the influences of broader systems and power bases that shape those interactions. The framework needs to be dynamic and accommodate change agendas and hence be able to accommodate an action-reaction process between players, both within the institution of the Trial and between the Trial and the broader context. It is also helpful if the framework is one that can recognise the inherent anxiety experienced by stakeholders in a change process.

A conceptual framework and associated methodological approach is required that acknowledges that human beings exist in an interactive relationship with their world and that they influence and are influenced by their context or environment. Hence a conceptual framework is required that:

- Incorporates rather than detaches the analysis of change from its context;
- Acknowledges individual and group perceptions of reality, as forms of knowledge that enhances an understanding of a change process;
- Accommodates group dynamics and acknowledges the potential for unconscious dynamics to facilitate or inhibit a change process.
This chapter presents various models of change, in order to arrive at a conceptual framework, that is able to accommodate the study of a change process. Given the Trial has taken place in the context of a broader health system reform agenda, an approach to its study needs to be one that accommodates the impact of the wider environment. An open systems framework is introduced and a number of models of change are presented and explored. These include planned approaches to change embodied in the organisational development and contingency models as well as more dynamic approaches to change embodied in a contextual approach. Chapter 4 introduces a psychodynamic frame for exploring unconscious dynamics inherent in organisational life.

3.2 A conceptual framework

Open systems theory provides a broad framework within which to explore the Trial. A number of theories sit under the umbrella of the systems framework. Some are more conducive than are others in providing a conceptual map enabling exploration of the Trial implementation process, in that they are able to encompass the requirements outlined above. While organisational development and contingency theories accommodate an organisation operating in the context of a wider system, they are limited. The organisational development models fail to acknowledge sufficiently a complex and changing external environment, while the contingency models operate on the dubious assumption that management is able to manipulate organisational structure and strategy to cater to the vagaries of an unpredictable and complex external environmental (Dawson, 1994; Wilson, 1992; Pettigrew, 1990).

The contextual approach (Pettigrew, 1985, 1985a, 1985b, 1990; Pettigrew et. al., 1988a, 1989; Whipp et. al., 1987) and the Tavistock sociotechnical approach (Rice, 1963, 1967 and Miller & Rice, 1967) are theoretical frameworks more readily able to accommodate the experience of the Trial implementation process. While they have weaknesses, discussed in the body of the chapter, they have the requisite strengths. They are able to accommodate uncertainty both within and outside the system. They accommodate the nature of inherent conflict both within the system and between the system and its
environment and both acknowledge that the organisational change process does not necessarily occur in a rational linear manner and hence eschew predominantly rational approaches to organisational change. While there exists overlap, both frameworks make contributions to organisational theory in different ways. The contextual framework focuses on the impact of social, political and historical factors on intra- and inter-organisational dynamics. The strength of the Tavistock sociotechnical model is that it acknowledges the place of the unconscious and hence provides a framework for exploring some of the seemingly irrational organisational dynamics that have been part of the Trial implementation process.

3.3 Open systems theory: an explanation and critique

Open systems theory has had a major impact upon the study of organisations, particularly with regard to the emphasis placed upon the nature and influence of environment, and on organisations as processes rather than structures (Burrel & Morgan, 1979). A vast literature has developed around systems theory and the term ‘systems’ has varied meanings that are often contradictory and conflictual (Patton, 1990). Systems’ thinking is a loose body of ideas and techniques and each practitioner will give his or her own version of which concepts are most important (Campbell, 1994). It embraces many ways of looking at the world. It is not intrinsically tied to any specific view of social reality (Burrel & Morgan, 1979). The literature on systems is broad and stems from a variety of different sources (Long, 1992). Although issues around systems theory are broad and at times confused, systems theory acknowledges real world complexities, viewing things as entities embedded in context and still larger wholes (Patton, 1990).

While systemic thinking is not an explanatory theory, in that it does not explain why organisations behave as they do, it is a framework for observing and understanding the world in terms of the connections amongst many parts (Campbell, 1994).

Kast and Rosenzweig’s (1979) conceptualisation of a system and sub-systems provides a framework for exploring organisational theory. Under this view the organisation is not a technical or a social system. Rather, the systems approach is based on the structuring
and integrating of human activity around the technical task, which constitutes the activities of the organisation. The technologies affect the types of inputs into the organisation, the nature of the transformation process, and the outputs from the system. However, the social system determines the effectiveness and the efficiency of the utilisation of the technology. The internal organisation can be viewed as consisting of a number of major sub-systems, including the goals and values, the technical, the psychosocial, the structural and the managerial subsystems.

Different management theories emphasise the role of different sub-systems, while discounting the role of others. Traditional management theories embraced in the work of (Fayol, 1949) emphasise the structural and managerial subsystem. The management science school (Taylor, 1947) emphasise the technical subsystem and methods for quantifying decision making processes, while the human relations and behavioural scientists (Maslow, 1943; McClelland, 1961) emphasise the psychosocial subsystem and focus attention on motivation, status and role relationships, group dynamics and influence systems. Kast and Rosenzweig (1979) view the socio-technical approach as differing from many of the other systems frameworks in that it considers all primary sub-systems and their interactions (Kast & Rosenzweig, 1979).

3.3.1 Planned change models: Organisation Development and Contingency approaches to change

Some models of change understand the relatedness of an organisation to its environment as one that is readily manipulated or ‘managed’ by the management subsystems. Organisations are conceptualised as concrete, homogeneous entities, which respond to rather than influence the environment, or are ‘active agents operating with others in the construction of the world’ (Morgan, 1986, p. 74).

Approaches which place focus primarily on the structural and management subsystem (Donaldson, 1987; Dunphy & Stace, 1990), construct the relationship with the environment as being more unidirectional, where the environment can be managed through appropriate strategy. Moreover many of these approaches assume ‘functional unity’ (Morgan, 1986), where actors behave mechanistically and altruistically in the pursuit of organisational goals (Pettigrew, 1990). The organisation is viewed as a
unitary system under the umbrella of a common task, where the social system is a positive force contributing to task achievement (Burrel & Morgan, 1979). Relationships that are established within the system provide for integration, coherence and stability thereby strengthening the systems security (Alderfer, 1972 in Czander, 1993, p. 178).

The contingency and organisational development (OD) approaches are consistent with a view of the world where the environment is treated as a variable to be managed. The organisational development (OD) approaches to change (Blake & Mouton, 1964; Lawrence & Lorsch, 1969; Lewin, 1952 in Dawson, 1994) adopt a normative framework, assuming ‘one best way’ to manage change that will increase both organisational effectiveness and employee wellbeing (Dawson, 1994). These models are based on the principle of achieving consensus and participation between individuals and the organisation. Effective participation will lead to consensus among those most affected by change (Dawson, 1994; Wilson, 1992; Pettigrew, 1990). They are also based on a static view of the external world, which views it as relatively stable. There are a number of models established to assist managers to analyse change, predict the likely consequences of change, and handle resistance and blockages along the way, as described in Lewin’s (1951) force field analysis. These models are not equipped to deal with the continuing dynamics of change as they are unidirectional, and assume the external environment is relatively static. Hence their strategies do not meet the demands of the unfolding and complex nature of ongoing change processes (Dawson, 1994; Wilson, 1992; Pettigrew, 1990).

Situational or contingency models are a variation on the OD planned approach to change. They provide a conceptual framework to respond to an increasingly unpredictable, chaotic and discontinuous environment (Limerick et. al., 1987, Kanter, 1990; Peters, 1987; Waterman, 1988; Kantrow, 1987; Morgan, 1988 in Dawson, 1994). These models assume that if organisations are operating in a dynamic and complex environment, then survival is contingent on their capacity to manage change in this environment. Whereas the OD change models assume there is one way to manage change, the contingency models offer the reader an array of strategies across a contingency smorgasbord (Rhaab, 1995). These models are underpinned by the work of Thompson (1967), Lawrence and Lorsch (1967), Burns and Stalker (1961), Pugh and
Hickson (1976) in Dawson (1994) and more recently in Donaldson (1987) in Dawson (1994) and Dunphy and Stace (1990). Strategy towards change is not treated as a single reaction to adverse contingent circumstances. Instead managers are offered a number of strategies for managing the change process depending on the situation. ‘The basic tenet of these models is that, whilst there is no best way of organising, it is possible to identify the most appropriate strategic form to fit the context in which business has to operate’ (Wood, 1979, p. 335 in Dawson, 1994, p 12). For example, Burns and Stalker (1961) identified a continuum of organisational forms ranging from ‘mechanistic’ to ‘organic’ concluding that organic, or more flexible forms of responding to change, were required to deal with changing environments, as opposed to ‘mechanistic’ or more rigid approaches. Dunphy and Stace’s framework (1990) is based on the concept that planned change can be managed along the lines of identifying the key contingencies, which gives managers a choice of strategies for managing organisational change in different circumstances.

Dunphy and Stace identify four types of leadership approaches to meet differing circumstances: ‘participative evolution’ which refers to incremental change through collaboration; ‘forced evolution’ which refers to incremental change through direction; ‘charismatic transformation’ which describes large scale discontinuous change achieved by collaboration; and ‘dictatorial transformation’ which describes major coercive change programs (Dunphy & Stace, 1990).

Contingency models of change are limited for the following reasons. First, they impose unidirectional rational models on what is a complex, political and dynamic process (Dawson, 1994, Pettigrew, 1990). They also fail to define ‘the environment’, which makes planned strategic change through a contingency approach questionable both empirically and theoretically as well as risky (Wilson, 1992).

Second, these models do not adequately explain organisational schism and major conflict. They do not provide an adequate perspective on resistance, conflict and anxiety involved in change processes (Czander, 1993) and do not acknowledge organisations as political entities (Morgan & Smirchich, 1980; Burrel & Morgan, 1979). These models treat organisational culture as a unifying force that is available for management to
identify as a controllable variable to enhance organisational effectiveness (Stapley, 1994).

Third, rational technical models of change, based on ontology of an objectively knowable world, are limited in their capacity to provide a conceptual framework for understanding the dynamics of an implementation process over time. They fail to accommodate the complexity of the change process (Dawson, 1994; Wilson, 1992; Pettigrew, 1985) in that they operate on the basis that the management of change can be assembled into a tool-kit of variables (Wilson, 1992). These models are said to be underpinned by ‘a biased, particularistic scientific model of functionalist logic and analysis’ (Wilson, 1992, p. 52), which formulate prescriptive solutions to the problems of managing transitions (Dawson, 1994). Moreover, they are considered by some to be inadequate ways of theorising about what actually happens during a change process (Pettigrew, 1985a). According to Rhaab (1995) contingency models offer an attractive manageable ‘how to’ in times when managers are seeking some sort of tangibility. Managers can manage the vulnerability of not knowing, by choosing from a ‘contingency smorgasbord’, secure in the belief that if there exists ‘fit’ with the market environment, the organisation is on the road to success. Hence they may be a defence against the anxiety of ‘adhockery, muddle and mere description’ (Donaldson, 1988, pp. 337 - 338, in Dawson, 1994, p. 12).

‘In practice, it is impossible to predict all future scenarios, or adapt to unexpected consequences of political decision making and power plays during a change process’ (Dawson, 1994, p. 181). Hence the actions of individual managers in individual organisations are not likely to be able to determine the outcomes of strategic change (Burrel & Morgan, 1979; Morgan, 1986; Wilson, 1992). Models that are solely based on management action to effect change, are not equipped to deal with a world, described by Pettigrew (1985) as being characterised by uncertainty, complexity, instability, uniqueness, and value conflict. It is a world where an event can have multiple meanings depending on whose reality is being interpreted.

Conceptions of simple causality are inadequate for understanding the dynamics of complex systems. An appreciation of mutual causality far more realistically depicts the
realities of how organisational life unfolds and is transformed on an ongoing basis. It also provides a means for influencing the unfolding. ‘By attempting to map system relations and identifying principle tendencies, it is possible to acquire what Bateson (in Morgan, 1986), referred to as ‘systemic wisdom’ and to frame interventions that attempt to influence the pattern of relations defining a system, rather than attempting to manipulate artificial causes and effects’ (Morgan, 1986, p. 254).

When we analyse situations as loops rather than lines we invariably arrive at a much richer picture of the system under consideration. There are many levels in which a system can be analysed and the choice of perspective will very much depend on the nature of the problem one is dealing with. Systems always contain wholes within wholes and the problem with which one starts becomes part of a larger problem. It is necessary to conduct analysis at a number of levels, socioeconomic at a macro level as well as a richer picture of the organisational and interorganisational dynamics. This allows reframing from a number of perspectives (Morgan, 1986, p. 252).

Fourth, contingency models neglect the political and/or irrational aspects of the organisation (Wilson, 1992). Czander (1993) contends that much of the current theorising around organisational change fails to deal with dynamics associated with resistance. He cites the work of various authors including Peters and Waterman (1982), Ouchi (1981), Kanter (1983), Deal and Kennedy (1984) and Kilman et. al. (1988) as failing to deal with the reality of a change process by omitting to factor in resistance to change, and assuming that people are a co-operative, supportive, quality orientated and proud team of employees (Czander, 1993)

Finally, approaches to the study of change that are developed in the commercial environment may be impracticable when applied to health care organisations, due to internal organisational and cultural differences between the two sectors. Rationalist models of change assume homogeneity in structure, culture and behaviour (Pettigrew et. al., 1988a). To the extent that there are differentials between sectors then an approach to change, which does not accommodate structural and cultural differences, is limited. Health care organisations are portrayed as having more abstract goals, more diffuse authority and fewer performance indicators than commercial organisations (Weisbord, 1976; Smith, 1985 in Pettigrew et. al., 1988a). Radical structural approaches to change have been unsuccessful in the British National Health Services (NHS) as such
rationalistic approaches to change ignore culture and process that are unique to the health sector (Haywood and Alasweski, 1980; Barnard et. al., 1979; Glennerster et. al., 1983; Hunter, 1980; Ham, 1981 in Pettigrew et. al., 1988a). Hence studying a change process in the health care sector requires a framework that is able to accommodate the realities and complexities inherent in that sector.

3.3.2 The contextual approach

Approaches to change that acknowledge complexity of systems can be found in the ‘contextual approach’ (Pettigrew, 1985, 1985a, 1985b, 1990; Pettigrew et. al., 1988a, 1989; Whipp et. al., 1987), the ‘systemic conflict framework’ (Wilson, 1992), and the ‘processual approach’ (Dawson, 1994, 1997). The theoretical underpinning of these approaches is based on a conceptual understanding of ‘mutuality of causality’ as opposed to ‘mechanical causality’. Organisational change is explained in terms of a dynamic pattern of complex interactions, in which interventions are likely to reverberate throughout the whole system, rather than through a causal relationship between the intervention and the outcome (Morgan, 1986). This approach views the organisation as a social system in which the context, history and antecedents of change are fundamental pieces of the jigsaw of evidence and understanding (Pettigrew, 1990; Dawson, 1994). It acknowledge intra- and inter- organisation conflict ‘characterised by conflict, politicking and inherent tensions’ (Wilson, 1992, p. 21).

Hence attempts to construct rational, linear and retrospective explanations of organisational experience are difficult given the existence of competing histories of organisational change and ongoing political agendas that are likely to influence individual reconstruction (Dawson, 1994). Politics, substance and the context of change interconnect in a way that is non-linear. ‘One cannot detach the analysis of change from the context, which provided form, meaning, and substance to that change episode’ (Pettigrew, 1985a, p.71).

Pettigrew argues the importance of bringing in historical, socioeconomic and political contextual factors into an analysis of change, and placing less reliance on what he refers to as ‘impotent management theories’, which guide management practice (Pettigrew,
Understanding and managing change is less about ‘foisting’ a prescriptive approach on a system than about exploring how an existing process can be speeded up. The danger lies in assuming change to be a simple phenomenon managed through a finite list of behavioural recipes and managerial competencies (Wilson, 1992, p. 129). The question is more about ‘how can the conditions that determine people’s interpretations of situations be altered, contexts be mobilised to achieve practical effects, and the organisation be moved in a different direction?’ (Pettigrew, 1985a, p.71).

Theoretically sound and practically useful research on change should involve the continuous interplay between ideas about context, the process, and the content of change together with a skill in regulating the relations between the three over time (Pettigrew, 1985, 1985a, 1985b, 1990; Pettigrew et. al., 1988a, 1988b). Pettigrew argues that much of the research on organisation change is ahistorical, aprocessual and acontextual in character, in that context is viewed as singular and unproblematic.

Beware of the myth of the singular theory of social and organisational change. Look for continuity and change, patterns and idiosyncrasies, the actions of individuals and groups, the role of contexts and structures, and the processes of structuring. Give history and social process the chance to reveal their uniqueness (Pettigrew, 1985, p.1).

The task should be to explore complex, haphazard and often contradictory ways that change emerges and to construct a model that allows an appreciation of conflicting rationality, objectives and behaviours. It should identify the variety and mixture of causes of change, to examine the juxtaposition of the rational, incremental, political and cultural views of processes, quests for efficiency and power, the role of exceptional people and of extreme circumstances, the untidiness of chance, the variable interpretation of policy and structural context, and to explore some of the conditions in which these mixtures occur (Pettigrew et. al., 1988a). Change is multifaceted: involving political, cultural, incremental, environmental and structural as well as rational dimensions. Power, chance, opportunism, accident are as influential in shaping outcomes as are design, negotiated agreements and master plans (Pettigrew, 1985a in Pettigrew, 1990 p. 268).
One of the core requirements of contextualist analysis is the requirement to understand the emergent, situational, and holistic features of an organism or process in its context. It highlights the importance of examining the content of a chosen strategy, the process of change and the context in which this occurs. Strategic change occurs at two contextual levels (Pettigrew, 1985a, 1985b). First, those aspects associated with culture, structure and politics of an organisation (termed ‘inner context’) and second, those linked to the business, economic, political and societal context in which organisations operate (termed ‘outer context’). The contextualist approach seeks to encompass a knowledge of the whole in order to explain the process by which managers mobilise and reconstruct contexts in order to legitimise the decision to change (Whipp et. al., 1987, p.19, in Dawson, 1994, p. 230). The basic analytical framework adopted by the contextual approach is the relationship between the content of a specific change strategy, the context in which change takes place, and the process by which it occurs.

While there exists a ‘dialectic’ between individual action and economic (or contextual) determinism (Wilson, 1992), the contextual model of change (Pettigrew, 1990; Whipp et. al., 1987) is one that combines both a deterministic and voluntaristic perspective and lends itself to understanding the complex and dynamic processes of change. Organisation-environment relations are determined by wider environment organisation linkages, and it is the patterning of these linkages which enables the deterministic nature of strategic dependencies to be examined (Wilson, 1992). However the model also acknowledges the role of management in the decision making process and hence management’s role and its impact upon strategy.

The analytical importance of context, content and process framework, plus its managerial corollary that formulating in the content of a strategic change crucially entails managing its context and process, suggests that managerial processes of assessment, choice and change are at the heart of the strategic development of firms (Whipp et. al., 1987, p. 50).

However a major weakness of the contextual approach ‘stems from the richness and complexity of a multilevel analysis’ (Dawson, 1994, p. 25). It does not constitute a user-friendly guide to practical management action’ (Buchanan & Boddy, 1992 pp. 61-62 in Dawson, 1994). The model is complex and there exist issues around the practicability of its application. Greiner (Pettigrew, 1985b) is ‘bothered’ by aspects of the model.
referring to Pettigrew’s model as ‘elusive’ (Pettigrew, 1985b). On a more substantive basis he criticises the model for its emphasis on the sociological and its failure to accommodate the psychological (Pettigrew, 1985b, p. 284).

Moreover, the contextual approach does not accommodate unconscious dynamics, which impact on organisational life, particularly during times of change (Stapley, 1996; Obholzer, 1994b; Kets de Vries et. al., 1991; De Board, 1978). However, to the extent that the contextual approach embraces power and influence as a reality of organisational life, making reference to irrational forces that arise in organisational life, it inadvertently acknowledges forces that can overtake and potentially influence a change process.

Despite the advent of data processing, management information, executive information and decisions support systems all designed to rationalise strategic change through enhancement of management knowledge, the processes of strategic change are predominantly shaped and outcomes largely determined by the exercise of power and influence (Martin and Clarke, 1990 in Wilson, 1992, p. 54).

Despite its limitations, the contextual approach provides an epistemological position that acknowledges the interplay of complex interrelationships within the organisational system and between the organisational system and its environment and hence is able to inform the methodological base and accompanying method to study the Trial.

### 3.4 Conclusion

This chapter has sought to review some of the conceptual frameworks that can enable the exploration of the Trial implementation process over time. Models which do not acknowledge the Trial’s interface with its environment as reciprocal and fluid are regarded as limited. They neglect the reality of mutual causality that depicts the Trial as an open system, which is both influenced and influences other groups of players in the system. The contextual approach is a conceptual framework that is able to accommodate the Trial as an open system, operating in an environment characterised by competing agendas of stakeholders, politics and politicking, of cost containment, and uncertainty. While it acknowledges the role management plays in the management of an implementation process, it also concedes that there are deterministic forces that impinge
on a change process, which are beyond the control of management. However the contextual approach is limited in that it does not acknowledge unconscious aspects of organisational life. The next chapter introduces a psychoanalytic framework, which provides a lens for hypothesising about observed behaviours through an exploration of unconscious dynamics.
Chapter 4

Conceptual Framework:

A Psychodynamic Approach

4.1 Introduction

Chapter 3 discussed some organisational theories, which provide a conceptual framework for the study of an implementation process. Whereas the contextual framework (Pettigrew, 1990, Whipp et. al., 1987; Dawson, 1994) provides an approach for exploring the ‘breadth’ of change, it does not capture sufficiently the ‘depth’ of change. In particular, it does not capture unconscious motivations, those sources of energy and motivation that are inaccessible to the conscious mind, even though behaviour and emotions are being affected. What may appear to be irrational can assist in understanding an implementation process, given that it includes aspects of the individual which conflict with consciously held beliefs creating anxiety and associated defences. These may be denied, suppressed or disowned and become more or less unconscious. Moreover unconscious dynamics have the power to impede or enhance the change effort. Menzies (1970) in her study of the health service points to the anxiety created in a change process such that role holders avoided change at all costs (Stapley, 1996; Czander, 1993; Obholzer, 1994b).

A meaningful study of an organisational change process involves an analysis of its internal and unconscious dynamics (Czander, 1993). Hence a methodology capable of capturing unconscious organisational dynamics is necessary to fully understand an implementation process. A conceptual framework that enables an understanding of organisational dynamics can be found in psychoanalytical organisation theory. This is a theory that explores the significance of, and the reasons for, the private images people hold of organisational life- the participant’s psychic reality. This includes unconscious fantasies, fears, and anxieties about themselves and others in their mutual organisational
roles. Approaching the study of an organisation through the lens of psychoanalytical organisation theory involves understanding the meaning of critical incidents and collective patterns of response to those events (Diamond, 1993). Psychoanalytical theory contributes to the building of a conceptual framework, because it contributes to the understanding of ‘difficulties’ and ‘confrontations’ by suggesting unconscious reasons for messy dynamics (Neumann, 1994). It offers an approach that is able to bring the irrational, illogical and the heavily emotional to the fore (Stapley, 1996).

The purpose of this chapter is to introduce a psychoanalytical framework and concepts, for data analysis in later chapters. This chapter introduces the Tavistock sociotechnical systems framework (Miller & Rice, 1967), which is an open systems model. A number of psychoanalytical concepts that link unconscious experience to organisational behaviour are presented. Given the breadth of psychoanalytical theory, I have chosen to discuss here only those psychoanalytical concepts that I use in the interpretation and discussion of the data presented in Chapter 7.

**4.2 Integration of systems thinking and psychoanalysis: Tavistock model of social systems**

One model able to integrate an open systems theory (Rice, 1963, 1967) with psychoanalytical theory is the Tavistock sociotechnical model (Miller & Rice, 1967). The Tavistock social systems theory lends itself to the application of psychoanalytical theory (Czander, 1993). It provides a framework that is able to accommodate an understanding of the relationship of a group to its social environment, by addressing practical problems and opportunities in social systems from a simultaneous and sequentially ‘deep’ and ‘broad’ perspective. The psychodynamic theory provides the depth, while organisational theory, provides the breadth (Neumann & Hirschhorn, 1999). The tension between systems thinking and psychoanalysis creates the dynamic, which is fertile for the development of new understanding. ‘The systemic approach contributes the essential inter-relatedness of the emotional experience, such that emotional experience is not bounded by one’s own individual skin, but is bounded by the system or systems within which individuals interact, in collaboration or conflict with each other and with their context’ (Hutton et al., 1994, p.187). The psychoanalytic approach is fundamental to the recognition of the centrality and significance of emotional
experience in all human endeavours, both at a conscious and unconscious level. Both are fundamental to an adequate understanding of organisational life, its dilemmas and challenges (Hutton et. al., 1994).

Conceptually, the Tavistock sociotechnical model provides a framework for studying the relationships between the parts and the whole in organisations, and also between the organisation and its environment (Miller & Rice, 1967). The model provides a window for exploring the inherent tensions associated with organisational life. In particular the model enables an exploration of the difficulties work groups have in defining their primary tasks (see below), and managing their boundaries and the unconscious dynamics underpinning these difficulties.

The Tavistock sociotechnical model is dynamic and presented as a system of activities required to perform a task of converting inputs into outputs. A boundary exists between the external and the internal organisation, and boundaries exist between the subsystems within the organisation. Boundaries need to separate what is inside from what is outside. This approach includes being clear about the primary task, attending to the flow of information across the boundary, ensuring that the system has the resources it needs to perform the task, and ensuring that the task continues to relate to the wider system and its external environment. Organisation exchange occurs across these boundaries, which need to be regulated in order for the system to achieve its task.

Management of boundaries and the role of management are crucial to organisational functioning. In this theoretical framework, the task of management is to control and regulate the exchanges between the subsystems of the organisation and between the organisation and its environment, so as to permit optimal performance of the primary task (Rice, 1963, pp. 13-15 in Burrel & Morgan, 1979, p. 156). Individuals in the organisation need to take up roles within the group with particular tasks so that the organisation can achieve its primary task. When management loses its boundary position and becomes either drawn into the system or cut off from the system, the primary task of the organisation become threatened and organisational dysfunction will result (Roberts, 1994). Boulding (1953) refers to the importance of the management function in his discussion of parallels between the living system and the organisation.
He argues that all living matter, including the organisation, has unstable components, which must be managed in order to avoid the decay, trauma, conflict and entropy that result in deterioration of the system. This, he says, is the work of management and the rationale for the design of structure (Boulding, 1953 in Czander, 1993).

The Tavistock sociotechnical systems framework is dynamic in the way it depicts interaction within the system and between the system and the external environment. It acknowledges the inherent nature of conflict in that it assumes that the demands of the various subsystems (including the external system) do not always coincide and that organisations may be subject to dysfunctional interactions across their internal and external boundaries (Miller & Rice, 1967). Emery and Trist (1965) propose that all subsystems have two functions, a task function, which is the technology of the subsystem, and a sentient function, which is where the emotional and social bonds between organisational members develop. The total effectiveness of the system depends on the balance achieved between the social and technological components, what Bridger (1980, p. 527) refers to as ‘scanning, balancing and optimising the system as a whole’. When these functions are not integrated, the system increases its propensity to constrain the efforts of other subsystems, resulting in conflict (Czander, 1993).

4.3 Psychoanalytical concepts: Task Analysis

4.3.1 Primary task

The concept of the primary task derives from Bion’s (1961) theory in which he introduces the concept of the ‘work group’ and ‘basic assumption’ groups. Work group activity is geared to task while basic assumption activity can obstruct and divert work group activity (Bion, 1961). This is discussed in more detail below. The primary task corresponds to the overt work-orientated purpose of Bion’s work group activity. The primary task of the organisation is the task it must perform in order to survive (Rice, 1963). The survival orientation both enables and directs management to focus away from short term goals and frame specific goals in a manner that is more basic and enduring (Morgan, 1986).
The concept of a primary task can be seen as an oversimplification given that enterprises are complex in that many task systems exist. Different groups within the organisation may have different definitions of the primary task, as the task of these subsystems may conflict or compete. However, used as a heuristic concept (Miller & Rice, 1967) it can be an invaluable starting point for thinking about what is going on in the group or organisation and how authority is defined. As conditions change the primary task may shift either temporarily, at times of crises or permanently (Roberts, 1994).

Gordon Lawrence (1977) developed the idea of the primary task as a tool for examining organisational behaviour by proposing that people within an enterprise pursue different kinds of primary tasks. The ‘normative’ primary task is the formal or official task, the operation of the broad aims of the organisation and is usually defined by the chief stakeholders. The ‘existential’ primary task is the task people within the enterprise believe they are carrying out, the meaning or interpretation they put on their roles and responsibilities. The ‘phenomenal’ primary task is the task that can be inferred from people’s behaviour of which they may not be consciously aware. Analysis of the primary task in these terms can highlight discrepancies between what an organisation or group says it sets out to do and what is actually happening. It can thus serve as a tool for individuals and groups within an enterprise to clarify and understand how the activity, roles and experiences of individuals and subsystems relate to each other and to the enterprise as a whole (Roberts, 1994, p.30; Lawrence, 1997).

4.3.2 The potential for perversion or corruption of the primary task

Chapman (1999) offers a framework for exploring task avoidance and the notion of task corruption. In her framework task avoidance can occur in varied forms and for varied reasons, resulting in task substitution such that the primary task is avoided, left, or ignored in favour of a ‘phenomenal task’, which is engaged in its stead. The avoidance of the primary task and its substitution for the phenomenal task occurs at an unconscious level (Chapman, 1999). Although not explicitly stated I have inferred that the avoidance of primary task refers to avoidance of the normative primary task.
She introduces a number of constructs, including *task tenets* and *task power*. *Task tenets* are held beliefs about the task, which derive from the internal world of the doer. They can become dangerous and capable of corrupting the task when beliefs are so thoroughly entrenched that they take on the aspect of dogma in that they may not be questioned without damage either to the system or the questioner.

*Task power* is the degree to which task engagement can influence the values and behaviour of system members, other systems and their members, and other tasks. Powerful tasks breed powerful systems; powerful systems have highly influential cultures; powerful cultures are more vulnerable to corruption than less powerful cultures. However, powerful tasks have as great a potential for healthy engagement, particularly if task values are in place and need not necessarily lead to task corruption.

Chapman contends that to be corrupt, the task avoidance needs to be destructively motivated, whether at a conscious or unconscious level. She presents four ways in which changes in task can occur; some of which she contends involve corruption of the task while others do not.

Changes in task can occur through:

- **Substitution** where phenomenal task supersedes the primary task. This occurs when a task is hated and avoided so that members consciously and unconsciously avoid the primary task by substituting a phenomenal task. This phenomenon does not necessarily involve corruption of the task.
- **Amputation**, where parts of the task are ‘lopped off’ or neglected in favour of other parts of the task. This occurs when aspects of the task are denied to the point that role holders behave as if these aspects no longer existed. This phenomenon does not necessarily involve corruption of the task.
- **Simulation**, which involves the system or individual adopting the appearance of task engagement, precisely in order to avoid task engagement. Chapman views this form of avoidance as corrupt, as it involves a destructive intent. Not only is real task killed off, and system energies devoted to the appearance of task being done, but task values are subverted and task power becomes abusive.
Organisations, which behave as if the system were engaged in the real task, are characterised by poor morale, low system energy, high levels of politicking, questionable ethics and high levels of conflict. Where simulation occurs in a system with significant task power, life for members of that system can be difficult.

- Mutation occurs where the primary task of the system is twisted in such a way that the doer is damaged or destroyed, and one or all of the task aspects suffer. Task power becomes abusive as its influence on values and behaviour is negative. Task values are subverted. Task idea is manipulated and the task tenets are lost or become evil. This is patently task corruption.

Chapman (1999) offers a way of protecting against task corruption by establishing a set of values, which guard against corruption of the task. These include:

1. Survival, which is the defining value. The five below are a subset of survival;
2. Authenticity, which Chapman introduces as a task attribute, which members view as worthwhile or containing elements of authenticity providing the drive for task engagement;
3. Uniqueness, in that a task must be unique in order to exist and be perceived to be so in the minds of task doers;
4. Accessibility, in that the performance of the task is viewed by the task doers as capable of being achieved, as opposed to a grandiose or omnipotent task that is beyond the range of people’s capabilities;
5. Emergence, in that there must be capacity for the task to evolve and change over time in response to the demands of a complex environment of other systems and tasks;
6. Generativity, in that the task acknowledges the social context within which a system finds itself. Observing these value guards against the system becoming self feeding and self serving.
4.4 Object relations theory

4.4.1 Some theoretical concepts

Object relations theory is a psychodynamic theory of early childhood emotional development, expounded by theorists such as Klein (1952); Fairbairn, (1954); Winnicott, (1971), Kernberg, (1976). Each of these theories varies in that they focus on a particular aspect of object relations (Cashdan, 1988). For the purpose of the thesis I will focus on the work of Klein and Winnicott. Klein’s work highlights the operation of mechanisms such as splitting and projective identification, while Winnicott focuses on the notion of maternal transference and countertransference and the notion of ‘good enough holding’.

The object relations’ school of psychodynamic theory places primary emphasis on the importance of the individual’s relations with actual (external) and phantasised (internal) objects. The term object is used rather than person because the object of relations constitutes more of an image than a person. It can be an organisation, a group, an idea, a symbol and particularly in infancy, parts of the body (Czander, 1993). In essence Klein (1952) proposed that humans at an early age utilise the psychological mechanism of splitting and projection to cope with unpleasant emotions. In order to preserve the experience of a caring, attentive mother in the inevitable situations in which the mother is not fulfilling all the infant’s needs, or when the infant is enraged or envious, the infant mentally creates two images of mother, a bad one to be rageful at, and a good one to be the comforter. This psychological mechanism is called splitting: ‘an action undertaken in phantasy which can be used to separate things which belong together’ (Segal, 1992 p. 36 in Kram, 1998). This mechanism allows an infant, and later an adult, to cope with fears about survival by separating the self from painful feelings. In an organisational setting an employee can displace internal conflicts onto work activities or objects and therefore control external threats and temporarily ‘resolve’ internal conflicts (Czander, 1993).

Closely related is the phenomenon of projection and projective identification. Klein proposed that infants learn to distance themselves from destructive feelings by projection, that is disowning the unwanted feelings and actively ‘placing’ them outside,
e.g. into someone else (Kram & McCollom, 1998). In some forms of object relations’ theory, the concept of projective identification refers to patterns of interpersonal behaviour in which a person induces others to behave or respond in circumscribed fashion. Projective identification involves the behavioural and emotional manipulation of others, through their unconscious collusion. It lifts projection from the inner world and views it as the realm of interpersonal relationships (Cashdan, 1988). It is a form of communication that begins with the denial and rejection of feelings inherent in a person’s unconscious image of a situation, and the attribution of those feelings to someone or something else, rather than him or herself.

The recipient of the attribution is subtly pressured into thinking, feeling and behaving in a manner congruent with the feelings and thoughts projected by the other (Krantz & Gilmore, 1991). This is described as introjective identification, which is the complementary process of taking in and identifying with the projections of the other, usually without knowing it. In this way projective and introjective identification become two main vehicles for unconscious communication and understanding in all human relationships. These processes can also become a basis for shared unconscious misunderstanding and consciously destructive ways of behaving (Cashdan, 1988). For example, a health unit divided over ‘cost’ and ‘care’ issues may have introjected tensions existing in the broader health system around the allocation of the health care dollar, resulting in divisiveness and conflict. A consultant engaged by the organisation to assist the organisational dynamics might be idealised as a potential saviour. To the extent that the consultant colludes with the process and ‘over functions’ then the consultant has introjected the projection.

Splitting, idealisation and projective identification operate to create rudimentary structures made up of idealised good objects kept far apart from the persecutory bad ones (Steiner, 1987, pp. 69-70 in Lawrence, 1998). Klein refers to this state as the ‘paranoid position’ (Cashdan, 1988), which involves regression to infantile states of development, so that earlier patterns of behaviour remain available as alternative modes of functioning (Diamond, 1993). These dynamics exist when vulnerable groups become the recipients of projections as occurs in scapegoating (Schwartz, 1990; Wells, 1990 in Kram & McCollom, 1998) or when rival groups are projected into as occurs in

The other position the ‘depressive position’ reflects a period or state in the child’s psychological growth in which the child comes to appreciate the mother as a whole, both good and bad object, rather than a ‘part object’. Hence the child is forced to acknowledge both good and hateful feelings towards the mother. In this state splitting is reversed and destructive urges are counterbalanced with concern such that persecutory anxiety is replaced by depressive anxiety. In adult life, this is a position that concerns itself for the object, or other. This position is one of integration, of responsibility for integrating conflicting emotions and parts of the individual in relation to objects (Harris, 1988 in Lawrence, 1998). It involves the capacity to take back less acceptable aspects of oneself, which had previously been projected onto others, making reparation possible, which can aid reconciliation, mediation and consensus.

4.4.2 Application of object relations theory to groups and organisations: Social defences against anxiety

Kleinian theory has been applied to the theory of groups and organisations, where splitting and projection and projective identification help to explain group dynamics in which group members collectively deny difficult emotions and project them onto other groups (Cashdan, 1988). Jacques (1955) links the mechanisms of individual projective and introjective identification to social behaviour. He describes a process where external objects are shared with others and used in common for purposes of projection, resulting in fantasy social relationships becoming established, through a process of projective identification with the common objects. These phantasy relationships are further elaborated by introjection.

He argues that there exist primary dynamic forces pulling individuals into and out of institutionalised human association, which are a defence against paranoid and depressive anxiety, and in particular against the recurrence of the early paranoid and depressive anxieties first described by Melanie Klein. All institutions are unconsciously
used by members as mechanisms of defence against the more psychotic anxieties, which arise when the external or internal situation presents a stressful situation, too painful to bear and the individual regresses to primitive psychic defence mechanisms. In organisations, this is revealed in social defence systems, which help individuals avoid feelings of anxiety, guilt, and uncertainty (De Board, 1978; Hirschhorn, 1988; Krantz, 1995). In this sense individuals externalise those impulses and internal objects that might otherwise give rise to ‘psychotic’ anxiety and pool them into the life of the social institutions in which they associate.

‘Psychotic’ anxieties refer to primitive anxieties, examples of which Lawrence (1998) describes as the fear of annihilation, the fear of being made nothing, the fear of not being able to make sense of what reality may be, the fear of disorder and chaos, the fear of disintegration, the fear of loss, ending and death. These fears are acutely present in the individual’s psychic life during earliest infancy and can be reactivated at any time in subsequent adult life when persecutory circumstances trigger them (Lawrence, 1998, p.54). These anxieties are all pervasive and beset the whole of mankind (Obholzer, 1994b). When psychotic anxieties are triggered, organisational members are predisposed to the mobilisation of primitive defences of splitting and projection.

Anxieties can arise out of the nature of the work, which can elicit primitive and past personal anxieties, which are the anxieties felt when something triggers elements of past experience, both conscious and unconscious (Obholzer, 1994b). The Menzies (1960) study concerns the powerful anxieties stimulated in the course of fulfilling the nursing role. Nurses confronted with death, illness and dying were seen as employing defence mechanisms against psychotic anxieties of annihilation, which resulted from providing care for patients. These defences took the form of ritualistic distancing mechanisms described by Menzies (1960) or basic assumption behaviour described by Bion (1961).

When the particular nature of the work elicits anxiety, anti-task activity arises as a defence. While the primary task activity relates to the demands of the external environment, anti task activity or basic assumption activity (Bion, 1961) is driven by demands of the internal environment and anxieties around psychological survival. This can arise when the primary task is unclear due to an inadequate task definition, as a
result of insufficient guidance to staff and management as to what they should be doing or how to do it, or whether they are doing it effectively or not (Roberts, 1994).

The work group, unconsciously and tacitly comes together to defend itself from its own internal fears and anxieties, rather than to pursue the primary task. Anti task activity is regarded as typical of groups under the sway of basic assumptions. Individuals exhibiting this behaviour are said to be in basic assumption mode and behave as if the group has come together for something other than the task, for pairing, for dependency or for fight or flight (De Board, 1978). This is done unconsciously and the defensive function of the structure of the institution usually goes unrecognised.

For example, in order to avoid the anxiety associated with an environment of rapid change and uncertainty organisational members may collectively collude in projecting onto management the feelings that management is omnipotent, and capable of satisfying all desires of dependency. To the extent that management responds by developing structures, which emphasise predictably, certainty and control, it colludes with a dependency relationship that attempts to deny reality.

4.4.3 The holding environment

The ‘holding environment’ initially described by Winnicott (1960), refers to the development of a bond between mother and child. He uses the term ‘good enough mothering’ to refer to the waxing and waning of nurturance that describes normal mother-child interactions (Winnicott, 1971. P.11 in Cashdan, 1988, p. 36). One of the sobering realisations of childhood is that the mother is neither perfect nor a devil. This does not stop the child from clinging to the fantasy of perfection and idealising the mother. The split is there (Cashdan, 1988). Maternal tolerance and containment of the child’s aggression and sexuality enables the child to discover that his or her impulses and actions do not have to be destructive but can be mobilised to serve a task. That is, the child can develop without the disruption of human relationships. The establishment of integration, and the development of ego relatedness both rely upon a ‘good enough mothering/ holding’ (Shapiro & Carr, 1991; Stapley, 1996).
4.4.4 The organisation as a holding environment

The concept of the maternal holding environment has been extrapolated to embrace an organisational holding environment, as in family, organisation, and wider society (Stapley, 1996; Shapiro & Carr, 1991). These basic features of the holding environment are task, boundaries and role. Task refers to the reason for an organisation’s existence and role is a position one holds to enable the task to be undertaken (Shapiro & Carr, 1991).

Stapley (1996) conceptualises both an internal and external holding environment, which embraces the unconscious and conscious, respectively. The organisation becomes a partly conscious and partly unconscious holding environment. The internalised holding environment is the psychological holding environment, which derives from the phantasy activity of unconscious systems and internal object relations. The external holding environment includes all the formal structures and strategies, leadership, organisational task, roles of members of the organisation, knowledge and skills and values and attitudes shared by the organisational members. To the extent that an organisation can be viewed as an open system, the partly unconscious and partly conscious holding environment is influenced by the external environment.

When an organisation loses sight of its task or adopts an inappropriate task, the consequent role confusion for members can produce pathological symptoms. Within the structure of a holding environment, containment of impulses and interpretation take place through acknowledgement of individuality (curiosity), bearing painful affect (containment) and putting events in perspective (empathetic interpretation in context). Individuals become aware of their projections and reinternalise them, and hence are able, through a better sense of themselves and more empathetic view of others, to join with others in different roles in a shared task (Shapiro & Carr, 1991).

An understanding of the role of the ‘containing or holding’ function of the institution assists in the facilitation of an implementation process. Implementation of change processes is likely to be resisted, as by its very nature it dismantles the structures which were erected in the first instance to defend against anxiety (Obholzer, 1994b).
4.5 Role of management in providing a holding environment

Anxiety is inherent in organisational life and occurs in the process of one’s engagement with organisational life. It has been a central issue in the study of the implementation of the Trial. The task of dealing with anxiety is a critical task of management. It involves management providing an environment which is able to contain anxieties promoted by the inherent nature of organisational life.

To provide a containing environment, management must be sufficiently aware to take on the projections of the individuals in the organisation (Stokes, 1994a; Stapley, 1996). Bion’s (1970) metaphor of the ‘container’, where the management system takes in the anxiety projected into it and returns it in a modified and more bearable form, is an apt way of exploring the management task. The manager is able to restrain anti-task activity when he/she becomes an object of the collective group’s transference, which emanates from both real and imaginary anxiety producing events. The task of management is to provide a ‘good enough’ holding environment (Winnicott, 1960) so that organisational members are able to take up their roles. Reliable holding is as important to the self esteem of the members of an organisation as it is to an infant. Where there exists no basic trust and the holding environment is viewed as being either socially, physically, and /or psychologically ‘not good enough’, there is likely to be an anti task culture (Stapley, 1994).

Clarification of the primary task is critical to the provision of a holding environment and involves behavioural practices that acknowledge the interdependence of the task and sentient systems. During a change process, clarity around the primary task assists in ameliorating the inevitable level of disturbance organisational members experience during a change process (Obholzer, 1994b; Hutton et. al., 1994). This is particularly salient in the service sector, where technology cannot be specified without attention to an interpretation of human exchange between the providers of the service and the client or customer (Hutton et. al., 1994). Stokes (1994a) contends that in order to constitute a reliable container, management must clarify the primary task of the organisation, and plan and define roles consistent with the primary task. Hutton et. al. state that reliable holding requires management to ‘create the structures which enable the primary process to come into view at all levels of the institution’ (Hutton et. al., 1994, p. 200).
involves understanding the emotional experience of living and working within an institution, and requires ongoing discussion about the primary task of the organisation to ensure that staff and management do not view the primary task differently (Obholzer, 1994b; Hutton et. al., 1994).

Clarity about the primary task, clarity regarding authority structures and role relatedness enhances reliable holding. Murphy and Reed (1990) distinguish two ways of seeing relations with people. The first way is to see them in terms of personal relationships, how people relate to and feel about one another. Quality of the relationships is judged on whether there is a liking or disliking of one another. Context, position and background are disregarded. The second way is to see relations with others in terms of relatedness. The notion of relatedness reflects connections between persons through their working roles derived from the shared experience of working together.

To have the best opportunity of providing containment requires management, and hence the organisational culture to be in depressive position. This involves the ability to tolerate and encourage the unconscious and irrational spheres of organisational life, such as being vulnerable to uncomfortable or frightening experiences in both themselves and in other organisational role holders (Obholzer, 1988; Krantz, 1995). It is only from the depressive position that creative activity can occur (Klein, 1975). Organisation members will not form the potential space for the expression of ideas unless there is sufficient holding and the organisation is able to nurture play and creativity, and hence learning (Diamond, 1993).

4.6 Conclusion

This chapter has sought to develop a conceptual framework, which can explore unconscious dynamics inherent in a change process and hence enable the exploration of the Trial implementation process in the context of the reality of anxiety that underpins life in a complex world. To enable this understanding, the Tavistock sociotechnical framework and relevant psychoanalytical concepts have been introduced.
Chapters 2 and 3 together offer a conceptual map for studying the Trial implementation process, that is able to embrace conscious motivations, rooted in economic and political concerns, as well as unconscious motivations. Theoretical derivatives from the contextual/processual and the Tavistock sociotechnical approaches have informed the methodology and will inform the analysis and interpretation of data.
CHAPTER 5

METHODOLOGY AND METHODS

5.1 Introduction

This chapter sets out the methodology and methods consistent with an exploration of the experience of stakeholders involved in the Trial implementation process. Section 5.2 discusses the link between theory and method and presents the case for qualitative methodology as the most appropriate for the exploration of stakeholder experience of an implementation process over a period of time. It also notes the importance of making apparent the researcher’s ontological assumptions. This is followed by section 5.4, which is an explication of the research design, which bounds the research and connects the inquiry to specific methods of collecting and analysing data. A longitudinal case study approach has been chosen as a research design. Theory, scope and method are informed but not prescribed by the processual/contextual approach (Pettigrew, 1985, 1990, Pettigrew et. al., 1988a; Dawson, 1994; 1997, Whipp et. al., 1987). Sections 5.5 to 5.7 outline and examine the methods chosen. Section 5.8 discusses processes employed to ensure integrity of the data and section 5.9 discusses the process of analysing the data.

Part 1: Methodology

5.2 Linking the conceptual framework to a methodological approach required for the study

Methodology is the theory of method, enabling the linking of the conceptual frame with a method. ‘Methodologies are the theoretical assumptions about the value of certain forms of knowledge, and methods are the research means whereby those kinds of knowledge are produced’ (Taylor, 1994, p.5). The methodology and associated method chosen depends on the theoretical underpinning held. The way one chooses to approach research is a function of the way the world is seen and hence what is looked for and what is found.
For example, empirico-analytical methodologies include an assumption that knowledge that is real and trustworthy is found through objective means, and that the inquirer will need to use methods that involve strict observation, manipulation and measurement of variables to produce new knowledge of that type. Conversely, interpretive methodologies are based on the assumption that knowledge that is real and trustworthy is found through qualitative methods, and research interest is invested in finding knowledge through people’s subjective accounts of their experiences (Taylor, 1994, p. 5).

Given the potential for controversy regarding methods decisions, the paradigmatic perspective underpinning research method needs to be made apparent (Morgan & Smircich, 1980; Wilson, 1994). Researchers interested in using qualitative methods need to be prepared to explain and defend the value and appropriateness of qualitative approaches (Patton, 1990, p. 477). If the researcher’s orientation to social inquiry is not made clear, the basis for the method chosen is also not clear, leaving the researcher and research method vulnerable to interpretations others may make about the appropriateness of the particular method chosen and the resultant findings. My experience with this study was one where a lack of understanding of the qualitative research method led to tensions in a research team, which was orientated towards quantitative research. This will be discussed in more detail in the body of the chapter.

While some aspects of quantitative research rely on an established set of techniques that have been used to examine similar problems, for example, the randomised control trial used in controlled experimental studies, qualitative research is more eclectic and there a number of different theoretical orientations, some of which are better suited to some research problems than are others.

My interest is in the organisational dynamics that occurred during an implementation process in the health care sector. This has been a dynamic process as the Trial is an emerging entity. The way that actors have interacted over time has changed and is reflected in the emerging structures, processes and outcomes (Ryan et. al., 1999). Unlike a methodology orientated to a snap shot perspective of individual’s views at a point in time, meaningful data gathering and analysis needs to accommodate a dynamic
process emerging over time. It needs capture flux and change rather than stasis (Long, 1999a). The methodology needs to be one that acknowledges the fact that human action is rarely fixed, clear or unambiguous, but is continually negotiated and renegotiated in the ongoing interactions that take place. Hence the methodology needs to be iterative, interactive, hermeneutic, at times intuitive and most certainty open (Guba & Lincoln, 1989, p. 183). It needs to capture interactions and actions involving multiple actors and perspectives as well as the central role of ‘context’ in generating knowledge. It is also a methodology that acknowledge the researcher in the research process as it relies greatly on the researcher’s capacity to piece together and interpret what may be highly complex.

The earlier chapters outlined a number of theoretical models that can accommodate an exploration of an implementation process over time, suggesting that there are a number of ways to explore a change process. The contextual/processual (Pettigrew, 1990; Dawson, 1994, 1997) approach is a methodological approach that involves a detailed examination of an organisation over time, through the analysis of what is qualitative data. The contextual approach is consistent with sociology’s interpretative/phenomenological/hermeneutic/constructivist paradigm, all of which fall under the umbrella of a relativist ontological base (Guba & Lincoln, 1989). The nuances underpinning the differences in these paradigms are not regarded as significant in the impact on methodology and method (Guba & Lincoln, 1989) and hence will not be explored in this thesis. Discussion on the differences can be found in Burrel and Morgan (1979).

The underlying assumption of the interpretative paradigm with regard to the ontological status of the social world is that the social world is a subjective construction of the individual in the context of the group/organisation (Bion, 1961; Shapiro & Carr, 1991). ‘Constructions come about by virtue of the interaction of the knower with the already known and the still knowable or to-be-known’ (Guba & Lincoln, 1989, p. 143). The interpretative/phenomenological paradigm is concerned with understanding human behaviour from the actor’s own frame of reference. What people say and do is a product of how people interpret the world. The social world is of an essentially intangible nature and is in a continuous process of change (Burrel & Morgan, 1979). It assumes that the
stakeholders construct realities, influenced by a variety of social and cultural factors that lead to shared constructions. Constructions come about through the interaction of a constructor with information, contexts, settings, situations, and other constructors (not all of whom may agree), through a process that is rooted in the previous experience, belief systems, values, fears, prejudices, hopes, disappointments, and achievements of the constructor’ (Guba & Lincoln, 1989, p. 143). ‘There exist multiple socially constructed realities and ‘truth’ is defined as the best informed and most sophisticated construction on which there exists consensus, although there may be several constructions that simultaneously meet that criterion’ (Guba & Lincoln, 1989, p.84). Hence interpretative methodologies acknowledge the role of context and subjectivity in the generation of knowledge.

An interpretative/phenomenological paradigm requires qualitative methodologies, as these acknowledge the nature of the social world as one that occurs at the level of subjective experience. It is a knowledge that is personal and practical, deriving from the perspective of people engaged actively in their own worlds (Taylor, 1994). Qualitative methodologies refer to research procedures, which produce descriptive data: people’s own written or spoken words and observable behaviour (Bogdan & Taylor, 1984). They also make room for what Shapiro and Carr (1991) refer to as the ‘interpretive stance’, which is a way of evaluating experience from the context of one’s role and experience as participant and participant observer. Feelings of anxiety experienced in the research system can alert and inform the researcher of powerful forces operating within the client system. Through an exploration of transferential and counter-transferential issues that arise between the research and client system, one is able is to develop hypotheses about organisational life (Alderfer, 1988; Smith, 1988). The task of the qualitative methodologist is to capture this process of interpretation.

This is an approach to inquiry that seeks the perceptions of stakeholders involved in the process and hence is based on inquiry that views the interpretation of stakeholder experience as relevant data. The experience of stakeholders needs to be situated in order to give it meaning. The context in which the Trial organisation exists and interacts cannot be ignored. Studying the experience of members of the Trial organisation is done in the context of the history of the organisation, tensions associated with the economics
of health care reform, and the interplay of organisation power bases and interactions over time. The implementation process has been complex, as stakeholders have brought into the Trial ‘baggage’ inherent in the competing agendas characterising the health care reform debate, whose acuity has become more pronounced in an environment of cost rationalisation. This has impacted on organisational dynamics. Hence a methodology is required that accommodates a time dimension, accommodates individual and group perspectives and accommodates contextual influences.

Part 2: Methods

5.3 Introduction

In the following section I will discuss the methods used in the current study along with the rationale for employing these methods.

5.4 Research design: the case study

An approach for exploring the change process involved in the Trial is derived from a naturalistic methodology and underpinned by the work of Whyte (1955); Pettigrew (1985a & b, 1990); Dawson (1994, 1997) and Guba and Lincoln (1989) and involves the study of an implementation process as a complex case study. These approaches centre on the collection of longitudinal data over time and the importance of context in examining how change unfolds. A longitudinal qualitative case study approach focuses on providing narrative accounts of a continuously developing and complex dynamic of people in organisations. It provides a useful framework to elucidate the experience of the individuals and groups because it enables an understanding of complex social phenomena through understanding individualised outcomes.

A case study approach is a narrative device which permits the telling of a story, about a bounded system, be it a person, event or organisation, in order to illuminate important findings about a person or about the entire broader social unit (Ely, 1991). A case study approach is valuable where broad, complex questions have to be addressed in complex circumstances (Keen & Packwood, 1995). The major strength of a case study approach is its capacity to investigate phenomena within ‘real life contexts’ (Yin, 1994, p. 3) and
in-depth, and to utilise multiple methods of information collection and multiple sources of information. The case study method can deal with a full variety of evidence – documents, interviews, and observations and impressions as well as statements from others about the case. This variety of evidence can be considered simultaneously and in context. Further, it explains causal links that may not be captured through other strategies. Thus the case study approach is particularly advantageous when studying ‘how’ or ‘why’ questions about a contemporary set of events over which the investigator has little or no control (Yin, 1994, p 9). The case study method constructs an understanding of complex social phenomena through understanding a series of individualised outcomes. Thus the case study approach provides a useful framework to elucidate people’s experiences with co-ordinated care because it lends itself to the evaluation of how individuals perceived the process of co-ordinated care as it unfolded over time.

Pettigrew et. al.’s study of change in the National Health Sector (1988a) and change at Imperial Chemical Industries (1985), and Whyte’s (1955) study of a street gang in the slums of Boston, are examples of the application of a longitudinal case study approach to research. The assumptions underpinning this method are set out as follows.

- The researcher's tacit knowledge is used. This is prior knowledge that the researcher has gained from the field and from the literature, which enables the researcher to make judgements such as when it is appropriate to ask certain questions. Tacit knowledge is ‘the notion that knowledge is created through a process of knowing’ (Pettigrew, 1990) akin to Schon’s (1987) notion of ‘artistry’, which is achieved through ‘countless action of recognition, judgement and skillful performance’ (Schon, 1997, p. 22 in Howard, 1996).
- The research requires the collection of data over periods of time. Hence incorporating a longitudinal element into the research design is a critical part of the process.
- The model does not construct a single account but accommodates conflicting histories of change and accommodates multiple perspectives of reality. ‘The contextualist does not assume that scientific truth is out there to be discovered by
a process of knowing, rather definitions of acts in contexts emerge and are created by a process of making’ (Pettigrew, 1985a, p. 57).

- The model uses the ‘highly adaptable’ instrument of the researcher as research instrument (Berg & Smith, 1998). Hence the reliance on qualitative methods. These include talking to people, observing their activities, reading their documents, assessing the unobtrusive signs they leave behind (Guba & Lincoln, 1988).

The Trial implementation process can be approached as a case study. As such the case comprises the organisation of the Trial operating in an open system, where other players influence and are influenced by the dynamics occurring within and between the Trial and its environment. The role of the qualitative researcher is to explore and to understand the dynamics of the change process from the perspective of the subjects involved. This is a process requiring qualitative methods. Qualitative methods permit the study of selected issues in-depth and in detail (Patton, 1990, p. 13). Qualitative methods allow us to know people personally and in the context of their role and to see them as they are developing their own definitions of the world. Understanding of individual and group experiences as the program unfolds is sought through participant observation including in-depth interviewing, focus groups, observations of the researcher as both participant and non-participant, and content analysis of documents

5.5 Participant observation

Qualitative methodologies offer flexibility in the selection of methods so that different units of analysis can be studied. A compendium of different methods has been used in this study to enable the exploration of the experiences of stakeholders, over a two and a half year period, from the beginnings through to the closing stages of the Trial. These fall under the category of participant observation, which is a field strategy that ‘simultaneously combines document analysis, interviewing of respondents and informants, direct participation and observation and introspection’ (Denzin, 1978b p. 183 in Patton, 1990, p.206).
There are limitations to what can be learned from what people say in response to questions. Hence to understand more fully the complexities of many situations, direct participation in and observation of the phenomenon under study is required. Patton (1990) makes the point that the process of participant observation gives the researcher an insider’s view of what is happening. The researcher not only sees what is happening but also feels what it is like to be part of the setting. Experiencing the program as an insider is what necessitates the participant part of the participant observation. The challenge is to combine participation and observation so as to become capable of understanding the program as an insider while describing the program for outsiders (Patton, 1990).

Bogdan (1972) describes participant observation as ‘research characterised by a prolonged period of intense social interaction between researcher and the subjects, in the milieu of the latter, during which time data, in the form of field notes, are unobtrusively and systematically collected’ (Bogdan, 1972, p. 3 in Bogdewic, 1992). Participant observation enables the researcher to focus on how the activities and interactions of a setting give meaning to certain behaviours or beliefs by ‘observing the interpersonal events’ (Whyte, 1955). It enables the context within which stakeholders undertake their work to be observed as it unfolds. Hence the sequence and connectedness of events that contribute to the meaning of phenomena can be identified, providing the researcher direct access to observe elements of the culture of an organisation. Finally participant observation provides the researcher the opportunity to integrate what is said with what is observed. Hence, this is a research method that enables an understanding of the processes, events, and relationships in the context of a social situation (Bogdewic, 1992).

Patton (1990) refers to a continuum in the participant observation method, which varies from complete immersion in the setting as full participant to complete separation from the setting as spectator. Gold’s (1958) typology of naturalistic research roles has outlined four models through which the observer may gather data: the complete participation, the participant-as-observer, the observer-as-participant, and the complete observer. The midpoint of these roles seeks to balance involvement with detachment, familiarity with strangeness, and closeness with distance (Gold, 1958 in Adler & Adler,
1994). This can vary over time. In the presented case I was both an onlooker as well as a participant observer. Over time my role in the organisation became increasingly that of participant observer in contrast with onlooker, as both my confidence increased and others began to show trust in the research process.

5.6 Application of method of participant observation

I was interested in studying the organisation dynamics associated with the implementation of the Trial process over time and hence sought to observe group dynamics: how groups were organised, communication patterns both within the Trial and between the Trial and others, decision making processes and authority relations. I used a variety of methods to enable the exploration of the experiences of stakeholders, from the beginnings through to the closing stages of the Trial, some two and a half years later. The methods of inquiry I used are listed below.

- In-depth interviews and a focus group were undertaken to obtain the perceptions of stakeholders involved in the organisation of the Trial. All members of the Trial organisation were interviewed at least once. This involved 22 participants including the CEO of the Southern Health Care Network. Most were interviewed formally on more than three occasions. In addition conversational interviews (Patton, 1990) were held with organisation members on a regular basis. One focus group (Focus Group A) was held towards the end of the Trial to encourage members to reflect over the two and a half year period.

- In-depth interviews and a focus group were also conducted with other stakeholders, who interacted with the Trial. Included were general practitioners and other service providers and State and Commonwealth public servants. Twenty-five general practitioners were interviewed. Most were interviewed on one occasion. Of those, some were members of the General Practitioner Reference Group (see Chapter 2). These general practitioners were interviewed on two or three occasions. Interviews, both individual and group, were conducted with public servants, general practitioners, agencies including The District Nursing Service, Berwickwide Community Health Centre, Connections and Dandenong Hospital.
In-depth interviews were conducted with 39 patients who consented to be part of the Trial. These interviews provide another context in which to understand the Trial organisation dynamics.

In-depth interviews were held with members of the evaluation team. I interviewed all the seven members of the evaluation team. I also attended evaluation team meetings.

Document analysis was conducted, including minutes of meetings, policy and planning documents.

My own observations, perceptions, feelings and reflections were noted. These derived from attendance at weekly management meetings, meetings of advisory bodies, such as the Consumer Reference Group, the Service Provider Reference Group, the General Practitioner Reference Group, quarterly forums for dissemination of information to stakeholders and other interested parties, informal discussions and meetings, face to face and telephone conversations. Data was also gained by time spent with the organisation of the Trial in more informal settings, such as chats and social events, which further led to my understanding of the ‘culture’ of the Trial.

While the interviews provided me with perceptional and attitudinal data, my observations provided me with contextual data. In addition my observations in the field were able to validate and confirm or question what was being said. Through observation I was able to obtain insights that were not available from the interviews, but which I sought to explore through further interviews. Sometimes this was possible, because what I observed was visible and available to others and could be confirmed. At other times behaviours that I observed could not be confirmed immediately and needed to be held in abeyance, until such time that I could feel sufficiently confident to corroborate or discard my observation.

For example, although I did not attend meetings of the Monitoring Group, I developed a sense that these meetings were very stressful for the Trial manager, referred to as Trial manager A. My reading of the minutes (which read like accountancy reports), combined with my observation of her behaviour towards staff after attending the meetings, suggested she was under immense stress to achieve outcomes set by the ‘funders’, the Federal and State governments. Her staff seemed too immersed in recoiling from what
they experienced as aggressive attacks to be able to think about why she may be behaving in the way she was. As far as they were concerned she was power hungry and a ‘bully’. When the new Trial manager, who shall be referred to as Trial manager B in the body of the data, arrived towards the end of the Trial, she confirmed the stressful ‘head kicking’ nature of some of the Monitoring and Management Committee meetings.

This process of observation, reflection, seeking confirmation, further testing, questioning and interviewing was a circular continuous process from which themes and patterns and working hypotheses began to emerge. This was derived from Whyte’s (1955) classical study of the social structure of an Italian slum which poignantly shows how participant observation can be used in research. He developed a methodology and theoretical meaning based upon observing interpersonal events between groups and between group leaders and members of larger institutional structures (Dawson, 1997).

5.6.1 Interviews

One of the principal instruments used in the fieldwork has been the in-depth, open ended, face-to-face interview. The process involved a series of personal interviews conducted over the two and a half years with stakeholders within the Trial institution as well as those interacting with it. The number of interviews I held with each person varied. Some individuals were more available than others due both to work load and desire to be interviewed. I was particularly interested in the perceptions of Trial personnel perceptions who included both Trial managers, the recruitment manager, the special projects manager, the administrative staff, the Executive Director of a Division of General Practice, members of the General Practice Reference Group, and those who held the two case manager and two service co-ordinator positions. I was interested in exploring with stakeholders their:

- Expectations and perceptions of Trial goals;
- Perceptions of what constituted Trial success and their feelings in relation to this;
- Internalisation and taking up of roles;
- Intra- and inter-organisational relationships;
- Decision making processes; and
- Perceptions of impediments to the Trial operation.
There are a number of ways to conduct the in-depth interview. Patton (1990) refers to three approaches: the informal conversational interview; the general interview guide approach; and the standardised open-ended interview approaches. These approaches differ in the extent to which interview questions are pre-determined and standardised.

The standardised open-ended interview consists of a carefully arranged set of questions with the intention of taking each respondent through the same sequence, asking the same questions with essentially the same words. The informal interview approach relies on the spontaneous generation of questions in the flow of an interaction that occurs generally as part of ongoing participant-observation fieldwork. The general interview guide approach involves outlining a set of issues to be explored with each respondent before interviewing begins. An interview guide provides broad subject areas within which the interviewer is free to explore, probe and ask questions to elucidate and illuminate a particular subject (Patton, 1990).

I chose to use the interview guide and the conversational interview approaches, because a pre-determined questionnaire may lead me to miss information and hence opportunities that could throw light on the experiences of the participants with respect to co-ordinated care. The interview guide approach enabled me to deal with pre-defined areas of interest, as well as providing the flexibility and opportunity for participants to discuss aspects of the co-ordinated care process that I may not have considered and had not included in the interview guide.

I also used focus group interviews. These are interviews with a small group of people on a specific topic. Participants are asked to reflect on the question asked by the interviewer. Participants get to hear the responses of other group members and to make additional comments beyond their own original responses as they hear what others are saying. Focus group interviewing was developed in recognition that many of the decisions people make are made in a social context, often growing out of discussions with other people (Patton, 1990).

This approach is consistent with an interpretivist approach, which does not constrain the inquirer with a priori questions, but leaves room for emergent issues and hence
emergent hypotheses to be explored. Hence, it allowed potential research questions to
emerge. This method can be time consuming, and cumbersome to analyse compared to
research designs which rely on methods that allow the investigation to completely
control conditions of the study by manipulating, changing, or holding constant external
influences, and in which a very limited set of outcome variables are measured.
Moreover, it may be difficult to generalise results (Dawson, 1997; Zyzanski et. al.,

5.6.1.1 Interviews held with Trial organisation

I initiated the one-to-one interviews and initially arranged for them to be conducted at
the Trial premises, which was most convenient for the participants. When I arrived for
the interview, participants often informed me ‘that walls have ears’ and preferred the
interview to be conducted away from the Trial premises, where discussion could be
more open. We usually chose to have a coffee in the local shopping centre. This process
created some discomfort for me, as we had to pass the Trial manager’s office to go to
the car park. It was important for me to optimise my relationship with her as she had the
power to limit my entry into the organisation. Interviews lasted between one and three
hours, depending on time available. Notes were taken during the interview process and
transcribed subsequently. Interviews were not audio taped as the analysis process would
have been too time consuming given that I was conducting some two hundred
interviews over the period (including patient interviews). Formal interviews were
conducted with members of the Trial organisation over the two and a half years on three
occasions each.

My interviews were relatively unstructured and provided space for individuals to
discuss their fears and fantasies about their roles and the roles of others. By exploring
the psychic reality of individuals, including fantasies, expectations, attributions,
assumptions, fears and anxieties about themselves and others in their mutual
organisational roles, the researcher begins to discover the organisational identity
(Diamond, 1993). It is through a process of exploring the intersubjective world of the
experiences of organisational members that one discovers something unique about the
culture of the organisation, and hence a perspective on how things are done. This
requires the inquirer to proceed in the field with empathy, which involves being able to understand the stance, position, feelings, experiences, and worldview of others. The value of empathy is emphasised in the phenomenological doctrine of ‘verstehen’, which means ‘understanding’ and has profound implications on the way one studies human beings. In particular, it refers to a unique capacity human beings have for undertaking human inquiry into human affairs (Patton, 1990).

In addition to arranged interviews, there were informal conversational interviews. Members of the Trial organisation initiated contact with me to convey their feelings and perceptions about an event, a meeting, or about other internal or external stakeholders that they had either forgotten to mention or did not want to mention in the presence of others. This was to ensure that I was alerted to the issues that Trial members regarded as important. Often I was approached after a meeting or was contacted by telephone. Information conveyed in this way was noted and placed in an 'interview notes' file.

5.6.1.2 Interviews with other stakeholders

Interviews were also conducted with other stakeholders including State and Federal public servants, general practitioners, the Dandenong District Division of General Practice, nurses, social workers, mental health workers, specialists, managers, working in various settings (hospitals, community health centres, district nursing).

Given time and cost constraints, interviews had to be ‘purposive’, meaning that data collection had to be strategic and aimed at enhancing understanding of the questions under study (Patton, 1990). In order to obtain these information-rich cases, I sought assistance from the Trial management team and the Dandenong District Division of General Practice, who acted in the valuable role of ‘key informants’ in providing me with the names of individuals from different professional and interest groups. They chose individuals who might well be willing to openly share their experience and insights regarding aspects of the Trial. Key informants can provide particularly useful information about what is happening to subgroups to whom the researcher/evaluator does not have direct access (Patton, 1990). Chosen were service providers, case managers, policy makers, specialists and members from the various reference groups,
who could provide a broad range of perspectives, both positive and negative. Over time, as I developed my own networks, I relied much less on key informants.

Most individuals were interviewed on at least one occasion. Some, such as certain members of the General Practitioner Reference Group, were interviewed two to three times. Others were interviewed on one occasion.

### 5.6.1.3 Focus group interviews

While individual interviews enable people to voice opinions and views that they may find difficult or sensitive to voice in a group situation, focus group interviews are useful in providing data on how individuals interact. They can prompt insights and solutions otherwise not produced. (Brown et. al., 1989 in Patton, 1990). Focus groups also generate greater breadth of information, as compared to individual interviews, which provide more depth about a topic (Miller & Crabtree, 1992). This technique is also able to yield responses to the same issue from multiple respondents in a shorter period of time than if each person was interviewed separately. Issues that are contested can be put to the group and discussed. Moreover, focus groups enable a comparison between what people say as individuals and what they say (and not say) in a group situation. Hence the focus groups constitute a potential process for triangulation of data derived from other methods. A focus group was conducted with the Trial organisation towards the end of the two and a half years as an opportunity for reflection and to discuss learning gained, through the experience. The Trial manager chose not to attend as she felt it could inhibit the discussion.

I also initiated a focus group with general practitioners and members of the Division of General Practice. I conducted group interviews with State government personnel, hospital network personnel and a number of interviews with community health service personnel. I initiated these, which lasted between one and two hours.
5.7 The role of the researcher

5.7.1 Developing the research relationship: gaining entry

Given that all social research occurs in the context of a relationship, the role of the researcher in the research process cannot be ignored. The integrity of the research relationship is crucial for a study which seeks to gain perceptions of stakeholders over time, and in context. Without the relationship there can be no research. Hence, it is necessary to discuss the context in which the research relationship was developed and the process of gaining entry into the Trial organisation.

The process of conducting fieldwork has involved a myriad of relationships with patients, doctors, Trial management, service providers, case managers and evaluators. It has required a strategic approach, selecting groups and individuals that can enhance an understanding of the questions under study, without offending those who for the moment, may not be as important to the exploration.

The process of gaining entry was one that required sensitivity. Although the presence of the local evaluation team was part of the contract that the Trial organisation had negotiated with the Commonwealth, the methodological approach was the domain of both the local evaluation and the Trial. It was up to these groups to develop a methodology appropriate to the primary and secondary hypotheses (see Chapter 2). There were guidelines stipulating that there be both a quantitative and qualitative element to the evaluation. How the evaluation was undertaken was left open. My role was to undertake the qualitative work. My methodological approach required my presence in the field as I was seeking information about what Patton refers to as ‘day to day, incrementalist, and conflict laden realities of program implementation’ (Patton, 1979, p. 328). The other evaluators were responsible for conducting a randomised control trial consisting of a randomised sample of 2,500 people taken from the Greater Dandenong Area, to ascertain whether the Trial Model of Co-ordinated Care had improved patient quality of life. The methodology underpinning this process was one of logical positivism and aims were outcome orientated.
The relationship between the manager of the local evaluation team and the manager of the Trial organisation was tense throughout most of the Trial period. Problems were due to a failure by both parties to effectively negotiate the scope of the evaluation, which exacerbated anxiety. Although the evaluation was supposed to be both outcome- and process-orientated, these were never defined or negotiated. There was no agreement about the extent of the evaluation team’s presence in the field. The manager of the evaluation team believed that intellectual independence of the evaluation required objectivity and hence, geographical distance. The manager of the Trial organisation wanted the evaluators to have a greater presence on site on condition that she could decide the nature of their presence (minutes of meeting, observations dated October 15, 1998). The evaluation manager took these differences personally. At one point the evaluation manager refused to attend those meetings in which the Trial manager was present. Meetings between the Trial and the evaluation team became increasingly less frequent and were non existent during the major part of the Trial. The evaluation manager’s attitude influenced the research process in so far as my fellow evaluators had minimum presence in the field. It was only towards the end of the Trial that the two groups began to come together, mainly for the purpose of the final report, and on the evaluators’ territory. By that stage a new Trial manager had arrived.

Unresolved differences between the Trial and the evaluation spilled over into my relationship with the Trial, and affected my ability to gain entry. My presence in the field was imperative for my research. Initially this created difficulty with members of the Trial who had little trust of the evaluators due to the ongoing tensions. Although in theory I had access to management meetings, I was limited and controlled in terms of my freedom to attend meetings. For example, when I attended a meeting of the General Practice Reference Group, the evaluation manager informed me that my presence had created problems, despite the permission I received from the chairman of the group. There were other examples where gaining entry proved to be difficult. I knew I had to ‘make friends’ in order to conduct my research in the way I saw fit.

Bogdewic (1992) provides a number of tips for the establishment of rapport in research relationships. He suggests that researchers should be unobtrusive, honest, self revealing and reflective listeners. Over time tensions slowly eased as I built up the trust of
members of the Trial organisation. They permitted me the opportunity to continuously
delve into their experiences through discussion, interviews, and observations of their
meetings and to be present at more informal settings such as coffee in the kitchen. I was
invited to social functions such as farewells to staff and Christmas parties. Although the
evaluation team was often invited to some of the more formal social events, I was the
one who generally went along. I was also privy to the Trial’s records, documentation
and minutes of meetings of the Management Committee and Monitoring Committee,
where much of the Trial business occurred. Trial members also provided me an entrée
to other stakeholders, including patients and service agencies. In return I was a
reflective listener. I was often thanked for what participants regularly referred to as a
‘debriefing session’.

As my relationship with the Trial organisation developed and I became more familiar
with people and processes, I was able to come and go as I pleased, to talk to whoever I
wanted to, and to attend most meetings. I found myself in a position where I was being
invited to more meetings than it was possible for me to attend. The Trial manager also
became more open with me. While in the early stages of the evaluation I perceived her
to be reticent during the interview process, over time she became more comfortable with
me and began to share her concerns. Moreover, she no longer attempted to control the
meetings I attended.

Difficult dynamics were also evident within the research team. Barry et. al. (1999)
assert that despite the benefit of the different knowledge bases that are brought together
in a multidisciplinary team approach, there are also difficulties. A multidisciplinary
team potentially yields more information and makes the research more exciting than in
cases where teams or individuals are restricted to a single mode of knowing. Teams can
also reduce the loneliness associated with research and provide emotional support to
members. However, the nature of teamwork itself increases the opportunities for
uncomfortable conscious and unconscious feelings (Bion, 1961). Group membership
causes insecurities and can also entrench positions, with communication becoming more
complex (Barry et. al., 1999). Alderfer (1988) argues the case for the conscious
incorporation of self-dynamics into the research procedures, on the basis that the way
the research is undertaken impacts on the knowledge that is gained. He asserts that
research should include more detailed accounts of relationships among investigators in their different roles and between investigators and respondents.

I held interviews with members of the evaluation team in order to ascertain their perceptions of the Trial process and the organisational dynamics around the evaluation. These indicated tensions within the research team. I also witnessed tensions at the weekly team meetings I attended. I have not included this information as data in the findings chapter (Chapter 6), but refer to these tensions in the methodology chapter to assist the reader in understanding the context in which the evaluation was undertaken. In order to contain the scope of the thesis I have chosen only to focus on those dynamics within the evaluation team that affected my capacity to undertake the task at hand. For example, the evaluation manager wanted to minimise the evaluation presence in the field, and my presence in the field was continually being questioned on the basis that my objectivity was being impeded by too much contact in the field. Moreover, at meetings there was little attention devoted to information obtained from my interaction in the field. The qualitative research was invariably last on the agenda, while the research team focussed on quantitative method and outcomes (costs and numerical outcomes, reflected in minutes of meetings between 1997 and 1999).

5.7.2 Role of researcher as research instrument

There are a number of requirements that underpin the role of researcher as research instrument. These include:

- The capacity of the researcher to engage in inductive analysis;
- The capacity of the researcher to reflect upon and acknowledge the nature of her presence in the research process, and,
- The capacity of the researcher to be able to use her emotions as a tool for understanding broader dynamics taking place in the field (Berg & Smith, 1988; Smith, 1988; Alderfer, 1988; Berg, 1980; Smith, 1976).
5.7.2.1 The capacity of the researcher to engage in inductive analysis

Fieldwork is an interpretive enterprise mediated by the subjective experience of both the researcher and the subjects (Hunt, 1989). It is the researcher who decides what to research, how to frame the research questions, what questions are asked in interviews, and how answers are probed. The nature of the researcher’s involvement influences the direction of the research. The researcher makes decisions about what to look for. The researcher is the screen and vehicle through which information is interpreted, translated and fed back. It is the researcher who makes sense of the behaviours that people display and the meanings they attribute to events. It is the researcher’s capacity for reflection and intellect to tease out what is meaningful from impressions, recollections and records. It is the task of the researcher to manage the tension around order and chaos, to counteract an inclination to impose order on unfamiliar events too quickly and commence on a process of theory building and possibly generalisation, without becoming lost in the process (Berg, 1980). This requires what Long (1999a) refers to as psychological sophistication and maturity; the capacity to tolerate anxiety, ambiguity and other forms of psychological and social pain.

The principle of the inductive approach is central to naturalistic evaluation in that key evaluation issues emerge from intensive on-site knowledge, rather than being formulated prior to data collection (Cook & Shadish, 1986; Glaser & Strauss, 1967). An inductive approach involves the researcher making sense of the situation without imposing preexisting expectations on the phenomenon under study. Important analysis dimensions emerge from patterns found in the case under study without presupposing in advance what the important dimensions will be. To the extent that qualitative methods rely on inductive logic, inductive analysis not only allows for, but also demands a capacity by the researcher for critical thinking. The qualitative methodologist attempts to understand the multiple interrelationships among dimensions that emerge without making prior assumptions or specifying hypotheses (Patton, 1990). ‘Perhaps the simplest rule for method in qualitative casework is this: Place the best brains available into the thick of what is going on. The brainwork ostensibly is observational’ (Stake, 1994, p. 242).
5.7.2.2 Acknowledgement of the researcher in the research process

An argument put forward by the sociological and psychoanalytical literature is that the impact of our own emotions may be suppressed or deflected but never adequately disposed (Smith, 1976). The notion of using our emotionality as a source of data to be examined, rather than subjective error to be suppressed, has been well-established (Berg, 1980; Smith, 1988). The researcher is part of the phenomenon being studied, and hence the researcher’s own presence in the research process requires acknowledgement. Fieldworkers need to become increasingly aware of understanding how their own personal experience structures field relations and the kinds of material gathered (Hunt, 1989).

In undertaking the research I reflected carefully on similar work that I have been involved in, and noted my own valence for seeing the world in political and often conflicted terms, and my interest in understanding the root of the perceived organisational pain. As the daughter of Holocaust survivors, and arriving in this country as a child of school age I have, experienced feelings of being a member of an ‘out’ group, and at times struggled with feelings of marginality which have no doubt been internalised, and which are likely to influence the way I view events around me, and how I respond.

Hunt (1989) asserts the need for the researcher to be intensely mindful of the ‘dual intentionally’ of the research role, attempting to enter into the world as a subject but remaining faithful to the primary role of researcher. I have taken heed of the need to adopt this stance.

I have chosen a conceptual frame that can accommodate the inevitability of differences amongst the various interest groups, both within the system and between the system and its environment, and have discounted some of the other frameworks, which assume organisations are functionally integrated systems, and relationships are integrated, coherent, and stable (Morgan, 1986; Czander, 1993). Hence my research approach has needed to be pluralistic. I have sought to ensure that the perceptions of the various interest groups are captured.
I am, however, aware that unconscious processes may operate, resulting in the projection of one’s internal struggles onto the world. Long and Newton et. al. suggest that it is only in retrospect that one can begin to comprehend irrational and unconscious aspects of one’s experience as this is mostly impossible in the field (Long & Newton et. al., 1997). Hunt (1989) also acknowledges unconscious processes that mediate the relationship between researcher and subject. She differentiates between introspection and self-reflection. Reflection is about the researcher’s activities and reactions, and is assumed to provide data regarding the social and emotional world of the subjects. Introspection refers to the researcher’s associations to experiences that evoke anxiety, boredom, anger or love, which may provide clues to transference relationships that hinder or enhance the researcher-subject relationship (Hunt, 1989).

Being aware of my own potential for transference and biases, I chose an iterative and dynamic methodology that would enable data to be fed back to the Trial for review. This feedback mechanism could then alert me to other views. Was I unduly focussing on the organisational pain? Was I over vigilant in ensuring that those that I perceived to be in relatively marginal positions in the Trial hierarchy had a voice? Were there other aspects of the Trial process that I was not considering and not capturing? The data I present in the next chapter captures the conflicted nature of relationships during the Trial process. Members of the Trial organisation concurred with my interpretation of the Trial processes and the associated organisational dynamics. The evaluation manager was however uncomfortable with the findings, and would have preferred that they were not included in the final report to the Trial.

5.7.2.3  Emotion as a tool for understanding dynamics of the organisation

An alternative way of dealing with our emotions is to use them as a source of data. What transpires within the individual investigator may, in fact, be a rich source of data about the dynamics of the organisation he/she is working with. Feelings are a result of our experiences within the system. If we can introspect, we open up a whole new domain of potential data about the system. The organisation influences the internal dynamics of people who interact within it and the participating researcher and research team are no exceptions. The external tensions may well become reflected in the
individual’s internal processes (Smith, 1976; Berg & Smith, 1988; Krantz & Gilmore, 1991; Stapley, 1996).

An understanding of parallel processes has been part of the therapeutic world for a long time. Parallel processes are defined as the tendency for two or more systems that have significant contact with each other to show similar affects, behaviours, and cognition (Alderfer, Brown, Kaplan & Smith, in Berg & Smith, 1988). Hence it is likely that processes operative within the researched system will be played through, in parallel form, in the key dynamics that are driving the researchers.

My own personal difficulties with the direction of the evaluation and my relationship with the evaluation manager have been documented in my personal diary. I have attempted to reflect on my perceptions, biases and feelings experienced during the research process. These reflections constitute both another data source, and a means of validating the data obtained through the research process. In order to contain my database I have not presented my reflections on the organisational dynamics of the evaluation team in the findings chapter of the thesis. I am, however, mindful that conflicted organisational dynamics in one domain are likely to penetrate into other domains. This phenomenon is referred to as ‘parallel processes’ in some of the group dynamics organisational literature (Berg & Smith, 1988) and refers to transferential and countertransferential dynamics that exist between individual and group interactions. This understanding has assisted my analysis and interpretation of events. Hence given the tensions surrounding health care reform in the broader domain (Chapter 2), it is not unexpected that these tensions would infiltrate the Trial and the evaluation, affecting dynamics within and between these institutions.

5.8 Establishing integrity of the data

Ensuring validity of qualitative method is necessary to ensure integrity of the research design and method chosen. However, assessing rigour in qualitative work according to the tenets of quantitative research is inappropriate in that it fails to accommodate the essence of qualitative research (Guba, 1981; Agar, 1986 in Kreftig, 1991). Imposing criteria that are applicable to quantitative data (Yin, 1994; Campbell, 1975) undermines
the very essence of qualitative method and what it can offer. At best, qualitative data is relegated to a secondary role. For example, traditional positivist principles of being objective and avoiding moral and emotional commitments are inappropriate if the research relationship is predicated on inducing ‘verstehen’. The assumption that there is something intrinsically positive about researcher objectivity, can be interpreted as a ‘denial of connectedness’ (Stoeker, 1991, p. 96). He suggests that in striving for so called ‘objectivity’ one ignores and denies important information, and hence one behaves in a less than objective manner (Stoeker, 1991).

Researchers need alternative models appropriate to qualitative designs that ensure rigour without sacrificing the relevance of qualitative research (Guba, 1981; Kreftig, 1991). A different language that replaces the terminology of reliability and validity with the criteria of consistency, plausibility, credibly and adequacy more appropriately fit with the basic tenets of the qualitative paradigm (Kreftig, 1991; Charmaz & Olesen, 1997). ‘Seemingly irrational, idiosyncratic, and individualistic actions have their own logic and are inherently social in origin’ (Charmaz & Olesen, 1997). Approaches for ensuring integrity of research method are found in Gilchrist (1992), Patton (1990), and Altheide and Johnson (1994). Gilchrist (1992) presents four criteria modified from her reading of Kuzel and Like (1991) in Gilchrist (1992). These include:

- Member checks requiring the recycling of analysis back to key informants;
- Searching for disconfirming evidence, the argument being that a proposition deserves trust only after it has survived serious attempts to falsify it;
- Triangulation, which refers to the use of multiple data sources such as multiple informants, and multiple methods;
- Thick description, which ‘involves a thorough description of the transactions or processes observed, that are relevant to the problem, evaluand and policy option’ (Gilchrist, 1992).

Patton (1990) points to the need for researcher credibility in terms of both ethical behaviour and the capacity for intellectual rigour. ‘Creativity, intellectual rigour, perseverance, insight – these are the intangibles that go beyond the routine application of scientific procedures’ (Patton, 1990, p. 477). Given the political context in which evaluations are often taken, the researcher also needs to be viewed as ethical, for the
trustworthiness of the data is directly tied to the trustworthiness of the evaluator, who collects and analyses the data (Patton, 1990). Making transparent the researcher’s biases values, assumptions, and feelings about the research relationships further enhances integrity. This requires a process of self-scrutiny, which Berg and Smith (1988) regard as a necessary responsibility of the researcher in the research process. ‘Since what the researcher does not know about his or her own involvement in the research endeavour may affect other people, there is an implicit injunction that the researcher engage in systematic self-scrutiny’ (Berg & Smith, 1988, p. 27).

My approach has been one that focuses on data triangulation as a way to validate and cross check information I obtained. The multiple method approach makes it possible to cross check different types of data in constructing a narrative of the process of change (Dawson, 1997; Patton, 1990). I have used different sources of data, observations from the field, observations obtained from meetings of the evaluation team and interviews I conducted with members of the evaluation team, as well as interviews I conducted with other stakeholders, who interacted with the Trial organisation. In addition I used minutes of meetings of the evaluation team and the Trial team as well as other documentation, such as reports to the Monitoring Committees (Southern Health Care Network, 1997-1999a) and the Management Committee (Southern Health Care Network, 1997-1999b), and attendance at forums, where Trial members presented. Additional perspectives and reflections were documented in my reflective journal. I looked for consistencies and inconsistencies in terms of what was said in open forums in contrast with what was said to me personally. I noted nuances and changes in body language as data. On a number of occasions I have checked my assumptions regarding both unspoken behaviour, and inconsistent communication. Had people changed their mind? Were there political reasons for public statements that were made?

I fed back to the Trial both on a verbal basis as well as by providing the Trial with one written detailed thematic report (Piterman et. al., 1999) and a number of regular, thematic reports provided on a quarterly basis. These were presented to the Trial for comment, discussion, negotiation and further interpretation as part of the iterative process I engaged in. Was there anything in my description and interpretation which was not concurred with, or created discomfort and why? Ultimately was I as a
researcher seen as credible and ethical, and was my interpretation sufficiently adequate or ‘good enough’ (Winnicott, 1971) to gain the credibility of those reading my work?

5.9 Analysis

My approach to analysis is based on what is referred to in the literature as a hermeneutically circular process (Addison, 1992), also depicted by the metaphor of the Shiva’s circle (Miller & Crabtree, 1992). The approach involves the researcher in a circular procedure, a process which involves the continuous interplay of academic preconceptualisation (based on prior knowledge through experience and literature) and detailed empirical descriptions of emerging themes and topics, out of which new concepts are refined and interpretations developed. The naturalistic approach suggests that the inquirer cannot be constrained by a priori questions and needs to leave room for emergent issues and hence emergent hypotheses to be explored (Dawson, 1997, Guba & Lincoln, 1989).

Analysing and interviewing were progressive. My analysis began with the process of recording my observations. Recording data is time consuming and tedious but it enables reflection. After conducting every interview, I would type it up or dictate it. During this process I jotted down ideas and themes and, in this way, working hypotheses began to emerge. Some I wished to test further in the field, while others I had no need to test as there was sufficient confirming evidence from the various sources. I moved back and forth between collecting, analysing, reflecting and writing. Interviews were used to cumulatively draw out themes in successive interviews. The time between formal interviews was approximately nine months and I used this time to formulate working hypotheses, which could be tested in subsequent interviews. The typed transcript of my interviews, combined with the data gained from observation, informal conversational interviews, and observations and perceptions in my reflective journal, became the basis for the development of further analysis, ideas and themes, which became the basis for the final analysis.

This iterative sequence of data collection followed by conceptualisation continued until the project came to an end. During that time I had developed a number of working hypotheses and interpretations which have informed the thesis.
Pettigrew’s (1979) study of a private British boarding school uses a design anchored around the study of social dramas, which allows varying readings to be taken of the development of the organisation (Pettigrew, 1979). Long (1992) also segments her study of group dynamics over time ‘into particular moments or states that contain meaning’ (Long, 1992, p.140). This is a process of organising and analysing the data by identifying major events in the history of a case and considering these as central foci, traumas or social episodes (Harre, 1979; Forgus, 1979 in Long, 1992, p140).

Examining the dramas or events afforded the opportunity to study the organisation of the Trial in the context of what the players experienced as significant events, and hence enabled the study of the growth, evolution, transformation and winding down of the Trial over time. I sought the views of members of the Trial organisation around what they considered to be significant periods of the Trial. The focus group discussion segmented the life of the Trial into three marked periods. These were

- The beginning, characterised by a drive for recruitment, also referred to as ‘confusion’;
- The live phase of the Trial referred to as ‘the drive to cut costs’, also referred to as ‘the dark ages’;
- The winding down phase referred to as ‘the learning’, also referred to as ‘the divorce’.

Within these headings I explored the issues which arose from the data and which I considered meaningful for both the organisation and analysis of the data. These included:

- The development of the partnership process;
- The way stakeholders experienced trial beginnings;
- The different expectation stakeholders had of the Southern Health Care Network Model of Co-ordinated Care, and the implication these different expectations had on the implementation process;
- The way stakeholders experienced roles, responsibilities, and priorities;
- Authority relations;
• The experience of relationships both intra-organisational and inter-organisational, particularly the split between those involved in patient care and those who had administrative tasks;
• The experience of trial closure.

The content of the interviews was analysed according to these events. Each event provided a clear point of data collection and enabled the evaluation to be organised around people and processes at a point in time. Each event acted as an in-depth case study within the overall case study and thereby provided a dramatic glimpse into the current workings of the Trial in the context of other players and events. Having identified the events, I broke the data down into its various constituent components, then located the data under one or a number of different categories and sub categories, before building connections across the material as a whole. Dawson (1997) refers to this approach as a process that enables an open contextual description of the dynamic process by which change unfolds. The process of synthesising and categorising the data brought forward a number of themes. I extracted the major themes and developed working hypotheses, which both formed the basis for further exploration or became a finding.

Quotations, which are included in the case study, were selected in accordance with the analysis and interpretation developed in the findings. The product of my inquiry is a detailed interpretivist account presented in the form of a case study.

5.10 Conclusion

This chapter examined the methodological underpinning of the research and describes and explains the method used in exploring how members of the Southern Health Care Network Trial organisation (the Trial), experienced the change process. The case study design chosen is an appropriate way of framing the research, as it accommodates the investigation of highly complex situations within ‘real life’ contexts and enables the utilisation of multiple methods of information. Organising the data around meaningful events has enabled the presentation of the development of the Trial over time, from beginnings to the winding down stage, through the experiences of the stakeholders involved. This is a method that is underpinned by a regard for and acceptance of the
uniqueness of the human situation, and the existence of multiple realities as opposed to a more reductive view of the world. This extends to an acknowledgement of the place of the researcher in the research process.

The next chapter presents and discusses the research findings. Because the breadth of the research and the number of stakeholders interviewed I have needed to be selective in the focus of my presentation. Hence, I have created an arbitrary boundary between the organisation of the Trial and its environment such that the research processes and knowledge generated occurs around this conceptualisation, and enables me to focus on the organisation dynamics of the Trial (Morgan & Smirchich, 1980).
Chapter 6

Findings

6.1 Introduction

This chapter reports the findings. It interprets the organisational dynamics surrounding an implementation process from the perspectives of members of the Trial organisation and the general practitioners with whom they interact. The scope of the research has been broad. I have used the generic term interview for material I have obtained from a number of sources including telephone conversions and informal conversations. Moreover, what was said to me in more informal situations was generally reiterated during a follow up interview.

For the purpose of the thesis, I have had to be selective with the data I present and have placed an arbitrary, yet useful boundary around the Trial organisation in order to contain the data. I have focussed on organisational dynamics within the Trial organisation and explored the relationships around an implementation process between management, representatives of the Divisions of General Practice (Divisions), service co-ordinators, case managers, administrative staff, and care co-ordinators, who have been aligned with the Trial. Where more than one interview was conducted I have numbered the interviews. I have also been selective in the number of quotes I use in the body of the thesis. Where the quotes are long, or there are a number of different sources making the same point, I have placed the raw data in the appendix (See Appendix 2) for easy reference.

The data below have been organised to capture aspects of the implementation process through the stages of the Trial’s development over the two and a half years: the beginning, the middle and the winding down stage, in the context of the partnership relationship and the broader health care reform agenda.
6.2 Context

Given that the co-ordinated care trials are government health care reform initiatives, the data is interpreted in the context of a broader health care reform agenda, whose acuity has become more pronounced in an environment of cost rationalisation. Data also needs to be interpreted in the context of the Southern Health Care Network Trial Model of Co-ordinated Care. The background chapter (Chapter 2) has outlined aspects of the external context surrounding the Trial. It has also outlined the Trial Model of Co-ordinated Care.

Co-ordinated care involves a major change initiative embracing a number of strategies including a reorientation of the finance system towards funds pooling, combined with a new information system and strategies to integrate the services currently provided by various organisations. The model, as articulated in the primary hypothesis, is exploring more effective co-ordination of care at no extra cost, through a process of capitated funding, flexible purchasing and disease management (Chapter 2).

The task of the Trial implementation process within the time frame provided by the Commonwealth cannot be underestimated. It is a complex enterprise and requires skills in design, establishment, communication and co-ordination between the various parts of the Model. It has been a demanding exercise involving the management of finances, management of confidential patient data and other information, and the management of the competing interests of stakeholders both internal and external to the Trial. It has required bringing patients and providers on board. It has necessitated an inordinate amount of communication given that co-ordinated care is a new enterprise requiring a major change in health funding and delivery. Management’s accountability to staff, reference groups, the government and the service system at large has continually been tested.
Part 1: Findings

6.3 The Setting: The Partnership

This section presents some of the difficulties that ensued in forming a partnership. In particular, it highlights the different perspectives each partner held around the design of the Model of Co-ordinated Care, the role each partner expected to play in the Trial process, and expectations of responsibilities in regard to how decisions would be made in relation to the allocation of resources.

6.3.1 Forming the partnership organisation: relationship between strategic partners

The Trial organisation involves a partnership between the Southern Health Care Network and the Divisions of General Practice. The partnership is significant in that it underpins and bounds the organisation of the Trial. Although there has been a previous history of forming partnerships between the Network and the Divisions around projects, these have had their difficulties. The following examples reflect this.

We have been involved with the Southern Health Care Network on 3 different projects, the GP (general practitioner) liaison, pre anaesthetic project and co-ordinated care. They have screwed us every time. We fixed their stuff up for nothing. We were not even on their letterhead. The Trial is 90% SHCN. It is only now that they have put us on their letterhead. (Care co-ordinator A, active member of Division of General Practice, interview 1)

The Southern Health Care Network has done nothing for us. For example, on another project we were involved with, we had expectations that the hospital would notify doctors when patients went into hospital, but they did not. They did not liaise and hospitals did not notify doctors although they were supposed to. In the future we will try to do things ourselves without the hospitals. I have had too much experience with the Southern Health Care Network that would say to me ‘we don’t get involved with them’. The hospital philosophy is that everything revolves around the hospital. (Care co-ordinator A, interview 2)
We were involved with the pre-admission project with the Network. Then they pulled us out. We can’t trust them. (Care co-ordinator B, active member of Division of General Practice, member of General Practitioner Reference Group, interview 1)

The Australian Medical Association (AMA) was opposed to general practitioner involvement with the co-ordinated care trials. The AMA connected co-ordinated care with the American style ‘managed care’ approach, which was viewed as threatening general practitioner independence. The AMA also argued that co-ordinated care was ostensibly for the chronic and complex cases, which constituted about 10% of the population, and hence was not mainstream for most doctors. However, the then Chairman of the Division (Chairman of Division during first half of Trial) encouraged the Divisions to take part in the Trial, on the basis that Divisions of General Practice should be involved in designing their own future. Hence the partnership was formed despite opposition from the Australian Medical Association (AMA).

The relationship between the partners to the Trial organisation, the Network and the Division of General Practice, reflects the difficulties inherent in bringing separate cultures together. This was manifest in an inability to transcend the culture by forming a separate language of partnership. Throughout the period of the Trial both partners continued to view themselves as separate institutions, representing a separate constituent. The language of ‘Division’ and ‘the Network’ permeated the culture of the Trial institution. It was always two organisations with competing interests.

The task of forming a partnership involved a process of bringing together different organisations and different cultures to form a transient organisation responsible for the design, development and management of the implementation of the co-ordinated care model.

The Network did not address the different cultures of stakeholders, different power bases, different agendas and different purposes. There is always likely to be conflict when you’re dealing with groups with their own agendas, from different cultures, with different power bases negotiating at the boundary of these cultures. The Network was ensuring its own interests were looked after. The Division wanted to look after its own doctors. The Division provides a pro GP line, but as far as the Network is concerned, the GPs are just
one of a number of providers. The Division felt negative from the start. (Trial manager B, interview 3)

The Network saw one of its main roles as taking on the corporate and financial aspects of the model, the management and distribution of the funding pool. The Network also took on the management of the database, necessary to obtain a profile of patient utilisation rates. The Network had taken on the legal and financial undertaking, and was accountable to the Monitoring Committee (representative of State and Commonwealth governments). The Division’s focus was on service delivery. The Division was given the responsibility of managing the delivery of the care co-ordination function. This involved the setting up of the care co-ordination function, case management and service co-ordination roles, and the establishment of agreements with the service sector. However, the Network and the Divisions had conflicting priorities regarding the task of co-ordinated care and this was played out throughout the implementation process.

The Division has viewed the Network as a big business, corporate and cost orientated culture, with antipathy towards general practice. It has viewed the Network as having little understanding of the community and little understanding of general practice. This was acknowledged by the Trial manager.

The Network do not have experience in the community, and do not know how to get along and work with the community, and did not understand the depth of feeling and anxiety about those feelings. (Trial manager A, interview 3)

6.3.2 Tension associated with the Network’s dominance in the management role

The partnership was one in which the Network took on the dominant management role in the decision making process. The Network CEO’s view has been that the other players on the committee were there in a limited decision making capacity; what he referred to as a small ‘c’ (committee) role. Hence, in essence the Network management drove the management of the Trial, with the Trial manager (a Network employee) as the management face of the Trial.
As will be demonstrated below the Network’s ascendant role on the management committee was continually the subject of tension and conflict. The Dandenong District Division of General Practice was never able to come to terms with a small ‘c’ role, which they regarded as nothing more than a rubber-stamping role. The Division felt betrayed by what it perceived as a lack of equality in the relationship. The Division executive was concerned at being referred to as small ‘p’s’ in the partnership arrangement. They believed they had been promised equal partnership status, even though the Division acknowledged the role of the Network as the auspicing agency, and hence, the agency responsible for taking the risk. The Division viewed the Network and the Network’s CEO as coming from a position of power and strength, with which the Division could not compete. The following quotes demonstrate this.

Committee of management is meaningless, it is a rubber stamp, and doctors on committee of management have no say. (Care co-ordinator A, interview 1)

Care co-ordination was a lesser partner and we had no control over what happened. The Southern Health Care Network explained to us that they took the greater risk, as they provided more funding. I asked why was cost the biggest factor in determining who made the decision. It was because the Southern Health Care Network provided more money. They were the powerbrokers in the decision making. (Executive Director Division of General Practice, member of the General Practice Reference Group, focus group A held with Trial personnel towards end of Trial)

We were wooed, it is true, and we were told that we were equal partners, they appealed to us. Jack (CEO at the time) has a way of making you feel important. (Executive Director Division, interview 4)

It is a small ‘c’ committee of management. It is not a real committee of management. You are just fucking wasting your time. This has been shown to us on a number of occasions (Care co-ordinator A, interview 1)

The Network believed there was never an intention for an equal partnership. The Division would never have been able to manage the Trial on their own and hence, should not be making significant decisions. Moreover, the Network was taking the biggest and only financial risk, and the Division did not understand the complexity of
the funds pooling model, and did not want to take on financial accountably for the model. For example;

Jack (CEO at the time) was clear that this was not an equal partnership. It was about working together to improve the service system but the management would not be equal. This scene was set from day one and was fundamental to colouring the relationship between the Division and Network. (Trial manager A, interview 3)

There was a collision between the Trial (Network) and the Division. We are aligning partnership and power with dollar risk and responsibility. If we are to be equal partners we should share equal risk. If we’re bearing equal risk then the GP Division did not put in money. They didn’t put any money, whereas the Southern Health Care Network put $6–7 million in. (Trial manager B, interview 3)

The impact of the inequality in power was that the Network was viewed as making all the significant decisions regarding funding and recruitment without the Division’s involvement. The selection of the Trial manager was of particular concern. The Division did not feel that they had a say in this decision and some of the other major recruitment decisions.

The Division also felt that financial support to the care co-ordination function was inadequate. There was inadequate funding for administration and the Division members questioned the Network’s financial management of the fund:

The proportion of money that Division gets for co-ordinated care compared to total amount of money for co-ordinated care stinks. Its pathetic, we get 10% or less. All the money is spent on Trial management and IT budget. A lot of the IT is of no use to us. The IT budget is bizarre, they want to knock up a whole lot of money for their own IT. They also spent a whole lot of money on their hospital pharmacy. (Care co-ordinator A, interview 1)

The Network’s view was that the Division had negotiated ‘a bucket of money’ for their involvement with the Trial.

We pay a packet of money to the Division to do things and it is not done. In the end we don’t even bother asking. (Special Projects Manager, interview 3)
There was a lack of trust in the partnership, with mutual accusations that information was not being shared. The Network viewed the Divisions as dragging their feet and taking endless time to make decisions.

They are slow, they drag their feet, and in the end they so “no”. We invite them to something and we do not get a reply, but if we do not agree with them they accuse us of not negotiating. (Special Projects Manager, interview 2)

One of our frustrations was that we would request information and it was not forthcoming and hence a confusing situation was created. We would ask Mary (Trial manager A’s second in charge) for further breakdown, but never got it. They did not trust us, and did not trust what we would do with that information. If we give it to the Division it was like giving it to the wrong hands. (Executive Director of Division, interview 4)

Nevertheless, it was acknowledged by the Network that managing a project with partners holding unequal power can create tension. The Network management conceded that the setting up of Trial structures should be mindful of avoiding such problems. However, this required willingness for change and there was a view held by some of the Network staff that general practice is resistant to change.

Forming partnerships is an important process. We are talking about different cultures and hence we cannot minimise the task of bringing a number of organisations and cultures together. These organisations and cultures were brought in under the Network and includes the hospitals and five health centres. The composition of the committee is symbolic, it needs to represent the various interest groups. To the extent the composition of the committee doesn’t represent the various interest groups then these groups don’t have a say, resulting in problems down the line. I wonder if there is some way that we could have done this differently at the beginning to get people on side. There may have been ways through both the formal and informal structures that could have sorted out some of this inequality of power issues. The structure may not have been conducive to getting on. (Trial manager B, interview 2)

6.3.3 Tension around the design of the Model

Philosophically, both parties acknowledged the importance of systems reform and more effective integration of health care for the patient. For instance the Network CEO said:
The Trial is about learning how to improve systems, using the Trial to learn how to develop a system of care for which the Trial is a metaphor. Keeping people out of hospital is a good thing because it saves money. It’s about saving money. Keeping people out of hospital is a good thing because it’s about a more healthy community. There is an enormous demand for services. How can they be provided effectively so that the community can be serviced? There is a pressure on us to use those resources effectively. (Network CEO, interview 1)

However, there were differences in the way each party conceptualised the design and the operationalisation of the model. The then CEO of the Southern Health Care Network was the architect of the Southern Health Care Network Trial Model of Co-ordinated Care and was heavily committed to it. His population-based model was ostensibly risk averse in that it sought to spread risk by including a cross section of the population rather than focusing on those with chronic complex diseases, who are traditional high users of the system. Hence approximately 75% of the clients had no need for care co-ordination. Although the idea had a solid base, in that risk needed to be managed, the numbers not requiring care co-ordination were viewed to be unduly large, affecting stakeholder perceptions of the Trial and Trial outcomes.

It was Jack’s (CEO) idea, as flawed as it was. He develops a firm idea and gets it through despite the best evidence to the contrary. Jack’s intellectual capacity and the power of the Network was a force to be reckoned with. For example, the Model was aimed at getting clients just from hospital costs, which left about 80% of the people not needing co-ordinated care. He did not want to apply other filters as he wanted to manage the risk. You do need people who will not be a significant risk but it should have been 20% in the low risk. It ended up with 80% percent in the low risk. (Trial manager B, interview 2)

Jack could run roughshod over the Division because the Southern Health Care Network was putting in more money. (Trial manager B, interview 3)

Jack’s style is to push and bully. (Executive Director Division, interview 4)

Jack does business without accountability. There are those in favour, you follow the vision or life is difficult. There is a tacit understanding that money would be directed in a particular way towards a particular program if you toe the line. There is no accountability in funding allocation. That is, there are first rate and second rate citizens. You follow the line then you have a program and you have a job. (Case manager A, interview 3)
Nevertheless, it was acknowledged by some that a population-based model provides a snap shot of the diversity of health and social issues faced by the population.

It was important to have a population example, because it reflects the diversity in the population. It was able to identify broader health needs. You have on the Trial kids with disabilities, psyche issues, drug issues, as well as the clinical issues. (Service co-ordinator A, interview 1)

6.3.3.1 Network perspective

The Network viewed the aim of the Trial as primarily concerned with testing a funding model. It believed it was taking the biggest and only financial risk, and that the Division did not understand the complexity of the funds pooling model, and did not want to take on financial accountability for the model. The focus of management was to minimise its exposure to risk. Contribution to systems reform was to occur through the substitution of high cost acute care by community based service provision.

Interventions introduced to enhance the co-ordination of the patients’ care had to be budget neutral. Budget neutrality requires that total service use and associated expenditure of Trial participants should be equivalent to what expenditure would have been had there been no Trial. The requirement of budget neutrality is not intrinsic to the concept of co-ordinated care. However, it was a requirement of the Commonwealth co-ordinated care trials, and hence the Trial Model.

Brokerage funds were considered and rejected, and a model was chosen that controlled both service risk and financial risk. The Network was the custodian of the pooled funds ($13 million held in a third party bank account) and hence had committed to underwrite both a legal and financial risk. The Division had no ownership of the legal structure and liability and did not put its own entity into the consortium and take up risk. The Network did not want to risk being a provider of care and saw its role as ‘a banker and purchaser and not as a provider of care’ (Ross, 1998).
The Commonwealth wants to ensure sound management of its money. It is interested in tracking the basis of the primary hypothesis, doing more for the same cost. It wants to ensure that it’s all managed and run in a sound way according to accounting principles. It’s about contract management. There was a belief that some of this would happen through substitution. (Trial manager B, interview 3)

We need to achieve substitution. At an accountability level we cannot afford not to. This is not an issue of communication, but an issue of philosophy or values. (Trial manager A, interview 2)

Other trials have a social work model, where they look after each patient. Ours is more sophisticated. The Trial is primarily concerned about funding a model of care. It is not about case management. We know case management works. If you are going to provide services, then the money needs to come from somewhere else, which means you have to save. Some of the other trials have a social work model, which is about pets, dressing gowns, meals, and window cleaning. (Special Projects Manager, interview 2)

The language was always about costing and KPIs (key performance indicators). Cost was constantly made an issue, achieving of substitution seemed the aim of co-ordinated care. What care co-ordination was costing had to be saved through substitution before we could think about purchasing other services. That was the driving force. (Executive Director Division, interview 2)

This decision had implications for the design and operationalisation of the Trial. In particular, this impacted on the role of brokerage funding in the Model. There was no funding for health professionals to purchase the assistance they considered was required to service patient needs.

The implications for Network risk were confusing for most of the players, and according to the Trial manager, were not appreciated or understood. The Network management felt that the Division did not appreciate the ‘capacity and capability’ required in managing the risk and how this impacted on the operational elements of the model. It considered the Division to be unwilling to deal with change and to take the intellectual leap and risk inherent in a project of the size and scope of the Trial.

There was never anything said about brokerage funds. It was all about managing risk. Risk was both financial and service risk in that we did not know client demand…The
Divisions had no ownership of the legal structure and liability. They did not put their own entity into the consortium to take up the risk. The Divisions did not appreciate the ‘capacity and capability’ required in managing the risk. They did not understand the funding model. They did not understand substitution. The Divisions are 5 years old. They need to ratchet themselves forward and stop running like a cottage industry. They need management with expertise. The Trial is complex and threatening and requires them to take a bigger intellectual leap and intellectual risk. (Trial manager A, interview 3)

Pool funding, care co-ordination, case management, service co-ordination, we had to explore it all and analyse it before it was implemented. We had to go through all the “what ifs”, the range of possible actions and analyses. It was a massive administrative task. It’s OK to do creative, innovative new stuff, however we needed to translate and operationalise it. The planning was creative; there was always something new. With something new we will get resistance and we had to counter incredible resistance. We had to counter the incredible resistance of 400 angry and frightened general practitioners. The Division was not helpful. There was war on all sides and the Trial (the Network) had to create a crash-through mentality. Within the Trial there are many councils of war as well. (Trial manager B, interview 2)

The Division is conservative and lacking in vision. It is not that keen on taking anything new. They are quite happy to develop CME (Continuing Medical Education) evenings but do not want to be involved any more. They are passive and task orientated. The Division wants everything nice and neat. They do not want change. When doing something a bit more imaginative the Division of General Practice finds it hard. (Special Projects Manager, interview 1)

Time constraints exacerbated the tensions by reducing the time available for dialogue. Given the complexity of introducing a new intervention in an environment of relative scarcity and the contesting of multiple agendas, time was needed to successfully bring the partners on board and negotiate the arrangements of the partnership. Difficulties were exacerbated by what stakeholders on both sides considered was a rushed process. There was pressure to expedite the process and ‘make decisions fast’. There was no time for dialogue, and differences were not adequately addressed. Failure to satisfactorily negotiate expectations around roles, concerns about the nature of the partnership and the decision making process and questions of who is the fund holder and the future of fund holding have resulted in unmet expectations on both sides.
We had a fixed, short time frame. There was pressure. We did not have the luxury of consultation. It was a hard-edged process requiring the pushing of decisions. It was not possible to do what we were supposed to do in the tripartite agreement and bring in consultation. The reality was that we had to push to achieve agenda. People were saying, “why are you pushing us around?” (Trial manager A, interview 3)

6.3.3.2 Division perspective

The Division management viewed the Network’s goals under the leadership of the then CEO as ambitious and not necessarily focussed on the provision of patient health. The Network was seeking to extend its power base into the community. This affected the design of the Trial Model of Co-ordinated Care. The Division management believed that the design of the model was not geared to the provision of patient care. There was an undue focus on the management of risk, resulting in a failure to provide for brokerage funds to purchase services for patients, which the Division considered as essential to the models of co-ordinated care.

The Division believed that the Network’s view of risk was narrow and defined from a purely financial perspective. The Division did not consider financial risk as a sufficient basis for the Network to take control of the partnership. Moreover, the Division felt that the Network’s focus on the financial aspects of risk did not acknowledge the risk that was being taken by the Division in becoming involved in the Trial. Risk needed to be considered from the perspectives of the membership perceptions and how other Divisions perceived the Dandenong Division. The AMA had been opposed to the co-ordinated care trials. They feared managed care. Given the role of the Division is to represent the needs of general practice, the Division had to weigh up becoming involved in the Trial, as opposed to looking after the needs of the majority of general practitioners.

The Division wanted to do things differently. We had hoped for more movement in the funding pool for general practitioners and for case managers to be able to purchase and offer a better quality of care so that, for example, we would be able to purchase a service for those with COPD (chronic obstructive airways disease). We were told that we had misunderstood and there had to be saving in cost of care co-ordination, before money could be spent. We would have liked that money to go into purchasing some of the services. We could have spent a bit of money up front to see if it created savings up front.
We had a misconception that there would be more access to services; we thought there would be brokerage. We wanted to demonstrate that if you put more money into the community services, you could improve the community sector. I thought we were trying to demonstrate how the system could work with the freedom of the dollar, so that we can influence the allocation of funding in the future. But that did not happen. We were naive.

(Executive Director Division, focus group A)

It was money. The Network became involved in the Southern Health Care Network Coordinated Care Trial for money. The Southern Health Care Network used the Trial to sneak across money into the Network. A fair bit of the budget is going into administrative things that have nothing to do with the Trial. There is $25,000 allocated to the Western Alliance Medical Pharmacy. It looked like the Network was grabbing money to fund the hospital. The purpose of co-ordinated care was to develop a computer network for the hospital. We became disillusioned with the Trial. We would not get involved in anything like this again. The Trial is seamless with the Southern Health Care Network. (Care coordinator A, interview 2)

Division will not be keen on the hospital being a fund holder. The Southern Health Care Network does not have patient’s interests at heart. The Trial is not interested in patients. They have not provided extra services. Co-ordinated care could work better if there was opportunity for extra services. The budget for co-ordinated care is not there. (Care coordinator A, active member of the Division of General Practice, interview 1)

6.3.4 Failure to arrive at common purpose: Split between ‘cost’ and ‘care’ roles

The development of an effective working relationship was paramount in order for the partners to undertake the necessary tasks involved in designing and implementing a co-ordinated care trial. Expertise was required in managing the provision of health care within budget constraints. Each side of the partnership needed to trust the other side’s capacity to effectively undertake its task. Both partners came into the partnership with different strengths.

Failure by the partnership to arrive at a common purpose and resolve fundamental operational aspects of the Model had implications for the operationalisation of the Model. A trusting working relationship failed to develop and an ensuing culture of mistrust pervaded the Trial implementation process. The managing partnership was unable to provide the containment to enable the Trial team to work in a co-operative
way. There was much disaffection manifest in high turnover of staff, and staff becoming caught up in the political agendas of the managing partnership.

Arlene left because there was no trust for Mary (Trial Manager A’s second in charge) and Karyn (Trial Manager A). There was no strong leadership (Care co-ordination manager A, interview 1)

It is getting to me. There have been times that I actually looked for another job. If someone gave me the right money and the right job I would be out of here (Trial administrative/IT manager).

Lynnette, the Director of X, has just resigned. No one has left the Trial happily. (Case manager A, interview 3)

(See Appendix 2, s.3.4 for more such quotes)

Failure to adequately resolve differences, and the ensuing mistrust that this created, has impacted on the way players internalised the model and the way they took up their roles, exacerbating the anxiety inherent in this complex and new initiative.

A split ensued in the organisation of the Trial between those supporting what was perceived as a Network agenda and those supporting what was perceived as a Divisional agenda, resulting in a divide between those responsible for managing costs and those responsible for the delivery of the care co-ordination function. This was played out in the day to day organisational dynamics of the Trial, and became embedded in the culture of the Trial, creating antipathy between those responsible for management and those responsible for service delivery.

My role is sitting in the middle. I understand what is going on within me and try to understand it in other parts of the organisation. There are systemic problems. There is a fundamental suspicion of management and there is fundamental suspicion of the coalface. Both parties come with enormous mistrust and assumptions about one another. For example the assumptions that the Trial has of the Division, that management has of the coalface and that case managers have of management, are played out within the Trial dynamics. (Role holder responsible for bridging understanding between Division and Network, interview 3)
The Trial reminds me of the hospital separation between the hands-on clinical and the administration. It seems like the culture of a hospital has been embedded into the Trial. They really didn’t understand what it was like to be a case manager, general practitioner or service provider. It takes a long time to blend those two different agendas together. (Service co-ordinator A, focus group A)

On the one hand you have the fiscal economic drive and on the other hand you had the warm, fuzzy case managers. How do you manage this tension? I was somewhere in the middle of that. I can understand where care co-ordination and case management is coming from and can also understand the bigger picture. (Recruitment manager, interview 3)

Within the office there are two groups, those that deal with clients, and those that do not deal with clients. If you mention cost or money or substitution then you are not considered to be human. Service co-ordinators want to go to general practitioner with the client, but how are we going to pay for this? (Special Projects Manager, interview 2)

(See Appendix 2, s.3.4 for more such quotes)

The problematic partnership needs to be viewed in the context of pressures on both parties. Impacting on both the Network and the Division relationships are pressures that arise from burgeoning health costs and an increasing pressure on those providing services to become accountable for costs (Chapter, 2). Many of the tensions between the partners are a reflection of the broader tensions between those providing care and those managing the costs inherent in a purchaser-provider model discussed in Chapter 2. These tensions have percolated into Trial dynamics through the stages of the implementation process.

The current culture of the Trial needs to be viewed in terms the context within which Trial is placed. The Trial has to be viewed in terms of broader environment. All the players are affected by current policy of the day. It’s about being fast and being expedient. The Monitoring Committee is concerned with throughput, rather than quality assurance. The Trial has sat in amongst all this. The Southern Health Care Network Trial Model of Coordinated Care mirrors the lack of communication system wide. It failed to co-ordinate roles. (Service co-ordinator A, interview 5)
Part 2: Findings

6.4 Beginning Phase: Confusion

This section presents the findings associated with the Trial establishment stage. It points to stakeholder difficulties in conceptualising the Trial Model of Co-ordinated Care and the mistrust by some of the co-ordinated care agenda. It also highlights the difficulties experienced in recruiting participants to be part of the Trial.

6.4.1 Tension around objectives of co-ordinated care: What is overt and what is covert

Difficulties in establishing a workable partnership base, combined with a complex model that had to be implemented in tight time constraints, influenced stakeholder perceptions of the Southern Health Care Network Co-ordinated Care Trial. Although there was general support for better co-ordination of patient care, there was confusion about the Model’s operations and concerns expressed around the existence of ‘other agendas.’ In particular there was a concern that the Trial was a front for a Government cost cutting agenda and the potential dismemberment of Medicare. General practitioners were suspicious, fearing government intervention and the introduction of ‘managed care’, with its potential to dismantle the current system of general practice.

The AMA president says that co-ordinated care is the thin edge of the wedge towards managed care and that general practitioners were being led like lemmings into disaster. (Care co-ordinator D and member of the General Practitioner Reference Group)

The purpose is to bring together all disparate services and co-ordinate care for people. But maybe there is another agenda that we are not privy to. Maybe the big picture is putting a cap on Medicare as there already exists on hospital services. (Recruitment manager, interview 1)

The aim is to move towards a British-like system where doctors are paid by the numbers on their lists irrespective of what you do for them. It’s numbers rather than quality. I don’t know if this is going to provide for better health care. If you wanted to make an impact on people’s health you would look at some specifically high-dependency diseased people. The whole thing is designed so people can count beans. It is all about cost and ways of doing it cheaper. (Care co-ordinator C, member of General Practitioner Reference Group, interview 1)
I am as suspicious as ever. I like the idea, I think it is a good thing, but I believe there is an underlying agenda. It is to control general practice and get us on wages. Future of doctoring will be as glorified social workers. (Care co-ordinator E)

Whatever system we get, call it managed care or packaged care, co-ordinated care will never pay for GPs doing a lot of unpaid work. The fact is that with increasing morbidity, government bureaucrats do not wish to pay fee for service for chronically sick patients. (Care co-ordinator B)

There is a mega purpose and I am not sure where they are coming from. I am interested in care co-ordination and I am not a political person. But care co-ordination has a background agenda. Something else is going on behind the scenes. A seamless service provision across the Network seems to be main agenda (care co-ordination manager A, interview 1)

(See Appendix 2, s. 4.1 for more such quotes)

### 6.4.2 Rushed and confused

The data points to a rushed implementation process, and to an underestimation by the Trial managers of the time involved in bringing people on board. The time frame for the process of planning, development and implementation was tight. There was little time for discussion, consultation and negotiation of expectations, roles and responsibilities. Development occurred *on the run*, creating subsequent confusion and anxiety. There was no time to allay concerns that were being expressed by administrative staff, case managers, service co-ordinators and the medical profession who were central to the Southern Health Care Network Model of Co-ordinated Care.

The tight time frame meant that there was insufficient time to effectively involve the broader health system. The perception, particularly during the first year of the Trial, suggests other agencies and stakeholders felt confused with the Southern Health Care Network model of Co-ordinated Care. The Model was poorly understood and stakeholders expressed feelings of exclusion from the Trial initiative. They were not able to translate the Model into a way that was meaningful for them, and were not able to identify significant benefits from a health systems perspective.
The beginning of the Trial was confused. There was difficulty about what we were trying to achieve. Roles were not defined as well as they should have been. There was no proper avenue for communication. It was about getting on with the job. But it was difficult when you were not sure what you were supposed to be doing. The Trial was extremely fast. It is not management’s fault, I don’t think anyone had an idea. At the beginning, for example, the case management and service co-ordination roles were not defined. We did not know how this fitted into the Southern Health Care Network Co-ordinated Care Model. (Care co-ordination manager B, interview 1)

At entry there was confusion and there was conflict. I entered a war zone. I did not know where the players were coming from. I did not know who were the ultimate decision makers. What was the confusion and conflict all about? Where did the people place themselves in it? If you are going into the war zone and don’t know what is going on you will end up with a bullet I couldn’t help but get drawn into conflict yet I did not know the history of all this. (Case manager A, interview 4)

The metaphor for the Trial has been thinking on the run. It’s not as if we had lots of time to plan things. It was planning and development on the run. Relationships were not established and forged, and roles were not defined. There was no lead up time to do this. The Trial started on the run. (Service co-ordinator A, interview 7)

At the beginning there was so much fear. The Trial was trying to explain what we really didn’t understand. We assumed or I assumed others understood. But nobody really understood. (Role holder responsible for bridging understanding between Division and Network, focus group A)

(See Appendix 2, s. 4.2 for more such quotes)

6.4.3 Focus on recruitment of ‘clients’

Trial administrative staff were under pressure to recruit ‘the numbers’ and obtain participation from the client population as funding for the Trial was contingent on the number of ‘clients’ that could be recruited onto the Trial.

We were trying to get people recruited. We did not prepare the rest of the community for our entry. We polished up our co-ordinated care tools but we did not prepare the environment for the live phase. It was a hit and run system. (Case manager A, focus group A)
Initially it was about getting the numbers. It was getting the recruitment and getting consent. The funding pool hinged on a number of people that we were able to recruit. The money was contingent on getting the numbers so there was a lot of pressure. It was an enormous effort, and a few Trials got axed because they did not get the numbers. (Service co-ordinator A, interview 7)

6.4.4 Recruitment of medical practitioners

Most medical practitioners were vigorously opposed to the Southern Health Care Network Co-ordinated Care Trial, particularly at the beginning of the Trial (Piterman, 2000b). Selection of the general practitioner as care co-ordinator was an alienating process for general practitioners. It was contingent on the client accepting to be part of the Trial intervention group and nominating the general practitioner as the care co-ordinator. This meant that general practitioners were co-opted onto the Trial indirectly through their patients consenting to participate in the Trial. General practitioners felt they had no choice but to take on the role of the care co-ordinator. ‘We were badgered into it’. If the general practitioner did not wish to take on the role of the care co-ordinator, the Trial would designate the patient to another general practitioner, who was willing to take on the role of the care co-ordinator. This meant, in effect, that the general practitioner would lose the patient to another general practitioner.

Basically I felt I had no choice. I felt compelled to oblige. I felt I was held by my balls. (Care co-ordinator C, interview 1)

We had committed patients and we had to beg doctors to come on. I would like to see a future Trial where GPs were not badgered into this. It is not ideal. It is much better if GPs had volunteered. We would have got more commitment. (Care co-ordinator D and member of the General Practitioner Reference Group)

The process twisted general practitioners’ arms up their back. If you will not be a care co-ordinator, then someone else will get your patient. If we could do it differently we would not have gone down the track of clients being selected in the way they were. The general practitioners know their patients. If we are looking at a future model, the general
practitioners would be recruiting the patients and then we would get one hundred percent support. (Executive Director Division, interview 3)

Interviews in the early days reflected mistrust and confusion with co-ordinated care. The language of co-ordinated care was new. Many doctors were confused about the language and terminology associated with co-ordinated care. Who was the care co-ordinator? What was this person supposed to be doing? Who was the case manager? What was the role of the case manager? Some did not know that they were designated as *the care co-ordinators*. During the interview process a number of general practitioners referred to me as the care co-ordinator.

Despite the rhetoric of co-ordinated care which guaranteed the care co-ordinator ascendant status in the Model, many did not want to become involved in the co-ordinated care process and only did so because this was a Government agenda and they did not want to alienate the Government. As far as many general practitioners were concerned there was already enough monitoring and interference from external sources.

Trends today are cost minimisation. We need to prescribe cheapest drug or otherwise we will be questioned by Government and asked for money back. Government is antipathetic in contrast to hostile. There have been lots of changes, new expectations, drugs, guidelines and regulations. We need to know the environment, but no one helps us manage these changes. Some of my colleagues are threatened and feel that co-ordinated care will take patients away from them, so they participated. But they opted out when they saw how much time it was going to take. I believe general practice needs all the help it can get but I was concerned that if I didn’t accept co-ordinated care, I would lose my patients to another doctor. I have told my patients that the reason they are on the Trial is because they have cost the Government a lot of money. Most patients saw this as a bit of bureaucracy. (Care co-ordinator F)

There are a lot of people in this area who find contact with nebulous semi-government agencies as negative. It is one more way that the government is interfering with their lives. I was a bit negative initially because I felt I would be out there filling out their forms. Although it helps some people on Level 2, others regard it as a bit of a nuisance, then others have loved it. I found the first few letters from the Trial appalling. How could patients understand what Co-ordinated Care was about? They talked about control and
intervention groups. It was too complex for anyone to understand let alone many who are semi-literate. (Care co-ordinator G)

Meetings with members of the general practitioner reference group, who were involved in selling the Trial to general practitioners through education sessions, reported general practitioner concern. One care co-ordinator reported the following:

There was concern about care co-ordination being the thin edge of the wedge and the gateway to American style managed care. There was also a fear that the Network would take control of the patent’s management and the general practitioner would be shut out of the system. GPs were worried about deprofessionalisation and deskillling of general practice, with other professionals taking on the practices that had traditionally been the domain of general practice. (Care co-ordinator C, interview 2)

I was present at an education session designed to introduce general practitioners to co-ordinated care. After the presentation by the Chairman of the General Practitioner Reference Group, an atmosphere of silence pervaded the group. There were no questions.

For many, the Trial aroused anxieties, which exacerbated the already existing low morale and lack of trust in government (Report of the General Practice Strategy Review Group, 1998). However, those general practitioners in leadership positions felt it was better to get involved and have a say than to have their futures determined for them.

I would much rather be involved in helping to design managed care than having it designed for me. I’m quite philosophical. It’s all up in the air. I want to get involved before they destroy patients, general practice and standard of health in this country. Managed care for people with chronic illness will mean that we can’t order CAT scans, because they won’t come under budget. Better things are going to cost more. There is going to be lots of problems and we’ll have to come under budget. There will be a change in the way doctors will be doctoring. ‘Packaged care’ softens the blow, packaging of care for chronic illness is like budget holding. (Care co-ordinator B, interview 1)

It was better to be part of it than have it happen to you. You can make things happen. You can watch things happen. Or you can ask what happened. (Care co-ordinator C, interview 1)
6.5 The Middle Phase: Alienation

The confusion evidenced earlier in the Trial continued during the middle stages. Many felt that a culture that did not allow questioning and exploration had developed. This exacerbated feelings of confusion as well as contributing to a growing cynicism.

What does co-ordination mean? What is it that we define as co-ordination? There are different perceptions of co-ordination? What are we talking about? GPs say they are care co-ordinators. But no one knows what it means. The real meaning of co-ordinated care was never really defined. What is co-ordinated care in the primary hypothesis? We did not know what co-ordinated care is, did not think it through, and did not want to think it through. It’s about the primary and community health sector being the poorer second cousin to the acute sector. The broader system co-ordination is not dealt with. Co-ordination has a political agenda (Service co-ordinator A, interview 7)

This section presents the findings of stakeholders’ perceptions during the ‘middle’ stage of the Trial. Stakeholders regarded the priorities of Trial management during this period as the management of costs, which was resented by many. The findings point to conflicted dynamics between stakeholders, in particular, between those holding management roles and those responsible for patient care. There were also conflicted dynamics between those responsible for patient care; between medical practitioners and the case managers (nurses) and service co-ordinators (social workers), as well as occasional problems between the case managers and service co-ordinators.

6.5.1 Focus on outcomes: Focus on unplanned admissions as a key success indicator

It became increasingly evident during this stage that management was under pressure to manage risk and control budgets. One of the key indicators of the effectiveness of the co-ordinated care process was a capacity to show that unplanned admissions in the intervention group were lower than unplanned admissions in the control group. If high cost acute care can be replaced with community based service care, costs would be reduced and the individual can be kept in the community. Hence, a major focus of the risk management strategy was to reduce unplanned admissions, ensuring that the patient was effectively managed in the community and did not ‘hit’ the acute sector.
There was pressure to meet the objective set out in the primary hypothesis, using unplanned admissions as a major performance indicator, despite the Commonwealth’s public stance that it did not have preconceived expectations regarding success of the Trial. Moreover, some questioned the Trial’s integrity, arguing that in fact this was not a trial in the scientific sense. They believed pressure existed to achieve certain predetermined outcomes.

If the Trial doesn’t show that it can save money, then in Government and Trial’s eyes it will have failed. Costs are the major goals of the Trial. Unplanned admissions would be very important (Trial administrative/IT manager).

If we think of it as a scientific study it is even more perverse. We have not thought through our assumptions and are not working according to a scientific process. The hypotheses were not hypotheses at all. They were predetermined outcomes. The way we used the language of science and experimentation is a concern because there is impediment about thinking scientifically. If the unconscious and conscious task of the Trial is to learn and explore, we need to look at whether the primary task has been perverted or corrupted. And what has been perverted? Is this something to do with identification of primary task or is it to do with identification of the perverted primary task. In my role I am trying to broaden the discussion. I’m trying to inject a sense of reality (Role holder responsible for bridging understanding between Division and Network, interview 2)

The role of the Trial manager is to pilot something new, but was this a pilot?
It was more about foreseeing wanted results. Was the Trial set up for research or was it set up to come up with set results? They have not even waited for results of evaluation and already setting up new co-ordinated care trials, which are likely to make same mistakes. Is this really an evaluation? Another example is the push for unplanned admissions results. They are not saying “aren’t these interesting results” what they are saying is “why aren’t unplanned admissions going down?” A lot of expectations are put into the co-ordinated care trials. Was this going to solve health system problems? (General practitioner (not a care co-ordinator) and member of the General Practice Reference Group)

Philosophy is a precursor and provides the capacity to develop a philosophical base. We do not come into the Trial with a preconceived notion of reform. Earlier in the piece I was continually being put on the spot about commitment to the future of health. We do not
have a preconceived notion otherwise we would not have had a Trial. (Commonwealth public servant)

The focus on a reduction in unplanned admissions became the dominant performance indicator of Trial success. The perception by stakeholders was that other aims of the Trial were secondary at best.

The emphasis on unplanned admissions and pressure to achieve substitution created anxiety in those responsible for the delivery of care, as this requirement for performance was viewed as an unrealistic goal. The care co-ordination team felt helpless to undertake what was considered to be an impossible task. The care co-ordination team felt their performance was contingent on the unrealistic goal of reducing unplanned admissions, achieving substitution. They felt that management was focussed on costs to the extent that the quality of health service delivery was of no interest. Many of the patients requiring co-ordinated care were chronic and complex and at the end stage of their illness, hence were likely to end up in hospital as an unplanned admission, irrespective of attempts to care for them in the community, and were regarded as ‘offenders, reoffenders or recalcitrant’. Focus on outcomes (getting unplanned admissions down) was seen to take precedence over the provision of health services such that health care professionals felt that the Network priorities were not interested in co-ordinating patient care, as reflected below.

There was pressure on the service co-ordinators and case managers to reduce unplanned admissions. It was not in their role description to have a budgeting component. Yet they were being told that there were too many unplanned admissions, which were costing, and it was their role to reduce unplanned admissions. (Care co-ordination manager B)

The suggestion to come up with a way to prevent unplanned admission was ridiculous, a useless target, creating a lot of pressure. (Case manager B, interview 2)

We were called into meetings to come up with answers of how we can achieve substitutions. What are factors that precipitate unplanned admission? We had to come up with a checklist. There was pressure from management to come up with answers. (Service co-ordinator A, interview 7)
Emphasis of top management is funding and funding outcomes. I sometimes wonder if health outcomes are important at all. Funding takes precedence. It’s all so much on a political level and I wonder what other aims of the Trial are. (Trial administrative employee, subsequently care co-ordination manager B for last year of Trial, from February 1999)

The emphasis was on cost and reducing unplanned admissions. The Division felt enormous pressure to cut costs, even though we were told the cost is not the driving force. It was assumed that there would be some magical way that GPs would reduce unplanned admissions, just because they were care co-ordinators…. People are seen as offenders or reoffenders or recalcitrant if they come into hospital. We should consider it not as unplanned admissions but rather as unexpected admissions. (Executive Director Division, interview 4)

(See Appendix 2, s. 5.1 for more such quotes)

6.5.2 Preventable/Unplanned Admissions Working Party

Concern that co-ordinated care intervention was not reducing unplanned admissions led to the establishment of a unplanned admissions working party, with the aim to identify individual unplanned admissions, determine which were preventable, and recommend strategies to prevent further hospital episodes (Osborne, 1999). Individuals who had more than one unplanned admission were targeted. The preventable admissions working party was made up of two general practitioners, a specialist from the acute sector, a member from the Centre for Clinical Effectiveness, and members of the co-ordinated care Trial team, including the care co-ordination manager and a case manager.

Attention has been given to unplanned admissions in the Trial on the assumption that they, unplanned admissions, were in some way preventable, and by reducing unplanned admissions acute care expenditure could be reduced. Examination of unplanned admissions indicated that most were appropriate and perhaps even planned. (Osborne, 1999, Report of the Preventable Admissions Working Party)

The Working Party’s belief was that the notion of unplanned/preventable admissions has been overstated in the Australian context. In the context of the co-ordinated care trials, there is little evidence to suggest that unplanned admissions to be other than
planned, elective admissions for acute problems or an exacerbation of chronic illness (Osborne, 1999).

At the meetings of the Unplanned Admissions Working Party, we felt pressured to come up with solutions to reduce unplanned admissions. We didn’t, and it was interesting that I was the one that presented at the Quarterly to say that we had found no solution. (Role holder responsible for bridging understanding between Division and Network and member of the Unplanned Admissions Working Party, interview 2)

They came up with no plan that was going to be effective. It’s too complex a topic. It could not be done in six months, had no aims or directions. The targets were useless targets, and there was a lot of pressure to come up with ridiculous expectations. There is a suggestion that there was a way to prevent unplanned admissions. (Case manager B, member of the Unplanned Admissions Working Party, interview 2)

The Unplanned Admission Working Party was about substitution. It was trying to identify factors that might precipitate unplanned admissions. This was very difficult to do, to predict key factors that are a catalyst for unplanned admissions. (Service co-ordinator, interview 7)

The results of the Preventable Admissions Working Party have given management the tools to deal with pressure from the external funders regarding the status of admissions into the acute sector. (Trial manager B, interview 4)

### 6.5.3 Implications of a management focus on the culture of the Trial

Network priorities on the management of risk had implications on the day to day operations of the care co-ordination function. The task of achieving unplanned admissions was seen as the only goal management regarded as relevant during the middle stage of the Trial. This was viewed by members of the Division, members of the Unplanned Admissions Working Party and case managers and service co-ordinators as both impossible and unrealistic. There was no space to challenge the management focus and attempts to do so were not appreciated. Hence a number of role holders chose to psychologically disconnect themselves from the Trial.

Given the focus on the task, there was a perception that management did not care about the care co-ordination function, resulting in cynicism towards the aims of the Trial,
resentment of management and low morale amongst staff. Low morale, conflict, high levels of politicking, and questions regarding the ethics of management pervaded the culture of the Trial.

Comments made by some suggested that management was only interested in the care co-ordination in order to get funds. Service co-ordinators and case managers, particularly, felt that their contribution was of no interest to management. However, other role holders in support positions to the Trial also did not feel supported. They cited as examples, the fact that they were not invited to meetings with the Trial management, were not invited to the strategy day, and were last to get computer support. Moreover they felt that they were given the very difficult task of keeping ‘clients’ in the community with no brokerage funds. This led to antipathy towards the Trial management, which was aligned with the Network. In particular there was antipathy towards Trial manager A, who was seen as someone who does not provide support to the service delivery task.

6.5.3.1 Cynicism towards Trial focus

There was cynicism towards the Trial and the integrity of its focus was questioned:

What we have demonstrated is how you can get a nebulous wishy-washy concept and put it into place, but can we improve health outcomes by keeping them out of the acute sector? This we cannot. (Service co-ordinator A, interview 5)

Is this an exercise in high quality project management? Project management is necessary but has this become an end in itself? What is the primary task? Is the task being perverted? I am used to institutions having the task perverted. There is negative entropy in this organisation. They degenerate to various components and away from the difficulty of the primary task. It is a fact of organisational life, that one has to consistently guard against perversion of the primary task. Is the process contributing to the primary task or is it detracting from the primary task? Is it just an end in itself? (Role holder responsible for bridging understanding between Division and Network, interview 2)

(See Appendix 2, s. 5.3.1 for more such quotes)
6.5.3.2 Cynicism towards management

The relationship with the Trial manager and the staff was seen as problematic, particularly with those who had responsibility for the care co-ordination function. Divisiveness was prevalent and a number of role holders complained of being scapegoated publicly if they were not perceived to achieve targets set out in the Model. There was also a suggestion that data be misrepresented to meet management needs.

There are competitive dynamics with other trials. In this particular organisation there is individual psychopathology, there is psychopathology within the Trial, there is psychopathology between groups, that is the Trial and the Division and other players. We are all put in a double bind in conflicting roles. The best leader is one who can work with that and provide a space for working out roles in the organisation. A major reason for problems in the Trial is because leadership has an internal lack of self and hence created problems. (Role holder responsible for bridging understanding between Division and Network, interview 3)

Most of us have had ‘run ins’ with Karyn (Trial manager A). There is no discussion about other people’s needs. I don’t think she listens. I cannot get through to her, when she doesn’t want to. She is a bully! She is not respectful of other people’s skills and knowledge. She is a strong powerful person, knows where she is going but she is not a good leader. She does not listen, inconsistent one thing one day another thing another day. She keeps a lot to herself. Her management style does not want our input. We end up having no input and no say. All of us react badly. She hoeds into someone in a meeting. She’s hoed into me, she’s hoed into Anna. Tina has copped it a couple of times. We are trying to support each other. A few of us have tried to tell her and we cannot get through. Jean left because of Karyn’s management style. (Trial administrative/IT manager)

The Trial is a small hot house largely female, characterised by bitching, divisiveness, unhappiness, and people not feeling valued. There are closed doors and taps on. People shut doors and taps are on to make sure the walls aren’t listening while people have conversations. There are abuses of the system and some people have felt disaffected, taking ‘sickies’ etc. Karyn (Trial manager A) was a frightening, controlling, bossy mother. They were looking for new leadership. The Trial was ready for a different type of leadership. (Trial manager B, interview 1)

In meetings one person gets targeted all the time. It’s often Rhonda. When they target people in group, the meeting loses trust. It’s difficult to do a good job for Karyn. She is
very critical and balled me down in meetings. I suffered a public humiliation. (Care co-
ordination manager A, interview 1)

I often saw people in tears. Everyone is superficially friendly but after the meetings
people are in tears. This is as a consequence of the challenging, manipulation and the
threats. This was reinforced by Jane Roberts who left. Jane would not be compromised.
She refused to misrepresent data. This was always challenging. I wonder if John, who’s
taken over, is producing data in a way that is wanted? Is he much more willing to do what
Karyn wants? Is the culture of Trial the same as the culture of Network. Lynnette, the
Director of X, has just resigned. No one has left the Trial happily. (Case manager A,
interview 3)

However there were those who supported the management.

Now all this tension within the Trial, that’s rubbish. Irene left because she wasn’t happy.
She wanted things her way. She never fitted in with the job anyway. Different jobs suit
different people, and this one didn’t suit her. I can see this job leading to other projects
and opportunities. I have been in contract jobs for the last few years. It doesn’t worry me.
Management is good, Jean (Trial Manager B) is focussed on issues, good at working her
way through things. Jean is good with money and has dealt with budgets before. Jean is an
experienced manager. She can identify issues within the Trial, she’s good with staffing
issues, and she’s good with money and issues that go with money. (Special Projects
Manager, interview 2)

(See Appendix 2, s. 5.3.2 for more such quotes)

6.5.3.3 Lack of perceived support for the care co-ordination function

Case managers and service co-ordinators felt that the demands placed on them by the
Trial to meet the unplanned admissions agenda was not possible given the difficulties in
navigating an already constrained system. Fragmentation between the acute and
community sectors, rigid service categories (which require the client to fit in neatly to
aged or disability criteria in order to access services), and a lack of brokerage funds to
purchase services, limit the ability to service patient needs. Moreover, for service co-
ordinators there are limitations inherent in a large caseload of about 180 to 200 clients
each on their books. The caseload for case managers was 40 patients.
Unless you fit into a category, age level, or disability, the reality is that you won’t get services. The majority of clients on Trial would not be receiving service co-ordination or case management because they do not fit into the box. Normally, they would not get case management. It is going to be difficult once the Trial is over because these people are not eligible. There is an enormous amount of running around getting people services and never gaining assistance. I don’t know how they do it because it is hard enough for me. When Rita was being evicted from her house, child services could not do anything because she was not a priority client. Even though she was eligible, she was not a priority client. Their son is on the waiting list to get a service, but gets leapfrogged because other cases are more serious. So that even if you are eligible because you make the criteria, you are still not guaranteed of getting the service. The service co-ordinator has to be a continuous advocate to make sure that you stay on the list. (Service co-ordinator C)

These difficulties were compounded by a perceived lack of support from management for the role holders. The service co-ordinators and case managers felt that they were ‘the lowest cog in the wheel’. Although the care co-ordination manager represented them at Trial weekly progress meetings, service co-ordinators and case managers did not feel heard and did not feel embraced by the management structure of care co-ordination.

Both the service co-ordinators and case managers were housed externally for the first 18 months of the Trial. Their position descriptions were developed with the view that these positions were a contract service. They were to be viewed as transitory and flexible, subcontracted to prop up existing services. These roles were ancillary to the Model, adjuncts to the care co-ordination role. Individual case managers and service co-ordinators were not housed at the Trial premises. Management viewed these positions as contract positions, regarding whether one person or many persons held the role as irrelevant. It was the position that was contracted. As such, the position rather than the role holder was recruited, and it seemed irrelevant to the Trial whether one or a number of case managers were made available. Case managers and service co-ordinators felt depersonalised by this attitude because particular people held responsibility for the positions over the period of the Trial. Moreover, the service co-ordinators, in particular, felt that their positions had not been adequately scoped. They felt that the needs of the position transcended the position description provided, which described the role function as ‘a clerical, telephone based booking and scheduling function’, ‘a quick swift
simple expedient process of information and referral’ (Southern Health Care Network and Dandenong District Division of General Practice, 1997b).

Some were content with these arrangements, while others felt that they were not part of the team and were excluded from many of the meetings and discussions that took place. They were not part of a strategy day held at the organisation of the Trial, which was to them symbolic of their lack of status. It was not until the arrival of a new Trial manager that their input was sought at weekly progress meetings and they were asked to join. For some it was too late and the resentment was too embedded. Others were more keen to contribute to what was referred to as ‘the winding down’ period.

There needs to be collaboration in the way that enables the other to do their job. There is a high level of stress in the Trial. One of the outcomes is that anything is possible even when there is no support. But at what cost is it to the human being? One of the costs was enormous turnover in the Trial. There were a lot of people leaving. The role of management is to provide space to do our jobs. There was a lot of dysfunction. (Role holder responsible for bridging understanding between Division and Network, interview 3)

There is little support for care co-ordination. When I wanted to send my staff on a course, I was not supported on the basis that there was no money in the budget. Every time I ask Mary (Trial manager A’s second in charge) how much is in budget I get a different figure. I now have 3 different figures. (Care co-ordination manager A, interview 1)

There was rubbishy furniture shoved in front of me, I was put in a corner. There was ‘toing and froing’ as to who was paying for what. I thought, what the heck am I trying to do? I cannot understand the Trial. (Case manager B, focus group A)

Keeping case managers and service co-ordinators off site was a lost opportunity. Karyn (Trial manager A) felt it best to keep them away because the Trial is about fiscal issues and information. I’m amazed at the low level turnover of the case managers and service co-ordinators, why they stayed and didn’t leave. (Recruitment manager, interview 3)

The case managers and the service co-ordinators have been dumped with carrying the anxiety of the care co-ordination process. (Role holder responsible for bridging understanding between Division and Network, focus group A)

(See Appendix 2, s.5.3.3 for more such quotes)
6.5.3.4 **Pushing role boundaries**

Service co-ordinators and case managers felt that the role definitions for their positions were too simplistic and limited. They attributed this to the limited way in which health delivery needs have been scoped in the Model, reflecting the lack of emphasis management placed on the health delivery function. Despite the perceived lack of management and financial (no brokerage funds) support, case managers and service co-ordinators responded by pushing the boundaries of their roles, often using their own initiative to introduce interventions to ensure that patients received assistance. This was particularly so for the service co-ordinators, who had a caseload of about 200 ‘clients’ each. They felt the caseload underestimated the needs of their patient base.

Right at the beginning the roles were simplistic and narrow. It was based on the community health centre concept of service co-ordination, which is like a duty intake system in the community health services. It was extremely limited. As the Trial progressed the complexity of the issues became apparent. The patient base was far more complex and our roles had to change. Our role changed from that which was prescribed earlier on by L (consultant who developed position statement for service co-ordination). The service co-ordination function is a different role in our Trial, than what is associated with service co-ordination in the community health centres. (Service co-ordinator A, interview 7)

There are a lot of unanticipated outcomes with the role of service co-ordinators developed by L. As it turned out, our role is bigger than the initial design. The idea was that this was a quick expedient process, a swift and simple information and referral service. In practice it is a lot more involved. In reality the service co-ordination role is to be a hustler pushing, shoving, arm wrestling, jumping queues and getting agencies to be flexible. Even when we get people on a waiting list we have to keep pushing the system to ensure they stay on. (Service co-ordinator A, interview 2)

The desire by service co-ordinators to case manage some of their patients was questioned by management, who viewed the desire as meeting the service co-ordinator’s professional needs as much as the patient’s needs. Moreover, management was concerned that the way the service co-ordinators/case managers took up their roles risked client dependency and the development of ‘permanent’ clients. On a number of
occasions management commented on a perceived rejection of the aims of the Trial by the case managers and service co-ordinators.

There was not a misunderstanding of what the Trial is about. It was a rejection of the Model. There was a philosophical rejection of the Trial. Those in care delivery positions needed to understand how interventions were paid for. The linkage between financial management and care co-ordination was poor. (Trial manager A, interview 3)

This rejection was not unexpected given the Trial manager’s strategic approach to separate care co-ordination from the financial management functions. This approach was reflected in her decision to geographically house the care co-ordination separately and to exclude the case managers and service providers from meetings and the planning day.

Moreover, the Trial manager regarded it as inappropriate to burden the care co-ordination team with the machinations of the financial arrangements. She wanted them to focus on the care co-ordination function and not worry about the financial issues.

We cannot have doctors, nurses, and case managers concerned about management issues.
(Trial manager A, interview 1)

6.5.3.5 Lack of culture for reflection and exploration

The methodology of trialling an intervention requires room for discovery and room to be flexible. The culture of the Trial was regarded as one of ‘doing’. Time constraints meant that there was little time for reflection and exploration.

I feel there was no space to talk about the assumptions. We all had different assumptions about what we were doing, but we could never talk about them. There is also a complexity about what we were doing but there was no opportunity for thinking in the Trial. There was an assumption of a greater wisdom but nobody really had it. Why were we doing what we are doing? (Role holder responsible for bridging understanding between Division and Network, focus group A)
There is also the issue of what is permissible and what is not permissible data. A metaphor for the Trial is about secrets. (Role holder responsible for bridging understanding between Division and Network, interview 3)

The culture is one of expediting without reflection. They are rushing putting a whole lot of things into place that could result in chaos. (General practitioner and member of the General Practice Reference Group)

I felt there were restraints. There were things you could not question, assumptions that you could not question. There were discussables and undiscussables. There were things that people were not ready to hear. You could not question the focus on cost savings. (Service co-ordinator A, interview 7)

(See Appendix 2, s.5.3.5 for more such quotes)

6.6 Relationships within the care co-ordination system

Tension was also evident within the care co-ordination system. The Trial Model of Co-ordinated Care reinforced the historically ascendant role of the general practitioner. Accordingly care co-ordinators’ support for the service co-ordination/case management function was based on a view of the service co-ordinator/case manager providing a support, administrative and facilitation role, rather than being a partner involved in managing the patient’s health. In most cases the care co-ordinator did not meet the service co-ordinator/case manager face to face, or speak to her on the phone. Most communication was via fax. This created feelings of resentment from the service co-ordinators and case managers.

General practitioner reticence evident in the beginning stage continued through the middle stage. The term ‘waste of time’ was used frequently throughout the Trial process, mainly referring to what care co-ordinators regarded as poor patient selection criteria, in that most patients had no need for co-ordinated care.

I have ten patients. Three of them need it. All the others do not need much at all. For others it’s just a waste. There is no dispute that selection criteria had disadvantages for further Trials (Focus group B, members of Division of General Practice and interested care co-ordinators)
For majority of patients, who are involved in it, it is a waste of time. The selection process is at fault. Vast majorities of people who have been in hospital do not need fancy case management (Care co-ordinator J)

Mother finds the whole process a hassle and we both complain about the waste of time. In Emery’s case co-ordinated care is useless in terms of time and money spent. (Care co-ordinator H)

Doctors have found it a waste of time only because the wrong people have been chosen. Healthy patients also think this is a waste of time for them. When I talk to my colleagues they think co-ordinated care trial is just a waste of time. They think they are already doing the job, and patients are also getting all these documents and a whole lot of paperwork, and they think it is a waste of time. Basically the selection process was useless. However, if I have someone out there like a case manager that I could ring up and ask them could you do this and this for this person, I think it would be good. It would help me. (Care co-ordinator K)

I think it’s a waste of time. They gave you an average, which included Level 1s. I can see that Linda sees a number of doctors and gets into specialist referrals but on average it does not mean anything. It would be more valid to have upper Level 2 patients. (Care co-ordinator L)

The initial reticence towards the Trial permeated into care co-ordinators’ relationships with the case managers and service co-ordinators. During the initial stages care co-ordinators did not seek the support of the case managers and service co-ordinators, viewing them as unnecessary, given that in 95% of cases, case management was not applicable.

The report from the case manager is a useless document, which tells me nothing. It is quite unfriendly. It smells of hierarchy. I have infinite knowledge of community services availability. I know what is around and make it my business to find out. We have always co-ordinated care but now this is formalised. (Care co-ordinator H)

It is a superficial relationship. (Care co-ordinator I)

If doctors were doing the job properly, case managers would be irrelevant. We should be doing what service co-ordinators and case managers are doing. (Care co-ordinator C)
For 200 years doctors have been the case managers. This is now changing because there are too many bureaucrats, who are tertiary trained and need something to do.

I wouldn’t know who the case manager is, I thought you were case manager. I got some interaction with Trial to hurry up and get documentation in. I don’t remember anything the case manager has done. (Care co-ordinator J)

I have not had much to do with them. The number of high risk patients needing help is small. (Care co-ordinator A)

Over time care co-ordinators began to appreciate some of the benefits of co-ordinated care. However, the need for the case management/service co-ordination service was viewed as limited, only applicable to situations where the patient is viewed as complex and chronic.

I think I have changed my attitude to co-ordinated care since its inception. In 1997 I thought co-ordinated care was a nuisance. A few patients used to ask me whether they should go on it and I said “No”. Subsequently I realised it is better than I thought it initially was. In our clinic we have some 20 to 30 patients on Co-ordinated Care. The low levels we hardly see much of. The patients regard it as a nuisance. Service co-ordinators and case managers have organised all sorts of things for the patients. I see it as useful for people with complex problems. It is however a nuisance for Level 1. (Care co-ordinator G)

The Trial has provided us with a wonderful service. I can ring someone up if I think Maureen (patient) is not coping and she can come out and make sure that Maureen and her husband are looked after so they can stay at home and not go to a nursing home. (Care co-ordinator M)

Similarly the case managers and service co-ordinators viewed general practitioners as being limited in holding the role of care co-ordinator, believing in some instances that case managers/service co-ordinators were better equipped to undertake this function.

Communication between GPs and the case managers/service co-ordinators has been poor. We have been the care co-ordinators, but no one is bold enough to actually say it. We are all beating around the bush. The doctor is not the care co-ordinator. The service co-ordinators and case managers have been the care co-ordinators. In the early phases of the
Trial we would not have said that overtly, as we do now. No one wanted to hear that because the whole hypothesis of the Trial is based on the GPs in the position of care co-ordinators. (Service co-ordinator A, interview 3)

There was also tension between the case managers and service co-ordinators. Service co-ordinators were paid less than case managers and had a higher caseload.

There was tension for me always. I was always second best and paid less than the case managers. It’s more about case management than it is about service co-ordination. It’s a hierarchical model with service co-ordination at the bottom. (Service co-ordinator A, interview 7)

I feel underpaid. Susan (service co-ordinator A) and I have made the job grow. This is not just a job making appointments. It is different. It’s about job quality versus quantity. They should have employed another service co-ordinator if they want more quality. Some clients never ring me, but there are those that are very demanding. Our service is not supposed to be a crisis intervention service, but often we have to manage these things. The KPIs (key performance indicators) in the activity report understate what we do, so that the Trial’s picture of what we do is understated. There is a big discrepancy in pay between case managers and service-co-ordinators. (Service co-ordinator B, interview 2)

(See Appendix 2, s.6 for more such quotes)
6.7 Winding Down Phase: Reparation (‘Divorce’)

As an overview it can be said that the winding down stage was characterised by some capacity for reparation. Much of the energy and tension associated with both the beginning stage of recruitment, ‘getting the numbers’ and middle phase, ‘reducing unplanned admissions’ was dissipated in this stage, and a space for learning was created. Another Network person, Trial manager B, took over the Trial management role and was responsible for the facilitation of the closure and the sharing of learning. The pressure for substitution no longer dominated the focus and this provided the space for exploration of other agendas that were embedded in the secondary hypothesis. Morale of staff improved as Trial staff no longer felt pressured to reduce unplanned admissions. There was a greater focus on the learning that had been gained and the potential hope that the learning could offer future health care reform policy. 

The focus during the ‘winding down phase’ was on:

- Consolidation of the learning, ‘sharing the lessons’ of co-ordinated care and how this learning can be used for future co-ordinated care trials, and for a general contribution to the debate on health systems reform;
- Developing strategies for closure, including transfer of assets and computer equipment and the archiving of co-ordinated care medical records;
- Development of patient strategies for the post Trial period. ‘The Commonwealth has made it clear in the Tripartite Agreement that there would be no additional funding from this purpose’, (Southern Health Care Network, 1999a, p.3).

There was some improvement in the morale of staff during this phase, because the focus of Trial became more reflective in its orientation. There was a greater emphasis on learning and reflection. However, this occurred with some cynicism. For some, it was too late.

The winding down stage means that the ‘undiscussables’ can now become more discussible. The coalface had not been invited to the meetings. Now in the wind down stage we have been invited to the meetings and we are glad to be able to participate in the Trial. Now our views are taken on board. Now management is concerned about the ethics
so they need us to guide them through the closing closure process. (Executive Director Division of General Practice, focus group A)

When I got to the management committee it was no longer a head kicking activity. When I came along it had been established that the intervention was costing more and there was no substitution. Are we getting better care for the same dollar? Are we managing the funds pool? The management committee is now probably less interested in the dollar, and more interested in patient care, how we are handling things with doctors. It is about doctors’ rights and responsibilities, consumers’ rights and responsibilities and local issues. (Trial manager B, interview 3)

The goals of co-ordinated care were hugely unrealistic. In two years you are supposed to reverse trends in unplanned admissions. It has only been in this last year that we stopped to explore the care planning model, and stopped focussing on outcomes. The Trial has been very influential in affecting future health care reform. The climate around the Trial has changed in terms of policy and that has affected the operation of the Trial. Now we are talking about primary health care reform, service system changes, and future of co-ordinated care trials. Our co-ordinated care trial has not only been affected by the broader health system but has also affected future decisions in this broader health system. What we have learnt has impacted. (Service co-ordinator A, interview 7)

Jean has been brought in for reflection mode and she has brought reflection mode with her. Why don’t we get service co-ordinators and case managers to write about what they do? (Service co-ordinator A, interview 7)

I didn’t realise that it was almost deliberate not to have them at the meeting. There was a management directive that they do not come. That changed because of Jean (Trial manager B). They were reinstated but it was a bit too late. There was lots of action at the beginning. There was tension between the coalface and management. I don’t know if it has changed. People have unfortunately got used to the split. In some instances the damage has been done and has put some people off. Initially when I took over this position we discussed the split at length and tried to take action. Now the case managers and service providers get invited to the weekly meetings. (Care co-ordination manager B)

At the beginning it was unplanned admissions, substitution costs, care improvement panels. Now it’s about what can we salvage? (Executive Director Division, interview 4)

Nevertheless, for some there was no capacity to make reparation with the past.
The winding down stage was the divorce, after an unhappy marriage. We call it ‘learning’. But it was about claiming the credit for what worked. The Network wanted to come out squeaky clean. We must be able to demonstrate that we have covered our bums. There are moral and ethical reasons for doing this. (Case manager A, interview 3)

Some expressed an ethical concern of what to do with ‘clients’ who have become accustomed to the receipt of assistance:

There are no services for the client after the end of the Trial. Is this about dependence and abandonment? Do you keep them abandoned? Do you help them grow up and detach or do you just abandon them? The Trial is working on this. There is anxiety within the Trial; a performance anxiety. (Role holder responsible for bridging understanding between Division and Network, interview 2)

The assessment of ‘clients’, and the passing on of those ‘clients’ deemed to be unable to manage their own health to appropriate agencies, has not occurred without hiccups. The care co-ordination function was required to justify costs and numbers before management would accept taking responsibility for patients’ health post Trial. A process of negotiation took place as management attempted to reduce numbers requiring post-Trial assistance, while the care co-ordination function attempted to protect their decision and maintain numbers.

Again, there was tension, reflecting the overriding theme of Trial dynamics, ie the split between management and coalface priorities. The care co-ordination function resented the process of having to justify numbers requiring post Trial care, while the administrative function was required to justify to the funders (Commonwealth and State Governments), the dollars and therefore numbers required.

There is a political issue here, which is clashing with our professionalism. We should not have to worry about the money; it is not our role. We should be worrying about patient care. We are not able to pare down the numbers any more. We are being administratively bullied. We are supposed to downsize the number of people that we consider need care post the Trial. How can we realistically talk about this with the GPs? Monica (care co-ordination manager B) is saying that they have 27 people. Jean (Trial manager B) says that they can only have 12 people. Hence there is a conflict between those involved in the administration and those involved in providing the service, a conflict that has been a
theme throughout the whole Trial. The Trial is putting pressure on us to cut costs. In our role as case managers and service co-ordinators we have not only provided the tangible benefits but also the intangible benefits, the family support and the therapy. We should not professionally have to justify why a person needs more support. We have to justify to the administrators and we should not have to do that. We feel like soldiers, cannot say ‘no’ to the next level. There is a hierarchical system of management and it’s getting in the way of our professional boundaries. There is a divide and conquer approach. They are putting pressure on some service co-ordinators and case managers to differ with the doctors and knock down the numbers. We do not want to sell this group out for dollars. If you can’t accept professionally what we are telling you then there is a problem. After two years we have not been able to get our own structure to accept our professional judgement. That is a problem. We have had an 80% response back from the GPs confirming that they agree with the case managers and service co-ordinators as to who needs care after the Trial. (Case manager A, team meeting care co-ordination team)

(See Appendix 2, s.7 for more such quotes)

6.8 Summary

This chapter has organised and presented the data to offer a first level interpretation (Lazar & Lohmer, 2000) of what has been manifest in the organisational dynamics over the Trial time frame. It has presented the issues and conflicts, which were apparent between players at various stages through the Trial trajectory from the setting up of the partnership, which underpinned the Trial’s management and operating structure through to the beginning, middle and winding down stages of the Trial. The data point to difficult individual and group relations.

The data presented have in the main been based on the interviews conducted. Bryman (1988, in Dawson, 1997) suggests that such research is characterised by an absence of process compared to participant observation studies. However, my presence in the field over the two and a half years has enabled the development of knowledge from experience, referred to as ‘tacit’ knowledge (Polanyi, 1962, 1983, in Dawson, 1997; Altheide & Johnson, 1994). This more subtle and intuitive understanding has been paramount in informing the direction of the research and making the decisions on how to interview, when to interview and whom to interview about what. The next section
interprets the data in the context of the conceptual framework for the research and the literature, which support the interpretation.
Chapter 7

Interpretation and discussion

7.1 Introduction

The purpose of this chapter is to provide a ‘deeper’ level of interpretation by linking emerging conceptual and theoretical ideas inductively derived from the case to stronger analytical themes within the case and to the wider theoretical debates within the literature. This chapter presents an interpretation of the implementation process in the light of, first, case study findings of the previous chapter; second, background issues pertaining to current health care reform; and third, theoretical perspectives that have been presented in this and earlier chapters.

The Southern Health Care Network Trial Model of Co-ordinated Care was conceptually complex and constituted a major change initiative in health care reform. Change creates anxiety (Obholzer, 1994b; Menzies, 1960). Moreover, given the tension in the broader domain around the introduction of a market approach to health care funding and delivery, the potential existed for wider political, structural and financial issues and tensions to be played out within the Trial system.

Chapter 3 presented a theoretical framework that enables exploration of an implementation that is complex. The contextual approach (Pettigrew et. al., 1988a, 1990; Dawson, 1994, 1997) provides a frame for the study of an organisational change process from both a voluntaristic and deterministic perspective (Wilson, 1992). This framework has enabled an approach the data from the standpoint of what is occurring within the organisation of the Trial as well as placing the Trial organisation in the context of the broader issues impacting upon it. The contextual framework provides what Neumann and Hirschhorn (1999) refer to as ‘breadth’, enabling an explanation of how more conscious elements of the wider social domain may have been imported into the Trial culture, influencing the implementation process. A psychoanalytical framework presented in Chapter 4 provides what Neumann and Hirschhorn (1999) refer
to as ‘depth’, acknowledging the existence of unconscious processes, which may have impacted on the implementation process.

The case study material presented in Chapter 6 provides a description and interpretation of organisational dynamics at the first and manifest level. The data presented points to vexed intra- and inter-organisational relationships. There are a number of ways these dynamics could be explored and hence a number of questions that could be asked with respect to the findings. Was organisational disaffection due to the inherent nature of the change process? Was it due to incompetent management? Or, was it due to the particular nature of the model of co-ordinated care, which is underpinned by a market paradigm? (Chapter 2). No doubt this is not an exhaustive list of questions and there are other ways in which the data might be explored. Moreover, interpretation of the data transcends a single explanation, suggesting that reasons for the difficult organisational dynamics are complex and interrelated.

In this Chapter I argue that adopting a managerialist approach imported from the broader social domain (Bain, 1997) to frame and guide the funding and delivery of a new health care initiative has led to confusion in the minds of role holders around task and role. In particular, it has led management to adopt a role focus that is narrow and cost orientated. Effective management requires an acknowledgement of the interdependence of the task and sentient systems and the willingness and capacity to embrace both systems. Social defences of ‘managerialism’ operate to split off the leadership aspect of the management role (Krantz & Gilmore, 1990). A focus on managerialist outcomes and failure to provide effective leadership has thwarted the capacity to focus on the primary task of the Trial, and has exacerbated the already heightened anxiety inherent in the change process.

In order to argue the case it is necessary to present a background to economic rationalism and managerialism in the Health Sector. This is done in Section 7.2, which presents and argues that the rationalist paradigm, which underpins a managerialist model, neglects necessary emotional aspects inherent in a management role, thus limiting role holder capacity to take up the role with integrity. The remainder of the chapter is structured as follows. Section 7.3 presents the controversy in the public
domain around the introduction of a market paradigm and managerialism into the health sector. Section 7.4 argues that an unencumbered application of a market model into the health sector has the potential to set up dynamics in the organisation which are consistent with a paranoid schizoid position, and what Lawrence (1997, 1998) refers to as a totalitarian state of mind. This can lead to the potential for perversion of the primary task according to the tenets of the Chapman (1999) model. Section 7.5 discusses the significant place of the sentient task in the provision of health care and Section 7.6 analyses the findings in light of the theoretical precepts discussed in this and earlier chapters.

Throughout this chapter reference is made to material from other chapters, in particular, the case study material presented in Chapter 6. In the service of clarity, citations will be provided at the end of each paragraph and the reader is encouraged to refer to this chapter for more detail. Citations to chapters and sections will be denoted by ‘c’ and ‘s’ respectively, so, for example, Chapter 6, Section 2, will be cited as ‘C. 6: S.6.2’.

### 7.2 The introduction of a market model into health care delivery

The economic rationalist paradigm is increasingly underpinning the corporate sector (Saul, 1997) and is part of a trend in the western world, where the business market metaphor becomes the dominant metaphor as far as social policy is concerned (Long, 1999b; Soros, 1997). It is based on a rationale, of radical individualism (Long 2000; Soros, 1997) characterised by the prevalence of the individual over society, identification of ourselves as consumers more than citizens, and the emphasis on rights over responsibilities (Feuchtenberg & Ramsay, 1995). Its tenets contend that an economy needs to be run like a market with as little interference as possible; that human effort can be counted as a commodity; and that the conduct of an organisation’s financial accountability is the main criterion by which to measure performance (Rees, 1995a).

The introduction of a market paradigm has resulted in service industries increasingly taking on the rhetoric of production. Services previously provided by governments (in the spirit of public service) are now more likely to be provided through private
companies, such that health care is delivered within a business context (Swerissen & Duckett, 1997; Mooney, 1998; Buchanen, 1999; Anaf, 1999). Hence institutions assigned to meet important dependency needs of individuals are no longer buffered from market forces, and are increasingly exposed to the dictates of ‘bottom line’ accountability (Krantz, 1994).

The current trend towards reliance on a market paradigm to integrate and co-ordinate the funding and delivery of health care is based on the argument that enhanced conditions of competition among doctors, hospitals and insurers should be supported. Its rationale is that managing economic issues effectively will have a ‘trickle down’ effect in that social benefits will accrue to the community (Anaf, 1999). This is because enhanced conditions of competition among doctors, hospitals and insurers is necessary to contain health care costs, which are allegedly burgeoning. Moreover, competition will provoke a shift in the health care power balance from providers to consumers (Komesaroff, 1999b).

A market approach to health care has been contested by those who argue that the market paradigm cannot be relied upon to provide public services on both practical and ethical grounds (Komesaroff, 1999b; Mintzberg, 1996; Hancock & Mackey, 1999). Those who eschew the application of market economics to health care delivery contend that opening up medicine to commercial interests and the promotion of economic competition undermines fundamental values and seriously threatens patient care (Komesaroff, 1999b; Halasz, 1999). Their concern is that health care becomes ‘commodified’ and treated in the same way as if it were subject to the tendering process, similar to producing hamburgers at the lowest price (Buchanan, 1999, p.27). Hancock & Mackey (1999) contend that a market left to its own devices is a poor allocative mechanism in an area like health, which is prone to market failure. The market performs badly on criteria such as protecting equity, fairness and universal access to health services. Prytula (1999) maintains that the ‘market’, if it can be personified, is self-interested and without compassion. It is driven by forces mostly unconscious, along ‘basic assumption’ activity lines, resulting in fight/flight, pairing, and dependency activities more than task based ‘work’ (Bion, 1961). Hence ‘leaving the market to
control prices and costs in health is a foolhardy business, rather like leaving a shark to protect your pet fish’ (Prytula, 1999, p. 142).

Those who are concerned about the market determining the allocation of health care resources question the tenets underpinning a market paradigm. In particular, they question the concept of ‘perfect knowledge’, which assumes individuals are informed and have consumer choice. Health needs are not eclectic or subject to choice in the same way as buying a new television might be. There may be no choice of provider in a rural or remote area (Hancock, 1999b). Moreover, decisions regarding health care are complex, and individuals do not have perfect knowledge. Patients by and large are ill and vulnerable, and do not behave like a hypothetically healthy and ‘rational citizen’ or ‘client’ (Komesaroff, 1999b; Anaf, 1999; Buchanen, 1999; Halasz, 1999).

7.3 The rise of managerialism

The policies of economic rationalism are embraced by an ideology of ‘managerialism’, which is an approach to management that is crafted in the commercial sector. Its ideology is based on a belief system that views efficient management as able to solve almost any problem (Rees, 1995a). Managerialist reform involves a ‘paradigm shift’ in administrative practice, which is a shift from process (bureaucratic) accountability to accountability through quantifiable results (Boston et. al., 1996 in Hancock, 1999b). It relies on competition and policies of economic rationalism to determine the allocation of resources. Transferring managerialism to the public sector involves cutting back the responsibilities of government and relying on competition and market forces.

A managerial approach to management can be said to stem from the emergence of rationality as an administrative paradigm. Rationality reemerged as an administrative paradigm partly as a defence against the perceived dysfunction and pejorative connotations of emotions. The emphasis on rationality has led to a pervasive neglect of emotionality in organisational life (Shrivastava & Schneider, 1984 in Ashworth & Humphrey, 1995), leading to rationalisation, which itself is a psychic defence.
In the rationalist paradigm, emotions are consistently devalued and marginalised, while rationality is privileged as an ideal for effective organisational life (Putnam & Mumby, 1993). Max Weber (1968), who articulated the principles of a ‘rational legal bureaucracy’, stated that a bureaucracy progresses the more it can be ‘dehumanised’ (Weber, 1968 in Ashworth & Humphrey, 1995). In this view of the world, emotionality is regarded as anti-task in organisational life, and emotional labour is marginalised, as reflected in the low status it holds in occupations requiring frequent emotional labour such as counselling and nursing. To the extent that emotions are required, as exemplified in the provision of empathy in a counselling situation, they are often reframed in a construct that renders them palatable to the organisation. Putnam and Mumby (1993) refer to their ‘commodification’ for the achievement of instrumental goals.

Gabriel (1999) contends that emotions they are referred to by a small number of euphemisms, like stress or job satisfaction, which give them some scientific weight and also offer the prospect of containing, managing and controlling them in the same way as knowledge, money, and technology. It reinforces the view of people in organisations as ‘emotionally anorexic’ (Fineman, 1993, p. 9 in Gabriel, 1999). Ashworth & Humphrey (1995) present ways in which emotional expression in work settings is regulated and circumvented to render it socially acceptable to a rationalist paradigm. They describe four possibly overlapping means, which are described as follows. ‘Neutralising’ (emotion) occurs by preventing the emergence of socially unacceptable emotions through, for example, a company policy that prevents a person from working in the same department as his wife. Where emotion cannot be prevented, it may be ‘buffered’, and hence compartmentalised, as occurs when medical students are trained to display ‘detached concern’, oscillating between the human concern necessary for establishing rapport with patients and the professional detachment of hard, rational decisions. Where emotional expression is an inherent component of role performance, the manner in which emotions are expressed may be ‘prescribed’, such that the emotional response is considered appropriate. Hence a flight attendant is trained to be cheerful. ‘Prescription’ may require the suppression of felt emotions, so that during a turbulent flight the attendant is required to appear calm.
A number of authors are concerned with the focus on rationality embodied in economic rationalism and the associated rise of managerialism (Pettigrew et al., 1988a; Krantz & Gilmore, 1990; Zaleznik, 1991; Rees, 1995a, 1995b; Mintzberg, 1996). They view the tenets underpinning managerialism as being narrow, and as cost and outcome orientated. Pettigrew et al. (1988a) bemoans the grafting of a ‘managerialist’ culture onto the NHS (British National Health System). He contends that this has been perceived as both betraying the complexity of the NHS and ignoring or underestimating the power of clinicians and professionals in key management positions (Pettigrew et al., 1988a). Krantz and Gilmore (1990) regard managerialism as concerned with administration, procedure, and efficiency at the expense of vision, leadership and craft. Zaleznik (1991) contends that a managerial orientation with its emphasis on form over substance, on structure over people, and on power relationships over work, is at the heart of the disability of modern business. Rees contends that the underlying philosophy of managerialism is subversive in that it is an approach to the conduct of work and the treatment of human beings where economics takes precedence over society and human beings. Its practices are associated with a fundamentalism characterised by control and authoritarianism, greed and bullying, intolerance of critics, and exclusion of the majority from the decision making processes (Rees, 1995a, 1995b). Such an approach has attendant human costs.

Models of service delivery based on the rationale of economic rationalism are orientated around the objectives of efficiency and effectiveness. Inherent in organisational strategies based on the values of efficiency is the depiction of a view of the world that is ordered and where human costs are not permitted to cloud the efficiency equation (Rees, 1995a). MacIntyre concludes that claims about effectiveness and efficiency are about control, and what he regards as ‘the manipulation of human beings into compliant patterns of behaviour’ (MacIntyre, 1984 in Rees, 1995a). Models underpinned by the tenets of economic efficiency require a management to operationalise the requirements inherent in such approaches and to collude with its tenets. The claims that managers, who adhere to the principles of economic efficiency by restricting themselves to the rational realm of facts and measurable effectiveness, are objective and neutral and therefore should not be contested, is according to some authors a ‘moral fiction’ (Rees, 1995a; MacIntyre, 1984). ‘Managerialism is not divorced from social and economic
policies nor is it a set of neutral and scientific techniques uncontaminated by political struggles for power.’ (Rees, 1995a, p.15). Both Rees (1995a, 1995b) and Lawrence (1998) suggest that certain individuals have a personality predisposition for narcissism and coercive behaviour and are likely to be chosen for management positions in a culture that has split off its capacity for being humane. Rees refers to certain individuals ‘waiting in the wings for the call to demonstrate their toughness and efficiency, their willingness to disparage old professional practices and traditions in the interests of new corporatism’ (Rees, 1995a p.16).

To the extent that a market approach accords priority and ascendancy to those aspects of the task that are measurable and therefore manageable, it may lead to the neglect of the more intangible contributions which are associated with those aspects of the work which require emotion. A management that colludes with the underlying tenets of a market paradigm may perpetuate a culture that diminishes the status of the role holder, who provides emotion and the emotional labour required in the facilitation of the task. The importance of attaining balance, ‘balancing and optimising’ (Bridger, 1980) between the technical and social systems is well expounded in the literature (Roberts, 1994, Czander, 1993, Miller & Rice, 1967, Bridger, 1980). Neglect of the emotional and sentient aspects of the task can lead to an undermining of the primary task, which is the task for which the institution exists to perform and which the organisation must undertake in order to survive (Miller & Rice, 1967). An organisation that denies emotion denies reality by engaging in activity which threatens its own survival.

### 7.4 Managerialism as a defence against uncertainty

Several authors argue that economic rationalism is an organisational and social defence against anxieties about the uncertainties and changes occurring in a world increasingly dominated by global markets (Long, 1999b; Lawrence, 1998). These authors argue for a link between managerialism and primitive psychic defence mechanisms, placing managers and others as having a greater disposition to a ‘paranoid-schizoid’ position (Lawrence, 1997, 1998; Krantz & Gilmore, 1990; Schwarz, 1990). These mechanisms when operating in an extreme fashion remove organisations from reality, in that adherence to managerialism is concomitant with idealisation and hence the splitting off
and projecting outwards of those aspects that do not concur with an idealised view of the world. Deification of economic rationalism as a rescue package and collusion with its underlying values of individualism and its tenets which emphasise predictability, certainty and control as an end in itself rather than a means to an end, may well be a defence against the uncertainty pervading organisational life. Because of the pain inherent in navigating an unpredictable and changing world, managers and other role holders collude in a process that attempts to define the world as a certain, predictable and safe place and to banish uncertainty. This process of collusion can occur both consciously and unconsciously.

Independent thinking can potentially threaten this collusive process. Institutional psychic defence mechanisms of denial, splitting, projective identification and scapegoating are mobilised in an attempt to protect the phantasy world. The process is consistent with a totalitarian state of mind (Lawrence, 1998; Schwartz, 1990), which prevents other states of mind. Pring (1997) contends that the enthusiasm in which management theory has been embraced is akin to fundamentalism to the extent that it denies the reality of other ways of viewing the world. He cites Saul (1997) who argues that a management approach emanating from a culture of economic rationalism offers rhetoric, propaganda and a dialectic which attempts to normalise what is untrue by constructing abstract notions that obscure real events, narrow public debate and misuse and corrupt language.

The metaphor of ‘arms length relationship’ has been used by Mintzberg (1996) to describe what he views as disconnectedness in the way management approaches its role in an environment controlled by the forces of supply and demand. Mintzberg (1996) argues that obsession with a management approach that focuses on a market paradigm, where managers become ruled by measurable hard data and trends, disconnects managers from reality. He cites the destruction of the public school system in the United States as the consequence of a management hierarchy disconnected from the task of educating children.

Similarly Lawrence (1997) argues that the introduction of a market model into the British health system has led to the organising metaphor of the purchaser-provider (C.2:
S.2.4.1) to take precedence over the doctor/nurse/patient relationship, resulting in the undermining of the primary task. At a conscious level the purchaser-provider frame attempts to give the appearance of control. However, at an unconscious level it serves as a societal defence against the pain inherent in a society faced by illness and poverty (Feuchtenberg & Ramsey, 1995). Reducing a service that is essentially social to one that adheres to tenets of a market economy is a defence against the pain of providing health care, a defence against the inability of the health system to prevent death (Obholzer, 1994a; Stokes, 1994a). An attempt to bypass and deny the pain and despair that often permeates human service work leads to disconnection with the primary task such that the business of health care is tantamount to monitoring the throughput of patients ‘as either convalescents or cadavers’ (Sievers, 1998).

When institutional defences obstruct contact with reality, it can hinder an organisation from fulfilling its task and adapting to changing circumstances (Halton, 1994). The focus on what is measurable and controllable, to the exclusion of other organisational imperatives which are more social and human in nature, is tantamount to relinquishing the management task and hence the primary task of the organisation. Those aspects of the task which are less tangible and less able to be controlled (illness and death) are denied, while attention is focussed on what can be controlled (cost). By splitting off a main task of management, and constructing a role that involves the control and manipulation of actuarial and accounting principles, managerialism has provided a way for role holders to defend against the anxiety associated with the complexity and ambivalence inherent in the management task. The splitting off of those aspects of the management role which are not able to be contained in balance sheet economics disconnects management from a broader reality as it attempts to impose control on a world that is not fully controllable. The trend towards reductionism and simplification is congruent with avoidance of the ‘depressive’ position. When organisations have come to be construed as accountancy models, leadership and the organisational culture is stuck in a ‘paranoid-schizoid’ position and cannot move to a ‘depressive’ position (Lawrence, 1997), which requires a more complex appreciation of the management task.

A managerialist approach predisposes management to focus on the management of efficiencies and the containment of costs. In such a culture, this more limited primary
task supplants the idea that any enterprise exists to perform work-orientated tasks. Company management identifies the primary task as making or saving money, rather than it being the outcome of successfully executing the broader, work-orientated primary task, which is a statement of purpose that gives meaning to the working lives of role holders in the institution (Lawrence, 1997). The pressure to contain costs can occur at the expense of providing patient care, such that the integrity of the primary task becomes compromised. This inevitably predisposes the psyche of the individual to hold the paranoid schizoid position with all its propensities for splitting (Lawrence, 1998), and is consistent with unconscious processes which can result in task corruption according to the tenets of the Chapman (1999) model. In essence the official primary task becomes lost. The phenomenal primary task, the task that can be inferred from people’s behaviour, becomes the management of costs as opposed to the official or publicly stated task of the organisation, the normative primary task which is the delivery of health care within cost constraints (Lawrence, 1977; Roberts, 1994; Stokes, 1994b).

This idealised view of the world may appeal in the short term, as it relieves organisational members of the responsibility of working through the pain of change, but it offers little in the way of anything that is more realistic and effective. Organisational role holders deny reality by colluding with a phantasy which involves the omnipotent deification of conscious activity, where objective outcomes and performance indicators linked to targets provide a construct of control (Feuchtenberg & Ramsey, 1995).

The pressure to collude with these ideals creates dysfunctional organisations, where effective learning cannot occur.

### 7.5 Importance of the sentient task in health

The construction of a task that is narrow and cost-orientated neglects those sentient aspects of the task so necessary for the effective execution of the primary task. The need to attend to the sentient task is particularly poignant in the health sector. First, as suggested earlier, the provision of health services involves the interpenetration of the technological and human dimensions (Hutton et al., 1994). Health services can only be delivered in a relationship. They are not like goods where consumption can be separated
from the relationship. Health care services invoke and are sustained in complex ongoing reciprocities in a way that buying a television is not. Delivering health care requires a management that is mindful of the core technology of providing health services and hence the importance of emotional labour, not only in the roles of those at the front line of providing service delivery, but in the containing function of the management role. This is particularly so in the provision of health care, which is inherently anxiety producing (Obholzer, 1994a; Menzies, 1961). A work environment in which there exists an undue focus on cost effectiveness at the expense of other aspects of the primary task, particularly the sentient system, is likely to exacerbate organisational tensions and stress (Stokes, 1994b) leading to conflicted organisational dynamics. Such a culture diminishes the capacity for learning so necessary for organisational survival.

Second, attention to the sentient task provides the space to acknowledge the important containing functions of institutions, particularly those providing public services such as education, health and police. Health care is concerned with life and death, suffering and distress. It confronts both members of the organisation providing care as well as consumers and society at large with their relative powerlessness in the presence of pain, decrepitude and death (Obholzer, 1994a). It is hypothesised that in the unconscious there is no such concept as ‘health’. Instead there is a concept of ‘death’ (Obholzer, 1988). Hence the area of health care is susceptible to the primitive and powerful unconscious phantasies of death at individual, institutional and societal levels (Obholzer, 1988). The health services sector serves as a social system defence against death (Lawrence, 1997; Menzies, 1970; Obholzer, 1988, 1994a). This is because unconsciously health systems are construed as being wonder institutions, which could provide an indefinite postponement of death (Lawrence, 1997). To the extent that the management of a health care system becomes the major and final representation of organisational health and survival, it becomes the unconscious object of endless projections about death from the medical staff, nursing staff, the patients and their relatives as well as from the surrounding community. These projections mirror the more psychotic defences of the respective role holders, and their split off anxieties, illness, suffering, despair and annihilation (Sievers, 1998; Obholzer, 1994a). A management that denies the existence of these psychotic anxieties is unable to contain or modify them.
Third, superimposing a change process on an activity that is inherently anxiety producing is likely to exacerbate the anxiety (Krantz, 1994) because change threatens the anxiety-containing functions of institutions (Obholzer, 1994b). Lawrence, 1997). The stress impacts particularly on those directly involved in providing health care, as the core technology of providing health care involves emotional labour. They bear the pressure of undertaking an inherently stressful task (Menzies, 1970; Krantz, 1994). The outcome has powerful consequences on organisational dynamics particularly in a culture which increasingly undermines and diminishes the role and the task that front line health workers (medical clinicians, nurses, social workers) undertake, exacerbating their vulnerability to the powerful emotional dynamics characteristic of such work (Krantz, 1994). To effectively implement a change process in the human services sector, particularly one that involves providing services in a climate of increasing cost constraints, requires a management that is mindful of these dynamics and views its role as attending to them (Obholzer, 1994b).

To the extent that a managerialist approach has resulted in the erosion of the notion of a ‘public service’, it has not only eroded the role of being a provider of care and a provider of employment, it has also eroded the containing functions (Bion, 1971) that institutions provided for unconscious societal projections. The withdrawal of the provision of an intangible public good, which has served the moral and spiritual welfare of society as a whole, has societal consequences. The unresolved dependence, which increases through the relinquishment of the containing function of institutions, is not worked through. Instead individuals disguise their unresolved dependence by assuming a state of ‘pseudo independence’ (Long, 1999b), which describes a position in which the individual is psychologically withdrawn but masks this through a superficial mode of being in relationships. This detachment impacts on the capacity for full psychological presence, ‘relatedness’ to role and task (Murphy & Reed, 1990).

One main task of management is to provide a holding environment necessary for the achievement of the primary task. In an environment driven by the need for cost containment, management’s task is to assist the group put market and commercial realities into perspective, modify group behaviour and enable a ‘reowning’ of
projections. Hopefully this orientation will result in a decrease in splitting and a reduction in polarisation and antagonism between groups within an institution or between an institution and its environment. Clarification of the primary task is critical to the provision of a holding environment and involves behavioural practices that acknowledge the interdependence of the task and sentient systems (Hutton et. al., 1994).

7.6 Analysis of the organisational dynamics associated with the implementation of the Trial Model of Co-ordinated Care

This section uses theoretical concepts outlined in this, and other chapters to interpret the findings presented in chapter 6. It argues that a culture of managerialism evident in the broader domain has impacted on the design of the Trial Model, the priorities of management, and the manner in which the implementation of the Trial was undertaken.

7.6.1 Importation of a market model

The data in the case points to a Trial culture that is characterised by staff disaffection, reflected in tense relationships both within the organisation of the Trial and between the Trial and its environment. A culture of managerialism pervading the broader system domain (Bain, 1997) is likely to have permeated the Trial and become internalised into the specific dynamics of the Trial culture, shaping the way players have interpreted the Trial Model of Co-ordinated Care and the way they have taken up their roles. Bain’s (1997) concept of the social domain provides a theoretical basis for an explanation of the interpenetration of social defences. He suggests that organisational defences exist in parallel within a number of organisations. Social defences within one particular institution are shared across institutions that comprise the ‘social system domain’. Hence institutions cannot be viewed as ‘stand alones’ and should take into account the wider system domain defence system.

The debate around the introduction of competition policy to allocate what many consider to be a dwindling health dollar has been emotional (as discussed in C.2: S.2.2). Given the vociferous opposition by sections of the community to the introduction of a market model to the provision of health care, a model of co-ordinated care was always likely to arouse anxiety. The financing and delivering of health raises a number of
important philosophical and ethical issues around social justice and the nature of society (Mooney, 1998). These are contentious and emotional. This suggests that role holders are likely to have arrived with preconceived notions surrounding co-ordinated care. This is reflected in the fact that anxiety was already at a heightened state during the early stages of the Trial. Stakeholders arrived with fears and fantasies.

Tensions between the hospital and the general practice communities are historical and preceded the introduction of co-ordinated care. The advent of specialisation and a growth in technology has led to the exclusion of general practitioners from hospital bed rights. This has reduced their capacity to develop new skills in the management of particular conditions and to undertake procedural work in most hospitals. Hence general practitioners can no longer perform anaesthetics, minor surgery, and to a lesser extent ‘low-risk’ obstetrics, and no longer have admission rights for medical and surgical conditions in most major hospitals.

Moreover in the main areas of interface between general practice and the hospitals, communication between has been poor around pre-admission assessment and discharge planning. This trend has created antipathy between general practice and the hospitals, as general practitioners have felt disenfranchised. Despite attempts to improve integration, through general practitioner involvement in pre-operative assessment, GP-emergency department’s communication, and admission notification and discharge communication and discharge planning, general practice’s willingness to embrace co-ordinated care has been tentative (National Health Strategy, 1992; Harris & Powell-Davies, 2000, Bolton & Mira, 2000).

For some members of the medical profession there was concern that the Trial was a front for the introduction of American styled managed care. They feared that the Network would take control of the patient’s management and the general practitioner would be shut out of the system. The Australian Medical Association (AMA) was reluctant for the medical profession to become involved in the co-ordinated care trials, associating them with the American style managed care model. Managed care was associated with a cost cutting agenda and the ‘deprofessionalisation’ of medicine (C.6: S.6.4.4).
David Brand, the past president of the AMA, voiced his opposition to managed care.

The Australian Medical Association argues that managed care is about control. Health funds cannot directly influence the costs of an episode of care. The single most important determinant of how each patient is treated and for how long, is the doctor. To control costs, the funds must control the doctor. …To my way of thinking health funders will bribe, coerce or bully doctors into changing their behaviour—behaviour that will benefit the funds at the expense of the patients. ….The AMA will opposes any measure which place the financial interests of the health insurance companies ahead of the clinical care of patients (Brand, 1997, p. 58)

Pring (1997) regards the term ‘co-ordinated care’ as a euphemism for American-style managed care, arguing that because the term ‘managed care’ has become ‘odious’, there has been an attempt by managers to re-label it as co-ordinated care.

Other stakeholders including the Trial administrative staff, case managers and service co-ordinators indicated that they had concerns regarding the introduction of co-ordinated care. The interviews suggest that stakeholders felt that they were not being told the whole story. The interviews convey a lack of trust and an undertone of secrecy, with hidden agendas being masked by outward rhetoric. Concern was expressed at the prospect of Network dominance and the prospect of cost cutting (C.6: S.6.4.1).

### 7.6.2 Trial experience

The suggestion that there was interpenetration between the broader system and the Trial is not to say that organisational role holders were not responding to the specific Trial experience. It suggests unconscious processes heightened stakeholders’ ‘valency’ to introject events in the broader system, given their likely experience with a market model elsewhere in the system. This is evidenced by the fact that many stakeholders came on board feeling reticent and/or negative about the introduction of co-ordinated care, even though many were not quite sure what it was all about (C.6: S.6.3.1, S.6. 4.1).

However, there is also evidence of a poorly managed implementation process, suggesting that role holders responded to the specific Trial experience. The culture of
managerialism may have impacted on the way management understood and took up its role. Management was unable to provide the necessary holding required for the facilitation of the implementation of the co-ordinated care intervention. Long & Newton et. al. contend that a successful organisational intervention requires the capacity for successful collaborative work, which is an outcome of mature working relations between individuals and groups. The development of maturity depends on a number of factors including a good holding environment for work, the capacity to negotiate tasks and roles clearly, and the desire as well as the ability to learn from the experience of engaging task with others (Long & Newton et. al., 1997). Failure on all these criteria was evident in the Trial implementation process. The culture of the Trial implementation process was characterised by:

- Failure to negotiate the fundamentals of task and relationship between the strategic partners (C.6: S.6.3)
- Expediency, rhetoric and obfuscation at the expense of communication (C.6: S.6.4.2);
- An obsession and focus on measurement, particularly financial key performance indicators (C.6: S.6.5.1);
- Marginalisation of the role of providing health services and a lack of dignity afforded those role holders, (C.6: S.6.5.3.3);
- Coercive hierarchical authority relations which dominated the culture of the implementation process and scapegoating, such that those who did not align with the management ethos were punished (C.6: S.6.3.2, S.6.5.3.2);
- No capacity for open dialogue and discussion, denying role holders the opportunity to fully take up their roles in a way that invited thinking and questioning (C.6: S.6.5.3.5).

The following section explores and interprets the data under the criteria suggested by Long and Newton et. al. (1997):

- Provision of a holding environment and negotiation of a partnership relationship;
- Capacity to negotiate tasks and roles clearly;
- Desire and ability to learn from the experience of engaging task with others.
7.6.3 Provision of a holding environment: Failure to develop a containing partnership

Problems in developing a strategic partnership basis and failure to sort out issues around priorities of the Model pervaded the Trial implementation process. An infrastructure required for holding was not developed. An effective partnership arrangement between the Network and the Division was essential for the establishment of a stable holding authority. However the potential partners failed to develop an instrumental structural arrangement necessary to underpin Trial operations. Structural arrangements and decision making processes, so necessary for reliable holding (Obholzer, 1994b; Stapley, 1996), were deemed as ineffective and inappropriate by the Division executive resulting in divisiveness. A process to agree on the Model’s conceptual framework and the respective roles that the Division and Network would take up was not adequately developed (C.6: S.6.3). Sdrinis and Denemoser (2000) refer to the considerable ambiguity in the correspondence between the Trial and the Division about the role of the Division, particularly regarding the partnership and fund-holding functions of the Division. Time constraints, conflicting demands and repeated changes to the care co-ordination model added to the confusion about roles during this period.

Undue focus on finance dominated the partnership agenda and determined the power relationship between the partners. The Network was the ascendant player in the relationship in that it held financial power. Trial success became aligned with the Network agenda, which focussed almost exclusively on the management of risk, reflected in a reduction in unplanned admissions. Although the Division held responsibility for the provision of services to patients, this was regarded as a lesser role than financial management. The ascendancy of this function rendered the Network as the powerful and dominant player in the partnership, while the Division was rendered as infantalised. The Network regarded the Division as naïve and 'lacking the capacity and capability to take the intellectual leap’ that was required in managing the risk and understanding how risk impacted on the operational elements of the model (C.6: S.6.3.3.1, S.6.3.3.2).
There was a lack of attention placed on the more meaningful aspects of sorting out the relationship issues between the partners. Relational issues remained unresolved throughout the implementation process resulting in chronic tension between the parties. Interviews with members of the Division executive indicated a belief that they had been wooed and seduced. They believed promises made had been made and broken and information withheld. This led to discord in the way both parties understood the terms of the partnership and the financing arrangements of the Trial Model. The Division executive understood that it would be an equal partner, while the Network was adamant that there had never been an intention of partnership equality, in that it had taken the financial risk and therefore it should hold the power in the relationship. The Division could only hold a small ‘p’ partnership position as the power in decision making rested with the partner who took the financial risk. The Division understood that there would be brokerage funds available while the Network contended that brokerage funds had been considered but were rejected on the basis that savings had to be created before money could be spent. A lack of brokerage funding was viewed as limiting the capacity of those delivering services to do so effectively (C. 6: S.6.3.2, S.6.3.3.1, S.6.3.3.2). The lack of control over funding and staff allocation, a lack of clarity about roles, and a lack of decision making power meant that the Divisions found some decisions being made without adequate consultation (Sdrinis & Denemoser 2000).

Given that a partnership involves the drawing of new boundaries akin to an intergroup relationship, the likelihood of anxiety associated with losing one’s identity and/or power exists. This is because an intergroup relationship requires the drawing of new boundaries, which gives rise, both physically and politically, to the anxiety-laden possibilities of losing one’s identity and/or power. These are defended against both consciously and unconsciously (Gould et. al., 1999). A strategic partnership requires the stakeholder partners to draw on their emotional wherewithal and capacity to fully locate themselves within the uncertain boundaries of the newly created joint enterprises. Most rational bases for alliances can run into powerful irrational dynamics, which can derail even the most manifestly sensible relationship. Kets de Vries (1999) refers to unhealthy collusions, which take on the form of a neurotic collaboration, where one partner keeps the other bound to a set of complementary reactions. Through a process of projective identification the partnership relationship may enact unconscious dynamics which are
anti-task (Bion, 1961), and which do not provide the transitional space (Winnicott, 1975) for new learning to occur. Hence it is paramount to attend to the emotional and relational aspects of the relationship (Gould et. al., 1999).

Historical tensions between the two organisations combined with the fact that the partnership was transient, contributed to a failure to develop the necessary working relationship that would be able to provide ‘good enough’ containment (Winnicott, 1971). The structural arrangement between the Division and the Network failed to engage both parties sufficiently to enable relinquishment of their separate identities, at least temporarily and in part, and to locate themselves within the uncertain boundaries of the newly created Trial organisation. Instead the structure that developed was a defence against a mature working relationship and hence the capacity to undertake task. The ambivalence felt about the relationship manifested itself in a pattern of social defences against anxiety ranging between Bion’s (1961) basic assumption of dependency and fight/flight. This is discussed below.

The collusive relationship that ensued between the Network and the Division may reflect unconscious dynamics of dependency, in which the Network took on the ascendant status and the semblance of control, while the Division took on a victim status, which was reactive and survival orientated (C.6: S.6.3). Despite complaints about Network bullying tactics, the Division succumbed to the Network agenda. At other times a fight/flight stance was evident where members of the Division and Network split off projected aggression onto one another, while idealising their own group and leader. This was evident in the lack of trust groups felt for one another, failure to communicate and share information, and perception of one another’s incompetence and incapacity to undertake the task, and a lack of understanding of the imperatives of one another’s roles (C.6: S.6.3)
7.6.4 Implications of structural divisiveness on organisational dynamics: Incapacity to negotiate task and role clearly

7.6.4.1 Split between the ‘care’ and ‘cost’ tasks

Tensions in the strategic partnership seem to have been played out within the organisation of the Trial impacting on the implementation process. Gilmore & Seitchik (1995) note that unresolved political issues in joint ventures are often displaced and find expression at the boundaries of other functions and in subsystems lower in the organisation.

The failure of the Division and the Network to reconcile differences and establish a workable partnership arrangement impacted on the culture of the implementation process and heightened the propensity for psychologically primitive dynamics to pervade organisational life and thwart the implementation process. Misunderstanding and misconception was exacerbated by an implementation process which was characterised by a culture of expediency and the need to ‘make decisions fast’. There was no time for the necessary dialogue which may have allayed concerns experienced in the process. Differences were not adequately addressed, particularly in the early stages. The implementation process managed the complexity by denying its existence. Steps required in an implementation process were bypassed. There was inadequate time devoted to preparing the stakeholders for an understanding of the Model and the process of implementation (C.6: S.6.3.4, S.6.4).

Management failed to provide sufficient clarity to distil much of the confusion and fear that was prevalent amongst Trial members and others who interacted with the Trial. Confusion turned to alienation and cynicism. By the middle stage cynicism had set in. Some felt that this in fact was not a ‘Trial’ in the true exploratory sense, as the management of the Trial had a predetermined agenda. Outcomes had to be achieved to satisfy the ‘funders’ and there was little opportunity for exploration and discovery (C.6: S.6.5.3.5).

There was a divide in the organisation of the Trial between those supporting what was perceived as a Network ‘big business’ agenda (management), and those supporting what
was perceived as the Divisional agenda (provision of service through a delivery of the care co-ordination function). The ensuing culture of splitting, reflected in a denial of the necessary relatedness to one another’s roles, led to fragmentation and pervasive task and role confusion. This resulted in problematic intra- and inter-organisational relationships, which have dogged the Trial during its implementation and thwarted its capacity to bring stakeholders on board (C. 6: S.6. 3.3.1, S.6. 3.4, S.6.4, S.6.5.3, S.6.6).

Splitting existed at a number of levels. These splits occurred at both a structural level, reflected in tension between the managing partnership and at an operational level, manifested by tension between those in management and those involved in service delivery (C.6: S.3). The ascendancy of the Network over the Division in the partnership arrangement was played out in group dynamics within the organisation of the Trial such that the financial tasks and those role holders holding responsible for their achievement held ascendancy over those role holders in service delivery positions. Splitting was also evident between those in management positions and those providing health services, such that those in caring positions denied their administrative/financial side and projected this onto management while management denied the caring role (C.6: S.6.3.4, S.6.5.3.3, S.6.5.3.4).

The role of management was cut off from the task of providing service, such that the primary task became the testing of a funding model. By reducing the primary task to the management of risk, other tasks essential to the provision of care were marginalised. Those responsible for service delivery, in particular care co-ordinators, expressed cynicism towards the way selection criteria were designed to manage for risk, resulting in most patients on the Trial being rendered ineligible for case management and service co-ordination (C.6: S.6.6).

There was also a disconnection and a distancing from the patient, through a distancing of the institution and players who provided patient care (C.6: S.6.5.3.3). Those individuals who held roles that required patient care felt diminished and marginalised by the Trial experience, believing that the primary task was to manage costs (as opposed to the provision of patient services). They felt their roles were marginal to the Trial Model and felt their professional integrity devalued and ridiculed. A focus on the patient was
viewed as tantamount to creating dependency relationships (C.6: S.6.3.3.2, S.6.4.1, S.6.5.1, S.6.5.3.2).

Case managers and service co-ordinators cited as examples the fact that they were excluded from weekly team meetings, were not invited to the strategy day, which involved discussions about Trial strategy and was designed as an opportunity for stakeholders to express views, and for management to present a vision. They were last to receive computer support, resulting in duplication of work. They did not receive support for training and were expected to achieve what they regarded to be ‘the impossible’, which was to make a difference to patient health status, translated in a reduction in unplanned admissions while receiving no brokerage funds from the Trial (C.6: S.6.5.3). Failure to provide brokerage funds was seen as hampering the capacity of case managers and service co-ordinators to take up their roles in providing delivery of quality service to the patient. The only way they were able to assist patients was by ‘hustling’ the system and jumping queues. This meant that patients, who were not part of the Trial and hence were not receiving the advocacy support provided to those receiving case management and service co-ordination, lost out by being placed at the back of the queue (C.6: S.6.5.3.3, S.6.5.3.4). Pejorative references were made towards those who did not align with the Network goals. Care co-ordinators were referred to as slow in taking up change and unwilling to take intellectual risk (C.6: S.6.3.2). The work of case management was referred to as the provision of pets, dressing gowns, meals, and window cleaning as opposed to the more sophisticated task of funding a model of care (C.6: S.6.3.3.1).

This perception created antipathy towards management and the Trial aims, which were viewed as an extension of the Network culture of cost cutting. There was a perception that management was contemptuous of the care co-ordination function and that patient care was not perceived as important in its own right. It was only important to the extent it impacted on unplanned admissions as a major key performance indicator (C.6: S.6.5.3.2).

Management viewed those in the care co-ordination function as unwilling and unable to take responsibility for the cost constraints. However no effort was made to meaningfully
embrace this group in a way which would enhance role relatedness and enable the integration between the ‘care’ and ‘cost’ functions. In fact initiatives were taken which exacerbated the split by exacerbating the separateness of the functions. For example Trial Manager A subsequently excluded from meetings those staff directly involved in the provision of care to patients. This was bitterly resented and viewed as a step to delegitimatis and marginalise their roles further. Trial Manager A’s rationale for this was the desire to protect those involved in front line service delivery from concerns about day to day financial issues (C.6: S.6.5.3.4). Nevertheless, she held service providers accountable to costs, as reflected in the pressure placed on the service provider function to contain unplanned admissions (C.6: S.6.5.3).

Krantz (1994) refers to the toll of overwhelming feelings and confusion that the demands of a market paradigm applied to the delivery of health care creates for role holders. Role holders are expected to take responsibility, be held accountable for self management, and to respond to the dictates that require inner motivation, while being exploited and devalued by their organisations. This exacerbates their vulnerability to the powerful emotional dynamics characteristic of such work.

Role holders, particularly the case managers and service co-ordinators, survived by disconnecting themselves from the Trial and colluding with the split. They presented only that part of themselves that did not overtly threaten the status quo. Winnicott refers to a ‘false self’ (Lawrence, 1998), which Sebek describes as ‘the self adapted to the requirements of totalitarian power, in terms of subjugation, passivity, resignation and obedience’ (Sebek, 1993, p.2 in Lawrence, 1998). Care co-ordinators were generally uninterested and not involved with the Trial. Both the language of co-ordinated care and the selection process for care co-ordinators were perceived as alienating. Many did not know that they were being referred to as care co-ordinators and did not embrace the role (C.6: S.6.4.4). Moreover, there was also fear, as discussed above, associated with managed care. In the short term, the setting up of defensive structures may constitute a survival mechanism. However, in the longer term defensive structures are dysfunctional in that they keep at bay people and thwart the potential for creative contribution (Miller, 1993).
Failure by management to provide the necessary containment also led to internal conflicts within the care co-ordination team, exacerbating underlying professional tensions that may have existed historically between care co-ordinators, who are medical practitioners and other professionals involved in patient care, such as nurses and social workers. A divide was evident between those providing psychosocial services (nurses and social workers) and medical practitioners. Case managers and service co-ordinators resented the care co-ordinator as the professional that the Model designated to hold the ascendant position. They believed that the design of the Model underestimated the role that psychosocial, as opposed to medical services, played in patient care (C.6: S.6.6).

7.6.4.2 Impact on Roles

Failure by management to manage the boundary between the ‘cost’ and ‘care’ functions led to internalisation of this split. Hence most role holders internalised the split in some way. Many introjected the negative projections, resulting in loss of confidence and insecurity regarding their performance. This was particularly evident for role holders who had reporting responsibilities to both the Division and the Network and hence were responsible for managing the boundary between provision of services to patients and managing the funding requirements. Care co-ordination managers, in particular, experienced feelings of tension in their attempt to serve two different masters, and provide effective care within the cost constraints. Although they reported to the Division of General practice, they also had a reporting relationship to the Trial manager. This experience of being in the middle is described by Feuchtenberg and Ramsey (1995) as being in a double bind. The discontinuity is held inside the manager and cannot be publicly acknowledged, as to do so would risk one’s survival at work. Other role holders introjected the split between the ‘cost’ and ‘care’ tasks. They either cut themselves off from the cost imperative of the task or cut themselves off from the service delivery imperative, constructing their own ‘illusory reality’ (Hirschhorn, 1988), by creating a fantasy world where they are in control.

The case managers and service co-ordinators turned their attention to the arena of the patient, where they felt useful and wanted. They took up roles beyond what was specified by the Model and in some cases beyond the call of duty. Patient’s receiving
case management and service co-ordination regarded the service highly (Piterman 2000a). One case manager continued to provide nursing services to a patient over Christmas, despite the end of the Trial and hence the end of her official involvement as a case manager (Piterman 2000a).

In practice both case managers and service co-ordinators felt that the demands made on them by Trial management were unrealistic, reflecting a management cut off from patient needs. They felt that the role constructs specified by the Model undermined the professional integrity of the role holder and the capacity to realistically meet patient demands. The transitory and over flexible way in which positions were constructed denied the role holder continuity with the patient. It also denied role holders the opportunity to participate in a manner that transcended the performance of a series of tasks. A number of Trial members, mainly females, most from nursing and social work backgrounds, complained about the limited task-orientated nature of the way their positions were framed, with no sense of a broader picture or vision. Treating case managers and service providers as contracted adjuncts rather than members of a team also exempted management from responsibility to the individual role holder (C.6: S.6.5.3.3). The service co-ordinators, in particular, resented the lack of patient contact specified by the Trial Model. The Model identified the service co-ordinator role as ostensibly a ‘clerical, telephone-based booking and scheduling function’ (Appendix 1) and did not involve face to face contact between the patient referred to as ‘the client’, and the service co-ordinator.

Both case managers and service co-ordinators attempted to maintain task integrity by pushing the boundaries of the role specification to take up the roles, that they believed were required to meet patient demands. They constructed an ‘illusory reality’ role (Hirschhorn, 1988) which gave them authority to take up the role they deemed necessary, but which collided, at times, with the organisational role construct (Levinson, 1959). ‘When official authority is effective, it helps role holders feel authorised to work…When official authority appears vulnerable or fraudulent people no longer feel delegated or authorised, and because they feel increasingly anxious they construct an illusory reality that cannot threaten them’ (Hirschhorn, 1988, p. 195).
Case manager and service co-ordinators’ attempts to push role boundaries resulted in tension with management, who believed that the way they undertook their roles, transgressed the boundaries of the roles set up in the Model, creating dependency relationships with the ‘consumers’. One of the criteria for the Model’s success was the achievement of ‘consumer empowerment’ through the co-ordinated care intervention (Leigh et al., 1999). Management argued that dependency relationships were not conducive to ‘consumer empowerment’. Given that the majority of individuals eligible to receive case management and service co-ordination were generally those referred to as ‘chronic and complex’, in that they were chronically ill and suffered from a number of disease groups, they were not always in a position to make informed decisions. Many were close to death, as the Trial included many persons who were very ill and had a higher than average chance of dying during the course of the Trial (Segal et al., 2000). A significant number died during the Trial implementation period (C.6: S.6.5.3.4). To collude with the notion of a consumer, as opposed to a vulnerable and ill patient, strips the patient of the right to be ill and the dignity afforded to one who is ill. It treats the patient as a consumer in the market place, who can choose what he/she buys. Framing an ill patient as a consumer in the market place obscures the reality of the illness. Moreover, treating an ill person as an empowered consumer impedes the service provider’s professional status, in that it undermines the capacity to uncompromisingly care for a sick patient.

In my role as an evaluator to the implementation process, I interviewed patients and those providing services to patients. Many were too ill to be in a position to make decisions. Some had suffered from strokes, which rendered them both physically and mentally impaired. One case involved a patient, who insisted on living alone, although she was both demented and incontinent. I interviewed her daughter, who had become stressed at having to daily go through her mother’s cupboards to remove the faeces that her mother was storing in the cupboard. Given her mother’s circumstances, she questioned the concept of the patient as an empowered consumer (Piterman 2000a).
7.6.5 Desire and ability to learn from the experience of engaging task with others.

A culture of splitting and scapegoating evident in the Trial organisation impeded the capacity for the creation of a learning environment. The culture that became apparent is consistent with behaviours Lawrence (1998) attributes to a totalitarian culture, which he and others (Schwarz, 1990; Krantz & Gilmore, 1990) view as consistent with a paranoid-schizoid stance. In such a culture, thought and capacity for thinking become diminished because of the fear of holding and expressing views which question those held by authority. Moreover such cultures cannot cope with what is uncertain and unexpected. (Lawrence, 1998).

The cost-driven construct by which Trial success was assessed resulted in a culture of measurement where performance was judged by a narrow band of key performance indicators. Weekly staff meetings were characterised by an atmosphere of intimidation. There was pressure for the achievement of outcomes, which were financially orientated. Meetings were not forums for open discussion. Rather they were reporting sessions, where individuals were asked to report on their progress regarding tangible measurements such as the recruitment of numbers, costs of patient care, service usage rates etc. Those who were deemed as not meeting standards, were coerced and publicly humiliated at meetings. A number of staff expressed their experience of being intimidated, of being ‘bailed down’. Scapegoating was prevalent in that those organisational members who did not subscribe to management’s view or who pushed boundaries and sought explanations were singled out for punishment. Individuals felt bullied, stressed and confused by the tight time constraints, and by a culture which provided no capacity for open dialogue and discussion, denying role holders the opportunity to fully take up their roles in a way that invited thinking and questioning. As a consequence role holders felt precluded from being involved in the process of change, which they deeply resented (C.6: S.6.3.2, S.5.3, S.6.5.3.2). Trial manager A in turn was being pressured at meetings of the Monitoring Committee, to which she was accountable, and which set many of the financial standards for Trial success.

The notion of a trial suggests possibility and openness to learning. A trial requires all those involved to stay with the ambiguity, and to contain the need to impose ideological
preferences, and not follow idealised models of what is believed to be cost effective and/or care effective, in order to provide the space for the emergent. For creative learning to take place, an organisation has to be in a depressive position (Stacey, 1997). According to Klein (1975), it is from the depressive position that one can experience the guilt and concern that allows us to make reparation, which is a source of creative behaviour. Winnicott (1971) introduces the term ‘transitional’ to connote a zone intermediate between inner fantasy and outer reality, between the disintegrative and ordered zones of the mind. This is the space where play and hence creative enterprise can occur. Bion’s (1961) basic assumption behaviour and its associated psychotic fantasies is akin to the disintegrative zone of behaviour for a group (Stacey, 1997). The sort of learning that genuinely enhances organisational capability is difficult to achieve in an organisational culture that is so caught up in bottom line outcomes and results, that it has no time, or inclination for exploration.

Role holders need the space to think together, bring curiosity to the task, and link ideas together in pursuit of shared purpose. If they do not feel permitted to explore and make mistakes, learning is thwarted. In order to create genuine learning environments, people must learn in public and expose both their experiences (with all their irrational subjectivity) and their areas of ignorance (Krantz, 1998). Similarly Gould (1993) argues that learning involves putting oneself in the position of learner and by doing so creating an environment for learning and creating.

A learning environment is one in which one is free to explore and ask questions. Gould (1993) uses the notion of personal authority and argues that ability and capacity to take up one’s own personal authority and shape organisational authority deeply affects how individuals take up their organisational roles, and how authorised they feel to take initiative and accomplish objectives (Gould, 1993). This can only occur in a culture that does not impose a belief system, and does not destroy individual thought by requiring collusion with an ‘organisational ideal’ (Schwartz, 1990). Without adequate personal authority one cannot hope to take up organisational authority and perform the task (Gould, 1993, Hirschhorn, 1998).
The arrival of Trial Manager B for the ‘winding down stage’ of the Trial set the scene for a reparative climate and more open relationships, which enabled a greater focus on reflection and learning. The Trial interventions had not shown benefits in terms of the financial key performance indicators (Segal et. al., 2000; Southern Health Care Network Coordinated Care Trial, 1999b) and for some, the Trial was viewed as having failed (C.6: S.6.5.1). However, there had been other opportunities for learning and these could now be explored. The efforts of the care co-ordination team, particularly the case managers and service co-ordinators were now being openly acknowledged, and their contribution sought (C.6: S.6.7). For example, Trial Manager B involved the care co-ordination team in dealing with the sensitive issue of how to manage patients’ post-Trial. This process confronted the ‘cost and care’ split that was evident during the earlier stages of the Trial between those responsible for managing the dollars and those responsible for patient health. Both groups were involved in the post-Trial initiatives and hence had to confront those parts of their roles that had been split off. For some, the attempts at reparation were viewed as long overdue, and overwhelming feelings of cynicism made this task impossible (C.6: S.6.7).

7.7 Working with an impossible/hated task

The normative primary task of the Trial was to implement the Trial Model and to test:

whether a generically applied intervention of care co-ordination, operating within a framework of existing services, can make a difference to the health and well-being of a group of ‘at-risk’ people in a defined population (Ross et. al., 1999, pp. 149-150).

Attempting to provide patient care in an environment of cost constraints is a reality that governments and health care providers are forced to negotiate and confront. How much health can be provided for a given budget outlay? To the extent that one of the constraints of the Southern Health Care Network Co-ordinated Care Trial Model was budget neutrality, resource constraints were a reality and what could be provided in terms of patient care was limited. Richardson (1998) contends that the achievement of the goal of improved health care delivery at no additional budgetary cost (budget neutrality) is difficult, if not impossible. He likens it to the difficulty experienced by a
new enterprise that is attempting to establish itself with no additional capital or access to capital markets.

Hence the normative primary task of providing patient care within the constraint of budget neutrality may well be one of impossibility. Where task impossibility can be acknowledged, the potential exists for the depressive pain to be worked with. The culture of managerialism that permeated the Trial denied impossibility and could not work with it. There was no capacity for questioning and testing of assumptions. Moreover, to do so threatened one’s survival in that the Trial organisation ejected those who had in the past asked uncomfortable questions (C.6: S.6.5.3.5). Members of this group were intimidated, blamed and humiliated into creating what was impossible, a reduction in unplanned admissions. This was despite the findings of the Unplanned/Preventable Admissions Working Party which showed that, ‘there is little evidence to suggest that unplanned admissions to be other than planned, elective admissions for acute problems or an exacerbation of chronic illness’ (Osborne, 1999).

Pressure on those providing care to reduce unplanned admissions was unrelenting.

Those that sought to provide patient care found the task of reducing unplanned admissions impossible. They could not reduce unplanned admissions, while at the same time serving the patient. The care co-ordination team felt helpless to undertake what was considered to be an impossible task, given that many of the patients were chronic and complex and at the end stage of their illness. Despite the coercive pressure placed on those providing services, unplanned admissions could not be controlled because illness and death could not be controlled. The realisation of impossibility at all levels exacerbated anxiety and defensive activity and hence the conflictual intra- and inter-organisational dynamics (C.6: S.6. 3.3.1, S.6.5.1).

Managing the implementation of the co-ordinated care process is a complex enterprise. It requires the capacity to embrace all possibilities including the possibility that providing patient care within the constraints of budget neutrality is inherently limiting. A managerialist approach, by denying the complexity and hence reality, seemed to have created a fantasy world where pain and death could be avoided by focussing on the
management of risk. A paranoid-schizoid state was suggested: reality was split off in order to avoid the pain inherent in the depressive position. The normative primary task seemed to be superseded by the phenomenal task of containing costs, such that the management of the implementation process was ostensibly about the management of financial risk. The phenomenal primary task of managing for costs may have arisen as a defence against institutional and societal pain associated with the inability to manage what is unmanageable. Management of risk became an all pervasive metaphor for the Trial and was reflected in many of the decisions that were made. This in itself proved to be an impossible task. Those who sought to manage risk found the task impossible, given the inevitability of ill health and hence of people arriving at the hospital as a potential unplanned admission.

Chapman (1999) explores circumstances in which the potential for task corruption exists. (C.4: S.4.3.2). In her article she contends that many tasks required in contemporary organisations are hated. This in itself need not necessarily result in task corruption. Task corruption emanates from destructive intent, where ‘task values’ are not protected and ‘task power’ is abusive. Chapman offers a way of protecting against task corruption by establishing a set of values, which guard against corruption of the task. She argues that a task must be ‘accessible’ in that it is viewed by task doers as capable of being achieved. Tasks that have been rendered grandiose or omnipotent, beyond the range of people’s capabilities, are susceptible to the potential for task corruption.

Hatred of a task can arise if the task itself is so ‘hateable’ that role holders substitute a phenomenal task for the primary task. A hated task can lead to role holders ‘amputating’ aspects of the task by ignoring the hated parts of the task to the point where those aspects of the task that cannot be dealt with are denied out of existence. Task amputation can constitute a form of task corruption under certain conditions. Chapman contends that vulnerability to task corruption exists when the location of the hatred it engenders at the unconscious level (of the system or the individual) cannot be worked with, and thus cannot be compensated for. The case study of the Trial implementation presented a situation where task impossibility was denied and could not be acknowledged and worked with, hence the potential for task hatred and task corruption.
Invoking the power of a managerialist approach to management may well be a defence against reality, and hence, against impossibility. At a conscious level managerialism is rationalised on the basis of moral neutrality and scientific objectivity (Rees, 1995a) and upheld as inherently good (Pollit, 1993 in Rees, 1995a). Hence the deification of commercial imperatives. Given the impossibility of providing patient care within the constraints of these imperatives, the normative primary task is split off such that task values are not protected and task power is high and becomes abusive (Chapman, 1999). This enables the abandonment of all other roles of management and the relinquishment of the normative primary task. Although in the short term impossibility may be denied, and an infrastructure established to disconnect from the patient, and from the institution of patient care, this evokes unconscious anxiety, given the inevitability of the universal reality of death, and hence the impossibility of realising unrealistic economic imperatives.

7.8 Conclusion

This chapter has argued that the market paradigm, imported from the broader corporate environment and introduced into the funding and distribution of health care, is a social defence against the lack of certainty pervading organisations and health services in particular. The Trial implementation process was characterised by a culture that sought certainty by framing the provision of health care in a manner which colluded with a fantasy of control. This resulted in ascendancy provided to those aspects of the management function that could be controlled, such as managing cost and a neglect of those aspects that were not conducive to control, such as managing illness and ultimately death. Moreover, there was no capacity to question the design of the Model and its process of implementation. The ensuing culture was one in which uncertainty, and hence reality, was denied and the capacity for individual thought repressed. These are traits consistent with what the literature describes as totalitarian cultures (Krantz, 1998; Lawrence, 1998; Schwarz, 1990).

Learning about the process of providing health requires role holders to confront their own vulnerability and that of others. Irrespective of the fantasies of omnipotence that
control strategies may offer, there is no way to control the inevitability of illness and death. Subsuming the primary task for one couched in a managerialist frame can render a primary task corrupt, as it disconnects ‘cost’ from ‘care’. To the extent that a managerialist approach denies the fullness of reality by framing the world according to what can be measurable, and ‘amputating’ (Chapman, 1999) those aspects of the task that do not collude with this fantasy, the task becomes hated and vulnerable to corruption. Attempting to maintain the fantasy through a repressive regime, so that task power becomes abusive, can render the task corrupt.
Chapter 8

Conclusion

8.1 Overview

This thesis has studied organisational dynamics during an implementation process. In particular it has studied the introduction of the Southern Health Care Network Co-ordinated Care Trial in the context of a climate where demands placed on health budgets have resulted in the introduction of market focussed reform agendas and managerial approaches to their implementation. The thesis explores the hypothesis that a managerialist frame imported from the broader social domain (Bain, 1997), and introduced into the Trial, has influenced the approach management has taken to the implementation process, with a resultant impact on the organisational culture.

The thesis argues that the ambiguity and confusion around the primary task of the Trial Model has led to anxiety expressed in conflicted and difficult intra- and inter-organisational dynamics. Failure by management to accommodate tensions that exist between providing care and managing cost led to a split in these functions. This has impacted on the effective facilitation of the change process and capacity of stakeholders to embrace the model.

Where there are problems with the definition of the primary task, there are likely to be also problems with boundaries, so that instead of facilitating task performance, they serve defensive functions (Roberts, 1994, p. 35).

This study’s conclusion is that the effective implementation of a change process requires an approach to its management that is mindful of the inter-penetration of the sentient and technical aspects of the management role. An approach to the management of an implementation process that denies the sentient task, and reduces the change process to a narrow band of efficiency indicators, limits its capacity to enrol and sustain commitment from role holders. Successful organisational change is contingent on the
capacity to enrol committed and supportive role holders, who are able to think, to work with experience, and to link creatively to others (Krantz, 1998).

Limitations in applying a managerialist approach to the management of change are summarised as follows.

First, introducing a managerialist approach to the funding and delivery of health care services approaches this sector in the same way as the corporate sector, and hence denies the uniqueness inherent in the provision of health services that sets it apart from other sectors. Health care services can only be delivered in the context of complex and often ongoing relationships. They are not like goods where consumption can be separated from the relationship (Hancock, 1999b; Buchanen, 1999). By denying the core technology inherent in providing health services, which is emotional labour, such an approach undermines the roles of those involved in providing service delivery, hence impacting on the way role holders take up their role.

Second, an overemphasis on cost effectiveness and efficiency indicators obscures and erodes the intangible public good that health care services have traditionally provided society. Besides providing care through its primary task, health care services also serve to assuage societal anxiety associated with death by providing the psychological containment for the unconscious tensions associated with the fear of death (Obholzer, 1994a; Stokes, 1994b; Morgan, 1986).

Third, such an approach operates within a unitary frame of reference (Morgan, 1986) and deals with diverging views by a process of denial and suppression (Rees, 1995a, 1995b). Managers supposedly have all the answers because facts and measurable efficiency indicators provide rationality and objectivity, which are thought to transcend political and moral controversy and therefore cannot be contested (Rees, 1995a). The consequence of this approach is that those who contest the ascendant way of viewing the world are regarded as not wanting to do their jobs and not having the right attitude. Inherent in this view of the world is that there is one truth and hence critics cannot be tolerated. This approach denies the capacity for individual thought and the creative
potential that diversity brings, and cultivates the potential for a culture of totalitarianism.

Fourth, by suppressing the reality of divergence and denying expression to differing views, the potential for collision between different interest groups with competing interests is likely to be enhanced. Moreover, the potential exists for unconscious motivations, inherent in societal interactions, to manifest and impede the change effort.

Finally, given that the debate around the allocation of the health care dollar cannot be divorced from issues of equity and social justice, a managerialist approach that focuses on efficiency measures in solely economic terms, and denies capacity for debate, has the potential to undermine fundamental democratic principles and goals of equity and justice and seriously damage patient care (Hancock, 1999b; Komesaroff, 1999b)

In choosing an appropriate conceptual framework, methodology, and method to explore the implementation of a medium term change process, there were a number of assumptions made, which derive both from the literature on change and the tacit knowledge gained from my own work as an organisational consultant. Most significant, was the assumption that managing a change process is a complex enterprise. Hence, the need was for a framework and method that is able to capture much of the complexity inherent in organisational life. Conflicts and power plays between individual and groups shape the way organisational members respond to a change process. Moreover, unconscious motivations impact on observed behaviour, even though they are mostly inaccessible to the conscious mind, hence need to be allowed for in order to better understand the implementation of a change process. Models of change, which assume homogeneity in culture and structure, do not give due weight to the human dynamics inherent in a change process (Hunter, 1986 in Pettigrew et. al., 1988a). Pettigrew et. al. (1988a) cite cases suggesting why it is impracticable and inept to apply purely rationalist models of change to the study of health care organisations, arguing that these models do not pay requisite attention to conflict and power issues, and erroneously assume organisational strategy is inherently rational.
The Trial involved the implementation of a change to the funding and delivery of health care within the bounds of budget neutrality. As the literature suggests, the allocation of the health dollar is an emotional issue. There exists significant debate around how the increasingly scarce health care resource should be distributed (Mooney, 1998; Richardson, 1998; Rosenthal, 1999). These societal concerns are played out within organisations responsible for the delivery of health. Hence understanding the implementation of the Trial Model required an exploration of the competing interests and power plays that reflected the day to day political dynamics that shaped organisational life during this medium term change process. A qualitative methodology using a complex case study method was chosen as this method enables an exploration of the detailed processes through which individuals and groups engage with one another.

While this thesis has focussed on the results of one complex case study, the analysis and debates raised in relation to the case study encourage exploration into the factors that drive the effective management of change in the health care sector. The notion of a ‘system domain’ (Bain, 1997) suggests that institutions within a sector cannot be viewed as standing alone and should take into account the wider system domain defence system. Managing a change process within the health care sector requires policy makers and managers to be mindful of the pervasive influence of the broader systems domain, in which market values increasingly determine the direction of health care. An excessive focus on a market approach, to the exclusion of other areas of interest, diminishes the capacity for pluralism and threatens the values of equality and justice.

8.2 Lessons for the future

This thesis has explored the process of implementing the Trial Model from the perspective of the players involved in an implementation process. At present discussion is under way regarding further co-ordinated care trials and the Commonwealth is now funding a new round of co-ordinated care trials. A number of divisions of general practice, the Southern Health Care Network and a number of community providers are in the process of working together to develop a proposal (Monash Division of General Practice, 2000).
What can be learnt about the possibilities of co-ordinated care by studying the experience of the implementation process? How can the learning gained from the experience of the Trial offer a contribution to future program development and more effective program implementation? How can the learning gained contribute to the health reform debate and subsequent policy?

There are a number of issues that need to be addressed to assist the facilitation of the new trials specifically, and program implementation in the health sector more generally. Any program which aims to develop closer integration of care needs to be contained within a supportive management structure, as well as a funding and policy reform agenda. These are still lacking in Australia. General practice and other health services remain unintegrated at these levels. Issues that need to be addressed include the split between Commonwealth and State funded health services and the consequent restrictions on cost-shifting between them, and the methods of payment to general practice which currently provide little incentive for integrative activities (Harris & Powell-Davies, 2000).

It is beyond the scope of the thesis to address the broader structural and financial systems that underpin the Australian health system. In this section I focus on some of the management aspects, and offer some suggestions to assist the process of health program establishment and implementation which I base on the learning that has been gained from the case study, and the experiences cited in the literature by others. In particular, my suggestions are aimed at:

1. Establishing a climate where a variety of stakeholders with diversity of interests and needs can find the commonality of purpose to develop the necessary work organisation to effectively implement a change program in the health sector.

2. Managing the process in a way that provides ‘good enough’ containment to enable stakeholders to effectively take up their roles in a manner that encourages an awareness of their relatedness to other roles (Murphy & Reed, 1990).
One of the major stumbling blocks to the effectiveness of the Trial implementation process was the failure by the managing partners to arrive at a commonality of purpose. Tension between the managing partnership resulted in equivocation and ambiguity around the primary task of the Trial Model of Co-ordinated Care. The ensuing confusion percolated throughout the Trial organisation resulting in a culture of suspicion and mistrust, and eventual splitting between the ‘cost’ and ‘care’ aspects of the task such that stakeholders could not embrace the Trial Model.

8.2.1 Establishing partnerships

A primary prerequisite for the effectiveness of a change process is the provision of a containing environment (Obholzer, 1994b; Stapley, 1996). A containing environment provides the wherewithal for individuals and groups to manage themselves and their systems in such a way as to make improved use of resources, be they psychological or physical (Obholzer, 1988). Strategic alliances/partnerships formed for the purposes of facilitating a change process need to be contained by a sufficiently ‘good enough’ environment, such that robust partnerships can be forged, and groups and individuals are enabled to take up their roles. For this to have the best chance of occurring the following suggestions are made:

1. There needs to be attention to the financial, strategic and operational dimensions of the relationship. Expectations need to be discussed, established and agreed to. Otherwise, confusion pervades as reflected in the misunderstanding regarding whether or not ‘brokerage funds’ (C.6: S.6.3.3.1) had been agreed to or not.

2. There needs to be attention to the emotional and relational aspects of the relationship. Group and inter-group dynamics are essential in realising the effort’s strategic logic (Gilmore & Seitchik, 1995). Neglecting to attend to do these can lead to performance difficulties, and/or eventual dissolution of the alliance down the track as the partnership is not able to withstand problems that inevitably arise (Gould et. al., 1999).

3. There needs to be an acceptance of the inevitability of unconscious processes between the partnership alliances. Groups coming together will share collective
unconscious assumptions about other relevant groups that constitute their social/organisational environment. These assumptions are manifested in both conscious and unconscious process, including projections, attributions, and stereotyping which shape the ensuing quality and character of inter-group relations. Despite conscious acceptance of the benefits of a strategic alliance, group relations are infused with ambivalent and paranoid feelings which unless addressed may be chronically enacted, and displaced throughout the organisation to the detriment of the alliance.

4. There needs to be an acceptance of the inevitability of unconscious processes associated with working in the health sector which are likely to further heighten projective activity discussed in (3), as attempts to defend against the anxiety associated with one’s powerlessness in the face of death become manifest.

5. There needs to be an acknowledgement of the influence of the broader system domain (Bain, 1997; Krantz & Gilmore, 1990) on both the conscious and unconscious life of a group. What influence does the broader social domain have on individual and group mental models (Senge, 1990) around health care reform, and co-ordinated care? Hutton et. al (1997) introduce an approach to assist individuals and groups explore internal mindsets that they may hold around how activities and relations are organised, structured and connected internally which involves an exploration of the organisation-in-the-mind. What is the co–ordinated–care-model in-the–mind of individuals and stakeholder groups? What impact do trends in the direction of health care reform have on how individuals and groups construct their internal models, which determine how they view co-ordinated care, their perceptions about other groups, and the way an implementation process should be operationalised? Any approach to future trials needs to explore and address how the broader domain has infused the way individuals and groups have shaped their understanding of the task at hand.

Opportunities for dialogue between the various stakeholders need to be created. Obholzer refers to the need for structured systems of dialogue to exist between the various potential component parts encouraging a depressive position state of functioning
Individuals and groups need to experience, reflect and discuss their basic psychodynamic ‘scripts’ in order to access the psychic energy, passion and the commitment necessary for the making of strategic decisions (Lazar & Lohmer, 2000). Emotional entanglement at an unconscious level prevents proper thought and action at the structural, strategic and economic levels (Gould et. al., 1999). It is only by dealing with these issues and providing the opportunities for understanding, surfacing and working through the powerful underlying feelings and experiences that arise as an alliance develops, that a possibility exits for the creation of a common culture and mode of operating. Providing an opportunity to understand and share can assist in the development of an internal holding environment. This in turn needs to be assisted by creation of effective structures, processes, and procedures to form a stable external organisational ‘holding environment’ that can withhold inevitable partnership strains (Gould et. al., 1999; Winnicot, 1960; Stapley, 1996). Failure to understand, acknowledge and work through the powerful irrational processes that may derail or infuse partnerships will undermine the quality of the collaboration, as the nature of the alliance becomes a reflection of the mutual projections, shared anxieties and the social defences against them (Gould et. al., 1999). Sommerlad (1993) in her discussion paper on alliances in the British National Health Service (NHS) suggests a formal organisation or role to perform strategic and co-ordinating functions on behalf of alliances and networks between parties.

8.2.2 Creating the containment to manage an implementation process

1. There needs to be clarity around the primary task, involving behavioural practices that acknowledge the interdependence of the task and sentient systems in the implementation of a health care reform program. A process that encourages open dialogue and discussion between stakeholders will inevitably confront the need to integrate the ‘cost’ and ‘care’ issues in relation to the task of a co-ordinated care trial, the way incumbents take up their roles and the sense of value and worth afforded those roles.

2. There needs to be acknowledgement that a managerialist approach that places emphasis on measurable outcomes as the only basis for program success denies the
more process-orientated dimensions of the ‘care’ roles and program outcomes. The more intangible considerations that make up ‘emotional labour’ need to be factored into an assessment of effective program outcome.

In short, the partnership of consortia members and the management of change processes themselves need a sensitive and responsive management that attends to internal dynamics as well as the task at hand.
Appendix 1

Roles and responsibilities of the care co-ordination function as designated in the conceptual framework of the SHCN model of co-ordinated care

The following section describes the care co-ordination model as developed by the Southern Health Care Network and Dandenong District Division of General Practice (SHCN and DDDGP Co-ordinated Care Trial, Resource Kit - July 1997). It sets out in detail how the conceptual framework depicted the way roles and responsibilities in the care co-ordination function were to be taken up.

1. General practitioner as care co-ordinator

The process of co-ordinated care focused extensively on developing the role of the general practitioner as care co-ordinator by providing the remunerative incentive and the support service through service co-ordination and case management. The Model reinforced the role of the care co-ordinator as the person with overall responsibility for the client in terms of monitoring, changing service needs and reassessing risk level. Its design was influenced by the Commonwealth’s guidelines on the Role of GPs in Co-ordinated Care Trials in 1996, which described the GP as ‘the central focus of primary health care…’(Commonwealth Department of Health and Family Services, 1996).

The Southern Health Care Network Trial Model provided for additional health services, through the care co-ordination intervention. The Dandenong Division of General Practice negotiated service co-ordination/case management agreements with the community agencies. Two case managers and two service co-ordinators were brought in from the community based agencies to support the care co-ordination function and the care planning process. Beyond this support, the Model was built on existing services in the primary/community care sectors.
The care co-ordination function involved the care co-ordinator undertaking a care plan and working as a team with the case manager and service co-ordinators to co-ordinate the patient’s care.

1.1 Becoming the care co-ordinator contingent on client nomination

Care co-ordinators were general practitioners, who consented to take on the care co-ordination function as part of the Southern Health Care Network Co-ordinated Care Trial. The process of taking on the care co-ordination role was to follow the client consenting to participate in the Trial and nominating a general practitioner to be the client’s care co-ordinator. The process of recruitment of care co-ordinators followed the ‘institutional approach’, which used hospital databases of Dandenong and Monash Medical Centre, to identify clients who met eligibility criteria. The ‘institutional approach’ involved the consenting clients to nominate their general practitioner at the time they agreed to participate in the Trial. The care co-ordinator was most often the client’s usual general practitioner. Clients without a general practitioner or any other obvious care co-ordinator were to be offered a general practitioner from a central listing of interested and supportive general practitioners. If the client’s general practitioner did not wish to participate in the Trial, the client was to be offered another general practitioner. Those general practitioners, whose patients consented to participating in the Trial and who were categorised as intervention group clients, were invited to participate in the Trial.

Other trials used ‘the GP approach’ where GPs were responsible for identifying clients or the ‘multi-focal approach’, in which referrals came from a number of sources including GPs (National Evaluation of Co-ordinated Care Trials, June, 1999).
1.2 Task of the care co-ordinator

The care co-ordinator was pivotal to the care co-ordination function. The care co-ordination function involved:

- Assessment of clients;
- Implementing a care planning process involving working with clients to identify their medical and social health needs and the services that meet those needs;
- Care plan implementation, monitoring and review;
- Integration with other service providers to link needs to services.

1.3 Care planning process

The Southern Health Care Network Model of Co-ordinated Care required the care co-ordinator to undertake the care planning process jointly with the patient. The care planning process was an integral part of the care co-ordination framework. The care plan was to be the primary communication tool by which the care co-ordinator communicated with both client and service co-ordinator/case manager. Its aim was to describe the objectives and plan of care over a defined period of time. The client and care co-ordinator were to develop a care plan, which the care co-ordinator was to oversee, implement, review and amend at regular intervals.

As part of the care planning process, the care co-ordinator was to complete a risk assessment of the patient. The risk assessment tool was the screening tool used to assess the client’s access to assistance. The degree of assistance offered essentially related to the complexity of the care plan and the ability of clients to manage that plan for themselves. The Trial offered the care co-ordinators two distinct levels of assistance to facilitate clients’ compliance with the care plan. Clients deemed to be at medium risk were to receive service co-ordination and clients deemed to be at high risk were to receive case management.

It was anticipated that completing a risk assessment and care plan would take up to an hour for clients with complex medical or social circumstances. The aim of the initial
session with the care co-ordinator was to establish, together with the client, an agreed comprehensive plan of care and to have the client agree to follow the plan.

1.4 Approval of care plan

The Dandenong District Division of General Practice was responsible for the approval of the care plan. This did not involve clinically reviewing the care plan. Rather it was aimed to ensure that the care co-ordinator filled in the relevant sections of the care plan. Once the care plan was approved and depending on the risk assessment score, the Division linked the care co-ordinator with the service co-ordinator and case manager. Clients were offered the services of either a service co-ordinator or a case manager. Where a client was being case managed and required service co-ordination, the case manager was to undertake to provide these.

1.5 Care co-ordinator accountability

Care co-ordinators were responsible to the Trial through the Dandenong District Division of General Practice. The care co-ordinators were responsible for ensuring that overall individual client care plans were relevant and remained relevant to the client throughout the life of the Trial. If significant changes occurred to a client’s health or social circumstances, the care co-ordinator was responsible to ensure that changes were made to the care plan.

2. Role of support services

Service co-ordination and case management constituted an intervention to facilitate the care co-ordination process. Case management models vary in the intensity of the intervention, in the involvement of the case manager in the client’s day to day life and in the degree of responsibility the case manager has for decision making with regard to the client and the care plans. The Southern Health Care Network Model of Co-ordinated Care focused on the care co-ordinator as the key decision maker. The case management and service co-ordination constituted support and ancillary roles.
2.1 The role of the service co-ordination

Service co-ordination was the Trial intervention applied to clients who were assessed as Level 2 (medium risk) clients. Service co-ordination involved linking clients to the health and community services recommended in the care plan and then following up to ensure that services were received by clients. The Southern Health Care Network Coordinated Care Trial Model defined this role as a ‘clerical, telephone-based booking and scheduling function’ which did not involve face to face contact between client and service co-ordinator.

2.2 Aim of service co-ordination

The aim of the service co-ordination function was to assist the implementation of the care plan by helping clients access services recommended by the care co-ordinator. In particular, it involved:

- Reviewing current service use and arranging services recommended in the care plan;
- Reminding the client about appointments;
- Maintaining regular contact with clients to facilitate compliance with the care plan, ascertaining whether problems were resolved or new ones arose;
- Recording and reporting back (written reports) to the care co-ordinator details of service use, changes to services delivered to clients, problems accessing recommended services, or problems with client compliance;
- Maintaining a diary of service use, relevant appointments and waiting list details for each client.

The Trial employed two service co-ordinators to manage about 500 patients between them. Each service co-ordinator managed about 250 clients.

Client contact was expected to be of limited intensity ‘as the scope of the job is clerical and co-ordinating’, requiring about 10 hours of service co-ordination over the 2 years trial.
2.3 Reporting relationship

Service co-ordinators were accountable to the client’s care co-ordinator for client related activity. The service co-ordinator was to report back to the care co-ordinator on all matters relating to the client and to provide a written report to the care co-ordinator prior to patient review. Administrative accountability was to the Dandenong District Division of General Practice via the care co-ordination manager.

The Southern Health Care Trial Model of Co-ordinated Care based the service co-ordinators in community health centres, in order to maximise access to valuable and relevant local knowledge and to promote links and share expertise with community service agencies. The decision to house the service co-ordinators externally was not supported by the Dandenong Division of General Practice, who preferred the service co-ordination function to be housed centrally.

2.4 Communication with the care co-ordinator

Once the care co-ordinator recommended service co-ordination, a service co-ordinator was appointed by the Trial, who made contact with the client’s care co-ordinator. This involved an introductory telephone contact to establish communication between the service co-ordinator and the care co-ordinator.

Further communication between the service co-ordinator and care co-ordinator was to occur through reminder phone calls regarding the client’s review appointments. Communication also occurred in circumstances where the service co-ordinator considered that the client needed an early care plan review date. This may have reflected difficulties in client compliance or significant changes in a client’s social circumstances.

Service co-ordinators were also required to make introductory telephone contact with clients to establish what services would be offered, to confirm aspects of the care plan, which needed some action taken and to ensure the client understands the role of the service co-ordinator.
These initial contacts will inform the service co-ordinator about the scope of service delivery, which needs intervention and the available resources.

3. Role of case management

Case management constituted the Trial intervention to clients assessed at risk Level 3 (high risk) according to the risk assessment tool. These were clients whose health needs were regarded as complex, who were socially and/or emotionally disadvantaged and whose ability to manage an agreed care plan without substantial and active support and supervision was limited.

3.1 Aim of case management

The overall aims of case management was to minimise the risk of health deterioration and maximise the chance of health improvement by intensive clinical co-ordination and monitoring of the Trial client’s compliance with the care plan.

Wherever possible clients with a case manager already in place were to have the same case manager for Trial purposes. Clients with no obvious case manager already in their circle of health and community care providers were allocated a case manager by the Trial.

The process of case management involved active and regular telephone and personal contact through home and hospital visits with clients, family, carers and service providers. The aim was to facilitate and direct activities with a view to assist clients comply with the care plan and to alert the care co-ordinator to pertinent changes in client circumstances. It also involved monitoring the client during an acute sector episode.

Case management had a clinical focus and a clinical monitoring function, which required a considerable and sophisticated understanding of disease states, treatment regimes and health networks (community, acute hospital, general practice). The ability
to discriminate between insignificant problems and those likely to exacerbate a client’s state of health and possibly cause a need for hospital admission was a basic skill of case managers.

Each case manager had a caseload of high risk clients. It was expected that an average high risk client, who received case management would have 72 case manager hours allocated over a 2 year period, with provision being made for individual circumstances.

The case manager was to be directed by the client’s care co-ordinator - via the care plan - with specific aims of avoiding unplanned hospital admissions, minimising service duplication and establishing ongoing communication between specialist, acute sector medical practitioners and general practitioners. It was designed as a support role ‘to foster the client’s ongoing relationship with the care co-ordinator and not for the case manager to become a care co-ordinator.’ The model emphasised the temporary nature of the relationship between case manager and client. ‘The client will be encouraged to view case management as an off shoot of the care plan, not an additional ongoing clinical connection’.

A secondary aim and a vehicle to secure the communication described above, was to try and minimise a client’s length of stay in hospital after any admission.

3.2 Reporting relationship

Administratively, case managers reported to the care co-ordination manager. Clinically case managers follow the direction determined by the care co-ordinator via the care plan and liaised and reported regularly with the care co-ordinator on all client related matters.

3.3 Links with the acute sector

When clients are admitted to either hospital, the Trial was to be notified to enable communication with care co-ordinator for all Trial clients in the intervention group. For clients receiving case management, the case managers were to ‘follow’ the client into the hospital system and actively promote the role of the care co-ordinator in the client’s
care. The case manager was to participate in discharge planning, arrange case conferences and promote early discharge wherever appropriate.
Appendix 2: Additional Data

This appendix constitutes additional data to that provided in the case study in chapter 6. It aligns with the sections set out in chapter 6, such that section 3.4 in the appendix follows on from section 3.4 in chapter 6.

3.4 Failure to arrive at common purpose: Split between cost and care roles

There was much disaffection manifested in high turnover of staff, and staff becoming caught up in the political agendas of the managing partnership.

There are different goals and agendas from different players. There is no concept of a team. This is a part of the leadership problem. When Mary left there was no fanfare to see her off. If anybody leaves they leave on bad terms. (Care co-ordination manager A, interview 4)

I’m leaving because I have been frustrated in my role, I didn’t believe in the process of co-ordinated care. My heart was not in reconsenting. I had done two lots of recruitment and the third lot did not appeal to me. Trial prides itself that it has a fantastic data base and they can create all this longitudinal information MBS PBS. But they have no IT support. Now we have a high paid consultant, who comes in a few days a week. Lack of access to IT frustrates all our roles. There’s not enough ownership for me to go on. There’s not enough ownership in my job. For example, I couldn’t go to the conference. I do all that work and someone else presents my work. (Recruitment manager, interview 3)
I left the Trial because my contract has expired but I do not want to stay on because there is no direction or room for advancement. (Trial administration employee C)

A split ensued in the organisation of the Trial between those supporting what was perceived as a Network agenda and those supporting what was perceived as a Divisional agenda, resulting in a divide between those responsible for managing costs and those responsible for the delivery of the care co-ordination function. This was played out in the day to day organisational dynamics of the Trial and became embedded in the culture of the Trial creating antipathy between those responsible for management and those responsible for service delivery.

I do not see myself as being in line with the Trial. I will not meet overall objectives of the Trial because the results I get are unlikely to demonstrate change. What we are looking for is improvement in quality of life not health utilisation and health costs. The management and service delivery functions are neighbours but not necessarily cohabiting. Karyn (Trial manager A) is not really concerned about quality of life issues. (Case manager A, interview 2)

Both parties have brought in baggage with them. There is acute sector baggage and community sector baggage. (Trial Manager A, interview 3)

4.1 Tension around objectives of co-ordinated care:

What is overt and what is covert

Difficulties in establishing a workable partnership base, combined with a complex model that had to be implemented in tight time constraints influenced stakeholder perceptions of the Western Alliance Health Care Network Co-ordinated Care Trial. Although there was general support for better co-ordination of patient care, there was confusion about the Model’s operations and concerns expressed around the existence of ‘other agendas.’ In particular there was a concern that the Trial was a front for a Government cost cutting agenda and the potential dismemberment of Medicare. General
practitioners were suspicious, fearing government intervention and the introduction of ‘managed care’, with its potential to dismantle the current system of general practice.

If you believe that co-ordinated care is for the benefit of the patient, then I have no problems with the concept and there is no conflict because we are all on the same side. If this is for the benefit of some other party such as governments, then there is potential for conflict because different parties have different agendas. (Care co-ordinator F)

The Trial is focussed on working with community based case managers, general practitioners and service providers and to communicate with general practitioners and engage them so that they can provide better co-ordination of care. But I believe that this is not the only agenda. Care co-ordination is a front for something else. There is a mega purpose and I am not sure where they are coming from I am interested in care co-ordination and I am not a political person. But care co-ordination has a background agenda. Something else is going on behind the scenes. A seamless service provision across the Network seems to be main agenda (care co-ordination manager A, interview 1)

Trial is about cost shifting and getting people through acute sector more quickly. But if we are looking to pool funding, we need to convince providers that co-ordinated care is more than this. There is some suspicion and lack of trust. If it makes the service system more rigid, then we will be reluctant to pool money, although we may have no choice. We need to openly discuss certain questions, such as how is this going to work, who makes the decisions as to what services can be bought for the client. Does client make decisions? If client is empowered to make those decisions, what is a case manager’s duty of care to ensure the client does not get ripped off by providers? (Health service agency)

The purpose of the Trial is to decide whether it is useful to have case managers and service co-ordinators and whether clients’ health can be
improved and they can be kept out of hospital. (Case manager B, interview 1)

4.2 Rushed and confused

The tight time frame meant that there was insufficient time to effectively involve the broader health system. The perception particularly during the first year of the Trial suggests other agencies and stakeholders felt confused with the Southern Health Care Network model of Co-ordinated Care. The Model was poorly understood and stakeholders expressed feelings of exclusion from the Trial initiative. They were not able to translate the Model into a way that was meaningful for them and were not able to identify significant benefits from a health systems perspective.

Initially there was no understanding of the Co-ordinated Care Model despite Karyn’s (Trial Manager A’s) attempts at training. Neither the staff nor the doctors understood the Model. The model is conceptually complex in the terms of health system reform. People need to be able to translate it into a way that’s meaningful for them. Whether it’s hip pocket reform or whatever, it needs to be understood. Some doctors saw it as a managed care reform. They feared that they were going to lose control, and feared that we did not successfully counter the possibility that they would lose control. There is anxiety about something new. We did not successfully bring them on board. I wonder if there is some way that we could have done this differently at the beginning to get people on side. (Trial manager B, interview 2)

We see no difference with co-ordinated care. Its been going on for a year, and it’s been like a fog. We are not sure who is doing what. (Discharge nurse, Acute sector)

The Trial had to make decisions fast; there is no time for dialogue. Of the nine Trials the Southern Health Care Network Co-ordinated Care Trial was the first Trial to get up and running. It was the first Trial to get the
recruitment. We did not have the luxury of consultation. We had a short
time frame to get things done. It was not possible to do what we were
supposed to do in a tripartite agreement and bring in consultation. (Trial
manager B, interview 2)

At the beginning there was so much fear. The Trial was trying to explain
what we really didn’t understand. We assumed or I assumed others
understood. But nobody really understood. (Role holder responsible for
bridging understanding between Division and Network, focus group A)

The Trial was so busy trying to manage the task that we did not look at the
implications of the task. It was hard to focus on. We were trying to do the
task without thinking of what effect the task was having on the
environment. We should have considered more about marketing to the
broader health system and we should have considered more about closure
issues. The system was excluded. Other agencies did not know about the
Trial. Other agencies and community case managers from other agencies,
always had problems providing reports to us. People from the post acute
care did not really see a big difference. We were so internally focussed that
we missed the boat externally. (Case manager A, focus group A)

5.1 Focus on outcomes: Focus on unplanned admissions as key success indicator

The emphasis on unplanned admissions and pressure to achieve substitution created
anxiety in those responsible for the delivery of care, as this requirement for performance
was viewed as an unrealistic goal. The care co-ordination team felt helpless to undertake
what was considered to be an impossible task. The care co-ordination team felt their
performance was contingent on the unrealistic goal of reducing unplanned admissions,
achieving substitution. They felt that management was focussed on costs to the extent
that the quality of health service delivery was of no interest. Many of the patients were
chronic and complex and at the end stage of their illness, hence were likely to end up in
hospital as an unplanned admission irrespective of attempts to care for them in the
community. Focus on outcomes (getting unplanned admissions down) was seen to take precedence over the provision of health services. Health care professionals felt that the Network priorities were not interested in co-ordinating patient care.

The emphasis was on cost and reducing unplanned admissions. The Division felt enormous pressure to cut costs, even though we were told the cost is not the driving force. It was assumed that there would be some magical way that GPs would reduce unplanned admissions, just because they were care co-ordinators. We thought we were testing co-ordinated care and assessing services and rewarding the general practitioner for care planning and case conferencing. When things were not going the way the Network wanted it to go, it was somehow implied that GPs were not doing enough to improve things. Was it assumed that through care planning you would actually get unplanned admissions down? Divisions feel a lot of pressure is on the GPs as a whole. Division feels that there is the expectation that GPs as care co-ordinators must raise standard of care and stop people being admitted into hospitals. The fact is that no matter how well you as a doctor co-ordinated care the socio economics factors can get in the way. We will not show improved outcomes if our performance indicator is cost. There are positive outcomes but they will not show up if we continue to be so cost focussed. None of the Trials have been able to address or reduce the unplanned admissions. Sometimes people need to be in hospital because the intervention was often too late in the program of chronic disease, or there may not have been no social support and the best place for the patient was to present at the hospital. Because of the population based design of the Trial and the fact that the range of patients are diverse, it was not possible to impact on the Trial in the way the Trial management expected the doctors to impact on the Trial. People are seen as offenders or reoffenders or recalcitrant if they come into hospital. We should consider it not as unplanned admissions but rather as unexpected admissions. (Executive Director Division, interview 4)
In the middle part of the Trial, the big focus was on computer, funding pool, and substitution. The stuff about care co-ordination was ancillary to the Trial. When we talked about service gaps on the ground, we were not heard. There was a huge emphasis on getting substitution. We were called into meetings to try to figure out how we would get substitution. The fund pooling, achieving substitution was a big phase in the Trial. There was pressure to achieve this but this was an unrealistic pressure. We did not have brokerage funds, plus a lot of people were sick and they belong in hospital and we were not going to get substitution. On the whole the funds pool and substitution and the computer system and unplanned admission was what was important. They were what dominated; they were the things that we were looking at. The care co-ordination model, our role, the GPs role, the rigidity of the risk assessment tool was not looked at. (Service co-ordinator A, interview 7)

Service co-ordinators have no way of saving an admission sitting at the other end of the phone and as for case managers, unless they have brokerage funds, which they didn’t, to buy services in the home, you are not going to stop them, the patients, from going into hospital. Plus there are the chronic complex patients, who are so ill that they will inevitably end up in hospital, irrespective of what you do. The expectation of us was unreal. We left the Trial team meeting feeling we had not met expectations. We used to hate those team meetings. They were all about outcomes. I don’t even know what the expectations were. People were doing their job and what other achievements could be made. Karyn (Trial manager A) was saying, “Why aren’t GPs getting involved? Why aren’t their behaviours changing? It’s up to you”. (Care co-ordination manager B)

Over last 3 months it was found that unplanned hospital admissions were higher for the intervention than the control group, which means care co-ordination is not working and I am not doing my job. Karyn (Trial manager A) came to me with a list of unplanned admissions and the implication for
me was that my case managers and service providers are not doing their job.
(Care co-ordination manager A, interview 2)

Although we cannot prevent admissions, we were able to reduce the time and admission stays in the acute sector. But the Network is not interested because these costs are the same once they hit the acute sector. We were told we had to achieve substitution, but substitution was not qualified. There was no process to track ourselves and to assess whether there is substitution.
(Case manager A, interview 4)

5.3.1 Cynicism towards Trial focus

There was cynicism towards the Trial and the integrity of its focus was questioned

What has Trial done? You cannot ask patients “do you want us to cut your lawns for you?” The Network (the Trial) does not provide funds for helping patients who need help. We are doing co-ordination to the limits of what is available for the fees we get. Where is the money for co-ordinated care? Co-ordinated care was supposed to offer us more opportunity but there is no slack in the system. There is no opportunity for physio. We need psyche services and more in the field of rehab and physio as well as OT (Occupational therapy) and speech therapy. We need a PADP scheme (extra help in house) to set up an alternative to hospitals. Trial had opportunity to do all these things but didn’t. So, for example, we couldn’t support hospital in the home. If we got people out of hospital early and purchased care in the community, that was not of interest to the Southern Health Care Network because they would end up paying more because of the way case mix works. (Care co-ordinator A, interview 1)

For the general practitioners we’ve shown that they can create a care plan, and identify services, but in the end, irrespective of how brilliant the care plan is, you cannot implement it if you cannot enable people to have the services. The general practitioners said they may be able to plug up holes in
the dam and they may have felt more supported with case management and service co-ordination, but in the end it would not make a difference if you were just plugging the holes. (Executive Director, Division, focus group A)

5.3.2 Cynicism towards management

The relationship with the Trial manager and the staff has been problematic, particularly with those who have responsibility for the care co-ordination function. Divisiveness was prevalent and a number of role holders complained of being scapegoated publicly if they were not perceived to achieve targets set out in the Model. There was also a suggestion that data be misrepresented to meet management needs.

I do not like Karyn’s (Trial Manager A’s) management style because people are not included in the decision making process. I do not feel valued. Karyn behaves as if she does not trust people. She behaves as if we are dispensable. She does not tell us what she is doing and when she is not there. She sets up people. She positions herself in between and buffers herself using other people as a shield. I am very uncomfortable when she tries to do it to me. People feel disenfranchised. Karyn is good with money but not with anything else. In the end finance will be the only indicator for Trial effectiveness. People I work with talk about getting another job. There is confusion about our contracts and a lot of anxiety about when contracts will be renewed. In meetings one person gets targeted all the time. It’s often Rhonda. When you target people in the group, the meeting loses trust. (Care co-ordination manager A, interview 2)

Karyn’s style of management is divide and conquer. It’s about giving her control. Others are disempowered and disenfranchised. I feel like a meat in the between the Trial and the Division. Service co-ordinators and case managers are the meat in the sandwich between the agencies and the Trial. (Care co-ordination manager A, interview 4)

No one talks to each other. I don’t think that there is one person who knows what coordianted care is all about. I don’t think Karyn (Trial Manager A)
has her finger on the pulse. It is not a happy environment here. People meet at lunchtime. They talk about work, but people will never talk about what they feel. They will never talk about the real issues. They talk to one another quietly about it. A lot of people say that if another job popped up they would take it. I am looking for another job. I am putting in applications in between doing work. There is a difference in management of the Trial and management of the people. How do you know whether you are doing a good job? Often I do not know whether what I have done is relevant. I do not know if I am doing a good job. There is no performance indicator of my work. Janet supports me when I need to discuss things with her. I would have liked to do a lot more training courses, but I was not given the time for these. I feel it was considered a waste of time for me to do the courses. (Trial administration employee C)

I did not like the management style. I always felt there was some agenda that I did not understand that there was something that I ought to know and I felt incompetent. Karyn (Trial manager A) must be under enormous pressure. There is a lot of money going out of the Southern Healthcare Network and they (Network) resent it because it’s going towards the Trial. They say ‘what is happening to our dollar’? So this puts pressure on Karyn. The other thing is that politics have become a bit ‘school yardish’. People tell me exactly what she says about me and that makes me feel terrible (Executive Director Division of General Practice, interview 3)

Pressure on Karyn (Trial manager A) was enormous to achieve substitution. There was criticism of her style in that people felt that she was not available because she was wearing a number of hats. People were ‘pissed off’ because she was not around and then came back and criticised. I like the fact that she wanted to hear from all of us about what we were doing and she wanted us to understand the big picture. The management was dealing with the political and policy issues, we were dealing with the grass roots. We brought a human element into the Trial, because we had to meet the demand and the needs that we were being confronted with but the Trial
itself was not about being human. When I came here people breaking down and crying. (Service co-ordinator A, interview 7)

However there were those who supported the management.

I like working for Karyn. It’s different working for a female manager. She is good tempered and understands. For example when my son got into trouble at school she understood. (Personal assistant to Trial managers).

Karyn has CEO characteristics. She is black and white. But she is supportive to me. She is a good manager and she has vision. (Trial manager B, interview 1)

5.3.3 Lack of perceived support for the care co-ordination function

There are not many resources put into this position. A new person will be taking over my job. She is supposed to be doing it in four days, so there are even fewer resources put in to client work. Value of what we do is not as much value as the political agenda. But they must realise that they need to support us in what we do, otherwise the Trial will not work. (Service co-ordinator B, interview 2)

I do not go to progress meetings often but when I do it is all about KPIs (key performance indicators). No one is asking how clients are getting on. It’s as if Trial believes it will be evaluated on KPIs. Management does not communicate. The left hand doesn’t know what right hand is doing. We find out after the event. We know things are happening such as the planning day but we have no idea when it was on. I am not consulted about decisions coming out of the GP reference group. (Trial administrative employee D)
5.3.5 Lack of culture for reflection and exploration

There is no vehicle for professional discussions about what works and what doesn’t. Any involvement with the GP Reference Group was only with one of us at a time, where we gave them information. We never knew what was going on in the GP Reference Group. We were never invited to be part of it. We’re just there to provide them with information. There are progress meetings, which we are never invited to. For example at the last one, there were discussions about how many case managers, service co-ordinators are going to be required after June. We were not given that feedback, but the decision was very threatening to us (Case manager A, interview 3)

I need direction and I do not get any. Maybe they need someone who is tougher than me. My role does not just demand task orientation. It demands human resources and sensitivity. I’m pretty good and do not doubt myself often but occasionally I begin to feel uncertain about myself. Occasionally I feel someone else could do a better job. I went and did an introduction to management and paid for it myself, I did not want to tell anyone. I wanted to do it, and it gave me the confidence that I am doing the right thing. My management style keeps people in jobs and does not bully them. There are times when I have seriously thought of leaving, but I have other goals that I am pursuing. I have survived by detaching myself from the Trial. (Care co-ordination manager A, interview 1)

The care co-ordination manager felt undervalued and this reflected through to case managers and the service co-ordinators. I know at the end of those Tuesday progress meetings I would have to debrief her. The care co-ordination site has been problematic. Expectations were not explained. (Care co-ordination manager B)

They (case managers and service co-ordinators) resent saying things, because now they feel they’re not heard and they have not been included. They are the lowest cogs in the wheel, or they have been so in the past.
Doctors as well treated them as ancillary citizens. They would have liked more recognition in the early days and they would have liked more input. For example, there are things that arise just by the very nature of being present at a meeting. They did not know about these things because they were not invited to team meetings so they fell behind the eight ball. They were not invited to the Strategy Day either. (Care co-ordination manager B)

Focus is funds orientated. It's about getting care plans in so we can get funds activated. Service co-ordinators and case managers are not getting the resources required to fulfil their positions. Although there was all this focus on computers, we were last to get computers and last to get computer support. Attention was focussed on the funds pool and substitution and there was no attention given to the care co-ordination model and ways it could be improved. (Service co-ordinator A, interview 7)

The case managers and the service co-ordinators have been dumped with carrying the anxiety of the care co-ordination process. (Role holder responsible for bridging understanding between Division and Network, focus group A)

I felt there were restraints. There were things you could not question, assumptions that you could not question. There were discussables and undiscussables. There were things that people were not ready to hear. You could not question the focus on cost savings. This was the big agenda item. How can you achieve cost savings and do health cheaper? The Trial could have been more action research orientated if there was a will. We were doing and not reflecting. These have been limitations. The roles have changed but the systems and structures that we operate in have remained static. Interventions have remained static. For example we have had inflexible care planning with inflexible time frame. There has been no flexibility to change systems. (Service co-ordinator A, interview 7)
I was handed a two page flyer about what the Trial is about and whenever I asked what the process was that brought about the decision, I realised I could not ask questions. I could not ask how come this is happening. We were all at war. There were secret plans. You were not allowed to ask what the plans are. (Case manager A, interview 4)

Are we interested in research or are outcomes already preestablished? Were we interested to find out what would happen or did we decide as to what should happen? Is this supposed to be learning? (Trial administration/IT employee A)

There are many undiscussables, things that we are not allowed to talk about. We could not talk about the dilution effect, so many Level 1s and nothing done for them. We could not talk about the fact that a level 1 going to GP for a once a year visit is not significant. We could not talk about the selection criteria of $4,000 as too low to identify those who were high cost users. We could not talk about the care improvement panels, which the GP Reference Group said that were not supposed to be part of the Trial. (Care co-ordination manager A, interview 4)

They did not want us at the meetings. They stuck rigidly to the model. They did not want to know what we had to say. They feared the data. They were more concerned with how many care plans were back. If they had spent more time at the outset clarifying roles and expectations things would have gone better. It was a culture of doing not of reflecting. (Case manager A, focus group A)

6 Relationship within the care co-ordination system

Those that eventually came on board saw the role of case management/ service co-ordination as beneficial but limited in that it was only applicable to situations where the patient is complex chronic, which constituted 5% of people on the Trial
Co-ordinated care is something that general practitioners have been traditionally doing for a long time but perhaps not that well. 15 years ago and earlier there weren’t a lot of facilities out there. You had your local general practitioner, physio, district nurse, and home help. Over last 10 years a lot of paramedics and other services sprang up. It’s difficult to keep up with what is out there. One of the positive things about co-ordinated care is that it enables us to make decisions through the case manager. We cannot keep up with all the services, out there. Working with the case manager has been a positive experience. (Care co-ordinator N)

Similarly the case managers and service co-ordinators viewed general practitioners as being limited in holding the role of care co-ordinator, believing in some instances that case managers/service co-ordinators were better equipped to undertake this function.

Case management is a huge task and if the general practitioner is not going to do it, someone else has to. It needs to be done if we are going to keep people out of the acute care. When we get care plans from the general practitioner, we do our own mini assessment on top of medical assessment and let general practitioner know about social aspects. More often than not, they do not know the social aspects. Ignoring it would be ignoring a big piece of the jig saw puzzle. For example a patient is diabetic, has a heart condition but he is also emotionally abusive and having an alleged affair with his wife’s daughter (stepdaughter). I could have chosen to ignore this information, but I did not. (Service co-ordinator A, interview 2)

Doctors do not take much notice of the service co-ordinator report. For example, I will ascertain that patient uses eight services and doctors will tick less than three. It’s as if they do not read the service co-ordinator report. (Case manager B)
7 Winding Down Phase: Reparation

There has been some improvement in morale of staff during this phase, as the focus of Trial has become more reflective in its orientation. There has been a greater emphasis on learning and reflection. However this has not occurred without some cynicism. For some it is too late.

I didn’t realise that it was almost deliberate not to have them at the meeting. There was a management directive that they do not come. That changed because of Jean (Trial manager B). They were reinstated but it was a bit too late. There was lots of action at the beginning. There was tension between the coalface and management. I don’t know if it has changed. People have unfortunately got used to the split. In some instances the damage has been done and has put some people off. Initially when I took over this position we discussed the split at length and tried to take action. Now the case managers and service providers get invited to the weekly meetings. (Care co-ordination manager B)
Appendix 3:
Consent

SWINBURNE UNIVERSITY OF TECHNOLOGY
HUMAN EXPERIMENTATION ETHICS COMMITTEE
FORM OF DISCLOSURE AND INFORMED CONSENT

Introduction of coordinated care in the Southern Health Care Network: Perceptions around the management of change

INTRODUCTION AND RATIONAL TO THE DOCTORAL RESEARCH

The purpose of the doctoral research is to explore the organisational dynamics associated with the introduction of coordinated care in order to learn more about effective program implementation and hence more about the effective management of change.

The doctoral research focuses on the perceptions of the Trial management team in the implementation of coordinated care. Specifically this will be around the ways:

- goals are set;
- roles are constructed;
- tasks are undertaken and performed; and,
- the project has been managed.

It also seeks to explore the perceptions of major stakeholders including the Division of General Practice, members of the general practice reference group and general practitioners in the community, who are all key stakeholders in the Southern Health Care Network Coordinated Care Trial model. What were their experiences of coordinated care? In particular, what were their perceptions around interventions such as the risk assessment tool, care plans, case management, service coordination, and care improvement panels as well as the management of the funding pool?

The research aims to evaluate process and explore organisational dynamics during a period of change.
Exploring organisational dynamics involves exploring organisational structures, decision-making processes and management systems of the Trial. It involves exploring and examining difficulties and conflicts that have ensued in the process. It involves understanding relationships both within the Trial and between the Trial and those it interacts with. Researching the dynamics of an implementation team over a period of two and a half years provides an opportunity to learn more about the nature of change over time. By observing what works and what does not work, there exists an opportunity to refine and clarify some of the current thinking and assumptions about the management of change.

There are both benefits to the individual and society associated with conducting this research. A greater appreciation of changes taking place in our own health system and its impact on major stakeholders adds to the body of knowledge about change management and health care reform. It also enables the development of theories, which enable extrapolation to future program development, more effective program implementation and policy making.

You are free to withdraw consent and to discontinue participation in the study at any time.

The investigators are Hannah Piterman and Susan Long (Supervisor)

Any questions regarding the project titled Introduction of coordinated care in the Southern Health Care Network: Perceptions around the management of change’ or questions concerning the procedures can be directed to the Hannah Piterman are of Susan Long of the School of Business on telephone 92148145.

In the event that you have any complaint about the way you have been treated during the study, or a query that Hannah Piterman (Senior Investigator) has been unable to you can write to

The Chair  
Human Experimentation Ethics Committee  
Swinburne University of Technology  
P O Box 218  
HAWTHORN. VIC. 3122
Evaluators

Dear Fellow Evaluators

As you know I am in the process of undertaking my doctorate. My topic is ‘Introduction of coordinated care in the Southern Health Care Network: Perceptions around the management of change’. I have enclosed a copy of the proposed research.

The Higher Degrees Committee at Swinburne University of Technology has approved my doctoral proposal. I have also received ethics approval from the Swinburne University of Technology, Human Experimentation Ethics Committee to conduct my doctoral research.

I am seeking interviews to ascertain
• your perceptions of your role as a member of the evaluation team
• your perceptions of the issues impacting the trial (management, data, presence of evaluators, fact that this is a trial) and
• anything else that you consider relevant to the evaluation of the Southern Health Care Network Coordinated Care Trial.

Thank you for your support so far.

Yours sincerely

Hannah Piterman
Doctoral Student
Swinburne University
Trial Organisation

Dear

Thank you for your interviews.

The interviews were conducted for the purposes of gathering your perceptions of the Southern Health Care Network Coordinated Care Trial and have been incorporated into reports to the Southern Health Care Network and the National Evaluators. I would like to incorporate some of the material into my doctoral thesis, which is titled ‘Introduction of coordinated care in the Southern Health Care Network: Perceptions around the management of change’. I have attached some preliminary details of the purpose and focus of my research.

The Higher Degrees Committee at Swinburne University of Technology has approved my doctoral proposal. I have also received ethics approval from the Swinburne University of Technology, Human Experimentation Ethics Committee to conduct my doctoral research.

Although the Southern Health Care Network has sought and received ethics approval for the interviews I conducted with you, I am seeking your consent to use some of the material in my doctorate. I have written to Pauline Ross and Jan Davies and have obtained their in principal approval. I now seek your consent to use material from our interviews for my own research.

Enclosed is a consent form, which enables me to use the data you, provided in the interview I conducted with you. My fax number is 95336811.

Thank you for your support so far.

Yours sincerely

Hannah Piterman
Doctoral Student
Swinburne University
General practitioner

Dear Dr

Thank you for your interview.

The interview was conducted for the purposes of gathering your perceptions of the Southern Health Care Network Coordinated Care Trial and have been incorporated into reports to the Southern Health Care Network and the National Evaluators. I would like to incorporate some of the material from the interview conducted to use in my doctoral thesis, which is titled ‘Introduction of coordinated care in the Southern Health Care Network: Perceptions around the management of change’. I have attached some preliminary details of the purpose and focus of my research.

The Higher Degrees Committee at Swinburne University of Technology has approved my doctoral proposal. I have also received ethics approval from the Swinburne University of Technology, Human Experimentation Ethics Committee to conduct my doctoral research.

I am seeking your consent to do this. Although the Southern Health Care Network has sought and received ethics approval for the interviews I conducted with you, I am seeking your consent to incorporate some of the material into my doctorate. I have spoken to Ann Peak from the Dandenong Division of General Practice and her suggestion was that I seek individual consent from doctors that I have interviewed for the coordinated care trial

No additional interviews are required. Enclosed is a consent form enabling me to use the information. My fax number is 95336811.

Thank you for your support so far.

Yours sincerely

Hannah Piterman
Doctoral Student
Swinburne University
Consent Form

I have read and understood the information. Any questions I have asked have been answered to my satisfaction.

I agree the research data collected for the study may be published on the condition that my name is not used.

Name of Participant

Signature                  Date

Name of Principal Investigator

Hannah Piterman
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