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Implementing National Health Reform – Is Organisational Culture the Key?

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ABSTRACT

Implementing National Health Reform – Is Organisational Culture the Key?

In a famous quote attributed to Peter Drucker 'culture eats strategy for breakfast'. The impact of local health organisation culture on the implementation of national health reforms has been noted in a range of studies (Davies 2002; Franco et al. 2002; Ormrod 2003). This classic 'top-down versus bottom-up' disjunction (Sabatier 1986) reflects the competing perspectives on health policy held by different actors in the policy subsystem (Palmer and Short 2010).

This paper reports on the application of the Cameron and Quinn (2011) Competing Values instruments to front line health care management (Scott et al. 2003). In the context of the Tasmanian Department of Health and Human Services, the Competing Values results suggest that the top-down, economic focus of the Australian National Health Reform Agreement (Council of Australian Governments 2011) is antithetical to the professional culture and orientation of local health service providers.

The implications are that a change management approach to local organisational culture is required for the successful implementation of national health reform. Preparatory work undertaken in this area by the Chief Executive Officer, and other senior staff, within the Southern Tasmanian Health Organisation is outlined.

Tasmania is not unique in these matters. This paper will be of interest to other jurisdictions, policy-makers and policy implementers.

The Evolving Landscape of Local Services

Through the *National Health Reform Agreement* (NHRA), the Australian Government has initiated a major restructure of the health system (Council of Australian Goverments 2011). The stated aims of the Australian Government is to end the political 'blame game'; to increase local ownership of health services; and to increase access, efficiency and funding transparency (Commonwealth of Australia 2011).

Prior to mid-2012, the Australian Government part-funded State governments for the provision of health and public hospital services, largely on a 'block funding' basis. Hospital and other health services were, in turn, largely block-funded by the State government, based on historical levels of service provision and previous funding allocations. In many states and territories, including Tasmania, these historical allocations proved insufficient to meet current demand, resulting in regular cost over-runs. These were generally resolved with 'top-up' state funding to health and hospital services at the end of each financial year. In turn, states and territories would try and back-fill their budgets by pressuring the Australian Government for additional health and hospital funding.

Aged care was funded through a mix of Australian Government, State Government and consumer contributions. Primary health care, largely delivered by General Practitioners, was also subject to this funding mix. Private health insurance supported primary health care and private hospital care and, to a limited extent, public hospitals.

The NHRA commits the Commonwealth, state and territory governments to implement new health system funding arrangements, including the establishment of local hospital networks and Medicare Locals. These new arrangements are being phased in over time, with different elements being put into place between 2012 and 2018.

Medicare Locals are funded by the Australian Government and expected to promote coordinated primary health services (including access to General Practitioners, nurses and other health professionals) and work closely with local hospital networks. These organisations have transitioned from the Commonwealth-funded General Practice Divisions/Networks to a broader base in primary health.

Over time, the Australian Government is to have the majority funding and policy responsibility for aged care services, including the Home and Community Care program, in all states and territories except Victoria and Western Australia.

The *Tasmanian Health Organisations (THO) Act* 2011 is the legislative mechanism that establishes local hospital networks in Tasmania, in line with the requirements of the NHRA (Parliament of Tasmania 2011). It outlines the powers, functions and governance arrangements for THOs, their Chief Executive Officers (CEOs) and Governing Councils.

As independent statutory authorities, THOs have autonomy over the day-to-day management of hospitals and other health services. They are directed by legislation, however, to use certain client services (such as Ambulance Tasmania) and corporate services (such as payroll), in order to achieve state-wide economies of scale. They are also required to establish local clinical governance arrangements.

Under these arrangements, the State Government is responsible for service planning, purchasing and performance monitoring, through the Tasmanian Department of Health and Human Services (DHHS). This is described as 'system management'. The Ministerial Charter and the Service Agreement are the main instruments for Government direction.

National Financial Drivers

The Australian Government continues to provide part funding for hospital services. This funding is now determined in a number of ways, the three main being:

- an activity based funding (ABF) formula which takes account for patient acuity;
- 'block funding' for rural and regional hospitals and for teaching and training functions; and
- through National Partnership Agreements for specific activities/levels of activity.

Penalties for not meeting set activity targets have also been put into place. Both the new funding arrangements and new penalties are being phased in over time, in line with changed service delivery arrangements.

Both the ABF formula – the 'national efficient price' of public hospital services – and the 'block funding' formula are to be determined by the (new) national Independent Hospital Pricing Authority. It is to be informed by a (new) national Clinical Advisory Committee representing clinicians and a (new) Jurisdictional Advisory Group consisting of representatives from states, territories and the Australian Government. The Independent Hospital Pricing Authority will also call for public submissions each year, to inform its work.

A (new) National Health Funding Pool, run under an independent Administrator, is to hold and distribute funds to local hospital networks and to State managed funds. A (new) National Performance Authority is to monitor and publish the performance of local hospital networks and Medicare Locals. The current Australian Commission on Safety and Quality in Health Care is named in the NHRA as expanding its role to monitor and publish clinical performance against national standards (Council of Australian Goverments 2011).

Intended and Unintended Consequences

The continuation of the dual funding roles, and the evolving landscape of local services, is highly unlikely to end the political 'blame game' between the Commonwealth and the states (Palmer and Short 2010, 81) as health policy implementation is not a 'purely technical exercise of assessing health needs and providing resources to meet those needs' but is 'inevitably influenced by the demands of powerful structural interests in a political market place'.

The creation of local hospital networks – the Tasmanian THOs – do, however, create legal entities which are at 'arms-length' from Government, much like other Tasmanian Government Business Enterprises such as Forestry Tasmania and Hydro Tasmania.

The inclusion of Governing Councils in these arrangements may increase local 'ownership' in the sense of sharing the responsibility for delivering health and hospital services as specified by the Service Agreements and within the broad policy directions of the Ministerial Charter. This does not equate to local control (Woodruff 2011).

National financial drivers may increase funding transparency but the increase in patient access and system efficiency that is expected from the move to ABF ignores the on-going fragmentation of the primary care and hospital specialist care under the new arrangements (Arya 2011). Although some authors applaud the emphasis on population health and service planning role that will be taken up by Medicare Locals (Keleher 2011), this division of labour maintains the acute/primary care divide. It also separates public health planning from the state government units that have developed expertise in this area. The impact of this new division of responsibilities on the public health role and capacity in other areas, such as pandemic control, is yet to be tested.

A more immediate impact of these new arrangements is the move towards ABF, at a 'nationally efficient' price. DHHS data shows that Tasmania's average cost-weight adjusted separation has been consistently above the national average since 2005-06. The additional cost for services delivered above the nationally efficient (average) price will be met solely by the state/THO, with no Commonwealth contribution. This will strongly focus the attention of Boards and CEOs and Governments on cost reduction. This is clearly one of the key intended – if unwritten – consequences of the NHRA and reveals it to be primarily an economic reform program.

The Importance of Organisational Culture to Policy Implementation

The health and human services sector is characterised by professional staff who hold considerable authority and autonomy, impacting directly on client and budgetary outcomes. Structural change, by itself, will not change the behaviour of front-line practitioners (Parker and Glasby 2008, 449) due to barriers such as 'low level of ownership for organisational outcomes; an inability to change clinical attitude and behaviour;… low levels of policy awareness and organisational deliverables'. This represents a classic 'top-down versus bottom-up' disjunction for policy implementation (Sabatier 1986).

While structures provide context and communicate important message about what is important (Davies 2002, 142), 'organisational cultures help shape the ways in which structural reforms play out'. This is because neither policy nor organisations are value-neutral. There is a substantial literature on the impact of values, beliefs and assumptions on policy (Sabatier 1987; Sabatier and Weible 1999) and also specifically in relation to health policy (Ormrod 2003; Littlejohns et al. 2012a; Littlejohns et al. 2012b) and health reform (Sturmberg et al. 2012).

As an expression of values, beliefs and assumptions, organisational culture may pose a risk to policy implementation (Franco et al. 2002, 1262): 'any reforms that threaten values shared between workers, whether this be a sense of team spirit, or a desire for autonomy due to one's professional status, are likely to be resisted'. Or, in the words of a famous quote attributed to Peter Drucker, 'culture eats strategy for breakfast'.

The impact of organisational culture may be particularly relevant in health policy: the context of a complex organisation, where professionals hold considerable authority and autonomy (Braithwaite et al. 2011, 259): 'a plan for reform of the health system must take into account differing stakeholders' objectives and values'. More broadly, organisational culture has been shown to have an impact on organisational performance and effectiveness in the healthcare environment, in Australia and elsewhere (Lok et al. 2011).

In the context of Tasmania, research mapping organisational culture amongst DHHS front-line and middle managers suggests that the 'top-down' economic focus of the NHRA is antithetical to current organisational culture. Over the nine months between September 2011 and May 2012, 132 participants (middle/front-line managers and aspiring managers) participated in six DHHS Management and Leadership Foundation Courses and documented their beliefs about their own professional approach and the DHHS organisational culture.

Measuring DHHS Organisational Culture

Organisational culture is not a 'surface' phenomenon, it is undetectable most of the time. There are a number of instruments currently in use to describe and categorise management roles and organisational culture in health care (Scott et al. 2003). The Competing Values instruments (Cameron and Quinn 2011) have been widely applied in a broad range of contexts. Documented studies within the health and human services field have occurred in Australia (Leggat et al. 2006), the United Kingdom (Michie and West 2004; Hann et al. 2007) and the United States (Wicks and Clair 2007; Gregory et al. 2009). The Competing Values approach has also been used in staff development programs (Faerman et al. 1987).

Foundation Course participants complete three Competing Values questionnaires and, as part of the process of group work, their ideas and reflections on the results are written out for display and discussion by table groups. The first of these three, the Competing Values Management Survey (Quinn and Cameron 1983, cited in Edwards, Yankey and Altpeter 1998) looks day-to-day activities and results in scores against various 'roles' and foci (Figure 1).

Figure 1. Competing Values Management Roles (Quinn 1988)

Flexibility

Internal	**Facilitator** helps interaction, is diplomatic, tactful. **Mentor** shows consideration, is caring, empathetic.	**Innovator** envisions change, adopts a creative approach. **Broker** acquires resources, is politically astute.	External
	Coordinator maintains structure, is dependable and reliable. **Monitor** collects facts and information, is technically expert.	**Producer** initiates action, is task oriented and work focused. **Director** provides structure, is decisive and directive.	

Control

The documented results of the Competing Values discussions have been largely consistent across all Foundation Course groups. There is a numerically and substantially strong identification with the Mentor and Facilitator roles as most health and human services participants/managers strongly believe that they try to show personal empathy and individual concern for staff and clients. The documents describe the managerial role as 'engaging in conversation continually to support, guide, give/receive feedback' (March 2012) and 'mentoring informally as part of the role' (September 2011). Participants also state that they

generally prefer an inclusive, consensus decision-making style with which to resolve conflicts as they arise: ‘exploring opportunities with staff/stakeholders/colleagues’ (May 2012).

The second most common roles that emerge in the results are those associated with Coordinator and Monitor. Coordination, in order to maintain a well-organised unit, anticipate workflow problems and avoid crises is supported by the Monitoring role, which describes compliance with rules, records, reports and error-checking. This was seen to be central to team work and the basis of the management role. Comments included the need to be ‘realistic and optimistic’ when delivering services (April 2012). There was a recognition that this experience is ‘often role dependent’ as ‘the person is drawn to the placement – if not can be the wrong person/wrong job’ (March 2012).

Producer and Director roles – associated with delivering on results, quality improvement and goal achievement – were cited more often than the Innovator and Broker roles. The delivery of safe, quality health and social care is, more often than not, bound by regulation, legislation, evidence-based practice and scientific compliance. Even when respondents felt they were personally inclined towards a more innovative and experimental approach, the requirements of their role may not enable this. From the participants’ point of view the question is ‘how do personality styles match with roles needed in current jobs?’ (September 2011). For senior management, the question speaks to how to create an appropriate place for innovation within the health and hospital system.

The second Competing Values questionnaire administered as part of the Foundation Course is the Organisational Culture Assessment Instrument (Cameron and Quinn 2011). Scores are first calculated for the current organisational culture and then for how the organisation needs to be in the future if it is to achieve its goals. This results in scores against four organisational culture types (Figure 2 below).

Most participants describe the current DHHS as a controlled Hierarchy: ‘all fairly similar with emphasis on control’ (October 2011); ‘dominated by control’ (September 2011); ‘our organisational culture is heavily controlling (managing)’ (April 2012). This was not always seen as a bad thing: ‘acknowledge that control is still very important in our roles within health due to legislations/regulations’ (September 2011).

The next strongest current organisational culture was that of the cooperative Clan. This is not surprising – as one table put it: ‘we are all coordinators – so we have cooperative control’ (April 2012). The Rational and Adhocracy cultures were less often cited in the current culture. The results describing the desired future organisational culture also showed a stronger preference for the Clan approach with ‘better leadership/nurturing’ (October 2011); ‘in future less control – more teamwork’ (April 2012).

However, both Hierarchy and Adhocracy were preferred as a ‘second stream’ approach, with calls for ‘evidence based management’ and a balanced approach that included ‘setting constructive boundaries still allows a balance of innovation and risk’ (September 2011). ‘Control and management with a personal touch’ (April 2012) with ‘more freedom to be creative’ (October 2011).

Figure 2. Competing Values Organisational Culture Types (Cameron and Quinn 2011)

Flexibility

	Clan Cooperative: a very friendly place to work where people share a lot of themselves. Our organisation is held together by loyalty and tradition. Commitment is high. Our organisational culture focuses on teamwork, participation and consensus. We collaborate.	**Adhocracy** Responsive: a dynamic, entrepreneurial and creative place to work. People stick their necks out and take risks and have a commitment to experimentation and innovation. Our organisational culture encourages initiative and freedom.
Internal		External
	Hierarchy Stable: a very formal and structured place to work. Leaders pride themselves on being good coordinators and organisers who are efficiency minded. Our organisational culture focuses on stability and performance with secure employment and predictability. We control.	**Rational** Market: a results-orientated organisation whose major concern is with getting the job done. People are competitive and goal-oriented. Leaders are tough and demanding. Our organisational culture focuses on the achievement of measurable goals and targets.

Control

The third and final Competing Values exercise undertaken during the Foundation Course, the Fundamental Leadership Survey (Quinn 2005), requires respondents to identify a demanding leadership experience from the past – a time when they were at their best as a leader – and to check off a list of qualities displayed. Participants are then invited to think about how their 'usual' job is undertaken and to check off the list of qualities displayed in their 'normal' or 'day-to-day' work. These results are discussed.

The documented results of the Fundamental Leadership Survey discussions suggest a disjunction between managers' self-described 'core values' and the opportunity (or lack thereof) to express these – simply 'not liking the decisions you have to make' and 'lack of motivation/commitment to the decision' (November 2011). Participants felt that they 'don't have control over governance' (October 2011) and that their day-to-day is taken up with 'people business', 'supporting/motivating people', 'keep staff attention in the face of pressure from public' (March 2012). Beyond the people-issues, focus was on 'avoiding unnecessary crises', 'trying to maintain work life balance' and to 'look after oneself' (May 2012).

The conflict is consistently described as resulting from 'both the position and individual management priorities' (October 2011). At the same time, there is a strong sense that 'position impacts on role and vice versa' (September 2011) and that this requires 'some adaptation to role requirements' (March 2012).

Discussion, Implications for NHRA Implementation

The Competing Values surveys present an overall picture of the 'typical' DHHS manager as someone who has a holistic and humanistic approach - focusing on people first, in order to coordinate and monitor the delivery of safe, reliable services. She operates within an organisation that currently over-emphasises control, and is perceived as a rigid, siloed and bureaucratic. This leads to a certain degree of alienation from 'management' decision-making. She would like a more balanced organisational approach into the future, with an increase in the ability to personally innovate creatively to achieve results. Improving how the organisation competes, as measured by the achievement of externally-set goals and targets, was not identified as a personal priority, although recognised as a national trend.

It is acknowledged that the dominant roles (Mentor and Facilitator) are more congruent with the methodology used to collect the data than are the other roles available in the Competing Values framework. Group work results in 'collaboratively generated knowledge' (Kolfschoten et al. 2011) and respondents most comfortable in these collaborative, communicative roles were also most likely to express these characteristics during the Foundation Course. Similarly, the emphasis on the Clan approach to organisational culture has been typically associated with professional autonomy within formal (bureaucratic) organisations in health services (Mannion et al. 2009).

The ability to talk about a single organisational culture in an organisation of over 11,000 employees, delivering the full range of health and community services across the whole of the state, is also limited. At the same time, each employee has a picture of 'their DHHS', depending on where they work.

Foundation Program participants are middle, front-line and aspiring managers – a particular 'slice' of DHHS that broadly reflects the distribution across the professional, organisational, and geographic divides. The only exception to this picture is the relative paucity of medical staff participants. These are significantly under-represented in the participant profile.

The overall organisational culture measured is the result of each of these subcultures combined. Cameron and Quinn (2011) acknowledge that organisational culture is made up of a number of subcultures, but maintain that each of these subcultures contains common attributes that make up an overarching culture typical of the entire organisation.

The DHHS Competing Values exercises have clear implications for NHRA implementation in Tasmania. As noted previously, the introduction of ABF at a 'nationally efficient price' will require an organisational focus on cost-effective delivery, based on measurable goals and targets. This is a focus that is not emphasised in Foundation Course participants' Competing Values results at present: either through management roles, organisational culture, or leadership style. The organisational expectation that managers will prioritise these goals runs the risk of further alienating them from active participation in organisational governance.

These results also shed light on the clinician/administration divide so prevalent in health and hospitals – there is a relatively poor alliance between education in clinical speciality and work environment. While individuals may emerge as clinically sound, they may not be temperamentally fit for the current service environment, resulting in significant tensions. These tensions are likely to be exacerbated in a system increasingly designed in a financial, rather than clinically informed, way (Abbasi 2009).

Work in Progress: Transforming DHHS Organisational Culture for the Future

There is no doubt that change is possible. Large, longitudinal studies using the Competing Values instruments on National Health Service Hospital Trusts in the United Kingdom show a change in the organisational culture balance. Over the course of the implementation of a series of 'pro-market' policies, including increased competition and payment by results. Over a seven year period, questionnaire results showed the shift from an extremely strong emphasis on the Clan approach to an equally strong emphasis on the Rational approach. The study also showed an increase in Hierarchical or bureaucratic organisational culture over this time, which the authors relate to the increase in clinical guidelines and protocols (Mannion et al. 2009).

The information emerging from the Management and Leadership program provides some indication as to the on-going staff development required in order to position Tasmanian organisations advantageously under ABF and the NHRA. Where this work has already commenced prior to the publication of these results, as is the case in Southern Tasmania, it provides additional support for the approach being taken.

As part of the preparation for the implementation of the NHRA in Tasmania, work has been undertaken by the CEO, and other senior staff, within the Southern Tasmanian Health Organisation. This has included a series of six 'Delivering on Results' workshops (full day or half day) undertaken between October 2011 and March 2012. More workshops are planned for the second half of 2012. To this point, a total of 175 staff have attended.

The purpose of these sessions has been to give staff information, knowledge and confidence, with increased capability and permission to manage in the new environment. Topics have included sharing an understanding the current financial position, the impending ABF environment; how the organisation can become more efficient in relation to resource management, rostering and leave management; and exploring the impact of organisational culture: what is it now and what do staff want it to be into the future.

The workshops have communicated the need to be accountable and achieve results in relation to the incoming national financial drivers. The initial focus was to develop shared goals, with agreed Key Performance Indicators (KPIs) as indicators of progress towards those goals, so that they would be realistic, and meaningful to staff.

The key challenge is to translate the value of a focus on KPIs as beneficial for clinicians and patients. Top-down funding reform needs to mean something to clinicians who have had no involvement. Key opportunities for THOs in the new environment have been identified as a chance to reduce bureaucracy, increase transparency and to progress agreed-on goals. Because the money follows the patient, there is the opportunity to take a stronger emphasis on patients and the decisions clinicians make about their care.

As the NHRA is incrementally implemented over the next several years, there is no doubt that organisational culture will influence the ability of existing services to make a successful transition to the new structure.

Tasmania is not unique in these matters. This paper will be of interest to other jurisdictions, policy-makers and policy implementers.

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