LOCAL ORGANISATIONAL AND SOCIO-POLITICAL CHARACTERISTICS IN URBAN COMMUNITY HEALTH SYSTEM DEVELOPMENT

Mohammad Afzal Mahmood

Thesis submitted in fulfilment of the requirements for the Degree of Doctor of Philosophy

Department of Public Health

University of Adelaide

February 1999

TABLE OF CONTENTS

LIST OF TABLES

LIST OF FIGURES AND DIAGRAMS

ABSTRACT

The main objective of this research has been to analyse the role of local organisational and social factors in community-level health system development in two Australian regions. On the basis of an extended report of empirical work in Western Adelaide and South Western Sydney, the thesis argues that health system development at the interface between service and community is a political process which becomes more tangible in the face of an organisational change. On the basis of my field research, I argue that local health services resist the efforts of health bureaucracies to displace the political with rational arguments about the development of the health care system.

The inspiration to undertake this work arose from difficulties in reorienting the health service provision in one district of Karachi, Pakistan towards a district health system based on primary health care. Those efforts highlighted some barriers to an effective role of the community in health system development.

The Australian settings chosen to investigate these ideas were the Western suburbs of the Adelaide metropolitan area and South Western Sydney. At the time of the research, an amalgamation of community health services at the regional level and a greater coordination of the public sector health services with general practice were being implemented respectively in these areas. These changes provided windows to identify how the proposed organisational changes were perceived and implemented by the local health care workers and the community.

Community health services acquire specific characteristics, such as a dense network of relations with other organisations and community members, with a resultant ability to negotiate a proposed change and make it fit somewhat to the local needs. The community configuration in terms of multicultural orientation, cohesion, and economic prosperity determines the level of community participation. These services acquire a particular mode of working under the influence of these networks and needs. Changes in a health region create turbulence and political activity comes to the fore, revealing existing networks and their importance. Services then evaluate any proposed change for its potential effects on the local needs, local networks and the work patterns.

DECLARATION

This thesis contains no material which has been accepted for the award of any other degree or diploma in any university or other tertiary institutions and, to the best of my knowledge and belief, contains no material previously published or written by another person, except where due reference has been made in the text.

I give consent to this copy of my thesis, when deposited in the University Library, being available for loan and photocopying.

Mohammad Afzal Mahmood

February 1999

ACKNOWLEDGEMENTS

I wish to acknowledge the support of many people. Their support at both professional and social levels was a major factor helping me to complete the research and the writing. Firstly and most importantly – my special thanks to my supervisors, John Moss and Neville Hicks, for academic support and encouragement. They were always available whenever I needed their advice. Their help stretched from supporting me in conceptualising analysis framework to organising access to the research sites. My special thanks for their personal and social support as well.

I am deeply indebted to all the interviewees, for sparing time to help me gain an insight into the working of the local health services. I am thankful to the managers from various community health centres for providing access to documents relevant to the research.

I wish to thank my fellow students and friends, Stephen Gray, Hessam Lahsaee, Anne Stacey and James Flint, for their social support as well as for their timely and helpful comments on my research and thesis. I am especially thankful to Stephen Gray for his readings of sections of my thesis and his help on computer hardware problems.

I am thankful to the staff of the Department of Public Health, the University of Adelaide, for providing a supportive and friendly environment. I am especially thankful to Anthea Page for her help with transcribing the data and for her support in dealing with word processing problems. My sincere thanks to Annette Braunack-Mayer, Jane Edwards and Judith Raftery for their helpful comments on my research. I

am highly grateful to Tony Worsley, Carole Gannon, Nicky Hudson and Brian Symon for their support. Thanks are also due to Gay Lewis, Florence Kalambokas, Peta Guy, Deidre Simpson, and Phil Ryan.

I wish to thank the University of Adelaide for granting me an Overseas Postgraduate Research Scholarship. I am grateful to the Department of Community Health Sciences, the Aga Khan University, Karachi, Pakistan for granting me an extended study leave.

My sincere thanks to Professor Ian Webster and Associate Professor Adrian Bauman for their help in organising my stay and data collection in Sydney. Thanks are due to the South Australian Health Commission and South Western Sydney Area Health Services for allowing me to include area maps in the thesis.

Beyond my professional circle, I am deeply indebted to my friends Ahson Umar, Atta-ur-Rehman, Javed Qureshi, Nasir Mahmood, Dr. A. K. Farooque, Khalid Farooqui, Ehsan ul Haq and Isolde, and families of Hessam Lahsaee, Stephen Gray and Rebecca Brian.

Finally, my special thanks to my family members; to my wife Sheba for her support for my studies, to my son Airaf who missed his grand parents, cousins and other childhood chums because of my studies, and to my daughter Anamta for cheering me whenever I felt sad.

I dedicate this thesis to my mother and father whom I could not visit in the last four years as they waited patiently for me to complete the thesis.

CHAPTER 1

Overview

1.1 INTRODUCTION

> *"Organisational change encompasses a lots of things – what is important is that we continue to ensure that the mainstream health services have basic awareness of and sensitivity to the needs of a diverse population."*

This was what a health worker said to me about her own perceived role within a changing organisation. Her remark highlights how services and personnel become concerned that a proposed change might not be sufficiently sensitive to locally specific health and health care needs. To keep it in tune with the local realities, they try to adapt the change proposal.

The last three decades of this century have seen major changes in the organisation of public sector health services. One of the most salient examples, particularly in developed countries, has been the shift towards regionalisation. Another is the reorientation of health systems towards primary health care under the influence of the Health for All movement. Both developing and industrialised countries have subscribed to the ideology – although the actual movement towards primary health care (PHC) has been achieved to very different degrees by different countries. Generally, the driving force behind regionalisation has been the ideology of 'economic efficiency', particularly in industrialised countries where the epidemiological and demographic transition as well as technology-intensive hospital-based care has put enormous pressures on budgets earmarked by government for public sector health services.

The rise of these organisational concepts can be traced to an increased awareness that curative medical care and vertical programs aimed at the prevention or eradication of a particular disease cannot achieve optimum health[1]. Achieving better health is more difficult, particularly for those communities that do not have access to an equitable share of social and physical assets. The perceived government shortage of funds, and the promise that Community Health Services (CHS) might reduce overall health care spending are other reasons for an increased emphasis on the change towards community-based health services as well as changes towards regionalisation and new funding arrangement.

As is the case with the overall health care system, the CHS are going through various organisational changes in an attempt to maximise efficiency (sought by governments) and effectiveness (sought by CHS proponents). Efficiency has been the more powerful value, if one considers the plethora of regionalisation, district health systems concepts, and changes in the funding arrangements such as contracting-out and the purchaser-provider-separation. Once formulated at the top levels of the hierarchy, these changes are presented to local services for implementation. The community setting, including local health and social services, has certain characteristics which play an important role in determining the fate of the policy and the effectiveness of the resultant health services. However, policies targeted at community health services often fail to consider the role of that community in policy implementation and health services development.

[1] The term Vertical Programs is often used to define special health programs at the country/state level that target a particular disease or a health issue. These programs are managed and delivered often through a separate infrastructure at the national level. These programs were very common in the late seventies and eighties. Malaria Eradication and Tuberculosis Control are examples from developing countries. The Measles Eradication Program re-introduced in Australia in 1998, in the wake of an increasing threat of epidemic outbreak, could be considered an example.

The community – local people, services, and personnel – tries to influence the policy during its implementation phase to make it serve local needs. How a community attempts to adapt a change, by negotiation and even resistance modifies policy development. However, this process is often not seen by the hierarchy as a legitimate policy process. For that reason, resistance by the community to a given policy is erroneously perceived to be unnecessary and counter-productive.

While coordinating a program to reorient local governmental health services in a district of the Karachi metropolitan corporation, I observed this resistance process first hand. This experience led me to speculate that often organisational change policies do not address the local context in which they are to be implemented. In turn, this motivated me to attempt to understand the process of policy development at the local level.

1.2 AIM AND OBJECTIVE

- The overall aim of this research was to find out the role of the horizontal linkages at the community level in influencing the vertical link between a local agency and its central management. In effect, this was to understand the role of street-level workers and community members in implementation of policies proposed by the hierarchy.

- The objective of my research was, then, to explore and enhance understanding about community level organisational and socio-political factors influencing the development of local health care systems in urban settings, using two different

Australian examples. In the light of my understanding of Karachi's health services context, I began with a presumption that the existing organisational network of health services in a region and its socio-political context shape, to varying degrees, the implementation of health system development strategies and their intended outcomes.

Globally, a large number of people now live in urban areas. In developing countries there is an unparalleled growth of urban areas because of the concentration of industry in these areas. By the year 2025, there will be more than 30 mega-cities of more than 10 million people. Karachi is already a mega-city. While Australia is one of the most urbanised nations in the world, it has no mega-city, though Sydney-Newcastle-Wollongong may be headed that way. However, Australian cities present quite a few problems, which are common to cities around the world. There are sub-populations which are socio-economically disadvantaged, and accessibility to health services is uneven; poor communities are less well served[2].

Urban communities have their own peculiar problems such as a lack of community identity, environmental pollution, and ethnic conflicts. Some cities also become a centre of political activity against the incumbent government, leading to subtle punitive actions such as delaying development of their social infrastructure. Professionals often do not live in the urban communities in which they work.

[2] It should be noted, however, that while intra-city inequalities do exist, there is a major problem of urban-rural imbalance in health services provision in Australia. That urban-rural inequity is not the subject of this thesis, however.

Considering the structural barriers for socio-economically disadvantaged people to study at higher levels, this is truer for poor urban communities.

The organisational framework at the local level sets the stage for, and influences, the pace of the implementation of new initiatives. Comparative analysis of the two Australian study areas reveals overlapping as well as discrete (area-specific) factors which need to be considered when planning and implementing developmental strategies. Such cross-site qualitative analysis is an effective method of identifying major patterns at various sites[3]. Significantly, the health systems favoured in developing countries frequently have their conceptual origins in developed countries such as Australia and the UK. For me, studying the Australian health regions was important from this perspective as well.

1.3 RATIONALE

One of the factors which influence national health systems is the ideology adhered to by the international health and development related institutions. Other contextual issues which determine patterns of health care delivery include: the dominant political ideology; resource availability; general patterns of national governance; and medical technology.

I argue that the organisational properties of local health services and also social factors influence health policy development. Organisational issues such as the extent of

[3] Herriot RE, Firestone WA. Multi-site qualitative policy research: optimising description and generalisability. Educational Researcher 1963; 12:14-19.

pluralism in health care, the interaction between public and private services and between health and social services, the fragmentation of various types of health care, and the level of harmony between different levels of government all may affect health system development. Local social phenomena having a bearing on the process of change in health services include the configuration of the community in terms of classes and conflicts and economic development. This thesis focuses on the interaction between such local contextual factors and organisation of health care. Social factors are considered, not only because they influence the need and demand for health services, but also because organisational phenomena cannot be understood unless the role of the culture is understood[4].

1.4 OVERVIEW

This research is an exploratory field study, introduced by a discussion of the organisational and socio-political context of health services in one district of Karachi. This discussion is utilised to establish a framework for my analysis of two Australian health regions - one in Adelaide and one in Sydney. The criteria used to identify health regions in the Adelaide and Sydney metropolitan areas included that the population size be comparable to the notion of a 'health district' (discussed in some detail in chapter 2); the potential of the area to provide insight into important social issues; the range of health care services provided; and a recent organisational rearrangement. Although these two case studies and the example of the Karachi district health system development identify some parallels, they reveal much specificity as well. The findings

[4] Schein EH. Organisational culture and leadership. San Francisco: Jossey-Bass, 1985.

inform us about the processes within community settings as they influence policy development at the local level.

Chapter 2, Definitions, defines for the purpose of this thesis, some key terms. These terms include organisation, policy, community, community health and primary health care.

Chapter 3, Health services in the community: stakeholders and their interactions, covers some important literature on CHS and its development in Australia. The review focuses on three concepts: community health services; organisational change; and the policy development process particularly during the implementation stage.

Chapter 4, Pakistan – organisational and community characteristics, briefly describes the community setting and the health system in Karachi, Pakistan. This discussion aims to identify important socio-political, cultural and health services factors which impinge on the implementation of developmental strategies, as well as on the effectiveness of health services. This narrative is based on a close working relationship with the various levels of health care providers and their parent institutions, and an interaction with the community members, and developmental agencies.

Chapters 5 and 6 cover **methodological concepts** and an outline of organisational and social **characteristics of the study sites** respectively. In the methodology chapter I have tried to highlight not only the research method but also the factors which have relevance for the validity and generalisability of the research. Data collection

techniques included in-depth interviewing and focus groups, conducted among health care providers, consumers and community. The data were analysed by classification into significant classes of processes and interactions. Emerging categories and patterns were challenged to define alternative explanations in the light of secondary data, relating to responses to and the fate of past organisational changes. As this research considers the role of local organisational and community characteristics with respect to policy development, it is important to know the context within which these health services exist. Chapter 6 provides an overview of the community setting, leading to the discussion of the role of the setting in the next four chapters.

Chapter 7, Framework for policy analysis: community perspective, provides, in the light of the field research, an approach to analysing health system development from a community perspective. While the literature review, observations in Karachi and the research in Adelaide and Sydney helped develop this framework, I have placed this chapter before the discussion of the situation in the research sites (Adelaide and Sydney). This is because this new analytic framework incorporates the concepts of "participation", "interaction", "personnel", and "organisation" in the local policy development process, and also because the chapters on the changes in Adelaide and Sydney are described using these concepts.

Chapters eight and nine describe the implementation of the amalgamation of CHS in the Adelaide metropolitan area. **Chapter 8, Amalgamation of CHS: perceptions in the community**, addresses how the amalgamation was perceived by the staff of various health and social services and the community members. These perceptions, which were based on the existing situation in the area and the role of the hierarchy,

determined who took what action. **Chapter 9, Amalgamation of CHS in Adelaide: a horizontal view**, discusses the implementation process and considers the attempts of local stakeholders to influence local health system development.

Chapter 10, Integration of Area Health Services in South Western Sydney, aims for further understanding of the community and area characteristics which help or undermine changes in the pattern of service provision. Because of the difference in the nature of the policies – amalgamation in Adelaide and integration in Sydney – it becomes apparent in chapter 9 and 10 that, while community dynamics directly influenced policy implementation in the case of the Adelaide amalgamation, they were only indirectly influential in the Sydney integration. The main direct policy players in the case of integration were organisations and their staff (at the individual or professional group level). This is in contrast to the amalgamation, where community individuals and groups were also directly concerned with the change.

Chapter 11, Promoting the community perspective in policy development, summarises important concepts and highlights the contributions of this research to the study of health services organisations and their working in the local context.

CHAPTER 2

Definitions

Terms such as organisation, policy, structure, community, primary health care, and community health services are central to the discussion of the organisational and socio-political context of community health services. Often terms such as primary care and primary health care are used alternatively in health department documents. For the purpose of the thesis, I use these terms as defined in the following few pages.

2.1 ORGANISATION

Organisation in this thesis means a formal group which fulfils the criteria suggested by Blau. He defines organisations as formal groups which have procedures to mobilise and coordinate the efforts of subgroups and individuals in the pursuit of joint objectives[1]. At a more specific level, Weber's account of bureaucracy provides criteria to define an organisation. Those criteria ask for a set of rules and regulations and task distribution. Organisations have a hierarchical authority, specialised administration staff, and impersonal orientation of their officials[2].

Using a sociological framework, organisation refers, in this thesis, to what sociologists define as the 'formal' organisation, having certain goals, rather than to the 'social' organisation, which refers to structures such as families and which operate without any explicit goals[3]. Formal organisations lay out clear administrative (financial and personnel) frameworks to achieve those goals.

---

[1] Blau PM. On the nature of organisations. New York: John Wiley & Sons, 1974.
[2] Weber M. The theory of social and economic organisation. Glencoe; Free Press 1947.
[3] For a discussion of the definition of the formal and social (informal) organisations in terms of goals, social interaction and integration see David Silverman (1970) chapter one "Organisations: problems of definitions".
Silverman D. The theory of organisations. London: Hienemann, 1970.

2.2 POLICY

Although policy, as a political activity, could be considered as any vision, legislation, or practice that is based on value judgements, in this thesis I use Considine's definition of policy "as the continuing work done by groups of stakeholders who use available public institutions to articulate and express the things they value"[4]. This definition is more applicable to the type of policy I consider in this thesis – the amalgamation of CHS and integration of public and private services[5]. The focus, in this thesis, is on legislative change proposed by the health department or the area management for internal restructuring of services. "Health Policy" in the sense of an act of parliament and which changes the funding or emphasises on the health system at the national level is not the main concern of this thesis. My aim is to identify the policy actors at the local levels.

2.3 STRUCTURES AND ENVIRONMENT

The environment of an organisation consists of other organisations, individual community members, community groups, clients of health services, and professional interest groups. The term structure refers to the network of relations between these various elements of the environment as well as the socio-political dynamics of the community. This usage of the word "structure" is borrowed from anthropology where

[4] Considine M. Public policy: a critical approach. Melbourne: McMillan Education Australia, 1994.
[5] For types of policies see Lowi TJ. Four systems of policy, politics and choice. Public Administration Review 1972; 32:298-310.

it denotes relations between people or between people and things[6]. In that tradition, social structure refers to the enduring, orderly and patterned relationship between elements of a society[7]. This usage of the word structure is in contrast to its use as a synonym for organisational structure and which leaves cultural and social factors in the community not as a part of it but in direct conflict with it. Literature on community health often uses the term structure for organisational structures. One such use is found in the article by Valdez et al[8].

In summary, in this thesis, the word "structure" is used to discuss community-level political and social dynamics and inter-organisation relations, against the more traditional and commonly-used term "environment of health services". In other words, structure includes both the elements of the environment and the interaction between these elements.

Environment	Other organisations, community members, groups, professional interest groups.
Structure	For this thesis: service and policy related interaction and relationship between various components of the environment (environment plus linkages).

To point to the internal organisational factors such as size, availability of specialists,

---

[6] Williams R. Key words: A vocabulary of culture and society. London: Fontana Press, 1983.

[7] Similar definitions of social structure are found in Political Sociology by Tom Bottomore, and in Social Theory as Science by Keat and Urry (1982).
Bottomore T. Political Sociology. London: Hutchinson, 1979.
Keat R, Urry J. Social theory as science. London: Routledge & Kegan Paul, 1982.

[8] Valdez RB, Giachello A, Rodriguez Trias H, Gomez P, de la Rocha C. Improving access to health care in Latino communities. Public Health Rep. 1993; 108: 534-9.

power relations, and hierarchy I use the phrase "organisational characteristics".

2.4 LINKAGES

Linkages refer to interactions between an organisation and its environment. As defined earlier, 'structure' includes these interactions, and the literature on the type and extent of community structures provides information on organisation-organisation and community-organisation interactions[9]. These local interactions take various shapes and characters and are classified into 'inter-agency' (inter-organisation or service-to-service) and 'inter-professional' linkages as well[10].

Another way to classify linkages is to rank them into 'vertical' and 'horizontal or lateral'. Horizontal linkages exist between local agencies, between agencies and community members, and between agencies and local political groups. Vertical linkages exist between the more central management hierarchy and the agencies in the community[11]. Interaction and linkages are used alternatively in this thesis much as they are used in the literature. Network is another term often used to represent such interaction.

---

[9] Wellman B, Berkowitz SD, editors. Social structures: a network approach. Cambridge: Cambridge University Press, 1988.
Freudenberg N, Golub M. Health education, public policy and disease prevention: a case history of the New York City coalition to end lead poisoning. Health Education Quarterly. 1978; 14:387-401.

[10] Hunter DJ. Managing the cracks: management development for health care interfaces. Int J Health Planning and Management. 1990; 5:7-14.

[11] "Centre" denotes higher-level decision and administrative functions, such as at the level of Health Commission, in contrast to the local agencies operating within the community.
A description of the link between centre and periphery in the Australian context is provided by Sax.
Sax S. Organisation and delivery of health care. In Gardner H, editor. The politics of health: the Australian experience. Melbourne: Churchill Livingstone, 1989.

2.5 COMMUNITY

A community is usually defined as people with a shared ideology and common goals. On the one hand, community is defined as political entity and refers to the patterns of social interaction[12]. Others, however, have discussed the concept of community as an aggregate network of inter-organisational relations[13]. These definitions make the community health services (CHS) a part of the community, as they develop relations with other agencies and with people from the area. For that reason, I consider community, particularly for the purpose of this research, to refer not only to the local people but also to their agencies[14]. With a criss-cross of interactions between clients and CHS, and interactions between CHS and other agencies in the social sector, these agencies become an integral part of the community.

---

[12] Mcleroy KR, Bibeau D, Steckler A, Glanz K. An ecological perspective of health promotion programs. Health Education Quarterly. 1988; 15:351-377.

[13] Laumann EO. Galaskiewicz J, Marsden PV. Community structures as inter-organisational linkages. Annual Review of Sociology 1978; 4:455-484.

[14] Jackson defines community in terms of a common political situation and interests leading a group to develop solidarity. He also points out that living in the same place is of secondary importance for people to act together as compared to a common socio-economic situation.
Jackson K. Some fallacies in community education and their consequences in working class areas. In Fletcher C, Thompson N, editors. Issues in community education. Farmer Press; Barcombe, 1980. (quoted by Piette D. Community participation in formal decision-making. Health Promotion International. 1990; 5:187-197.
For definition of community see also: Goodin RE, Pettit P, editors. A Companion to contemporary political philosophy. Blackwell, 1993.
Bryson and Mowbray draw attention to the system preserving effect of the usage of the terms community and community development. They point out that the prefix community has been added to the name of various institutions. 'Community' like other terms such as democracy and welfare is considered and accepted as good based on the notion that traditional communities did not suffer from problems, whereas the cities and the modern society do. This tends to attribute the problems to modern urban and industrial systems rather than to a class oriented society.
Bryson L, Mowbray M. Community, the spray-on solution. Australian Journal of Social Issues. 1981; 16:255-267.

2.6 COMMUNITY HEALTH SERVICES AND PRIMARY HEALTH CARE

Community Health Services (CHS) are considered to be the vehicle for primary health care (PHC) and a large number of articles cover PHC principles such as accessibility, culturally sensitive services, community participation and equity[15]. The definitions of what is PHC and what constitutes a CHS are numerous but highly confusing as terms such as primary care and primary health tend to be used interchangeable. Since the 1970s, PHC has been promoted as a philosophy of health care that provides comprehensive and integrated care[16]. Debates on the inefficiency of the vertical programs of the 1960s and the ineffectiveness of centralised systems caused a shift

---

[15] See for example:
Gross PF. Consumer participation in community health services: lessons from overseas. Australian Journal of Social Issues. 1975; 10:1.
Sardell A. Neighborhood health centres and community-based care: Federal policy from 1965 to 1982. Journal of Public Health Policy. 1983; 4: 484-503.
Bracht N, Tsouros A. Principles and strategies of effective community participation. Health Promotion International. 1990; 5:199-208.
Sherraden MS, Wallace SP. Innovation in Primary Care: Community Health Services in Mexico and the United States. Soc Sci Med. 1992; 35:1433-1443.
Neuberger J. Community health services. BMJ. 1992; 305:1486-8.
Crichton A. A critical analysis of recent Canadian health policy: Models for community-based services International Journal of Health Planning and Management 1993; 8:295-314.
Welton WE, Kantner TA, Katz SM. Developing tomorrow's integrated community health systems: a leadership challenge for public health and primary care. Milbank Quarterly. 1997; 75:261-288.

[16] "PHC Health for All" refers to the WHO Alma Ata Declaration where PHC has been defined as "essential care based on scientifically sound and socially acceptable methods and technology [which] form an integral part both of the country's health system, ... and of the overall social and economic development of the community ... bringing health care as close as possible to where people live and work". PHC was considered as the key to Health for All because the PHC concept includes universal coverage and care according to need, provision of comprehensive services which are affordable, culturally acceptable and effective, community participation for self reliance, and intersectoral collaboration.
WHO. Strengthening ministries of health for primary health care. WHO Offset Publication No. 82. Geneva: WHO, 1984.

towards comprehensive and integrated care in communities[17]. Health care based on primary health care (PHC) consisting of prevention, promotion and treatment at all three levels of care viz. primary, secondary (district hospital) and tertiary (care at a more specialised hospital). On the other hand, this comprehensive approach to PHC has had its critics, who have offered other models of care emphasising that PHC should address a particular issue or a disease at a given time rather than be comprehensive in approach, which in their view would be a less cost effective approach[18].

The word community health service (CHS) is used mainly to point to those services which provide a range of preventive and promotive care to individuals, families and the community at large by employing a multi-disciplinary staff which often includes

---

[17] The term vertical programs is used to describe programs, particularly run at the national level, which are aimed at preventing a particular disease or promoting a particular aspect of health in isolation from the mainstream health system infrastructure. These programs have their own hierarchy within the government health departments and usually have separate resources and infrastructure as well as management and management information system.
Smith DL, Bryant JH. Building the infrastructure for primary health care: an overview of vertical and integrated approaches. Soc Sci Med 1988; 26:909-917.

[18] For detailed reading on the role and definition of PHC, readers are referred to
WHO. Alma Ata 1978: Primary Health Care. Health for All series No. 1. Geneva: WHO, 1978.
WHO. Formulating Strategies for Health for All by the year 2000. Health for All series No. 2. Geneva: WHO, 1979.
WHO. Glossary of terms used in the "Health for All" series No. 1-8. Geneva: WHO, 1984.
WHO. Eighth general program of work covering the period 1990-1995. Health for All series No. 10. Geneva: WHO, 1987.
Kaprio LA. Primary health care in Europe. Euro Report and Studies No. 14. 1979.
WHO. Primary health care in industrialised countries: report on a WHO meeting. Euro Reports and Studies No. 95. 1983.
Walsh JA, Warren KS. Selective primary health care: an interim strategy for disease control in developing countries. New Eng. J. Med. 1979; 301:967-974.
Soc Sci Med Editorial, The debate on selective and comprehensive PHC.1988; 26:877-878.
Smith DL, Bryant JH, Building the infrastructure for primary health care: an overview of integrated and vertical approaches. Soc Sci Med 1988; 26:909-917.
Rifkin SB, Walt G. Why health improves: defining the issues concerning comprehensive PHC and selective PHC. Soc Sci Med 1986; 23:559-566.
WHO. Hospitals and health for all: report of an expert committee. Technical Report Series no 744. Geneva: WHO, 1987.

doctors as well. These services are usually government run or are funded and operated by some non-governmental organisations. Often the term 'community-based health service' is used to describe a service which is not only physically located in a community but whose management is substantially drawn from that community. Some Aboriginal health services in Australia fit such criteria of community-based organisation.

The use of PHC terminology, and an increasing emphasis on CHS, reflects that severe inequalities in health exist between various population groups. The Black Report in the UK and similar studies in Australia pointed to these inequalities[19]. It is argued that health inequalities are the result of the contextual factors that traditional medical services tend to neglect. Within the primary health care philosophy of community empowerment, CHS started to include strategies which attempt to address economic and political determinants of disease and death.

The enthusiastic use of primary health care (PHC) language within the CHS movement during the 1980's suggests that this may have been a two way process, with the advent of the PHC philosophy also serving to reinvigorate the CHS movement. These two are closely linked and the terms community health and primary health care are now much confused and are often used as synonyms. Within the literature in this field, it is frequently unclear whether the term PHC is being used to refer to a philosophy of

[19] Townsend P, Davidson N (editors). Inequalities in health: the Black Report. Harmondsworth: Penguin, 1982.
Moss JR, McMichael AJ. Inequalities in health: the epidemiological evidence – and the gaps. In McNeil J, King R, Jennings G, Powles J, editors. A textbook of preventive medicine. Melbourne: Edward Arnold, 1990.

health care or is essentially concerned with the structure of community-based health services. Examples of this confusion are particularly numerous in the literature from (and prepared for) health departments[20].

At this point it is necessary to briefly discuss the concept of organising CHS into a district health system, as it is relevant to changes such as regionalisation of health services. The proponents of regionalisation seemed to borrow the strategy from the district health strategy of organising CHS. The district health system has been proposed as a vehicle for providing PHC through a network of services serving a circumscribed population[21]. Four key principles of the district health strategy are integration, intersectoral collaboration, comprehensiveness, and community participation. One finds suggestions that health services with a focus on intersectoral collaboration are needed to reduce health inequality in Australia[22]. Such suggestions are then utilised by health departments to propose regionalisation and amalgamations. In industrialised countries various groups, such as women and indigenous populations, have played a major role in the development of these services. This is an important point. CHS are perceived by various sub-population groups as being the result of their

---

[20] See, for example, the National Health Strategy Issue Papers – particularly the Issue Paper #1. The Australian Health Jigsaw: Integration of health care delivery. National Health Strategy Issue Paper No 1. Melbourne, 1991 (section on primary health and community care program pg 63-73).

[21] WHO. Eighth general program of work covering the period 1990-1995. Health for all series no 10. Geneva: WHO, 1987.
In this report, WHO describes 'district' as a geographical area that includes all component of a health system required for community and first level care ... and "a district health system includes all the relevant health care agencies in the area, whether government or otherwise ... contributing to health in homes, schools, work places and communities ... it includes self-care and all health care personnel and facilities ... and including the hospital at the first referral level ..."
WHO. Integration of health care delivery. Report of a WHO Study Group. Technical Report Series 861. Geneva: WHO, 1996.

[22] Whitehead M, Judge K, Hunter DJ et al. Tackling inequalities in health: the Australian experience. BMJ 1993; 306:783-787.

struggle for better services. These groups may not want to lose their identity by going through a change where they have to amalgamate with mainstream health services.

In Australia, Primary Health Care as a level of service provision is well developed and involves a comprehensive range of services in the public sector (eg. Community health centres, school health services) and in the private sector (GPs, Pharmacists)[23]. However, Owen and Lennie argue that if the health system is to be made multidisciplinary and locally responsive to the community, there is still a need for a fundamental shift in public policy towards PHC. This would require that a balance be struck between the for-profit private sector and the rest of the health system. In contrast to the private sector, the community health services component of the health system has adopted the PHC approach. In Australia, community health services were strengthened by the launch in 1973 of a coherent Community Health Program. However, the Community Health Program failed to achieve a substantial move towards PHC. For the reason that the community health services in Australia are mainly controlled by the State, the emphasis on community health services varies from state to state. Raftery notes that South Australian community health services have incorporated a broader social view of health. This has resulted in community development movement and comprehensive service provision[24]. In New South Wales, on the other hand, the community health services stayed illness-focussed[25].

---

[23] Owen A, Lennie I. Health for all and community health. In Baum F, Fry D, Lennie I (editors) Community Health: Policy and practice in Australia. Sydney: Pluto Press, 1992.
[24] Raftery J. The social and historical context. In Baum F editor, Health for All: the South Australian experience. Adelaide: Wakefield Press, 1995.
[25] Eager K. Managing community health from within an area health service. In Baum F, Fry D, Lennie I (editors) Community Health: Policy and practice in Australia. Sydney: Pluto Press, 1992.

CHAPTER 3

Health Services in the Community: Stakeholders and Their Interactions

3.1 OUTLINE

Essentially, this research examines the role of horizontal linkages in influencing the vertical link between a local agency and its central management. In doing so, it focuses on community dynamics.

The importance of this can be related to an observation by Brown who suggests that economists, technocrats and planners – three types of health services researcher – are seldom in a position to provide political leadership [read policy leadership] with directly useful advice[1]. In his opinion, this is because, in addition to some internal conflicts of interest, they do not emphasise the likely consequences that will follow the enactment of their recommendations. They are unable to provide insight into the processing of policies. What will be the effect on the interaction between a health agency and its peer agencies is not considered relevant at the time of policy drafting. Essentially, Brown is asking for inclusion of a community perspective when developing health policies. Earlier, Blau had asked for an input from the community perspective for effective working of organisations because such an input leads to a better understanding about the community needs and help in identifying mechanisms which make organisations sensitive to those needs[2].

While central (i.e. state and national) policy makers are more concerned with the

[1] Brown LD. Knowledge and Power: HSR as a political resource. In Ginzberg E, editor. Health Services Research: key to health policy. A report from the Foundation for HSR. Harvard University Press: Cambridge Massachusetts, 1991.
[2] Blau PM. On the nature of organisations. New York: John Wiley & Sons, 1974.

national and international economic and political context, it is local needs and the local socio-cultural context that influence community organisations. This difference in views is reflected in the way local services handle policy development.

In this chapter, I argue that health services development at the community level is a political process much like the broader policy development process at the national level. The argument is constructed around two related issues: (1) the recent trend of organisational changes in health services and (2) the nature of health care organisation in a community setting. The analysis of these two areas leads to a theory about how the organisational and socio-political characteristics at the local level turn a 'rationalist approach towards organisation' into a political process. This argument is developed in the next three sections.

In section 3.2 of this chapter I briefly point out the current overall trend in health systems development. My brief explanation of this trend provides a background within which changes are envisaged and policies are proposed. Generally, there is an inclination towards retrenchment in public sector health expenditure. Within this overall trend often primary health care is considered, by government departments, as a strategy which could help reduce the public sector health care cost rather than as a strategy to achieve better accessibility and equity in health care.

Section 3.3 of this chapter, "Health policy: influences and interest groups in Australia", points to the overall policy environment in Australia and its influence on

health system development. As this thesis attempts to identify the influence of community structures on health care policies, this section highlights the role of external factors and interest groups in health policy in Australia. This discussion suggests that there is a lack of appreciation of work-face staff and community as policy actors. This situation might give birth to conflict and resistance to change. This is because the hierarchy's reasons for change are often in conflict with needs as perceived by the community and the service providers. One example is the perceived undermining of the principle of community participation through re-organisational policies. Community participation is one of the main principles of primary health care (PHC) and CHS commonly considered to be a vehicle to achieve that participation. Policies adopted by the central authorities can undermine local efforts to attain better community participation[3].

In section 3.4 of this chapter, "Policy Development Process", I point out that:

- The hierarchy considers policy development as their domain and sees the role of work-face staff as the implementation of the policy. Implementation is considered as merely a technical process and not a component of policy development;
- The community context of health services includes interaction of an organisation with others and with the community;
- This community context contributes to the policy development process, particularly during the implementation stage.

[3] Carr-Hill RA. Efficiency and equity implications of the health care reforms. Soc Sci Med 1994; 39:1189-201.
McArthur AA. Community Partnership - A formula for neighbourhood regeneration in the 1990s? Community Development Journal. 1993, 28:305-315.

The interaction of CHS with the community ensures that there are some efforts to modulate the policy so that it fits to the local needs in terms of participation and local networks. Information on local circumstances including local politics is required for better planned health services[4].

In this chapter I use some Australian examples to illuminate the policy process. For the same reason, in the next chapter, I have given some space to briefly discussing a community and health services project conducted in the Karachi metropolitan area[5]. That project attempted to strengthen existing health services and to reorient them towards the district health system model of primary health care. My account in the next chapter reveals the way various sectors within the health care system interact, and also suggests some of the socio-political dynamics of the community and the health services.

3.2 OVERALL TREND IN HEALTH SYSTEM DEVELOPMENT

In the past two decades in particular, under the influence of the Health For All through Primary Health Care (PHC) movement, the overall theme in many countries has been advocacy for a shift from hospital-oriented medical care to comprehensive (preventive, curative and promotive) care at the community level. Since the Health for All

[4] Hurley J, Birch S, Eyles J. 1995, Geographically decentralised planning and management in health care: some informational issues and their implication for efficiency. Soc Sci Med 1995; 41:3-11.

[5] My discussion about Karachi's health services could be considered as an adjunct to the literature presented in this chapter dealing with the context of the community services. The discussion of the project in Karachi in chapter 4 helps the reader in making a transition from the more abstract ideas presented in this chapter to the discussion of the real world of service operation.

declaration in 1978, the rhetoric of health systems change has focused on strengthening health services in the community[6].

A principal factor in the popularity of PHC is its potential to reduce health inequalities and the over-emphasis on secondary and tertiary services[7]. PHC has been promoted as a solution to problems such as the lack of separation between curative and preventive care, and the lack of community participation and to curb a phenomenon where a majority of services work in isolation from each other[8]. Such a change has been favoured in industrialised countries since governments are anxiously looking for mechanisms to ensure effective universal coverage while slowing down the escalating costs of institutional care. Western European countries have been looking for more efficient mechanisms to deliver health care, and many are focusing their attention on strengthening Primary Health Care[9]. Even Canada's health system, reputedly providing effective health care, is a target of such changes. As a result of the escalating cost of aggressive therapy and technology-intensive institutional care, there has been a move

---

[6] Often WHO documents and other literature on CHS use the term 'periphery' and 'services at periphery'. I like to avoid using these terms to avoid a negative signal that CHS may be less important than hospitals or other institutions. One of the respondents during my research in Adelaide objected to my use of the word periphery when at one stage during the interview I wanted to demarcate clearly between the hierarchy (the South Australian Health Commission) and the health services in the community (CHS). She pointed out that from the perspective of people at the work-face, SAHC is at the 'periphery' of health provision.

[7] Rifkin SB, Walt G. Why health improves: defining the issues concerning comprehensive primary health care and selective primary health care. Soc Sci Med 1986; 23:559-566.
Lerberghe WV, Pangu K. Comprehensive can be effective: the influence of coverage with a health centre network on the hospitalisation patterns in the rural area of Kasongo, Zaire. Soc Sci Med 1988; 26:949-955.
Smith DL, Bryant JH. Building the infrastructure for primary health care: an overview of vertical and integrated approaches. Soc Sci Med 1988; 26:909-917.

[8] WHO. Primary health care in industrialised countries: report on a WHO meeting. EURO Reports and Studies No.95, 1983.

[9] OECD. Health care systems in transition: the search for efficiency. Social Policy Studies No.7.OECD Paris, 1990.

towards community-based alternatives and a shift away from a heavy focus on physician care in secondary or tertiary care institutions[10].

This era has been described as the era of retrenchment and not expansion[11]. While there is a shifting focus from technology-intensive costly curative care to primary health care, CHS by themselves have been the subject of organisational rearrangement within this context of cost containment. The Australian health system has not escaped the recent international trends. The three important Australian emphases have been: (1) the strengthening of community health services and primary health care, with the objectives of universal coverage and health improvement through prevention and promotion[12]; (2) regionalisation, in an attempt to adjust health services to local needs[13]; and (3) more recently, financial re-arrangements such as case-mix funding, purchaser-provider separation and movement towards managed competition in order to enhance cost-effectiveness and, possibly, consumer participation[14]. Purchaser-provider

---

[10] Deber RB, Hastings JE, Thompson GG. Health care in Canada: current trends and issues. J Public Health Policy. 1991; 12:72-82.

[11] Muller HJ. Public health in a retrenchment era. State University of New York Press: Albany, 1985.

[12] Raftery J. Health policy development in the 1980s and 1990s. In: Baum F, editor. Health for All: the South Australian experience. Adelaide: Wakefield Press, 1995.
Raftery J. The social and historical context. In: Baum F, editor. Health for all: the South Australian experience. Adelaide: Wakefield Press, 1995.

[13] Lawson JS. Decentralising health services in Australia. World Health Forum 1991; 12:96-98.

[14] The National Health Strategy not only favours a consolidated area management but also favours purchaser-provider separation. For example in the following quote the authors of that paper warn about the problems associated with not having a purchaser-provider separation – " The following issues need to be considered .... c. which model of area management should be adopted: one which separates the role of funder and provider to encourage competition and a population focus; or, one where health authorities directly manage the services they fund, thus increasing their direct managerial authority?"
The National Health Strategy. The Australian Health Jigsaw: Integration of Health Care Delivery. National Health Strategy Issue Paper No. 1. Melbourne, 1991.

Raftery's discussion is mainly about the community health in South Australia. Generally, in whole of Australia the government did not have a strong policy to strengthen PHC.

separation and managed competition are the changes favoured in industrialised countries[15].

Organisational rearrangements which are intended to make the system more efficient may not sit well with the principles of PHC such as community participation, equity, accessibility, and culturally sensitive service provision. For example, strategies such as regionalisation tend to pull services away from the community and towards the hierarchy. This can increase the gap between needs and service provision. Woelk provides an example from Zimbabwe where the centralisation and bureaucratisation tendencies of government led to ineffective PHC services[16]. PHC services were then unable to provide comprehensive delivery of health care and had little community involvement.

3.3 HEALTH POLICY: INFLUENCES AND INTEREST GROUPS IN AUSTRALIA

This section sketches the influences on policy development in the area of health care in Australia. The discussion of these influences is important in understanding the context which leads to certain perceptions by locals (community and street-level workers) about a proposed policy. Within that context of overall policy development the locals try to influence the policy according to the demand of the local circumstances. I argue

[15] Saltman RB, Van Otter C. Public competition versus mixed markets: an analytic comparison. Hlth Policy 1989; 11:43-55.
Harrison S. Working the market: purchaser/provider separation in English health care. Int. J. Hlth Services. 1991; 21:625-635.

[16] Woelk GB. Primary health care in Zimbabwe: can it survive -- An exploration of the political and historical developments affecting the implementation of PHC. Soc. Sci. Med. 1994; 39:1027-1035.

that health policy development is the result of the interaction between three types of interest group (government, professionals, and community groups). The nature of this interaction is determined, to some extent, by external factors such as national demography, cultural values and national politics. The actions of the three interest groups are governed by conflicting ideologies. In this conflict, the government and its bureaucrats as well as professionals enjoy a power advantage compared to the community and its interest groups. This can be seen in the development of health policies.

With the aid of some examples, I discuss the effects of this conflict and the relative power of different interest groups on health policy development. One of these examples is the development of community health services (CHS), where the interest groups are particularly visible. CHS came into being with the ideology of devolving power to the community and hence improving the equity in health. However, the notion of devolving power conflicts with the economic rationalist ideology held by the government and its bureaucrats. I argue that policies such as regionalisation and amalgamation proposed by the government should have been seen as a reaction of economic rationalists to the ideology of devolving power.

3.3.1 Classification of Policy Influences

Before I go on to discuss the overall policy environment in Australia and the interest groups involved, I would like to briefly present a classification of factors which influence policy development generally. Najman and Western, who were early

empirical researcher into Australian health policy, identified four influences on policy formulation at the national level. These influences are situational issues leading to revolution, the economic environment such as a trade deficit, structural factors which depend on the national politics and demography, and cultural values and beliefs[17]. Najman and Western pointed to the role of cultural and political values in health system development in Australia. By consolidating Roemer's and Terris's classifications of health systems based on value systems and economy, they developed a link between Australia as a welfare state and the Australian health system based on insurance as reflecting the political and societal value system[18,19]. Their description of the policy process also points to the important role of non-quantitative factors such as perceived need, values and beliefs in determining who will be participating and to what extent, in the formulation of policies at the centre and in the implementation of the policies in the community. The categories of policy influences, as defined by Najman and Western and by Liechter, reflect in the discourse of different interest groups.

---

[17] Najman MJ, Western SJ. A comparative analysis of Australian health policy in the 1970s. Soc Sci Med 1984; 11: 949-958.
An example of the situational factor contributing to the policy development would be the gun control policy introduced in Australia in 1997 after the Tasmanian tragedy. Despite resistance by the gun lobby and by its sympathisers among right wing political parties, it became possible to quickly enact legislation against the general public's access to automatic and semi-automatic rifles. A psychologically unstable person's access to an automatic weapon and his killing of thirty three innocent citizens created an atmosphere where it was possible for (required of) the government to make and implement this policy.
A similar classification by Leichter categorises policy influencing factors into situational, structural (political structure, economy, socio-demography), cultural (political culture, general culture) and environmental (international political environment, agreements) factors. He also points out that policy analysis has concerned itself mainly with the national influences, and the community context for policy development is often ignored.
Leichter HM. A comparative approach to policy analysis: health care policies in four nations. Cambridge, London: Cambridge University Press, 1979.

[18] Roemer M. Systems of health care. New York: Springer Publishing, 1977. Terris M. The three world systems of medical care: trends and prospects. Am J Publ Hlth 1978; 68:1125-1131.

[19] Roemer classifies health systems into free enterprise, welfare state, transitional state, underdeveloped state, and the socialist state according to the political realities, while Terris' classification of health systems depends on a country's political and economic activity.

For a discussion of community health policy in Australia see:
Milio N. Making policy: a mosaic of Australian community health policy development. Commonwealth Department of Community Services and Health, Canberra, 1988.

3.3.2 THE PREVALENCE OF THE ECONOMIC RATIONALIST IDEOLOGY IN GOVERNMENT CIRCLES

Because government is the major player in the development of health services, it is relevant to identify the prevalent ideologies which influence government's approach to policy development. Generally, the overall context within which policies are being developed in Australia since the early 1980s has been one of economic rationalism. The proponents of economic rationalism are those who believe in the free market and marketisation of the economy. These proponents use a high gross domestic product per capita as an indicator of the success of their policies with little emphasis on distributional measures[20]. The emphasis is overwhelmingly on efficiency. This governmental approach to policy is influenced by interest groups such as the Business Council of Australia and the Committee for Economic Development in Australia. Bureaucratic circles do not seem to realise that an increase in per capita GDP does not raise everybody's boat, and the absence of an emphasis on distributional policies may further increase the gulf between rich and poor.

Pusey suggested that the main reason behind such an approach to policy, which has little understanding of the broader social system, is that the senior bureaucrats in Canberra have been educated in the neo-classical economic tradition, and they are the prime movers of the policy. They favour a distinction between social spheres and

[20] Argy F. The balance between equity and efficiency in Australian public policy. Public Policy Program, The Australian National University, Canberra, 1996.

economic spheres of society. Within this context, Pusey asserts that there is no longer much support for a welfare system[21].

Saunders suggests that the national and international influences which favour such liberal economic principles in Australian policy erroneously give precedence to economic good over social good. Instead, economy, he suggests, should only be a means to a higher goal of social well being and quality of life[22]. This is exactly what Polanyi means when he claims that economic order ought to be merely a function of the social order in which it is contained[23]. On the other hand, the economic rationalists seem to propose a marriage between free market principles and social justice objectives[24]. It is hard to see how this can be realised without undermining the social justice principles[25].

The economic rationalist approach has led to governments putting forward policies of privatisation and to cuts in public sector health services. The more free market oriented Liberal Party governments have embraced this ideology more enthusiastically. For this reason, the protest against such a policy development approach has become louder.

---

[21] Pusey M. The impact of economic ideas on policies in Australia. In Argyrous G, Stilwell F, editors. Economics as a social system. Annandale NSW: Pluto Press, 1996.

[22] Saunders P. Towards a balanced vision: the role of social goals, social policies and social benchmarks. Social Policy Research Centre Report and Proceedings No. 116. Sydney: The University of New South Wales, 1994.

[23] Polanyi K. The self-regulating market. In Argyrous G, Stillwell F, editors. Economics as a social system: readings in political economy. Annandale NSW: Pluto Press, 1996.

[24] Fred Argy's article "the balance between equity and efficiency..." is an example of such a proposal. Argy F. The balance between equity and efficiency in Australian public policy. Public Policy Program, The Australian National University, Canberra, 1996.

[25] Vintila P. Markets, morals and manifestos. In Vintila P, Phillimore J, Newman P, editors. Markets, morals and manifestos. Fight back! and the politics of economic rationalism in the 1990s. Institute for Science and Technology Policy, Murdoch University: Perth, 1992.

Many commentators who openly side with the Australian Labour Party's ideology have joined Pusey and others to raise an alarm against the decreasing role of the State in distributive policies. One such criticism of recent policies is by Botsman . Using the platform of the Evatt Foundation (the Labor Party think tank), he criticises the Howard Liberal government for taking the 'easy' option of cutting public spending for health care. He argues that the current policies will create a two-tier system, where less well-off people will be served by poor quality health care[26].

3.3.3 Interest Groups and Their Influence on Policies

The story of national-level policy development in the area of cancer and tobacco control in Australia alerts us to the role of interest groups and their networks, political lobbying, and party politics in health policy formulation[27]. Gray notes that, in consequence, policy change is a slow process that depends to some extent on rational planning but also to a great extent on the role of various key players and the negotiations and bargains between those key players. The role of the interest groups becomes very clear when we read:

> *"...in 1975, [Prime Minister] Malcolm Fraser gave us a radio and television advertising ban [on tobacco] subverted in the closing minutes of debate by the Country Party with an amendment which was to legitimise sporting advertising and the take-over of sport by the tobacco industry for another 17 year..." (Gray 1997).*

[26] Botsman, P. Not yet dead, not yet born: the state of the Australian health system. In Sheil C, editor. Turning point: the state of Australia and New Zealand. Sydney: The Evatt Foundation, 1997.

[27] Gray N. Forty years of public health. Division of Epidemiology and Biostatistics, European Institute of Oncology: Milan, 1997.

The story of the community health program in Australia provides a detailed description of the role of various national-level interest groups. The Community Health Program (CHP) was initiated with Commonwealth funding with a view to prevention, to concentrate less on institutional (hospital) management of sickness episodes and to achieve more equitable distribution of services for illness care and health promotion[28]. At various times since the beginning of the CHP, Duckett suggests, this program was influenced by the different political ideologies of the Liberal and Labor governments. He points out that the Liberal government has adopted health policies that reflect their free market economic ideals (1976-83),

The equal health advocates, who represented the community-level organised interest, were behind the creation of the community health policy at the very beginning. Duckett explains that these equal health advocates as an interest group lost ground to the economic rationalists during the years of Liberal government[29]. While the Labour government had tried to reinvigorate the community health policies from a stronger welfare perspective (1983-85), it has been criticised for its lack of commitment to renew a national approach to the community health policy[29A].

As pointed out earlier, the government departments and their senior bureaucrats act as an important interest group in shaping these policies. Another powerful interest group has been the professional monopolists. Nancy Milio visited Australia several times after 1983 to review Australia's community health policy. She highlights the role of professional bodies in determining the community health policies and inadequate

[28] Hospitals and Health Services Commission. Report on a community health program for Australia. Canberra: Australian Government Publishing Services, 1973.

[29] Duckett S. Structural interests and Australian health policy. Soc Sci Med 1984; 18: 959-966.

[29A] Milio N. Keeping the promise of community health policy revival under Hawke 1983-85. In Baum F, Fry D, Lennie I, editors. Community health: policy and practice in Australia. Sydney: Pluto Press, 1992.

preventive and promotive programs[30]. For example, initially the development of community health programs met with strong resistance from the medical profession[31]. McPherson points out that one of the major factors which influence policy in Australia is the presence of a strong medical infrastructure. Medical practitioners hold a strong political position which is difficult to challenge[32].

Duckett pointed out the influence of the economic rationalists within the government and Milio pointed out the power of professional bodies. Palmer and Short and Raftery have also pointed to the important role of equal health advocates, such as the feminist movement and indigenous groups, in lobbying effectively for women's health centres and Aboriginal health centres[33]. These and other commentators have pointed to the strong role played by the women's movement and indigenous groups in getting community health established and strengthened. Hawe, for example, argues that community-led conflict-based strategies have helped in securing more resources for

---

[30] Milio N. Keeping the promises of community health policy: Revival under Hawke 1983-85. In Baum F, Fry D, Lennie I, editors. Community health: Policy and practice in Australia. Sydney: Pluto Press, 1992.
Milio N. Next steps in community health policy: matching rhetoric and reality. Community Health Studies. 1983; VII: 185-192.
Milio N. Making policy: a mosaic of Australian community health policy development. Commonwealth Depart of Community Services & Health, Canberra, 1988.

[31] For example, the Australian Medical Association did not like the idea of appointing doctors to CHS and the New South Wales government, therefore, decided against doing so. South Australia, however, with the Labor Party in power at that time (and with Whitlam's Labour government in Canberra) was able to act strongly by establishing several community health centres. Consequently, in South Australia general medical practitioner services were included in community health centres.

[32] McPherson PD. Health for All Australians. In Gardner H, editor. Health policy development, implementation and evaluation in Australia. Melbourne: Churchill Livingstone, 1992.

[33] Palmer GR, Short SD. Health care and public policy: An Australian analysis. Melbourne: Macmillan, 1989.
Raftery has traced the origin of the current focus by the South Australian Health Commission on Primary Health Care to the women's movement of the mid-seventies, to some key players having an inclination towards social health objectives and to an emphasis on PHC internationally by WHO.
Raftery J. The social and historical context. In: Baum F, editor. Health for all: the South Australian experience. Adelaide: Wakefield Press, 1995.

these services[34]. In interpreting the role of interest groups fully, we need, however, to consider another dimension as well. The nature of the policy itself determines, to some extent, which interest group will be on the side of community activists and community groups. For example, for changes towards tobacco control and cancer prevention the community might find the medical profession siding with it against the industry and the government. On the other hand, professionals resisted changes such as community health which aim at reorienting the health system towards the principles of community participation and equity.

In some of the areas of health care in Australia, interest groups' participation in national-level policy development is greater than the participation in some other areas of health care. Howe's description of the greater role of a number of interest groups in aged care policy is one example. She describes the role of interest groups such as the Australian Geriatric Society, the Australian Nursing Federation, consumer and advocacy groups, the Australian Nursing Home Association, and the Australian Pensioners' and Superannuants' Federation most of which devoted considerable effort t lobbying State and, especially Commonwealth governments[35]. Gardner identifies this interest group influence as the pluralist framework of the political process in Australia[36].

---

[34] Hawe P. Needs assessment must become more change-focused. Australia and New Zealand Journal of Public Health. 1996; 20:473-478.

[35] Howe A. Participation in policy making: the case of aged care. In Gardner H, editor. Health policy development, implementation and evaluation in Australia. Melbourne: Churchill Livingstone, 1992.

[36] Gardner H, editor. The politics of health: the Australian experience. Melbourne: Churchill Livingstone, 1989.

It must however be concluded that organised interest groups representing communities have been relatively powerless compared to professionals and governments. These powerful interest groups have managed to undermine the community participation and equity related principles of community health by introducing certain organisational changes. The following examples from Duckett and Lane point to this phenomenon. Duckett describes how in New South Wales organisational restructuring made community workers directly accountable to the State government rather than to the local community groups[36a]. Lane explains that in NSW in the 1980's, when community health gathered momentum, the State intervened by continuous organisational restructuring and management changes. She suggests that a long history of community action in Western Sydney against poor planning and lack of resources is directly linked to such corporate strategies because the State tried indirectly to impose control through grants to powerful interest groups[37]. Such neglect of the local needs and dynamics is not new. Hicks argues that even in the 1940s and 1950s the policy debates at the State and Commonwealth government levels were often removed from local concerns[38].

Summarising the role of various interest groups and their ideologies, an overwhelming influence on policy has been of the ideals of economic rationalism espoused by senior bureaucrats in Canberra. The other influential group has been professional monopolists – the medical fraternity which is at the centre of all health system debates. In this way we can see that the health policy development in Australia happens from a party-political-ideology perspective, economic perspective, and techno-professional

[37] Lane M. The history of community work in NSW. In Lane M, Lee G, editors. Community work: Current issues; future directions. Sydney: University of Sydney, 1987.

[38] Hicks N. Cure and prevention. In Curthoys A. Martin A. Rowse T, editors. Australians from 1939. Sydney: Fairfax, Syme and Weldon, 1987.

[36a] Duckett S. Structural interests and Australian health policy. Soc Sci Med 1984; 18: 959-966.

perspective. Two perspectives we see missing to a larger extent in Australia in those years are the community perspective – as is the case traditionally with policy development everywhere – and an ethical perspective[39]. A preoccupation by policy proposers with cost-effectiveness is what Hicks suggests, referring to the terminology used by Max Weber, as an overemphasis on zweckrational (technical action, calculation of the appropriate action to achieve a desired end) at the expense of wertrational (moral action) in Australia. To reach this conclusion, Hicks made use of Pusey's finding that the central government agencies in Canberra are occupied by "formal rationalists". Both, Hicks and Pusey agree that the major policy influences in Australia are positivism, economic rationalism, individualism, and managerialism[40]. To me it seems that this emphasis on these principles by senior bureaucrats, as well as the power imbalance between government and professionals and community groups, leads to policies which do not reflect the true needs of the community and various other community-level stakeholders. This sets the stage for conflict between the hierarchy and the locals during the implementation stage of policy development.

---

[39] Palmer and Short point to four influences on the responses of State governments to Commonwealth funding for the community health program. These four influences included the political complexion of the State, the attitude of the medical profession towards the community health program, the stage of health system development in the State, and the level of community participation in health and social services. The level of community participation as an influence on the State government's policy is the one which I call a community perspective in health policy development and in policy analysis. Palmer and Short point out that because the government in South Australia was from the Labor Party, it accepted the grants in contrast to the refusal by the Victorian Liberal Party government in 1973. This helps in understanding the role of the 'political complexion in the State'. On the other hand, while Palmer and Short do mention that community participation was an influencing factor, they do not provide clarifying examples.
Palmer GR, Short SD. Health care and public policy: An Australian Analysis. Melbourne: Macmillan, 1989.

[40] Hicks N. Economism, managerialism and health care. Annual Review of Social Science. Health Policy. 1995; 5:39-60.
Pusey M. Economic rationalism in Canberra. A nation-building state changes its mind. Cambridge: Cambridge University Press, 1991.

3.3.4 Organisational Restructuring Serving the Interests of the Hierarchy

Administrative amalgamation of community health services in the Adelaide metropolitan area and the development of linkages between private and public health services at the region and sector level in South Western Sydney are the foci of my inquiry. In chapters 8, 9 and 10 of this thesis, using these policy changes, I highlight the local characteristics which have the potential to influence health policy and health services development. For this reason, it is important that I briefly outline here the objectives and role of powerful interest groups in proposing such policies. The overall policy environment at the national and State levels, which favours cost-containment over equity, might affect the acceptance by the locals (street-level workers and community members) of such organisational restructuring. Locals attempt to influence these changes so that the emerging new structure caters to the health care needs of the community as well as to the personal and professional needs of street-level workers. The political process of influencing the policy during implementation involves understanding the objectives of the hierarchy in introducing these changes, communicating the change and its potential effects to organisations and community members, and identifying mechanisms to influence the hierarchy.

There are clear links between the prevalent ideology and the proposed changes. The 1990s have been an era of health system restructuring with a view to cost containment. There has been a greater emphasis on privatisation with a push towards greater reliance on private health insurance. Hospitals are being contracted out under the economic principle of efficiency – given in the name of "choice" and with the ideology that

public is equivalent to "inefficient". While hospital services could be contracted out or privatised, the community health services fall in a different bracket as it is hard to see how CHS can be privatised while retaining their community development ethic. In the case of community health services, regionalisation and amalgamations as well as strategies including purchaser-provider-separation are being considered to scale down the public dollars spent. These changes are examples of recent marketisation of health care in Australia where health policy seems to be taking much the same route as it has done in economic rationalist regimes such as the United States of America. In Australia, there has been a deeper emphasis on social justice in policy development compared to the United States. However, in recent years such emphasis is under threat from the increasing influence of neo-rationalists. Equity, community participation, a multidisciplinary team approach and accessibility are the principles of community health. Fry believes that because the community health in Australia has been working in a cost-containment environment, it became increasingly difficult for community health to receive due policy recognition. This made difficult to maintain quality of community health with regards to its principles[41].

Changes such as administrative amalgamation and regionalisation are being proposed with a claim that they will help achieve integration and decentralisation. Barrett suggests that the successful development of an integrated health care system is dependent on a cooperative, community-oriented, and democratic spirit[42]. In contrast, the regionalisation tendencies in Australian CHS are proposed and implemented with

[41] Fry D. Quality assurance and community health services. In Baum F, Fry D, Lennie I, editors. Community health: policy and practice in Australia. Pluto Press: NSW, 1992.
[42] Barrett B. Integrated local health systems in Central America. Soc Sci Med 1996; 43: 71-82.

the main motive of cost containment. Additionally, regionalisation is confused with decentralisation. For example, Lawson describes a coordinated system, which includes curative (hospital) and preventive services in a region managed by the regional health bureaucracy, as decentralisation which in effect is regionalisation[43]. Decentralisation entails devolving decision powers to the lower (street bureaucracy) levels whereas regionalisation merely reflects that services in a particular region are to be managed separately from other regions and does not necessarily involve devolving decision making powers. For example, the Adelaide metropolitan health services are being managed as a separate entity by the South Australian Health Commission through its Metropolitan Health Services Division, while country services are being managed through another branch. Having examined the reasons for these changes in Australia, I agree with Considine who argues that the hierarchy contemplates regional or local "autonomy" only as a device to enable their managers to remove impediments so that the hierarchy achieves its objectives[44].

Additionally, we need to consider another dimension while discussing the motives behind the hierarchy's policies for restructuring community health services.

---

[43] Lawson JS. Decentralising health services in Australia. World Health Forum 1991; 12:96-98. WHO. Decentralisation has been proposed to increase the responsiveness of health services to local needs, to mobilise community participation, and to improve equity and accessibility of health services for all (WHO 1984). In fact it has been noted that certain strategies are wrongly labelled and promoted as decentralisation. For instance decentralisation is confused with privatisation (Vaughan 1984). This confusion may be associated with the World Bank philosophy of "privatisation as an integral part of the process of replacing the burden of central administration by decentralising market forces". In the 1980s, The World Bank promoted a transfer of functions from government to non-government institutions as a form of decentralisation (The World Bank 1983).
WHO. Strengthening ministries of health for primary health care. Offset Publication No. 82. Geneva: WHO, 1984.
Vaughan P, Mill A, Smith D. The importance of decentralised management. World Health Forum. 1984; 5: 27-29.
World Bank. World Development Report. World Bank, Oxford University Press: 1983.

[44] Considine M. Policy: managed or expert. In Gardner H, editor. Health policy: development, implementation and evaluation in Australia. Churchill Livingstone: Melbourne, 1992.

Community health services are diverse mainly because the needs of communities are different. The hierarchy sees this diversity as a problem leading to ineffective management. This mindset has some in-built problems. Changes such as amalgamation at the regional-level, proposed by the hierarchy, may fail to recognise the special needs of CHS in different areas as determined by the demography and by the relationships of CHS with its environment.

3.3.5 Community Structures Influencing Policy in Australia

Commentaries by various analysts on policy development in Australia have focussed mainly on the national-level interest groups and ideological movements such as the bureaucrats in the hierarchies, the Australian Medical Association, the feminist movement, and the ideologies of the Liberal and Labour governments. One of the reasons for such top-down national interest group focus is because these analyses are concerned with the overall policy guidelines – for example who are the prime movers of policies such as regionalisation. There is little discussion of work-face level influences on the implementation phase – a phase where policy analysis should ask questions such as what will be the input of community structures once the regionalisation is proposed. While we do come across analyses which have a community focus, these analyses are conducted from the 'evaluation' point of view rather than 'policy input' point of view. These evaluations focus mainly on service out-puts rather than focussing on whether these services and projects were compatible with the socio-political structures in the communities and whether these social and organisational structures contributed to the implementation of these projects.

Evaluation of integration projects is an example[45]. One example of the difference between evaluation point of view and policy input point of view is the way authors report the development of patient registers and recall systems by shared care programs as an indicator of success – although it is not reported whether the existing links between the general practitioners and the other organisations had any influence on the way the projects ware implemented and conducted in an area.

In Australia, in recent times, government's inclination towards privatisation or contracting out services to the private sector and funding cuts might have led to increased networking at the local level. However, there are no studies pointing to an increase or decrease in the extent of local interactions. Theoretically both scenarios are possible. While decreased funding and decreased ability to provide services to clients may require more interaction, an ongoing change and preoccupation with organisational rearrangements all the time may lead to decreased interaction with the other agencies in the area.

A few strategies adopted by local groups to participate in the policy process are discussed by Howe[46]. Describing the case of aged care policy, Howe points to strategies such as lobbying, submission making, committee representation, and community consultation. She argues that consumer forums are influential as they facilitate consumers' participation which then indirectly influences policy. She also

[45] Centre for General Practice Integration Studies (CGPIS). Integration Projects 1993-94: Report. CGPIS. School of Community Medicine, University of New South Wales. 1996.

[46] Howe A. Participation in policy making: the case of aged care. In Heather Gardner, editor. Health policy: Development, implementation and evaluation in Australia. Churchill Livingstone: Melbourne, 1992.

points out that consumer groups at the community level, seeking to strengthen their base, combine forces with other groups through forming coalitions of similar interests if these coalitions were not there before the policy was proposed. There is a direct as well as an indirect input into policy; the community and its groups representing the elderly may join with the local health services in resisting a change which is perceived to be detrimental to aged care in the local context.

Although community structures (inter-organisational relations) *in general* are discussed extensively in the literature, little is known of the relationships for community-based *health* services. Walker has attempted to bridge the gap in the Australian context, by a study which deals with the concept of mediating structures in community health[47]. By analysing the Victorian community health centres, Walker claims that organisations in a community develop relationships with each other and with the local population. These relationships serve three purposes: (i) service provision to the client; (ii) peer support; and (iii) organisational support[48]. The importance of informal networks which operate with invisible rules, compared to more formal links for which certain rules are set by the collaborating agencies or individuals, is a central theme of my 'report from the field' in chapters 9 and 10 of this thesis.

[47] Walker R. Inter-organisational linkages as mediating structures in community health. Health Promotion International. 1992; 7:257-264.

[48] These linkages are valuable resource for an organisation as they help to influence the external environment in favour of that organisation (Hakansson 1987).
Hakansson H, editor. Industrial technological development: a network approach. London: Croom Helm, 1987.

3.4 POLICY DEVELOPMENT PROCESS

There are various paradigms, presented in the literature, ostensibly to *analyse* policies. These different analysis frameworks also serve, in practice, to *promote* one or another policy development process. In this fashion, frameworks become tools to develop policies. Policy analysis deals with questions such as what is the present policy, who are the policy makers, what are the methods of policy making, and what is the role of interest groups and how do they provide insight into the decision making process and power relations[49]. This intentional function of an avowedly analytical process is common to elite, Marxist, structural, pluralist and corporatist perspectives. The elite perspective of policy development, for example, heavily emphasises the role of professionals in determining the policy options, with little input required from the community or various other interest groups. Pluraist view to policy process considers that power is not concentrated in one group and most of the interest groups have the potential to influence policy process. Structuralist view suggests that policy development is limited by options available within the prevailing social, economic and political value systems. While Marxist view is concerned with the economic dimensions and class relations, in corporatist view to policy making the state encourages the representations and interests of select groups and organisations including businesses and trade union[50]. However, the consensus seems to be that most of these actors play some role towards a given policy.

[49] Ham C, Hill M. The policy process in the modern capitalist state. Sussex: Harvester Press, 1984.
[50] Gardner H, editor. Health Policy: development, implementation, and evaluation in Australia. Melbourne: Churchill Livingstone, 1992.

Policy text books, aiming for clear taxonomies suggest that policy development can happen in two ways. Rational policy development is where people envisage all possible scenarios and decide on the basis of all relevant information (technical as well as economic) about various policy options. Rational policy development process requires clear understanding of the objectives of the policy and requires detailed information on the advantages and disadvantages of alternatives strategies to achieve the policy objectives[51]. Political policy development – ad hoc or incremental – is the other and more common mode, where policy adds to already existing policies an element of accommodation of the struggle between various interest groups[52]. My field research indicates that the two ways of policy development are less distinct in practice than they are usually represented in academic taxonomy.

The political perspective on the analysis of the policy development process highlights the conflict between professional monopolists and corporate rationalists and community interest groups[53]. According to this doctrine, the professional monopolists (doctors, nurses) favour the status quo while corporate rationalists (senior management, for example, at the South Australian Health Commission) would like to

---

[51] Goodin RE. Political theory and public policy. Chicago: Chicago University Press, 1982.
Palmer GR, Short SD. Health care and public policy: An Australian Analysis. Macmillan: Melbourne, 1989.

[52] For a critique of both rational and incremental theories of policy development, the reader is referred to a review article:
Gregory R. Political rationality or 'incrementalism'? Charles E. Lindblom's enduring contribution to public policy making theory. Policy and Politics. 1989, 17:139-153.
Gregory makes a point in favour of incrementalism in social policy development where he points out that "it is often difficult to agree whether or what the problems to be eradicated are, or on how they ought to be addressed". My use of the word incrementalism here is nearer to an explanation of the term where it is considered that policy making is concerned with negotiation and bargaining among groups with competing or overlapping interest.

[53] Alford RR. Health care politics: ideological and interest group barriers to reform. Chicago: The University of Chicago Press, 1975.

reduce spending, achieve efficiency, and introduce organisational changes. Kouzes and Mico add another tier of interests to the policy development and working of organisations. They divide the human services organisation into policy domain (the level of organisation where policies are formulated), management domain (which favours a business-like approach and hierarchical control – corporate rationalists in Alford's framework), and services domain (where professionals believe in their right of control under the principles of autonomy and self regulation – professional monopolists). Kouzes and Mico assert that these three domains are incongruent with each other[54]. In doing so, they appear to follow Bell's emphasis on a separation between technical and political sides of the human service organisation[55]. While these theories were not developed with community-level health care organisations in mind, they do claim to be applicable to most situation of human services organisation.

I would argue that these theories of human service organisation, giving precedence to the policy domain over the management domain, appear to miss two important issues. Firstly, the professional at the street level often takes responsibility for managing the program as well, which may essentially merge the two domains. This merger may make the street level managers-cum-professionals powerful enough to confront the 'policy domain'[56]. Secondly, the environmental influences of political and professional communities are considered, by these theories, only at the national level and that again separately for each domain. A three-sided conflict is more plausible for national-level policy development in which actors such as the Australian Medical Association,

[54] Kouzes JM. Mico PR. Domain theory: an introduction to organisational behaviour in the human service organisation. Journal of Applied Behavioural Sciences. 1979; 15:449-69.
[55] Bell D. The cultural contradictions of Capitalism. New York: Basic Books, 1976.
[56] Lipsky M. Street-level bureaucracy: dilemmas of individual in public service. Sage, 1983.

politicians and bureaucrats, and consumer and community groups approach a particular policy with different aims. However, the dimensions of conflict are changed in the community setting. It is more likely that, at the community-level, work-face managers, community, and health care medical and allied staff, while having their own differences at the local level, often join hands during the implementation phase of the policy development process. This is not to claim that there are no conflicts at the community level, and sometimes even change itself exacerbates the existing conflicts.

The theory which comes closer to defining what happens at the community level is described under the title 'muddling through'. The concept of muddling through was presented by Lindblom and has been discussed by others as a process of comparing policy options and choosing the one which most closely attains the desired results, considering influences from various policy actors[57]. As policy development is often considered a domain of the hierarchy and the national level groups, there is little discussion about the role of local factors, even in the concept of policy development through a process of muddling through. I argue that the process of comparing does not stop at the higher levels. Even if only one option is provided, the local situation tries to create some for the purpose of comparison and select the one which suits local needs.

---

[57] Lindblom C. The science of muddling through. Public Administrative Review 1959; 19: 79-88.
Lindblom C. Still muddling, not yet through. Public Administrative Review 1979; 39: 517-526.
Lindblom's criticism of 'policy development as a rational process' and his alternate model is better known as 'incrementalism'.
Gregory R. Political rationality or incrementalism? Charles Lindblom's enduring contribution to public policy making theory. Policy and Politics. 1989; 17: 139-153.
Delaney FG. Muddling through the middle ground: theoretical concerns in intersectoral collaboration and health promotion. Health Promotion International 1994: 9: 217-225.
Webb A. Coordination: a problem in public sector management. Policy and Politics 1991; 19: 229-241.
Walker R. Inter-organisational linkages as mediating structures in community health. Health Promotion International 1992; 7:257-264.

The nature of the policy development process changes, however. It becomes a local versus hierarchy contention. Considering these conflictual and muddling through view of the policy development process, it needs to be checked whether the community interests and the professional interests of the locals overlap in negotiating the proposed policy.

3.4.1 Structural and Community Context of Organisation

Peterson , while discussing the possibilities of introducing health reforms within changed political and structural factors during the 1990s, defines the structural context as the representational community of *organised interests* and *government institutions* (my italics) by which politics is either thwarted or translated into action[58]. In the light of my brief discussion of the national and international influences in Australia, I would like to suggest that the larger national level political and structural context play a role in defining national level reforms. On the other hand, I am inclined to suggest, in the light of the existing literature and my observations in Karachi, that organised interests at the community level determine, to some extent, the fate of any health system change introduced to that area.

To understand the role of the structural context we need to understand the role of social and organisational structures on the working of organisations. Social structure, for Nadel, is the distribution of people among social positions that influences role

[58] Peterson MA. Political influence in the 1990s: from iron triangles to policy networks. J Health Polit Policy Law. 1993; 18: 395-438.

relations among people[59]. Distribution along parameters such as age, sex, and occupation helps in defining social structure[60]. Similarly, people belong to ethnic groups, committees, religious groups, firms, and political parties; distribution along these various lines also provides a structure to the overall community. Blau in the introduction of his book, "On the nature of organisations" mentions that in addition to being influenced by social values and institutions (organisational structure), organisational goals and regulations are influenced by social structures[61]. In addition to understanding the role of values and social structure, there is a need to understand individual behaviour. To find out the effect of structures on the organisation one must look at the social context not only in terms of values and norms and social interaction but also at the characteristics and behaviours of individuals.

The environment in which they operate influences organisations. Members of organisations belong to other social organisations and constitute the contemporary overall social structure. While decisions about reorientation of health systems are taken mainly under the influence of outside phenomena, such as WHO movements or economic rationalist ideologies, structural adjustments at the local level are claimed to be shaped by the local socio-political and health services organisational context[62]. Nearly thirty years ago, Silverman pointed out that any attempt to explain why organisations are as they are must take into account the environment in which they are located and emphasised the difficulties in implementing the policies which are

[59] Nadel SF. The theory of social structure. Glencoe: Free Press, 1957.
[60] See working definitions of words structure, context and environment in chapter 2.
[61] Blau PM. On the nature of organisations. New York: John Wiley & Sons, 1974.

[62] Van-Der Geest S, Speckmann JD, Streefland PH. Primary health care in a multi-level perspective: Towards a research agenda. Soc Sci Med 1990; 30:1025-1034.

directive in their approach and are not worked out in collaboration[63]. Organisations are considered to be open systems where transactions between them and their environment feed back into the functioning and designing of the organisation[64].

Kaluzny and colleagues suggested that health services design evolves through a combination of three mechanisms: a rational perspective that sees the design as a fit between the environment and the organisation; an ecological perspective, which is a function of the nature and distribution of resources in the organisation; and an evolutionary perspective, which allows little role for outside forces[65]. Health services evolution at the local level seems, to me, more of a combination of first two processes. Understanding the design characteristics of health services is important as it determines the boundaries within which managers operate. Often managers extend those very boundaries (space) within which they operate in developing links with the structures in their environment. Once they have developed those relations, they then have to conduct their organisation in a way which caters to the service needs and organisational needs of their environment. The client in the case of human service organisations is considered as an important link to the environment. Yeheskel notes that these organisations are highly dependent on their environment. He considers the interaction between staff and client as a critical force in determining the success of

[63] Silverman D. The theory of organisations: a sociological framework. London: Hienemann, 1970.

[64] Katz D, Kahn RL. Organisation and the system concept. In Brinkerhoff MB, Kunz PR, editors. Complex organisations and their environments. Dubuque, Iowa: WMC Brown Company Publishers, 1972.
Woodward J. Industrial organisation: theory and practice. London: Oxford University Press, 1965.

[65] Kaluzny AD, Warner DM, Zelman WN. Designing effective organisations. In Kaluzny AD, Warner DM, Zelman WN, editors. Management of Health Services. Englewood Cliffs NJ: Prentice Hall, 1982.

organisational efforts[66]. Similarly, Harmon points to an active role of the client of a human service organisation regarding operation of the service[67]. While the theorists have pointed to the role of the environment in the evolution of organisations, their research usually considers one particular component of the environment at a time. Some articles concern themselves with the clients, others with the agencies in the environment. It is important to note that the context of organisations includes clients, community groups, and other agencies and a mesh of interactions linking agencies, clients, and groups with each other. Every interaction is based on different need and serves some particular function.

In addition to the social structure, various organisational issues at the local level, within which services have to work, affect the implementation of a proposed change[68]. A major organisational issue at the local level is the effect of inter-organisational linkages. While discussing the role of inter-organisational linkages, Buchko refers to a process of 'structuration' which means an increased interaction among organisations; emergence of patterns of coalitions; and an increased interdependence on each other. This process leads to institutionalisation of inter-organisational interaction. Concentrating on industrial organisations, he describes barriers to change in terms of coercive isomorphism where dependence on client or supplier agencies lead to

---

[66] Yeheskel HF. Human service organisation. Englewood Cliff NJ: Prentice Hall, 1983.

[67] Harmon MM. Action theory of public administration. New York: Longman, 1981.

[68] Political processes of power and conflict are important elements in the working of organisations. Krupp S. Pattern in organisational analysis: A critical examination. Philadelphia: Chilton, 1961. and Gouldner AW. Reciprocity and autonomy in functional theory. In Demerath NJ, Peterson RA, editors. System, change and conflict: a reader on contemporary sociological theory and the debate over functionalism. New York: Free Press, 1967.
Individuals, their values, the institutions, and their organisation influence the working of agencies in the local setting. For this reason I include in my inquiry and discussion the role of individuals within organisations and individuals in the community. Therefore it is important to discuss role relations among the community and their influence.

pressures, and normative isomorphism where professionals from the 'network' struggle together to define their work patterns[69]. As Buchko's paper is mainly concerned with for-profit agencies, it could be counter-argued that pressures for community health services may arise from normative isomorphism and institutionalised patterns of working together rather than from coercion.

In summary, organisations in the community operate as open systems and their design and functioning are influenced by the structure around them. Their effective working and sometimes survival depends on the existence of other organisations and groups in their surroundings. With the intensity of need-based interactions in which community health services get involved, it could be said that the local health care system takes the form of an ecosystem[70]. This argument could be extended further to consider the quantum physics theory of Many-Worlds[71]. By borrowing from this theory, it could be said that the boundaries of various health and social services tend to fuse. Workers in an organisation would belong to many other groups in the area at the same time – as sub-atomic particles are claimed to exist in more than one universe at a given time (figure 3.1).

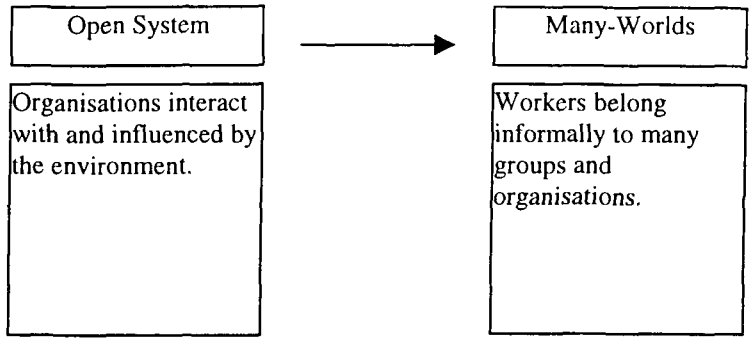
---

[69] Buckho AA. Barriers to strategic transformation: Inter-organisational networks and institutional forces. In Shrivastava P, Huff A, Dutton J, editors. Interorganisational relations and interorganisational strategies. Advances in strategic management series. Greeenwich Connecticut: JAI Press Inc,1994.

[70] This discussion is consistent with the phenomenon, described by Aiken and Hage, of organisational diversity leading to innovations and inter-dependency in turn leading to further diversity and long term organisational commitment to other organisations in the surroundings.
Aiken M, Hage J. Organisational interdependence and intra-organisational structure. In Brinkerhoff MB, Kunz PR, editors. Complex organisations and their environments. Dubuque, Iowa: WMC Brown Company Publishers, 1972.

[71] For a description of many-worlds quantum physics theory see Everett (1973).
Everett H. The theory of the universal wave function. In DeWitt BS, Graham N, editor. The many-worlds interpretation of quantum mechanics. Princeton, NJ: Princeton University Press, 1973.

Fig 3.1: A theory of organisation beyond open systems



These characteristics of community health services in terms of formal and informal interactions and many-world operation have implications for policy implementation. It could be said that while formal networking (e.g. collaboration through an official memorandum of understanding) in effect safeguards an agency's individual identity amidst a plethora of organisations, informal networking (inter-personal day-to-day cooperation between workers from many organisations) blurs the boundaries of agencies with a resultant decrease in their "individual" and "separate" identify within the community. Overlaps and intermingling of boundaries and services of various agencies may not only exist; community people may see only a fused state of services as if no distinct boundaries exist between various agencies. By analogy, the community could be seen as a swimming pool which is arbitrarily divided into various lanes so that swimmers do not bump into each other. Turbulence or displacement of water in one lane due to the action of one swimmer is felt throughout the pool. To some extent, this turbulence is decreased because the lane dividers and the edges of the pool are designed to reduce turbulence. The same could be said of the state of community. Once an agency becomes part of that community by establishing its horizontal linkages, it is part of the pool. That agency's actions, service cuts, and organisational

changes will affect the others. As agencies lose their "individual" character once they are part of the pool, a change cannot happen without some effect on the rest of the community. Policy formulators and paymasters seem reluctant to acknowledge this fluid nature of service provision. They perceive clear administrative and organisational boundaries and may believe that they can induce organisational changes to "their" agencies without causing any disturbance to the overall service provision at the community level.

Changes emanating from the national structural and cultural context have to embrace the local realities. National politics and social factors reflect on the local situation only partly; local structures are quite different and have their own separate influence - albeit on a small scale. Ham points our attention to policy at the local level being pluralist and incorporating competing interests of the local stakeholders[72]. Organisational rearrangement could be considered as occurring within a two-layered context. The national context is the outer layer that reflects the overall economic and political environment within which the policy development institutions of the country work. Within it is the local community context which includes the community's dynamics, its social structures, and the arrangement of services within the community.

In this section, I have tried to highlight the nature of organisations in communities. In the next section, I discuss, in some detail, the working of organisations in a community

[72] Ham C. Health policy in Britain. London: McMillan, 1985.

in terms of local interactions and the influence of the local structures on the policy process.

3.4.2 POLICY PROCESS IN THE COMMUNITY

It has been argued that the wider community needs and values do influence policy[73]. However, such analyses of the policy development process review the influence of community need and values mainly from the perspective of larger lobby groups representing interests and values at the national/state level. In practice, changes proposed to the existing services in the community invite the attention of many local stakeholders. In order to develop a comprehensive understanding of any policy process, we should identify the key policy actors at the inter-face of the hierarchy and community as well.

One view of the policy inter-face between the hierarchy and the community concerns how services operate. Rules and regulations are the main tenet emphasised by the hierarchy in their recommendations on how local services should operate. These rules and regulations are given, usually, in the name of objective evaluation emphasising certain targets whose achievement needs to be reported regularly in order to estimate the performance of local services. This functional rationality, promoted by the hierarchy, asks the local services to behave according to a set of pre-determined rules: services, though, are interested in achieving certain ends demanded by the local

[73] Kimberly JR, Zajac EJ. Strategic adaptations in health care organisations: Implication for theory and research. Medical Care Review. 1985; 42:267-302.

context (health care needs, and interaction with the community and its organisations). To do so, the local services need to devise means which often go beyond the set of rules and regulations, and at times are in conflict with those rules. This incompatibility between rules and the contextual needs is reported by Young and Saltman. They suggest that the strategic decisions on how an organisation such as a hospital should be working only partially result from policy development at the top of the organisation[74]. Day-to-day work determines, largely, the choices made by the workers who are exposed to the surrounding structures. It seems that strategic decisions tend to grow step by step under the influence of local needs and work practices. The same observation is even more applicable to community health services. Community health services (CHS) are known to network extensively with other services and groups[75]. The horizontal linkages between organisations are fundamental to the development of collaborative approaches and help in coalescing interests between different agencies. Through this process, these linkages influence the organisational structure at the community level[76]. This process of networking, which is given the name structuration by Buckho, affects the implementation of change[77]. Under the influence of horizontal linkages, which enhance the political power of local interest groups, policy decisions

---

[74] Young DW, Saltman RB. The hospital power equilibrium: an alternative approach to the cost containment dilemma. J Hlth Politics, Policy and Law, 1981: 6:391-418.

[75] Flynn R, Pickard S, Williams G. Contracts and the quasi-market in community health services. Journal of Social Policy 1995; 24:529-550.
Delaney FG. Muddling through the middle ground: theoretical concerns in intersectoral collaboration and health promotion. Health Promotion International 1994; 9: 217-225.

[76] Walker R. Inter-organisational linkages as mediating structures in community health. Health Promotion International 1992; 7:257-264.
Mcleroy KR, Bibeau D, Steckler A, Glanz K. An ecological perspective on health promotion programs. Health Education Quarterly 1988; 15:351-377.

[77] Buckho AA. Barriers to strategic transformation: Inter-organisational networks and institutional forces. In Shrivastava P, Huff A, Dutton J, editors. Interorganisational relations and interorganisational strategies. Advances in strategic management series. Greeenwich Connecticut: JAI Press, 1994.

do not remain the same during their implementation[78]. For example, an organisation may change its present shape but may not attain the exact configuration proposed in the relevant planning documents. The organisational linkages will influence the re-arrangement so that the new shape caters to the needs of the local context. The networks influence the local organisation structure and "sew" many local agencies together into a larger whole. For this reason, local organisations may confront a change proposed to one organisation as if that change were proposed to all those organisations in the community. Close interaction and communications encourage individual organisations to take into account all inter-relations within the overall system in their reaction to change[79].

This discussion about the potential role of local structures towards a given policy is consistent with the observation made by Warre. He suggests that the plethora of community organisations make locally relevant decisions through bewilderingly complex interactions between them[80]. Potential participants in the local implementation of policy include the target population, local advocacy groups, local service providers, and other local agencies. These groups participate by joining public

[78] Van der Geest S, Speckmann JD, Streefland PH. Primary health care in a multi-level perspective: Towards a research agenda. Soc Sci Med 1990; 30:1025-1034.

[79] Formal and informal communications are considered as internal organisational structures which influence policy development (Rosengren 1972).
Rosengren WR. Structure, policy and style: strategies of organisational control. In Brinkerhoff MB, Kunz PR, editors. Complex organisations and their environments. Dubuque, Iowa: WMC Brown Company Publishers, 1972.
Considering a set of agencies as one organisation at the community level essentially makes the interaction between these agencies as an internal structure in turn influencing the change. For some time, intra-organisational informal relations have been considered as a dynamic force (Selznick 1948).
Selznick P. Foundations of the theory of organisations. American Sociological Review 1948; 13:25-35. Cited in Blau PM. On the nature of organisations. New York: John Wiley & Sons, 1974.

[80] Warre RL. The inter-organisational field as a focus for investigation. In Brinkerhoff MB, Kunz PR, editors. Complex organisations and their environments. Dubuque, Iowa: WMC Brown Company Publishers, 1972.

forums, by reviewing drafts of the policy proposal, or as a source of background information. Cooksey argues that policy options are limited if these potential participants are not involved in the policy implementation process[81]. I would regard this process by which the locals influence policy as modifying functional rationality (rules and regulations from hierarchy) into substantial rationality (determined by locals needs and networks). This influence of the local structures on policy implementation, and a shift from functional to substantial rationality, is similar to the phenomenon described by Pressman and Wildavsky where an increased number of transactions (interactions) at the local level may lead to policy 'failure' (in terms of the objectives stated by the hierarchy)[82].

Under the influence of the local structures (organisations, community and their interactions), policy development in the community seems to take a less structuralist view. Facts and values are merged to a large extent. It could be postulated that the local managers, at least in cohesive and organic communities, in collaboration with the community individuals, groups and workers from other agencies, act in accord with the local needs and feelings. The community and its networks compel the street-level workers and managers into taking a policy leadership role. The managers have their own motivation to use the local political potential for their personal motives – promotions and status. My emphasis on the role managers play is based on the observations made by Sanders who suggests that street-level workers and managers define what a policy means[83]. Using Donald Schon's

[81] Cooksey JA, Krieg RM. Metropolitan health policy development: barriers to implementation. Journal of Public Health Policy 1996; 17: 261-274.

[82] Pressman JL, Wildavsky A. Implementation. Berkeley, University of California Press, 1973.

[83] Sanders W. The politics of daily life in Australian income security administration. Politics. 1985; 20:36-47.

classification of managers, I suggest that many of the managers at the community level work as "underground managers" – who try to maintain and operate informal and underground networks.

In addition to the phenomenon of horizontal linkages, another important factor which may influence the policy development capacity of locals, is the policy-administration dichotomy. Implementation of a policy is often considered as only an administrative task rather than a political process but there are grounds for regarding implementation of policy decisions as separate from policy development[84]. Considering implementation as a component of the policy process is important because implementation takes place in communities, and this is the stage when local policy actors can exert their influence on policy.

However, the literature on the implementation process is confusing, to say the least. Sabatier and Mazmanian have suggested five conditions for effective policy implementation which include: a sound theory relating changes to objectives; unambiguous policy decisions; implementing managers possessing political skills; no conflict between various different government policies at a given time; and the availability of support from a constituency (interest groups)[85]. Importantly, the political

[84] Williams W. The study of implementation: an overview. In Williams W, Elmore RF, Hall JS et al, editors. Studying implementation – methodological and administrative issues. Chatham, New Jersey: Chatham House Publishers, 1982.

[85] Sabatier P, Mazmanian D. The conditions of effective implementation: a guide to accomplishing policy objectives. Policy Analysis 1979; 5: 481-504.
Gardener's (1992) observation that implementation has altered policies in Australia becomes clear when we note that two of the five pre-conditions proposed by Sabatier and Mazmanian – support of a constituency and sound theory relating changes to objectives – have not been met quite often.

skills which Sabatier and Mazmanian would like managers to have are to negotiate with the constituency and not with the hierarchy. In pointing out these conditions, as well as in suggesting a vertical hierarchical integration so as to eliminate the resistance to the proposed policy, Sabatier and Mazmanian favour the theory that the implementation process should not interfere with the policy objectives. Confusion is created where they point to the importance of the role of the interest groups and the diversity of activities of target groups towards 'compliance' of implementation.

The policy-administration dichotomy has its foundation in the early tradition of policy analysis which made a clear distinction between policy formation, which is a political activity, and administration which is a technical job. Waldo's "Administrative State" provides an example where administration is considered merely a technical activity[86]. More recently, however, this dichotomy is considered, by some, as perceived and not real. In this tradition, implementation is a component of policy development[87]. Because of an ambiguity between what is administration and what is policy, the study of the political-administrative system as a whole is preferred over attempting examination of individual (technical, political) elements of the policy process.

I would like to argue that these two propositions – that implementation is or is not a component of the policy process – have different implications for local health system development. If policy is considered by the local administrators as a separate entity

[86] Waldo D. The administrative state. New York: The Ronald Press, 1948.

[87] Wilenski P. Public power and public administration. Sydney: Hale & Iremonger, 1986.
Majone G, Wildavsky AB. Implementation as evaluation. Policy Studies Journal 1978; 2: 103-117.
Barrett S, Fudge C, editors. Policy and action: essays on the implementation of public policy. London: Methuen, 1981.

from administration, the horizontal linkages may not be considered by these administrators as an important tool to influence the "policy". In that case, they would 'receive' the policy from the hierarchy, and implementation will only be a technical process with a heavy emphasis on 'how to implement' and little or no emphasis on 'whether to implement' and what component of the policy to implement'.

Policy implementation research has been conducted by three distinct approaches: top-down policy implementation analyses, bottom-up looking at the local transactions, and some synthesis and reviews. Lester and colleagues point out that there is a theoretical pluralism, with no consolidated theory on policy implementation because the implementation process is dynamic and complex[88]. Elmore classifies the study of implementation into forward mapping and backward mapping. By making a point that it is a myth to assert that explicit policy directives and greater attention to administrative responsibility will lead to improved implementation, he rejects forward mapping which is a process examining implementation by starting with the objectives of the policy and following its specific steps. Forward mapping assumes that policy makers (at the hierarchy) control the organisational, political and technological processes that affect the implementation[89]. My research is comparable to what he calls backward mapping, as this type of research starts at the point where administrative actions intersect private choices and which question the assumption that policy makers ought to, or do, exercise the determinant influence over the processes of implementation.

---

[88] Lester JP, Bowman AO'M, Goggin ML, O'Toole LJ Jr. Public policy implementation: evolution of the field and agenda for future research. Policy Studies Review 1987; 7: 200-216.

[89] Elmore RF. Backward mapping: implementation research and policy decisions. Political Science Quarterly 1979; 94: 601-616.

3.4.3 ANALYSING POLICY FROM THE COMMUNITY PERSPECTIVE

Horizontal linkages make health services in the community act as a social system. Additionally, compared to other spheres of life, health care providers work for (on) the customer himself/herself rather than working on his/her car or house. There is a direct community feedback to the provider of services. These processes ensure that the working of the health system involves values at the local level[90]. Health services, with their horizontal linkages with other agencies and with the community at large, act as settings for social interactions. Services receive local values; these values in turn determine the rules for the organisation's working. Greater social, ethnic and political homogeneity favour communal activity and cooperation leading to better input towards health system development at the local level[91].

By considering health care as a social system, any change happening within it ought to be understandable using theories of social change. Health services, particularly those provided by the government, could be considered as an extension of bureaucracy. At the same time, health care providers, by virtue of their profession, enjoy a powerful status in society[92]. In so far as bureaucracy and the medical profession (and other allied professions, the health technology industry and the pharmaceutical industry) within the

---

[90] In a sense already mentioned change towards purchaser-provider separation which attempt to give corporate rationalists (funder/owner) a political edge on medical monopolists (purchaser/providers), may also weaken the value input into health services development.

[91] Uphoff NT. Political considerations in human development. In Knight PT, editor. Implementing programs for human development. Washington DC: World Bank, 1980.
Elling RH. Cross-national study of health systems: political economies and health care. New Brunswick, NJ: Transaction Books, 1980.

[92] Friedson E. Profession of medicine. New York: Dodd/Mead, 1970.

health (social) system own the means of production of health care, the community strives to be in a relatively better power balance with the area health services. This they try to achieve by agitation against a proposed change and/or by "underground" undermining of the proposed change which the community sees as further reducing their power.

A health system hierarchy, such as the Health Commission or the Department of Health, enjoys the "means of political mobilisation". They have links with the politicians, academics and universities, and they have funds at their disposal. Additionally, they have the hiring/firing authority. Etzioni tells us that the centre (hierarchy) controls through the play of status and class, but economic control by paycheque is by far the most prevalent method[93]. Compared with this situation, the workers, staff and consumers at the local level, which together make the "other class" in that political struggle, have very little of these means of political mobilisation. This class has to struggle hard for a longer period of time to establish networks and communication channels and to gain political power so that they are able to influence or negotiate decision making with the central authorities.

At the conclusion of this review of a considerable literature on the administration of public policies for human welfare, I find myself persuaded that there is a potential for conflict between professional authority legitimised on the grounds of expert knowledge, and the bureaucratic authority which is associated with procedures and sanctions. I suggest that in CHS the street-level workers tend to take the role of experts

[93] Etzioni A. A comparative analysis of complex organisations. New York: Free Press, 1961.

as they claim to possess knowledge on the needs of the community and how the system can be made effective in the local context. This 'knowledge' is used against the claims of the central authority that the rules and procedures provided to the local organisations are effective tools to provide efficient services. This happens as workers develop peers group relations and develop 'abstract' knowledge of the community, with their intense interaction with the local population and with the organisations in their surroundings. In this process, the street-level professionals and bureaucrats tend to side with, and to some extent depend on, the community rather than with their seniors in the hierarchy. This is somewhat consistent with the Weberian theory of social change. Weber saw social change as a slow, evolutionary process with a continuous cyclical process of erosion and rise of bureaucracy[94]. For Weber, the main principle of social organisation is the bureaucracy and its authority. Weber saw a competition between bureaucracy and status groups as well. This point could be used to understand why health care providers, particularly the mid-level and work-face managers who have not yet achieved higher social status, often seem to take a stand with the community against changes proposed by the central hierarchy. By this process, local managers and health care providers try to erode the authority of higher levels of bureaucracy. As they use community for this authority-eroding process, they try (or pretend), as a bargain, to make local services fit to the local needs.

The main argument of this chapter has been that local interest groups try to implement policies in a way which suits the local needs most. This line of argument implies that,

[94] Collins R. A comparative approach to political sociology. In Bendix R et al, editors. State and society: A reader in comparative political sociology. Boston: Little, Brown & Co. 1968.
Orum AM. Introduction to political sociology: the social anatomy of the body politic. Englewood Cliffs NJ: Prentice Hall, 1989.

in dealing with the central authorities, a local agency and its environment act, to a certain extent, as a single class. It is important here that by taking this line I do not intend to say that differences within an agency or within the overall structure at the community level do not exist. Strategies adopted by organisations are much influenced by their internal dynamics as well[95]. Strategic organisation behaviour theory suggests that each organisation has a formal and informal strategy which expresses its internal dynamics to some extent[96]. Gale suggests that health systems are fragmented on the basis of professional (doctors, community health nurses, community health workers) and departmental lines. This fragmentation leads to a lack of compatible policies and procedures between teams[97]. This fragmentation at the local health care team level may jeopardise their policy development role. It could be said that the level of this internal conflict is suppressed or inflated during a change depending on how that change is perceived by various mini classes in the community.

[95] Michels R. Political parties: A sociological study of oligarchical tendencies of modern democracy. New York: Collier, 1962.
[96] Quinn JB. The strategy process: concepts , context and cases. Englewood Cliffs: Prentice Hall, 1988.
[97] Gale L. Why a traditional health outcome approach will fail in health care. Australian College of Health Services Executives National Congress, 1997.

CHAPTER 4

Pakistan: Organisational and Community Characteristics

4.1 INTRODUCTION

This chapter discusses health services development in one district of Karachi, Pakistan. It is an account of what I observed as member of a team while working on several community development and primary health care programs in an area. These programs were in support of the government's plan to reorient the existing services towards a district health system based on primary health care. I wanted to analyse the influence of the local environment, which I had observed in Karachi in detail, and that is why I continued my research in Australia, as detailed in chapters 5 and 6.

The example of Karachi's health system development not only points to what motivated me to embark on my Australian research but also adds to the discussion about what influences policy during its implementation. This discussion helps in understanding health system development with regard to the specific local socio-cultural and organisational environment within which health services operate, and which acts as a framework for policy development locally. The Karachi example illustrates the importance of understanding community dynamics and local organisational issues, and of incorporating them into reiterative planning for regional health services.

Efforts at re-orienting governmental health services in a district of the Karachi metropolitan area towards a comprehensive system of health care based on the philosophy of primary health care (PHC) illuminated the complex nature of the public and private health services, as well as the interaction between the two. Working closely with these services revealed the fragmented organisation of the governmental health

services in that area and how that fragmentation interfered with policies which aimed at implementing integration or intersectoral collaboration. In this chapter I also point to the policy influence of the situation where populations targeted as a health region lacked community cohesion. This lack of cohesion among communities living in the metropolitan area adversely affected their capacity to intervene politically in the working of the local health services.

My work in Karachi during 1993-95 was field-based research and development. My work, as leader of a team from a local university, aimed at developing a PHC prototype by working closely with the community and the existing health services[1]. Although the team was providing services through community health nurses (CHN), community health workers (CHW), social workers and general practitioners, the main feature of the work was field-based research to identify mechanisms for better community participation, community development, and integration of the local health care services. As the field-based activities, particularly those aiming at community development, were research oriented, I was careful in noting down relevant events, community dynamics, and characteristics of health care provision from a participant observation point of view.

My observations indicated a need to comprehend the complexity of existing health services provision at the local level before one embarks on a health services

[1] As a faculty member of the public health department of a local university, I worked amongst a few adjacent squatter settlements to develop a PHC prototype during 1988-91. Another project aimed at community development and assisting the government health department in reorienting services towards an integrated health care system in 1993-95 was based in the same area of the Karachi metropolitan area. Working with the same communities for five years helped a great deal in understanding some of the community and health care characteristics that influence health system development.

reorganisation mission; health systems are complex phenomenon no matter how few or how inadequate the services are in an area.

In brief, in the case of Karachi the issues which influenced health care policy included: the role of government in terms of funding and management, as the services controlled by one level of government had little interaction with health services provided by other levels of government; historical hierarchical management practices without participative planning at the community level; imbalances in terms of curative-preventive care with less than adequate health funds mainly spent on curative care. Lack of interaction between public, private and NGO sectors, and fragmentation between health care and the rest of the social development infrastructure were other factors which adversely affected the district health system development. Another important factor was the lack of community cohesion, which reduced the community's potential to participate in the health system development.

The importance of highlighting such characteristics is to guide a potential change in health care towards improved accessibility and effectiveness. It became obvious that understanding community dynamics is as important for health system development as to understand the demography, burden of disease, health service to population ratio, the extent of comprehensiveness and utilisation patterns. Information on structural features of the health system is required for achieving a better understanding for effective and efficient health systems[2]. Along these lines, literature is available which reflect on health systems development considering structural issues at the national

[2] OECD. Health Systems in Transition: The search for efficiency. OECD Social Policy Studies No. 7. Paris OECD, 1990.

levels[3]. However, the earlier research focused mainly on the larger structural features, such as national economy or hierarchy within the health department. This chapter, and this thesis as a whole, informs the reader about the importance of looking at structural features which are operating at the community level.

With discussions at Alma Ata, Riga and Ottawa having shown the way, WHO and other international health care advisory bodies have promoted PHC over the last two decades[4]. Similarly, regionalised systems of health care based on the district health philosophy have been promoted as an effective method to deal with the problems of lack of integration and intersectoral collaboration at the local level[5]. Services in the community come in direct contact with their users; this is where PHC principles of participation, planning based on local needs, sustainability, and horizontal integration

---

[3] Some of this literature is already mentioned in chapter 3 of this thesis. For example see:
Bossert TJ, Parker DA. The political and administrative context of primary health care in the Third World. Soc Sci Med 1984; 18: 693-702. Duckett S. Structural interests and Australian health policy. Soc Sci Med. 1984; 18: 959-956. Enthoven AC. What can European learn from Americans? In Health Care Systems in Transition: the search for efficiency. OECD Social Policy Studies #7. OECD, 1990. Palmer GR, Short SD. Health care and public policy: An Australian Analysis. Macmillan, Melbourne 1989. Peterson MA. Political influence in the 1990s: from iron triangles to policy networks. J Health Polit Policy Law. 1993; 18: 395-438.

[4] Despite conflicting evidence on the effectiveness of community health workers (CHW) in systems which lack a supportive and supervisory framework, in 1994 the Government of Pakistan initiated a program to recruit, train and appoint 30,000 CHWs at health outposts for outreach services – with a loan from international agencies and with an advice from UNICEF and WHO. A situational factor at the national level, the need of the political party in government to provide employment, provided the opportunity for international agencies to promote this program and help government implement it without critically viewing its importance. While that program was proposed under the influence of national structural issues, the implementation and effectiveness of that program depended on the local factors such as the availability of support and supervision within the community and district level health services.

[5] Tarimo E, Fowkes FGR. Strengthening the backbone of primary health care. World Health Forum 1989; 10:74-9-79.
Health system development with a district health philosophy which calls for planning services for a circumscribed pre-identified population has been discussed under various titles. For example, in the USA a similar approach at integration and working for a pre-identified population with PHC principles is labelled as "Community-Oriented Primary Care" by Wright.
Wright RA. Community-Oriented Primary Care: the cornerstone of health care reform. JAMA 1993; 269:2544-2547.

could be achieved -- at least theoretically. I noted that community cohesion, for example, is a factor which influences participation. My aim however, is not to generalise from a limited set of local observations to summarise the situation in Australia or Pakistan as far as community cohesion is concerned. The aim is to point out that community cohesion does influence health development at the local level. This is to make clear that policy implementation requires that one is aware of the community characteristics where that policy is going to be implemented. As the policy makers further up in the hierarchy are seldom aware of the local situation, they need to be willing to accept a change in the policy that makes that policy suitable to the local circumstances.

4.2 KARACHI: REORIENTING SERVICES TO A PRIMARY HEALTH CARE-DISTRICT HEALTH SYSTEM

International agencies such as WHO, UNICEF and the World Bank have an unfortunate tendency to urge ideas upon developing countries for organisational change which have their origins in the different circumstances of the industrialised nations. The organisational changes are often introduced without actually identifying their compatibility with the local culture and work ethos, or without looking into their potential to be accepted in the local circumstance as legitimate changes offering a better balance between local needs and community health development[6]. Organisational changes which have been implemented on a large scale in developed

[6] Barret B. Integrated local health systems in Central America. Soc Sci Med 1996; 43: 71-82.
Barret, by providing examples of community health and social development programs in El Salvador, Guatemala, Honduras and Costa Rica, points out that often government policies and the programs by the international agencies favoured programs which aimed at pacification and control of population rather than programs which fostered community ownership and serve the local needs.

countries over the last decade have been minimally scrutinised in terms of their implementation and interaction within the existing organisational set-up and local socio-political realities.

In a district of Karachi, the socio-political and organisational factors, which influenced health system development, came to the fore as the government health services were being reoriented towards a system based on Primary Health Care (PHC)[7]. My co-workers and I targeted the public sector health services with the objectives of introducing missing linkages such as out-reach care, liaison with private services, effective referrals, a health management information system, and community participation. The health services strengthening process was to help the managers identify shortcomings in terms of effectiveness and management, and implement strategies to redress these deficiencies. Furthermore, social, cultural, and political issues were identified by working with communities in four adjacent squatter

[7] Health services provision is primarily a responsibility of the provincial governments in Pakistan. Government at the federal level is responsible for disbursement of health funding to the provinces, for policy guidelines and for interaction with the international funding and advisory bodies. While the provinces are divided into districts for management and health care provision, essentially all planning took place (up until 1994-95) at the provincial level. More recently, there has been a focus on regionalisation and planning at the district level for two reasons. Over the last few years, since the "new democracy" in 1988 at the end of a ten year military governance, the recent government seemed more inclined towards the policy of local planning. More importantly this is linked to the new funding and organisation arrangements opted for by the governments under the influence of international funding and advisory bodies such as the World Bank and WHO. Recently there have been some developments regarding PHC with the government notifying comprehensive and integrated PHC as a policy priority. A committee working on the 8th five year plan (1993-98) recommended that further investments in tertiary care facilities should be selective and the savings should be directed to PHC programs – an intervention which had similarities with what was being proposed to the public sector in industrialised countries. Little attention was paid to the fundamental differences between developed and developing countries in terms of affordability of private care. The government's approach (under instructions from funding agencies) in Pakistan, was to shift its major responsibility away from direct financing and provision of secondary and tertiary care and gradual shifting of this level of care to the private sector. The PHC approach focussed on making District Health Management Teams (Area Health Board) involving community, interaction with private health care providers, out-reach preventive and promotive care, and identification of mechanisms to develop linkages between peripheral services and larger hospitals.

settlements with populations of about 8000 each in the same district where governmental health services were targeted for district health system development.

These efforts at strengthening the health system were made while the Sindh provincial government was implementing a World Bank funded program, the Family Health Project (FHP), in various urban and rural districts. Health managers at the district as well as "in-charges" of health outposts were to be trained for better management to improve accessibility and effectiveness of their respective services[8]. At the same time, out-reach preventive and promotive programs, out-patient specialist care clinics, and secondary level hospitals for non-specialised in-patient care were to be introduced in order to reduce the load on tertiary care hospitals.

To realise the objectives of the project, various stakeholders in health care provision at the community level had to be involved in the process. These stake holders included: governmental health services, traditional practitioners, the non-governmental for-profit and not-for-profit sectors, and the community members. Difficulties in achieving the objectives of the projects led to reflections upon the shortcomings in their original blue prints. A close examination of the health services organisational set-up in Karachi revealed forces and factors which were important with regard to implementation of any organisational model, but which were not given due emphasis in the original plans for the proposed change.

[8] "In-charge" is the usual Pakistani term for leader (manager, administrator, head) of a small organisation.

4.2.1 CHARACTERISTICS OF COMMUNITIES

Squatter settlements are residential areas without planned housing and official land tenure. In the Karachi Metropolitan Corporation, the typical population of these settlements is about 8,000 – 10,000. Some important socio-political issues at these settlements, which affect the implementation of health services, are described below.

Sindh is the second largest province of Pakistan, with an estimated population of about 40 million. The rural population of the province is ethnically very different from a large proportion of the residents of the three major cities, Karachi, Hyderabad and Sukkur. This ethnic divide is in addition to the huge urban-rural imbalance in terms of the civic and industrial infrastructure. While the rural areas of the province have the worst conditions in terms of physical infrastructure and social services provision, Karachi, the provincial headquarters of Sindh with a population reaching 10 million, has its own problems in terms of inadequate civic facilities for about 4 million poor living in some 500 squatter settlements. A majority of people living in middle class suburbs belongs to an ethnic group that migrated to Karachi from India in the first few years after Independence. On the other hand, a large number of people living in squatter settlements migrated to Karachi mainly from semi-urban and rural areas of the other three provinces, Punjab, North West Frontier Province (NWFP) and Baluchistan. Despite sharing a core culture influenced by the overall culture of the sub-continent and by religion, ethnic groups in Karachi are culturally very diverse with at least five major language groups.

Squatter settlements have basic amenities like water supply and electricity, and a

majority has gas connections for household purposes. However these supplies are usually deficient and the sewerage system is often in an appalling condition.

A squatter settlement essentially contains various 'communities' invariably constituted around ethnicity, occupation, or even political affiliation. This fragmentation hindered the development of common agendas, despite the fact that a majority suffers from similar health and social problems. Various community-based voluntary groups representing their own section within the larger geographical community take responsibility for health and social work. These groups, with little management training and with inadequate human and material resources, are only capable of working through a "service approach" rather than a "developmental approach". Service approach refers to a mode where these groups offer medical care, transport service, and other services such as assisting locals in negotiating the red-tape at the governments departments. On the other hand, a development approach refers to strengthening communities politically and supporting communities in developing social (education, health) and physical resources at the community's level.

These squatter settlements are diverse in terms of population size; although the majority has a population between 8,000-10,000, there are a few larger settlements as well. The squatter settlements are distinguished by their particular name, although it is often difficult to find where one settlement ends and another starts. Generally, each settlement is populated by a majority from one ethnic group, with other ethnic groups in a minority. Ethnic diversity, grouping on the basis of occupations, and conflicting political affiliations hinder their ability to work together for the same cause.

Understandably, people migrating to Karachi from the same area started living near to each other. This clustering was based on the migrants' need for the comfort of being close in a city where they did not have social support to the extent they used to enjoy in rural areas or small cities where they lived near their relations or tribes. Another reason was the propensity to be introduced to a similar type of job by earlier settlers of the same ethnic group. Thus, not only do the majority of people in a squatter settlement belong to the same ethnic group, often people with a particular trade or occupation happen to live together.

This does not mean that the adjacent areas comprise people sharing the same culture. Two geographically adjacent squatter settlements are often very different in terms of ethnicity. For example, in a population of 35,000 from 4 settlements where I worked, there are at least four major ethnic groups living together. In this particular case, fragmentation was on the basis of religion as well. About 5,000 Hindus were living as a cluster right in the middle of the Muslim population.

In terms of socio-economic class within these settlements, people range from the poorest the of poor – the Hindu community working as beggars, hawkers, and sweepers; to quite wealthy people who have a great deal of influence – for example some families who had a major ownership in Karachi's private transport industry. Each squatter settlement represents a variety of dwellings from one room houses to a few larger mansions occupied by people who have made their fortune after migrating to Karachi but still prefer to stay in these squatter settlements. These are influential

people because of their economic prosperity. They act as selected or self-declared leaders, and often have political influence through party politics as well. They prefer to live in these areas as they make these settlements their power base for provincial or federal party politics.

With the present bitter political divide between left and right wing parties in Pakistan, the population of any settlement is divided, with roughly equal numbers of people on each side of the divide. To get representatives of various sub-population groups on one platform to work for health development proved to be an up-hill task. At the same time, it was not feasible to work on a health and social agenda without getting involved with the local branches of the national-level political parties. Since political leaders were inclined to favour their voters rather than their constituency, a large number of community people and service providers in the private or NGO sector were sceptical of any organisational efforts involving political workers or leaders.

To add to the complexity, different ethnic groups had different political affiliations as well. Party politics in Pakistan still revolves around feudalism, and people's voting preferences are based not on what a party has to offer but mainly on the leaders' qualifications, such as whether he belongs to the same ethnic group, whether he comes from an influential (on the basis of economic status, caste, religion) family or tribe, or whether he is from the same religious denomination. National-level political parties have their bases, and are popular, in one particular province. For these reasons, the three sub-communities in that area which migrated from NWF Province and Punjab voted mainly for the Pakistan Muslim League (PML – the political party that had its

power base in Punjab and NWF Province). On the other hand, the Sindhi community living right in the middle of these three communities supported the Pakistan People's Party (PPP – the party of Benazir Bhutto, which at that time had support mainly from the rural areas of Sindh province). Paradoxically, the Hindu community living in that area, despite having their socio-cultural roots in rural Sindh, and despite being traditional supporters of the Bhutto family, turned against the PPP. This was most probably because the PPP was unable to lift the status of these poorest of poor people despite being led by the most influential family in Pakistan and Sindh politics for the last three decades.

This context is not complete without mentioning that at that time, despite the PPP being in power, this area voted heavily in favour of a PML candidate who won the provincial assembly seat. The PPP leader from this area, who had earlier won elections from this seat, was infuriated at the situation and was actually in a vengeful mood. Politically, he was still powerful as his party was in power nationally, in addition to being part of the provincial coalition government. This had implications for the health system development as the efforts for the community development were hampered. Community participation, which would have been much easier to achieve had his support been available, was adversely affected.

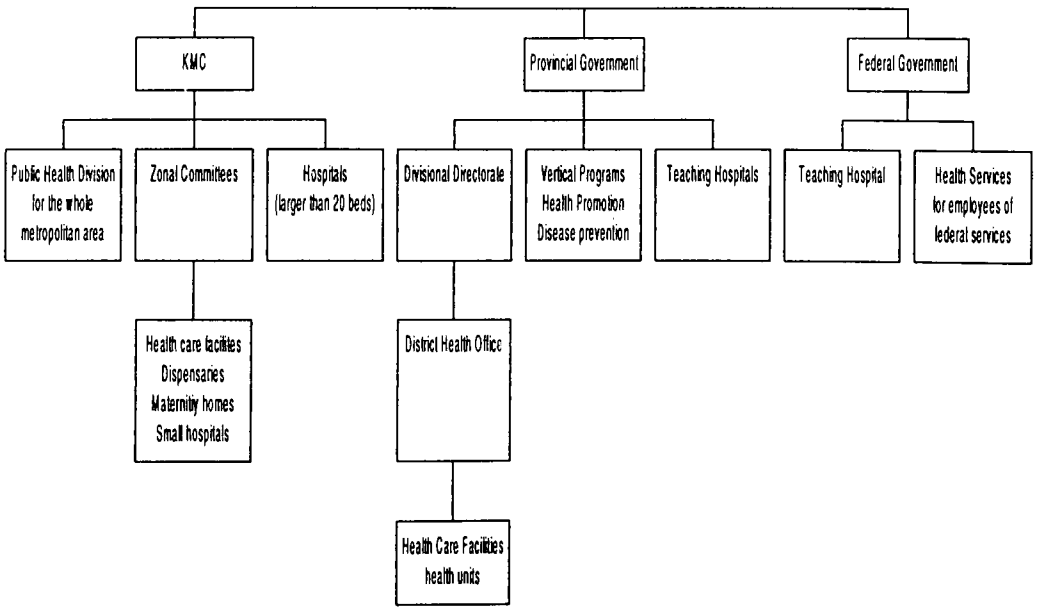
4.2.2 HEALTH SERVICES ORGANISATION

Health services provision in Karachi and its management is complex and fragmented to the extent that even within the services provided by the same level of the

government - either federal, provincial or local – medical care and preventive services are separated. Even within the curative services provided by the Karachi Metropolitan Corporation (KMC), hospital administration was arbitrarily divided into two levels. Hospitals with less than 20 beds were overseen by the zonal municipal committees, while hospitals with more than 20 beds came under the domain of the more central and overarching administration of KMC[9]. Various vertical programs, mainly preventive, which are run through separate infrastructures, further complicate the situation. These administrative arrangements have their roots in the overall management patterns of a hierarchical civil service structure making participatory planning and management for health regions difficult to achieve. See for example figure 4.1, which points to the hierarchy as well as complexity of the health care provision.

[9] At that time, the Karachi Metropolitan Corporation had five Zonal Municipal Committees. Each Zonal Committee was responsible for managing the medical services provision in the respective Zone (district).

Fig 4.1 Organisation of Public Sector Health Services in Karachi



The spectrum of private services stretches all the way from faith healers to tertiary care hospitals, which make the latest technology available to the rich on a fee-for-service basis. There are no formal horizontal or vertical linkages within the private sector or between the private and public sectors. While private health care providers saw little monetary benefit in interacting with the public sector, the public sector was sceptical about working closely with the private sector due to a perception that the already-constrained public sector resources might be utilised by the private sector for their own benefit.

In summary, the governmental health services in Karachi need to be sub-classified into at least three levels, namely: (1) Karachi Metropolitan Corporation (KMC), which provides primary level services such as dispensaries (health out-post for out-patient care) and maternity homes, and also owns various secondary and tertiary care hospitals, (2) the provincial government, which provides services through some dispensaries and maternity homes and owns a teaching hospital in that district, (3) the

federal government, which provides primary care through some dispensaries (for employees of the federal government institutions) and owns the largest teaching hospital in the district.

The primary care facilities were not planned to provide services to a particular number of people living in a circumscribed geographical area. This resulted in several areas having a number of dispensaries and others having very few. Services by the KMC were further fragmented with a division between medical services such as dispensaries, hospitals, and health services such as flies and dog control and collection of vital statistics.

There has been a history of political confrontation between the local and provincial governments in Karachi. During my period of work and observations, the provincial government represented rural areas of the province, which have a population ethnically very different from the Karachiites. Hence, achieving a close working relationship, implied by a District Health System, between services run by the KMC and services run by the provincial government became difficult to achieve.

To add to this complex public sector scenario, a large number of private medical practitioners, and private for-profit maternity homes and hospitals provide services to Karachiites. Private services, which prosper because of inadequate public sector services, have little interest in working closely with the governmental services. Commercial objectives of private service providers diverge from social objectives of

an integrated coordinated service provision. Additionally, a large number of charitable organisations provide mainly out-patient curative services and maternity care by deciding their target population, objectives and strategies, in complete isolation from the governmental or for-profit private sector.

4.3 LOCAL FACTORS INFLUENCING HEALTH SYSTEM DEVELOPMENT: EXAMPLES

The following are some of the observations which I made while working for the Family Health Project, and for other primary health programs initiated by the university, in the District South of Karachi. These observations helped in gaining an understanding about barriers to health system development in communities.

4.3.1 USE OF A COMMUNITY FACILITY

A community group came into existence when the primary health care (PHC) team from the university began motivating local people to work on community development initiatives. This group had members from the community at large as well as members from the local voluntary groups. The majority of the members of this group had favoured the political party in opposition at that time (reflecting the sentiments of the overall community). This group took a lead in using the local health outpost for meetings for the purpose of community development activities. The group, however, was composed of people mainly from ethnic groups that did not support a local politician who had lost the election although his party was in power at the provincial

and national level. That politician refused to support the group, despite being approached by them several times. He perceived the use of the health outpost by this emerging community group as a political activity which could further undermine his position. To thwart the process, he once warned the group that in a divided community such activities might lead to physical conflict. Despite the fact that the health outpost belonged to the KMC and his party did not have much symbiosis with the KMC, he was able to stop people using the health outpost because governmental facilities/buildings cannot be used by the public for political activities. This conflict at the community level decreased the interest of community members in such health and social development activities[10]. Some of the community members actually became afraid that this conflict might result in further tension in the community. It would have been much easier to work on community development activities and to promote community participation if these various tensions had not existed. There is no doubt that health system development, and community participation and community development activities are political in nature. However, because of the community and political peculiarities of that area, these political activities were being seen and labelled as party politics.

[10] At one stage the group, particularly the women who were more bothered by the lack of sufficient water supply, lack of adequate health care and by the fact that many houses were without gas supply, got strong enough that they started visiting government bureaux on their own. At one such meeting, when the women felt that their demands were not listened to attentively by the Karachi Water & Sewerage Board (KWSB), they themselves took from the KWSB store quite a few iron covers for the sewerage access holes in their area. They made their point that they wanted their situations improved so they were taking at least something to bring home. Sewerage in these settlements often presents a physical risk as often manholes are without lids and people and children fall into those manholes.

4.3.2 VOLUNTARY GROUPS

Large numbers of locally-based voluntary community groups working on health and social agendas are active in these settlements. Every squatter settlement had at least two or three active voluntary groups which, in contrast to voluntary groups in Australia, were composed of young people in their teens and early 20s. These boys are ambitious to do some service for the squatter settlement or for a section of the population within that settlement[11]. These groups have a high attrition rate and often disintegrate quickly. Furthermore, working on a developmental agenda is difficult for them, as they are not skilled in managing group activities or how to deal with the government bureaux and their red tape. After mapping the strengths and needs of these groups, the project team started working on developing links between some of them, strengthening their capacity for developmental activities.

Most of the community activists and motivated people did belong to one or other such voluntary group. For that reason it was important that these groups participated and represented the community in the health and social development activities. With the lack of community cohesiveness mentioned earlier, over a period of two years these groups from the area kept on working in almost complete isolation from each other, with little improvement in the local environmental or health care situation.

[11] There was one group only, which had a few girls as members. There were, however, two groups, which consisted of women and were working to help women develop skills, which they can use to earn a living. Larger NGOs and their branches in squatter settlements do have women members.

4.3.3 DEVELOPMENT OF A DISTRICT HEALTH MANAGEMENT TEAM

The conflict between the health systems of the Karachi Metropolitan Corporation and the Health Department of the Sindh Provincial Government led to difficulty in establishing a District Health Management Team (DHMT) and in particular in deciding who would chair that "all important" committee[12].

As the KMC and the provincial government services both sensed there was power linked to the concept of a DHMT, there was a long debate about the structure of the team and about who should chair it. This caused a delay in the establishment of a committee and the initiation of training sessions for the governmental and the KMC work-face managers on community development as well as managing health care services at the district level.

4.3.4 COLLABORATION BETWEEN PUBLIC AND PRIVATE SECTORS

The provincial government and the KMC were reluctant to include private-for-profit and not-for-profit organisations in their planning and health system development, fearing that they would ask for grants and shares from the Family Health Project budgets. One of the senior KMC health service officials once remarked that these non-government organisations (NGO) come to a meeting with an empty briefcase and want that briefcase to be filled with government money at the end of the meeting, particularly when these NGOs have learnt that the government has received funding

[12] Cooksey's discussion of political barriers to policy implementation because of a conflict between local government (Suburban Cook County) and the state (Illinois) in implementing health policy highlights similar issues.
Cooksey JA, and RM, Krieg. Metropolitan health policy development: barriers to implementation. Journal of Public Health Policy. 1996; 17: 261-274.

from an international agency.

4.3.5 THE FRONT-LINE HOSPITAL

The Family Health Project (FHP) envisaged a role for a front-line hospital for each district as it was realised that the health system is comprised of either health outposts, which see out-patients only, or tertiary care teaching hospitals that have to cater even to day surgery patients. Missing was a front-line hospital which could decrease the load of the tertiary care hospitals and which could become a referral as well as training support to health outposts. The FHP central management was under the control of the provincial health department. They wanted to build a new hospital in the area and were less willing to upgrade a KMC health outpost to a front-line hospital. The work on the front-line hospital was further delayed by added confusion caused by yet another local factor. As mentioned earlier, it was a time when the KMC was seen by the provincial and federal governments as an institution belonging to the ethnic majority in Karachi which did not vote for the party in power. Amidst all this, the provincial assembly member from that area who had made an election promise to build a hospital, was able to get sanctioned an annual development grant (a fund separate from the FHP budget) to build a new hospital in the area. This initiated a debate about whether that particular hospital should act as the front-line hospital or whether one of the KMC health outposts should be upgraded to be the front-line hospital. Another interesting way to look at this situation with regard to health system development, is to look at how a particular community is viewed by the party in power: whether they believe that the

community "belongs" to them or to the opposition. This is somewhat similar to the 'safe-seat' phenomenon in Australia[13].

4.3.6 Local Staff versus Hierarchy

The in-charges of health outposts (community health centres, Maternity homes), with experience of working in those localities for some time, were more aware of the need to interact closely with the other services and to involve the community in order to make services more accessible and comprehensive for clients. However, these work-face managers had little scope to plan locally under a traditional hierarchical model of management; they were required to act exactly according to directives from their respective departments. Fearing being penalised by their superiors, they were not willing to initiate community participation, interaction with other services in the area, or improving the out-reach component of PHC. Here again another local characteristic operated. With a first hand knowledge of the community's needs, two work-face managers started taking initiatives regardless of their hierarchies employing delaying tactics. These two in-charges were politically strong in the local context, so they were not afraid of taking initiatives for which other managers waited for a green signal from their respective superiors. One of these managers who took initiatives early was a young idealist who wanted to do something for the community and felt strongly about the appalling conditions in which the people had to live. He was willing to risk transfer

[13] The safe-seat phenomenon points to a predilection by a particular community to elect members of parliament from the same political party – a large majority of people living in these safe-seat areas share the political ideology. In contrast, "swinging-seat" areas are those where there is no clear majority of people favouring a particular political party. An important thing to note in both the 'Safe-Seat' and the 'Community Belonging to Opposition' phenomena is that the community is penalised because of its characteristics, configuration and ideology for which they tend to favour one or the other political party.

from Karachi to somewhere in the rural area. The spouse of another manager who volunteered to open her centre for local planning was a senior officer in the Karachi police. In a situation where staff are usually forced to act, or not to act, through job-related fears, having such a background helped that manager play down the threat of retaliation by the hierarchy. At the same time, that manager was a trained obstetrician and had developed a good trusting relationship with the local people, but was unable to help them during labour and post-natal care. She was unable to provide assistance to the community despite being a qualified obstetrician because the maternity home did not have facilities such as a functional labour room and an operating theatre. This situation further motivated her to work closely with the FHP team with a hope of making the maternity home functional as soon as possible.

Table 4.1 summarises a few important local characteristics, which were visible in Karachi's squatter settlements and did impinge on the health system development in these localities.

Table 4.1

Issues Influencing Health System Development in Communities

Organisational Factors	Community Context
• **Complexity of services in an area:** government at all levels involved with service delivery.	• **Community:** Diversity or cohesion on the basis of ethnicity, socio-economic class, political affiliation, occupation, or religion.
• **Fragmentation**: Separation of public health and medical care in both the provincial governmental and local government health care infrastructure.	• **Activists & Voluntary Groups:** Their capacity to work together or in isolation on a community development agenda and their ability to participate with health and social service delivery in the area depends on issues such as group composition, human resources, level of training to work with government bureaux, and their fear of working closely with the government.
• **The level of NGO activity** in an area and the distrust between NGOs and government with negative perception of each other's role in health development.	
• **Extent of the Private Sector:** Whether that private sector is mainly composed of general practitioners in that area or if it has larger powerful private hospitals, whether there are any institutions representing private sector components or the private sector as a whole with which the government or NGOs could negotiate working relationships.	• **Political Structure:** Issues such as politicians working for their voters rather than their constituency, whether a community, 'belongs' to opposition or government, and the politicians being keen on working for some visible projects such as hospitals rather than outreach but "invisible" services.

The context of the health services in the rural areas of Sindh province or in the rest of Pakistan may not be as complex as it is in Karachi. However, discussion about the health services of Karachi is important because of the setting of this research is urban and/or peri-urban. The topic of urban health derives its importance from the large number of people in developing countries who are migrating from rural to urban areas. While cities are growing larger and larger with quite a few mega-cities around the globe, many rural areas are becoming urbanised and are adopting social and service dynamics similar to that found in cities.

Discussion of Karachi's health services situation points to how health services are shaped by the influence of local organisational and socio-political factors. An in-depth understanding of these issues is required so that people involved with developing a policy framework are better informed, so in their policy documents they do entertain the role of local factors. As Morgan suggests, the patterns of organisation that unfold over time do so in an open-ended evolving way and successful strategic development cannot be too narrowly focussed[14]. The role of the local context must be identified because changes that would be introduced to an existing set of services without considering the context are prone to be ineffective.

Pointing to this complexity of health care provision is not to suggest that a centrally hierarchical model is the best, but to highlight the importance of considering local reasons for working relationships or fragmentation thereby to understand problems of

[14] Morgan G. Images of organisation. Beverly Hills: Sage, 1990.

policy implementation and to make services effective and accessible. The Family Health Project's aim to reorient the local services towards a system based on the comprehensive primary health care philosophy was not a wrong policy per se. However, the implementation of the change came across many obstacles and many of the objectives of the policy were not met. That was for the reasons that the policy proposal did not entertain the realities on ground, and the state-level players did not wish to incorporate the role of community-level stakeholders. In fact, some of the community characteristics which influenced the local health system development became visible only in retrospect.

CHAPTER 5

Research Design and Analysis

5.1 INTRODUCTION

In this section I try to make my field work methodology as transparent as possible. This is for two reasons. Firstly, it has been argued that many procedures used in qualitative research are not described in detail, leaving the reader bewildered as to how the analyst arrived at the implications of the study[1]. Presenting critical decisions and procedures helps readers to judge the internal validity of the research as well as to assess the validity of generalisations from the study. Secondly, the link between the data and the analysis is obvious only if the methodology is illustrated by clear examples from within the data. Essentially what we achieve by this process is to make methodology part of the analysis and discussion, rather than a separate list of manoeuvres.

Qualitative methods are an important research paradigm for program evaluation which wants to examine those internal dynamics between clients and interventions, and between interventions and services[2]. The utility and value of qualitative methods is now well recognised for health and social sciences research[3]. With a change from a mechanistic view of organisations to understanding them as a more human phenomenon, organisational research has moved towards an anthropological

[1] Anspach RR. "Field research and the sociology of (sociological) knowledge" in Deciding who lives: fateful choices in the Intensive-Care Nursery. Berkeley: University of California Press; 1993.
[2] Steckler A, McLeroy K, Goodman R et al. Towards integrating qualitative and quantitative methods: an introduction. Health Education Quarterly 1992; 19:1-8.
[3] Wolcott HF. Writing up qualitative research. Qualitative Research Methods Series 20. Newbury Park: Sage, 1990.

paradigm[4]. While it is argued that an understanding about organisation is best developed by qualitative methods[5], a combination of strategies has been proposed, under the name of triangulation, for better validity of the research[6]. Triangulation is the use of three or more different research methods in combination[7]. Various triangulation methods include data sources triangulation, research triangulation, methods triangulation and theory triangulation (Gifford S 1996)[8]. In the case of this thesis a proto-triangulation is achieved by comparing and contrasting the different Adelaide and Sydney experiences of community health reform.

In addition, although 'triangulation' might suggest direct observation, in this research I was not looking directly at how people were acting in the face of a change. Rather I asked them how they worked together and what happened during the change, what they did by themselves, what they knew about what others did, and what reasons caused those actions. By narrating what happened during the change, the respondents reflected on the perceptions they had developed about the change. They were able to explain the reasons for involving other organisations and community groups; this helped in gaining an understanding about the extent and the role of linkages in the community.

---

[4] Kinnunen J. The importance of organisational culture on development activities in a primary health care organisation. Int. Journal of Health Planning and Management 1990; 5:65-71.
Jones M, Moore M, Snyder R. Inside organisations: understanding the human dimensions. Beverly Hills: Sage Publications, 1988.
Frost P, Moore L, Louise M. Organisation culture. Beverly Hills: Sage Publications, 1985.

[5] Marshal C, Rossman GB. Designing qualitative research. Newbury Park CA: Sage Publications, 1989.

[6] Strauss AL. Qualitative analysis for the social scientist. Cambridge University Press, 1987.
Thomas S, Steven I, Browning C et al. Focus group in health research: a methodological review. Ann Rev Hlth Soc Sci 1992; 2:7-19.

[7] Pope C, Mays N. Reaching the parts other methods cannot reach: an introduction to qualitative research methods and health and health services research. BMJ. 1995; 311:42-45.

[8] Gifford S. Qualitative research: the soft option? Health Promotion Journal of Australia. 1996; 6: 58-61.

5.2 DECISIONS INFLUENCING THE DATA COLLECTION

Decisions about research methods could make a difference in terms of respondent bias or the openness with which the respondent reflects and respond on questions. Selecting the research site, timing for data collection, sampling methodology, making contacts through phone and recording and note taking during the interviews are examples of decisions which could affect the validity of the research. These decisions also determined my ability to get access to those people who actually had detailed information about the study sites and the health services. For example, I can now see how my timing to collect data in the Sydney metropolitan area coincided with the "Silly Season". I arrived there in November and people were preparing for duly earned long vacations at Christmas and New Year. I had to conduct interviews in November or January, as not many people were available for an interview in December. I was able to contact the people I set out to interview only because I was able to postpone the interviews to January. I highlight some of the decisions which impinge upon both the quality and quantity of data in the following sections.

5.2.1 SITE SELECTION

My principal interest was in what insiders say about how things happen in the face of a policy introduced by the central hierarchy. My chief practical problem was to select exemplary research sites. With my previous experience and inclination to work in areas of relative socio-economic disadvantage, I started consulting colleagues about the feasibility of working in the Northern or Western suburbs of the Adelaide

metropolitan area. Both these areas are relatively underprivileged in terms of social infrastructure and in terms of social indicators such as employment and education. However, there is an important difference in terms of community cohesiveness. Although there is a more multi-ethnic mix in the Western suburbs as compared to the Northern suburbs, the Western Suburbs are particularly known for their separate community identity within the metropolitan area. This issue is highlighted in the section on community cohesiveness and its influence on the health system development. The people who were able to help me access the area, and find a few persons to start talking about the research, had better working relations with health care providers and managers in the Western suburbs than their counterparts in the North. I had worked in the North for my Master's degree research and had some impressions about the working relationships in that area. I was concerned that this might influence my analysis if I collected information from that area again. In Adelaide's Western suburbs, however, only the first few interviewees knew me personally. Afterwards I was interviewing people who knew neither my academic supervisors nor me. The same was true for the interviews conducted in the South Western Sydney area: although I set out from 'mother ship' in each city, I was soon sailing alone in both.

In Adelaide, the South Australian Health Commission's (SAHC) organisational charts described the administrative boundaries of the Adelaide Central Region, with which the Western section had been linked, and identified senior and mid-level management concerned with health administration in the study sites. This helped in identifying different community health services to which the change was central. Directories of

health and allied services provided information on the number and type of services available in the study sites. In Sydney, such information was available from the Area Health Services (AHS) Management and the Division of Public Health of the AHS.

5.2.2 Studying a Region

I took a deliberate decision to not to work on a suburb level, but on the level of a "health district" or "health region" – because health services develop their links on the basis of their jurisdiction because from there they can draw resources. Formal links are between services, particularly the public services, be they community health services (CHS) or other publicly funded primary or secondary health care agencies within a region as defined by central authorities.

In the next chapter both research sites, Adelaide and Sydney, are described in detail in terms of the socio-economic and health services provision (including maps). Briefly, the Adelaide central planning region includes suburbs in both the east and west of the metropolitan area. I had an inclination to work in the Western suburbs but wanted to keep a focus on the whole central planning region as well. Although I did interview some people from the Eastern part of the central planing region, the majority of the interviewees were from the Western part. Two interviews were conducted with managers in the Northern planning region, in addition to reading relevant materials on how the amalgamation was achieved in the Northern region. This was done mainly for two reasons. Firstly, as managers are employees of the SAHC they are often transferred from one centre to the other or from one region to the other. I felt it

important and necessary to interview those who served in the central region for some length of time but were then moved either up in the hierarchy or were transferred to the Northern region[9]. Secondly, not only were the community dynamics in both these regions different, but some informants suggested that the managers in the North and West were quite different in terms of their approach to the change. Interviewing a few persons with different approaches to the change highlighted the role of the management in enticing the interest of the community and the service environment of the CHS towards the incoming change.

In Sydney, the South Western Area Health Services (AHS) are divided into five sectors for administrative purposes. As each sector has a comprehensive set of health services serving a large population, I conducted interviews mainly in three sectors – Fairfield, Liverpool and Campbelltown. However, my discussions with the people from these sectors and with the AHS management did include the health care changes at the overall AHS level.

5.2.3 AFFILIATION WITH THE AREA HEALTH SERVICES AND ITS STAFF

The Western suburbs being an under-privileged area of Sydney was the major criterion for my going there. A colleague of my supervisors was working there in a senior position within that Area Health Service (AHS), and as well as with the university

[9] Data collection and sampling frame is driven to a large extent by the relevance of certain concepts which become clear as the research progresses and the researcher recognises those new indicators and collect some data.
Strauss AL, Corbin J. Basics of Qualitative Research: Grounded theory procedures and techniques. Newbury Park, Sage 1990.

linked to the AHS. That contact facilitated access to the AHS and permission to use their office for the period I stayed in Sydney. I introduced myself as a visiting student from Adelaide. Only a few interviewees knew about my affiliation with the person who helped me get access to the AHS and its management. I conducted interviews in key informants' offices or homes. The only community activist whom I had to interview in my office within the AHS management office block made an observation many times during the interview, without prompting, that he was happy with the way the hospital was operating now and with how AHS was trying to involve the community in the decision making process. This gave an indication how association of the researcher with the organisation that is the focus of the research might colour the response.

5.3 FRAMEWORK FOR INFORMATION COLLECTION

Methods for information collection could be classified into two categories: (i) Provoked information, where interviews and focus groups were conducted with key informants; (ii) Natural (or secondary) information, which refers to the collection of relevant documents to do content analysis[10].

Provoked	Secondary
In-depth interviews	Content Analysis
# 29 in Adelaide	Minutes of meetings
# 36 in Sydney	Official documentation
Focus Groups	Process documentation
# 4 in Adelaide	Documents pointing to linkages
# 1 in Sydney	
	(Adopted from Juha Kinnunen)[11]

5.3.1 SAMPLING TECHNIQUES

The two main strategies used to identify key informants were snowballing where I asked the interviewees to provide names of other key informants, and purposive sampling which involved a deliberate choice of respondents[12]. Two criteria suggested the appropriate number of interviews in my case – purposive sampling and "theoretical

[10] "Key informants are people who are knowledgeable and whose insight can provide help in understanding what is happening".
Patton MQ. Qualitative evaluation and research methods. Newbury Park, CA: Sage, 1990.

[11] Kinnunen J. The importance of organisational culture on development activities in a primary health care organisation. Int. Journal of Health Planning and Management 1990; 5:65-71.

[12] Patton MQ. Qualitative evaluation and research methods. Newbury Park, CA: Sage, 1990.

saturation". Theoretical saturation is a concept that considers the collected data as sufficient when further interviewing stops providing new information and merely repeats what has been reported by previous interviewees[13]. Strauss pointed out that rigidity in sampling size and sampling methodology hinders theory generation[14]. In terms of purpose, I decided on the categories (e.g. manager, community people, hierarchy) of potential respondents before I started conducting interviews. The majority of interviewees were selected by the snowballing method. Additionally, I selected some interviewees regardless of whether snowballing indicated them or not[15]. This was to make sure that stakeholders from various predetermined categories were enrolled for the interviews. These categories included staff at the community health services (CHS), public health services other than CHS, community organisations, lobby groups from the community, the local council and its health and allied services, the local press; and university academics involved in the local areas service provision or research (Table 5.1).

The 'purposive' strategy also promised to overcome any bias in the sampling in case people provide the names of only those whom they know very well or with whom they share ideology or work. One such example is the local media. Most of the organisations and local health services at times advertised in the paper. On occasions, some staff would leak information to the local press in order to propagate a message

[13] Glaser BG, Strauss AL. The discovery of grounded theory. Chicago: Aldine, 1967.
[14] Strauss AL, Corbin J. Basics of Qualitative Research: Grounded theory procedures and techniques. Newbury Park, Sage 1990.
[15] This method is known as 'purposive sampling' -- a deliberate choice of respondents, subjects, or settings, or theory. See
Pope C, Mays N. Reaching the parts other methods cannot reach: an introduction to qualitative research methods and health and health services research. BMJ. 1995; 311:42-45. and
Patton MQ. Qualitative evaluation and research methods. Newbury Park, CA: Sage, 1990.

against or in favour of a particular project or a policy. Nevertheless, the local press was not mentioned in Adelaide by interviewees as a source of information, not withstanding that several interviewees collected clippings from the local paper and used them during the interviews. My purpose, to avoid bias, was also helped when, on many occasions interviewees provided me with the names of those who in their opinion did not share their ideology and would provide information from quite different perspective. It could be said that strategies to identify the interviewees need to consider people who, in the researcher's judgement, hold key information but are not mentioned in the snowballing process which the 'theoretical saturation' considers.

5.3.2 SAMPLE SIZE

In Adelaide, 29 interviews and 4 focus groups were conducted. Another 26 people whose names were provided by the key informants were not interviewed. In addition to the phenomenon of theoretical saturation, the exclusion was based on other factors such as: that interviewees provided names of more than one person in various categories; health professionals and managers from the study site wanted me to talk to their counter parts in other areas of Adelaide; and some names provided by the senior management were neither related to policy making for the study site nor they were involved in implementing services. Key informants belonged to various categories mentioned earlier. If names of a few people from the same category were mentioned as potential interviewees, the persons from the study site were considered for the interviews before conducting the interviews with people from outside the study site. After two or three interviews with persons falling into one category, interviews were conducted for persons from other categories (Table 5.1a & 5.1b)

Table 5.1a

Interviewees and focus groups – Adelaide

Central Management & Planning

A staff member, Central Health Services Planning Unit,
A senior staff, Metropolitan Health Services Division, South Australian Health Commission
An Ex-Director CHS, now at Health Commission
An Ex-CEO Adelaide Central CHS

Community Groups & Activists

Convenor "Friends of a Local Hospital"
A community volunteer at "Our Place"
FOCUS GROUP with the community activists

Staff CHS & Women Health Services

Team Manager at a community health centre
Director, Women Health Services
Director one of Northern CHS
Director one of Western CHS
FOCUS GROUP, CHNs from various CHS
FOCUS GROUP, the staff of a health centre
FOCUS GROUP, managers of health centres

Local Governments

Community Development Officer
Director Community services
Crime Prevention Officer, local government

Community Members on CHS boards

Community member on the Board of CHS
Community. Activist & Ex-chairperson at CHS board

Services other than CHS

Coordinator - a church-based non-government organisation
A staff member, Family Centre
Staff member local branch of CAFHS
Worker with a school health project
Acting Director local Child and Adolescent Mental Health Service
Worker, Social, Health & Welfare Council
Staff at an Aboriginal Health Centre

Division of General Practice (DGP)

Community Liaison Officer at the Western DGP
A senior staff at Eastern & Central DGP

State & National Level Lobby Groups

Local representative of Australian Medical Association (not recorded)
Australian Nursing Federation representative working with community (not recorded)
A senior staff, Hospitals & Health Services Association of South Australia

Local Press

Reporter, suburban newspaper
Reporter, suburban newspaper

Table 5.1b

Interviewees and focus group – South Western Sydney

South Western Sydney Area Health Services (SWSAHS) Central Management & Planning

A senior staff, Health Promotion Unit,
Coordinator, Ethnic Health,
A senior staff, Planning Division, (university lecturer as well)
Area Advisor,
Community Paediatrician

University Academics affiliated to SWSAHS

A senior staff at the Population Health
A senior staff at the Epidemiology Unit

Other academics (from university working with AHS)

A senior faculty member, Public Health, University of Western Sydney

A faculty member University of New South Wales
Coordinator, General Practice Integration Studies, University of New South Wales

Shared Care

Incharge, Aged Care, Liverpool Health Services
Incharge, Diabetes Shared Care, Bankstown
Incharge, Diabetes Shared Care, Liverpool
Incharge (Professor), General Practice Unit, Fairfield Hospital

Division of General Practice

Chairman, Liverpool DGP
Chairman, Fairfield DGP
Chairman, Campbelltown DGP

Community Members

Health Activist, Liverpool, Ex-councillor Liverpool
Health Activist, Fairfield
Health Activist, Liverpool
Health Activist, Consumer Consultative Committee

CHS and Hospital Staff

General manager Liverpool Health Services
General manager, Fairfield
General Manager, Campbelltown
Community Project Coordinator, Hoxton Park
Voluntary Coordinator & Public Relations Officer, Liverpool Hospital
Director, Community. Health & Allied Services, Fairfield
Manager, Community Health Centre, Campbelltown
Ethnic Obstetrics Liaison Officer, Fairfield
Community project coordinator, Liverpool
Director Nursing, Campbelltown Health Services
Incharge, Palliative Care, Bankstown

Local Governments

Councillor, Fairfield, ex-Mayor and worked on Fairfield Health Forum
Frail, Aged and Disability Worker, Liverpool Council

Local Press

Reporter, Health & social issues, suburban newspaper, Liverpool

Others

FOCUS GROUP, Staff Migrant Resource Centre, Campbelltown
Manager, Cancer Council, South Western Sydney

In Sydney, 36 interviews and one focus group were conducted. These interviews covered different categories of stakeholders, including university academics. Universities were directly involved in service provision with many academics holding conjoint appointments with the Area Health Services (AHS), particularly in the health promotion area.

All of the 65 interviews (29 in Adelaide and 36 in Sydney) as well as the focus groups were conducted by myself. The interviews were of 50 minutes duration on average – with a range of about 40 to 90 minutes. Snowballing was started by interviewing a senior level manager and a health planner for each research region. In Adelaide, these senior level managers referred me to managers taking care of the various community health centres, to four people at the South Australian Health Commission (SAHC), and to a health activist. Three interviews were conducted with people who were not mentioned by any of the interviewees. Four focus groups were conducted with the staff of a community health centre, managers of community health centres in one area of the region, a community health nurses' forum formed to address recent changes from the nurses' point of view, and a group of health activists from the community. In Sydney, in addition to the 36 interviews, one group discussion was held with the staff of a migrant resource centre.

5.3.3 Response Rate

Only one person, in South Western Sydney, out of all those who were contacted refused me an interview. Another, in Western Adelaide, asked for a questionnaire so

he could fill it out in his free time. Both of them were general practitioners (GPs). The GP from Adelaide was selected for the interview because he was the local representative of a national level lobby group representing one cadre of health professionals. The other, who was practising in Liverpool area of South Western Sydney, was selected as a GP who was not involved with the Divisions of General Practitioner (DGP). However, during the preliminary telephone discussions both seemed to have little information with regard to the amalgamation of CHS (in Adelaide) or the integration of health services (in Sydney). While, from the qualitative research point of view, I was looking for subjects who had in-depth information so as to help find the influence of various stakeholders in the local health services development, it could be said that their refusals did not severely affect the information I was to receive. This in itself indicates that general practitioners as a political group, seemed to have little involvement with policy development at the local level. Perhaps they do not see themselves as a lobby group that needs to be active at the local level although, in that case, it is difficult to imagine the reason for having a local representative.

5.3.4 Interview Logistics

While pointing out the importance of an adequate time length for the interviews, allowing the subject to speak her/his concerns, and creating an environment conducive to openness, Bogdan and Taylor alert us to the rather more important concept that, ultimately, what is important is not the procedure but the frame of reference[16]. They

[16] Bogdan R, Taylor SJ. Introduction to qualitative research methods: a phenomenological approach to the social sciences. New York: John Wiley & Sons, 1975.

point out that a clear understanding of goals, subjects and interview situation leads towards an in-depth knowledge. However, while it was important for me to keep an eye on what my goals were for this research and what I intended to look into, it is important to narrate how I contacted potential interviewees and to describe the logistics of interviewing. This discussion derives its importance from various perspectives. Researchers may be under a false impression that contacting and interviewing a few individuals would not be a difficult proposition. This assumption may lead to under-estimation in terms of time and budget, and have serious connotations for the overall organisation of the study. Occasionally, the person providing the name of someone provided the contact telephone number as well. For the majority I had to identify the contact by checking with the workplaces where they worked. In a few cases, the provider of a name was not even able to identify where that person was working. For a few people I had to ring only once informing them about myself, what research I am conducting, and that I would like to interview him/her, and that person was able to identify a date and time for the interview. However, for most of the interviews I had to make an average of five calls to trace the interviewee, then arrange, confirm and remind interviewees of interviews.

In Adelaide, it took three and a half months to complete the interviews and focus group discussions and to collect the secondary information from various centres and organisations related to the change in focus. In Sydney, interviews were completed in two months. This was probably because of the experience I had gained in Adelaide in contacting people. I had a time frame in mind for my stay in Sydney and was less

lenient as far as the scheduling of interviews were concerned[17]. However, it is worth mentioning that it took more than one year to arrange access to the Area Health Services (AHS) in South Western Sydney. Even before I started conducting interviews in Adelaide, I asked an academic working with the AHS to identify any change which was happening at that time and which I could use to highlight the local health system development. With his assistance, I was granted permission to use the facilities at the AHS office and conduct interviews with the staff of any component of AHS. However, the staff came to know about the research only when I contacted them and identified myself as a student from Adelaide. For a free and uninhibited flow of information it was important that I was not taken as another staff member from their health services.

All but two interviews (one each in Adelaide and Sydney) were conducted either at the workplace or in a few cases at the home of the respondents. The exceptional interviews were conducted at my workplace, as that was convenient to the respondents. Conducting interviews at the respondents' workplace was not only convenient to them but helped in collecting secondary information as well. More importantly, conducting interviews at the community health centres and other services provided me opportunities to meet their colleagues; to get to know the working of individual services, and to have some impression of the activities and the types of clients using their services.

In both study sites, interviewing and secondary data collection involved a lot of commuting. For example, the study site in Sydney included Fairfield, Liverpool and

[17] I am thankful to the interviewees as they obliged by conceding to my time frame rather than theirs.

Campbelltown which are considerable distances from each other. I was based at the Liverpool Hospital, with Fairfield about 12 kilometres to the Northeast and Campbelltown another 18 kilometres to the Southwest. Generally only one interview was conducted in a day. I decided not to conduct more than two interviews in a day. This strategy left time for making notes on the contents of the interviews before listening to the tapes. I was able to spend a little extra time at the interviewees' workplaces.

Names of the persons, and references to written material provided by the respondent were also noted. Names of individual respondents and of institutions are confidential and have been kept by me only in order to analyse the data and to understand the context of a particular response by a particular interviewee. The data is safely kept at my office and home.

5.3.5 Open-ended Questions

Questions asked during the interviews were open-ended; respondents shifted/jumped from one idea to another frequently. I interrupted only when I felt that the respondent had started talking about a phenomenon of little relevance to the issue being addressed. For example, on the question "what health and social services you are working with?", if the respondent started discussing the detailed nature of her work with (say) the education department, and that again with little reference to the local population or local educational institutions, only then did I interfere. To bring the discussion back to the local level I asked questions, for example, "you mentioned working with schools in

the area and the assistance you get from other agencies, could you please expand on that?" Open-ended questions gave leeway to the interviewees to shift from one idea to another and present a synthesis, from their perspective, on what was happening around them.

5.3.6 TRANSCRIBING

Out of 70 interviews and focus group recordings, 46 were transcribed by myself. Twenty (20) were transcribed by a friend who worked at the University Public Health Department and who had experience in transcribing interviews conducted for public health research. It was necessary for the transcriber to know my accent (English is not my first Language) and the context of the study to transcribe the contents accurately. Four of the recordings were not formally transcribed because of poor recording quality; I had made some hand written notes immediately after these interviews and further notes by listening to those four tapes a few times. On an average each hour of recording took five hours to transcribe. I considered it important to record even the mood and the level of assertion with which a respondent answered a question or pointed to certain issues. These characteristics of conversation were noted in parentheses [ ] while transcribing. As I did two-thirds of the transcribing myself, listening to respondents for long hours helped not only to better understand the content but also to formulate hypotheses about the content.

5.3.7 COLLECTION OF SECONDARY INFORMATION

The term 'secondary' information covers what I introduced, earlier in this chapter, as

natural, not provoked information. Respondents were requested to identify any written material which could highlight: the process of implementing the change; interactions between agencies in the region; and the mechanisms of service delivery. In the Adelaide Central Health Region, twenty seven documents were collected. These documents ranged from annual reports to memoranda of understanding between local agencies. There were draft submissions by the community health services to the South Australian Health Commission on the process of amalgamation and the proposed organisational structure. In the Adelaide Central Region, the implementation process of amalgamation was monitored by a Process Coordinating Group (PCG). This group consisted of community health services (CHS) directors and a nominee from the staff of each CHS in the region. Their task was to ensure that the process proceeded and the amalgamation was implemented in the stipulated time. Collected documents included minutes of the meetings held by the PCG over one and a half-years. A full list of the documents collected in Adelaide, and in Sydney, is attached as Annex I. Additionally, I was allowed to go through, and copy, relevant information on the process of amalgamation in the Northern Adelaide Region. This information, which was kept at one of the community health centres, was reviewed extensively and notes were made.

In Sydney, sixty four documents were collected, including policy and planning documents and annual reports of the South Western Sydney Area Health Services. Information on various shared-care projects was collected from various Divisions of General Practice, hospitals, General Practice Unit, and Community Health Services. These shared-care programs were aimed at developing linkages between the general practitioners and the Area Health Service. These reports were read carefully and notes

were prepared to be read in conjunction with various themes and issues discussed in the thesis. A data set of document titles was created as it helped in retrieving any of these documents for re-reading and referencing.

Collaboration and networking at the local level is one of the important mechanisms of PHC provision; these issues are of central concern in this thesis as well. The collected documents, for example, were read to find out the level of interaction and whether or not that existing interaction was considered during the amalgamation process; and whether CHS tried to make the new organisational structure fit to the existing interactions.

5.4 DATA ANALYSIS

A computer software package "NUD-IST", common in Australian qualitative research, was used for data handling but it was the tool, not the driving force, of my analysis. After developing the transcripts of interviews using the Microsoft Word processor, each transcript was divided into data-bits (a paragraph or few sentences)[18]. NUD-IST was used to arrange data into various categories. Using NUD-IST, it was possible to combine information located within different categories. For example, the information

[18] The idea of splicing text into data-bits, committing them to different categories, and linking various categories through hyperlink is borrowed from Ian Dey (Dey I. Qualitative data analysis: a user friendly guide for social scientists. London/New York: Routledge, 1993). The transcribed text from interviews was split (after being backed-up in its raw form) into sentences and paragraphs which were coded to decide on what categories they belong. These coded sentences and paragraphs are considered as data-bits. For example, the following sentence is an example of a data-bit which was assigned to the category of "community participation: "I think people are on a continuum in a sense, on one extreme are people who are very much involved in all the aspects of the change [and] there are people who just sit along and are not much concerned about what is happening".

on the issue of 'local interaction' was placed within different categories such as 'formal' and 'informal'. Using NUD-IST it was possible to browse all this information for an individual respondent, for a category of respondents, or for the whole data set. Decisions about the categories are made by the researcher, not by the program.

My categorisation and data analysis was based on the grounded theory of qualitative research[19]. The grounded theory approach aims at developing a theoretical framework which provides an understanding about the phenomenon in question. This approach could be contrasted to the type of analysis where pre-existing theories are used to develop an analytic framework in order to 'test hypothesis'[20]. In the grounded theory tradition, the process of data analysis has been classified into four stages leading from general concepts to the development of specific theories[21]. These four stages are: (1) *Exploration,* in which raw data is searched for concepts relevant to the main question of the research (such as the interactions at local level). (2) *Specification,* where each concept is further developed by identifying various relevant variables (such as the reasons and intensity of interactions at local level). (3) *Reduction,* which is developing new theory about a concept and its variables. Identifying the influence of interaction on the amalgamation process could be labelled as reduction in the scheme of this research. (4) *Integration,* which tries to develop linkages between various concepts and tries to

---

[19] Glaser BG, Strauss AL. The discovery of grounded theory. Chicago: Aldine, 1967.
Strauss AL, Corbin J. Basics of Qualitative Research: Grounded theory procedures and techniques. Newbury Park, Sage 1990.
Turner BA. Some practical aspects of qualitative data analysis: one way of organising the cognitive processes associated with the generation of grounded theory. Quality and Quantity. 1981; 15:225-247.

[20] Analytic framework based on some pre-existing theories is sometimes used in case study evaluations. Keen J, Packwood T. Case study evaluation. BMJ. 1995; 311:444-446.

[21] Peter V, Wester F. Qualitative analysis in practice. Department of Research Methodology, Social Science Faculty. Netherlands: University of Nijmegen, 1990.

develop an overall understanding of the issue and to formulate conclusions. The main thrust of grounded theory's reduction and integration stages lies in the question "what is the main story?"[22]. In that sense, I tried to look at the data from both research sites to find out the main stories which were overlapping, and whether some information was site specific.

This research is not to identify evidence for what I already 'know'; I did not put a proposition up front that "more intense collaboration among local services would lead to a greater influence on the organisational re-structuring" and then set out to prove it. This research is more like identifying what the situation is out there - equivalent to an exploration to develop an in-depth understanding and generate hypotheses. I would like to see the discussions as stirring a debate to raise questions about the process of health system development and to find out who the actors are. In laboratory terms we could equate this debate to centrifuging a fluid to separate precipitate from supernatant. While personal experience in Karachi and Adelaide was a force motivating me to embark on this research, the experience and knowledge gained through my work in Karachi becomes another source of data approved by Glaser and Strauss's view that a slice of data which should be used is the "anecdotal comparison" particularly if the experience was "lived" by the researcher.

[22] Strauss AL, Corbin J. Basics of Qualitative Research: Grounded theory procedures and techniques. Newbury Park, Sage 1990.

5.4.1 CLASSIFYING AND ANALYSING THE DATA

One approach to analysing multi-subject interviews is to code the data in terms of themes and hypotheses[23]. The stages of the grounded theory, as mentioned earlier, require that data is classified and searched for various concepts. Once all interviews were transcribed, they were converted into text-only files for the purpose of slicing the data into data-bits using NUD-IST. The volume of the material was huge, with the main task of managing and deductions still ahead. As nicely put by Wolcott, the major task in qualitative research is not the data collection but to "get rid of the data"[24]. Getting rid of the data involved categorisation, identification of data-bits as well as pruning of the data by deselecting some of the less relevant discussions. There is no doubt that this process involved my judgement, however. I classified the data into three major areas.

The first category is the information directly relevant to the main question of interaction; the bulk of the data fell in this category. It includes information such as whether a person is part of a lobby group or is a member of the board of directors; how they interact with the health and social services; or how they negotiate with the central hierarchy on behalf of the local services. Let me take as an example a response from one key informant (news reporter for the local suburban newspaper) and follow it to highlight how I decided what was to be considered as "directly relevant". The issues on which reports are published in the local press reflect whether the local press tries to

---

[23] Bogdan R, Taylor SJ. Introduction to qualitative research methods: a phenomenological approach to the social sciences. New York: John Wiley & Sons, 1975.

[24] Wolcott HF. Writing up qualitative research. Qualitative Research Methods Series 20. Newbury Park: Sage, 1990.

take part in a particular policy development process. Those issues and their discussion by the reporter were considered as directly relevant to the purpose of the study. Similarly, "what were the sources of that reporter" provides an idea about the local networks and points to the willingness of different institutions to use each other to affect the local health system development. Privatisation, contracting out of services at the local hospital, mergers between different health care services and the disbanding of some services were the issues commonly reported by the newspaper – sometimes through investigative journalism, on other occasion by publishing briefs from the affected services.

The second category is to do with "indirectly relevant" data-bits. Perception of a respondent about what was happening between two other institutions or between a service, to which the respondent did not belong, and the local people, is an example of indirectly relevant material. A news reporter's ideas on who were the motivated people participating in the health development process and how they influenced this process is another example. Such information is not published in the local newspaper; nonetheless such background knowledge was available to the reporter and provided clues as to who were the policy movers at the local level. Discussion by respondents of privatisation of a hospital in another area of the metropolitan as a reason behind local people lobbying for their hospital to stay public is another example of this category.

The third category is classified as "important but not relevant to the central research question". Why that reporter was motivated to report on health and social services is an important issue related to personal motivation; in that person's case perhaps it was

the way her grandmother was treated at the local hospital. These personal factors may enhance community participation in the policy making process. "What is happening?" at the local level was the central question. "Why it is happening?" was also considered a relevant issue as far as an institution or the community as a whole was concerned. The motivation of the local press is altogether a different matter when compared to the motivation of a reporter. A paper probably cannot ignore an issue as cogent as the social consequences of boarding housing in a metropolitan area. These issues are of news value, and even if the paper does not have any altruistic reasons it will publish material on such issues of local concern. An analysis category "personality" was there to discuss the role of motivated people, but not to explore the rationale behind their motivation. It is a major area to be explored by social psychologists. The data-bits in this class were retained, not discarded, in a different file.

To facilitate the analysis, the data were classified in another fashion as well. Some interviews were conducted with people from within the services which were the focus of the change. Others were people who spoke on behalf of the recipient of services. Additionally, a few interviewees were neither the service provider nor recipient of those services. Local governments fell in this category; they were mainly concerned with the overall supply/demand balance in the area and therefore their interaction with health and social services was of a different nature. The decision to create these categories was actually taken when I decided to interview people from these three different areas. In South Western Sydney for example, some interviewees were at the centre of the integration activities. Some other interviewees, however, belonged to agencies or groups which were not directly involved with the integration activities but

did interact with the Area Health Services (AHS) or the Divisions of General Practice (DGP). The interviews with the personnel from DGP, AHS Shared Care Programs, and AHS hospital managers belonged to the first category. On the other hand, the local consumer groups or the local councils set the context, or are affected by the changes in the AHS, but are not at the centre of the change.

Three actions during the course of data collection helped towards categorisation. Developing themes around which interviews were conducted, discovering issues of relative importance from the literature, and reading transcriptions and writing preliminary descriptions without going through computer-assisted systematic analysis helped in identifying various categories around which data was spliced. I was able to write some description before systematic data analysis as I collected the data and transcribed it myself – categories emerged as I went through collection and transcription. Hughes has earlier pointed out that 'analysis categories' emerge from reading field notes and that some core issues related to the research question could be developed from these emerging categories during the course of reading field data[25]. For example, the first few interviews raised the issue of the role of personal motivations and personality characteristics towards local health system development. In the subsequent interviews, I started asking questions about "personality". This process lead to the development and discussion of a category during the course of the fieldwork. In a sense, the analysis was already started, in my head and in the notebook, while collecting the data. This fits with the notion that, in qualitative research, data

[25] Hughes C. From fieldnotes to dissertation: analysing the stepfamily. In Bryman A, Burgess R. (editors) Analysing qualitative data. Routledge: London, 1994.

collection and data analysis are inseparable.

To begin with, about 66 categories were created (and entered into NUD-IST) within the few major larger categories such as "Health Service Providers", "Client & Community", "Interaction & Linkages" and "Background information on social & organisational factors". Later some of the categories were merged with each other in an attempt to keep their number to an essential minimum. On the basis of existing knowledge on what influences local health services development and more importantly with increasing awareness about the nature of information provided by the respondents, I was able to develop these preliminary categories into which data-bits would be allocated.

Each category was defined in terms of what information would be submitted to that category. A definition was constructed for each category as well as sub-category. These definitions helped in assigning the data-bits to various categories. For example, "Orientation of managers" was a category where I kept the information about the ideology of work-face managers, such as whether they seemed to believe in managerialism or whether they held some other ideology, such as community participation, which is in conflict with managerialism. This difference in working pattern was the reason for creating category "Pro-hierarchy". For example, the sentences and paragraphs pointing to the way local managers compromise the principle of community participation to accommodate economic rationalism and commands received from high-up were assigned to this category. Comments such as "my understanding of that region is that they had a certain amount of consultation but not

[to the extent we had in our region], it [the amalgamation] was virtually imposed on them ... I think the Health Commission put [managers of its choice] in charge over there and they somehow did it [the way SAHC wanted the amalgamation to happen]" reflects the way management is classified and compared by the workers at those centres. This was a reason for people to believe that managers from a particular health region were less participative in nature; and a reason for me to commit this statement to the category "pro-hierarchy".

While this classification and categorisation could be considered as "data entry", it was more a proto-analysis itself rather merely the feeding of statements into the computer. Not only was the whole data set read in the light of existing theories and labelled accordingly but, through critical review, new categories were being generated as well. "Interaction and linkages" is one of the most important themes in this research. The text of each interview, for example, was searched to find various perspectives on the issue of interaction and linkages. This process not only highlighted the extent and role of the local linkages; it also helped to reveal the issue of interaction from various new angles. For example, the category "source of information to the local press" was invented because my reading the transcriptions revealed that the press receive information through various channels. These information channels are dependent on the perceived importance of an issue and the motivation of stake-holders in linking up with the press. Table (5.2) points to various issues which appeared as important preliminary categories while I was skimming the raw data.

Table 5.2

Issues for Analysis

Services:

Pro-ideology, pro-hierarchy managers
Staff
- Living somewhere else
- Commitment
- Turnover

Links with the private sector
Following fashion in introducing a change
Community dynamics
Political powerlessness in a "safe-seat area"
Champions in a vacuum
Ethnic groups and health services
Holistic care in a multicultural community
Role of the local government
- Health care provision
- Influencing decision making

Academic Staff
- Turnover compared to other staff
- Difficulty in changing the norm
- Incompatibility between ideologies of academic & health providers

Local Media
Interaction
Horizontal Links
- Community - Services, Individual - Service, Group - Service
- Formal, Informal

Vertical Links
- Services—central management
- Community—central management
- Other services—central management
- Community—political institutions

Policy Implementation Dichotomy

5.4.2 ANALYTIC MEMOS

Memos that reflect upon the site, the respondent or the issues discussed by the respondent, are an important tool for qualitative data analysis[26]. I made notes on interviews to reflect on major themes discussed by the interviewees. These memos covered issues such as the use of terminology by the different players, community participation or community consultation, and local managers as professional monopolists. These memos later provided frameworks for analysis and discussion. The following are a few examples.

> ***Analysis and the use of adjectives***
>
> Community members use affective adjectives; adjectives which reflect attitudes such as 'good', 'bad', 'wonderful', 'disgraceful'. They do not use words denoting beliefs; words such as 'appropriate'. On the other hand, academics as well as managers of health services use cognitive adjectives such as 'ineffective', and 'appropriate'. Using this memo, I have tried to use adjectives which were used by the respondent rather than making my own judgement to find an equivalent cognitive adjective, I tried to avoid changing 'good' into 'appropriate'.

> ***New jargon and health system research***
>
> Newly coined terms "outcome-based projects" and "outcome-based research" seem to have replaced titles such as "applied research". This usage has something to do with the economic rationalisation and an effort to make projects oriented towards evaluation where they shift their gaze from impact to outcome. Documents from the Department of Health, Housing and Community Services, National Health and Medical Research Council are becoming prolific in the use of these terms. Outcome-based research in lieu of applied research may be a better term. However, the term outcome-based projects gives a false impression; it seem to suggest that all existing or past projects did not care about benefits to the community. Here is another point to ponder; the community seems more interested in process whereas the health service providers and funders are more interested in achieving a certain outcome - with little regard to the community and client approval of the process to achieve that outcome.

[26] Schatzman L, Strauss A. Field research: strategies for a natural sociology. Englewood Cliff NJ: Prentice Hall, 1973.

Terminology change from "community" to "region"

Documents from SAHC as well the CHS show that the term community is replaced, to some extent, by the word region. Their reason seems to be that the services are now to be organised at the regional level rather than at a level which was considered as "a community" by the health services. If community is defined at a neighbourhood level, service providers might not see themselves working near to the community, as they are now part of a larger region-based organisation. They may be using the term regional health services for two altogether different phenomena; they now see themselves at a distance from the community or this term is used merely to make a clear distinction from existing CHS while comparing the new with the previous organisation.

Perceived powerlessness

Often policy analysts focussing on the larger policy issues try to find out to what extent decisions such as the introduction of case-mix or purchaser-provider split strategies are being influenced by the consumer. This approach portrays the consumers, and community institutions negotiating on consumers' behalf, against a powerful government bureaucracy on one hand and the powerful medical profession on the other. With a perceived helplessness of consumers in influencing the policy process Bates suggests that only the most assertive and persistent consumer can stir in any planned developments[27]. I would agree that for the larger national policy level this perception could be true. However, such an approach does not appreciate the negotiation power of the community and its structures to influence the detailed planning and implementation. This negotiation, causing amendments and/or delays, at times successfully tries to make the planned change fit to local needs. This process tends to lessen any deleterious effect of new development on the balance of local needs and service provision.

[27] Bates E. Health systems and public scrutiny: Australia, Britain, and USA. UK: Croom Helm, 1983.

5.5 CONCLUSION

The methodology as described in this chapter, which I employed for this research, helped in gaining an in-depth understanding of two Australian health services situations at the community level. While I achieved an understanding about the health system development in Karachi, as mentioned in the preceding chapter, as a participant-observer, interviews and analysis of secondary information were the mainstay of research methodology in Adelaide and Sydney. A combination of methods including key-informant interviews, focus groups, and analysis of secondary information provided a tool to explore the role of various local policy actors in terms of their interactions and the role of that interaction in influencing the health system development. Principles of data collection in interview research – purposive sampling, snowballing and theoretical saturation – served well to identify the information needed for an insight into the working of health services in the Adelaide and Sydney community settings.

Analysis by way of grounded theory helped in understanding the reasons for local networking and collaboration. This approach to the analysis also helped in developing a theory about the importance of these networks and collaborations in determining the fate of policies proposed to health services in the communities. The frank and open discussions by the key informants, about the local dynamics, and the rigorous and systematic approach with which I tried to identify and analyse the ground realities, helped in discerning the community's perceptions about, and actions towards, the proposed changes to their health systems.

CHAPTER 6

Context of the Proposed Changes: Community Dynamics and Health Services Provision in Adelaide and Sydney

5.5 CONCLUSION

The methodology as described in this chapter, which I employed for this research, helped in gaining an in-depth understanding of two Australian health services situations at the community level. While I achieved an understanding about the health system development in Karachi, as mentioned in the preceding chapter, as a participant-observer, interviews and analysis of secondary information were the mainstay of research methodology in Adelaide and Sydney. A combination of methods including key-informant interviews, focus groups, and analysis of secondary information provided a tool to explore the role of various local policy actors in terms of their interactions and the role of that interaction in influencing the health system development. Principles of data collection in interview research – purposive sampling, snowballing and theoretical saturation – served well to identify the information needed for an insight into the working of health services in the Adelaide and Sydney community settings.

Analysis by way of grounded theory helped in understanding the reasons for local networking and collaboration. This approach to the analysis also helped in developing a theory about the importance of these networks and collaborations in determining the fate of policies proposed to health services in the communities. The frank and open discussions by the key informants, about the local dynamics, and the rigorous and systematic approach with which I tried to identify and analyse the ground realities, helped in discerning the community's perceptions about, and actions towards, the proposed changes to their health systems.

CHAPTER 6

Context of the Proposed Changes: Community Dynamics and Health Services Provision in Adelaide and Sydney

6.1 INTRODUCTION

This chapter describes the study sites in terms of their socio-economic situation, specific health needs, and organisation and provision of health services. This description is to act as a backdrop against which I discuss what was happening and who was involved in the process of change in health services[1]. Milio points out that such data should include information on the social climate, the nature and size of organisations, the perceptions of the interested parties, the strategies these parties deploy to influence policy, and their view of short and long term feasibility of a given policy. In this thesis the perceptions and strategies of parties relevant to the two case studies are discussed in the following chapters. This chapter is concerned with the context and the nature of the organisations and the relevance of these two for the policy development. One of the study sites was the Central Adelaide Planning Region (of the South Australian Health Commission). Within this region the focus was mainly on the community health services within the Northwest suburbs. The other study site was the South Western Sydney region where the focus was on health services in Fairfield, Liverpool and Campbelltown areas[2].

Although there were differences in the extent and organisation of health services in various regions and different States of Australia in the mid-nineties, there were also

[1] Milio N. Making healthy public policy: developing science by learning the art: an ecological framework for policy studies. Health Promotion. 1988; 2: 263-274.

[2] The Adelaide metropolitan health services are divided into three planning regions, namely Southern, Central and Northern. The cities of Port Adelaide and Enfield, and Woodville and Hindmarsh belong to this Central Planning Region. This region does include other councils as well. In fact two of the five CHS which went through amalgamation are placed in other parts of this Central region. South Western Sydney Area Health Services are sub-divided, for management purposes, into five sectors. In addition to the Liverpool, Fairfield and Campbelltown sectors the AHS includes Bankstown and Camden/Wollondilly areas.

many similarities[3]. I will discuss the Adelaide services before describing those in the South Western Sydney (SWS). Therefore, the description of the context and organisation in SWS mainly focuses on those organisational and social issues which were different from those in Adelaide and require some discussion. In addition to social indicators and ethnic mix, the two case study areas (in South Australia and New South Wales) differ in terms of regionalisation. At the time of the research (1995, 1996) regionalisation had already been in place for some years in NSW. In South Australia, however, the services were operating under the Metropolitan Health Services Division of the South Australian Health Commission (SAHC). While the management of the community health services and of the local hospitals in a particular sector (e.g. Fairfield or Liverpool) within the SWS Area Health Services was unified, the community health services in the Adelaide metropolitan were working (and being managed) separately from the local hospitals. This organisational difference, for example, is of relevance to the type of policy I was tracking. It is important to know here that the amalgamation was promptly accepted and implemented in a region of the Adelaide metropolitan area where some CHS were associated with the local hospital. In the Western suburbs, however, CHS historically operated in a highly autonomous fashion and this is where the policy of amalgamation was considered to be negative by the local interest groups.

The purpose here is not to count and describe each and every service. The aim is to highlight certain specific features which have implications in terms of the local health

[3] Under the Australian federal system, health services policy making is the responsibility of both the Commonwealth and the States. Because they operate in similar policy environment, the States' health policies are often similar.

services development. Australian health services in recent times have been working within an overall context of a shift towards regionalisation and Purchaser-Provider Separation. During the years 1993-94 and 1994-95, the Health Commission in South Australia was focussing its energies to decrease health care expenditure. Various strategies that were being promoted included the development of a Casemix Funding Unit and a Private Development Unit within the Commission. Earlier, the Adelaide metropolitan area was divided into three regional planning divisions – South, Central, and North – for the purpose of planning health services and implementing so-called Owner-Funder-Purchaser-Provider Separation (OFPPS)[4]. The amalgamation of health services was linked to these ideas of reorganisation and efficiency or reduction in expenditures[5]. Although in 1995 there was no consensus among officials at the SAHC how OFPPS should be implemented, the regionalisation of the metropolitan health services was obviously a strategy where such funding schemes could be applied. In that sense, the amalgamation was proposed with two aims. Firstly, the explicit agenda was to rationalise management to save money. Secondly, the amalgamation would bring all community health services in one region under one management creating a situation where schemes such as OFPPS could be implemented. In the proposed funding scheme, a region could be made responsible for deciding the types and number of health services to be bought from a provider.

[4] Owner-Funder-Purchaser-Provider-Separation (FOPPS) is the term used in South Australia to describe what is generally call purchaser provider separation. See South Australian Health Commission Annual Report 1994-95.

[5] In the 1994-95 Annual report, the South Australian Health Commission (SAHC) claims that "the rationalisation of services was fostered through amalgamations".
South Australian Health Commission (SAHC). 1994-95 Annual Report. SAHC Adelaide,1995 (p.3).

6.2 SERVICE PROVISION & SOCIO-ECONOMIC INDICATORS

North Western suburbs in the Adelaide metropolitan and the Liverpool, Fairfield and Campbelltown sectors of the South Western Sydney AHS had about 150,000 – 200,000 people, a population compatible with the district health philosophy used as basis for the planing of services at the local level[6]. Additionally, this population size has the potential to provide an insight into the social dynamics relevant to health services and their impact on proposed health services change. A range of services from government to private, and from community centres to tertiary hospital, are available. Patterns of service provision in an area, working relationships between various components of the local health system, and the role of these components towards the proposed change help in developing an understanding about health services organisational factors[7]. Health systems, in the study sites in SA and NSW, are mature in terms of having gone through a number of changes over the past few years. The recent Australian tendency towards regionalisation provides opportunity to examine the interaction of local structures. The same is true for both the regions considered for this research.

These areas were considered for the research for another reason as well; they represent populations from relatively lower socio-economic groups in the metropolitan area. For

[6] WHO. Eighth General program of works covering the period 1990-1995. Health for all series no. 10. Geneva: WHO, 1987.

[7] Aiken M, Hage J. Organisational interdependence and intra-organisational structure. In Brinkerhoff MB, Kunz PR. (editors) Complex organisations and their environments. Dubuque, Iowa: WMC Brown Company Publishers 1972.

disadvantaged groups, in particular, the primary health care (PHC) philosophy and CHS approach have been promoted to decrease health inequities, increase accessibility and increase community participation in decision making. The North Western suburbs of the Adelaide metropolitan area are relatively socio-economically deprived. The population of the Western suburbs was 153,975. 25-30% of families in these areas were on a low income. The youth unemployment rate ranged from 14-20% (up to 35% in one part of Western Adelaide suburbs). 15 to 20% of people were born in non-English speaking countries[8].

This situation is comparable to the one in the Liverpool, Fairfield and Campbelltown sectors of South Western Sydney. According to an epidemiological profile of South Western Sydney Area Health Services (SWSAHS), Fairfield, Liverpool and Campbelltown had populations of 175,145, 98,162 and 137,882 respectively, in the 1991 census. In terms of social disadvantage these local government areas (LGAs) were ranked in the lowest quintile of all LGAs in New South Wales[9]. The proportion of people born in non-English speaking countries was 27.4% in South Western Sydney. In Fairfield, however, this proportion was 47.8%. The unemployment rate in SWS was 15.4% at that time; this rate in Fairfield was 21.9%. 17.8% of households were on a low income (less than $16,000 per annum)[10]. The percentage of unskilled

[8] SAHC. A social health atlas of South Australia. South Australian Health Commission. 1990, Adelaide.

[9] Sullivan E, Fahey M, Bauman A et al. Health in South Western Sydney: an epidemiological profile, 1995. Epidemiology Unit, SWSAHS. The study used the Jarman 8 Index of social disadvantage and deprivation. Jarman 8 Index is derived from eight census variables which include elderly living alone, children<5 years of age, single parent families, unskilled workers, unemployed, overcrowded housing, changed address, and non-English speaking background.

[10] A planning document of the South Western Area Health Services reports that up to 48% of families living in SWS suffer from low income.
South Western Sydney Area Health Services (SWSAHS). Directions for promoting health in South Western Sydney: Strategic plan for promoting health 1996-2000. SWSAHS, 1995.

and semi-skilled people in Fairfield was up to 30%[11]. Health services inaccessibility was underlined by a high population to general practitioner ratio of 1350 to 1.

6.3 ADELAIDE METROPOLITAN HEALTH SERVICES DIVISION

The Metropolitan Health Services Division (MHSD) of the South Australian Health Commission (SAHC) was responsible for planning and for disbursing funds to the public sector hospitals and community-based services in the Adelaide metropolitan area (population 1,023,000 in 1991). In addition to hospitals, community health services (CHS), and women's health services (WHS), MHSD also covers mental health services, domiciliary care and rehabilitation, child and family services, hospice care and dental services. The Health Commission's expenditure on the metropolitan hospitals and community-based services (urban as well as country) in 1994-95 was 55% and 10% respectively out of a total budget of $1,405 million. Other divisions of the SAHC deal with the country health services, environmental health, disability, finance, and human resource development.

With the headquarters of SAHC and MHSD, during 1993–1995, two important changes were taking place which had a bearing on amalgamation. As mentioned earlier, these changes were targeted at regionalisation and a change in funding pattern towards Owner-Finder-Purchaser-Provider-Separation (OFPPS) and contracting out of

[11] Glover J, Woollacott T. A social health atlas of Australia. (Catalogue No. 4385.0) Canberra: Australian Bureau of Statistics, 1992.

services to the private sector. In 1993, the Adelaide metropolitan area was re-mapped by the SAHC into three regions namely North, Central and South. These two changes were in effect being pursued with the overall goal of 'efficiency'. The following paragraphs from a SAHC document, which was targeted at the community, points to this base of the intended changes – and defines OFPPS.

> ... There has been a lot of pressure to limit public sector spending and to shift some functions into the private sector. Within the public sector there have been moves to re-organise along private corporate lines. This has meant establishing "market-driven models" for resource allocation. In other words some of the roles of public organisations such as SAHC have been split up to resemble the roles of private sector suppliers, contractors, consultants and management organisations. This has been done with the twin aims of encouraging efficiency and creating a consumer-focus which makes the organisation more responsive to the needs of the user. ...
>
> The Purchaser/Provider Split involves giving the hospitals and other health units the primary role of provider. The role of purchaser is taken by MHSD. The purchaser uses its planning capacity (including community participation) to identify needs and to develop a services plan (or "shopping list"). MHSD then goes to the health units and "buys" specific services in specific volumes at agreed prices. The final deal is sealed through an annual Health Service Agreement signed by both parties.[12]

All these changes were inter-linked as proposed in the 1993 Planning and Management Strategy of SAHC, which aimed for establishing planning regions/areas which, in turn, would help in introducing the OFPPS[13]. At the time of establishment of the planning units, the community health services (CHS) were operating as separately incorporated units and the amalgamation was not yet proposed. In fact the main reason behind the development of regional planning units was to realise the OFPPS[14]. This is important

[12] Central Health Services Planning Unit, SAHC. A guide to the South Australian Health Commission and its Area Planning Units. Booklet 1. 1995. (p.7-8).

[13] SAHC, Planning and Management Strategy MHSD, SAHC, 1993 & Central Health Services Planning Unit, SAHC, Booklet 1. 1995.

[14] The Planning Units and SAHC, however, claimed that the most important function of the Unit is to make sure that community participates in the planning process.

to remember, because when amalgamation was proposed to the CHS, they clearly saw it as part of the larger agenda where all sorts of changes (amalgamations of hospitals, contracting out of hospital services, OFPPS, regionalisation) were promoted to achieve rationalisation and reduce public spending on health care.

As the South Australian Health Commission (SAHC) adapted this strategy as a key to the cost-effective use of the funds, discussion of this concept is relevant for the purpose of this thesis for many reasons. Firstly, the main aim of all these changes preceding amalgamation was administrative efficiency. The perceptions developed by the local workers about losing their jobs because of the restructuring were not only because that amalgamation was proposed to decrease administrative expenditures, but also because of a background where every change was aimed at decreasing expenditures. Secondly, OFPPS, the planning for which immediately preceded the amalgamation, was linked to the development of the Planning Units. These Planning Units had the same geographical boundaries within which the amalgamation was proposed. This made the amalgamation strategy very much part of the larger regionalisation agenda at the metropolitan health services level. Generally, for many workers and community people, particularly for those from the Western suburbs, regionalisation was against the ideological basis of community health. Community health was seen as to making health care accessible and giving the community a better say in decision making. Thirdly, SAHC tried to link the concept of the OFPPS with "community participation" – a concept central to the community health philosophy. The Planning Unit was required to have advisory panels with a 60/40 community majority to produce regional plans in terms of what services are required and in what

numbers. Despite an effort by the local Planning Unit to disseminate information about these changes, the introduction of so many proposals for change at one time created confusion among both the public and the staff of CHS. The confusion was obvious from the remarks of interviewees. A sense of fear of service loss by the community and a sense of fear of job loss by the staff seemed to cause a barrier for effective communication and for the implementation of the proposed changes. The first reaction by the community and the staff amidst all this confusion was to resist any change.

6.3.1 THE PROPOSED CHANGE – AMALGAMATION

Local perception, and the resultant resistance to change implementation, needs to be considered in the light of recent reductions in CHS budgets. Going back several years (1992-93), the SAHC budget reduced the amount of the money available to the CHS services. Before that, for some years the budgets of these community health services were protected from reductions and the CHS budgets remained stable over a period of time. They were not reduced while budgets of the hospitals were reduced. However, with the reduction in funding, the efficiency of an approach of having multiple incorporated health units was questioned. The Parliamentary Estimates Committee agreed to adopt reductions in the budget of CHS. Cuts were imposed on both the community health services and the women's community health services. Although this generated a lot of political lobbying by various community groups, the Estimate Committee gave the green signal to the proposed administrative changes.

In 1994 the Metropolitan Health Services Division (MHSD) proposed an

administrative amalgamation to its various health units. Amalgamations were aimed at savings, and to help the rational distribution of services and to facilitate project planning[15]. In the Northern metropolitan region, for example, the major objective was to reduce the spending in administrative costs from 36% of the total budget to 28%. The restructuring strategies included amalgamation of the management and the clinical services of public hospitals and the amalgamation of CHSs within their respective planning region.

Prior to the amalgamation, each of the five CHSs in the Central region was a separate administrative (incorporated) unit with its chief executive officer and board of directors. The proposed amalgamation aimed for one administrative unit made up of these five with one chief executive officer and one board of directors. This meant restructuring the whole administration and the health services provision structure underneath. The Health Commission saw it as taking away most of the top layer and some of the middle layer of administration.

The relationship between regionalisation and amalgamation could be understood from the conflict in strategies proposed by the Health Commission and the one proposed by the Women's Health Services. It was proposed to the Women's Health Services (WHS) that they should amalgamate with other generalist community health services within their respective planning region. The WHS regarded this as the destruction of their capacity to provide services to women in a safe and sensitive environment. For

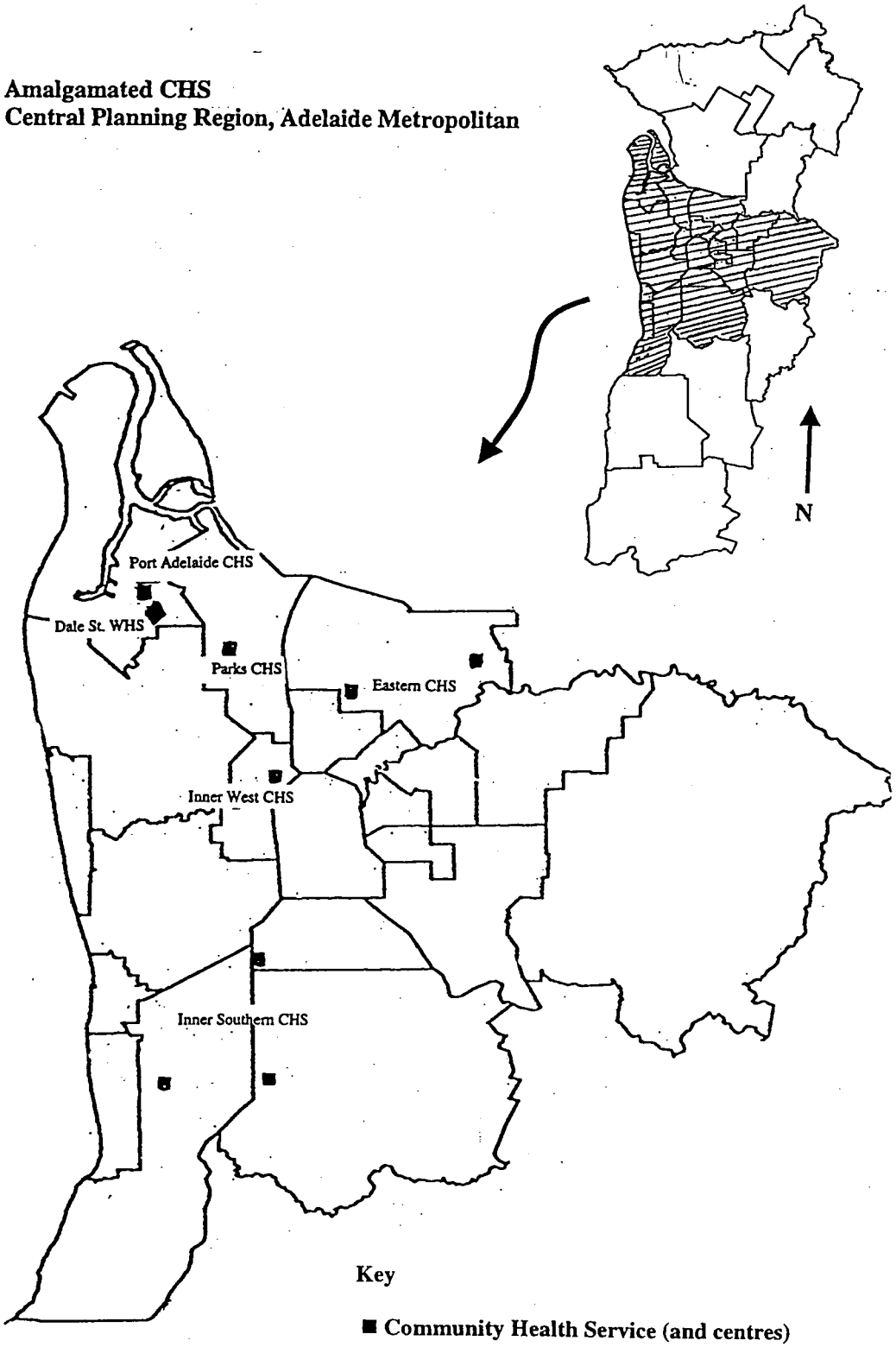
[15] South Australian Health Commission (SAHC). Annual Report 1994-95. SAHC, 1995.

that reason, at one stage during the amalgamation debate, WHS started discussing amalgamating with other WHS across the whole metropolitan area rather than amalgamating with generalist community health services. However, this was considered, by the hierarchy, as not congruent with the purposes of regionalisation. The way WHS then interacted with other services and negotiated their role within the new structure was very much influenced by this conflict between the strategy of regionalisation by the Health Commission and the ideological position of WHS.

6.4 THE COMMUNITY HEALTH SERVICES

In the study sites, apart from Women's Health Services (WHS), which serve sub-population groups with special health needs, community health services (CHS) for the general public are provided through a number of health centres (CHC). These CHS provide both out-reach and centre-based services of a wide variety that vary from centre to centre. This variety includes centre-based curative services provided to individual clients, and community-based preventive and health promotion programs. Because these community-based programs cover a large range of issues (from domestic violence to environmental health, and from aged care to the prevention of complications of diabetes), CHS come into contact with a number of community groups working for the general social uplift or for a particular health or social problem.

Amalgamated CHS
Central Planning Region, Adelaide Metropolitan



Key

■ **Community Health Service (and centres)**

◆ **Women's Health Service**

Scale: 1 cm = 8.5 km

Agencies and organisations with which CHS interact at the community level, range from groups of local volunteers to larger national level governmental and non-governmental organisations. Collaboration is considered by the local CHS as a key strategy to provide appropriate services[16]. Working for a variety of health and social issues and the resultant links to a large number of local institutions and groups, has created a situation where these CHS have, by default, become part of the community. Any changes introduced to these CHS influence their interaction with the general community and in turn invoke a reaction from the community[17].

To provide all these different kinds of services, CHS employ health workers from various professional groups[18]. This organisational characteristic might influence the

---

[16] Working with these groups and other agencies is central to the working of the CHS. For that reason the report prepared by the pre-existing CHS on the development of the Adelaide Central amalgamated CHS made sure that 'collaboration' and 'working with the local community' are clearly visible in the amalgamation process as the key principles. Statements such as "Collaboration is a basic principle which describes the ways in which Adelaide Central CHS develops and provides primary health care services and activities with its community" appear at many places in the report. (see pages 18, 20, 23, and appendix 5).
Adelaide Central Community Health Services (ACCHS). Development of the Adelaide Central Community Health Services. March 1996.
One important function of community health centres is said to be maintaining a "place to meet and make friends' and 'working with local people on a range of issues".
The Parks Community Health Services. Parks Health Observer. Annual Report 1994/95.
The annual report of the Women's Health Centre, for example, provides information on various agencies and groups with which the Centre works closely to get appropriate needed services for its target population. Interactions with agencies range from liaison for information provision to working together on issues such as domestic violence.
Dale Street Women's Health Centre. Annual Report 1994-95. Dale Street Women's Health Centre, 1995.

[17] One can imagine the links with the community and its various institutions which are required, and result from, providing services such as medical care, nutrition counselling, health checks, parenting issues counselling, domestic violence counselling and support, child development, podiatry, enuresis services and physiotherapy. Additionally, a number of projects, which run for a period of time, cover issues such as Food & Nutrition, Women's Health, Environmental Health, School Health, and Aged Care.

[18] In addition to the administrative staff such as receptionists, interpreters, and administrative officers, the staff at the CHS includes nurses, medical officers, podiatrists, physiotherapists, clinical psychologists, speech pathologists, social workers, nutritionists, community health workers, and ethnic health workers.

way a change such as amalgamation is implemented. A particular professional group might fear loss of territory more than the other groups while going through restructuring. That group then might like to negotiate the change through their professional group in addition to tackling the change from the platform of the CHS with other professional groups. This singular professional initiative might originate from the context within which a change is proposed. One example, in the case of CHS, was how Community Health Workers (CHW) and Community Health Nurses (CHN) overlap in terms of service responsibilities. At the time the amalgamation was proposed, CHNs were already worrying about losing ground to CHWs.[18A] CHNs feared that, with an expanding role of CHWs, many health care activities which used to be the domain of CHNs were being performed by CHWs. In such an environment, the amalgamation was perceived as a further threat since its objectives of cutting expenditures and pooling resources carried a threat to job arrangements and careers. The resistance offered to the change could have as much to do with workers' interests as with perception of the amalgamation as a threat to some other core PHC principles such as decentralisation, community participation, and equity.

6.4.1 INTERACTION WITH THE COMMUNITY

The documents from the study sites point out that one of the objectives of CHS is to provide a link between secondary and tertiary health services and community care that includes prevention and promotion. This objective reflects the fact that, historically, the development of CHS sought to promote the accessibility of services to those who are less well off. It also reflects the promotion of CHS as a way to increase the accessibility for those population groups that considered the 'mainstream' health

[18A] CHN and CHW are separate employment categories.

system unable to provide culturally acceptable services in a non-threatening and non-discriminatory fashion. The proponents of CHS, promote CHS as the best strategy for health development, and successfully lobbied in favour of making CHS a mainstream health service. The increased accessibility is believed to be achievable by working closely with the community as well as working on behalf of the community to negotiate and organise services at the hospital level. Linking CHS with the community was partly achieved by having a number of staff, particularly the community health workers (CHW), come from the local area. Out-reach care takes CHS close to the community as well[19]. Historically, the presence of more generalist staff such as counsellor, CHW and CHN, proved another reason for the community to feel at ease in linking up with these services; community members, according to the CHS view of the world, find it difficult to relate to specialists such as doctors, psychologist, dentists.

Interaction with the community, other than the service use by the community, has been achieved mainly through three mechanisms: the presence of community members on the board of directors of community health services; project work initiated by CHS in collaboration with community groups; and community members who supported the activities of a particular centre. Groups such as the "Friends of the Dale St. Women's Health Centre", "Friends of The Parks CHS" and "Friends of The Queen Elizabeth Hospital" are some examples. Community members on the boards of directors, and other community groups in turn acted as conduits for CHS to interact with a larger number of community members.

[19] very close at times- so that other health services, particularly the private sector curative care providers, consider CHS as having little to do with "medicine" or the "mainstream health system". CHS in a sense take the status of a "commoner" as compared to the "elite" "professional" status of the rest of the health care system.

A substantial number of community members worked as volunteers in their individual capacity to organise various groups or project activities. Volunteers often helped organise group sessions in a community meeting place. Most of these community members were women; a majority of them were from the Anglo-Saxon tradition. There were, however, a few indigenous people and people representing ethnic groups from some European and Asian countries. More recently, as more and more project work was geared towards community development and rehabilitation among ethnic groups from Asia, centres encouraged community members from these ethnic groups to participate. The interaction of a particular CHS with different ethnic groups varied from centre to centre – depending on the ethnic groups living in the area and certain identified needs of those groups. For example, interaction with ethnic groups from some Asian countries was more visible at The Parks Community Health Centre, while Gilles Plains CHC was working very closely with Italian women's groups, among others.

Although there were community members on the board of directors, and very many projects were being run with the help of community members and community groups, only a handful of active community members were visible (and mentioned by the CHS staff) in the local health care and social scene. These active community members were often found working on more than one project and working for more than one agency. Across three or four adjacent suburbs these active volunteers could be counted on the fingers of the same hand. For this reason, these active community members were known to most of the health and social services in the area. These volunteers often

acted as social activists and helped develop lobby groups supporting the activities of the local services. They had achieved, through this political process which involves local decision-making, more power in terms of their own involvement in decision making for the day to day activities of those services. By being active, and by organising political activity, they were able to generate persistent background protest about what should be the orientation of those services. I will return to this phenomenon of background noise later in chapters nine and ten where I discuss amalgamation and integration implementation and the role of the community.

The presence of community members on the board of directors and their 'recruitment process' are other aspects of the interaction with the community which had the potential to influence the health services. Each community health service had a board of directors composed of community members, staff representatives, Director ex-officio and Ministerial nominees. As was generally the case with regard to the gender of active community members, the community members on the board were usually women[20]. The community members on the boards were particularly those who had been active for some time in community development. These community members initially happened to know some staff members at the CHS or they themselves at some stage had used the services provided by that CHS. Additionally, some community members came in contact with the centre through collaborative project work. These members were then motivated, often by the CHS staff, to sit on the boards of directors.

[20] At the Women's Health Centre all board members were women. In 1994/95 there were, for example, three men and seven women on the board of The Parks CHS.

The process of recruiting community members to the board of directors involves advertising in the local press. However, the inquiry revealed that not a large number of people in the community were motivated to join the boards. The board members were often those people who had already been actively involved in some voluntary community development activities and happened to know the working of the CHS and had interacted with the staff. It was difficult to determine how representative of community the board members actually are. Nonetheless, these community members seemed to enjoy good networking with many community groups in the area. This involvement in a number of community development and health care activities provided them with opportunities to gain access to a large number of people. This involvement of the larger community and the dissemination of information seemed to just happen; you meet your mates from another group and you share what is happening at the CHS. In turn, this verbal communication reached other groups. The fact that the board members were often those who had already worked with the CHS staff and it was CHS staff who motivated them to be on the board created a situation where these board members almost always supported the staff's stance on a particular issue or change. Similarly, groups such as the "Friends of CHS" were often established by a regular client and had the support of the CHS staff. Because of this background, the board members and the support groups might lobby for (or against) a particular change in unison with the staff.

I found out that CHS worked with the community on various collaborative projects. These projects often targeted some sub-population group – for example a project to deal with smoking or drug dependency with an ethnic group. In some cases these

[20A] Laris P. Boards of directors of community health services. In Baum F, editor. Health for All: the South Australian experience. Adelaide: Wakefield Press, 1995.

projects, such as the environmental health project, were being initiated under the influence of a community member who happened to be close to the centre and had organised a community group to work on that particular concept. Usually a staff member rather than the whole centre was responsible to liaise with that community group. Therefore, this interaction was highly interpersonal and dependent on a particular staff member. This interaction could be defined as the "staff-community" interaction. The shift from "staff-community" to "centre-community" interaction seemed to take a long time. The centre-community interaction refers to a situation where a community member starts working for a number of CHS activities, and is less dependent on an interaction with a particular staff member. Because of the interpersonal interactions, it could be said that the perception of staff members about the change were important as it could have created similar perception among the community.

The use of out-reach and centre-based curative, preventive and promotive services by the community could be considered as 'minimum participation' on a scale which ranges from 'service use', to an 'active role in decision making about the type, extent and the framework for service delivery'. The issue of the use of CHS and its significance in terms of community participation is complex. A large part of service provision by CHS happened to be oriented towards disease prevention and health promotion. These services operated in a fashion where out-reach workers 'sell' their product, such as health promotion, at the local schools and other community places. It becomes clear that use of these project type services where the centre is reaching out to various groups cannot be compared with the use of centre-based services such as one-

to-one counselling sessions or visits to the doctor at the centre[21]. The number of physician contacts is different from the number of days spent at a school by a worker and the number of students who attended those sessions. Those students may be compelled to attend those sessions which does not necessarily mean that the community is participating actively for an identified need. Similarly, a women's group which may or may not be the representative of the female community at large may help the centre to organise activities/sessions which are attended by the same community members more often than the general community. I am pointing to this issue here because I consider service use, community participation, and policy implementation as inter-related concepts; this relationship needs a careful review. In this chapter it would be sufficient to say that CHS in the study sites seemed to enjoy good working relations with the community. By this I mean projects and services as well as political relations[22].

6.4.2 Women's Health Service

Each region had a Women's Health Service (WHS). All staff at the WHS were women. They provided services for a variety of issues such as domestic violence, fear of crime, and child abuse in addition to physical health issues. The women's health services

[21] The women's health centre, for example, identified its key activities in terms of one-to-one counselling and medical appointments, group programs for registered clients, and community work. More than 80% of activity fell in the category one-to-one counselling and medical appointments. About 2,500 clients used these one-to-one services over one year. Community activities which included advocacy, consultation, provision of health and health services information covered about 14% of their work. The community activities, however, helped to make centre-based services more accessible to the community.

[22] This comment is based on an understanding developed by reading reports on various projects and activities conducted by the CHS in collaboration with the community. It is based on anecdotal evidence, newspaper reporting on various community actions, and on literature pointing to the level of interaction with the community. It is also based on interviews conducted for the research. A detailed description about the level of community participation is given in the next chapter.

were introduced in the belief that women have specific needs for services which they can not readily access from other generalist health services. The concept behind the development of these WHSs was more or less the same as was the concept that underprivileged population groups such as Aboriginal need service provision separate from generic services. In both instances this is so that they can have services which are acceptable and readily accessible to them. This historical background of the WHS is important as the amalgamation required WHS to merge with the more generalist CHS.

6.5 HEALTH SERVICES IN THE WESTERN ADELAIDE SUBURBS

The general picture of service provision in the study sites will indicate the organisational environment of the CHS. These are the services with which CHS have to interact on behalf of their clients. I believe that the Western suburbs within the Adelaide Central Planning Region fulfil the criteria for being a health district. There is a specialised teaching hospital, in addition to the primary health care services both within and outside the public sector. In addition to the public sector hospital, there were, in 1995, three community health centres (CHC) and a WHS serving the population of the Western suburbs. Other public sector services included a migrant health service, a family planning PHC team, a pregnancy advisory centre, dental services, and a rape and sexual assault service. These are the local manifestations of statewide organisations, which provide services through outreach teams or by having a centre in the area. In addition to these statewide services, there are local services such as an out-reach rehabilitation unit of the local teaching hospital. Other service

providers include General medical practitioners, the Royal District Nursing Society (RDNS), the domiciliary care and rehabilitation services. Some important community-run services included an Aboriginal Sobriety Group, and groups attached to various community health centres and the local teaching hospital. Prior to the amalgamation, each community health service had working relationships with many of these agencies. My interviewees often mentioned developing collaborative projects and drawing on each other's resources for service provision. Table 6.1 provides a summary of the services available to the residents of the Western suburbs.

Table 6.1
Health Services in Western Suburbs

Community Health Services
- Port Adelaide CHS
- The Parks CHS
- Inner Western CHS

Women Health Services
- Dale Street WHS

Home-Based Care
- Royal District Nursing Society
- Western Domiciliary Care and Rehabilitation Service

Child & Adolescent Mental Health Service

Child, Adolescent and Family Health Service

Community-Based
- Kura Yerlo Aboriginal Centre
- Aboriginal Sobriety Group

Hospitals
- The Queen Elizabeth Hospital
- St. Margaret's Hospital

General Practitioners

Statewide Health Service
- Family Planning Service
- Rape & Sexual Assault Service
- Migrant Resource Centre
- Breast X-ray service
- Intellectual Disability Services
- Pregnancy Advisory Centre

Local Government
- Immunisation Services
- Youth Programs
- Environment Health

Church-Based
- e.g. Port Adelaide Central Mission

General practice comprises a major part of the PHC services in any region. The Central Health Services Planning Unit had found that the Western suburbs had more than

1,400 people per general practitioner in this area. This they compared to 966 people per general practitioner across Australia generally. Conversely, the rate of the use of GP services is 15-30% higher than the expected use[23]. In addition to the use of GP services by the community, another indicator of the interaction of GPs with the community and community-based services could be their level of involvement with the activities of the Division of General Practice (DGP). These DGP are set up to develop projects to upgrade the skills of GPs, to improve the standards of care to the community, and to promote the participation of GPs in community health care (Centre for General Practice Integration Studies 1996)[24]. In the Western suburbs of the Adelaide metropolitan area, in 1995, about 62% of GPs were affiliated with the Western Division of General Practice[25]. This was below the national average of 67%[26]. The South Australian Community Health Research Unit found that private general practitioners are frequently isolated and have few links with the community health services[27]. While divisions' level of interactions with CHS might vary from one area to the other, a low participation rate by GPs in their local division might have implication for the development of collaborative projects and the intensity of interaction at the local level.

---

[23] SAHC. Social Health Atlas. 1990.
SAHC. Central Health Services Planning Unit. Health Services in Adelaide's West: A profile (Booklet 5). 1995.

[24] Centre for General Practice Integration Studies (CGPIS). Integration Projects 1993-94:Report. CGPIS. School of Community Medicine, University of New South Wales. 1996.
Centre for General Practice Integration Studies (CGPIS). General Practice Integration: Literature Review. CGPIS. School of Community Medicine, University of New South Wales. 1996.

[25] GPs were defined as being affiliated if they were on the mailing list of the division – not a strong measure of affiliation.

[26] Todd R, Sibthorp B. What divisions do. An analysis of Divisions' infrastructure activities for 1993-94. Canberra: Commonwealth Department of Human Services and Health and the National Centre for Epidemiology and Population Health. 1995. Quoted in Centre for General Practice Integration Studies. General Practice Integration: Literature Review. 1996.

[27] South Australian Community Health Research Unit. Links between General Practitioners, Hospitals and Community Based Health Services. Bedford Park SA, 1994.

[24A] The stated goal of Division of General Practice was "to improve health outcomes for patients by encouraging general practitioners to work together, and to link with other health professional to upgrade the quality of health service delivery at the Division level".

6.5.1 LOCAL GOVERNMENT

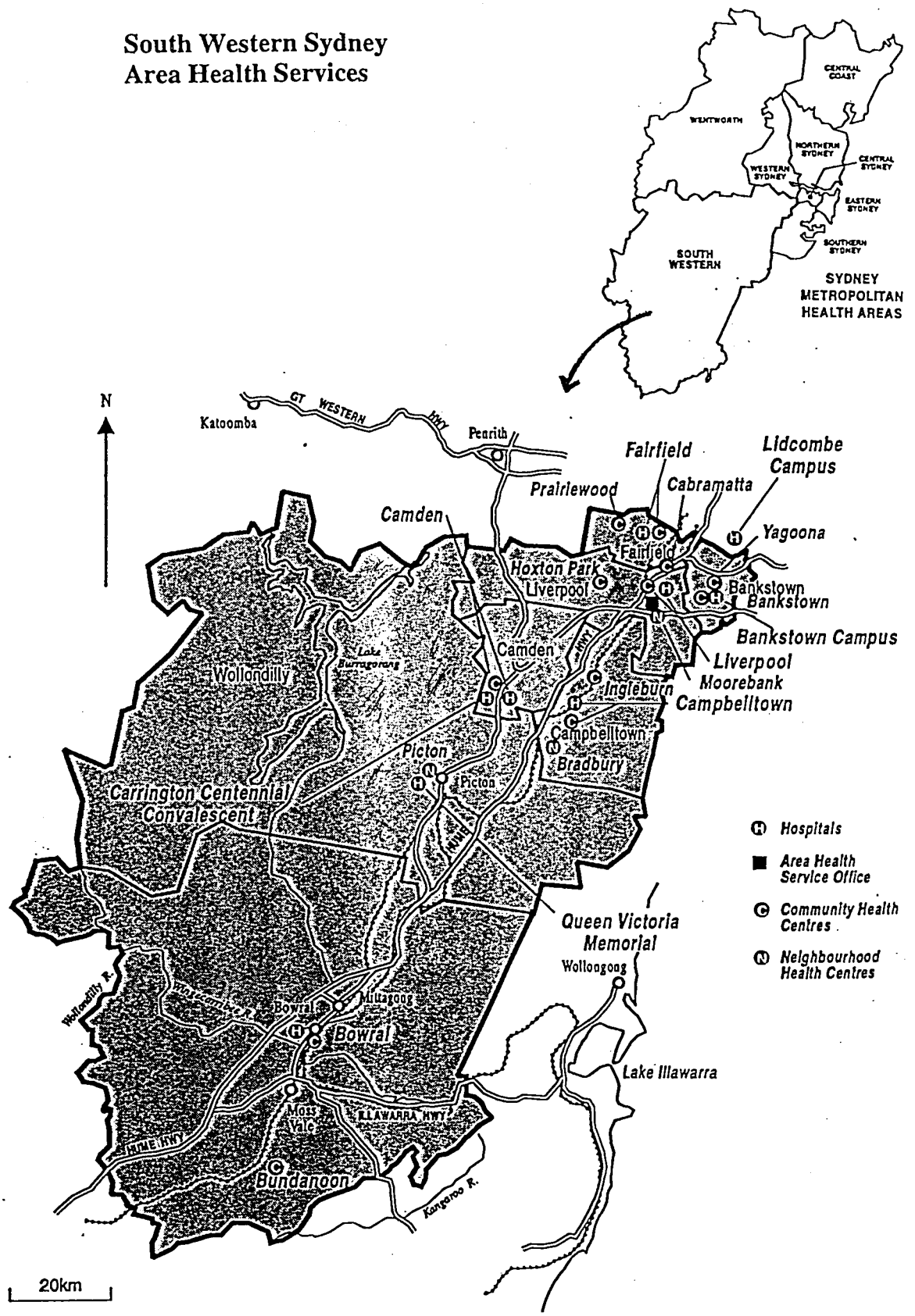
Local government is another important health and social care coordination vehicle in the local context. Although the Area Planning unit mentions the role of the local government as a major contributor to improving the health of the local population, the local governments are not much involved with direct service provision. However, they do provide services such as immunisation, and provide facilities such as community centres. In some places they provide a forum for various local health and social services to get together and share information. Moreover, local governments were involved in projects such as domestic violence and local safety in collaboration with CHS. However, it should be noted that when amalgamation was proposed and was being implemented, the local governments were involved in discussion about their own amalgamation into larger local government areas. This phenomenon of restructuring was mentioned by many interviewees as a barrier to effective collaboration at the local level. Changes at one's own agency might reduce one's capacity to contribute to the process of change of other organisations in the area. Different organisations worry about their own restructuring. For instance, two interviewees mentioned that it seemed a strategy of the government to introduce changes to every institution at the same time so that people become unable to struggle together and government as a result could successfully implement whatever changes it wants to implement. For example, a local activist who happened to be an employee of the Health and Social Welfare Council was unable to play an active role over the amalgamation of CHS as the staff at the Health and Social Welfare Council were resisting a proposal to disband the Council.

6.6 SOUTH WESTERN SYDNEY

In this section I describe the environment of health services in the South Western Area of Sydney focussing on the sectors of Liverpool, Fairfield and Campbelltown. The Area Health Services were promoting integration between two components of their own system (Hospitals and CHS) and the general practitioners and the divisions of general practices mainly by introducing various shared care programs.

The working of the CHS in South Western Sydney (SWS) and their internal dynamics were much the same as they were in the Adelaide – with two major differences. Here, I only discuss these differences. The CHS in New South Wales (NSW) did not employ doctors. The other difference was that regionalisation was already in place in NSW, and the CHS and hospitals in an area were governed by the same management. They shared a common sector-level management.

South Western Sydney Area Health Services



The CHS in NSW historically have never employed medical practitioners mainly because of the objections by the Australian Medical Association. This situation, on one hand, might have helped CHS to keep their focus mainly on the preventive and health promotion and on the socio-economic aspects of health inequity. On the other hand, this was a situation where CHS were unable to provide a "comprehensive" set of services that involved provision of curative care as well. However, since the Area Health Services came into being, this situation changed. By being part of the Area Health Services, the CHS are now very much part of the 'general health care system' in the public sector. The "affiliation with hospital", which was avoided by the Adelaide CHS (up until 1995), had already happened in SWS as they became part of the Area Health Services. In the process, these CHS in SWS had lost their autonomous status outside the influence of hospital and hospital-based services. The situation, however, might have improved their capacity to make curative services accessible for their clients as well as to develop projects that include a curative component.

The SWSAHS was established in 1988 under the Area Health Services Act of 1986[28]. The SWSAHS (AHS) covers a large urban, peri-urban and rural area. A board of directors has the overall authority in terms of decision making at the AHS level. In 1995, a majority of the directors were technocrats, with one member from the community, one member from the staff of a hospital, and a local entrepreneur and councillor who represented the area multicultural committee as well.

[28] New South Wales Government. Area Health Services Act 1986 No. 50. Reprint 1993.

For planning purposes, the AHS was divided into six sectors that serve seven local government areas. These sectors were Bankstown, Fairfield, Liverpool, Campbelltown, Wingecarribee, and Camden and Wollondilly Health Services. Total population covered by the AHS is about 720,000[29].

Each of the sectors within the AHS has a separate administrative structure with a general manager responsible for both the local hospital and the CHS. Service provision is mainly through hospitals, CHS, and Neighbourhood Health Centres[30]. The AHS management structure also included a Division of Public Health responsible community paediatrics, general practice, drug and alcohol services, epidemiology, health promotion, and HIV services. Activities of the Division of Public Health ranged from providing policy guidelines to the CHS and hospitals to partnership development with the local GPs. Other functions of the Division of Public Health included clinical service provision in the area of drugs and alcohol and project work (through a health promotion unit) for issues such as injury, cardiovascular diseases and smoking.

6.6.1 Sectors within the South Western Sydney Area Health Service

The local government areas (LGA) where the AHS provide services through its six sectors are quite different in terms of geography, community dynamics and service needs. Camden, Wollondilly and Wingecarribee are semi-urban/rural communities with a combined population of about 101,000 having much better economic indicators

[29] South Western Area Health Services (SWSAHS). 1995/96 Annual Report. SWSAHS, 1996.

[30] Community health centres provide a comprehensive range of prevention, health promotion, illness and disability management and community development services. Neighbourhood health centres are smaller facilities and mainly focus on basic primary care. The South West administrative structure makes a separation between different community health services. While sector management provides community health services in their respective sector, the Division of Public Health at the Area level deals with various services such as the Drugs & Alcohol Services.

at the individual and family level.

A combined needs assessment was conducted by Campbelltown and Camden-Wollondilly sectors in 1995-96[31]. Despite their proximity, compared to Campbelltown's 17.9% youth unemployment in 1991, youth unemployment in Camden was 9.3% and was 14.4% in Wollondilly. Indicators such as public housing and single parent families were also more favourable in the rural than in the urban areas of SWS. The Non English Speaking population ratio was much smaller in the rural than in the urban areas. Socio-economic disadvantage is the major reason to health inequity[32]. In areas such as Campbelltown, the higher needs for health and social services might require extra effort to make services accessible and effective. To work closely with the other services becomes more important in the wake of relatively inadequate resources and a higher burden of socio-economic disadvantage and disease.

Within the SWSAHS I mainly focussed on three sectors, namely Campbelltown, Fairfield and Liverpool. Each of these areas is clearly demarcated from the others in terms of geography and community dynamics. However, the services available in one sector were essentially a replica of services available in other sectors. The main reason for leaving out Camden/Wollondilly and Wingecarribee is that they are rural areas and my research was mainly concerned with the urban health care. My resources and

[31] Macarthur Planning Committee. Campbelltown & Camden/Wollondilly Health Services. Macarthur Needs Assessment. 1996.

[32] Townsend P, Davidson N. (editors) Inequalities in health: the Black Report. Harmondsworth: Penguin, 1982.
Moss JR, McMichael AJ. Inequalities in health: the epidemiological evidence – and the gaps. In McNeil J, King R, Jennings G, Powles J (editors) A textbook of preventive medicine. Melbourne: Edward Arnold, 1990.

available time precluded any extensive coverage of the Bankstown sector.

In 1991, the NESB (non-English speaking background) population was 26.3% of the Area's total population (the largest of any Area Health Services in NSW). The size and number of ethnic groups, however, differed markedly in the three urban sectors. The NESB proportion of population in 1991 was 47.8% in Fairfield, 13.8% in Campbelltown and 24.4% in Liverpool[33]. The multicultural orientation of the community is important not only because it may determine a different set of health care needs but also from the point of view of community participation in local health services development and local decision making processes. I will discuss this observation in chapters nine and ten of this thesis. Such an ethnic mix may require community liaison officers, for example. Additionally, the health services may be required to deal with high morbidity among a particular ethnic group. Or there may be a need for health education, for example in the areas of breast feeding and weaning, for a particular ethnic group. These characteristics play their part in determining the interaction between community and services, and the interaction between services, in these communities.

Two other issues, which point to a need for greater service provision, and to the policy development capacity of the locals, are the facts that these sectors are socially disadvantaged and that, in the case of Liverpool, the locals have always supported the Australian Labour Party. A "safe political seat" often leads to further disadvantage for

[33] South Western Sydney Area Health Services (SWSAHS). Health Plan for Non English Speaking Background Communities in South Western Sydney: 1995-1998. SWSAHS 1995 (figures quoted in this report are taken from Australian Bureau of Statistics Census 1991).

the residents. The party that always wins the election might not feel the need to invest in the local social infrastructure. On the other hand, the party that never wins might become indifferent to local needs and might develop a perception that even lavish spending on infrastructure developments is not going to change political preferences. With this apathy from both the mainstream political parties, and with a lack of confidence among people of low socio-economic status, these areas can suffer from inadequate funding and ineffective lobbying.

6.6.2 Integration of the Area Health Services with General Practice

Before I point out the objectives of the integration efforts in SWS, I should highlight a few important organisational factors within the AHS. Some sectors within the AHS had a vertical relationship with the area management for funding purposes and for policy direction. Some policies are imposed from the Area (through the board of directors which had overall authority for the whole area) while others are initiated locally at the sectors. These sectors, however, worked autonomously. For example, while the policy directions on integration with GPs came from the area management, the issues for shared care and the strategies to implement those shared care projects (as a strategy for integration) were chosen by the sectors themselves. Additionally, because of their autonomous nature of working, these sectors had their own planning processes in place. For example, the needs analysis in 1996 was only conducted in the Macarthur area as a local sector level initiative and was used for local planning[34]. At times, these sectors were competing for resources available with the Area Health

[34] Campbelltown and Camden/Wollondilly Health Services. Macarthur Needs Analysis 1996.

Services.

Each sector was working for a distinct population from a platform of hospitals which were different in terms of size and political influence on the health care providers in their respective sectors. More recently, as the Liverpool Hospital became a teaching institution it started attracting more specialists into the sector. Furthermore, the AHS administration is located close to the Liverpool Hospital giving it a further boost in terms of its status within the AHS. The availability of a specialist might determine which issues would be pursued for developing a shared care program with the general practitioners. At the same time, availability of more specialists might have helped in attaining better working relationships with the local GPs.

In the case of Fairfield Hospital, it is important to know that the academic Department of General Practice has been based there since 1991 with its core objectives to provide GP education and research and to improve relations between general practice and the public sector health services (hospitals and CHS). That department aimed at working closely with the five Divisions of General Practice in South Western Sydney. Although that department was aiming at achieving greater integration of general practice with the CHS and hospitals in all sectors, its physical closeness to the Division of General Practice in Fairfield could have contributed to the better integration in that sector compared to the other sectors. However, one needs to consider the dynamics at the divisions of general practice as well in order to understand the reasons for differences in the level of integration achieved.

Campbelltown is an urban settlement at the South Western fringe of the Sydney metropolitan area and is somewhat isolated geographically. Its hospital was going through expansion. The hospital was collaborating with the University of Western Sydney on various projects particularly in the children's services and youth health areas. The sector management was emphasising collaboration and inter-agency working through initiatives such as the needs assessment and by restructuring its own management. For example, in 1995-96, the Centre Managers' positions at Campbelltown and Ingleburn Community Health Centres were converted into the positions of Adult Services Coordinator and Children Services Coordinator respectively – with their new primary role as inter-agency liaison and co-ordination. The integration is dealt with in some detail in chapter 9 - "Integration in South Western Sydney".

6.6.2.1 The need for greater coordination

During the few years prior to the research period (1995-96), the AHS was feeling the pressure of economic realities where it was required to provide services to a growing population suffering from social and health inequities within the constraints of inadequate funding. On one hand, the socio-economic disadvantage and the resultant higher burden of disease required more resources. On the other hand, a situation where a lot of patients were being referred by the local health care providers to hospitals and specialists outside SWS added to the resource management problems for the AHS. The Health Department of NSW introduced a policy of "funds follow the patient" in which the AHS from where the patients are being referred has to reimburse the cost incurred to the AHS where patients actually receive specialist services or in-patient admission.

In 1988-89 the net outflow (patients moving outside minus patients from other areas being admitted in SWS hospitals) was 27,433 hospital separations. In 1986 the outflow numbers had been even higher and the AHS considered that the drop was because of the opening of the new Fairfield Hospital. The AHS attributed, in 1991, the outflows to the unavailability of teaching and referral centres[35]. The AHS claimed that patients were being referred to the Westmead, St. Vincent's and Royal Prince Alfred Hospitals for tertiary services which were not available in the area. A large number of Fairfield residents were using tertiary obstetrics services at the Westmead Hospital (in 1988-89 a total of 12,738 were referred to outside hospitals for obstetrics services). At that time, the AHS claimed that once tertiary services are operational at the Liverpool Hospital the outflow would decrease.

It can be said with confidence that the outflow was not only because of the lack of tertiary care and the unavailability of specialists. The reputation of the local hospitals compared to the hospitals in other areas has been pretty low[36]. Inadequate funding, lack of tertiary care specialities and unavailability of specialists were some reasons for this. However, a constant protest by the local hospitals about inadequate funding might have increased the perception among the residents that the situation in local hospitals

[35] South Western Sydney Area Health Services (SWSAHS). Corporate Plan 1991-2001: Shaping a healthier future. 1992.

[36] In a survey of general practitioners working in SWS, conducted by the General Practice Department at the Fairfield Hospital, quality of services was the second most frequent reason for referring patients out of SWS. Out of 140 GPs who responded to the questionnaire, unavailability of services was nominated as a reason by 93 GPs, while quality of SWS services was nominated by 47 GPs. A few GPs mentioned patient preference, after-hour emergency services, communication with GPs, and convenience as other reasons.
Department of General Practice. Fairfield Hospital. Survey of South West Sydney general practitioners opinions of hospital services. 1996. Department of General Practice, Fairfield Hospital, SWSAHS.

is deteriorating[37, 38].

GPs in South Western Sydney used to send their patients to the Westmead and Royal Prince Alfred Hospitals. This situation might have necessitated some strategies where specialists could be able to build working relationships with the local GPs and gain a reputation so that GPs trusted them for effective and appropriate service provision for their patients. Historically the local GPs had better relationships with specialists in hospitals which were considered as "centres of excellence" and where GPs had received their own training. These non-tangible links might have been the reasons, among others, for the outflow of patients from the area. The local hospitals had to develop a strategy to create a trusting relationship between the local GPs, hospitals and specialists and decrease expenditures incurred on patient outflow.

The main strategy to achieve close working relationships, or integration, was shared-care. Shared-care programs for diabetes, asthma, mental illness, obstetrics and pre and post admission care were introduced. The chairman in the AHS annual report 1993-94 points our attention to the need to work closely with the local GPs in the area. The report, however, sounds as if the integration was mainly the need of GPs, and the hospitals only supported GPs in achieving that need. In the preceding few paragraphs I

[37] In 1992 the net outflow was 37,977 hospital separations compared to 27,433 separations in 1988. Sullivan E, Fahey M, Bauman A et al. Health in South Western Sydney: An epidemiological profile. 1995. The figure quoted in the 1995-96 annual report of SWSAHS is "some 50,000" (SWSAHS Annual Report 1995-96). This figure seemed to be an over-estimation though as this figure was quoted in that section of the report which points to inadequate funding for the area and where the Board of Directors requested the State Government to increase the funding.

[38] In 1995-96 SWS received about 7.7% of the financial allocation for health services while servicing 10% of the state's population. SWSAHS Annual Report 1995-96.

have tried to point out why this was more a need of hospitals rather than of GPs. Under a heading "Excellence of GPs" the AHS report read as:

> ... Until recently, GPs tended to work in isolation only impinging on each other and the hospital when the need arose. With the formation of the Divisions of General Practice, GPs have better integrated themselves into the system to give better continuity of care to their patients. ... The Area Administration actively supports the creation of Divisions of General Practice and has networked the specialist appointments so the Sectors are also building networks. ... At the same time GPs have become involved in well-organised programs of continuing medical education and indeed some are involved in research. ... These closer ties between the hospitals, community health, general practitioners, primary nursing services and communities in general practice will provide a comprehensive network for the better practice of curative and preventive medicine – a comprehensive health care system[39].

Another cost saving strategy which hospitals were emphasising was to lower their average length of stay in hospitals. For example, between June 1994 and June 1995, the average length of stay was reduced from 5.2 to 4.8 days. Such strategies put an extra burden on the primary health care services (e.g. GPs, CHS, HACC) which have to cater for the pre-admission care and post-discharge care. Working closely with GPs is required to keep patient satisfaction at an optimum level. Working with GPs is also required if hospitals short of resources would like to avoid 'unnecessary' referrals. Shared-care programs were often aimed at reducing the number of complications by the specialist and the GP working in collaboration and therefore reducing hospital admissions.

[39] South Western Area Health Services (SWSAHS). Annual Report 1993-94. SWSAHS, 1994.

6.7 CONCLUSION

The characteristics, in the two study sites in Australia, which need to be considered in terms of their influence on health system development, include: relatively socio-economically under-privileged communities; a less than optimum capacity to influence the political decision making at the local and state levels; and a chronic lack of adequate health resources. Other important factor, which needs to be considered in order to understand the implementation process, is the context of the proposed changes. Cost saving as the main reason for the proposed amalgamation in Adelaide was explicit. While integration strategies was promoted as to achieve effective health care, the Area Health Services was aiming for cost reductions by the way of decreasing health funds flowing out of the area and by achieving fewer and shorter hospital stays. In areas with already inadequate health resources such initiatives might cause perceptions among the health personnel and the community that it will further compromise the quality and accessibility of their services. The nature of the working of health services going through the change needs to be considered as well. Because the community health services and women's health services have intense interaction with the surrounding community, the change involving these services may invoke a strong community reaction. Table 6.2 provides a summary of the proposed change, the organisations undergoing those changes, and the community characteristics in these areas.

Table 6.2 Summary of proposed changes

	SOCIO-POLITICAL & DEMOGRAPHIC CHARACTERISTICS	MANAGEMENT LEVEL	PROPOSED CHANGES	CHANGE PARTICIPANTS
KARACHI	About 2,000,000 people in District South. Mix of affluent areas and urban squatter settlements with poorest of the poor living amongst the wealthiest. Squatter settlements' population mainly consist of migrants from rural and peri-urban areas of Punjab and NWFP province.	Complex arrangement: services provided by the provincial Government, Metropolitan Corporation and the Federal Government. Pilot PHC development focussing mainly in the underprivileged and squatter settlements.	Developing links between health services in public, private and NGO sectors towards developing a district health system based on PHC approach. Development of out-reach activities from the governmental health out-posts. Development of linkages between primary, secondary and tertiary health services.	Medical and health services of the Karachi Metropolitan Corporation and the provincial government. Private sector, mainly GPs. Non-government organisations. Communities.
ADELAIDE	Static population, comparatively large number of various ethnic communities including 2% Aborigines. Strong community cohesion particularly among the Anglo-Saxon population of the area. Relatively socio-economically under-privileged.	Adelaide Central Health Planning Region of the SAHC	Public Sector: Regionalisation of the CHS by amalgamating four separately incorporated state-run generalist community health services and a women's community health service into a single incorporated unit.	Generalist CHS and Women's Health Centres of the SAHC.
SYDNEY	LIVERPOOL: Relatively low socio-economic working class Anglo-Saxon with modest number of people from other ethnic groups. Low image of the area in terms of fear of crime and community cohesion. Stable population. FAIRFIELD: Multi-cultural, inadequate funding, outflow of patients. Issues such as crime, safety and drug addiction. CAMPBELLTOWN: Expanding population with recent influx of ethnic groups, which have recently migrated to Australia. Health services need and provision mismatch.	Sectors within the South Western Area Health Services (Region)	Public and Private. Integration of the hospital-based services and community health services with the local general practitioners.	Hospitals (mainly some specific services targeted at specific client groups - such as diabetic services, mental health, aged care, obstetric care), Community Health Services, Divisions of General Practice and GPs.

CHAPTER 7

Framework for Policy Analysis

7.1 INTRODUCTION

The main objective of this chapter is to describe a framework for analysing policy implementation – a framework based on what I set out to find and what the literature points to as important milestones. I completed this framework, and wrote this chapter, only after I completed the field study and started analysing the information and writing the discussion chapters. In the light of the understanding from my work in District South of Karachi and from the literature, however, the nidus of this framework was in my mind before I embarked on the field research. In Abraham Kaplan's tradition, my existing understanding could be labelled as 'logic-in-use'. Issues related to the development of community health which are incorporated in this chapter in a single framework have been discussed earlier in the literature individually. As such, this consolidation and the overall framework could be viewed as a 'reconstructed knowledge'[1]. This framework, and the discussion, seeks to improve knowledge for the policy process[2].

To recap, the main aim of the research is to identify the local factors as they influence the policy implementation stage. The literature is concerned with the local factors from two perspectives, namely socio-political and technical. The technical perspective is mainly concerned with the issues such as organisational size, technology and

[1] Kaplan A. The conduct of inquiry. San Francisco: Chandler Company Press, 1969.
Kaplan suggests that "a reconstructed knowledge is helpful in making clear the unity underlying a multiplicity of particular techniques; it can show, for instance, that a very large class of inferences can be construed as governed by a very few simple rules of deduction".

[2] According to Hogwood and Gunn there are multiple policy analysis paradigms where some enhance the understanding of the policy process while the others help increase the knowledge for the policy development.
Hogwood B, Gunn L. Policy analysis for the real world. Oxford: Oxford University Press, 1984.

management structure. In contrast, the socio-political perspective focuses on interactions and motivations behind those interactions. The framework displayed in this chapter, is concerned mainly with the socio-political perspective. Diagrams used to illustrate the framework in this chapter are original, although most of the issues to which these diagrams and the framework refer have been discussed in the literature – but not in an integrated fashion as presented here, and as discussed in the next three chapters. I have developed a way of seeing the issues that is relevant for me. I hope that this way of seeing will be relevant for others who wish to analyse the health system development.

This research uses the socio-political framework to delineate factors within and outside of an organisation which is going through a change. The political perspective is used to consider the inter-organisational networks as well. The relations an organisation may have with other organisations and with the community are to be considered in the light of their potential to negotiate the policy implementation.

In dealing with factors within the organisation, one needs to describe the professional groups, and their role as they influence the organisational decisions. Understanding the ideological stance of the workers, managers, and members of various professional groups is important as well[3].

[3] The role of interest groups in the policy development process at the national level is well documented. Politicians respond to these interests of various groups to win power.
Stretton H, Orchard L. Public goods, public enterprise, public choice: theoretical foundations of the contemporary attack on government. New York: St Martin's Press, 1994.

In addition to within-organisation individual and group actors, other actors in the environment need to be considered. A way to look at the environmental factors is to ask whether they enhance or interfere with the implementation of a particular policy[4].

The focus of this research is the local socio-political and organisational factors as they affect health services delivery at the local level. However, the discussion about the amalgamation of community health services (CHS) in Adelaide and the integration in Sydney in the next three chapters also deals with the historical and current thinking at the State and Commonwealth levels, though briefly and only when such discussion adds to the understanding of the local context[5]. The local context operates within the overall economic and political context at the national level. Relations between international, national (States and the Commonwealth in the case of Australia) and the community level health services exist in the form of concentric circles with two-way feedback. Economic constraints, a professional and technical push and the states' prevailing political ideology (liberal, conservative, socialist) determine to a great extent, the formulation of policy. While these policies emanating from a particular national level determine the context within which communities operate, the communities (including local services) try to provide feedback to the national level through influencing policy interpretation and implementation. The amalgamation and the integration provide examples of this feedback process.

[4] The words "enhance" and "interfere" should not be considered as value-laden in this context. In fact, in the community, both interfering with or speeding up the acceptance of a particular policy ought to be considered as positive phenomena – both point to the role of the services and community in policy making.

[5] As mentioned in the chapter 2 of this thesis, I use the word structure to discuss community level social and political dynamics and inter-organisational relations. Context, on the other hand, is the overarching concept and includes, in addition to the "structures", the organisational characteristics.

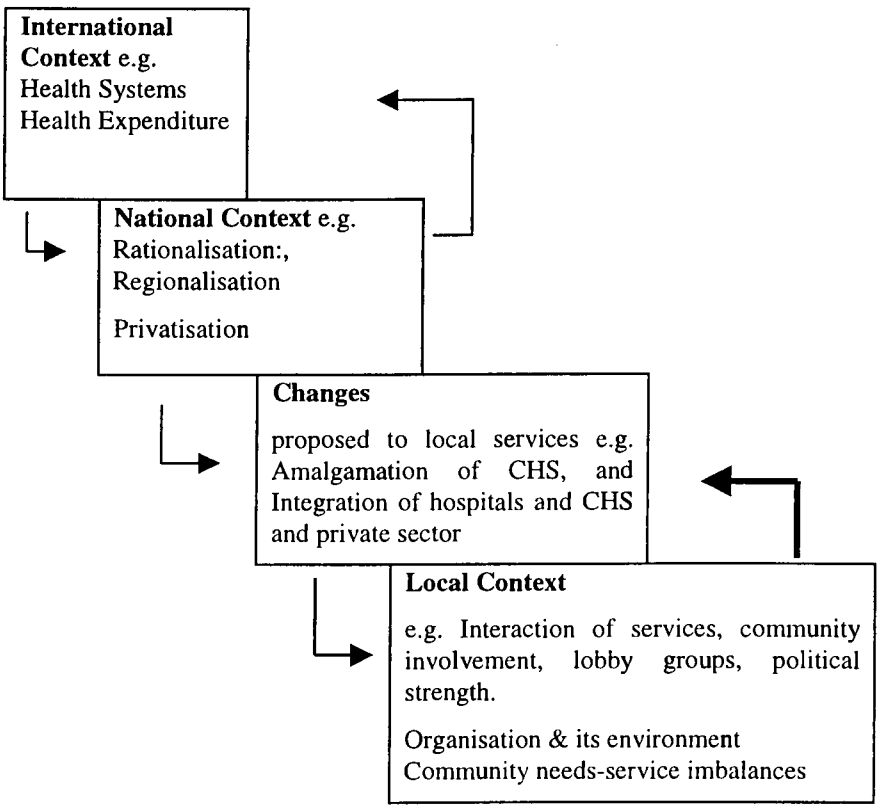
The example of current approaches to the problem of drug addiction highlights this feedback process. Current strategies to deal with the issue of recreational drug use are influenced by the international context, which does not favour policy formulation to decriminalise the use of recreational drugs. The main effort internationally is at stopping drug production and smuggling. This international agenda feeds into national policy making, where it hinders the formulation of policies which aim at decriminalising drugs and decreasing the social and physical health problems related to "a criminal hidden act". This national and international context reinforces the belief system where a heroin addict is seen as indulging in a criminal activity rather than as one who needs to be supported to decrease his health risks. Communities then confront the development of needle exchange programs. Now look at the process of reverse feedback – from community to national and international levels. Heroin trials and needle exchange programs in one community prove to be influential enough in generating debate in the country and help formulate policies favouring decriminalisation. From thereon the process may start contributing to the international context. Recently, in 1998, the decision by Ansett Airlines of Australia to install needle disposal units in toilets of passenger aircraft is a policy decision which is favoured by many interest groups nationally. International airline authorities approved the policy and were deciding on recommending this initiative to other international airlines.

Diagram 7.1 illustrates this interplay between the national context and the local context. On one hand, health system development policies affect the configuration of

local context in terms of interaction of services, dis-empowerment/empowerment of the community and its capacity to negotiate. On the other hand, local context resists/adapts/redefines policies through participation in the change process.

Diagram 7.1

Feedback between national and local contexts



The next three chapters – perception of amalgamation, process of amalgamation, and integration – refer mainly to the lower two boxes of diagram 7.1.

7.2 ANALYSIS FOR POLICY – A TAXONOMY

With the help of diagrams, this chapter explicate in some detail, the framework for policy analysis at the community level. Diagram 7.2 provides a summary of issues

which contribute to the policy and health system development.

Diagram 7.2

Analysis for policy: a taxonomy

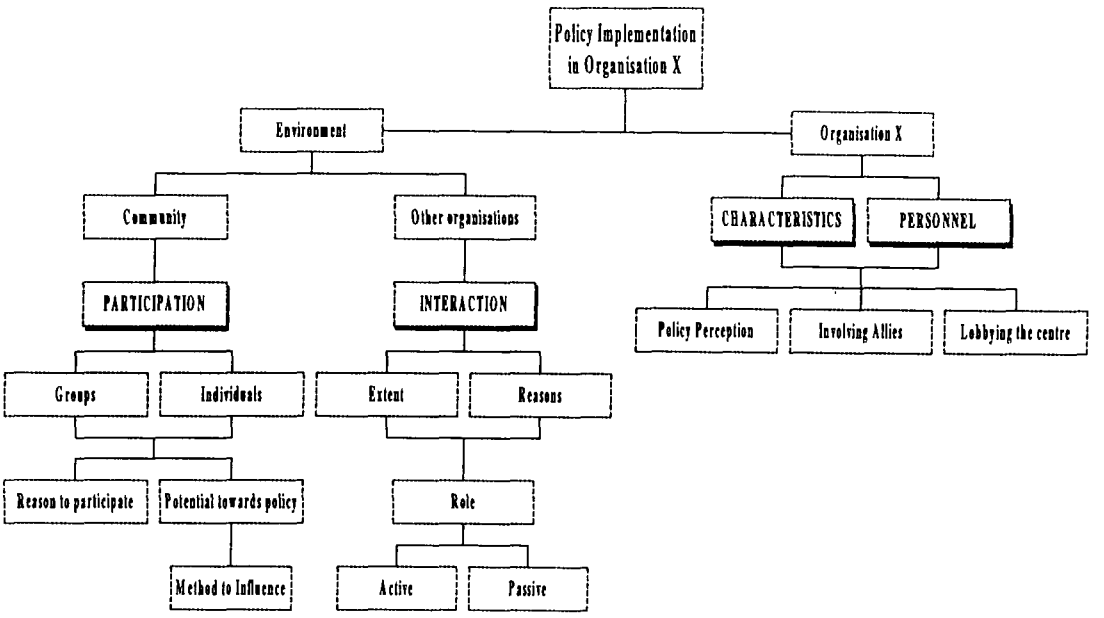


Diagram 7.2 points out that the analysis should include a look at both the organisation under change and its environment. The ideology that drives the working of a particular organisation in the community is an important element because it determines how a change will be perceived by that organisation. People in an organisation such as a community health service, which develops close working relations with its community and aims at achieving equity in health, might commit itself to the ideal of optimum community participation in decision making. Such an organisation would approach a change in consultation with the community and would resist a change which seems to take them away from the participation ideal. While the organisation as a whole might approach the change from an ideological perspective, the personnel and their professional groups within that organisation might approach the change from their own interests. The organisational ideology and workers' interests might influence any

negotiation between the hierarchy and the locals. The ideology and interests also motivate the personnel to involve local allies (other agencies and community members) in the process of change.

The structure and design of an organisation is a function of the environment of that organisation[6]. In other words, the environment determines the shape of an organisation. With this knowledge in mind, it is easier to understand that the community members and other agencies, would influence the change which aims at organisational restructuring. In diagram 7.2, the environment is considered in terms of 'other organisations' (health and social services, and other institutions such as media and local government) and the 'community members'. On one hand, the level of interaction with the other organisation, and the reasons for these interactions, determine whether those organisations would contribute to the process. At the same time, the configuration of the community in terms of cohesion and political power determines the level of participation by the community members.

This taxonomy alerts us to the issue that analysis for policy development should concern itself with both policy "actors" such as individuals, groups, organisations, and "processes", such as the extent of interactions, the role of health personnel, and participation by the community members.

This framework points to still another issue: organisations and community do not necessarily play a proactive role; the nature of the links often automatically influences

[6] Morgan G. Images of organisation. Beverly Hills: Sage, 1990.

the policy. For this reason, I use the terms "passive" and "active" role towards policy development at the local level.

7.2.1. Elements in the Local Environment

My definition of community not only includes people but also its social and health services, and its political institutions. The local structures – agencies and people as well as their interactions – which may influence the policy development in a community, so defined, include health and social services; local government; local people and their groups; media; and academic institutions which become part of that community by virtue of service provision or research.

The community context and its influence on policy development at the local level, needs to be discussed in terms of the following institutions and groups[7]:

Community Members

Community members, as individuals and as groups, contribute to policy development in the local context. Some community volunteers working with local organisations act as political activists in their individual capacity. As groups, they often politically support a particular service. At the same time, there are community groups providing support to community members who suffer from a particular disease. If an organisational change is perceived as threatening to what is available in the community

[7] Although these categories are not mutually exclusive nor collectively exhaustive e.g. individual GPs are people too, I am reserving the word 'people' for community people and not for any professional groups. This is because they might be using very different strategies to influence the policy process.

for people suffering from a particular disease or a condition, the interested group become politically active and lobby against that change. Examples of politically active groups composed of community members – in Western Adelaide – include the 'Friends of Dale Street Women's Health Centre' and the 'Friends of The Queen Elizabeth Hospital'. Similar groups supporting a particular organisation act as a medium for community involvement as well. These groups lobby for more funding and lobby against any job or service cuts proposed to the organisation. Other community groups, such as the Stroke Support Group, or the Diabetes Support Group, which lobby for services for a particular disease or a health issue, work closely with the local services and provide political support, as well as help in linking organisations with various population groups within the community.

Health Care Providers

In addition to the community health services and women's health services, the local health system includes other health care providers in the public and private sectors. The public sector includes state or commonwealth funded and administered services such as hospitals, family and community services programs, and child and adolescent mental health services.

The private sector could be classified into private for-profit and not-for-profit services. I use the words private and non-governmental organisations (NGO) for these two sectors respectively. The local private sector is mainly composed of general practitioners (GPs) working either individually or in a group practice. The Divisions of General Practice are concerned with reorienting GP services towards health promotion

and disease prevention are also private and not, ostensibly, for profit.

The non-governmental sector includes local charity organisations. Church-based services, such as the Port Adelaide Central Mission, provide support to individuals and families in need. They work in collaboration with the women's and community health services. Service clubs such as Rotary and Lions often raise money for community purposes.

Local Government

Local governments provide health and social services ranging from immunisation clinics to libraries. More recently, they have been getting involved in health and community development activities. In Adelaide, one local council was working in collaboration with the local community health service to prevent crime. Another local council participated in the planning process of the Adelaide Central Planning Division (of the South Australian Health Commission). Port Adelaide Council in Adelaide actively supported community members' struggle against a proposed increase in the size of the rubbish tip in the area. The community health services and the Liverpool council in South Western Sydney have been working collaboratively on projects such as physical activity promotion, women safety in the area, and Healthy City Liverpool. Another Sydney example is the Fairfield Health Forum in which the Fairfield Council actively participated to plan and lobby for better health care in the area. By such interactions with community members, and with the community health services, local councils play a role towards health system development in collaboration with other local organisations.

Media

The suburban newspapers are often involved in the debate about the health and social services in the area – in greater detail, and with more frequency, than the metropolitan newspapers. Metropolitan-wide newspapers and television and radio often present their side of the story with little input from the community people and other insiders, and they follow the issue only for a period of days. On the other hand, the local newspapers follow an issue for longer periods. Additionally, their coverage includes their own story line, the press releases from local government and other local institutions, letters from the local residents, and some news presented in the way the local staff and community want it to be presented. The stories in the suburban newspapers are often fed by lobby groups, community members and even by the local health personnel. These stories are used to get an even larger number of people interested in the change, and to get their support in resisting a change.

National Level Professional Groups

National level professional and lobby groups, such as the Australian Medical Association and the Australian Nursing Federation, have members present in the community. Some are politically active and work closely with the community members and health personnel. Their involvement, and their point of view, is driven by their group as they promote the ideas of their group. For example, a representative of the Australian Nursing Federation actively participated in the efforts of the 'Friends of The Queen Elizabeth Hospital' to resist contracting-out of hospital services. The Nursing Federation was against contracting-out of health services. Generally these

groups have memberships from the local area but have offices at the State level only. However, they play a role in guiding local services through the change, and at times provide political support to local services in resisting a change.

7.3 EXAMINING THE LOCAL DYNAMICS

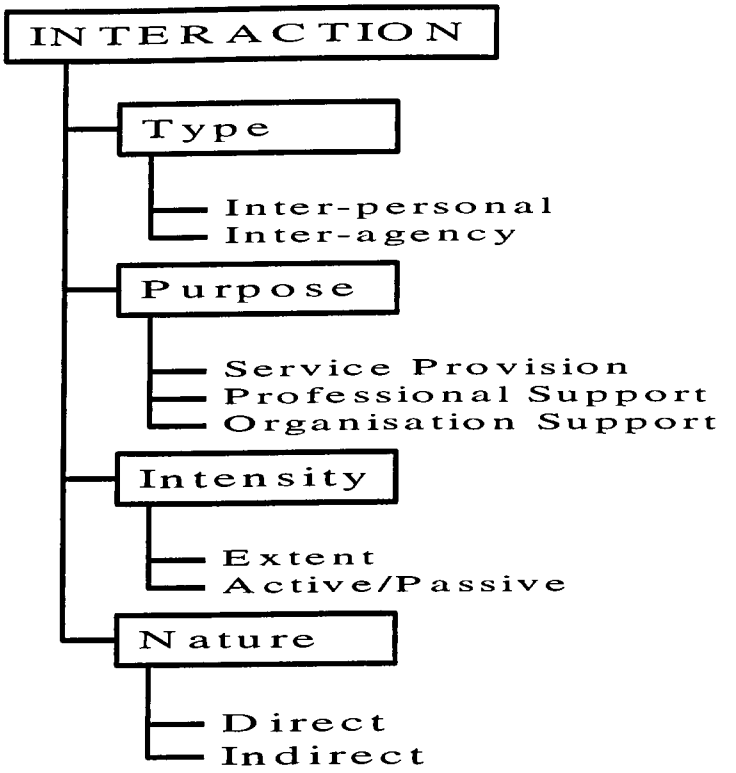
The diagram 7.2 pointed to four key elements of the local dynamics (the boxes in diagram 7.2 with capital letters). These four elements include *interaction* among health care providers, *participation* by the community, health care *personnel*, and the *characteristics* of the organisation as a whole. In the following few pages these four elements are discussed with the help of diagrams which present each of these elements in an expanded fashion and point to some relevant concepts.

7.3.1 INTERACTION

Local organisations possess horizontal linkages – with other organisations and with individuals in the area – as well as having vertical linkages with their parent institutions/departments. These horizontal linkages, which contribute to the local health system development, need to be discussed in terms of type, purpose, intensity, and the nature of the link (Diagram 7.3).

Diagram 7.3

Taxonomy of local interactions



These linkages are of two types, namely (i) inter-personal professional, such as nurses from various services in the area having interaction with each other, and (ii) inter-agency, such as community health services (CHS) interacting with the local council for a project. Both the inter-personal and the inter-agency linkages serve various purposes, a particular type of link often serving more than one purpose. These purposes range from making services comprehensive for a client to identifying peer support for learning or for political power. Comprehensive service provision is one of the major motives for the development of such links. None of the agencies in the area can provide all the needed services to their clients. Hence, the health care providers develop inter-personal links so that they are able to access other health services for their clients. These linkages are used to rally support for a particular agency as well.

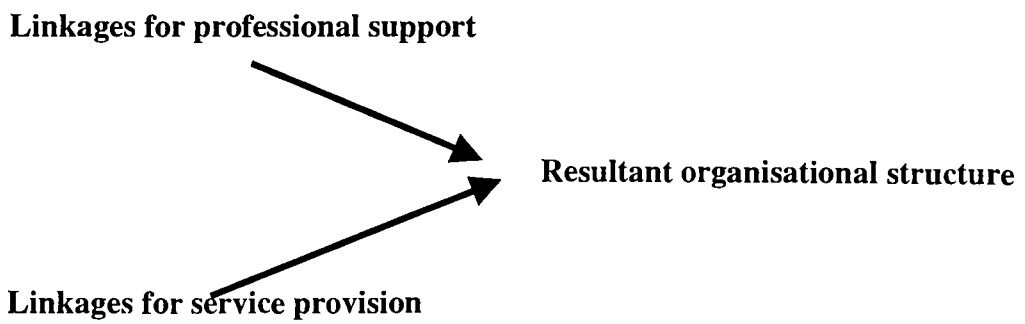
The value, and the influence of these links, depends on the intensity of the interaction. The intensity is defined in terms of the extent of collaborative work, and on whether the agencies actively sought out the interaction with each other. CHS interact with other health and social service providers who endorse the primary health care philosophy of integration and intersectoral collaboration. Factors that determine the intensity of the interaction include: the type of services provided by the agency; the duration for which the agency has been part of the community; the level of professionalisation; and whether an agency is focussed on a particular disease, on a particular clientele, or on the community as a whole.

The classification of interactions that is based on the purpose these relations serve does not reflect the intensity of networking. In the study sites, in Adelaide and Sydney, I observed that the relations could also be classified as *active* and *passive*. A passive interaction points to a cross referral of patients from one service to another. These agencies know, through formal and informal channels of information, what services are available from each other[8]. They use this information to refer the client. On this continuum of active and passive interactions the next category is of a working relationship where a staff member of one agency happen to know someone at another agency. In this case that staff member is able to phone the other agency and tell them that she is referring a patient to them. The most active working relationship is one where two or more services collaborate to work on a single project.

[8] At few places, the word "agency" is used for organisation (such as Women's Health Service and Community Health Service) to distinguish between an organisation and the "services (e.g. education, immunisation)".

It might be difficult to consider the role of a particular type of link in isolation. The following diagram (7.4) indicates that the linkages developed to serve different purposes, and affect the organisation in terms of its configuration and its work ethos. For example, the community health nurses as a professional group might lobby in favour of more nursing position at CHS. At the same time all those organisations with which CHS interacts, particularly those which receive assistance from nurses employed by the CHS, might contribute to the background protest against any perceived cuts in nursing positions.

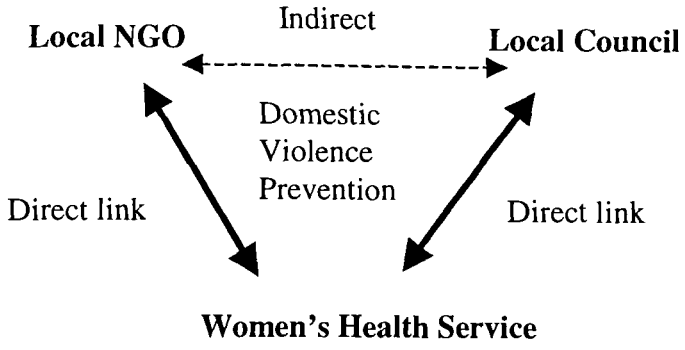
Diagram 7.4: Role of horizontal linkages



Another perspective on the role of linkages is to identify whether they result from a direct negotiation between the two parties – a *direct* link, or whether they result from a situation where two or more agencies are invited by a third agency to work on one of their projects thus creating an *indirect* link between the agencies who are being invited. Diagram 7.5 points to a situation where the women's health service has a direct link with the local non-governmental organisations (NGO) and with the council by virtue of one of its collaborative project. This project, however, provides an avenue for the personnel from the council and the NGO to interact with each other. This situation creates a link between the other two collaborating agencies (the NGO and the Council

in this example).

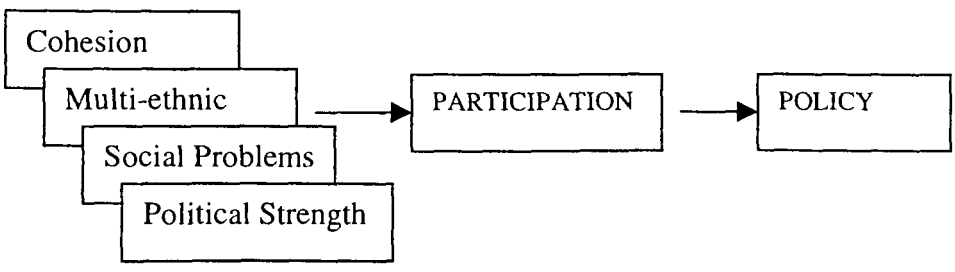
Diagram 7.5: Direct and indirect horizontal links



7.3.2 PARTICIPATION

The policy influence of the community members and their groups depends on various factors which I mention here briefly, and will put into a detailed community context from the two case study areas in the next three chapters. The role of the community needs to be analysed from perspectives such as community cohesion, level of group activity, political strength of the community, sub-communities within the community (multi-ethnic nature of the community), and whether the community suffers from some specific social, health, or health care problems. Diagram 7.6 points to the role of these factors in community participation.

Diagram 7.6
Community participation and policy development



Self identification as a "community" with a sense of cohesion is based on shared experiences of people living in one area. Common cultural background, a more or less similar economic status or common reasons for living in one area could be considered as factors leading to a sense of community. Such communities differ from other areas with regard to their participation in the local decision making.

The presence of sub-communities within a community in an area having multiple ethnic groups also affects the health system development in that area. Not only the need for health care is different for different groups, but also the participation levels differ from group to group. Participation in the affairs of "government agencies" may not be a familiar concept for ethnic groups recently migrated from Asia. This reluctance could be due to two reasons: prior experience of repressive governments, and a dependence on an extended family or clan rather than on people living a geographical neighbourhood. The multi-ethnic nature of the community also affects its cohesion, which in turn influences the potential to participate.

A third factor which determines community participation is the presence of certain health and social problems in the area. It seems that a lot of the energy of people living in socio-economically underprivileged suburbs is spent on lobbying the government for better solutions to one or another particular problem such as drug dependence, unemployment, fear of crime, or a general lack of funding. This phenomenon has the potential to affect community participation in both positive and negative directions. On

one hand, community activists are often preoccupied in lobbying for improvement in the situation, and so their participation in the working of existing services is less than optimum. These specific issues, on the other hand, bring health care personnel and the community members together and provide platforms from where community members start participating in the administration and decision making of the local community health services.

Another factor, which influences participation is the lack of political strength of the community due to belonging to an underprivileged socio-economic class, a lack of cohesion, and the presence of multiple fragmented sub-population groups. On the other hand, a high level of cohesion in terms of belonging to the same socio-economic class, having a similar ideology and belonging to the same ethnic group help the community achieve cohesion and strength to work together effectively. There seems to be one major exception: community cohesion in terms of all belonging to the same political party seems to weaken their political strength.

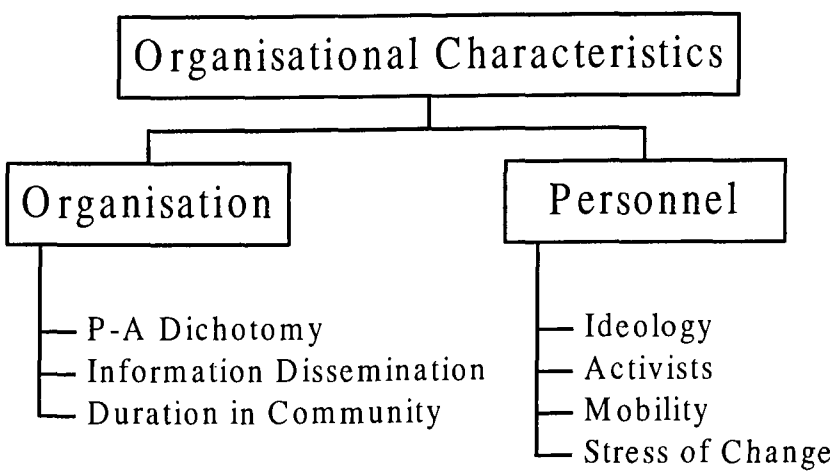
So far I have discussed two elements, namely participation and interaction, in the above paragraphs. The other two elements, as they appear in the diagram 7.2, are the characteristics of organisation as a whole, and the role of health personnel. These two issues are discussed together in the following paragraphs.

7.3.3 ORGANISATIONAL CHARACTERISTICS

My field research was not designed to analyse intra-organisational behaviours and their influence on organisation and service provision. However, some of these factors seem important in the light of the literature and experience, in terms of influencing policy development locally. These factors could be classified into two categories: (i) issues concerning an organisation as a whole, and (ii) issues related to personnel (Diagram 7.7).

Diagram 7.7

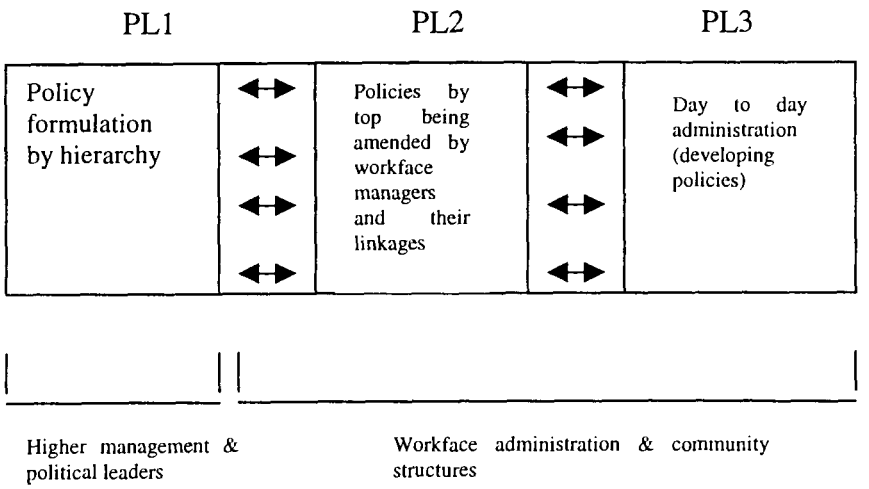
Organisation Characteristics: Policy Influence



Considering organisation as a whole, the perceived policy-administration dichotomy seems to affect the capacity to influence the policy. As mentioned in the literature review, a belief in the policy-administration dichotomy may actually put workers and managers in a situation where they are less motivated to act politically. The health care workers and the community members do not necessarily perceive themselves as being engaged in a policy making process even if they are actively lobbying with the

politicians and health services hierarchy for a change[9]. At the same time, a hierarchy which believes in this dichotomy, may consider any activities that are aimed at making policy fit to the local needs as interference in their role. Nonetheless, even the day-to-day administrative decisions at the local level feed into the approach taken by an organisation towards a change. For the purpose of analysis, the policy-administration interface could be considered as a three-stage process, where each level is a policy development stage with a two-way feedback between all three stages (Diagram 7.8).

Diagram 7.8
Policy-administration interface



The second issue relevant to organisational characteristics is the extent and pattern of information dissemination between various agencies, and between agencies and community members (Diagram 7.7). Dependent on the level and type of links, the information often travels informally where workers from an agency talk to workers

[9] Erica Bates points out that institutions are often unaware of their role. She suggests that even non-decision making contributes to the policy development process.
Bates E. Health System and public scrutiny: Australia, Britain, and USA. Croom Helm UK, 1983.

from the other agencies with which they have service-based or peer group links. Formal information dissemination is between agencies which have formal collaborative arrangements. Information on a policy may be shared with other agencies and the community members for various reasons. Looking at who were informed, and how, helps in finding out how an agency entices the interest of others in the policy development process.

Thirdly, diagram 7.7 points to the duration for which a health care or social service agency has been working in a community as another organisational characteristic which needs to be considered for policy and health system analysis. The longer the agency is serving in the area, the more intense might be the links with others.

Diagram 7.7 also points to the role played by the personnel as well. How a policy is perceived and implemented is greatly influenced by the ideology of major stakeholders, particularly the managers of local health services. Managers and staff members with a strong belief in the role of the community in health services decision making will be more amenable to a change which brings service provision nearer to the community. Similarly such personnel will be interested in a decentralised mode of management; they feel the need to be autonomous enough to be able to involve the community and other local agencies in deciding about the patterns of service delivery. Because they have a dynamic interaction with the community members and with its political institutions they are able to exert influence. A feminist manager of the women's health service is unlikely to be in favour of losing a separate identity of that specific service through amalgamation with the other health services.

Another issue relevant to the personnel and their capacity to influence the health system development is their mobility – quite a few persons leave an agency and join another within the area. This they do sometimes by choice and on other occasions because of redundancies. Such mobility helps agencies understand each other's perspectives and develop horizontal linkages.

The term 'activist' in diagram 7.7 refers to those personnel who join the health care services knowing that the area suffers from health and social inequalities. They believe that they should champion the cause of achieving equity for these areas and support efforts to improve the health status of the residents. Often these activists are influential and well-known health professionals and are able to mobilise state and commonwealth resources for community purposes.

Another relevant issue is that change causes stress; not only because it creates uncertainty but also because it adds to the workload for the local workers. Additionally, in some cases, the change ignites the friction between various groups and professionals at the local level. Personnel from the organisation undergoing change might react in many ways. They, being stressed, might like to give up on contributing to the process of change and thus might like to accept the change as it is and as soon as possible.

As far as the health and social services are concerned, there are a few other twists to the issues of individuals and their role towards health system development in the local context. In addition to the issue of different ideologies, there could be stereotyping in operation. While health services such as hospitals are male dominated, community health services, particularly the services targeting women and children, are mainly run by women. As women are stereotyped as weak; feminism has focussed on promoting a powerful role of women in decision making[10]. More recently, career women are now being seen as "lefty-ecologist" while males are stereotyped as bourgeois and bureaucratic[11]. This stereo-typing of each other's role as "bloody rationalist men" and "bloody radical women" may hinder the development of good working relations and cause difficulties in addressing policies jointly[12].

[10] Williams JE, Best DL. Sex stereotypes and inter-group relations. In Worchel S, Austin WG, editors. Psychology of inter-group relations. Chicago: Nelson-Hall Publishers, 1986.

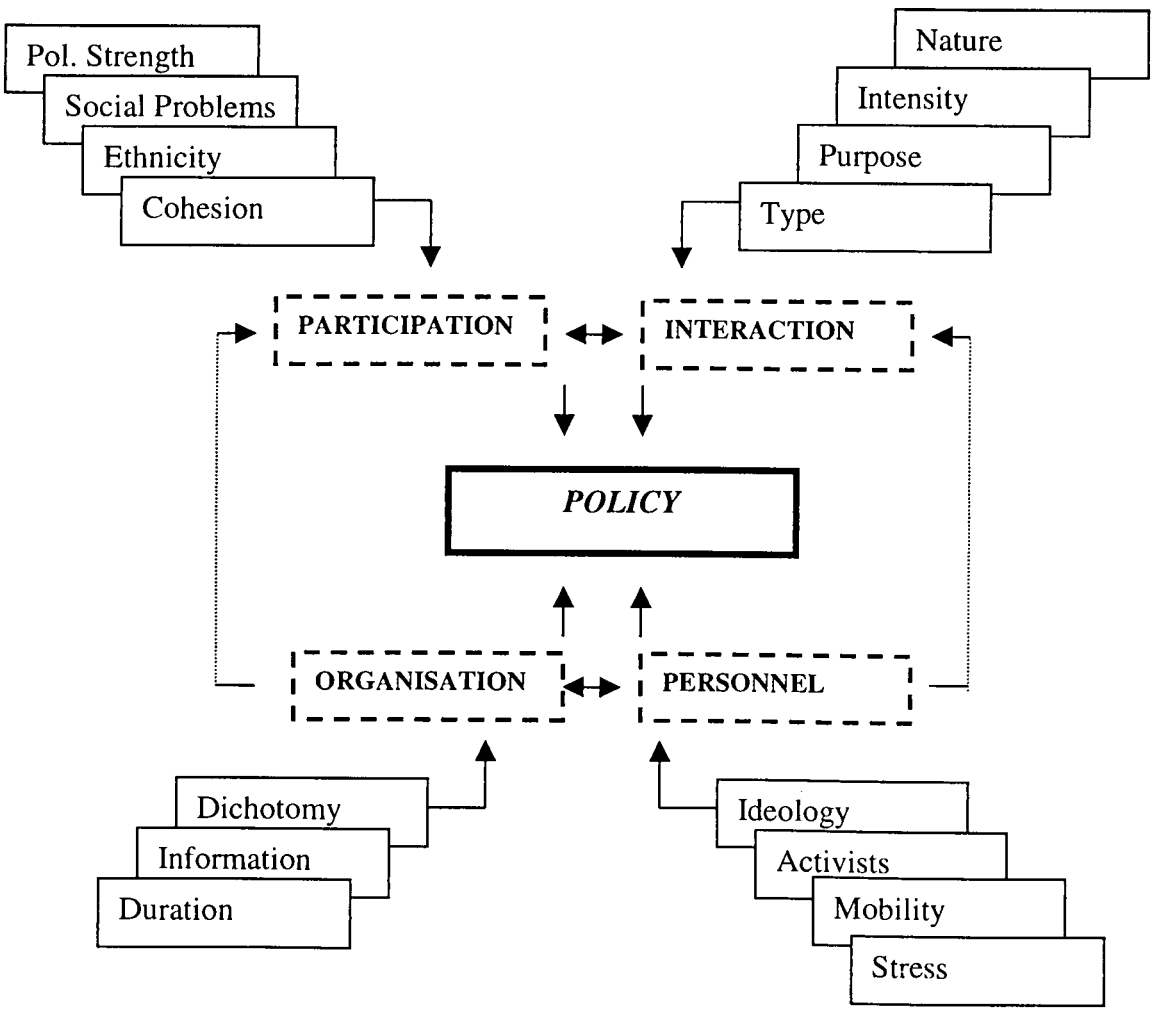
[11] Six B, Eckes T. Gender Stereotypes: a representative design for analysing cognitive categorisation of men and women. In Forgas JP, Michael IJ, editors. Recent Advances in Social Psychology: an international perspective. Amsterdam, New York: North-Holland (Elsevier Science Publisher B.V.), 1989.

[12] Hogg MA, Abrams D. Social Identifications: A social psychology of inter-group relations and group processes. London, New York: Routledge, 1988.
Billing M. Political ideology. In Nicholson J, Beloff H, editors.. Psychology Survey 5: The British Psychological Society, 1984.

7.4 THE OVERALL PICTURE

The following diagram (7.9) is an attempt to help visualise the effect on policy implementation of various factors and processes in the community. This diagram consolidates diagram 7.3 which points to the interaction between agencies, diagram 7.6, which points to the community participation issues, and diagram 7.7 which deals with the organisation as a whole and with the role of personnel. While the diagram 7.2 presented a taxonomy of policy analysis in the community, the following diagram points to the process by which a policy is influenced in the community.

Policy Influences at the Community Level
A Comprehensive Account
Diagram 7.9



In summary, community participation, interaction among local organisations, and certain characteristics of the organisation under change and of its personnel affect policy development in communities. The role of organisational interaction towards policy is in turn dependent upon the nature and utility of these interactions in day-to-day organisational functioning. Similarly, factors such as community cohesion and the prevalence of social problems might affect community's capacity to influence policy – as these factors determine participation. While the political and financial strength of the players is an important determinant of policy implementation, the diagram 7.9 provides a comprehensive framework to analyse policy influences. These policy influences are discussed in some detail in the next chapter.

The diagram 7.9 also points out that participation and interaction influence each other. It could be said that the interaction of an organisation with many others might create more opportunities for community members to participate. Additionally, it points out that the organisational characteristics not only contribute directly to the policy process but influence community participation and organisational interactions as well.

Considering these feedback processes and their influence on policy development, one can understand that the people in the hierarchy might get frustrated if they believe that the working arrangements in the community have nothing to do with a change they want to implement within 'their own' health service. The overall consolidated framework provides a tool to understand the health system dynamics in communities. This framework fosters input by locals (community members and organisations) into policy development as it advances a bottom-up community perspective approach to policy analysis.

CHAPTER 8

Amalgamation of Community Health Services: Perceptions in the Community

8.1 INTRODUCTION

This chapter is about how the amalgamation was perceived by the locals (community and staff). The next chapter, "Mechanisms of CHS Amalgamation", unfolds the story of how the change was processed under the influence of these perceptions and the local social, political and organisational factors. Essentially, the perceptions play an important role and for that reason they need to be incorporated in any framework of policy analysis. In this sense, this chapter adds to the framework for policy analysis provided in the previous chapter.

Before I discuss, in the next chapter, the amalgamation according to the four main categories of the framework – organisation, interaction, personnel, and participation – I discuss in this chapter, the way the perceptions of people influenced the implementation process. These perceptions determined, to a large extent, who took what actions and why. The amalgamation was seen as a potential threat to the personal interests of various stakeholders, ideologies concerning service delivery, working relationships, and service effectiveness.

"What we were told the objectives were? or what we think the objectives are?" was the response of a health care manager asked to state the objectives of the amalgamation. It points out that the objectives of a proposed change are interpreted by its implementers. These perceptions may determine the degree of acceptance or resistance to the proposed policy.

During the amalgamation, three factors appeared to influence actors' perceptions about the policy. Firstly, the interests of the *individuals* involved played a role; for example, does the person believe that the change in question will affect her job or role in the organisation. Secondly, the interests of any *professional group* affected by the change contributed to these perceptions as well. Relevant groups in this case were the community health workers (CHW), and community health nurses (CHN). Thirdly, the interests of the *organisation*, such as a CHS or the Women's Health Service, as a whole helped develop those perceptions. For example, the given policy was considered to be in conflict with values of community participation, equity, and cultural sensitivity.

The following remark points to the personal interests. It was made by a person for whom not only her ideological position, but also her personal interests were under threat from the proposed change.

> *All Women's Health Centres were very concerned about being merged with the generalist community health services. Because we always had our own specific identity and our own quite specific needs because they are meant for women.* LM (Director, WHS)[4]

For the head of an autonomous organisation, with a separate administration, the amalgamation was a process where her decision making role was to suffer a blow.

Here, it is important to recall, from chapter 6, that amalgamation as a change was thrown in amidst a number of other changes happening in the health system. These changes affected health care personnel, adversely in some cases. To some extent, the health care workers and managers' perceptions and responses were influenced by their beliefs about the effects of past changes in the same area or in other areas. Where a

[4] Initials have been changed and do not abbreviate the names of interviewees.

policy conducted in this or another area has had consequences which were perceived as unacceptable, similar policies inevitably caused concern among individuals and professional groups.

Professional groups were concerned that the change might undermine their role or reduce the number of jobs for their members. For example, the community health nurses (CHN) were already worried about the expanding role of the community health worker (CHW) at the expense of their own role. They became concerned about the amalgamation and its emphasis on efficiency. The new structure, they perceived, might be inclined to increase the positions for CHWs by decreasing the numbers of CHNs. Professional groups which perceive that the role of another professional group may increase at the expense of their group and their power are more likely to be concerned with the issue of their autonomy.

In addition to the individuals and professional groups looking at the change from their own interests, it was obvious that organisations as a whole tended to apply ideologies when evaluating the amalgamation. CHS were concerned that the amalgamation would increase the distance between the community and the administration and staff, and that it would adversely affect the principle of community participation. CHS were also concerned that, to play their advocacy role, they needed to be autonomous at the level of the community to which they provided services. For women's health services, the amalgamation was at odd with the ideology of having separate services for women.

In general, the interviews suggested that the CHS amalgamation was largely perceived to be a negative phenomenon. The following paragraphs sum up the way the amalgamation was perceived at the local level.

> *It is a sick joke that when you do not know what to do with services you just reorganise them or restructure them or regionalise them or localise them.* LM (Women Health Services)

> *I do not know anyone who has taken it positively. The Health Commission has got what they want. In terms of community, and its various boards, people are not happy. For them it is a backward step. There is general concern in the community that probably funding is reduced. There is an overall unease about what is happening.* BW (Adelaide Central Planning Unit)

8.2 STIMULI FOR THE PERCEPTION

The theory of dynamic conservatism points out that the existing social system provides not only economic security but also a framework of theory and values which enables individuals to make sense of their lives[1]. This theory suggests that organisations will do more than passively neglect, but rather actively avoid or minimise, a proposed change. This is arguably what happened in this case.

Health organisations, like other social systems, are complex arrangements of individuals, their work patterns, and their interests. If the stability of an organisation is threatened, the interests of the people who make up the organisation are also threatened. However, a change will not necessarily be perceived by all sections of the organisation as representing the same level of threat. It is likely that a section of an organisation that is only loosely attached to it will perceive a change to be of marginal relevance to its values and work patterns. For example, the local health system is

[1] Schon D. Beyond the stable state. London: Temple Smith, 1971.

comprised of public, private for-profit, and private not-for-profit components. Some of these components may only be loosely associated with the organisation. In this case, a staff member of CHS, a staff member of the WHS, a community member, and a person from the local council all appeared to perceive the amalgamation from their own perspectives. The response of each person reflected this perspective. The result was a continuum of reactions ranging from passive neglect to active minimisation. For example, one of the community health centres was located in a building belonging to the local council. The people at that local council informed me that they were not worried about the amalgamation, as it did not involve withdrawing the community health centre from its present location.

> *I have not necessarily got a problem with amalgamating administrative structures. I would have a real problem if this type of service (community health) was withdrawn from this physical location and I have not had indication as yet that this was a possibility.* CM (Health and Environment Officer of a local council)

On the other hand, a crime prevention program coordinator at another local council within the central Adelaide planning region was very concerned about the amalgamation. She was receiving support from a community health nurse (CHN) from the local CHS and perceived the amalgamation as a threat to that cooperation between herself and the CHN.

> *I suppose if [CHN's] job gets restructured, we might not be able to do that work together. Somebody might else pick it up [Her] role may be redefined and there may be no opportunity for her to continue the sort of work we do.* (Crime Prevention Project Officer of a Local Council)

Community members' perceptions, on the other hand, were mainly based on the current and future accessibility of the services. Some community members, actively involved with health care provision in the area, feared that amalgamation would mean lesser services to their area.

> *I even went in to see the Minister with some other people and he assured me that our services would keep working.* QP (community member)

The change was perceived by the staff (of CHS and other agencies in the area) in the light of its likely effect on their work, linkages, and service provision. If the workers affected by a change perceive that the change is mainly motivated by a desire to create redundancies, they might believe that the collaborative work would be sacrificed. Collaborations are usually with those agencies which were only loosely attached to the organisation being restructured. As a result, these links tended to be perceived to be more vulnerable, especially since the agencies did not always keep each other informed. In the case of the crime prevention project of a local council, the project manager was not informed by the CHS whether they would be able to continue working together after the restructuring. The only communication to the project manager about the restructuring was from the CHN who participated in the project, and who was uncertain about her future in the restructured CHS. It is possible the CHS did not inform the project manager because it was uncertain about the effect of restructuring, even one and a half years after the implementation process began. It is also possible that the absence of a formal link between the CHS and the project meant that the CHS was under no obligation to communicate its concerns to the project manager[AM1]. Such a situation has policy implications, because policy makers often do not consider strategies to address the effects of the change on these informal links.

In this case the project manager's negative reaction to the restructuring was the result of various factors. Firstly, at the time, the CHS was struggling to define its new structure and the community health nurse (CHN) was unable to ascertain whether she would be able to continue working on the project. Secondly, there was no official commitment (memorandum of understanding) between the two agencies to work together, hence communication to the project manager was casual and mainly through

that CHN. It is helpful to recall that collaboration at the local level is often initiated by workers who happen to know each other, and are willing to cooperate on a project which conforms to their ideology or work circumstances. The third factor was that while the continuing relationship between the CHS and the project manager was important, the project manager might have been worried about losing contact with that particular CHN. The observation by the manager that *"somebody else might pick it up"* suggests that the manager might have been optimistic to some extent about the prospect of a continued relationship with the CHS, but was worried about losing contact with that particular CHN.

So far I have been assuming that the project manager's responses were "rational" attempts to protect her project. However, individuals and organisations can respond from other political or ideological perspectives. The continuing existence of the project, and of her position as project manager, was dependent upon its collaborations with other agencies. This may explain her reaction to the restructuring. Morgan argued that such "non-rational" responses of individuals to organisational change may be explained by factors such as personal interests, group ideology and political affiliations[2]. The following observation shows the dilemma between rational and political thinking. In the first few sentences the interviewee tried to "rationalise" (justify) the amalgamation on the grounds that it would help pool resources. However, in the last sentence he dismissed his own argument on political grounds. Arguably he

[2] Morgan G. Images of organisation. Beverly Hills: Sage, 1990.
(It could be argued that all responses are the rational pursuit of some political or personal goal. In this context I am using "rational" to mean responses that seem to be justifiable relative to the goals and objectives of the health service in question.)

did that because all his peers in the area, particularly those directly affected, saw the change negatively.

> *... this amalgamation has provided an opportunity to have a bigger mass of people in any specific area. Earlier they may be having a worker working individually on that area. Now they could come together and may do comprehensive planning around that stuff. So that is one particular impact which I have noticed recently which has got some potential I suppose. I am not saying that it is a good idea. This amalgamation is going to be wrong.* KJ (Child and Adolescent Mental Health Services)

The following observation was made because of the interviewee's perception that the change would reassign the resources in such a way that the personnel would become more remote from the communities that they serve. In that sense the argument seemed a rational response to the situation.

> *"...Sitting here and working for the Port Adelaide area is different from sitting in Broadview and working. You may go North Haven from here, pick up some one and go to The Queen Elizabeth Hospital (TQEH). But it means that if we are based in Broadview we have to travel from Broadview to North Haven and with this extra time spent you cannot provide the same sort of services as when you are placed in Port Adelaide...."*
>
> (Project Manager Local Government)

On its face value, the above observation points to the potential inefficiency of regionalised CHS. However a careful look at the statement, and the circumstances in which that statement was made, tells another story. Individuals and organisations, having developed their networks in the local area, are more comfortable working from within this area and with the services they have known for some time. The workers were aware that it was not the case that the whole centres would be moved from one place to the other and be at a distance from the population. They knew that the amalgamation was more about developing a management hierarchy rather than displacing workers from one area to another and then asking them to serve the first

area. A perceived decrease in efficiency and effectiveness might have been used politically to counter the shift of management powers to more central levels.

Regionalisation was seen as a threat to the existence and effectiveness of the local groups. Perhaps for this reason the services promoted the idea that regionalisation would sever their links with the community.

> *The concern which I had with the amalgamation process was that it would lose its community base. If CHS or WHS are unable to support community activist or community action groups, these groups find it very difficult to survive and have a limited life. If you look at the CHS we have some paid workers and funding to support community groups in a whole variety of ways.*
>
> (A staff member at the Women's Health Service)

At the same time, these statements need to be read bearing in mind their sources. The local collaborations were very much the result of the perception of similar work patterns, value and ideologies. People working in women's health services (WHS) understandably seemed to find it easier to work with other groups interested in women's and children's health. This was true both for services as a whole and for individual workers. Workers felt that the ability to choose their own collaboration partners was important and they were unwilling to support any organisational change that could reduced this ability.

The local services seemed to negotiate with the central hierarchy their right to work with particular groups and services, often after the collaboration had begun. Such 'unsanctioned' work was legitimised on the grounds of community participation and to make health services fit the local needs. Agencies wanting to resist the change tended to argue that the change was not compatible with the previously negotiated and hence

legitimised arrangements. WHS resisted the amalgamation on the grounds that it was detrimental to community participation and would negatively effect their capacity to work with the community and community groups.

One also needs to look at the individual motivations behind a particular perception of a change. The statement that change will affect working relationships with community groups, quoted on the previous page, belongs to a person whose main role was to link WHS with the local groups. The following statement by one of the managers of CHS, on the other hand, refers to the reaction of people who perceived their jobs to be at stake.

> *I could not point to a deliberate act of sabotage. But I could certainly point to incidents where people were expressive of their deep suspicion, deep scepticism, fear, and wanted the whole thing to just go away.* JH (Ex-manager and CEO, Adelaide Central CHS)

In summary, the following three factors appeared to influence peoples' perception of the change:

1: When some component within the 'system' is "near" to the agency being affected by the change.

2. The professional groups' view of themselves and of their influence in the context of the existing organisation and its stability.

3. The individual, his/her work and his/her perceived vulnerability if the stability of the organisation is challenged.

The following table (8.1), is an effort to provide an idea about the frequency of particular reasons for organisations, groups, and individuals perceiving the change as a

negative phenomenon. This table points to a varied response to the same threat. For example, the concern that the amalgamation would affect the ideological base of community health was visible at the whole organisation level. It was obvious, from the documents and the interviews, that such undermining of ideology did not seem to bother individuals at a personal level. However, as part of the community health organisation they were very concerned about the potential threat to the community development process and the comprehensive nature of service provision.

Table 8.1
Reasons behind perceptions about the CHS amalgamation

	Cost-cutting	Ideology	Effectiveness	Work pattern
Organisation components	++++	+++	++	++
Professional groups	+++	+	++	+
Individuals	+++	+	++	+++

The number of "+" signs show the level of concern because of a perceived reason.

8.2.1 BACKGROUND OF THE CHANGE

The merits and demerits of the amalgamation were not the only issues which shaped the perceptions of the staff and the community. The amalgamation was seen within a larger framework of the past and present changes to the health and social services. To recap, the amalgamation of the CHS was part of a regionalisation strategy, involving the creation of three health planning regions. A health planning unit was established in each region, with a stated purpose to identify local needs and establish mechanisms for the implementation of a Funder-Owner-Purchaser-Provider-Separation (FOPPS)

model[3]. Within this context, the locals were concerned about their relationship with each other.

In the case of women's health, three options were talked about at the time the amalgamation was proposed. One option was for all metropolitan WHS to link up with the Adelaide Women's and Children's Hospital. Other options were for WHS to link up with other CHS in their respective regions, or alternatively, for all CHS and WHS to join together at the metropolitan level. This situation created much uncertainty, particularly because different individuals had different opinions and not all three regions wanted to follow the same route for amalgamation.

> *...it was not clear what was going to happen with the rest of the metropolitan area – because the original plan was to have three horizontal slices [regionalisation]. Now that was causing some concerns to primary health care and CHS as they were worried that it would cause an overwhelming of CHS by the hospitals, though these fears are sometimes justifiable sometimes not.* MN (Hospital and Health Services Association)

In summary, organisations and the staff at the work-face level tended to view the change in the context of what else was happening at the time. The conversations about the change with the staff and community suggested that policy developers need to carefully evaluate the context of past and parallel changes, as a proposed policy is not considered in isolation.

8.2.2 Amalgamation Viewed as "Cost Cutting"

One of the main objectives of the amalgamation was to cut administration costs. This specific aim paid little heed to the context of the past and parallel changes and led to

[3] SAHC, Central Health Services Planning Unit, SAHC Booklets 1: A guide to the SAHC and its Area Planning Units. 1995.

concerns among the staff that their jobs would be re-defined or made redundant. Not only the CHS staff but also the personnel from other agencies, which work closely with CHS, were concerned.

> *There is a sense of not knowing sometimes whether there will come a day when you won't be needed from tomorrow. But obviously you have to continue working.* (Community Health Nurse)

> *...With the cutbacks, some services, one does not know which but one presumes, some services will have been cut.* QP (community member)

> *There is a general concern in the community that probably funding is reduced. There is an overall unease about what is happening.* BW (Adelaide Central Planning Unit)

> *... They look for restructuring to make services more efficient to cut funding and that is the basis behind these restructures. The government wants to save money. They want fewer people to do more work and I think that is the main motivation behind restructure rather than actually the desire to provide better service. If they could provide better services with less money - fine, congratulations; but it does not happen very often.* AB (Crime Prevention, Local Council)

Even if the staff were not concerned that a particular service would be cut, they were nevertheless fearful of the concept of efficiency. When the SAHC linked the concept of amalgamation to efficiency, the staff argued the opposite.

> *I did not pick up if they [workers at CHS] had any false perception that CHS will be cut or reduced. ... [However] There was a concern that amalgamation is about efficiency and it is proposed to most of the departments but amalgamation some times may cost more money and not necessary save money.* LM (Women Health Services)

Another relevant issue is the role of simultaneous changes to other services in the area. As mentioned in the chapter 6 "Context of the Study", these included organisational restructuring such as amalgamation of hospital administrations, contracting out of hospital services, the development of regional planning boards, and efforts to establish funder-owner-purchaser-provider separation at the regional level.

Some of the staff [of a CHS] felt that their jobs were to go and I could not help to have that reaction on side with them. But again this is the part of economic rationalism and everything is going that way. RB (Division of General Practice)

The people in the Western suburbs believed that their services were not funded well enough to match the needs of the area. From their point of view, any change other than an increase in funding could be viewed as a further reduction in service. The proposed amalgamated region contained economically better-off eastern suburbs with a better need-service ratio. For some people, the idea of amalgamation with these communities was a cause for concern.

Eastern CHS has been well financed for a long time and that is unfair. So there has been this sort of contest between areas[4]. (A CHN at the focus group)

Senior managers agreed that, despite an effort to inform people about the real objectives, the change was viewed by the CHS staff as an attempt to prune services and cut staff numbers to a minimum.

Although a lot of information was being shared and staff were involved actively, some staff initially thought that there were some hidden agendas and it was very difficult to convey that we are not a mass murderer. JH (Director of one CHS, and later CEO of the Amalgamated CHS)

It is worth noting that "information" given to the staff may not necessarily serve the purpose of making objectives of the change more clear. Often information is used to influence decision making and/or to reduce resistance to a proposed change. In this

[4] Generally, however, this was not the main concern of the community health services in the Western suburbs. While they did object to amalgamation for other reasons, they were actually poised to gain a better balance in terms of needs and funding. It was the services and the community members in the Northeast part of the Adelaide Central Planning Region who were worried that, after the amalgamation, some of their services would be channelled to the Western suburbs.

case, the effect of the provided information was to avoid a "unanimous No" to the amalgamation.

The objectives of change often get over-ridden by circumstances at the local level. For central managers and the South Australian Health Commission, the objective of the change was efficiency in terms of trimming mid-level management to a minimum (from five to one incorporated units with a single CEO/Director). However, people's interests are tied to the local circumstances, and the staff at the local level read these objectives as a threat to their positions. Even one and a half years into the amalgamation, the difference between the objectives as projected by the hierarchy, and the objectives as interpreted by the work-face managers and the staff, was obvious. This was not affected by an improved communication between the staff and the hierarchy, involving creation of working parties of local staff involved in the implementation. It could be argued that the organisations and their staff did understand the objectives, but preferred to interpret the way they perceived its suitability to them. Every CHS has its own norms, working relationships with other agencies, and a particular level of autonomy from the hierarchy. It was the thought of not having the same relationship with co-workers and local managers after the change which created those perceptions. The locals considered autonomy as a necessary condition for effective service provision and accessibility.

During the amalgamation process, a survey of the workers conducted by the Workers Issue Working Party presented many questions raised by the CHS staff to the five directors – for clarifications and answers. The first question on this list was "what jobs

will go?"[5]. It is of lesser interest that the directors pointed out that it was more likely that their own positions would be cut. The more important issue at local level was the belief that the amalgamation was about job reductions.

Various professional groups within the CHS also lobbied for their own cause amidst fear that some of the positions within their group could be cut. Clinical psychologists, for example, proposed that a psychological multidisciplinary service should be adopted within the new organisation, and that the number of clinical psychologists in the new organisation should be equal to the number of social workers. Similarly, it was proposed that podiatry should be extended to domicilliary care service. Community health nurses' concern about their role being eroded by the community health workers is another example. These perceptions and the resultant discussions at the group or at the organisation level delayed policy implementation and affected the structure of the organisation. The new structure of the CHS as prepared by the Working Parties in consultation with the staff and work-face managers was unacceptable to the South Australian Health Commission (SAHC), and was sent back for revision on the grounds that it was less cost effective than the SAHC sought.

---

[5] Adelaide Central Community Health Service. Process Coordination Group Paper #1. Job Security: Directors' responses to workers' issues. 1995.
The amalgamation was proclaimed by the South Australian Health Commission in July 1995. By December 1995, the participating community and women's health services were able to develop one constitution, an interim board, and an interim structure. There was still need to develop the organisational structure for the new organisation, decide on issues such as the catchment areas, define a strategic plan, and identify a model of administrative structure. During the second phase, which led to the new draft organisational structure by March 1996, a Process Coordination Group and five Working Parties were identified. The role of the Process Coordinating Group, which consisted of the CEO, directors, and five nominees from branches (CHS), was to ensure the participation of the board, to facilitate the communication of information to all parties, and to ensure that the Working Parties got their discussion papers out on time. Working Parties, which had representatives from each of the five branches, were there to consult the staff, community and other agencies, and develop discussion papers on the organisational structure, workers' issues, administration, strategic planning and information/communication.
Adelaide Central Community Health Service. The Development of the Adelaide Central Community Health Service. 1996.

As the change was perceived and projected differently by different groups, there was a feeling that such "dis-information" might have a detrimental effect as far as accessibility of service by the community is concerned.

> *I think there is a danger as well that when these people do get up, even the Nurses Federation and State Opposition made the mistake of saying that The Queen Elizabeth hospital (TQEH) is going to be privatised [TQEH was not being privatised, it was contracting out services]. There is danger that rather than actually helping the community, they would go the other way and cost peoples lives as there are a lot of people who hear of "privatisation" and they automatically think that the hospital is going to become a private hospital, and they are not going to be able to go there. And ultimately that could cost lives.* FR (Suburban Newspaper)[6]

8.2.3 AMALGAMATION THREATENING WORKING RELATIONSHIPS

This research suggests that interacting with and involving the community was not only an ideological principle of primary health care (PHC), it was also of importance to the existence of the organisation. Organisations used the PHC ideology as a tool to maintain their stability while negotiating with the management hierarchy. They did so by claiming that the characteristics of their work, such as community development initiatives, were organisation-specific issues that could not be understood by the hierarchy which has a less intense interaction with the community.

> *I think we were concerned that the community link with CHS would lessen [as a result of the merger]. And it [control] is going to be more central. I was*

[6] This is a quote from an interview with a staff member at the local newspaper. The local newspapers employ little investigative journalism and mainly rely on what information is given to them in the form of press releases. However, newspapers seemed to get a good mix of information from various players. This is because the CHS, Regional Planning Unit, local hospital and some community groups regularly inform them about impending changes. The privatisation and contracting out of hospital services was a story which was followed extensively by the local newspapers. It could be said with confidence that reporters (even if not the newspaper) assigned in an area to cover health, and health services were able to point out the personal political motives behind projecting a particular change in a particular fashion by a group or individual.

concerned that if you take the process of decision making on need assessment and management further away from the community towards the centre, you need to think how much these people [at the centre] know about what is happening at the community level. LK (Director, CHS)

One staff member asserted that the importance of links with the community is not well understood by the policy makers and that an amalgamation which undermined the local interactions would negatively affect the working of the CHS:

The concern that I had with the amalgamation process was that it would lose its community base. If CHS or the Women's Health Service are unable to support community activist or community action groups, these groups find it very difficult to survive and [will have] a limited life. If you look at the CHS we have some paid workers and funding to support community groups in a whole variety of ways. FD (WHS)

Although the amalgamation proposal was not about closure or about relocation of services to another area, there was a belief among collaborating agencies that they would not be able to continue their working relationships with the CHS. With interpersonal linkages in mind, one could argue that the idea of relocation of managers away from a particular area caused the perception among collaborating agencies that they would not be able to keep in touch and make decisions – the greater the distance from the decision making centre of CHS, the less the chance to collaborate!

Because we have been working to improve our relationship with them and hopefully they have as well. But Divisions [of General Practice] are geographically based. So you could have the best working relationships in the world with some one, but if they go and move to another side of the city then you cannot work with them. NP (Division of General Practice)

Because people at CHS were worried that they might lose their jobs and because a lot of collaboration happens at the interpersonal rather than at the organisation level, the staff perceived that working relationships would suffer.

I was quite shocked to realise that actually something is going to happen and

then I thought I had to be involved and take it seriously because it may actually affect how we work. Staff member, a Community Health Service

I like to make fairly clear that was that person's personal decision [about stopping the project]. She said, "I am not sure what position I will be in six months. I am the one I want to do it because I am with you, I am not going to delegate it to someone else". TW (Community Coordinator, a Local Council)

The agencies which traditionally got services for their clients from other agencies might have been worried about where to refer their clients, and whether the restructured larger organisation would be as open to their needs and able to provide the same level of assistance.

I do not know what their rationale would be, but certainly let us just say for instance [that] I would be concerned if there was any drop in the level of services at the Dale St.[women's health services] because I use it so much. They seem so friendly and they are always open to take our groups. TW (Community Coordinator, a Local Council)

8.2.4 Ideology and Values

The community health services saw their role as bridging the service gap left by other components of the health system, such as hospitals and general practice. The CHS believed unrestricted contact with clients to be essential to fulfilling this function. Autonomy, meaning little interference from above and few pre-planned service delivery approaches, was seen to be a necessary condition for such contact. Amalgamation, because it was perceived to threaten the autonomy of individual CHS, was seen as undermining these values.

Community health has been under threat in a number of ways and threatened by some other options as well as by the option that we amalgamate. Like amalgamating with the hospital, which the hospital did not want to proceed with, and amalgamation of CHS which we did not want to proceed with. However, we all of us five services talked to our boards about it and analysed

pros and cons and agreed later that we would go ahead with it. GH (Director, a CHS)

Another principle considered important in the PHC and CHS context is that of making services more culturally acceptable. The women's health services were developed with the idea of having separate services for women in a non-threatening environment. Amalgamation was perceived as threatening this separation.

> *Their reservation was quite clear. They had fought long and hard to have a separate WHS and they fear that being in the mainstream they would lose their separate environment and there could be an organisation being looked after by men who do not share the same philosophy.* LK (Director, a CHS)

Although four other CHS were asked to merge, the WHS saw the amalgamation proposal as an attack on the concept of a separate WHS.

> *Over years of hearing comments such as why do you need a separate WHS, these comments had intensified during the merger as part of the general backlash against women's health services. And I think it is a political reality. I think the backlash is definitely a reality. And this is a reality that there has been less than whole hearted support from the bureaucracy for the women's health services ever since it started.* LM (Director WHS)

The WHS feared that they would not be able to sustain the same level of services if the new structure was to be decided mainly by input from generic CHS staff. Hence, on the Working Parties, they objected to the "majority rules" approach for decision making on the grounds that 80% of the members on these working parties came from the community health services.

Feedback from the WHS to the Process Coordination Group was overwhelmingly in support of the existence of a separate centre. The amalgamation was perceived to be a strategy which would decrease the potential of WHS to effectively contribute to health education and raise public awareness of women's issues. It is interesting to note here

that words such as "separate" and "specific" were used by both the hierarchy and the work-face staff in making their point. The staff and managers emphasised the ability of the WHS to provide services 'specific' to women. However, members of the hierarchy emphasised the separate (un-integrated) nature of the WHS as negative. The following quote by a senior official at the Health Commission (SAHC) reflects the prevalent thought at the central levels that a separate WHS is perhaps not an effective way of providing services to women.

> *There were of course doubts among the community about the proprietorship of the health units. The local groups felt that they are losing control and there was some lobbying because of that. The women's health movement had been very separate from the other health services.* TK (Metropolitan Health Services Division, SAHC)

8.2.5 Effectiveness under Threat

Cost-cutting and especially the potential loss of out-reach services were major concerns for a well informed community member who had worked with the CHS for many years as a volunteer, and at the time of the change was the community member on the local health services board.

> *But the thing which worries me as a community person and even though I am a board member it worries me whether an out-reach is going to be kept up or not.* QP (Community member)

For the community members and volunteers the out-reach component of CHS was a link between the community and services. The community seemed to be more involved in the planning and provision of out-reach services than for centre-based activities which are of a more technical nature. There was a fear that this effective component of the CHS would be slashed if there was a decrease in overall funding. Because of the perception that politically strong professions such as medicine place little weight on

out-reach services, people affiliated with out-reach care felt vulnerable to reductions and redundancies.

That personal interests fed these perceptions is made clear by the following example from the research sites. A CHS director who had been promoted to take the responsibility of implementing the amalgamation, a team manager at a community health centre, and a community member on the board of directors, all from the same CHS, approached the amalgamation from the perspective of their own interests. The director was concerned mainly with the effective implementation of the policy. The team manager, being a close associate of the director, was not concerned with the change to the extent other workers were, and in fact seemed rather excited about the concept of amalgamation. The community member, being a volunteer, was not worried about her job or about the administrative structure of the new CHS. Her main concern was the possibility of a reduction in out-reach services.

Out-reach has many facets. It can be ideologically driven and wants to put health services right in the middle of the community. It is a vehicle to mobilise the community to get involved in health and health care decision making, and it helps to make the CHS accessible to different population groups. In reality, the amalgamation posed little threat to the out-reach component. However, it was apparent that the perception of and the resultant discussions about the change were politically motivated. Out-reach services provided an option in which the community could participate; and those who participated actively, wanted to defend that territory.

8.2.6 AMALGAMATION AS AN OPPORTUNITY TO POOL RESOURCES

The amalgamation was proposed and promoted, by the Health Commission, as a strategy that would help pool resources, which could then be distributed within the various parts of the region according to need.

> *Well there are other perceived benefits [in addition to efficiency]. For example, some of the smaller group of health care professionals, say dieticians. If one of the two of them go on a holiday, you have only half of the personnel available for the work. However, if you have a slightly bigger group working in a number of campuses there is a lesser reduction in number of personnel if one or two are on leave. They can be moved around a number of campuses of one bigger organisation.* TK (Metropolitan Health Services Division, SAHC)

To some extent this message registered at the local level and this merit of the amalgamation was discussed.

> *Just recently a worker and myself gave a presentation to some of the Northern Regions Staff, Tee Tree Gully, Salisbury, Munno Para. That struck me then, that this amalgamation has provided an opportunity to have a bigger mass of people in any specific area. Earlier they may be having a worker working individually on that area. Now they could come together and may do comprehensive planning around that stuff. So that is one particular impact which I have noticed recently which has got some potential I suppose. I am not saying that it is a good idea. This amalgamation is going to be wrong.* KJ (Child and Adolescent Mental Health Service)

However, it is important to point out that this observation was made by a person from a collaborating service and not by a CHS staff member. He knew that the general feeling at the CHS level about the amalgamation was negative. So his response in the above quote is rational in the light of his previous experience, as well as his belief that he and his team would be able to interact with more staff from CHS at one time. However, he finished the sentence with an observation which is "politically correct" in a context where most of his peers were protesting about the change.

> *I was quite excited about the whole thing. Coming together as a big organisation community health may have much more power than they have as individual organisations.* ST (Team Manager, Community Health Centre)

It is to be noted that ST's name, as the key informant, was provided by JH, who had earlier been the director of the CHS where MI worked as team manager at a community health centre. The influence of this working association is reflected in the following statement!

> *I mean sure enough we've got community health in the East at the moment, but in terms of social statistics and health data the East isn't really seen as a needy area. What it [amalgamation] will enable us to do is to focus our attention to where services are needed. So there will be a larger concentration in the Western part of the Adelaide Central region. And I guess that is reflected already. We are focussing our services in the Western part of the Eastern corridor. Now that does not mean that we are going to abandon all those communities altogether, because we still be providing services from out-reach locations and to maintain contact with communities we traditionally worked with.* ST (Team Manager, Community Health Centre)

However, the community members who were from the same area, and who had worked with both ST and JH, were concerned about the reduction in the number of out-reach services.

8.3 CONCLUSION

In the previous few pages I have highlighted the way the change was perceived and the basis to such perceptions. These perceptions determined to a large extent the reaction of staff and community towards a particular change. Two important reasons behind these perceptions were the 'personal interests' of the street-level workers and the 'professional interests' of the groups to which these health care workers belonged. Within the overall context of various initiatives which were being considered for cost

effectiveness at the State and national level, the amalgamation was seen, by the workers and managers, as another strategy aimed at efficiency, with a potential for loss of jobs. This link of the amalgamation with efficiency and potential job loss gave rise to another perception. Professional groups such as community health nurses approached the change with caution. The members of a professional group felt that they might be less well off in the new structure in terms of status and number of jobs. Such perceptions motivated the workers and their professional groups to discuss the mechanisms to reduce the chance of them losing jobs and status. They then decided to actively participate in the process of change at the organisational level so that they could guard their interests. Such reasons behind the perceptions help us understand the role of 'horizontal linkages for peer support' in influencing the proposed changes and in influencing the relationship between the hierarchy and the locals.

The third factor, which caused the locals to consider the proposed change as a negative phenomenon, was that the street-level workers and community members identified themselves with the principles of primary health care such as community participation, empowerment, decentralisation, equity and culturally sensitive service provision. The locals (staff and the community) approached the amalgamation hesitatingly as they considered it, at least initially, in conflict with these principles of primary health care on which the community health services and the women's health services were based.

Another organisational characteristic which caused these perceptions among the locals was that the staff of the community health services (CHS) worked on various collaborative projects with many other organisations and groups in the community. These collaborative projects were often initiated by individual workers. The staff at

CHS and the agencies and groups with which that staff worked feared that they might not be able to continue working together. The staff members felt that: they might lose their job; they might have different job descriptions which would not allow them to work on the sorts of projects they were working on now; or that they might not have the level of autonomy they enjoyed before the amalgamation in pursuing a community development or health care agenda on their own.

The following chapter discusses the mechanisms by which various local stakeholders tried to adjust the change to fit to the local circumstances, and to decrease the uncertainty. Analysis in that chapter suggests that the communication of negative feeling about a proposed change could be seen as a strategy aimed at delaying or influencing the change.

CHAPTER 9

Amalgamation of Community Health Services in Adelaide: Viewed Horizontally

9.1 INTRODUCTION

This chapter unfolds the policy implementation process as it happened during the amalgamation of the community health services in Adelaide. Contrary to the expectation of the policy developers within the central hierarchy, a consequence of the implementation process has been the adaptation of the policy to local needs and work patterns.

I review the amalgamation using the structure for analysis proposed in chapter 7, "Framework for policy analysis – a community perspective". To recapitulate, in analysing policy implementation it is necessary to take the following elements into account: (1) intra-organisational issues, (2) community socio-political characteristics, and (3) other organisations with which the community health services (CHS) interact. In addition, this discussion considers the impact of the perceptions of the local stakeholders as well. In the previous chapter, I have discussed how the amalgamation was seen as a potential threat to the personal interests, ideologies concerning service delivery, working relationships, and the effectiveness of services.

A major theme in the review of the literature on policy development is that "implementation" is very much part of policy development. This viewpoint contrasts with the firm belief within government circles that the policy development process is over once the policy has been "legitimised" by the central decision making process. In

this chapter I draw on my field research to show that implementation is very much a political process and thus part of policy development.

In resisting change an obvious method employed by the local social and health services was to get local health system support groups involved. In an attempt to entice the public to contribute to the discussion about the policy, these services organised public meetings and sent newsletters to the local residents. Other methods used by these groups and staff from the services affected by the policy included: asking the local (suburban) newspaper to publish stories favouring their view; lobbying local members of parliament to raise the issue at parliamentary forums such as the Estimate Committee's proceedings; going to public meetings held for other reasons to raise concerns about their own agenda; and approaching other community groups thought likely to be interested in joining the debate.

This field research suggests that community responses to the implementation of change can be classified into two categories: (1) where community members themselves initiate an action; and (2) where health services staff use support groups to link up with the community and motivate them to participate in the debate – and to support the staff's struggle to influence the change. Privatisation or contracting out of services from a local hospital, amalgamation of women's health services with the general community health services and closure of a community health centre are examples of changes about which community groups and individuals took initiatives on their own. Such changes were considered radical and were perceived as drastically reducing the quantity or accessibility of services. On the other hand, for changes such as the amalgamation of CHSs, the involvement of community required an effort from the

staff. Within the amalgamation of CHS, the perceived closing down of one community health centre during the change and the amalgamation of the women's health service with the other CHS produced significant disquiet at the community and staff level. Issues such as a perceived decreased accessibility of local services after the amalgamation appeared less volatile but still caused many players to intervene in an attempt to prevent a dramatic change in the configuration of existing services and projects.

9.2 ORGANISATIONS

This section deals with those characteristics of a health service organisation as a whole entity, which influence the implementation of a change. The role of individual workers towards policy, and the reasons for their participation in the process, will be discussed in the next section. The issues discussed in this section include the policy-administration dichotomy and the information flow between various agencies within the area.

9.2.1 POLICY-ADMINISTRATION DICHOTOMY

The field research showed that the notion that policy development is the prerogative of the central hierarchy – with policies being given to the services for implementation – is widely held, by the policy planners within the hierarchy, and also by the workers and work-face managers. Policy is regarded as something that is received at the periphery from the Health Commission; services in the area are required to carry out that policy. On several occasions during the interviews, workers, work-face managers and

community members claimed that they had no role in policy because all policy decisions were made up at the top. Locals saw their role as an administrative one. While there were consultations, these were perceived to be merely a channel to inform the local staff about decisions already taken. This perceived dichotomy has implications for implementation where a change is perceived negatively by the locals[1]. From the point of view of central management, any local activity that delays or amends a change is interference in their policy development role. Despite being actively involved in various policy development actions, the community and local staff (apart from some local managers) did not view their activities as part of the policy development process. For them, their activity was administrative work involving the conversion of a policy into a plan. Implementation was not considered to be an act of policy development. Both the non-acceptance of the workers' policy role by the central hierarchy and workers' own lack of appreciation of their role in policy making, contributed towards causing unnecessary stress to the locals and made the implementation a tedious and delayed process.

The proposed amalgamation of the CHSs was a policy conceived mainly at the Health Commission level. However, the staff and the community became involved in the policy development process through two mechanisms: firstly, through day-to-day administration of the CHS; and secondly, through their involvement in the actual implementation of the amalgamation.

[1] The term "locals" is used in this thesis to represent local health services staff, local managers and community altogether.

Many day-to-day administrative decisions influenced the development of the policy. For example, a manager may consider that motivating a community person to join the board of directors (BOD) of a CHS is merely an administrative task involved in implementing the policy of having a board of directors. Nonetheless, the process of identifying community members for such boards is not value-free. Despite an open invitation to the general public to nominate persons for the board of directors, the community members who tend to join boards already know the work of the CHS and staff, and share workers' belief about how to work for better health services. Which community members join the CHS as volunteers or serve on the BOD also depends upon the awareness of the staff about the nature of community voluntary work pursued by various community members in the past. Thus the process of identifying community members is, in itself, a political process which later influences both the day-to-day working of the CHS as well as the implementation of changes such as amalgamation[2]. Community members invited onto the board of directors may be later used, subtly, to influence policies initiated by the central hierarchy[3]. While interpreting and implementing the proposed change, the community board members almost always supported the staff position. The following quote by a community member on the board points to the implicit political process through which these board members get to the board.

---

[2] In his book on social influences, John C Turner (1991) discusses theories of conformity. Normalisation and conformity are the processes which operate at the group (in this case staff of the CHS and the community members) where people gradually converge to each other's point of view and the community members move towards the majority's (in this case the staff) point of view. People who have conformed to the group's norm seem to have more chances to keep working with the CHS staff. Members of this group (BOD) might disagree with each other during day-to-day administration tasks. However, as conformity is a phenomenon relative to the outside world, the whole group acts in unison when they are pitched against the hierarchy.
Turner JC. Social Influence. Milton Keynes: Open University Press, 1991.

[3] Kathy Alexander's Ph.D. thesis gives a historical perspective on some of these issues.
Alexander K. Promoting health at the local level: a management and planning model for PHC services. PhD Thesis. University of Adelaide, 1994.

" We do talk to Ms. [work-face manager] as she is the one who brings us close to the health centre and head office. She is our contact to work out all details" Community Member on the BOD

However, it needs to be emphasised that the decision to motivate a particular person to join the board is not a deliberate effort on part of local staff to recruit people who will defend the staffs' ideology or work patterns. The process starts from the fact that community members who have successfully worked with CHSs to obtain services for their community group often want to continue their working relationship with the CHS. This scenario is an example of the processes whereby staff and managers are involved in policy decisions but often do not perceive their role as policy-linked and certainly could not calibrate their role in policy making. Even the board members did not see themselves as being involved in the policy process. The proposals which come from the top are considered as the policy.

"It was a decision given to us [by the Health Commission]. The decision was already made by the head office; when it came we were in shock. Even the staff [who] went to the meeting were in shock [to hear that]". Community Member on the BOD

It seemed that the locals had an impression that once the South Australian Health Commission (SAHC) decides on something, they then push for the staff and community to pursue and implement the decision. Little can be done to prevent the change or alter it. Community members on the board of directors felt that they have little role in decision making, particularly when it comes to larger issues such as organisational change or scaling down of services.

My group is very sad. One of the member [on the board] said they have already closed [decided to close] it and there is no worth going. ...I am not doing much personally, just advisory. There come some suggestions, you agree or not. Community Member

It was not only the community members affiliated with the CHS who were of the view that the SAHC is the authority in control as far as policy development is concerned. The staff and the managers in the community generally felt that their role in policy development is small.

> *Not much I think. I guess only in my contribution. I have been active, I have been on the working parties and contributed to various discussion papers. I made sure that my team gets involved in that. I don't think I had any great influence on the process.* ST (Team Manager Community Health Centre)

Despite putting a lot of effort into the process, the staff still felt that their efforts would be fruitless to a large extent.

> *I always feel that there could be another agenda and in fact the SAHC is going to do what it is going to do anyhow, and some of what we were doing in terms of input into the change was not of any purpose, and the ultimate outlook is going to be governed by what the SAHC wanted.* (A staff member at the focus group with the CHS staff)

> *At the end, I was still not sure whether what I ask is actually going to make a difference. By asking a question, you take the hell out of it as they would have to be accountable, and because of that you have not made yourself popular, but they have to be accountable. And I am still proud of that.* (A staff member, CHS).

The presumption of a hierarchical relationship between the services in the community and the SAHC was not only obvious from the tone of the interviewees from the CHS, people outside the CHS also pointed to the one-way nature of decision making.

> *They [health services and hospital managers] go to meetings to the Health Commission but it is not interactive, not two way. It is there to be "oh, this is what happening – and off you go".* MN (Hospital and Health Services Association)

Similarly, the other local agencies, which interact with the CHS, felt that the locals have very little chance of influencing or blocking a change handed down by the hierarchy.

I probably have been sort of feeling that it all has been inevitable you know, and what's going to happen is going to happen, and unless somebody stands up and jumps up and down about it nothing is going to happen. Everybody knows about it and everybody knows what is going to happen. There is not a feeling that you can do a lot about it. IJ (Division of General Practice)

I guess what happens is that there is a budget every year obviously and every year that budget gets slashed. So something, a piece of the cake, has to go. So they review what they see as important and things like that get chopped off. So they get cut off. And there is nothing you can do about it. We have to live in the real world. RQ (Family Health Centre, Child and Family Health Services)

I do not think it has any impact on the bureaucracy. All we can possibly be hoping to do would be to keep the community perpetuating the cycle at the community level. If there are community people interested and concerned about any changes in health care and are willing to actually protest, if they get coverage and if their concern gets coverage, they are more likely to be doing it continuously. And they are the ones who can make the difference. FR (Suburban Newspaper)

A noticeable issue was that the local services considered themselves as very much a separate entity and not merely an extension of the South Australian Health Commission (SAHC). This phenomenon was more pronounced during the change, when the locals used words "us" and "we" to represent the services at the community-level, while SAHC was referred to by "they" and "them". Staff and community made a clear distinction between the local services and the centre concerned with the policy and planning. With these perceptions it was natural that policies coming from the top were considered alien for not entertaining the local needs in terms of how services should be run.

At this point it is important to emphasise that, while locals did concede to the amalgamation as a policy 'which they have to accept', they did make an effort to influence the 'details' of that policy. The locals did not view their role as contributing absolutely nothing to the policy process. Although, most of the interviewees started

with negative comments, denying that they might have potential to influence any change, at various times during the interview, they pointed to the importance of their participation in the dialogue with the central management hierarchy. The staff and the community members did emphasise the importance of the struggle to make the policy fit the needs of the community and the local services – they contributed in order to have the new structure suited to their needs.

> *But then you strategically say well I may be sick of it, reading discussion paper after discussion paper, but it is important that I do it so that I am able to have a say so that the service turns into one where I like to come to work.* LM (Director, WHS)

> *We could have put structures in the hands of the commission instead of putting them in the hands of the project management group. All of those things could have happened which could have come up with different structures. I mean it could have come up with more hierarchy in the structure. It could have come up with a less hierarchical structure.* GH (Director, a CHS)

> *I think for me, that this centre is still there as a free standing Women's Health Service is significant as I really believe that its existence was threatened at one stage.* FD (Staff, WHS)

In summary, for the locals, the 'order to amalgamate' was a policy decision by the SAHC, and amalgamation did happen. The rest was merely 'deciding what shape the new organisation will take'. The fact that the locals were unable to avert the 'order to amalgamate' caused them to underestimate their potential to influence the development of the new organisation. This point becomes clear by comparing the perceptions of managers in the Northern planning region and the central planning region (research area) of the Adelaide metropolitan area. The staff and managers in the Western Adelaide metropolitan area did not like the idea of amalgamation, and despite the fact that they were able to resist the change for quite a long time and were able to influence the shape of the new organisation, these managers felt left out. On the other hand, the managers in the Northern areas, who shared the organisational ideology with

the hierarchy and liked the idea of amalgamation, felt that as if they had played a major role in decision making.

> ... *we were given total freedom here to develop our own directions. ... We decided in favour of the change by considering that it would be much better to decide how we want to achieve that change than somebody in Metropolitan Health Services Division [of SAHC] saying to us that you will do this or that.* AZ (Director CHS, during the implementation of the amalgamation, Northern part of the Adelaide metropolitan area, now at SAHC)

Despite the fact that managers in the Northern region were mainly operating within the purview of the SAHC policy framework, they perceived more autonomy. The main difference was in the perceptions. Staff in one region felt that they need to resist the change for CHS to work effectively. In the other region, the managers believed that they could have input into the new structure by rapidly accepting the policy and working in harmony with the hierarchy[4].

It was obvious that the CHS staff in the western suburbs were uncertain, in general, about the change and felt the need for more information on the process of amalgamation[5]. They wanted various committees (the Working Parties comprised of the local staff and community members) to communicate regularly to the staff at large. The uncertainty about the change and its potential effect on individual staff members were a cause for anxiety and stress among the staff. This uncertainty and anxiety was one of the reasons why the staff members were in touch with their own professional groups. The CHS are more akin to the behavioural theory of organisations where

---

[4] The Northern health region which felt that they were more autonomous and felt that they had more input into policy development was the one where the change was accepted wholeheartedly and in much shorter time. While the focus of the research was the Adelaide Central Region, I had access to documents from Northern region regarding the change. Additionally, the interviews with the SAHC hierarchy and the fact that the managers and staff from various regions were discussing the amalgamation regularly across the regions provided me a clear idea about the course of the change in the Northern region as well.

[5] ACCHS, Process Coordination Group (PCG). Minutes of the meeting, 23 May 1995.

individual characteristics are acknowledged and where group process are encouraged to maximise motivation. Implementation of decisions is more effective in organisations based on behavioural approaches – in contrast to the classical approach to organisation – because in such organisations, decisions which affect a person are often made by the group to which that person belongs[6]. While CHS had a participative approach to their decision making at the local level, the staff felt the need for the Working Parties, as implementation of the amalgamation required interacting with the staff from other CHSs as well. As these Working Parties had a member from each CHS, they provided a default mechanism for participative decision making. Impending changes cause uncertainty. Referring to Donald Schon's dynamic conservatism, Kouzes points out that human service organisations reflect feelings of doubt and stress[7]. CHS staff's linking up with their professional groups and their dependence on the Working Parties seems to give validity to these theories.

9.3 INTERACTION

Collaboration, mechanisms for working together, and the involvement of other services in the process of change are activities which help in understanding the policy implementation process. The type and extent of collaboration determines the level of involvement of other services in the policy process. Understanding the policy from these points of view becomes more important when one considers that working

[6] Kaluzny AD, Warner DM, and, Zelman WN. "Designing effective organisations," in Kaluzny AD, Warner DM, and WN, Zelman, editors. Management of Health Services. Englewood Cliffs NJ: Prentice Hall, 1982.

[7] Kouzes JM. Mico PR. Domain theory: an introduction to organisational behaviour in human service organisation. Journal of Applied Behavioural Sciences. 1979; 15:449-69.
Schon D. Beyond the stable state. London: Temple Smith, 1971.

together and intersectoral collaboration is a cherished principle of community health service provision.

> *I think there is an understanding to link up with other agencies and groups are encouraged to link with other agencies to provide services anyway. This has been known as by different words at different times. It has been called collaborative approach, co-operation, intersectoral approach. ... It makes a lot of sense to do it that way. It is part of the way community health operates.* Manager (At the group discussion with managers, Inner-Southern CHS – part of the larger Adelaide Central CHS)

9.3.1 Extent of Linkages

All three types of linkages discussed in the chapter 3 of this thesis were operating, to various degrees, at the local level. To recapitulate, these linkages are (i) linkages for peer support, (ii) linkages for organisational support, and (iii) linkages for service provision. However, it is worth noting that the workers and managers saw all these different types of interaction as being for the purpose of more effective service provision. Most of the interviewees focussed on the interactions mainly from the point of view of service provision. What the other reasons for initiating such links were and what purposes other than service provision they served were not highlighted directly. The following two quotes illustrate this emphasis by the staff on linkages as a vehicle for better services provision.

> *It depends on the common work you are actually doing. For example, speech pathologists focus here on under-five children so the idea would be to link their services with other agencies which provide children's services, play group, whatever. So some of that agenda is set by the contacts for work.* Manager (Inner-Southern CHS)

> *If I went into another area I would find it very difficult for some months to find out what resources are available. So it is not always things written down that you can sort of refer to.* RQ (Family Health Centre)

Interviewees emphasised greatly the importance of peer support linkages. It appeared during the field research routinely that such linkages were used to overcome red tape and be in a position to access services across agencies for their clients. However, during the change, the staff tended to use these linkages politically as well. This phenomenon seemed to occur because organisational changes were perceived as threats by the staff; if not by everyone, at least by various professional groups within the organisation. Groups feared that their members might lose their jobs or that their work might be redefined with a potential decrease in their role and power. For example, the community health nurses, working in several services, increased their interaction and networking during the implementation of amalgamation. They regularly met at their group level to discuss strategies to defend any redundancies in nursing positions because of the amalgamation. This was at the time when they also sensed an increasing emphasis upon and expansion of the role of community health workers. The nurses viewed the amalgamation – a strategy to improve efficiency – as linked to other ideas, such as the expanding role of the community health workers (CHW) in CHS. CHWs provided a more generalised service as compared to more specialised form of counselling by CHNs.

> *Well there was some concern. There was some. Like one of the agenda items was to actually talk about the fear or the possibility of some nurses' positions being lost to community health workers. So there is another kind of reason.*
> CHN

> *Because it was hoped, and we are still hoping, that it is not going to change the role of the nurses. It was a very much broader perspective that as women's health we were hoping to influence the processes that were to be established.*
> CHN

Nurses were aware that the conflict between CHWs and CHNs was there even before the amalgamation was proposed. However, there was a fear that the amalgamation might be used to reinforce the idea that CHWs could provide the same services as provided by a CHN.

> *The same thing happened to social workers. Their position was under threat to be taken by CHW as CHW get paid less. We have one community worker but she has worked for a long time. This issue [CHW or CHN] has been going on for quite some time. It is not necessarily part of the amalgamation. CHN*

Peer support linkages were used to avoid the negative effects of the change on members of the group. One can not say with much confidence what would have been the situation in terms of redundancies in CHN positions had there not been such pressure from CHNs and their group. However, the fact that nurses were able to keep their positions intact throughout the amalgamation could be attributed, to some extent, to this lobbying by the CHNs[8].

Using various types of linkages for policy influence might not be a conscious process at the local level. However, the peer support system is the one which was often utilised quite openly to influence the policies. The service provision linkages seemed to act more subtly, while organisation support linkages were often employed to create pressure in negotiating with the hierarchy. An example of such use of organisational

[8] Kathy Alexander had earlier pointed out these tensions among the team members at one of the CHS in the Adelaide Central Planning Region. She reported that the task management model helped in achieving cohesion among members and in achieving a congruent approach towards health and social issues. Generally, this culture is prevalent in the working of CHS.
Alexander K. Promoting health at the local level: a management and planning model for PHC services. PhD Thesis. University of Adelaide, 1994.
The impending restructuring during the amalgamation, and the overall context of retrenchment, however, created an atmosphere where individuals got worried about whether they would lose their jobs. In addition to being members of CHS team geared towards solving the health problems in the area, the nurses had another 'task' at their hands – to avoid potential redundancies.

support linkages was where the CHS got the support of the local lobby groups which lobbied with the politicians and maintained a constant background noise through letters, public meetings, and newspaper articles while the CHS was negotiating with the central management and politicians.

Linkages to provide political support at the organisational level operate in a much less tangible way than peer support networks and interaction for service provision. Actually, the political support network was based more on service provision needs than on a shared ideology by the supporting organisations; the greater was the level of interaction for services provision, the greater was the input into each other's policy development processes. Such support was more visible in case of organisations which provide services to the same clients or help their clients in receiving services from each other. In the case of the women's health service, this organisational support was both for ideological grounds as well as based on collaboration for service provision. The Women's Health Service was supported by the CHS in keeping its independent status and in keeping its work patterns to pursue the cause of women's health.

> *I myself was very upset and very much worried because I considered a free-standing Women's Health Service very important. ... I was at public meetings. I was keeping myself updated. Suppose I talk to a friend on phone, I would suggest – please write because we need every person to act.* FD (Worker, WHS)

The following quote is by a staff member of a service other than CHS. Her involvement to support WHS in raising their voice against the merger was mainly because of existing working relationships, rather than on the ideological grounds that women should be served through separate services. As her own work was mainly for female clients, despite mentioning the need for having separate services for women,

her main emphasis was on the fear of a drop in the level of services which would be available once the WHS becomes part of the general CHS.

> *... for instance I would be concerned if there was any drop in the level of services at Dale St. because I use it so much. ... Amalgamation with the more general health services would be bad, as purely women's health services gets sucked up by general community health services. For example, things like a female doctor taking care of patients, working on specific things like domestic violence, sexual abuse, and women's issues to do with breast cancer and all sorts of things. [WHS] seems the most appropriate place to send someone.* YZ (Co-ordinator, Taperoo Family Centre)

By openly resisting themselves, by promoting background protest through lobbying with the community groups, and with the support from CHS, the WHS was able to maintain autonomy to some extent within the amalgamated structure.

> *One of the key principles the five centres developed at those Working Parties was the retention of the Women's Health Centre as a separate unit within the organisation ...we knew that we had a very strong support within the region. One of the other directors used to be the director here. There was strong support from the other three [CHSs] as well.* LM (Director, WHS)

'Support for service provision' to a common clientele was the main type of horizontal linkage noted locally; both at the individual worker's level and the level of the organisation.

> *I think it is really important. It is very very important to tap into a big institution like the CHS because I can consult with them how they see the issues but also to work in association with them. They've got access to people from the community and some times that is really useful for me to have contact with such people.* AB (Crime Prevention Project, a local council)

Again, these linkages are usually based on informal networking between the local staff at various agencies. These workers happen to know each other; they help each other for a prompt service for their client if she/he needs to be referred. These linkages help to personalise the service provision, and in a way, make the service more accessible to the community. There are no memoranda of understanding for these informal person to

person or agency to agency links. Workers and agencies knew what services were available from others, and in case of need they would pick up the phone and request a favour – to fulfil the need of their clients. In the event of the policy change, staff members working informally with other agencies gave feedback to the amalgamation process and tried to preserve these functions which were being pursued in collaboration with other service.

These informal links, however, often act as precursors for a more formal relationship. An example of this phenomenon could be the informal links between a staff member from a CHS who was known to a staff member at the local council. Their informal collaboration on various community projects later helped that CHS to formally commit one of their staff to participate in the Crime Prevention Project of the local government.

> *"If Ms. [staff member from a CHS] gets a project in which I am interested or if I get a project in which she is interested, we liaise and work together. Most of the work which has come to me happens to be through informal networking"* AB (Crime Prevention, a local council)

Services readily accept that there are clients' needs which they cannot serve by themselves and this understanding motivates them to establish links, often informal in the beginning.

> *...I think there is quite a willingness amongst agencies to do that kind of work. And people certainly recognise the whole systemic nature of the family I suppose, that we can't do everything for the family and sometimes I need specialise counselling to arrange for them.* KJ (Child & Adolescent Mental Health Service)

As this informal interaction with each other contributes towards the planning process of agencies at the local level, I would argue that this phenomenon contributes to what structure an organisation would attain over time.

> *We have a lot of informal interaction – sometimes formal as they give us some reports but more so informal. We take that into account in our planning. ... Well, there are several sources; schools do a lot of referral ...[as well as] General Practitioners, Family and Community Service. ...We get a lot of referral by the word of mouth.* KJ (Child & Adolescent Mental Health Service)

Work patterns and service boundaries are stretched under the influence of these horizontal linkages. Agencies keep on adding services or changing their patterns of service delivery under the influence of these formal and informal interactions at the local level. To continue working relationships with other services in the area, agencies have to be flexible enough to accommodate what others want to do in collaboration. This phenomenon seemed to have implications for policy development. The locals thought that these informal networks, and the needs arising out of such relationships, were least entertained by the policy proposers.

It is not only that informal relations turn into formal collaborative work, often agencies develop formal working relationships without going through the informal stage. These collaborations are developed on the basis of an identified need for some services for which collaboration between these agencies is required. It was pointed out by the respondents that this direct formal interaction develops if both services have sets of service objectives which overlap and for which they seek partners to work collaboratively. Agencies occasionally developed memoranda of understanding to work collaboratively. One example where services were working together for some time but then later developed a formal memorandum of understanding to work together

is of a collaboration between services such as the Child & Adolescent Mental Health Service, the local WHS, and the two CHS. On the other hand, an example of developing formal links without going through the informal linkage stage was the collaboration between the local Division of General Practice and the eastern CHS.

> *We are developing a memorandum of understanding. It raises issues of general practice as well as issues related to the community, perhaps from a slightly different angle but with a clear overlapping. The GP might be using different words. GPs use the word patient, they use the word consumer for example. But they are coming together.* NP (Eastern Division of General Practice)

While the formal links were mainly entertained to some extent by the policy – the central policy development people knew about such formal links, the health services staff involved in the informal linkages felt the need to communicate and act to avert threats to those informal links.

Once the services had received the policy the next step was to communicate the policy to related individuals and the services in the area. This information sharing served many purposes. It seemed to be the first step to involve and motivate peers and the community to help resist or assist in the implementation of the policy. It also served to communicate to the collaborating individuals and agencies that if they had to discontinue working together it would be because of the change – and not because there was any decreased emphasis on working together.

Information about the changes planned or under implementation flowed from one service to the other, and from a service to the community through formal as well as informal channels. Formal channels included correspondence or meetings between the staff and executives of the CHS and various other services in the area. Informal

communication took place where staff from one service provided information about the change to the staff from other services whom they happened to know personally, or whom they knew because of a one-to-one working relationship or because of informally working on a project together. Similarly, the information flowed from the staff to community activists through both formal and informal contacts. The local newspaper was also considered as an important medium not only to communicate but also to lobby against the change.

9.3.1.1 Communicating to the staff at other agencies

Interaction of health care workers for peer-support and service provision was not limited to their workplace; they mingled socially as well. It seemed that whenever they met for a joint project or for a lunch together they discussed new developments, particularly the ones which are perceived to influence their working relationships. Despite the local services working closely with each other, it was informal networks more than formal channels through which information about the change was communicated to these services and individuals. The following quotes by the staff of the services which interact with CHS point to the lack of formal communication and involvement in the policy change.

> *... they are going through restructuring here and sometimes you have a bit of a whinge about what is going on and how things are [which] you know. You get together with someone with whom you work and just informally talk about what is going on, because it can impinge upon the services you offer and what you can do in your capacity.* AB (Crime Prevention, local council)

> *I was not formally involved or given feedback. There are community networks [where] people got to know each other. Then there was a public meeting as well for some information on funding cuts, amalgamation etc.* WY (Young Mums Group)

Officially I don't think we ever had [been informed of that amalgamation]. We probably heard about it. Oh I don't know. Yeah I really don't know. A long time ago it filtered in. I mean we have people who move around in close circles and we just started to hear. NP (Division of General Practice).

I do not know terribly much about it [amalgamation] except that I heard it rumoured. RQ (Child and Family Health Services)

In addition to getting sympathy from peers regarding a situation which was causing stress, the one-to-one dissemination of information was an important tool for informing those services which otherwise were not to be involved formally in the process of planning the new structure of the CHS. Through these informal networks, in addition to the formal communications between collaborating services, everybody concerned with health care provision in the area came to know about the change. These communications seemed to convey the concerns of the staff at CHS about the change and to generate support which later helped in increasing the background protest regarding the change.

The first sentence in the following quote by a manager at one of the CHSs refers to having little formal involvement of other services in the process of amalgamation. However, the interviewee acknowledges the role of informal communication networks when she says that "but they probably were":

I am going to say that I am not aware that there were any [agencies involved in the process], but they probably were [laughed]. Oh, I know in the suburb from where I come from people are really concerned about us moving as a result of the amalgamation process. ST (Team Manager, Community Health Centre)

This situation resulted from information sharing and knowledge about the change by almost all services in the area and set the platform for the CHS to launch the adaptation/amendment/negotiation process to make policy fit to the needs of the local services. A particular perception, which resulted from whether the change was communicated as positive or negative, led to the external pressure build-up at the community level. The hierarchy of each service started getting a continuous stream of messages that the planned change was unsuitable in its proposed form. The fact that many of these sister organisations at the local level were incorporated under the SAHC was helpful for the CHS, as most of the noise was reaching where the CHS wanted it to reach.

This informal personal information dissemination seemed to be much more detailed and told other services a great deal more about the proposed change compared to what was communicated through official letters. In fact, official letters formally communicating the policy were often read in the light of informal conversations.

9.3.1.2 Feedback from other agencies

Many services in the area were formally notified about the proposed change by the particular CHS/WHS which had previously worked with these service. These services included: Family Planning; Child and Family Health Services; Child and Adolescent Mental Health Services; Second Story; Legal Services Commission; Local Councils; and the Domestic Violence Wing of S.A. Police Department. These services work for a particular health or social issue and some of them focus on a particular population group. The CHS work closely with these services for various projects. In addition to

the formal notification, meetings were held between staff and managers from CHS and other services.

> *We also met with those services. As I was at Tea Tree Gully, I met community groups, local politicians and so forth. And other directors did likewise. We put out our information bulletin on what we were doing. We continued to do that throughout.* LK (Director, a CHS)

> *...community centres, drug and alcohol, family planning, councils ... women shelters, migrant health services, interpretative services, and the churches more recently, schools/pre-schools ... there are other services like the Housing Trust, FACHS, CAMHS and social security, all of those sorts of services that we would need at various times depending on what the situation of work is.* Manager (Inner-southern Community Health Services).

These lists of agencies to which the information about the change was communicated, point to the nature of the CHS work and the formal organisational linkages. In their official replies (usually a letter from the manager), these agencies expressed a hope that the existing collaboration would continue - implicitly pointing to their uncertainty that the change might lead to a breakdown in working relationships. Occasionally, they showed concern about the change in structure leading to difficult future collaboration or a perceived increase in their workload resulting from the restructuring. As mentioned earlier, services come to know the details of a change through informal communication channels. This knowledge gathered through communications with the staff was the basis for such concerns. For example, in the Northern region within the overall amalgamation there was a proposal for the merger of CHS Youth Teams into one stand-alone Youth Service. Another agency providing youth health services in the area showed its concern about the merger by writing that "regionalising youth services may mean that high need areas will absorb the total effort of the service [to the detriment of services in other areas within the region]". That agency admitted that the

need in some areas of the region is greater than the need in others. However, they seemed concerned that the restructuring of a particular service component had implications for their work. They felt that the amalgamation and the resultant merger of youth teams would leave them alone struggling to serve the needs of some areas in the region which would not be covered by CHS youth services.

It is interesting to note that a majority of the services to which information about the change was given seemed to have little interest or few worries as far as the official response was concerned. Often the official response was limited to thanking the director of the CHS for informing them about the proposed change. This official lack of concern was more pronounced in the case of government agencies, which might have considered these organisational changes as inevitable – changes about which nothing can be done. A staff member from one of the local services mentioned that they had gone through four organisational changes in the past six years. She mentioned that within the philosophy of rationalisation, any inefficiency perceived [by the hierarchy] in the existing set up or any potential efficiency achievable through a change led to the organisational restructuring.

The field research suggested that it is also valid to classify the interaction as 'direct' or 'indirect' as well. Direct links were those where the staff or agencies came together to work for a common project or provided a particular service jointly. Indirect links refer to situations such as where a community group worked with two agencies in the same area and thereby created a link between those two agencies. The individuals and

agencies interacting through such projects have to act to make room for their collaborative work in the new structure.

9.3.1.3 Value of links

The main thesis of this research is that the policies and procedures proposed by the central hierarchy were incompatible with the realities of working with the community. The extent of the local links, particularly the informal interaction, demands highly autonomous CHSs able to take a decision about organisational restructuring by themselves, so that they are able to continue working with the community groups and other agencies in their environment. It seemed that there was little understanding at the central level of the role that these linkages play. In the wake of the amalgamation, when the CHSs consulted their counterpart organisations in the community, and tried to accommodate the existing collaboration, it caused delays in implementation and frustrated the hierarchy. The new organisational structure, designed by the locals for the newly-amalgamated larger CHS in the light of their needs, was considered by the hierarchy as 'inefficient', and the draft was sent back to CHSs for revision.

My research revealed that informal linkages, whether they are at the personal or organisational level, are valued highly by both the individual workers and the service as whole. These linkages derive their importance from their help in developing collaboration without the need to go through the time consuming, and cumbersome bureaucratic process of initiating official collaboration[9]. Bureaucratic procedures and

[9] cf. Bozeman B, Reed PN, Scott P. Red Tape and Task Delays in Public and Private Organisations. Administration and Society 1992; 24:290-322 – on the way in which government involvement can contribute to delays in accomplishing critical tasks.

the resultant collaborative work were considered impersonal, and the complex working procedures, time delays and impersonal nature of the collaboration appeared as demotivating factors.

> *I guess it depends when you are ringing cold and you don't know the person and you don't quite know who you want to speak to and that sort of stuff can be a bit daunting – so I tend to go to the people I know...I think that [institutionalised interaction] would be good but I think the interpersonal stuff is really important. I am not going to mention any names, but I went to a meeting again at the larger health centre and there was no introduction really as to where they come from or nobody really said welcome it is your first meeting. I got really lost there and I never went back. So I think even though there may be some formal structures and formal meetings but interpersonal stuff is really important for staff to keep interacting with each other.* YZ (Taperoo Family Centre)

Looking at how workers operate together at the interpersonal or the agency level suggests that services do not necessarily need to change their existing objectives to initiate a collaborative task. A flexible reading, often by the staff and local managers themselves, of what services an agency is required to provide, helped in developing some informal working relationships at the local level. On the other hand, developing an official memorandum of understanding to work collaboratively appears to be a difficult process as it requires that the services which want to collaborate have clearly stated overlapping service objectives.

The presence of informal links and their utility for the local service provision meant that there was little perceived need for formal arrangements. In addition to improving service provision at the local level, these informal links served another important function where individuals and agencies received political support from their counterparts:

"The existence of informal networks assured that we were able to write letters, and to attend meetings to show our support [to CHS during the time of change]" FD (Worker, WHS)

Despite a high prevalence of informal links and despite these links being helpful at the agency levels as well, it was the individual workers who cherished these links more than the organisation as a whole. Although organisations had such working relations with the CHS, they often did not receive detailed information about the change. Detailed information dissemination to many agencies was mainly through informal channels.

" I think I have known about it [the amalgamation] for about six months now. S... told me. No one has written to me officially. S... just told me that they were going through restructuring" AB (Crime Prevention Project, Local Council)

" ... you get together with someone with whom you work and just informally talk about what is going on; because it can impinge upon the service you offer and what you can do in that capacity" AB (Crime Prevention Project, Local Council)

I noted that the peer support and professional linkages contributed towards shaping the culture of the organisation as well. CHS, at least in the research areas studied in Australia, seemed to be dominated by a "nursing culture", where nursing is seen as supportive, helping and believing in harmony and symbiosis. While the physician-dominated culture in hospitals is more of a autocratic nature, the nursing culture has been considered as the one that favours participation and delegation[10]. These organisational characteristics greatly influence the patterns of decision making. It was noted that CHS are organisations which do not have many "specialists". In South Australia, although some CHS employ medical practitioners, there is a majority of

[10] Kinnunen J. The importance of organisational culture on development activities in a primary health care organisation. Int. Journal of Health Planning and Management 1990; 5:65-71.

more generalist staff working on issues such as domestic violence, relationships, child development, parenting support, and environmental health. CHS are organisations which work closely with the community; the staff work on out-reach projects where the community feels less timid in negotiating with these workers about the local needs.

Another issue that seemed relevant to the issue of incompatibility between hierarchy and the locals (staff and community) is the fact that a majority of the staff members at CHS were women, while the Health Commission appeared to be a men's domain. Michael Hogg and Dominic Abrams discussion of authoritarian personalities, and Michael Billings' observations about the role of individuals in terms of their political ideology (extreme right/rationalist versus extreme left/radical) seemed to apply in this case[11].

Another characteristic of CHS is that they have a large number of workers from professions such as community health workers, social workers and community health nurses are groups which are more open and much less mystifying when they are compared to medical professionals with their approach towards the client and community. These are the factors which seemed to make the CHS an organisation where policies would be resisted and be difficult to implement if they were incompatible with the 'informal' and 'open' culture. Many health and social services display this culture despite belonging to different departments and despite bureaucratic

[11] Hogg MA, Abrams D. Social Identifications: A social psychology of inter-group relations and group processes. London, New York: Routledge, 1988.
Billing M. Political ideology. In Nicholson J, Beloff H, editors. Psychology Survey 5: The British Psychological Society, 1984.

hurdles – that of an extended family and not as a set of machines. A service was considered meaningful only when one happened to know who was the provider and what that provider could offer to the client.

> *No, I have not done any stats [that services are not enough]; but you see I would not refer someone unless I ask the agency first what their criteria were. I would not send that client on a wild goose chase. I would actually speak to the person concerned and ask what services they did offer and would my client fall into their criteria. I would not just refer them off.* RQ (Family Health Centre)

It has been argued that intersectoral efforts are not that successful, because national level efforts are rarely matched by the development of initiatives at the regional or local level[12]. I tend to disagree with these remarks because this research and my experience of working closely with the primary health care services in Karachi, suggest that intersectoral efforts would be successful only if intersectoral action is considered as a process which starts at a local level, rather than a process which start as a result of a policy of a department or bureau. In the Adelaide case, community level services wanted to work together as it enhances effectiveness in the local context. Additionally, there was a perception among the locals that the more effectively you link up with each other, the more politically powerful you become. For that reason, the managers, even if they are not rewarded by their hierarchy for working collaboratively, would like to work with other services. Local collaborations and networks strengthen the local staff in terms of their capacity to negotiate with the hierarchy but this process weakens the hierarchy's potential to implement policies in their original form. Official and formal collaborations are difficult to realise under time-consuming departmental procedures.

[12] Rathwell T. Realities of Health For All by the year 2000. Soc.Sci.Med.1992; 35:541-547.

9.4 PERSONNEL: ROLE IN HEALTH SYSTEM DEVELOPMENT

Personal characteristics of the staff and community members involved with the health and social service provision in an area are important in influencing health system development. In addition to being determined by the profession or speciality group of the worker, these personal characteristics appeared to be based on the level of exposure to the community through out-reach services and through projects with community groups.

Personal factors seem to influence the local health system through two mechanisms. Firstly, the level of collaboration for service provision and political support in the wake of a change depends on the willingness of a particular person. Secondly, how a person – particularly a manager – is perceived (and labelled) by others, regardless of whether that perception is fallacious, determines whether other individuals and agencies are willing to collaborate with that person or his/her agency.

It has been noted that professionals act at work more liberally than their professional education would suggest[13]. Schon suggests that the world, with all its existing interactions, linkages, and different agendas of various individuals and institutions acts in an open and complex fashion, in contrast to the packed nature of the knowledge. Policies, such the amalgamation of CHSs, are "pre-formatted packages" through which the hierarchy and some mid-level managers would view change happening in a certain

[13] Schon D. Beyond the stable state. London: Temple Smith, 1971.

way. This prescription [knowledge], however, was received and interpreted by local professionals in a way that conforms to the "unpacked" work situation with its locally specific rules of working. Unpacking the policy according to the local situation seemed to be truer for health professionals who happened to be in the community settings for a long time.

9.4.1 IDEOLOGY OF THE STAFF

How a change is perceived, and what the reaction to it will be, depends on local ideas and work principles. Ideological commitment of management and health workers is a major determinant of how social policy is implemented[14]. For the managers in the Western suburbs of the Adelaide metropolitan area, primary health care (PHC) principles such as culturally acceptable services which fit to local needs, seemed to be very important. Whether they believed in it or not, staff and managers in Western suburbs showed their concern, and were quite vocal about it, at various stages during the implementation. It seemed as if they were carrying a bumper sticker which pronounced community participation and culturally acceptable and appropriate services as the key principles of CHS. Although a health promotion bumper sticker on a car is probably not that effective in changing the behaviour of those who read it, it may reinforce the ideology of the driver/owner who has put it there in the first place.

[14] Alexander K. Promoting health at the local level: a management and planning model for PHC services. PhD Thesis. University of Adelaide, 1994.

The main reason given by the managers in the Western suburbs for objecting to the amalgamation was that the change would reduce the potential of the services to involve the community and to provide services in a fashion which is appropriate in the context of local needs and local norms. On the other hand, the managers in the Northern suburbs of the Adelaide metropolitan area seemed to be more in tune with the objectives set by the central hierarchy. The managers in the North, promoted the idea to the board of directors as well as to the local staff, that rapid acceptance of the amalgamation would help in achieving integration of primary health care and would help in maintaining a strong partnership with other agencies as well as with the community. My reading of the documents on amalgamation and a presentation by the local managers at an international conference suggests that the Northern managers were concerned about finding ways to meet the needs of the socially disadvantaged population within the constrained budget. The case they made for the amalgamation was that it would increase resource sharing between participating community health services and that a regional service would decrease administrative duplication. The Northern managers promoted the amalgamation to their boards by claiming that if the area service were regionalised it would lessen the likely impact of the budget cut. This pro-amalgamation stand was not visible in the Western part of the central planning region, where managers were more sceptical of the change. Considering that the board members already had some allegiance with (and under influence of) the local managers, the managers' stance helps in promoting an idea to the broader community via the community members on the board of directors and via other volunteers to sell a particular change.

In discussing the development of integrated health systems, Barrett used an analytical framework based on opposing forces such as professional versus popular, periphery versus centre, and biomedical versus traditional[15]. The notion of professional versus popular as opposing forces which decrease the potential for effective collaboration, is relevant to my discussion about the role of ideology in implementing policies at the local level. In the light of this research, I would argue that as the make-up of the CHS is less specialist (but with quite a few specialised tasks) there are less chances, compared to hospitals/GPs services, for a CHS to be incompatible with the other community services and the community groups. Organisations with diffuse and informal communications and with less reliance on technical and rational knowledge develop humanitarian ethics[16]. On the other hand, the hierarchies, such the South Australian Health Commission, do not enjoy the level of interaction with the community and groups comparable to CHS. Workers at the CHS and WHS acted in a 'popular' fashion compared to the 'professional' solutions proposed by the hierarchy.

This is not to say that all the staff members at all participating community health services were united in their approach to the change. One issue that generated debate, as identified from the minutes of meetings of the Process Coordinating Group (PCG), was the role of the team leader/director. With the CHS becoming a larger organisation at the regional level, the positions of director and team leaders were considered more powerful compared to the previous situation where teams had been smaller.

[15] Barrett B. Integrated local health systems in Central America. Soc Sci Med 1996; 43: 71-82.
[16] Rosengren WR. Structure, policy and style: strategies of organisational control. In Brinkerhoff MB, Kunz PR, editors. Complex organisations and their environments. Dubuque, Iowa: WMC Brown Company Publishers, 1972.

Individuals and the professional groups wanted to define the job descriptions carefully because it would later affect their operation.

9.4.2 Stress of Policy Implementation

Change causes stress because it almost always carries uncertainty. Stress caused by the implementation of the change was mentioned by many interviewees. The managers and the staff were required to implement the change to the satisfaction of not only the central hierarchy at the South Australian Health Commission but also to the satisfaction of the community and community services. The new organisational shape and how it would operate was to be negotiated with the community on one hand and with the central hierarchy on the other.

This proved a stressful task for the local staff. The staff had to take the community and the local services into confidence about the future working of the CHS in the area. At the same time, they motivated the community and the local services to increase the background protest about the lack of services in the area and to show their resentment of the propose policy of amalgamation. Another reason for their stress was the amount of time the implementation took; staff had to devote much time to the implementation and were hard pressed to complete day-to-day service provision.

> *It did cause stress, tension. People saying "I am sick of this bloody amalgamation, I am sick off the staff meetings talking about it". Even though people knew that it was important for us to do that so that we were right in there and making sure that women's health interests were being looked after.* LM (Director, WHS)

There was uncertainty about which jobs would be cut as a result of the change. Additionally, the staff seemed to be worried about the changing nature of their job.

> *Well, I think because how do they know whether they will keep their position. No position is permanent and they will have to apply [in the new organisation].* QP (Community member)

> *But there is a sense of not knowing sometimes whether there will come a day when you won't be needed from tomorrow. But obviously you have to continue working.* CHN

> *More recently I guess there has been more frustration. In particular we are aware that there is going to be reduction in employees. So people are feeling pretty low.* ST (Team Manager, Community Health Centre)

> *I talked to [local CHC] about doing a group and basically one of the reason why we did not do it, and it was to be a women's group over at [area], one of reason why we did not do it was because there was so much going on down at Port Adelaide. The person who was going to do it did not quite know what position we would be in and what was going to be happening you know in six months time. So we thought until the water comes down a bit we won't do anything. And we basically left it after that.* TW (Community coordinator, a local council)

The amalgamation proposal involved decreasing the size of middle management. This was another factor which caused additional stress to the managers who had to do brokering between the demanding hierarchy and the locals (staff and community) and their needs. Furthermore, the amalgamation caused friction between the local managers and the Northern managers because of the different approaches to the proposed amalgamation by these two groups of managers. For some time during the amalgamation, personal interaction and peer relations suffered heavily, and the managers from the North and the West were communicating only on official forums.

> *There were some damaging aspects of the change as well. Of course I lost my job as director. Then I had to work hard to recover my ego out of it, because it is very well to talk about and laugh about it, but when that actually happens it*

is not that easy thing a to do. AZ (ex-director CHS in Northern region, on friction between North and Central planning regions)

Various professional groups within CHS took a different stance on how to implement the change or lobbied for emphasis on a particular component of the service in the new structure. This situation caused friction between these professional groups and as such added to the stress, the stress caused by the policy implementation process in turn affected the policy development at the local level. At a later stage, as people felt frustrated, they wanted the change to happen one way or an other. Many staff lost interest in the process and wanted to accept whatever new shape the organisation would achieve.

Despite all this stress, a majority of the staff and managers coped with the situation rather well – at least in the sense that they did not leave unless their jobs were made redundant. A few staff members, however, were unable to cope and left.

9.4.3 Mobile Workforce

Another personnel-related factor relevant to health system development is the mobility of workers from one service to another. The pre-amalgamation (or pre-cost containment) history was that workers who moved to another service within the same area helped in establishing new links and helped in strengthening the existing collaborations. While staying in the same geographical area, workers often changed jobs from one service to another. There are many reasons for this mobility. Often workers (such as non-professional staff, social workers working on a particular

project) from the area were hired by an agency for a period of a few months to a year or two. At the end of that particular contract, these workers were usually able to find temporary work with some other local service. For example, a worker with the disbanded health and social welfare council started working on a project with the local women's health services. The local Division of General Practice hired a community liaison officer who was earlier working at the local CHS. One of the staff at one of the local CHS earlier worked with the local Aboriginal health centre. This mobility helped them to become familiar with the objectives, strengths and interests of various services. They were familiar with the local needs and community networks as well, so they were in a much better position compared to people from outside, to find work with local services. Should retrenchments occur in a particular service, the redundant workers were preferred by another service in the area which has some jobs available. Some workers are valued highly because of their local experience and are targeted by various services to undertake challenging community work.

> *The main reason I am involved with that project is that [a senior staff at the local CHS] had past links with this centre and she contacted me when I first started work and has called me up for various things and that is why I am involved there.* YZ (Co-ordinator, Family Health Centre)

> *I have been employed here just over a year. Because I was part of the Health and Social Welfare Council [earlier] I heard a lot of things [changes to CHS] are going on. I have more insight as I was part of the Health and Social Welfare Council.* CT (Community Liaison Officer, DGP)

It appeared that having staff who had worked at more than one service in the area, formal and informal linkages became easier to establish. These workers acted as channels for information dissemination and helped services understand each other's strengths, bureaucratic constraints, and work agendas.

I mean I do not know how we first came to know [about amalgamation] but certainly we have got good networks. The person who manages that used to work for [the local] council here anyway. TW (Community Co-ordinator, a local council in the research area)

We knew that we had a very strong support within the region. One of the other directors used to be the director here. LM (Director, WHS)

One example of this is of a community activist who happened to work with the local CHS and later moved to another service working for indigenous people. This worker then worked with the local council. During this time he served many community groups.

The following quote typically reflects the local situation, where people tend to work with various agencies concurrently and had happened to be employed by more than one agency at different times.

Well I am sort of two different things. My main interest is what we call Parks Resident Environment Group (PREG) and we work with [the local] council all the time and we have sent submissions to them particularly with ... [and I have my links with WHS] because we both [a staff at the WHS and the interviewee] started with the same organisation, the Health and Social Welfare Council. DS (Community member, board of director, a local CHS)

This mobility was more visible to me as an outsider. The staff and the community did not highlight, by themselves, this important feature of the service delivery. Key informants mentioned this phenomenon only when they were asked to reflect upon how they happened to know the other services. The phenomenon of many people having experience of working with more than one service acts as a local resource and has potentials to contribute to the local health system and community development. At

the research sites in South Australia, as well as in Sydney, however, this important aspect of service delivery which could contribute to system development, received little attention from both the local managers and the central hierarchy. Development of such a strategy would require an evaluation of existing 'resources' and an identification by the collaborating services of the potential role this resource could play towards collaboration and community development.

9.4.4 Inflow of Motivated Personnel

Working class suburbs such as South Western Sydney and Western Adelaide have ongoing problems with inadequate numbers of locally resident professional staff and specialists, combined with inadequate funding and unmet health care needs. Although large-scale organisational changes of health services have been introduced to every region throughout Australia since 1974, areas such as Western Adelaide or South Western Sydney have been especially subject to organisational rearrangements and funding changes. This is often in response to a continuous activity by various local interest groups in lobbying with bureaucrats and politicians on behalf of the community. This dynamic situation attracts motivated people –often from outside – to work for improvement in community services. Specialists having work experience with charity organisations, people who have worked in developing countries, and activists, as well as professionals with a concern for the rights of underprivileged populations not only find a cause to work for in such localities, they also find some space where they can foster working on the basis of their beliefs and ideas about public

health[17]. These individuals are politically influential due to their professional standing and also because they work closely with the community and influence the local decision making and the local health system development (HSD).

Some of these people came from academic institutions. University academics – being relatively autonomous in how they approach issues at the local level independent of government bureau – seemed to be in a better situation to contribute to the local HSD. They were able to take risks in making health development an openly political process[18]. I discuss this issue in a little more detailed fashion in the chapter about health services in South Western Sydney. However, it is worth pointing out here that the availability of such professionals could be of much help if their potential is recognised by both the planners and local service providers, and if these energetic people do not concentrate mainly on the economic structural issue of 'lack of funding'.

[17] In Adelaide I became aware of this phenomenon; people did not point to a single person or two. I developed a general perception that the role of a few people was more pronounced – this is what alerted me to this phenomenon. In Sydney however, I was consciously looking for the signs and key informants pointed to the roles of such people. A clustering of some motivated people who joined the area to improve the situation was noticeable. For this reason, the quotes pointing to this issues are mainly in the discussion about the South Western Sydney.

[18] Supporting community groups and activists in their lobbying for increased funding, promoting community views on how to address a local socio-economic or health issue, and making efforts to incorporate community perspective into how local professionals want to organise services are some areas where these academics played an activist's role.

9.5 PARTICIPATION[19]

So far I have discussed some important organisational and staff related factors which account for policy development at the local level. The factors which I have highlighted above seldom appear in published frameworks of policy analysis[20]. This neglect of organisational and worker-related influences seems to be for two reasons: firstly, the focus of policy analysis is mainly at the national level; and secondly, because of the policy-administration dichotomy, policy implementation research tends to be considered as separate from policy development research.

Most policy research, however, does consider influences such as social values, culture, geography, urbanisation, and political ideology on policy development. Many of these influences are discussed on the following pages – but with an important difference of emphasis. The difference is that I am looking at how these influences work at the local level, and how they affect the implementation phase of policy development, rather than looking at how, for example, the political culture of a country determines whether that country will have an insurance-based system or a laissez faire system. There is research however, which points to the role of local structures. Decentralisation for example, has been quoted as a management process which brings about more

[19] The word 'participation' is used in this thesis to highlight the involvement of the community, individual volunteers/activists, and community interest groups or service groups. On the other hand, the word 'interaction' is used to denote the interaction among services at the organisation or at the individual workers' level.

[20] For example, see the scheme for analysing public policy by Howard M. Leichter (1979 p. 41-42). This framework looks at (a) situational factors such as the economic cycle, natural disasters, and change of government (b) structural factors which include political, economic and socio-demographic structure (c) cultural factors such as political ideology and traditional social values and (d) environmental factors such as international political environment or agreements.
Leichter HM. A comparative approach to policy analysis: health care policies in four nations. Cambridge, London: Cambridge University Press, 1979.

community participation. However, Collins noted that even decentralisation has no universal correlation with community participation and he suggests that the social, economic and political structures in the community determine to what extent decentralisation will increase participation[21].

Community participation is an important principle of health care service provision, particularly in primary health care. It is important for services, which come in close contact, through their outreach programs, with the individual client as well as the community at large. This aspect of public health has been emphasised greatly by academics and researchers, as well as by the World Health Organisation (WHO) over the last two decades. This principle of participation is central to the philosophy of CHS which assert an interest in working closely with the community in order to raise its health status and to increase service accessibility.

Community participation however, is difficult to achieve. Probably because the nature and level of community participation in health care is ambiguously defined, the respondents in this research – both community members and health workers – did not concur on what optimum participation is and what purpose it should serve. The following quote by a staff member is about the process of community participation rather than the level and nature of the participation, but it does reflect a general feeling at the local level that the efforts for community participation needed to be enhanced

[21] Collin C, Green A. Decentralisation and primary health care: Some negative implications in developing countries. International Journal of Health Services 1994; 24: 459-475.

and streamlined to some extent. The interviewee pointed to the need for a clear vision about how to achieve an optimum level of participation.

> *...Some sites actually had it [participation]. They had open meetings with their community but it was standardised across the amalgamation area. I have always thought that we need a standardised format for involving the community.* Staff member (a CHS in the area)

Interviewees pointed to a need to increase the level of community control over CHS despite their conjecture that the services and workers in the Western suburbs of the Adelaide metropolitan area believe more in community participation than is the situation in other areas. Community health services did make an effort to involve the community directly in policy implementation.[22]

> *Well, as I said [regarding activists/community groups] that each organisation considered that community members have access to information and have their say in the process. Some of the CHSs called public meetings, some of them held a regular afternoon tea.* JH (Ex-Director of a CHS and Ex-CEO of the Amalgamated CHS)

Depending on factors ranging from the duration in which a service has been working in the area to the commitment by managers and workers to participation, the community involvement varied from service to service. The nature of the work, exposure to the community groups, collaborative projects with other organisations, and the culture of the community were various factors which were noted to be influential

[22] To recap – the influence of participation on policy is two fold: participation influences day-to-day working which in itself determines how a policy will be entertained by the local services. On the other hand, in the wake of a change, the usual practice seems to be that the services will invite the community to contribute to the process of implementation. This is a more direct way of influencing policy development at the time when the change is proposed. While discussing the role of services as a whole and the role of individual workers, I pointed to some of the reasons why services focussed on involving the community directly in policy implementation.

as far as participation is concerned[23]. Participation, in turn, influences health system development and policy in the local context.

In the light of the observations made by interviewees, it could be said that the level of participation lies on a continuum. On one extreme there are rural and semi-urban areas, where the Aboriginal community was in a position to hire and fire even the medical staff of their services. No urban areas reached that level of community participation, however. In urban areas even the community members on the board of directors often felt that they were often consulted only after the decision was made. The staff, however, claimed that they do their best to get the community involved in decision making. At the same time, when commenting on the policies of the hierarchy, the staff identified themselves with the community claiming that community participation is not valued highly by the hierarchy.

> *I think community participation is no longer a valuable commodity. When we start looking at economic rationalist thinking, which I perceive amalgamation is all about, community participation and community needs are so far down on the agenda that they fall out.* FD (Staff, CHS)

One of the reasons for the lack of community involvement is the lack of commitment by the government bureax to involve communities in the decision making beyond passive consultations - a process often used as a tool to get a plan "approved" by the community. There is a view which seems to be ingrained among professionals, managers and policy makers, that public participation means acceptance and

[23] For detailed account of these factors see, for example, sections 6.4.1 (interaction with the community), 9.4.1 (ideology of the staff), and 9.4.3 (mobile workforce).

compliance with government health plans – a process which often goes under the label of "Community Consultation". The following quote represents this ideology:

> *"It is about the way we work. It is keeping the community informed about what we are doing why we are doing it, and did they want to actually ask anything more."* LK (director, a CHS in the Northern Adelaide area)

With a social bias inherent in the State's organisation – the bureaucrats belong to different social class – a half-hearted effort to achieve community participation is what can be expected from the hierarchy[24]. Participation has proved difficult to achieve as there are constraints on services as well as barriers that relate to the community configuration and community dynamics. Participation depends, it has been argued, on factors such as rural or urban locality, and community cohesiveness in terms of social class and ethnicity. Service-related factors include: the level of professionalisation, ideology of the staff with regard to community participation in the planning process, and staff being member of or identifying with the same community.

While the minimum level of community participation could be construed as a mere utilisation of services by the community, an optimum participation would be one where the community is involved in decision making at all levels. This section is concerned with this 'optimum' community participation (i.e. in decision making) rather than with mere utilisation. At the local level, they felt that there was a lack of community interest in getting involved with the working of the health services.

> *We don't get heaps of people and sometimes I feel maybe we are getting institutionalised. We get a few people from the community, somebody from the local council, somebody from Neighbourhood Watch.* YZ (Co-ordinator, Family Health Centre)

---

[24] Dunleavy P, O'Leary B. Theories of the state: the politics of liberal democracy. London: Macmillan, 1987.

It is important to note that staff members were aware of different levels of participation in different CHS activities. While talking about day-to-day service provision, the staff and managers were of the view that they were able to invite the interest of community. On the other hand, they were concerned about the lack of community interest and involvement with the efforts of CHS in securing adequate funding and in resisting unwanted administrative changes. The same feelings were shared by health care personnel from services other than CHS and the state level organisations representing local services.

> *But it seems everyone has gone out to lunch, I think which is a great Australian pastime. It is just so different in the 1990s to what it was in the 1960's when everybody was prepared to enter into debate. You just wonder what further changes will be brought to the system before people say we have had enough of what you are doing.* MN (Hospital and Health Services Association)

However, this complaint was mainly about how people did not rally in large numbers such as attending public meetings, or holding demonstrations, or going to the minister's office. My observations were that the community does play some role in policy development. Despite a lack of 'visible' community participation in the policy process, community groups and individuals appeared to come in contact with the services. Through an ongoing interaction, albeit limited, these groups and individuals contributed to policy. The following section on the configuration of the community and community dynamics further highlights the factors that determined the type of participation and how that participation, or lack of it, influences policy.

9.5.1 THE COMMUNITY

The Western Adelaide suburbs, particularly Port Adelaide, are working class suburbs with some middle class pockets (West Lakes, Fulham Gardens, and Lefevre Shore). However, the Adelaide Central Health Planning Region is a larger geographical entity which does include economically better off areas. Within this larger region, the Western suburbs present a more-or-less cohesive community picture[25]. While fewer low-income families (as low as 7.3% in some suburbs) were living in the Eastern suburbs (part of the Adelaide Central Region), the Port Adelaide and Enfield local government areas had up to 33% of families with an income less than $16,000 in 1991 whereas only 17% of families in the Adelaide Metropolitan Area as a whole were in this bracket. The distribution of low-income families is highly correlated with most measures of low SES[26]. For a long time this area has contained a safe Labour seat for both the State and the Commonwealth Parliaments. People proudly identify themselves with the local football team; they don't feel the urge to go to the Adelaide city centre for shopping; they see Hindley street in the city (the 'fast' precinct) as causing damage to their teenagers; people seem to know each other, and on a bus ride from Port Adelaide to Taperoo everybody seemed to be familiar with everyone - a stranger is

[25] In general, the 'community' in the capitalist industrialised countries particularly in cities is considered as less cohesive because of the prevalence of the class system, high residential mobility and because many people do not live where they work and commute daily (Bryson L 1981). In traditional communities people used to live and work in the same geographical area throughout their life. Bryson L, Mowbray M. Community, the spray-on solution. Australian Journal of Social Issues 1981; 16: 255-267.

[26] South Australian Health Commission. A social health atlas of South Australia. 2nd ed. Adelaide: South Australian Health Commission, 1996.

easily picked[27]. This cultural history of the Western area is exemplified by the following quotes:

> *This is in fact a unique community which affiliates with the labour ideology. There are quite a few people who settled here and then stayed here. There are some people you may find who have not gone to the city for decades. I know many younger ones (in their teens as well who have not gone to the city, as they cannot see the point of doing so. There is a large working class which has a Port identity. It is very much generational too.* Staff (a community health worker, at local CHS)

> *There is a country town mentality, I think.* Staff (a community health worker)

This feeling of belonging to a cohesive community has infiltrated into the working of the local community and women health services. Community Health Services (CHS) tended to be more collectivist in terms of their ideology and working; the influence of the cohesive community culture seemed to make services in this area more participatory in their approach. Services tended to identify themselves with the community and often took a proactive role in joining the community in their political struggles to alleviate inequities in health and social services. Under these circumstances, the sphere of CHS activities in close association with the community increases beyond the original service agenda.

Earlier I pointed briefly the availability of motivated staff. The cultural characteristics as well as the availability of staff with a pro-participation ideology seemed to achieve a better community participation in these suburbs. It has been pointed out that in the

[27] Over the years I have lived in various suburbs of the Adelaide metropolitan area and have used public transport extensively. Generally, a bus ride in the Western areas was more enjoyable in that I often developed a feeling as if the bus was carrying a bunch of friends to a picnic as compared to a bus ride in the Eastern suburbs where everybody is busy with her/his book or office files. By a 'stranger', I mean even an Adelaidean of Anglo-Saxon descent. I do not make this generalisation on the basis that people looked at me with some amazement; I am from the Sub-continent and one rarely see a Pakistani or Indian in the Western suburbs.

past, with the availability of some pro-community CHS managers, the CHS in the Western suburbs had felt the need to participate and initiate political activity to improve health and the environment[28]. From this area, one finds many examples of the involvement of the local staff with the community at the political level which were way beyond the traditional health services agenda. For example, the local CHS staff joined the community in making health an agenda during the local council's election[29]. One sees this phenomenon not only because of the health promotion agenda of CHS, but also because of the way CHS operate in the community: it comes in close contact with the community and relationships prevail over tasks. The local community health services facilitated the local community and community groups to make health a political agenda for the local council elections through a Vote for Health campaign. I argue that, despite the managers' orientation, it would be difficult to achieve such an action in non-cohesive communities like the wealthier suburbs of Adelaide or Sydney. Of course those communities employ other political means to keep the level of services they have!

Self-identification as a community, and a culture of being politically active in local decision-making helped in linking community health and social services to the local population and politically active groups.

> *I think it is a strong community and we are lucky we can work with a lot of motivated people.* Staff (CHS)

---

[28] Alexander K. Public health professionals; they can not do it alone. In Brown VA, Preston G (editors) Choice and Change: ethics, politics and economics of public health. Selected papers from the Public Health Association of Australia 24th Annual Conference. Public Health Association of Australia, 1992.

[29] Alexander K. Promoting health at the local level: a management and planning model for PHC services. PhD Thesis. University of Adelaide, 1994.

> *The reason I said I cannot speak about other regions is that I think it is very important to keep on saying we are different and so responses which would come out would be different. For example The Parks has been going around for 20 years and was the first CHS to be established and got a firm history and background different from some of the health services for example in the North. Some of these are quite new and do not have that history or the same level of involvement with the community.* GH (Director, a CHS)

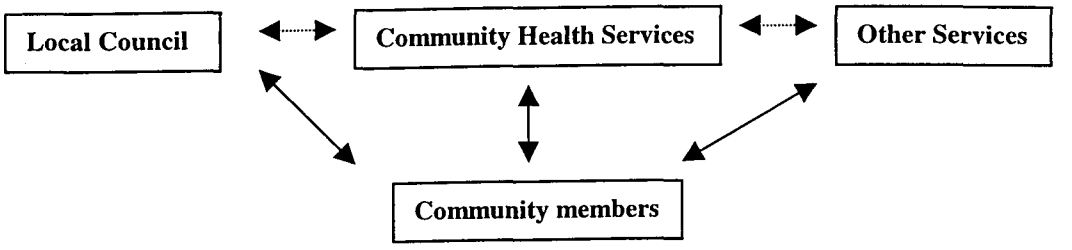
There is a sense of belonging and an emotional attachment to the local services. Community activists and groups are joined by services and even by the local councils to take overt political action. Resistance, by services, local councils, and the general public, to the proposed new airport in Sydney and to the proposed increase in the size of the rubbish tip in the Western Suburbs of the Adelaide metropolitan area are examples of this kind of working together. This community resistance was very much supported by the mayor and many members of the local council. These joint activities further linked the community with the local services and caused a change in work ideology from individualist to collectivist.

> *...we want to get rid of all that toxic stuff that is worrying people as there is so much asthma. People are committed to this cause. ... We work with people and if they [the Health Commission] move us somewhere else, then a lot of people will not be able to [continue working together].* DS (Community member on the board of a local CHS. She works for the environment group protesting against the increase in rubbish tip. Also works for the local neighbourhood house.)

As active community members often participated in the activities of several agencies at the same time, a spill-over effect of this person-agency interaction was a more intense agency-agency interaction. Using the same example of resistance against the increase in the size of the rubbish tip, a community member on the board of directors of a local CHS was also an active member of a group lobbying locally for a better local environment. In turn, that environmental group had close interaction with the local council. This situation helped in developing a link between the local council, the

environment lobby group, and the CHS. Figure 9.1 graphically represents this phenomenon where interactions between two agencies helped in linking other agencies as well.

Figure 9.1: Horizontal Linkages and the role of community



These horizontal linkages appeared to influence proposed changes more than what happens to a similar proposal in other areas. The more intense and numerous these interactions were, the greater the community influence on decision making was. The local services had to accommodate what the community wished to be done because the community supported the services by creating a continuous background protest against the change. Therefore, change takes longer in these communities because at a minimum the community must be taken into confidence if services want the existing linkages to survive. Delayed implementation of the amalgamation in the Adelaide central region could be attributed, to some extent, to an increased community activity. Staff and managers in these communities were quite conscious of the community dynamics. They considered this interaction to be a different approach to policies compared to regions where these links were not so well established.

> " ... *we are different and so responses, which would come out, would be different ... this centre is going around for 20 years ... it has got a firm history ... have a long standing relationship with the community ... Whereas health services in other regions do not have that history or the same level of involvement with the community* ...." GH (Director, a CHS)

The amalgamation in the Western region proved to be more political, with staff encouraging participation and the community actively involved in lobbying politicians and central management, particularly to keep the women's health services separate from the rest of the community health services. In the Northern region, I did not fully explore the situation. My observations are limited to a few interviews and to readings of the process documentation. However, this limited reading suggested that in the Northern region, the community-agency interaction was less intense, which in turn resulted in an amalgamation process that was rather of a technical nature. During the implementation stage, all three regions came in contact with each other on a more regular basis – the South Australian Health Commission (SAHC) wanted the other two regions to follow the lead of how the change was being implemented in the Northern region. There were regular meeting between executives and managers from the three regions, and staff members were being informed about the process in other regions. Staff in the Western region believed that the work-face managers in the Northern region were merely acting as an extension of the SAHC, promoting the change with little involvement of the community. In contrast to the situation in the Western areas, they believed (rightly or wrongly) that the change was forced on to services in the Northern region.

> *"Basically they [managers in the North] decided to do it like that over there "*

> *"It was virtually imposed on them "* Staff member (from the Western CHS)

> *"I think the SAHC put some people in-charge over there [Northern region] and they achieved it [the way the SAHC wanted it] "* Staff member (from the Western CHS)

In the central region, there was disagreement between locals and the hierarchy on the format of the new board of directors as well.

> *... we originally had community members on boards and a couple of ministerial appointments. But they told us that the new board would have a couple of community members and most of the board members would be appointed by the minister. And again that to me is obviously about control by them, ... and reducing the opportunity for community members.* Manager (at the group discussion with the Inner-southern CHS managers, part of the Adelaide Central Planning Region)

Richer links and greater reaction, in areas such as Western Adelaide, determined the level of influence these areas are able to have on policy. The fact that The Parks CHS became the Centre of the amalgamated regional CHS in itself points to the power which that particular service had achieved by having rich horizontal linkages. This phenomenon could be attributed to many reasons, including that The Parks centre is the largest in terms of staff and services. The Parks has attained importance in the light of its community involvement strategies and its involvement even in local politics. Staff and managers from this CHS have sought to gain strength by writing and publishing on local community development issues. The women's health service (WHS) got their power from being in a position to exploit the need for gender-specific services to be made available in a culturally appropriate fashion. This gave them the bargaining capacity. While The Parks CHC became the centre for the new structure, the WHS was able to maintain its position and separate status to a large extent. The staff and management belonging to the general CHS accepted the need to have a somewhat autonomous WHS within the new structure.

> *Well, how do you know what has been helpful? We are still here. The original suggestions to disperse WHS did not get carried out. Who knows why? It may be because the minister thought that this is too sensible to touch. It is hard to know. But the way women see it, if you do not participate and leave it, then we will lose it.* LM (Director, WHS Western suburbs)

For example, I myself was very upset and very much worried because I considered a freestanding Women's CHS very important. So I was at public meetings. I was keeping myself updated. Suppose I talked to a friend on the phone, I would suggest – please write because we need every person to act. I think that this centre is still there as a freestanding Women's Health Service is significant, as I really believe that its existence was threatened at one stage. FD (Worker, WHS)

Back in 1982, Hicks pointed to the extensive role of bureaucrats in Australian CHS policy and administration and their deliberate attempts to keep community out of the decision making about the way CHS operate, lamenting their lack of liberal and pluralist ethos[30]. It seems that CHS of 1990s have become pluralist in terms of diversities of activities. However, there is still a lot to be done to achieve a liberal approach so that the community has control over the structure and administration of CHS.

9.5.1.1 Multicultural communities

In common with much of urban Australia, the study areas have a multi-ethnic composition. Whether there is a high or low level of community activism is also partially dependent on the configuration of the community. Participation in the working of governmental agencies is a concept which is given much emphasis in the Anglo-Saxon culture. This is because of the emphasis on the principle of public participation in the modern democratic state. People from Asia or Africa are often reluctant to interact, beyond receiving services, with governmental institutions. This reluctance is probably ingrained in their psyche because of centuries-long exploitation

[30] Hicks N. The "community" in community health. In Potter J, Hodgson A. (editors) Working Papers in Community Health. Adelaide: ANZsearch/APHA, 1982.

of the masses by the hierarchy, monarchy, and autocratic governmental institutions. This exploitation, and often a forceful exclusion of the masses from decision making, has given rise to aphorisms such as "Don't approach an officer from the front or a horse from behind - you'll be hit hard". The level of economic development of a particular group within multicultural communities is another factor which might lead to less or more participation.

In the research areas, the differing level of participation across the range of ethnic groups was mentioned by the interviewees:

> *There are pockets. There are people who are really involved.* Staff member , (CHS)

> *We have very few community health groups based within the Division's area [Eastern part of Central region], very few. Historically the demography of this region has been seen as being affluent middle class, with small pockets of less well off. In addition to pockets of less well off we also have small pockets of ethnic groups: a large pocket of Italians in the north, we have small groups such as Iranians down in the east where we are sitting now.* NP (Division of General Practice)

Often the groups which were least involved in the decision making were those which required more services. Health services at the community level then had to target these sub-groups specifically.

> *I don't write English believe me for all my years in Australia. See they [officials up in the health care hierarchy] don't understand this thing. You need help and that is what they have to give to us...[in the past when I needed health care] I didn't know where to go, what office to knock on. It is strange, very wrong. Are we supposed to be ever happy? People understand the story. There are elderly people who do not speak English. They represent various different needs. Even they do not know why they are sick, they do not know why. Somebody is needed to explain it to them that look if you do this and look after yourself depending what the people got, it will be better.* DC (Community member, working with one community health centre as volunteer)

It was likely that restructuring would affect the services for these non-participating groups more than the services for those who are politically more active. Guarding the interests of these groups was mainly in the hands of the local workforce. The local workforce then acted as caretaker, and pointed out to the hierarchy that it is the local staff and not the hierarchy which understands such local needs, and that the new CHS should allow continuation of services for such hidden needs.

Another reason for the less than optimum participation could be attributed to the fact that ethnic groups such as Asians, and some European communities as well, still live in an extended family system. They often look up to the other members of the same ethnic group for economic and social support[31]. Hence, the community as a geographical phenomenon is often not appreciated by these groups. People from these ethnic groups, even if are not clustered in a geographical area, generally have better links with people from their own ethnic group as compared to the links with their neighbours. So a collective action for the ethnic group is valued more than a collective action for a geographical area. Since areas such as Fairfield and Campbelltown in Sydney are more multicultural, this issue is further discussed in the next chapter, which deals with health system development in South Western Sydney.

[31] Edna Bonacich, in her effort to develop a theory of middleman minorities, points to the sojourning nature of some immigrant communities, because of a longing for return to their homeland after completing the task. This makes these groups "strangers" in their adopted country with little integration into the surrounding communities. My experience, as I moved in the Pakistani and Indian community groups in Adelaide for about six years, also helped me understand this phenomenon. Bonacich E. A theory of middleman minorities. American Sociological Review. 1973; 38:583-594.

9.5.1.2 A few individuals representing the community

The fact that only a few community members were available to participate on an ongoing basis was another influence on the capability of the community to make the services fit the local needs and culture. It was noted that a community comprising many adjacent suburbs has no more than a handful of people who regularly took part in decisions about how the services were being run in the area. Other community people got involved episodically, for rallies and public meetings, particularly when they were approached by active community members and health centre staff wanting the community at large to be involved in the policy process.

> *I think you have to make specific effort to get people representing various groups in the community. They are in committees, but we also talk to them through our workers. But these groups are not as represented [on committee or board] but we did talk to them through our workers.* GH (director, a CHS in Western suburbs)

> *We don't get heaps of people and sometimes I feel maybe we are getting institutionalised in itself. We get a few people from the community, somebody from the local council, somebody from Neighbourhood Watch.* YZ (Family Health Centre)

The community has been considered as a setting where health services can address local needs and hence become more appropriate and culturally acceptable. Community-based care may be contrasted with care provided by institutions such as hospitals, which have been considered at times to be places where the rights of some population groups such as Aboriginals and women can be marginalised. It was thought that communities would be able, by participating in the affairs of health services in their respective localities, to assert some political and management control on the type, availability and patterns of service delivery. This appears not to have been achieved. One of the factors affecting community participation negatively is the resistance by

managers and professionals to sharing their decision making power[32]. Health and social service providers are warned about the problem that participation is often limited to a small vocal group from the community which may or may not represent the whole community and its needs[33]. In this situation the decision making power stays with the professional workers; it is easier to persuade a few community members who, over time, become closer to the services than to the community.

Often the active community members were those who had been involved with some sort of community work or had been politically active with unions in their work place. Often they started taking part in health development activities because of some personal loss or tragedy for which they themselves or one of their family members had received services, but found these services inadequate or ineffective. Usually these active community members are found to be working with and lobbying for a particular aspect of health care, such as rehabilitation, mental health, obstetrics or diabetes.

> *I do not know what motivates them. You could say that someone who had a bad experience or good experience with the health services and therefore they were so moved. I think there are a lot of people who had such an experience with a hospital or a particular service and they come out of the woodwork and stand up and fight. I think a lot of them perhaps have some sorts of connection with the nurses union, the labour party...* DS (Worker, WHS)

Some of these community members started interacting with the local services as they were motivated by a friend or family members to get involved in a particular project.

---

[32] Rathwell T. Realities of Health For All by the year 2000. Soc.Sci.Med.1992; 35:541-547.

[33] Hunt S. Building alliances: professional and political issues on community participation -- Examples from a health and development project. Health Promotion International 1990; 5: 179-185.
Bracht N, Tsouros A. Principles and strategies of effective community participation. Health Promotion International 1990; 5: 199-208.
Bryson L, Mowbray M. Community, the spray-on solution. Australian Journal of Social Issues 1981; 16: 255-267.

Generally these active community people have been living in these localities for many years, and often they happened to live there all their life. Living in the area for a long time helped in getting a better understanding about the local needs as well as in understanding the working of many local services. It was noted that, once these activists are known to an agency, there is tendency that they be contacted by other health and social services.

In addition to being known to the local services, these activists knew each other very well. They tended to be members of many community groups at a time, as well as participating with various health and social services. Within this scenario the consent of these few people is often considered as acceptance of a change by the community at large.

Because of the frequent interaction with the services and the professionals at those services, these active individuals tended to acquire some quasi-professional characteristics. These community members were well versed in medical and health care jargon – such professional language is a factor which otherwise alienates the community from decision-making. I also noted that as more and more of the time of these community members was consumed by the bureaucratic procedures, they become less and less in touch with the community at large.

The community members on the boards of directors of these services belong to this activist category of community people. There is not usually a big response from the community to advertisements in local newspapers asking for nomination of community members to serve on the board of directors.

Because these community members were those who trusted the local staff and managers as guardians of community interests, they seldom sided with the higher level bureaucracy if work-face management and staff opposed a change. The community and its representatives put a lot of weight in favour of what the local staff thought about a policy. Thus, it was difficult for the hierarchy to 'divide and decide'[34]. The hierarchy had to have local managers on its side if a policy was to be implemented speedily or be implemented in its original format. The amalgamation in the Northern region of the Adelaide metropolitan area provided an insight. Managers there accepted the amalgamation whole-heartedly; these managers were then able to sell the idea to the community with little resistance. No matter what was the ideology of the local CHS staff, they were generally considered trustworthy by the community representatives for decisions about what health services are good for the community.

9.5.2 Specific Issues in a Locality and Community Participation

In the Western suburbs of the Adelaide metropolitan area issues such as fear of crime, unemployment, unavailability of employment and recreational opportunities for youth and the resultant anti-social behaviour, and high rates of domestic violence were a cause of concern for the local people. The social and health care services seemed to commit some resources to activities addressing these problems.

> *So, as you can understand, working in an area such as Taperoo some of the situations with which you get involved are not always to do with health. It could be to do with domestic violence, just the financial crisis that they go through. There is lot of third generation unemployed down here and just the*

[34] If the community and the staff were not in agreement over how local services should be organised, it became easier for the hierarchy to act as the font of all wisdom and give an impression that they knew what would suit the local situation.

emotion that happened having mum and dad [who are unemployed]. RQ (Family Health Centre, CAFHS)

There are a lot of young mothers around the area. Some of them are really struggling. Others are doing quite well. But lots of them have moved into this area because there is a lot of Housing Trust accommodation. They may not know anybody there. There were also a lot of women who lived there, who got pregnant very young. ST (Team manager, a community health centre)

As these problems were quite visible and were considered as priority issues by the local people, community activity in lobbying for services or participation in the planning and delivery of the local services was geared in these directions. These issues are often raised by the local press as well, and this gives an impetus to work on these issues at the local level.

And also you have to, you know it's a big issue in the area, you cannot ignore it. Even if you did not have any altruistic motives. You cannot ignore it. Like in Semaphore and Port Adelaide there is a lot of boarding housing. So if you see any sort of news angle you have to write about it. FR (Reporter, suburban newspaper)

This phenomenon appeared to affect the local health and social care scene from several angles. These social problems were perceived as beyond the power and mandate of the local services, local government, or for that matter even the health department. Other than some small-scale activities, such as working around the local train station to make it a safer place, the main activity of the community groups and services revolved around lobbying the government for broader reforms in funding and job opportunities for the area. This usually involved organising public rallies and taking the matter to the local and/or state politicians and government bureaux such as the Housing Trust and the Health Commission. On the one hand, this situation has a negative effect on community member participation in the planning and provision of local health care

services. However, as the community services were considered insufficient relative to the prevalence of health and socio-economic problems, it proved easier to propagate a message that the proposed amalgamation was a form of rationalisation with a potential to further increase the imbalance between the local needs and services. People as a result became willing to participate in the discussions and lobbying.

One issue, which I would like to briefly discuss here, is of the 'lack of funding'. Community and services providers considered the available funding as insufficient relative to the high level of health care need. There was a feeling that, if the area were to receive more funds, the services would become effective in dealing with the health and social problems. The local health care workers, particularly the management and professionals, took an active part in creating that feeling, as they often initiated the debate at various public forums about the inadequate funding. This debate diverted the energies and the focus of the staff away from how to increase participation in decision making about day-to-day management and the planning of available services. Within this context, changes were seen as linked to the funding cuts and further increasing the imbalance.

> *You know every year you are getting cuts in funding, [yet] there are more issues you have to deal with. It just seems that Adelaide's burning and they [Health System Hierarchy and the government] are worried about a little bush fire somewhere else.* RS (Aboriginal Community Services, Western suburbs)

The community members working closely with the health services were also very concerned about the lack of funding.

> *But all these things can be provided if money is available - actually the big thing is money. And with the cut backs some services, one does not know which*

but one presumes, some services will have to be cut. QP (Community member on the board of directors)

Community group efforts to improve the situation in the area often revolved around lobbying for more funds. Funding was the main problem discussed at the management meetings attended by the staff and community members. Annual reports, minutes of meetings and other documents produced by the local services promoted the idea of lack of funding as a major risk to health service effectiveness.

> "The centre has always operated on a "shoe string" budget. In 1993-94 we received about 0.03% of the State health budget. In 1994-95 Dale St. received a significant budget cut."[35]

> "The context within which our amalgamation negotiations took place was a difficult one, for each of the CHSs involved took a sizeable cut in the 94/95 budget" [36]

> *That sort of leaves me to believe that slowly the funds are falling away and would be going to be less. Domiciliary care in the area were saying that they were threatened by a $15,000 funding cut which would have seen them cut eligibility for the service. I cannot recall correctly how they are going to restrict, but they were going to do it. You hear such stories often.* DS (Community member on the board of director of one of the CHS)

Energies which the community could have devoted to determining how the local health services were organised, had to be diverted to an even more challenging objective of getting more funds for the area. However, the local staff and community used the issue of inadequate funding to build resistance against the amalgamation. They emphasised that there was already a shortage of services in the area and this change would cause further deterioration.

---

[35] Dale Street Women Health Centre. Annual Report 1994-95, Pg.1.
[36] The Parks CHS. Parks Health Observer (Parks CHS Annual Report) 1994/95.

Because generally government has a policy of reducing everything. You would know that all kinds of different public servants have been axed from the public service in the last four five years. So I think it is all connected. I think the Health Commission has to restructure in its own way to adjust to those cuts which are introduced. I think I see it as a combination of both - not just one idea [Funding cuts, restructuring, and control]. Manager (Managers from Inner-Southern community health centres)

9.6 OTHER LOCAL POLICY INFLUENCES

In the following few pages, I discuss the role of some other stakeholders, such as the general practitioners, politicians and local governments, and suburban newspapers, in terms of local health system development. General practitioners draw their importance from the fact that they provide primary level care to a majority of people and as such act as gate keepers to the other levels of health care. Local governments, in addition to providing some health care and social services, are increasingly getting involved in the health improvement and health system development processes. I use the title local media for the suburban newspapers. These suburban newspapers are used as a vehicle for information dissemination, and are employed by the local services and community activists for involving the community at large in the process of change.

9.6.1 EMERGING POLITICAL ROLE OF GENERAL PRACTICE

Traditionally general medical practitioners (GPs) had little interaction with the CHS. Over the last few years, through initiatives such as provision of remuneration for GPs for preventive and promotive work, and with the advent of Divisions of General

Practice (DGP), a somewhat closer relationship has developed between GPs and CHS[37]. DGPs have helped in expanding these links between CHS and GPs.

The involvement of DGPs within the research area, depended much on the interpersonal relationships between the staff of a CHS and the willingness of the DGP to approach the CHS and initiate various projects together. The level of interaction varied across the region. For example, the Eastern DGP enjoyed a better working relationship with the local CHS. Compared to this, the links between DGP in Western areas and the local CHS were few. However, that DGP employed a good strategy in hiring a person, as community liaison officer, who had experience of working with the CHS in the Western suburbs. This person was helpful in networking with the local CHS where she had earlier worked on various community development projects.

Although the involvement of GPs is less than optimum and as such plays little role towards CHS policy at the local level, the emergence of DGPs helped CHS gain a boost in their political strength; DGP are about introducing prevention and promotion

[37] General Practice and Community Health Liaison Project (1991-95) in South Australia is an example where one of the strategies was to remunerate the GP for her/his cooperative work with the CHS. However, it is worth pointing out that thirty-four out of a total of thirty-five projects funded by the scheme were initiated by the CHS.
South Australian Community Health Research Unit (SACHRU). General Practice and Community Health Liaison Project 1991-95. Bedford Park: SACHRU, 1996.

into general medical practice[38]. It appeared that the availability of DGPs in the environment of the CHS and the resultant interaction further strengthened the position of CHS within the health system. CHS had found another agency which could support them in resisting a change. The amalgamation, for example, involved relocating a community health centre, which had good working relationship with the local DGP, to another area which was outside the geographical boundaries of that DGP. The Division was unhappy about this situation and wanted the Health Commission hierarchy to discuss it with them. However, by that time no meetings were held between the SAHC hierarchy an the staff from that DGP. DGP did raise their concerns with the staff of the local CHS. This is an example of the disruption caused by the shifting boundaries within South Australian health system.

> *We perceive it as a negative move. We do not see anything good out of that development, because we have been working to improve our relationship with them and hopefully they have as well. But divisions are geographically based. So you could have the best working relationships in the world with some one but if they go and move to another side of the city then you cannot work with them ... They can base their worker with us, but as we are geographically based, after they move to some other place we could never place out workers over there. If they are outside the area it just would not relate. GPs would not go there; patients would not go there.* NP (Division of General Practice)

[38] For two reasons it could be said that up until this stage the DGPs have supported CHS with regards to the primary health care principles and community health work ethos. Firstly, for their agenda of introducing preventive and promotive aspects to the general practice, DGPs are relying on the involvement of CHS. Secondly, the funding arrangements for CHS and DGPs are separate as the States fund CHS while DGPs are funded by the Commonwealth government. However, there might be some concern that the rise of DGPs could erode the policy space of CHS. General practitioners are a powerful professional group. DGPs are receiving large number of grants in health care areas which were earlier considered as the domain of CHS. This increasing emphasis on the role of general medical practice in the area of primary health care (beyond curative care) is happening during a time when community health services are going through budget cuts.

9.6.2 INVOLVING POLITICIANS

Local politicians from the area who contested the state and national parliamentary seats entered into the policy process at various stages. The local politicians were approached and lobbied by the community members – a process which helped in achieving a better balance in the negotiations about the change. On a few occasions, community groups, on their own or in conjunction with the staff of the local services, approached the politicians, particularly when they perceived the change being aimed at service cuts or when change envisaged shifting a centre from one area to another. This was a mechanism through which the community in conjunction with the local services was successful in making a change openly political – against an effort by the bureaux to present such changes as "technical". By taking the argument into the open political realm, the community successfully moved the game to a playing field which suited them more – compared to the administrative and technical field where the community considered themselves vulnerable against the central hierarchy. The community, and even the local staff, can be "dealt with" more easily if changes are labelled as "technical" by the hierarchy, because the hierarchy often lays claim to better understand these technical aspects of service supply, thereby projecting the change as leading to better services in the area.

The community members wrote letters and had meetings with politicians from the area and with the health minister with regard to amalgamation and perceived service cuts in the newly emerging CHS structure. The community was concerned mainly that they have access to appropriate services placed near their homes. It was not their concern that geographical boundaries of the newly proposed structure required CHS to operate at the larger regional level. The former was given as the main reason for their

contacting the politicians. Because the Northern region appeared to give a feeling to their community that amalgamation was not about service cutting, but would increase accessibility, there was less contact between politicians and the local community members to stop the change from happening.

9.6.3 CHANGING ROLE OF THE LOCAL GOVERNMENT

The local governments, of the late 1990s, at least in the research areas, appeared to be somewhat different from the local governments of the 1970s which were described by Jones as bureaucratic and conservative in their approach[39]. Direct health care provision by local councils is limited to services such as immunisation, and provision of some health education material. However, there were other avenues which helped local councils participate in the local health systems. One way the local councils contribute is by providing space (buildings) for the community health services to operate in the area.

> *I mean they are landlords here. So we obviously have some links with them and again we have service links particularly in services for old people. But they did not, they did not have any say in the amalgamation process. At the same time when we were amalgamating they were amalgamating. They did not have any impact on us at structural level.* GH (Director, a CHS)

One of the local councils from the area actually lobbied with the Health Commission to place CHS in their area and provided space to that CHS in the building from where other local government community services operate. This proximity helped collaboration on several projects. Additionally, local councils provided space for some periodic activities such as immunisation sessions and health promotion campaigns.

[39] Jones MA. Local government and the people: challenges for the eighties. Melbourne: Hargreen Publishing Company, 1981.

Similarly, one local government in the research area provided space for regular meetings between various health and social services in the area. This helped with information sharing between local services. CHS and the local councils were working on various community development projects together. One example I mentioned earlier was the crime prevention project. One CHS regularly invited local councillors to the board of directors' meetings.

9.6.4 SUBURBAN NEWSPAPER AS A COMMUNICATION TOOL

The local press appeared to work as a communication vehicle where services and the activists wanted to inform the general community about the impending changes or wanted them to be sensitised for some action to influence the change. It has been reported that during a pilot Healthy City project (1987–1990) in Southern suburbs of the Adelaide metropolitan area, the suburban newspapers of that area devoted more coverage to the issues of environment, community and health compared to the coverage of these issues by the suburban newspapers in the Northern suburbs during the same period[40]. This information alerts us to ask a few questions such as – is such increase in coverage because of the effectiveness of a health promotion program? Does an increase in coverage happen only when a change is taking place? And how this coverage is used by the local services to further their cause in accepting, changing or rejecting a policy formulated by the centre?

[40] Baum F, Cooke R. Healthy Cities Australia: the evaluation of the pilot project in Noarlunga, South Australia. Health Promotion International; 1992; 7:181-193.

Articles in the local press range from "press releases" to reports based on investigations by the news reporters. Press releases usually cover issues about changes in the services provision, while 'investigative journalism' is usually about the quality of health services as perceived by the community. Funding cuts or addition of some services to the area are issues of importance which are given a lot of space in the local press. Additionally, there are advertisements of a variety of nature such as an invitation to the community to nominate members for the board. Information on certain community development and health promotion programs and health education sessions is also sent to the newspaper. Articles in larger metropolitan wide papers, on the other hand, are mainly concerned with health budgets and service cuts.

Reporters assigned to cover the health and social services coverage in the local papers are often known to the community activists and the health care staff. These reporters are often alerted to a potential story from a phone call from an activist. In some cases they are even contacted by the staff of services.

> *Most often they [health services] make a contact. Most of my health stories have come from either like Nurses Federation in relation to the Queen Elizabeth Hospital and the proposal to re-develop the hospital, and like [the Central Region] Planning Unit contacting me. Sometimes different organisations place advertisement in the paper about different things what they are doing and that you know we night notice that and contact them and get a story.* CB (Suburban Newspaper)

Like other community activists the media gives more space to issues such as the lack of funding and privatisation. Well-covered stories revolve around drugs and alcohol, epidemics, privatisation of the local hospital or its take-over by another larger metropolitan hospital, and the lack of facilities such as emergency beds. Issues such as

amalgamation were considered by the local papers only after the media was "briefed", by the staff or community activists, about how that change was going to cause some decrease in the service supply.

Stories in the local media about the amalgamation helped in further stirring the ongoing debate and making the issue more open to the public. It became obvious that interested parties tended to use the paper as a tool to lobby against changes which they did not like. Again, the local paper tended to side with the locals. The local paper's policy to stand with the community – as it was its market – was obvious. It enabled the paper to be used by the community and the local services for some community protest against the paucity of media releases from the hierarchy. Once an article was published in the paper it was used to put weight to one's argument. Usually the community activists and staff carry clippings from the local paper and use them for making their case. One may question the virtuosity of such use of the local newspaper. However, the scope of this thesis is to highlight the community dynamics and the way services operate in the local settings and my aim here is not to discuss the ethics of various processes which hierarchy or community employ for their own purposes.

Local print media provides an interesting example of horizontal linkages. Unlike most other local structures, these linkages are usually uni-directional, that is, from health and social services to the media. In addition to press releases from the agencies, news/stories were leaked to the local media by institutions or individuals for later use in a way fitted to their own purpose. Probably because the agencies knew that the link between media and services was one-way, no one suggested media personnel as key

informants for the purpose of my research. However, the link between services and the media was valued by health and social services as it was often used, deliberately, to exert influence for the purpose of policy translation and to suggest how things needed to be done at the local level. Print media becomes important as one of only a few mechanisms which were used on purpose and as a planned activity to influence policy.

9.7 POLICY ANALYSIS IN THE LOCAL CONTEXT: SUMMARY

For a policy program to be effective, it should be compatible with, and fit within, the local political system[41]. In discussing the working of health care services, I have tried to point out the characteristics of the local political system in relation to health system development. Table 9.1 provides a summary of the local factors which should be considered for policy analysis from the local perspective in order to make policy fit to the local needs. These policy-determining factors could be divided into "dispersive" or "cohesive" forces. Dispersive forces cause a perceived helplessness, resulting in a low community confidence. On one hand, perceived helplessness and a feeling of being politically weak engender a feeling of being unable to influence the hierarchy. On the other hand, a prevailing mismatch between the need for social services and the provision of such services causes local activists, local community groups and the service providers to launch efforts to increase their local area's share of the health dollar. This activity then feeds into other actions such as resisting privatisation or contracting out of services, raising voices against the shifting of services from one area to the other, and joining health services in their struggle to make changes like

[41] Berman P. The study of macro and micro-implementation. Public Policy. 1978; 26:172-79.

amalgamation fit the local needs and work patterns. In contrast to the dispersive forces, the cohesive forces act more directly by favouring community participation and thus helping local services play a greater role in policy development.

Table 9.1:Local factors influencing health development

	SOCIAL	COMMUNITY	POLITICAL	Health PERSONNEL	Health SERVICES
DISPERSIVE FORCES	Stigma (poor suburb) Efforts geared towards the "main" problem of inadequate funds	Multi-cultural orientation[42]	"Safe seat" and political apathy	Unavailability of staff from within the community Turnover and commitment of the staff; particularly those who do not identify with, or live in the community Pro-hierarchy local health care staff Perception of own role in policy development	Image of the public sector health and social services Actual or potential conflict between public, private and Non Governmental Organisations sector, and conflict between health, social and other sectors
COHESIVE FORCES	Peculiar problems such as drugs, unemployment, crime and violence in Liverpool	Well settled groups, their power in getting access to better services Individuals/groups (activists/ethnic groups etc) and their involvement in health system development	Community activism particularly by Anglo-Saxon Australia (for general uplift of services) and role of different ethnic groups in securing services targeting their ethnic group. Local governments' willingness to be involved in the health and social sector beyond their traditional roles. Use of local politicians to boost health and social sector resources for the area by tapping parallel funds Suburban newspapers siding with the locals	Pro-PHC, pro-participation ideologies in public and private sectors Leaders within health and social sector staff - people coming from outside and working for these communities	Nature and the extent of work with various ethnic communities University out-reach and involvement in the local health system development Perceived utility of a service by other agencies and by the community in general

[42] The multicultural nature of the community and how it influences health development is a complex phenomenon. It is dispersive only when the sub-groups within the community are politically and socially un-integrated and have not yet achieved social and economic stability. This adds a burden on health services since they have to prepare themselves to cater for the need of diverse groups who have quite separate needs in terms of services and how these services are organised. However, it should be noted that this phenomenon also helps the locals. Health services use the 'specific needs' to achieve more autonomy in terms of organisational structures. In addition, they can lobby to get more funds and services to cater to the needs of many diverse groups. The health services in a sense can play the 'multicultural card' to resist, or lobby for, a change.

Some communities in larger cities suffer from socio-economic disadvantage and other social and health problems more than other localities in the same city. These larger and overwhelming problems such as drug dependence, crime, as well as a persistent mismatch (perceived and real) between need and service provision seem to operate as both positive and negative phenomena with regard to the role of the locals in health system development. While such larger problems seem to be diverting the community's attention from day-to-day working of the services, this situation, used appropriately, serves as a catalyst to enhance community activism.

One of the major organisational characteristics which influence the power relations between the locals and the hierarchy for policy development purposes is the prevalence of a network of interactions between different services, and between services and clients and community groups. These linkages with the other services and with the community in general determine to a large extent how a policy will be implemented in the local context. Linkages in turn seem to be dependent on the nature of the services; CHS with their preventive and promotive orientation develop rich links with the community and the surrounding services. At the same time, the community cohesion, the community configuration (groups) and the resultant community activism also determine the linkages. The duration for which a service has been working in the area and the staff ideology of democratic institutions and a belief in community participation works in favour of stronger linkages. Richer horizontals links help community health services in improving the balance of power relations in their vertical link with the hierarchy.

Availability of health personnel who have experience of working with many local service is another organisational characteristic which helps CHS for linking up with other services and to claim to have a better knowledge of the needs of the community while negotiating the implementation of a change with the hierarchy.

With the help of examples from the day-to-day working of CHS, and by pointing out how different components of the health systems approached the proposed amalgamation, this chapter highlighted that the implementation of a change is a two-fold political process. One aspect of this political process involved negotiations amongst various targets of the proposed change (CHS, WHS, professional groups within these organisations, and community members working with CHS) in order to guard against the enhanced role of some groups in the amalgamated CHS at the expense of others. The other aspect of the political nature of the implementation was the negotiation between these local interest groups and the hierarchy in order to prevent the amalgamation undermining the philosophical basis of community health. For CHS staff, this philosophical basis of primary health care principles is important not only because it helps in achieving better health and improving accessibility to health services; but also because it determines their current roles and power within the health system. From their perspective, it was necessary that the change be implemented in such a way that it does not weaken the capacity of CHS to cater to the needs of the community and to the needs of the staff.

CHAPTER 10

Integration of the Area Health Services in South Western Sydney

10.1 INTRODUCTION

This chapter analyses efforts in the South Western Sydney (SWS) area to integrate health services provided by local general practitioners with public sector hospitals and community health services provided by the Area Health Services (AHS). This analysis suggests some hypotheses with regard to those local characteristics which aid effective planning and introduction of changes, and which promote better health care and health. For example, the multicultural nature of the population of SWS, particularly Fairfield and Campbelltown, means that these areas are served by general medical practitioners (GPs) from many different ethnic backgrounds, many of whom were not trained in Australia. The composition of the GP population in these areas imposes a different set of constraints on any organisational change compared with areas which have a less-mixed ethnicity. Some of these doctors did not enjoy a good interaction with the health authorities in their country of origin. In Australia, they had to go through a tough examination (which is often seen as aimed at their exclusion) before they could start practising. This background might cause these doctors to be reluctant to work closely with the government.

These GPs may be wary of changes initiated and promoted by government departments or changes supported by associations such as the Australian Medical Association (AMA). Links with institutions such as the academic General Practice Unit at Fairfield Hospital offered them a better political position to have practice rights in the health services and to influence the local health system. Such a background of locally specific characteristics makes it necessary that proponents of change address these issues at the

very beginning rather than dealing with them on an ad-hoc basis during implementation.

The situation in an area is always linked to national and international issues. The interaction of GPs with government services is related to the role of the AMA and its influence on the Australian Medical Council's policies concerning utilisation of the services of foreign-trained doctors. However, these national and international factors are important only if a local community has foreign-trained doctors serving in the area.

The role of local factors for health services development is further illustrated by the following scenario. What happens in Pakistan or Eastern Europe may have more implications for health system development in areas such as South Western Sydney (SWS) than in the northern suburbs of Sydney because of the multi-ethnic composition of the communities in SWS. A community liaison officer at the local hospital who is of Bengali ethnic origin might have been acceptable for people from East and West Pakistan before the independence of Bangladesh. However, at least for a short period immediately after the war in 1971, people from western Pakistan would not have cared to interact with or receive services from a health care provider who come originally from Bangladesh. In recent times, this might also be true for Serbs and Croats.

The extent to which such issues influence policy and health services in an area depends not on an individual factor alone but on a complex interplay of these local characteristics. The specific characteristics of a community do not only influence health system development in an area directly. These characteristics interact with other factors, which are relevant to almost all sites generally. One example is the

professional friction between midwifery and medicine which has been noticeable in Australia recently. In some cultures the birthing process has not been medicalised to the extent it has in western industrialised countries. In such communities one finds a higher level of acceptance of services provided by midwifes at home (particularly if the midwife is a female) compared to doctors (particularly if they are hospital-based and are male). The community environment in this case would be more in favour of midwifery. Once again, the characteristics of the community influence the way the system develops: by affecting the availability of the type of health care provider and the way they operate; by affecting the relationship between various professional groups; and by creating situations where changes introduced in other areas might not be relevant or feasible in that community.

This chapter considers the efforts to associate the Area Health Services (AHS) with GPs, in order to understand the role of the context within which these services operate. The context is looked at in terms of the effect of community characteristics towards the availability of services. The context is also explored in terms of its influence in determining the special needs and work patterns and in subduing or further boosting professional conflict among health care providers.

The framework[1] applied to analyse the SWS situation is the same that I used to analyse the local context of the change in Adelaide. However, different changes were attempted in Sydney, and this meant that it was mainly personnel and health services

[1] A detailed description of the framework, which considers policy implementation from "participation", "interaction", "organisation" and "personnel" perspectives, is given in chapter 7.

related issues which came to fore, rather than issues related to community participation. The integration of the AHS with the local GPs seemed to be less political than the amalgamation of community health services (CHS) in so far as the perceived need (by the local service providers) for active community involvement in the implementation process was concerned. However, the various characteristics of the community were still identifiable as a backdrop to the change.

Depending mainly on whether the local managers and health care workers seek community involvement in the process of the change, the reaction of the community and of the services is different towards different changes. For example, changes such as the privatisation of hospitals produced more vocal and open protests from community activists and groups. However, in Adelaide with changes such as the amalgamation of The Queen Elizabeth hospital with the Lyell McEwin Hospital and the amalgamation of the CHS the community did participate, but this participation seemed to be solicited and passive rather than active. In the case of the integration in SWS the change was concerned mainly with the characteristics of organisation and its personnel, and community participation in the implementation was at a minimum. In a sense, participation in the implementation of changes in local systems appeared as a continuum from more obvious and volatile – when the change called for privatisation – to very little when services were integrated. Participation for changes such as the CHS amalgamation lies somewhere in between on this continuum.

10.2 BACKGROUND OF THE CHANGE: INTEGRATION

The main strategy for achieving the integration was the variety of shared care programs adopted by the Area Health Service (AHS) and by Divisions of General Practice[1A]. Shared care programs were being developed in the areas of mental health, aged care, palliative care, obstetrics and diabetes. A lot of emphasis was placed on diabetes. Most of the interviewees illustrated the process of integration by pointing to the diabetes shared care programs[2]. The reason for this seemed to be that there were diabetes specialists available within the AHS. The availability of some pre-tested health promotion packages also helped in designing the shared care program on diabetes. These health promotion packages mainly address secondary prevention (preventing complications of diabetes) and were considered to have a high success rate by the personnel concerned. Managers at the local level wanted to initiate collaboration with the general practitioners on issues with a high likelihood of success.

> *I think one of the peculiarities of diabetes is that the population is on the increase that has never been serviced well by specialists alone. There are not many people who specialise in diabetes and there is such an increase in the population needed to have something to improve their clinical care, so when we found a model that worked successfully we developed a program on it.* NB (Manager, Sector Health Services)

> *To start a shared care program or any new program you need to pick something you know will succeed. Once you get some success you go on to harder stuff. Now obstetrics and diabetes are the big menace, you know it works. We don't know whether depression and unemployment is going to work. But when we feel sure enough about the other two programs we try take some risk. But if you take risks with the first program it halts the whole program.* NB (Manager, Sector Health Services)

---

[2] Interviewees in SWS included personnel from the Area Health Services' (AHS) planning and health promotion divisions, mangers of health services, community health services, university departments affiliated with the AHS, personnel from divisions of general practice and community members. As mentioned in chapter 5 (Research Design and Analysis), these interviewees were identified through a combination of purposive stratified sampling and snowballing. A list of interviewees and a further description of the selection process appears in chapter 5 of this thesis.

[1A] The sharing was between GPs and specialists and GPs and other health care providers depending on the domain of interest.

While generally there are few specialists in the SWS, diabetes specialists were available in each of the sectors and their availability was one of the major factors in implementing the shared care program for diabetes. It is fair to say that diabetes is a high priority for medical care because of its prevalence, and because it is a risk factor for many other systemic diseases. However, the shared care programs were mainly initiated by the GPs (Divisions of General Practice[3]), specialists and hospitals all probably considering it a technical issue where community feedback or client feedback in the planning phase could provide limited help. The community groups, and the community in general, were involved once the shared care programs were envisaged and were under way.

Additionally, diabetes, unlike any other disease category, requires linking up most of the service providers including CHS. It requires health promotion (on individual as well as population approaches), a continuous link with GPs and specialists to treat the complications of the diabetes, and sometimes hospitalisation. Even if hospitalisation of a diabetic patient is required for some other ailment, it is helpful and often necessary to

[3] Very little direct interaction with GPs was at the AHS level and most of the interaction was mediated through DGP. If asked about the links between GPs and AHS, the respondents usually referred to the work done in collaboration with the DGP.
Divisions of General Practice: These divisions are legally incorporated regional groups of general practitioners (GPs). Developed under the General Practice Reform Strategy and the Divisions and Projects Grants Program of the Commonwealth government, these DGPs provide platforms for interactions with the other health care providers and with the state and regional government authorities. One of the major objectives of DGPs is to provide a mechanism for working closely with the health workers in hospitals, area health services, community health services and with consumers and community groups.
Centre for General Practice Integration Studies. Literature Review: General Practice Integration. School of Community Medicine, University of New South Wales. 1996.
It is not mandatory for GPs to join the division although about 67% had done so by 1995. The median catchment population is about 160,000. A large number (about 35%) of projects conducted by these divisions aim at increasing integration. Other projects cover issues such as health promotion and access to health services.

consult the GP and the specialist under whose care the person has been treated for diabetes.

Other links between GPs and the Area Health Service (AHS) were aimed at developing GP involvement in preoperative care, discharge planning and ambulatory care. Other issues, which were used to improve the links between GPs and hospitals, were the projects on immunisation and heart disease prevention.

Before I go on to discuss the objectives of programs aimed at integration, I would like to draw attention to a problem that has a bearing on the perception of such programs. Within the context of developing better linkages between the AHS and the local GPs, the word 'integration' is often used loosely. The word has found currency in the reports produced by the GP integration studies projects and has also been used, by the AHS, by the GP unit, and by the DGP to describe projects such as shared care. When asked what was meant by integration, the DGP, CHS, as well as hospital management and specialists involved with various shared care projects were unable to give a clear definition. The best meaning, which could be given to the word in the local context, was "working together". Various other terms were used synonymously, including cooperation, better communications, and collaboration and linking services. This clarification is important because integration is often defined in the literature as more than working together and often refers to a situation where integrated services/units have become one at the administrative as well as at the service provision level. In fact, managers believed that the areaisation was the first step towards integration where public sector local hospitals and CHS had to come under one management.

Integration with general practice! I see it as ... probably working more closely together ... and being complimentary in nature. MN (in-charge, Sector CHS)

The term integration to me could mean anything; it could mean takeover, ... to me it means there are different elements you can integrate around. Some of them are to do with education, learning together about consumers' needs, and learning together about how we can accommodate and work together. It could be interacting around like pooling our financial resources so that the health dollar goes further. And we do that in a variety of ways. The approach to integration we are trying to make, I suppose, getting services look more closely at the needs of the consumers groups and then look what we have to offer. CK (Area Health Services Planning, Health Promotion)

I think I'd rather use 'better coordination of cares'; that's the word I'd use. Integration as I see it is basically an organisational process where you bring two or more services under the same management umbrella. ... So yes there was an element of management integration, with the underlying philosophy of the sectors and basically what the Area was saying was, 'If we are going to get hospitals developed and CHS to work together effectively, we've really got to provide an organisational focus before that'. HP (Sector Health Services, hospital and CHS, Director)

The managers considered integration from the organisational perspective. When a public sector based specialist was asked what he meant by integration in the local context, he added the element of standardisation of patient care – coming from professional perspective.

But what we were dealing with in terms of integration was also integration of, not only the individuals and the communication, but an integration of standards of care. So that you would expect to get the same level of care, the same approach to management, the same need to ensure appropriate patient care across the sector, so that everybody knows their role and knows what they're supposed to be doing with a patient. CP (Hospital Based Specialist, In-charge of a shared care program).

This is an important issue in its own right because standardised practice may not be of equal effectiveness and accessibility for a multicultural community, particularly if community participation is not sought for integration efforts (shared care programs).

A community activist complained that the health services and health bureaucracy claim to be working closely with the community, but that their claim is propaganda rather than an actual improvement in terms of working together.

> *I think a lot of things are written ... I've got documents from the Health Department, and they take 10 pages to say what I could say in 1/2 page. Quite frankly, I have a friend who works in local government who said that she's supposed to be doing submissions all the time, but she'd rather be in doing something. That's what I feel, a lot is written but there's not much action.* FH (community member)

It appears that the needs of stakeholders intending to work together determine the degree of integration. If the need of a GP is that the service provided by her/him is perceived to be of high quality by the clients, in turn making his practice successful, she/he will participate in the integration activities in order to be in a position to provide necessary referral services to the clients. Compare this economic imperative to another situation where the patient's satisfaction and health are the main consideration. In this case the concern will be whether the patient got what s/he needed when s/he was referred to specialist/CHS/hospital.

> *One of the key things was that organisations needed to have a very good reason for doing it; essentially closer to their core business. Seems to me one of the things that happened with General Practice over the last few years is that there has been imbalance between the importance of integration for general practice and to the rest of the health services. In particular, if you take the area of linking with general practice and a hospital, until very recently in NSW it was pretty important for general practitioners because they were finding that they were losing contacts with patients, continuity of the patient care was not really very good. ... So there were all kind of reasons for GPs to have better information from and better links with hospitals. Now Area Health Services have to pay for the hospital costs if the patients [resident in their area] were treated in other areas. And the GP is the gatekeeper. ... They [GPs and AHS] are not coming from the same sources and they are not necessarily talking the same language, which is why I say I don't think. [integration would be fast and effective].* LM (a university academic at the Centre for General Practice Integration Studies)

The AHS viewed the integration and shared care projects as an opportunity to decrease the length of patient stay at hospital and to make their services more efficient.

> *I guess one of the key objectives for us is to minimise unnecessary hospital admission, especially for some of these conditions when once they come into the hospital, the hospital admission involves a period of 7 to 10 days in observation, very little else. We're just observing. They're quite healthy most of the time - they could be at home but for some reason they're here.* BD (General manager, a sector of AHS)

However, AHS was presenting the integration as a professionally and economically useful concept for GPs.

> *Shared care projects are, I guess, a means towards trying to get the Division interested in working with us. I see shared care projects as an opportunity to up-skill GPs to enable them to manage the sorts of patients that the GP has tended to send to hospital to manage ... there are attractions for GPs in shared care in terms of keeping the work with GPs rather than referring to specialists* ... HK (General Manager, another Sector of AHS)

The following remark not only points to what objectives AHS considers for the integration, it points to another important issue mentioned earlier in the thesis – that is the replication of health care models under international influences. A particular framework for health care provision favoured by health systems in other countries at a given time is often considered by the local authorities for implementation.

> *Theoretically health outcomes will be improved by doing this. [However] it's not driven by evidence, although there's some evidence from managed care in health maintenance organisations in North America, that integrated care is more efficient and more effective in improving health or improving health outcomes. There's not much evidence in Australia ...* DF (The Epidemiology Unit, AHS)

While there is no doubt that better communication between these four parties (GP, Hospital, CHS, Patient) would lead to better management and better health services, it seemed from the responses of the key informants that often the means were confused with ends and better communication was taken as an end in itself. Whether the aim of

the shared care program is to improve health or to decrease the number of patients being referred to hospitals by GPs, or whether it is to boost the practice of the local GPs are different concepts altogether. One of the main objectives of the AHS's in launching the integration efforts was to decrease the referrals to hospitals. This issue is important from the point of view of the focus of this thesis, namely local factors since the AHS was motivated to come up with these programs because of local characteristics.

10.2.1 The Perceived Nature of Change

That the type of the change in itself is important became obvious when I realised that the policy-administration dichotomy was not a major issue in the Sydney integration. This is in contrast to my observations of the amalgamation of CHS in Adelaide. While amalgamation there was targeted at one particular organisation, namely the CHS, the Sydney integration was aimed at bringing different service providers together. In Sydney no direct administrative shuffling or job cuts were involved. The integration did not provoke negative feelings in the majority of the stakeholders. Concepts such as collaboration and working together have positive connotations attached to them, and there is a large body of literature emphasising the value and benefits of collaborative work. Initiatives such as healthy city projects across the world have promoted the idea of a collaborative and intersectoral approach to health and social services. In a multicultural environment, working together and celebrating diversity are considered good things to do. Furthermore, in an era of cost containment most of the organisations are often short on funds. Integration has perceived benefits in terms of cost cutting. If nothing else, at least some costs could be shifted to the collaborating organisation! Additionally, it is important to underline another difference – the amalgamation in

Adelaide was concerned with social and community health services, while integration in Sydney was aimed mainly at developing links between clinical care providers.

All these factors meant that the integration in Sydney was more widely 'accepted' than the amalgamation in Adelaide. The overall climate in favour of collaborative work (at least theoretically) created an atmosphere where policies aimed at collaboration and integration were believed to have been around for some time, so the hierarchy was not seen to be pushing these policies onto the services. In fact, such policies were not considered, within this environment, as being proposed by the hierarchy; rather most of the people wanted to take the credit for initiating collaborative programs. In fact, the sectors and AHS claimed that the integration with the private services is the extension of their efforts to integrate hospitals with the CHS within the public sector health services.

> *I guess in terms of integration, the integration was making community health and the hospital, the initial component of it, was making them both responsible to the one executive structure at the sector level, which is the level at which you can start to look at moving attitudes and behaviour. What then subsequently happened, of course, within the sector itself we then went through a series of organisational changes that have in fact became more effective.* HP (General Manager, Sector)

> *This department covers the AHS so it is really responsible for liaison between DGP and AHS and for policy development and program development for the area health services.* PT (Academic GP Unit at Fairfield Hospital)

Areaisation seemed to work in favour of a collaborative approach to policy development, as most of the stakeholders are situated at the same level, have better linkages, and are approachable to each other. However, there has been a historical gulf between the hospital-based specialists and the CHS. At the same time, the GPs and CHS generally have been working in almost complete isolation from each other.

Additionally, it was felt that the Liverpool Hospital's gaining a teaching status was perceived by the local community health people as interfering with the CHS' health promotion and community development role. The following remarks from a CHS staff member about the AHS focus on the health development and on the level of involvement of GPs with the CHS alert us to these issues. The concern that GPs already have too much on their plates seemed to be based on a fear that the CHS role might be taken over by the GPs.

> *And it [biomedical model] particularly prevails here because we're upgrading to a teaching hospital. It's [shared care needs to be considered] in the context of what is historically happening now, we're going through a very big period of change. They're things that are being upgraded, all the money's getting sucked into the hospital and into the bricks and mortar* ... NS (Community Projects Coordinator, CHS)

> *I don't come across them [GPs], they don't particularly ring me up, and we are still quite poles apart. I do understand the work that they are doing, I don't understand the constant pressure though that's on GPs to do more and more kind of like community development work. They [hold] a great position within the society but I think that they can become like the schools have become. We believe that the schools are the settings to intervene for so many things. The teachers are all pulling their hair out saying the curriculums are already full, we can't take on any more concerns.* NS (Community Projects Coordinator, CHS)

As is the case with every policy change, the issue of "Us and Them" was visible with regard to the integration efforts in the South Western Sydney (SWS) area. In Adelaide, CHS and their associate agencies in the community had been 'We', while the Health Commission had been 'They'; the friction was vertical in nature, between the community and the hierarchy. In the case of integration in Sydney, GPs considered the AHS as Them; for AHS, GPs were the other party. The AHS aimed to increase linkages with GPs, having in mind that GPs refer a lot of patients to specialists and hospitals outside SWS. GPs felt that AHS has to change itself in order to allow GPs to be more involved in the affairs of hospitals, and that this would improve the quality of

services in the area. Both identified themselves with the same policy and believed it was to address different sets of problems from each of these stakeholders own point of view.

> *No, we're not sure what the benefits of the trial are yet. I think that what has enabled us is having the GP to take a bit more control of the situation because when we sent them, say, to antenatal shared care before, there was no antenatal shared care so the GP could never look after the mother. It was: 'you go to the hospital', and that's it.... people have been used to the organisation, their system. The GP has left the hospital and they didn't really want him to come back. The specialists own the hospital.* RK (Division of General Practice)

> *[The attitude of hospital-based staff and specialists] may be very inappropriate in front of patients and perhaps that does tend to undermine our position within the community. I mean, I send the patient down to the hospital and the person who's assessing it down there, says, 'Oh, the bloody GP shouldn't have sent this in', or, 'Can't they make a diagnosis of this, that and all the other', within the patient's earshot. The patient then comes back at me and sort of looks at me and says, 'Do you really know what you're doing?* SM (Division of General Practice)

> *There are several possible answers [why few GPs refer to the Diabetes Centre]. One is that waiting lists in the past have sometimes been quite long, and maybe they gave up. That's the first possibility. The second possibility is that they don't understand the need for diabetes education, and I think that's actually a serious problem in this area. But the serious problem is that people [GPs] simply don't appreciate the need to have their diabetic patients educated.* TN (specialist on Shared Care program)

10.2.2 Interaction between General Practitioners and the Area Health Services

The role of a third institution/agency became more important in the situation where two collaborating services (AHS/GP) wanted to work together, but had different sets of objectives. The University Department of General Practice (GP Unit) was in a position to help AHS negotiate with the GPs and Divisions of General Practice (DGPs) and to create a feeling that both parties were of equal importance. Despite the fact that the GP Unit was placed at an AHS hospital, it has been able to create an atmosphere

where GPs believe that the shared care programs are initiated by them and serve their benefit. This was because of the close relationship between some motivated GPs and the DGPs. The GP Unit, because of its status as a university department, was able to act independent of the AHS.

> *We were doing it [shared-care] before but now is being documented as to see, Is this shared care thing improving health care outcomes? Is it making any difference? What on earth is it doing? It's taking a lot of our time to document all this. Within the past we used to do it in a more haphazard manner. There's a protocol now as to when we should be doing it, and what we should be doing.* RK (Division of General Practice)

Shared care programs are not limited to the SWS. Though shared care programs are being tried by almost all areas, there are certain specific arrangements in this area, which affect these programs. While an academic from the AHS defined integration as "cultivating a culture of common goals among health care providers", the AHS had additional motives as well.

The University Department of General Practice at Campbelltown Hospital was opened in 1992. One of its objectives was to enhance communication between local GPs and the hospital. The GP Unit at Liverpool Hospital was established in 1986 and acted as the regional training centre for the Family Medicine Program. In 1989 it was transferred to Fairfield Hospital, and in 1991 became the Department of General Practice of the University of New South Wales. One of its aims was to provide continuing medical education for GPs in the SWS local government areas. This Unit was affiliated with the College of General Practitioners and was funded by the AHS, and therefore was linked to the area administration as well. In addition to the research and teaching and continuing education activities, it provided policy guidelines to the

AHS. The Unit claimed to be the first to initiate the idea of divisions of general practice. Since the late 1980s it had developed very close links with the local GPs, and had helped the division successfully apply for grants from the Commonwealth government.

Thus the GP Unit had not only influenced the AHS, but also the divisions of general practice, particularly the one in the Fairfield area. The GP Unit was well aware of the concerns such as: the lack of local GP input into decision making about local health services; lack of GP involvement in hospital-based care; and a lack of effective communication and referrals between GPs and the hospital[4]. On the other hand, the GP Unit was aware of the AHS's concerns about funds being transferred to other areas as a result of the large number of referrals (about 25,000 annually) by the local GPs to specialists and hospitals outside SWS. An AHS suffers a financial penalty if patients from its territory are being referred to the services in other areas – the "money follows the patient" funding formula[5]. This led the AHS to place further emphasis on developing links between the local GPs and hospitals and hospital-based specialists. The GP Unit acted as a mediator between the AHS and the DGPs. The academic support seemed to improve the political position of the local DGPs, increasing their access to Commonwealth funding. The GP Unit worked closely with the DGPs to enable them to successfully apply for grants from the Commonwealth.

[4] The communication between GPs and hospitals is an ongoing problem. Both the GPs as well as the AHS were considering strategies to improve the situation. For example, at a meeting in 1996 of the Population Health and Health Promotion executives from the AHS, the poor immunisation coverage in the area was attributed to a poor feedback from GPs to the National Register. The situation, it was suggested, could be improved by motivating GPs and supporting their role in immunisation campaigns.

[5] NSW Health. Caring for equity, efficiency and quality, The NSW Government's Economic Statement for Health. Sydney: NSW Health, 1995.

In brief, the main concerns of the local GPs were firstly that once a client has been referred to a hospital they rarely get any useful feedback, and secondly that they are not involved in hospital-based care[6].

> *The thing we have been talking about is establishing a formal agreement between sectors and DGP working on some of the problems in communications, particularly with the hospitals and GPs, setting up more consistent pre-admission communication and more timely and quality discharge communication and some automatic systems to do that* .... .. PT (General Practice Unit)

The AHS wanted to curb referrals outside the area, and wanted to introduce the concept of health promotion in order to improve the usage and acceptability of their services. Later in this chapter, while discussing issues related to the care of individuals, I discuss some reasons for this out-referral phenomenon. The shared care programs cater to the needs of both the AHS and local GPs. The situation could be different in an area where there are not that many referrals from GPs to outside specialists.

However, while out-referrals appear to be the main motivation behind the attempts by the AHS to improve local interactions, the integration was also proposed and pursued by the AHS from a holistic health care point of view. For example, in one of its documents, the Health Promotion Unit of the AHS recommended increasing engagement in the whole health care system by developing linkages and frameworks[7].

---

[6] Information flow has been the one area on which the local health services have been working for quite some time. A federally funded project for transfer of information via fax between practitioners (hospital ward, Accident and Emergency, GP and the specialist) regarding clinical management of patients with asthma was tried in 1992.
South Western Sydney Area Health Services (SWSAHS). Annual Report 1992-93. SWSAHS, 1993.

[7] South Western Sydney Area Health Services (SWSAHS) Health Promotion Unit. Health Promotion in SWS 1990-1993: review. SWSAHS 1993.

The South Western Sydney (SWS) suffers from a chronic shortage of medical specialists, and this shortage was reported as an important reason for GPs to send their patient outside the area[8]. There are many reasons for this shortage, associated with some specific features of the area. SWS is often seen to be on the metropolitan social fringe, with a high proportion of residents who are relatively underprivileged socio-economically. Because of this social stigma, very few specialists are willing to live or practice here, and are unlikely to want to commute 20-30 kilometres from Northeast Sydney to practice in an area where use of private services is low because of low private insurance levels. They also prefer to be associated with the large and more highly reputed hospitals in inner Sydney. Most of the specialists were trained in the inner Sydney hospitals and would undoubtedly enjoy better professional links and networks in those areas rather than in SWS. However, this situation has improved since Liverpool Hospital became a teaching hospital. Another factor, which has improved the situation to some extent, is the preference of affluent people to live in the hinterland between Sydney and Wollongong. Nevertheless, the local specialists were still fewer in number, and were new to the scene with fewer links. These specialists needed to interact with both local hospitals and GPs in order to achieve a professional and political clout in the area. While the AHS was able to lure some specialists to the area, it required further efforts to link these specialists to the local GPs. The shared-care projects were regarded as a vehicle to promote these links. Thus these projects served the need of the local specialists to make their services and expertise known to the local GPs.

[8] The shortage of specialists is obvious since in the category of General Medicine there are 0.11 specialists for 1000 population in the SWS compared to 0.25 per 1000 people in NSW overall. There is a shortage of GPs as well. In 1990 in the SWS there was one GP per 1350 population compared to one GP for 860 people in NSW.

To improve the links between primary and secondary care, the need for decentralised hospital outpatient services, where specialist consultations are held in a primary care setting, has been pointed out[9]. In SWS, specialists affiliated with the AHS shared-care programs were based at the hospital. This needs to be seen in the light of an important objective of these shared care programs, which was to improve GPs' access to hospitals and the information flow between the two.

While the availability of specialists in the area is an important factor in determining the shape of local health care, it is necessary as well to look at some characteristics of the GP population. For example, 37.5% of NSW GPs work in SWS, but only 3.1% live there. This is in stark contrast to Northern Sydney, where 10% of NSW GPs work, but 25.6 % of NSW GPs live.

> *There is a great reluctance amongst medical practitioners to travel out to South Western or far western Sydney to work. Few practitioners live in the area, and there's a great reluctance to travel to where need is, which is contrary to most aspects of the Hippocratic oath and the concept of caring for individuals. But it is not inconsistent with the lack of private schools and expensive suburbs for people to live in...Those that do usually have a slightly greater level of community awareness and commitment, and to name one - because I think it's relevant - the Head of the Division of ... has an understanding of the needs of communities and has been involved in the political debates about resourcing.* DF (Academic at the Epidemiology Unit of AHS)

Such factors, even if they are not a very significant influence on the quantity of services, were perceived by the locals as militating against the local community and doctors working close to each other.

---

[9] Moss F, McNicole M. Secondary care beyond Tomlinson: An opportunity to be seized or squandered. BMJ 1992; 305:1211-1214.

Let me say that I'm sure that geography has something to do with some doctors not wanting to come here because, especially if you have a family, then you've got to look for education opportunities, housing and so on. They don't really want to live in Liverpool or Cabramatta, do they? I mean, it wouldn't be socially acceptable to live there. PJ (Fairfield Councillor)

Well, I've written to Ken Brown at one stage asking how many of the consultants and the big people here live in the area. Dr ...does, maybe Dr ... does, but Professor ... lives over on the North Shore[10]*. I can name a few doctors that live way out of the area. They don't interact with our community on a personal basis so they're not interested in schools etc because they don't live in the area.* FH (Community Member)

The AHS through its various integration activities, particularly the shared-care programs, was trying to develop a better working relationship with about 700 GPs in SWS. Localities such as Fairfield and Liverpool have relatively few female doctors compared to elsewhere in the SWS and metropolitan Sydney. The reason for this, as provided by the interviewees, could be that Bankstown is relatively near to the inner Sydney suburbs where doctors prefer to live, and so it is easier for them to travel to Bankstown on a daily basis.

In summary, factors such as whether professionals live in the area, whether they are trained in the country where they are practising, and the level of the development of the DGP appeared to be the attributes that determined the level of GP involvement.

[The involvement of GPs in the programs of DGP] is complicated and it is not a simple relationship. Campbelltown for example has the lowest proportion of NESB doctors, whereas Fairfield has very high percentage. Fairfield has good cohesion. Campbelltown has relatively less cohesion. But it is complicated by the fact that in Campbelltown 80% of the GPs are in solo practice .... I don't actually think that ethnicity has much to do with it. I think if anything NESB doctors have accepted it more than the Australian graduates.... I think that solo GPs are fairly independent, but then many GPs in solo practices at

[10] Suburbs on the North Shore of Sydney are roughly at a 90-minute driving distance from Liverpool during peak hours. Central Sydney is at a 50 to 60 minute driving distance. Travel time in Adelaide is much less compared to the travel time for similar distances in Sydney. Port Adelaide is at a 20-minute drive from the Adelaide city centre.

Fairfield are involved in DGP... Bowral is quite a different area, it is more a sort of a rural setting, very committed and good quality GPs, ... they are more involved with the hospital ... for example the Diabetic Register down there has a 100% GP involvement and almost all of the diabetic patients enrolled in the register. PT (General Practice Unit).

Within the area, various sectors might differ in health services utilisation. One example could be the use of obstetrics and gynaecological services by the South Asian and Vietnamese community in the Fairfield sector. Such differences in utilisation patterns may require strategies which may not be acceptable to a particular professional group and may increase the friction between public and private sectors, or between two professional groups. An example, as narrated by an interviewee, was the introduction of nurse practitioners to promote the use of pap smear services in the Wingecaribee sector a few years ago. The doctors in that rural area, despite a very low pap smear rate under their own ministration, reacted to the use of nurse practitioners by questioning the quality of services provided by nurses. The CHS in that area were required to drop the strategy of employing a nurse practitioner and a doctor to improve the screening.

Integration with general practice! ... I see it as ... probably working more closely together ..on .. and being complimentary in nature ... I think ... I don't know what happens here [Fairfield] [but] Wingecaribee is a good example. It is a rural community so people are a bit more conservative. They are more threatened to be changed. So when we introduced a woman nurse practitioner, the general practitioners felt very threatened by that. They said that we provide this service [already]. ...And basically they didn't want me to fund the nursing position. We hired a GP to work with the nurse (in women's health services) because it had been acknowledged that the pap smear rate was very low across Australia. It was a Federal government initiative and it was funded federally to do this. Other doctors felt that we were wasting money in duplicating services. We discontinued the employment of the doctor. [later] I was able to convince the local GPs that it was not to duplicate and then as soon as there was an abnormal pap smear, the client was referred back to GP. [Patient not consulting GP for pap smear] is may be because she is a sex worker and is not comfortable to consult a GP; or may be because she is 14 or 15 and doesn't want to go to the family GP. So nurse provides an alternative ... KN (Director Sector CHS, earlier served at Wingecaribee)

Getting back to the issue of health personnel living outside the area, it was pointed out by the interviewees that many doctors in Bankstown, Liverpool, and Campbelltown commute from the Eastern and Northern suburbs or from the hinterland beyond SWS.

> *Bankstown has more women doctors because they are closer to the East where most of the doctors live and [Bankstown] has a high proportion of part time doctors.* PT (GP Unit)

The AHS considered GPs to be a very mobile population. It was stated that it becomes very difficult to keep record of doctors' addresses. On the other hand, the DGPs considered that one of the main reason for less than optimum communication and reporting between hospitals and GPs was the mobility of the work force in hospitals, particularly of medical registrars. It was difficult to train and work with such a mobile group to improve the reporting of case summaries to GPs. The interviewees pointed to the importance of facilitating human interaction if communication was to be improved. It was mentioned that while there were efforts to computerise the transmission of preformatted information, the problem boils down to the existence of a continuous working relationship between a stable population of GPs and a stable hospital workforce. With regard to inter-personal communication, it was mentioned that developing links with individual practices was more practical. The reason for this was a difficulty in achieving a continuous one-to-one interaction with a particular GP at larger practices[11].

[11] These practices seemed to have little concern about what was happening to the health and social services around them. Those which I approached for an interview denied me over the telephone, stating it was not possible to find some time for an interview. This feeling that these GPs at larger private conglomerate are somewhat oblivious of the rest of the health infrastructure in the area is obvious from the fact that only one interviewee asked me to interview a practitioner at these combined practices in case if he had some insight to offer.

The discussion in the preceding few paragraphs points out that the level of involvement of local GPs in shared care programs is determined not only by the context at the whole SWS level, but also by the specific circumstances of particular suburbs within the SWS.

10.3 AREA HEALTH SERVICES

The areaisation of health services in NSW took place in 1986. Areas are autonomous, with their own boards of directors and with their bureaucracy charged with a planning brief. The sectors within the AHS have somewhat different organisational structures. For example, in Liverpool Community and Allied Health are one division, whereas the Bankstown sector has a Community Health subdivision and an Allied Health subdivision. Because of these different organisational characteristics, linking up with GPs and DGPs takes different shapes in these two sectors.

Planning for health services delivery is conducted at the SWS Area, but has to conform to the state policy framework. While the Area distributes recurrent funds among its sectors and among the local hospitals and CHS, funds received for capital developments (e.g. hospital building) are already earmarked or are special grants and cannot be shifted to other priorities.

The major local issue affecting the working of the AHS is its general socio-economic situation. Up to 85% people in the Area do not have private insurance. In addition, due to its relative socio-economic disadvantage, the area has a higher prevalence of many diseases. High morbidity and low utilisation of private services act together to put a

heavy burden on the public sector services. This situation demands relatively more health funding compared to the funding required by better-off areas, but because of the lack of political power and consequent inability to lobby effectively, services remain inadequate.

While the AHS competes for funding with the other regions in NSW, there is also some competition within the area at the sector level. As each sector has demographic, morbidity, and social and cultural issues different from others, it is difficult to define hard and fast rules for the allocation of funds between these sectors[12]. The allocation of funds is important for programs such as shared care to work effectively, as some funds have to be allocated for linking up with GPs. The shared care programs do receive grants from within the area health services budgets, in addition to grants from the Commonwealth Government.

With a shortage of funds overall in SWS, the sectors then tried to arrange for extra funding from outside the Area Health Services budget.

> *The rule of the game is this. If you get money outside the SWSAHS funding, make sure it is additional funding that you can tap into. You don't play politics where you politically get money which is earmarked for something else if you want to stay as the manager even for that reason alone. If I use ...[Local MP Minister] I will be targeting funding outside the health budget already earmarked.* NB (Sector Management)

Within this competitive situation, resources available with one sector, for example the time of an expert for shared care, were not available to other sectors. In fact,

[12] See chapter 6 "Context of the Proposed Changes:..." for the demographic and socio-economic situation in various sectors within the SWS.

approaches to shared care programs for the same category of disease were strikingly different amongst different sectors as they were often run in isolation from each other.

> *[Diabetes shared care is] based on three separate models, one of which was produced in Macarthur ... but basically [all are] doing the same thing, using wherever possible standardised guidelines for patient management, developing registers, developing recall systems, raising patient awareness, raising doctor awareness, instigating appropriate education and so on.* CP (Shared Care Program)

> *We're trying to take a leadership role in changing the attitude of the local doctors and patients to appreciate that there is a new model of diabetes care available ... well I think that we are pushing patients to be assertive about their care and sometimes we're quite explicit about it ... trying to push people to say you know it's your health, you need to know what you want and go for it and ask for it.* TN (Shared Care Program)

> *[In contrast to the urban sectors within the AHS] The diabetes shared care in Bowral had all 36 of their GPs participating. I think it has to do with the mentality of people who live in small communities and the fact that they feel ownership for their community and so forth. That might be a way GPs see what happens in our community in terms of what happens in the hospital. But it's not the only influence.* TN (Shared Care Program)

While the GP Unit (university department of general practice) was considered a resource for the whole Area, the level of interaction of DGPs with that Unit varied among sectors. The physical proximity with the Fairfield DGP, as well as the historical working relationship of the local hospital with Fairfield GPs, helped the GP Unit to work more closely with the Fairfield than with the Bankstown and Campbelltown DGPs.

Another factor that impinged heavily on the efforts of AHS to work closely with the private sector is the shortage of specialists, the reasons for which were mentioned

earlier[13]. To recap, the reputation of the area as having high crime rate, low socio-economic status (some suburbs such as Cabramatta are more stigmatised than others), and underfunded hospitals especially in diagnostic services and tertiary and quaternary care, meant that there was a long standing shortage of specialists in the area[14]. GPs from SWS have traditionally developed referral relationships with more highly reputed hospitals in the inner Sydney area and with specialists working in those areas. The services in SWS have been perceived traditionally to be of low quality not only by the public, but also by the GPs working in the area.

> *We always felt neglected that most of our seriously ill patient had to go to Sydney or North Shore such as St Vincent's Hospital. ... councils in those eastern suburbs you probably know this, a lot of people going to these councils as councillors are university people well educated and they know what they are doing. They can take part in most discussions about the area. That is why they got the best transport service, best health service, they have got the best services generally. When you come to areas like Liverpool, because of the inadequacy of the people who sit around there, that is why we are still going up and down the wrong way. That is one of the problems. At the present moment on the Liverpool council six or seven out of eleven councillors don't contribute. They just don't contribute. It is beyond them.* KB (Community Member)[15]

> *In one survey which was conducted by the GP Unit, and I think the DGP might have been involved in it, GPs suggested "they need more specialists at hospitals ... there is need to improve the communication of services" and so on and so forth.* RK

In recent years, however, this area has started to attract specialists. In summary this is because: of the realisation of this problem by the AHS and the efforts to invite specialists to work in the area; the Liverpool hospital is affiliated with the University

[13] See Chapter 6, "Context of the proposed changes:..." (Section 6.6.2.1: The need for integration).
[14] More recently, however, the Liverpool and Fairfield hospitals have started attracting more specialists, mainly because of their affiliation with the university.
[15] This statement about the reason for inadequate social services needs to be interpreted cautiously, however, as the interviewee himself was an ex-councillor from the area.

of New South Wales (UNSW)[16]; the affiliation of the Campbelltown Hospital with the University of Western Sydney (UWS) for nursing; and the Fairfield hospital having an academic department of GP. Promised shared care projects have motivated some specialists to come to these areas.

> *Having a university affiliation attracts senior people to manage the services and attracts an intellectual development that increases the research profile of areas. ... the university affiliation has changed the staffing profile of Liverpool beyond, I suspect, what would have occurred naturally had there been no university affiliation. And that leads to more specialised and more academically competent service development.* DF (Epidemiology Unit AHS)

> *I think the fact that the University of New South Wales, ...[is] linked with the hospital has been a very positive and important move. Very important, because one of the difficulties we've had because there's been a reluctance of good doctors to come this way.* PJ (Councillor Fairfield & Fairfield Health Forum)

However, these newly arriving specialists have not yet achieved the level of interaction that is necessary for GPs to feel comfortable enough to start referring all of their clients to them. A good research question would be to compare the degree of utilisation of shared care programs in such areas with comparable programs in areas where GPs trust local specialists, and where the GPs themselves are a stable population. In a sense, as far as the shared care programs are concerned, it seems that the end is being confused

---

[16] The role of university's interaction with the local health services was not hailed by everyone. For example, the importance of university departments for shared-care programs is not valued highly by hospital-based specialists who believe that they were running, and are capable of running, shared-care programs with little assistance from the university academic departments such as the GP Unit. The following quote is from a specialist who is considered by the GP Unit to be the one who wants to do shared-care quite independently.

> *Well, to us, none. Nothing. Zero [the benefits of university in terms of shared-care]. You wouldn't necessarily expect it to ... Well, only by its presence being part of development of hospitals that have a teaching and research focus and therefore attracting people that have that and therefore people who want to push those barrows. I guess if you were running five private hospitals in the area with no university or teaching affiliation you would not have people who wanted to promote research as much perhaps as you do. So indirectly it has that effect, but I don't know in terms of a direct effect. CP (Shared-care Program, Sector Health Services)*

with the means. Continuous care is valued as a means of improving GP-specialist and GP-hospital interaction.

> *From a public health perspective, I think it's driven by economic restraints and the need to manage care or integrate care as fundamentally as the more cost efficient system. I don't believe it's driven by the need to involve GPs altruistically in the care of patients because, although that's a fundamental social value, that's been around for a long time and it hasn't happened, until there was economic pressure to drive it. ... it's a good thing to involve GPs in ... but it is driven fundamentally by economic pressure.* DF (Epidemiology Unit, AHS)

This situation has created a particular perception in the minds of interacting parties about the role of the other party, and about whether such an interaction is of any benefit to them. The participation in such programs and their implementation depends on the level of perceived benefits to the care provider; that a patient is able to get quality continuous care could only be considered as a by-product. AHS documents heavily emphasised the benefits of these shared care programs for the patients. Similarly, the interviewees from the AHS as well as the DGP personnel seemed to speak that these shared care programs were envisaged mainly for patient benefits. However, a closer look at the situation within the overall local context revealed other perspectives on the shared care programs with benefits to the AHS in terms of cost containment.

10.3.1 Role of Influential Professionals

Another important Area-specific issue was the availability of some motivated people in the AHS who acted as opinion leaders. The socio-economic disadvantage and a chronic shortage of political resources and funds motivated some leading public health

and medical professionals to come to the Area. As also seen in the Western suburbs of the Adelaide metropolitan area, the lack of social infrastructure and the underprivileged situation, in terms of socio-economic status motivated a few people with a strong community development ideology to raise the issues of equity and equal opportunity on behalf of the local population. By doing this, they gain an enhanced power balance against the hierarchy[17]. At the same time, these people were able to influence local opinion towards one of their preferred approaches to health care problems. In fact, in SWS, I noticed a phenomenon where an influential public health professional with a reputation for working closely with the community had joined the AHS. Over the next few years, in the capacity of an influential executive of the AHS, he was able to invite many people with an ideology similar to his own to work with the AHS. The majority of the professionals are those who may be considered to have a traditional medical approach to health problems and who rally community support mainly on funding for hospital-based services. However, professionals with a leaning towards a population perspective for health system development are appearing on the scene. These professionals are not only influential as opinion leaders at the community level, they are also well-reputed among the professional community and as such are effective in assisting the development of linkages between the private and public sector services in the area.

[17] The "motivated people" I consider here were mainly from the academic tradition who have found their opportunity to work with the AHS because of its affiliation with the university. These professionals/academics were well known beyond SWS and have probably been influential enough to be in a position to work in the area of their choosing (central or Northern Sydney). They enjoyed highly reputed status among their professional colleagues. Two of them, because of a vast experience of working at the interface of community and health system, and because they were involved in an active interaction with the community on various health promotion programs, were enjoying a position where they could be seen as having much influence on how community perceives and acts on a particular health matter.

> *I think, to begin, probably the influence [to initiate health promotion projects and links between different sectors] has come from [a particular person] because, I mean obviously he's a very keen supporter of the area of prevention and health improvement, and also he's a man who has very many influences as well. ... I mean he's shown a lot of leadership in these areas. But there has also been very much the trend for AHS to engage the support and link in with GPs - that's actually been a state wide trend, it's not just happening in SWS.* CS (Health Promotion Unit, AHS)

These few influential people have been helpful in lifting morale generally. There was a feeling that their presence was helpful in gaining an increasing community trust in the quality of the local public sector health services, and in enabling the AHS to work more smoothly with the local GPs. These feelings can be sensed when one carefully probes for peoples' motivations for collaboration. This feeling, however, is difficult to quantify in terms of the percentage of referrals to local specialists that can be attributed to the presence of these influential health professionals.

Other examples of the role of influential health professionals comes from the two divisions of general practice in the Area. In SWS, the availability of the GP Unit at Fairfield Hospital was one factor leading to the development of what was claimed to be the first Division of General Practice (DGP) in NSW. However, another important factor contributing to this development was the presence of a GP who happened to have worked closely with community organisations in the past, and who was motivated to develop links between GPs and the local hospital. This person had lived and provided services for many years, and had also been involved in community development activities. His desire to work closely with other agencies to make services more accessible meant that the DGP in the area was the first to accept funding from the Commonwealth Government to develop projects linking GPs with the other health services. On the other hand, it became difficult to make the Liverpool DGP functional,

at least initially, because the administration (GPs) of that division were not inclined to work on projects involving the community and the public sector because of an ideology favouring greater GP autonomy. The Commonwealth grants were seen as interfering with that autonomy.

> *The Liverpool Division unfortunately started not to accept Commonwealth funding and followed sort of a hard-line Australian Medical Association view of things. As a result the Liverpool Division was actually very slow to develop by comparison to the other sectors. ... They refused the first two rounds of funding, so it was sort of like two years that the Divisions were up and running really before anything was happening in Liverpool. Now the Division is fairly active. ... [the reason they refused the funds was because] a couple of hot heads, nothing more than that. A couple of hot heads who were able to hijack the agenda, through their own wisdom and what we need, I guess, to remember is that most GPs are pretty apathetic about that sort of thing. Most GPs look at it and say, 'Well, what's in it for us?'* HP (Manager Sector Health Services)

An interviewee also suggested that this reluctance was mainly the result of an autocratic attitude of the head towards solving problems.

The factors, such as the health services utilisation in an area, community configuration and participation, and availability of motivated health personnel, rarely work separately and are difficult to weigh in isolation. This is an important point. The whole discussion in fact helps us avoid the pitfall of reductionism in health care planning. Overzealous attempts at addressing one particular factor with little attention given to the context run a high risk of failure in addressing the health inequities in such areas. At the same time, the fact that the local stakeholders understand and point out the importance of such phenomena to a health system researcher suggests that there is a need for carefully recognising such issues while planning health system changes. For example, although one finds statements in the planning documents about 'mobilising local resources', the type of these local resources and the strategies to use them are

rarely highlighted. Strategies need to incorporate how local services, or the type of people I am mentioning, will use the assets. Attention to such factors is often lost or their importance is overlooked while everyone's attention is being devoted to the shortage of funding.

In the case of SWS, it is important to highlight that because the main emphasis was on attaining a better reputation for the hospitals, and on linking the hospitals and hospital-based specialists with GPs, the people in community health felt left out in the struggle for achieving more resources for community health. It could be said that each component of the health services tried to push its barrow as there are relatively fewer resources for which everyone is competing. However, the following observation of a community health project officer has weight in the light of recent emphasis on hiring specialists, linking specialists with GPs, and lobbying by the hospital-based specialist for more funds for hospital-based services.

> *We're upgrading to a teaching hospital. ... We're going through a very big period of change. They're things that are being upgraded; all the money's getting sucked into the hospital ... and into getting that kind of infrastructure. The one reason for that is, like I don't know what their concerns are, but they [hospital based specialists] are lobbying and advocating much more for their own level of service provision. So if they're in the cancer area or if they're in obstetrics, they're saying these divisions need more and more money. It seems to me that all the professors and all those people were up in arms about Andrew Refshauge's decision. I raised it in a meeting and said, "What's the strategy in terms of getting the community to be supporting the same concerns that the Professors have?". I mean the community doesn't have a clue. The community doesn't know in a sense what's going on - for the community they're getting more things at the moment!!* NS (Community Projects Coordinator)

10.4 THE COMMUNITY

The community, its culture, and the level of socio-economic disadvantage directly influence the services in an area. In the preceding sections, I have provided some examples of this influence while talking about the health care providers. In this section I change the focus to community participation. Community participation is now considered a health system principle in itself and each service component is expected to work closely with the community. Before I talk about the specific attributes which facilitated or impeded community participation in health services development, it is necessary to reiterate one particular facet of the integration. The development of linkages between the GPs and hospital, GPs and specialists, and GPs and the CHS was considered by both the local health bureaucracy and professionals to be a technical domain, the planning for which required little input from the general public. The planning of the integration mainly involved communication between professionals, and between professionals and managers. The following remarks by the health management and professionals highlights this technical view of planning for changes such as integration. Notice the emphasis placed by the first person on the skills available at the Area Health Service level and the value of that skills pool in developing programs to be implemented in all the sectors. The second person did not mention any role of the client or community members in the diabetes services review.

> *If we want to develop a particular project or service where there are good planning skills, resource skills, and knowledge skills within the sector, then we can do that fairly independently. We see the Area largely as a skills pool, a resource, so that whilst they're doing a lot of things on an area-wide basis, if we have a sector issue we want to take on, we'll often consult them.* DF (Epidemiology Unit AHS)

> *Diabetes Services Review Committee is made up of representatives of all the major diabetes service provision groups in the area. General practice and specialist diabetes services, diabetes educators, dieticians, public health and*

the planning people. That was basically the group that was involved in putting this [shared care in one area] all together. CP (Shared Care Program)

Community activists, CHS personnel, and hospital based professionals who were asked about the nature and extent of community participation clearly believed that interaction with the community was for issues such as hospital based services cut-backs, physical infrastructure development, and the general lack of funding. Community/client feedback into processes such as the integration came via proxy measures; professionals talking on behalf of their clients. This again reflects the extent of professionalisation of health and medical care, which by a single stroke considered planning and implementation of such changes as too technical for the lay community and better left to the professionals. It might be true that such changes are considered and implemented with good intentions for improving the accessibility of care; the shortcoming is that the problem of less than adequate consumer information stays unresolved.

As mentioned earlier, the integration was considered a positive phenomenon by the interacting parties as well as by the community. At the same time, such changes were not seen as political, and hence street-level public support was not considered essential. This is in contrast to the issue of the lack of funds. Health care professionals from the area were actively motivating people to lobby for increased funding.

There was no mention of any strategies aimed at involving the community in changes such as shared care programs, or in GPs' pre-admission/post-discharge links with the hospital. It became evident that, despite the emphasis on the value of community

involvement, it was actively sought out only for funding cuts and provision of extra services. Although it was claimed that the integrated provision of care would make services more effective and of better quality for the client, it was believed that GPs knew exactly what the need of the community and clients was in terms of referrals, admissions to local hospitals, and continuity of care. In this context, the strategies for implementing the change were left mainly to the professionals and health managers.

> *We see ourselves not only as providing care here but also a leadership role for diabetes in the local hospital and the surrounding community. And that's at all levels from patients up to health care providers. So that naturally leads us to get involved in things like GP shared care projects. Now the one that's in [shared care project in this area], I didn't initiate it, it was really the General Practice Division who thought they needed something like that.* TN (a Diabetes Specialist, Shared Care Program, Sector Health Services)

> *... I think the community needs to have an opportunity to actually know what is going on in CHS. ...there are significant numbers within the community that would like to be involved in the determination of the sorts of services we provide. ... the vast majority basically would prefer to leave it to the professionals for most of those services ...* HP (Manager of a local hospital)

> *I actually don't believe in community participation or integration for its own sake. We work with primary health care with clinicians. I don't say you should do community participation, integration, or central collaboration because it's a good idea. You only do it if it solves a problem. If it doesn't solve a problem, don't do it. If you can solve the problem tomorrow using a simple drug and you force everybody to have it, it would probably be a more cost-effective way of doing it.* TM (Advisor/Specialist, Sector Health Services)

While professionals claimed to have a good understanding of what their clients and community need, they, by commenting on the practices of fellow professionals, pointed to less than optimum concern for the health of the community.

> *There are several possible answers [why few GPs refer patients to the Diabetes Centre]. One is that waiting lists have in the past sometimes been quite long, and maybe they [GPs] gave up. That's the first possibility. The second possibility is that they don't understand the need for diabetes education and I think that's actually a serious problem in this area. ... people simply don't appreciate the need to have their diabetic patients educated. It's like, you give them a tablet and they're not overtly ill, that's all we need to do. That is, in fact,*

old style diabetes management. TN (Shared Care Program, Sector Health Services)

The community tended to involve itself in issues that were not presented as technical. Community participation was determined by what community activists (local people as well as influential professionals with the AHS) considered appropriate. Additionally, health promotion strategies invited people's attention more as these strategies affect the community as a group, in their workplace and/or in their homes. This is in contrast to strategies such as integration, which affect them as individual patients in the hospital or in the doctor's surgery. This example illustrates what health care providers or planners believe to be the benefits of community participation, and the types of activities in which they are likely to actively solicit community participation.

Many people from the health sector commented that there was community apathy about the work of health services. Health care providers perceived that the community members were so overwhelmed with their day-to-day life that they found it very hard to find time to participate. It was suggested that community apathy towards health services comes from the belief of people living in these areas that no one in government institutions is likely to listen to the demands of the locals.

I think people are a bit apathetic when it comes to getting up and protesting. I think most people have the fact that the government has not provided equity in health funding for SWS and most people are unhappy about that . But to get them out on the streets or have a public meeting for protest is a different matter. BA (suburban newspaper)

There are a lot of refugees in SWS from countries where political regimes are strict and frightening. And there is some community perception that the health service is part of the government ... and they will do anything to keep away from it or avoid it; [for example people from] South America, Indo-China, particularly Cambodia, some Middle Eastern countries, like Iran and Iraq.

...We have a large Syrian population in SWS that are quite fearful of the government in principle. DF (Epidemiology Unit, AHS)

While, in general, professionals as well as active community members pointed to the lack of an optimum community participation, they provided numerous examples of projects and issues where the community in general or a sub-section of the population had contributed effectively. There were two types of activities where the community seemed to be involved. Firstly, when local health care providers in the public sector wanted to motivate the community to lobby strongly for more funds and resources, mainly for hospital-based services. Secondly, the community itself seemed to be involved more in population-based activities. Strategies such as the needle exchange program developed by the Drug and Alcohol Unit of the Population Health Division of the AHS drew a lot of attention.[18] A high level of community participation depended on factors such as the degree to which the population as a whole is affected by the problem. Examples were the use of recreational drugs in an area, or the level of safety. In the case of SWS, specific social problems included high youth unemployment and anti-social behaviour, drug addiction and peddling, violence, and the general perception that public places such as railway stations and shopping centres are unsafe.

On a positive note, these specific problems provided an opportunity to define health and health care more broadly and to initiate intersectoral efforts. The problems provided an entry point for efforts to involve the community members. People are more exposed to problems which impinge upon their everyday life, and consequently

[18] While such programs help achieve a high level of community involvement (to resist or assist) these programs may cause friction between the community and the local health care planners and providers as well.

more likely to have ideas about how the situation might be addressed. For this reason the Needle Exchange or the Healthy City Program (developed by the local council and the Liverpool CHS), which emphasised the safety of public places, had the potential to increase community participation. The staff member from the local CHC who coordinated the safety program achieved a strong political position within the CHS, because she developed strong links with the community, which then lobbied against making her position redundant.

> *What ended up happening, though, is that we had a lot of community support. The council and the mayor would have received over 30 faxes from organisations around here saying not to cut the project and that we think it's a really good project, we really support it. I've got a whole folder in there of all of the stuff. So they lobbied, and the council still did it [cut the funding] because, again, it's all intermingled with a lot of politics [the decision to cut the project was ultimately made at the Labour Party caucus – despite the support of local councillors and mayor].* NS (Community Health Centre)

Within the context of pressure from various community organisations and other services which believed in the effectiveness of the project, the position and the project funding was then pledged by the AHS – an example of the local networks' influence on what shape a policy would take during its implementation.

At the same time, the institutions and people participating in the safety project went on to participate in other programs of that particular CHS.

> *The Safe Women Project, which continued here, is funded [now] by us and organised by the council. [In addition] the Safety Committee, which the council now has, has a historical link back to that. There's no doubt that the Healthy Cities and the Safe Women Project had an influence on the council's planning processes and some of the work that's been done are things like traffic interchange here, and it's also evident there's history now going forth. Now with our other project, which I was saying to you, on violence prevention, which is a general community development type of program which has grown out of the Safe Women Project, that's one that we fund but we work closely with council.* FG

Community participation is also influenced by whether a strategy involves the use of community facilities for health promotion, and the fear of side effects of a health promotion strategy such as the needle exchange program[19]. Another important factor to consider is the compatibility of a strategy with the cultural norms. Programs, which offer strategies that are considered radical by the community, do generate a lot of community interest. Often participants' opinions are divided on whether they should support or resist the change. Such a situation might delay the implementation of the program and cause 'frustration' to the hierarchy and health professionals.

> *...in relation to the drug problem, the government has said that needle exchange program could be established. There is no law about that, in fact the law which exists is opposite to that. The law states that people should not have implements on them. But the health developing [approach suggests] that reasonable incentive approach would reduce the risk of HIV. Well, at the community level they [community people] are getting two different views. There is that law [and] they have their own moral views about these things. The community has the democratic right to express its views about it. But of course I will work against it, and I will speak against it, and I will even take quite substantial risks to bypass it.* MT (Population Health AHS, University Academic)

I speculate that community participation can be achieved for programs such as integration, provided health care providers try to identify opportunities to develop population-based activities. The newly active community, having participated in population based-activities, might then be invited to participate in the planning of even curative services targeted at individual patients. The shared care programs did involve at least some group-based activities. An example of group-based activities occurred

[19] A number of community members, and some of their representatives in local government, opposed this program because for them it was an end of the pipeline treatment with a potential to increase the problem of drugs and violence in the area. They argued that the needle exchange causes an increased risk of needle-stick injuries to children playing in the parks, as needles are often thrown away after use rather than exchanged for new needles.

where specialists offered health education sessions to a group of people suffering form diabetes. The sessions dealt with health promotion strategies aimed at secondary prevention[20], and informing them about health services availability in the area. However, there were no suggestions that these sessions were utilised as means of involving the clients in defining health care objectives and in the design of shared care programs.

Even if the community is willing to participate and the conditions are right for participation, it is important to know health care providers, planners and community activists' perceptions about community apathy, and the reasons they provide for this 'apathy'. This perception in itself affects the way health care providers in the area see the role of the community. Health care providers and planners might think that the community would like to join only in activities which are of an overtly political nature.

Another factor, which was mentioned as causing difficulty in achieving community participation, is the multicultural nature of the community. The perception that some ethnic groups are wary of working closely with the governmental institutions was quite prevalent. This was based on the belief that ethnic groups, such as Vietnamese people, did not experience good relations with governmental institutions in their country of origin. There are also cultural barriers. For some ethnic groups, community

[20] Secondary prevention refers to the prevention of the consequences of a disease in terms of severity, flare-up, and complications. For example, effect of diabetes on other organs and systems (heart, eyes, blood vessels, skin, and kidney). Primary prevention in contrast is aimed at preventing a disease itself (e.g. vaccination for diseases such as whooping cough).

participation is an alien phenomenon[21]. Various ethnic groups, particularly those from Asia, have recently arrived and have not yet established themselves economically. They have fewer people of their ethnic origin in the health services as professionals or managers. These factors have been considered as limiting optimum community participation in the area.

An important factor determining the involvement of the community seems to be the length of time different ethnic groups have been living in Australia. Groups such as Greeks and Italians, which arrived many decades ago, have become established economically and have largely achieved social integration. They enjoy a better political status if not nationally then at least within the communities where they live[22]. Individuals from these groups are very much part of local professional and political institutions, in addition to being influential at the local government level. This strength in terms of socio-political assets leads to greater participation by these groups in local decision making. They are the ones who participate generally in addition to the Anglo-Saxon Australians. Within this context, the local services tend to cater to the specific needs of these more established groups.

The direct influence of the newly arrived groups on the local decision making is less than that of the other well established groups. However, their presence in the community does indirectly influence the health service set-up by influencing the need

[21] Ethnic groups such as Chinese, Pakistanis, Indians have more intense interactions with members of their ethnic groups rather than with people living in a particular geographical area (suburb). In the Sub-continent, for example, one's community is based on kinship, extended family and friends rather than on a geographical basis. This is true even for cosmopolitan cities such as Karachi.

[22] Martin JI. The migrant presence. Sydney: George Allen & Unwin, 1978.

for services and the need for different patterns of service delivery[23]. CHS in these areas often identify special needs of these groups and decide without reference to the hierarchy what services need to be provided. Once this has happened, the particular group may be approached and asked to support the project.

10.5 CONCLUSION

The local factors mentioned in this chapter were subtle but probably had a significant impact on the type of changes being pursued at the time of the research. One factor which came to fore with a force was the availability of some influential medical and public health professionals in the area. A few names were mentioned again and again by respondents as people who were at the centre of the programs to link the private with the public sector and to develop comprehensive programs for different health and social issues. It is difficult to estimate their contribution in quantitative terms, and it is difficult to speculate whether other people would have picked up the agendas these opinion leaders were pursuing. However, it is clear that this discussion of the local health care system would be incomplete without discussing the role of individuals within that system as well as their role for that system. Individuals do exist beyond the system as well and are able to influence it. It can be hypothesised that, despite the general systemic limitations and barriers in an area, the presence of motivated and influential people can put the system on a path to change. Local health care services and community members develop a confidence in such influential people's ability to

[23] The South Western Sydney Area Health Services' (SWSAHS) Public Health Department realises that one of the effects of social and economic disadvantage is the lack of confidence and skill in using the political process to achieve changes in living and working conditions
South Western Sydney Area Health Services (SWSAHS) Health Promotion Unit. Health Promotion in South Western Sydney 1990-1993: Review. SWSAHS, 1993.

lead, and look to them for opinions on the benefits or weaknesses of proposed programs.

To some extent, shared care programs were personality-dependent as well For example, concerned specialists in the Fairfield, Bankstown and Campbelltown sectors have taken relatively different approaches to diabetes shared care programs in their areas. The specialists enjoyed a high level of autonomy which placed them in a strong position to negotiate with their employer - the AHS. At the same time these specialists hold key positions within the AHS. For these reasons, specialists were in a position to plan shared care programs however they wished.

The patterns of utilisation of local health services are highly dependent upon local socio-economic indicators, and on the ethnic mix, as well as on the perceived quality and quantity of health services. The literature strongly indicates that, while lower socio-economic classes suffer from higher levels of morbidity, their utilisation of health services relative to need is lower than compared to that of more affluent sections. This inverse care is considered to be the result of fewer services being available, cultural accessibility issues, physical distance acting as a barrier, direct and indirect costs which the poor cannot afford, and the lack of information. In the Australian context, to interpret the utilisation of services and its links to the community characteristics we need to consider two issues. Firstly, universal insurance has by default made health care a right of every individual; therefore the issue of the direct cost to a patient is not so relevant in Australia. Secondly, despite the availability of private insurance, very few people from under-privileged areas such as SWS can afford to pay for this. The result is that the extra burden of the high prevalence of

diseases in these areas falls on public sector services. Within this context, whatever services are available are overburdened. Funding in direct proportion to proxy health indices is inequitable because people able to afford private health insurance reduce the public burden in affluent areas.

Changes intended to improve the quality and utilisation of services in such areas need to address whether there are specific problems leading to the under-utilisation of a particular service and whether there is a need for bilingual workers in the shared care programs. The issues which are important in this regard from the perspective of clients include whether health care services are perceived as helpful, or if there are problems with the cultural interpretation of the service being offered. The case study of integration attempts by the South Western Sydney Area Health Services alerts us to the effect of the nature of change, as perceived by the professionals, on the level of community involvement in the implementation. Professionals might perceive that initiatives such as shared care programs are too technical for community to participate. While a few professionals from the Area Health Services were actively motivating the community members to protest against the relative lack of funding, there was little emphasis on inviting community members to the shared care program planning and implementation.

Another message which comes out of this observation is that there is a tendency among local services (and their managers and professionals) to work ***with*** the community and develop local networks when their concern is to protest and negotiate with the hierarchy at the State level. Ironically, local services when interacting with each other tend to do so ***without*** the community, probably in a belief that the subject is

too technical and that they know what is in the best interest of the community. This makes it difficult for the community members to influence the policies proposed by the local Area-level hierarchy. The community's attention is either diverted to the overwhelming health and social problems such as crime, unemployment, drugs and lack of funding, or the community is used to influence the more central hierarchy.

Figure 10.1 summarises the role of local characteristics (personnel, health services, community characteristics) in influencing the development of a local health system. The figure is also an attempt to present a view on the process by which local characteristics influence health system development (HSD).

Figure 10.1: Link between community characteristics and HSD

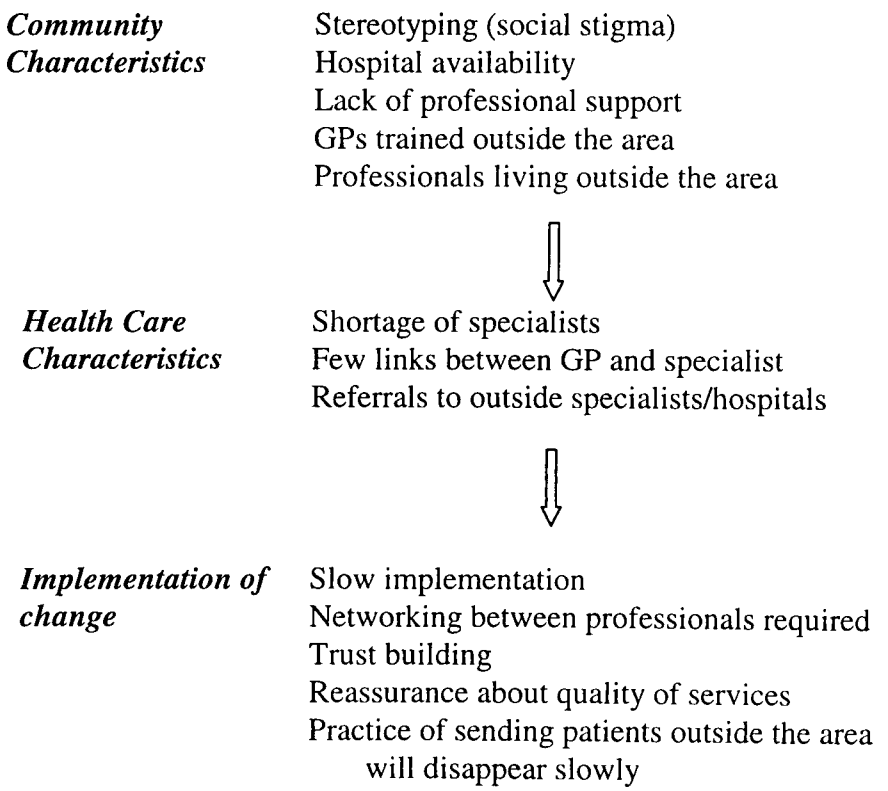


Figure 10.1 points our attention to the role of community-specific issues such as that an historical lack of close working relationships between local GPs and local hospitals make the development of shared care programs a difficult process. This figure shows that community's socio-political characteristics determine, to some extent, the nature and extent of service provision in that area. Community characteristics and the nature of health services in that area in turn influence the implementation of changes such as shared care programs. For example, because of the social stigma attached to areas such as Liverpool and Campbelltown these areas have the shortage of health care specialists. Local general practitioners (GP) have affiliations with specialists at inner Sydney hospitals. The major objective of shared care programs in these areas then is to link GPs with local specialists and hospitals. In contrast to this, in a community where GPs have confidence in the quality of care available at the local hospital, and where local GPs have historical professional links with local specialists, shared care programs will probably be implemented more effectively and with little effort. Furthermore, in that community the shared care programs will probably have a focus on 'effective and appropriate services' rather than on 'preventing out-referrals'.

CHAPTER 11

Promoting the Community Perspective in Policy Development

11.1 SUMMARY

On reflection I recognise that my account may appear, at times, to be only lightly grounded. I think it a legitimate defence to point out that it was a major accomplishment for an 'outsider', such as I was, to achieve the level of access to the communities (especially in Adelaide) where I did my research. Secondly, my experience as a project administrator in Karachi and my expectation that I will return to an administrative role have led me to keep that 'second-eye' open, even as I went about the detail of field work. That is, I tried to understand the impact of local dynamics on day-to-day administration of health care services with regard to the principles of primary health care. For completeness, I would like to have done extended interviews among the administration cadres of the South Australian Health Commission, who were attempting to attain cost containment via amalgamation. In the increasingly turbulent environment which developed in the SAHC during the time of my research, that would have been very difficult to achieve.

Although the case studies from Adelaide and Sydney as well the narrative on my experience in Karachi cannot be generalised to all situations, they do provide important insight into the working of local health systems. While working for health improvement in several communities in Karachi District South, I often felt tied down by the overall provincial and national context of health care provision in Pakistan. The planning models available to me did not sufficiently explained what was happening in the community. For me it was important to know how to utilise community-level political and professional resources to develop better health services. Similarly, I considered it essential that I understand processes which help reduce the effect of

national-level economic and political constraints on community health. Case studies from Adelaide and Sydney provided avenues to understand these phenomena.

Changes in service organisation are a constant phenomenon. If they are not to be destructive, it is important that various stakeholders understand and accommodate each other's point of view. Perhaps the best evidence of the point of view of stakeholders is reflected in their formal and informal objectives. A smooth change towards a better health system requires that objectives be made clear at the very beginning. For a democratic political process that aims at achieving community participation, it is important that the different stakeholders are able to communicate to each other their objectives. If the hierarchy does not understand the local situation and fails to communicate its objectives, this leads to negative perceptions about the outcomes of the change. Changes in administration and organisation are often seen as efforts by the bureaux to turn political decision making into rational administration[1]. My respondents seemed to believe that the South Australian Health Commission's policy of amalgamation was an example of this process, in that it is a technocratic solution serving a quest for economic efficiency[2]. Such an interpretation implies an inherent conflict in the system including a consequent risk that policy decisions, tending to corporate rationalism, will fail to address the complex social and political dimensions which surround community health services (CHS). These social and political dimensions may require a health care delivery pattern in which cost-effectiveness is

[1] Muller HJ. Public Health in a retrenchment era. State University of New York Press: Albany 1985.

[2] It seemed that for the amalgamation of the community health services the main objective of the South Australian Health Commission was cost-saving by reducing the number of mid-level managers. However, there was an effort on part of the Health Commission to claim that the amalgamation will lead to pooling of resources making CHS more effective.

subordinated to accessibility and appropriateness within the context of local networks and need.

The prevailing discourse of "shortage of funding" leads to community expectations about job cuts, which in turn are linked to service cuts. Community resistance to the process is often the result of this apprehension, because organisational changes are often perceived as a means of cutting services. Moved by that perception, the community and its structures then offer political resistance to the proposed change.

While the day-to-day activities of community-level health and social services do entail political decision-making involving a range of community groups, this political process increases during changes. The political nature of change in the local health and social sector is undeniable despite recent efforts by health bureaucracies to displace the political with seemingly rational arguments about health care system development.

The degree to which health system development is politicised depends very much on the level of community participation. Compared to the situation in Karachi, health system development in Australia is a much more overtly political process with regard to community participation and the interaction between various local organisations – people who are not in the dominant roles still have ways of getting their interests on to the agenda. In Karachi, the PHC district health system development was political but the actors came mainly from the government departments, hence the power and influence of the community was relatively small. In other words, it could be said that

the process in Karachi is political but one-sided. A dominant hierarchy suppresses low community-level political action.

This is not to say that the situation with regard to community participation is ideal in Australia. The reasons for less than optimum community participation are varied. One is that governments believe that the decision-making institutions are already democratic and community needs are represented[3]. Implicit in what my respondents were saying was that they seem to believe that hierarchy and government assume that they represent communities' interests. Within this context, often community consultation is erroneously considered as equivalent to community participation. The difference is that consultation aims at finding community acceptance of a government policy, while community participation seeks to actively involve local people in decision making.

An important factor affecting participation is the perceived technical nature of the proposed change. Under this perception, professionals and organisations may not bother to consider incorporating the community perspective into the change process. Changes such as the integration of general practice with the area health services are considered to be technical issues. For example, the issue of "developing a diabetic care model that decreases the need for patients stay in hospital" is likely to be considered a technical issue on which the community cannot provide valid input. But the community may well have preferences for the type of services they receive at home. Additionally, the community may well have a lot to contribute towards making service

[3] Rathwell T. Realities of Health for All by the year 2000. Soc Sci Med 1992; 35:541-547.

delivery by the general practitioners more appropriate and sensitive to needs in terms of time and place and cultural values.

It is widely understood that organisational change is required in the light of the rapidly changing environment within which corporate businesses now have to work. Dunphy – a well-publicised Australian professor of business management – and Stace propose a situational model for the management of change in the business sector in Australia. They argue that there are four types of change process, namely collaborative, consultative, directive and coercive. They conclude that there has been very little collaborative change development and the changes which have occurred usually happened through directive and to some extent consultative processes[4]. My research has assembled evidence that, unfortunately, not only are the reasons given for change in the business sector applied in the social sector, but also the same strategies for change.

Because the CHS work closely with many community groups, and because the amalgamation was viewed as leading to service cuts and ideology change, the amalgamation process invoked more participation and interaction. The stronger the links between community health services and the community, the greater the chance that the community will be able to negotiate the proposed changes with the hierarchy.

In addition to the nature of the change itself and to the degree of community participation, there are other factors which influence the implementation of changes,

[4] Dunphy D, Stace D. Under new management: Australian organisations in transition. Sydney: McGraw-Hill Book Company, 1990.

including the nature of the interaction with the other organisations and groups in the community; the organisational ideologies; and some health personnel characteristics. The level of inter-dependence among various community services and availability of some influential professionals or community members are other factors which determine how a proposed change will be approached by the locals.

In summarising the political process at the local level I have learned that:

1. Because of the intense day-to-day intense interaction with community individuals and community groups, the CHS turns into a major vehicle for community participation. For this reason, it is important that this potential of the CHS is utilised by other health care services and health care providers. For example, the recent efforts to link general practice with CHS have the potential to bring the community perspective into general medical practice.

2. Achieving optimum community participation in the management and organisation of health care services is a difficult enterprise. No single actor can unilaterally make it happen. Other factors, such as the ethnic mix and the economic status of the community also determine the level of participation. A health service in an ethnically and politically cohesive community may achieve more participation compared to a health service serving an area which has a high ethnic mix and a disadvantaged economic status.

3. In addition to community cohesion and socio-economic disadvantage, another community characteristic which influences health system development is the

prevalence of certain social problems such as a high crime rate, higher rates of use of recreational drugs, and high rates of unemployment. In such areas, the energies of the locals are spent to find solutions to these social problems. Such a situation has the potential to undermine community cohesion as at times these problems create a rift between the locals, particularly if they do not agree on the best approach to curb these problems.

4. A few people serve as proxy for the whole community as far as representation of the community for the day-to-day health services activities is concerned. These few people are often well connected to different sections of the community and can generate a great deal of interest in an issue amongst a large number of people – if and when the CHS wants the larger community to participate. While it is true that relatively few community members are involved in the decision making of a particular organisation, these members interact with various community individuals and groups. At the same time, community-based organisations have their own inter-organisational relations. The overall effect is a mesh of networking which gives CHS a culture of consultation and collaboration.

5. These community members are often approached by the local professionals or by the local management to initiate community action against or in favour of change. Funding inadequacy in particular concerns the community. However, there is a danger that the community will vent its anger in protest walks and see these actions as participation in the working of the health services. Day-to-day decision making

is then often left to the professionals and with the mid-level to senior-level managers.

6. Quite extensive horizontal linkages, which connect CHS with various local organisations, professional and voluntary community groups, are used to lobby against changes proposed by the hierarchy. Changes are resisted particularly if those changes are perceived by the locals as adversely affecting the interests of street-level workers, the local need-provision balance, and the mode of service delivery in the community. In this fashion, the horizontal linkages influence the vertical link between community-based health services and their respective hierarchy.

7. Mid-level management appears to be able to influence change by using their local networks and by claiming to have better understanding of 'locally-specific needs in terms of health and health services'. Through this approach mid-level managers achieve somewhat better power relations with their hierarchy. This leads to a situation where hierarchy concedes some amendments in the proposed change.

8. Several changes are being introduced at any given time. My research helped me understand that there are always more than a few policy agendas pursued by the hierarchy at a given time. The community and the local services may give only partial attention to a particular policy amidst a number of others. It has been argued that the attention span of the general public and the media is often episodic and that

this may weaken political support for a particular action or development[5]. In the light of my observations, I believe that it is important for the locals to keep an eye on this phenomenon and direct their energies to an issue which yields the most appropriate services compatible with local health care needs.

9. A few influential health professionals and academics are able to play an important part in influencing local health system development. Examples of this phenomenon are present in all three sites – Karachi, Adelaide and Sydney. In Karachi, an influential doctor, who had personal and family links with high ranking government officials, was able to accelerate the pace of change in at least making her centre more comprehensive and in developing working relationships with the other health care providers in the area. In the Western suburbs of the Adelaide metropolitan area, the resistance offered to the amalgamation could be attributed mainly to a group of professionals, and a few community members, who believed that the amalgamation would undermine the principle of community participation. In Sydney, a motivated general medical practitioner, willing to work closely with the community groups, CHS and hospitals, was behind the local Division of General Practice being more active in developing such links compared to an adjacent division. It is important that the community members and the street-level health workers identify this resource and utilise the political and professional influence of such people for community development.

[5] Downs A. Up and down with ecology – the issue attention cycle. Public Interest. 1972; 38-50.

11.2 RECOMMENDATIONS

In introducing a change, policy development needs to consider the ideological base of service provision in the target area. It is also necessary to consider the role of those institutions that are not the target of the planned change, but which are to be affected by it. In addition, local conflicts need to be assessed in terms of their influence on the health system development in that area. For example, considering the antagonism between the Karachi Metropolitan Corporation (KMC) and the Sindh Provincial Government health services, it would have been better to include some community members, in addition to the health managers, in the District Health Management Team for Karachi District South under the Family Health Project. In retrospect, I think there was a need to de-emphasise the role of professionals and managers (all health managers were doctors) at the very beginning of the process of re-orienting health services towards primary health care. The fact that we were trying to make a team consisting of doctors and managers only reinforced the power struggle between KMC health officials and provincial health authorities as both parties claimed to have the 'knowledge and methodology' to improve the health status of Karachiites.

The discussion of the health system development in the two Australian research sites helped in formulating a few recommendations which could be offered to the locals (community members and the street-level health care staff), to the hierarchy, and to the academics who will work with the community health services.

Locals:

1. While the community and staff understand their own situation better than any outsider, they do, however, need to periodically take stock of the overall situation in terms of community cohesion, the level of representation of the community, and the reasons for lack of political strength. There is a need to identify and make explicit which sections of the population are least represented on health and social service platforms. Similarly, it is important to identify which services the community feel comfortable to work with and the reasons for that.

2. The day-to-day working and long term planning of changes depend, in community settings, on the existing networks and interactions. While locals understand the importance of these linkages through experiential learning, to make full use of these networks for collaborative work and to contribute towards policy development, it is advisable that the local health managers have a sound understanding of the main theories of inter-organisational relationships.

3. Organisational planning, service provision, and collaboration could be improved if services within a health district measure the level of inter-dependence. This measurement should consider informal interactions as well.

4. For effective service provision and for strengthening the local decision making capacity, there is a need to map out the local resources. These resources might include community activists/volunteers and their expertise, the interests and

capabilities of various community groups, and health care staff who have extensive experience of working within a particular community.

5. Differences of opinion on how to approach a health problem, or whether to accept a change as proposed by the hierarchy, do exist between members from the same community. There is a need to recognise and appreciate these differences because they do not necessarily undermine the political strength of the community. Rather, these differences could be utilised to initiate a democratic decision-making process where community members start feeling comfortable with their role as a political organism. This is more important for communities in Karachi, where people feel helpless as they receive a persistent message that 'politics' and 'decision making' is something which is done at the parliament-level only.

Hierarchy:

1. There is a need to better understand, and accept, the political role of street-level workers. "Proposing" a change should mean to propose it and not to enforce or impose. If some locals do not like it, they should be given opportunities to implement an amended version or abandon it altogether. This is the first step towards better community participation. Community consultation strategies which attempt to bypass the local health services and create confusion in the community decrease the potential of local workers and community people to work together. Local staff should be considered vital to local health system development. They are the ones who are in contact with the consumers and communities and can help the hierarchy achieve better-planned services. To do so, it is necessary that the

proposed changes clearly distinguish between the goals of economic rationalism and achieving health equality. Efficiency and effectiveness are two fundamentally different issues and need to be addressed separately.

2. It is of the utmost importance to identify and appreciate the context within which a change is to be proposed and within which it will be perceived by the community. The same plan proposed to an area where there is chronic lack of funding and to an area which is enjoying appropriate funding is going to be perceived differently. Even if the proposed change has the potential to deliver effective services, a negative perception that the change is about service cuts will make the implementation a painful process and may affect the future utilisation of services negatively.

Academics:

1. There are many research questions raised by this discussion of local health systems. Academics may support the local system in mapping out the existing resources, the extent of formal and informal networks, and the reasons for and the level of inter-dependency at the local level. Similarly, they can support locals and the hierarchy in finding out the community resources in terms of individuals, groups, interactions and political strengths. Academics can support the community efforts to identify mechanisms to exploit these resources in reducing the gap between need and provision. The following issues can be pursued through community-based research:

i. Identification of networks and level of interdependency.

ii. Local definitions of culturally-specific and appropriate service.

iii. Availability of health care staff and their impact on service provision.

iv. Community configuration and the level of representation of various groups.

v. Potential for other health services to use the links the CHS have with the community.

vi. Need-provision imbalance and the socio-political reasons for such imbalance.

vii. Processes for turning episodic participation into a continuous relationship between community and health services.

Referring once again to my involvement with the Family Health Project in Karachi during 1993 and 1994, I must confess that as administrators and as academics none of us had a full comprehension of the issues I mentioned in the preceding paragraph as research recommendations for academics. Because of the University presence in those communities since mid-1980s to develop primary health care programs, we had some vague ideas about the community dynamics. However, socio-economic, political and organisational issues, which I have tried to highlight in this thesis, never became the focus of inquiry. Because of this lack of understanding on our part to clearly identify how community dynamics affect health services development, we took a managerialist approach to reorient the health services. On my return to Karachi, I will try to understand the community dynamics in the light of the above questions to which my research in Australia has pointed. These are the questions, the answers to which I

believe will lead to better health services, community empowerment, and better health status for the people of Karachi, and Pakistan.

In the end, on the issue of participation, I recall a page from my father's diary. When he finished his studies and was to return home from Karachi University, one of his friends wrote a couplet by an unknown sub-continent poet on that page of his diary. It translates: "you can have the whole universe supporting you through thick and thin and through troughs and crests provided you embark on the journey not to leave people behind but to be with them".

Bibliography

Adelaide Central Community Health Service(ACCHS), Process Coordination Group (PCG). Minutes of the meeting, 23 May 1995.

Adelaide Central Community Health Service. Process Coordination Group Paper #1. Job Security: Directors' responses to workers' issues. 1995.

Adelaide Central Community Health Service. The Development of the Adelaide Central Community Health Service. 1996.

Aiken M, Hage J. Organisational interdependence and intra-organisational structure. In Brinkerhoff MB, Kunz PR, editors. Complex organisations and their environments. Dubuque, Iowa: WMC Brown Company Publishers, 1972.

Alexander K. Promoting health at the local level: a management and planning model for PHC services. PhD Thesis. University of Adelaide, 1994.

Alexander K. Public health professionals; they can not do it alone. In Brown VA, Preston G (editors) Choice and Change: ethics, politics and economics of public health. Selected papers from the Public Health Association of Australia 24th Annual Conference. Public Health Association of Australia, 1992.

Alford RR. Health care politics: ideological and interest group barriers to reform. Chicago: The University of Chicago Press, 1975.

Anspach RR. Field research and the sociology of (sociological) knowledge. In Anspach RR. Deciding who lives: fateful choices in the Intensive-care Nursery. Berkeley: University of California Press, 1993.

Argy F. The balance between equity and efficiency in Australian public policy. Public Policy Program, The Australian National University, Canberra, 1996.

Barrett B. Integrated local health systems in Central America. Soc Sci Med 1996; 43: 71-82.

Barrett S, Fudge C, editors. Policy and action: essays on the implementation of public policy. London: Methuen, 1981.

Bates E. Health System and public scrutiny: Australia, Britain, and USA. Croom Helm UK, 1983.

Baum F, Cooke R. Healthy Cities Australia: the evaluation of the pilot project in Noarlunga, South Australia. Health Promotion International; 1992; 7:181-193.

Bell D. The cultural contradictions of Capitalism. New York: Basic Books, 1976.

Berman P. The study of macro and micro-implementation. Public Policy. 1978; 26:172-79.

Billing M. Political ideology. In Nicholson J, Beloff H, editors.. Psychology Survey 5: The British Psychological Society, 1984.

Blau PM. On the nature of organisations. New York: John Wiley & Sons, 1974.

Botsman P. Not yet dead, not yet born: the state of the Australian health system. In Sheil C, editor. Turning point: the state of Australia and New Zealand. Sydney: The Evatt Foundation, 1997.

Bogdan R, Taylor SJ. Introduction to qualitative research methods: a phenomenological approach to the social sciences. New York: John Wiley & Sons, 1975.

Bonacich E. A theory of middleman minorities. American Sociological Review. 1973; 38:583-594.

Bossert TJ, Parker DA. The political and administrative context of primary health care in the Third World. Soc Sci Med 1984; 18: 693-702.

Bottomore T. Political Sociology. London: Hutchinson, 1979.

Bozeman B, Reed PN, Scott P. Red Tape and Task Delays in Public and Private Organisations. Administration and Society 1992; 24:290-322.

Bracht N, Tsouros A. Principles and strategies of effective community participation. Health Promotion International. 1990; 5:199-208.

Brown LD. Knowledge and Power: HSR as a political resource. In Ginzberg E, editor. Health Services Research: key to health policy. A report from the Foundation for HSR. Harvard University Press: Cambridge Massachusetts, 1991.

Bryson L, Mowbray M. Community, the spray-on solution. Australian Journal of Social Issues 1981; 16: 255-267.

Buckho AA. Barriers to strategic transformation: Interorganisational networks and institutional forces. In Shrivastava P, Huff A, Dutton J, editors. Interorganisational relations and interorganisational strategies. Advances in strategic management series. Greeenwich Connecticut: JAI Press Inc, .

Campbelltown and Camden/Wollondilly Health Services. Macarthur Needs Analysis 1996.

Carr-Hill RA. Efficiency and equity implications of the health care reforms. Soc Sci Med 1994; 39:1189-201.

Central Health Services Planning Unit, SAHC, Booklet 1. 1995.

Central Health Services Planning Unit, SAHC. A guide to the South Australian Health Commission and its Area Planning Units. Booklet 1. 1995.

Centre for General Practice Integration Studies (CGPIS). General Practice Integration: Literature Review. CGPIS. School of Community Medicine, University of New South Wales. 1996.

Centre for General Practice Integration Studies (CGPIS). Integration Projects 1993-94: Report. CGPIS. School of Community Medicine, University of New South Wales. 1996.

Collin C, Green A. Decentralisation and primary health care: Some negative implications in developing countries. International Journal of Health Services 1994; 24: 459-475.

Collins R. A comparative approach to political sociology. In Bendix R et al, editors. State and society: A reader in comparative political sociology. Boston: Little, Brown & Co. 1968.

Considine M. Policy: managed or expert. In Gardner H, editor. Health policy: development, implementation and evaluation in Australia. Churchill Livingstone: Melbourne, 1992.

Considine M. Public policy: a critical approach. Melbourne: McMillan Education Australia, 1994.

Cooksey JA, and RM, Krieg. Metropolitan health policy development: barriers to implementation. Journal of Public Health Policy. 1996; 17: 261-274.

Crichton A. A critical analysis of recent Canadian health policy: Models for community-based services International Journal of Health Planning and Management 1993; 8:295-314.

Dale Street Women Health Centre. Annual Report 1994-95, Dale Street Women's Health Centre, 1995.

Deber RB, Hastings JE, Thompson GG. Health care in Canada: current trends and issues. J Public Health Policy. 1991; 12:72-82.

Delaney FG. Muddling through the middle ground: theoretical concerns in intersectoral collaboration and health promotion. Health Promotion International 1994: 9: 217-225.

Department of General Practice. Fairfield Hospital. Survey of South West Sydney general practitioners opinions of hospital services. 1996. Department of General Practice, Fairfield Hospital, SWSAHS.

Dey I. Qualitative data analysis: a user friendly guide for social scientists. London/New York: Routledge, 1993.

Downs A. Up and down with ecology – the issue attention cycle. Public Interest. 1972; 38-50.

Duckett S. Structural interests and Australian health policy. Soc Sci Med 1984; 18: 959-966.

Dunleavy P, O'Leary B. Theories of the state: the politics of liberal democracy. London: Macmillan, 1987.

Dunphy D, Stace D. Under new management: Australian organisations in transition. Sydney: McGraw-Hill Book Company, 1990.

Eager K. Managing community health from within an area health service. In Baum F, Fry D, Lennie I, editors. Community Health: policy and practice in Australia. Sydney: Pluto Press, 1992.

Elling RH. Cross-national study of health systems: political economies and health care. New Brunswick, NJ: Transaction Books, 1980.

Elmore RF. Backward mapping: implementation research and policy decisions. Political Science Quarterly 1979; 94: 601-616.

Enthoven AC. What can European learn from Americans? In Health Care Systems in Transition: the search for efficiency. OECD Social Policy Studies #7. OECD, 1990.

Etzioni A. A comparative analysis of complex organisations. New York: Free Press, 1961.

Everett H. The theory of the universal wave function. In DeWitt BS, Graham N, editor. The many-worlds interpretation of quantum mechanics. Princeton, NJ: Princeton University Press, 1973.

Flynn R, Pickard S, Williams G. Contracts and the quasi-market in community health services. Journal of Social Policy 1995; 24:529-550.

Freudenberg N, Golub M. Health education, public policy and disease prevention: a case history of the New York City coalition to end lead poisoning. Health Education Quarterly. 1978; 14:387-401.

Friedson E. Profession of medicine. New York: Dodd/Mead, 1970.

Frost P, Moore L, Louise M. Organisation culture. Beverly Hills: Sage Publications, 1985.

Fry D. Quality assurance and community health services. In Baum F, Fry D, Lennie I, editors. Community health: policy and practice in Australia. Pluto Press: NSW, 1992.

Gale L. Why a traditional health outcome approach will fail in health care. Australian College of Health Services Executives National Congress, 1997.

Gardner H, editor. Health Policy: development, implementation, and evaluation in Australia. Melbourne: Churchill Livingstone, 1992.

Gardner H, editor. The politics of health: the Australian experience. Melbourne: Churchill Livingstone, 1989.

Gifford S. Qualitative research: the soft option? Health Promotion Journal of Australia. 1996; 6: 58-61.

Glaser BG, Strauss AL. The discovery of grounded theory. Chicago: Aldine, 1967.

Glover J, Woollacott T. A social health atlas of Australia. (Catalogue No. 4385.0) Canberra: Australian Bureau of Statistics, 1992.

Goodin RE, Pettit P, editors. A Companion to contemporary political philosophy. Blackwell, 1993.

Goodin RE. Political theory and public policy. Chicago: Chicago University Press, 1982.

Gray N. Forty years of public health. Division of Epidemiology and Biostatistics, European Institute of Oncology: Milan, 1997.

Gregory R. Political rationality or 'incrementalism'? Charles E. Lindblom's enduring contribution to public policy making theory. Policy and Politics. 1989, 17:139-153.

Gross PF. Consumer participation in community health services: lessons from overseas. Australian Journal of Social Issues. 1975; 10:1.

Hakansson H, editor. Industrial technological development: a network approach. London: Croom Helm, 1987.

Ham C, Hill M. The policy process in the modern capitalist state. Sussex: Harvester Press, 1984.

Ham C. Health policy in Britain. London: McMillan, 1985.

Handy (1985) defines the task culture as a model which uses a common cause as a thread to develop a team. Handy C. The Gods of Management. London: Souvenir Press, 1985.

Harmon MM. Action theory of public administration. New York: Longman, 1981.

Harrison S. Working the market: purchaser/provider separation in English health care. Int. J. Hlth Services. 1991; 21:625-635.

Hawe P. Needs assessment must become more change-focused. Australia and New Zealand Journal of Public Health. 1996; 20:473-478.

Herriot RE, Firestone WA. Multi-site qualitative policy research: optimising description and generalisability. Educational Researcher 1963; 12:14-19.

Hicks N. Cure and prevention. In Curthoys A. Martin A. Rowse T, editors. Australians from 1939. Sydney: Fairfax, Syme and Weldon, 1987.

Hicks N. Economism, managerialism and health care. Annual Review of Social Science. Health Policy. 1995; 5:39-60.

Hicks N. The "community" in community health. In Potter J, Hodgson A. (editors) Working Papers in Community Health. Adelaide: ANZsearch/APHA, 1982.

Hogg MA, Abrams D. Social Identifications: A social psychology of inter-group relations and group processes. London, New York: Routledge, 1988.

Hogwood B, Gunn L. Policy analysis for the real world. Oxford: Oxford University Press, 1984.

Hospitals and Health Services Commission. Report on a community health program for Australia. Canberra: Australian Government Publishing Services, 1973.

Howe A. Participation in policy making: the case of aged care. In Gardner H, editor. Health policy development, implementation and evaluation in Australia. Melbourne: Churchill Livingstone, 1992.

Hughes C. From fieldnotes to dissertation: analysing the stepfamily. In Bryman A, Burgess R. (editors) Analysing qualitative data. Routledge: London, 1994.

Hunt S. Building alliances: professional and political issues on community participation -- Examples from a health and development project. Health Promotion International 1990; 5: 179-185.

Hunter DJ. Managing the cracks: management development for health care interfaces. Int J Health Planning and Management. 1990; 5:7-14.

Hurley J, Birch S, Eyles J. 1995, Geographically decentralised planning and management in health care: some informational issues and their implication for efficiency. Soc Sci Med 1995; 41:3-11.

Jackson K. Some fallacies in community education and their consequences in working class areas. In Fletcher C, Thompson N, editors. Issues in community education. Farmer Press; Barcombe, 1980. (quoted by Piette D. Community participation in formal decision-making. Health Promotion International. 1990; 5:187-197.

Jones M, Moore M, Snyder R. Inside organisations: understanding the human dimensions. Beverly Hills: Sage Publications, 1988.

Jones MA. Local government and the people: challenges for the eighties. Melbourne: Hargreen Publishing Company, 1981.

Kaluzny AD, Warner DM, and, Zelman WN. "Designing effective organisations," in Kaluzny AD, Warner DM, and WN, Zelman, editors. Management of Health Services. Englewood Cliffs NJ: Prentice Hall, 1982.

Kaplan A. The conduct of inquiry. San Francisco: Chandler Company Press, 1969.

Kaprio LA. Primary health care in Europe. Euro Report and Studies No. 14. 1979.

Katz D, Kahn RL. Organisation and the system concept. In Brinkerhoff MB, Kunz PR, editors. Complex organisations and their environments. Dubuque, Iowa: WMC Brown Company Publishers, 1972.

Keat R, Urry J. Social theory as science. London: Routledge & Kegan Paul, 1982.

Keen J, Packwood T. Case study evaluation. BMJ. 1995; 311:444-446.

Kimberly JR, Zajac EJ. Strategic adaptations in health care organisations: Implication for theory and research. Medical Care Review. 1985; 42:267-302.

Kinnunen J. The importance of organisational culture on development activities in a primary health care organisation. Int. Journal of Health Planning and Management 1990; 5:65-71.

Kouzes JM. Mico PR. Domain theory: an introduction to organisational behaviour in the human service organisation. Journal of Applied Behavioural Sciences. 1979; 15:449-69.

Krupp S. Pattern in organisational analysis: A critical examination. Philadelphia: Chilton, 1961. and Gouldner AW. Reciprocity and autonomy in functional theory. In Demerath NJ, Peterson RA, editors. System, change and conflict: a reader on contemporary sociological theory and the debate over functionalism. New York: Free Press, 1967.

Lane M. The history of community work in NSW. In Lane M, Lee G, editors. Community work: Current issues; future directions. Sydney: University of Sydney, 1987.

Laris P. Boards of directors of community health services. In Baum F, editor. Health for All: the South Australian experience. Adelaide: Wakefield Press, 1995.

Laumann EO. Galaskiewicz J, Marsden PV. Community structures as inter-organisational linkages. Annual Review of Sociology 1978; 4:455-484.

Lawson JS. Decentralising health services in Australia. World Health Forum 1991; 12:96-98.

Leichter HM. A comparative approach to policy analysis: health care policies in four nations. Cambridge, London: Cambridge University Press, 1979.

Lerberghe WV, Pangu K. Comprehensive can be effective: the influence of coverage with a health centre network on the hospitalisation patterns in the rural area of Kasongo, Zaire. Soc Sci Med 1988; 26:949-955.

Lester JP, Bowman AO'M, Goggin ML, O'Toole LJ Jr. Public policy implementation: evolution of the field and agenda for future research. Policy Studies Review 1987; 7: 200-216.

Lindblom C. The science of muddling through. Public Administrative Review 1959; 19: 79-88.

Lindblom C. Still muddling, not yet through. Public Administrative Review 1979; 39: 517-526.

Lipsky M. Street-level bureaucracy: dilemmas of individual in public service. Sage, 1983.

Lowi TJ. Four systems of policy, politics and choice. Public Administration Review 1972; 32:298-310.

Macarthur Planning Committee. Campbelltown & Camden/Wollondilly Health Services. Macarthur Needs Assessment. 1996.

Majone G, Wildavsky AB. Implementation as evaluation. Policy Studies Journal 1978; 2: 103-117.

Marshal C, Rossman GB. Designing qualitative research. Newbury Park CA: Sage Publications, 1989.

Martin JI. The migrant presence. Sydney: George Allen & Unwin, 1978.

McArthur AA. Community Partnership - A formula for neighbourhood regeneration in the 1990s? Community Development Journal. 1993, 28:305-315.

Mcleroy KR, Bibeau D, Steckler A, Glanz K. An ecological perspective of health promotion programs. Health Education Quarterly. 1988; 15:351-377.

McPherson PD. Health for All Australians. In Gardner H, editor. Health policy development, implementation and evaluation in Australia. Melbourne: Churchill Livingstone, 1992.

Michels R. Political parties: A sociological study of oligarchical tendencies of modern democracy. New York: Collier, 1962.

Milio N. Keeping the promises of community health policy: Revival under Hawke 1983-85. In Baum F, Fry D, Lennie I, editors. Community health: Policy and practice in Australia. Sydney: Pluto Press, 1992.

Milio N. Making healthy public policy: developing science by learning the art: an ecological framework for policy studies. Health Promotion. 1988; 2: 263-274.

Milio N. Making policy: a mosaic of Australian community health policy development. Commonwealth Depart of Community Services & Health, Canberra, 1988.

Milio N. Next steps in community health policy: matching rhetoric and reality. Community Health Studies. 1983; VII: 185-192.

Morgan G. Images of organisation. Beverly Hills: Sage, 1990.

Moss F, McNicole M. Secondary care beyond Tomlinson: An opportunity to be seized or squandered. BMJ 1992; 305:1211-1214.

Moss JR, McMichael AJ. Inequalities in health: the epidemiological evidence – and the gaps. In McNeil J, King R, Jennings G, Powles J, editors. A textbook of preventive medicine. Melbourne: Edward Arnold, 1990.

Muller HJ. Public health in a retrenchment era. State University of New York Press: Albany, 1985.

Nadel SF. The theory of social structure. Glencoe: Free Press, 1957.

Najman MJ, Western SJ. A comparative analysis of Australian health policy in the 1970s. Soc Sci Med 1984; 11: 949-958.

Neuberger J. Community health services. BMJ. 1992; 305:1486-8.

New South Wales Government. Area Health Services Act 1986 No. 50. Reprint 1993.

NSW Health. Caring for equity, efficiency and quality, The NSW Government's Economic Statement for Health. Sydney: NSW Health, 1995.

OECD. Health care systems in transition: the search for efficiency. Social Policy Studies No.7.OECD Paris, 1990.

Orum AM. Introduction to political sociology: the social anatomy of the body politic. Englewood Cliffs NJ: Prentice Hall, 1989.

Owen A, Lennie I. Health for all and community health. In Baum F, Fry D, Lennie I, editors. Community Health: policy and practice in Australia. Sydney: Pluto Press, 1992.

Palmer GR, Short SD. Health care and public policy: An Australian analysis. Melbourne: Macmillan, 1989.

Peterson MA. Political influence in the 1990s: from iron triangles to policy networks. J Health Polit Policy Law. 1993; 18: 395-438.

Patton MQ. Qualitative evaluation and research methods. Newbury Park, CA: Sage, 1990.

Peter V, Wester F. Qualitative analysis in practice. Department of Research Methodology, Social Science Faculty. Netherlands: University of Nijmegen, 1990.

Polanyi K. The self-regulating market. In Argyrous G, Stillwell F, editors. Economics as a social system: readings in political economy. Annandale NSW: Pluto Press, 1996.

Pope C, Mays N. Reaching the parts other methods cannot reach: an introduction to qualitative research methods and health and health services research. BMJ. 1995; 311:42-45.

Pressman JL, Wildavsky A. Implementation. Berkeley, University of California Press, 1973.

Pusey M. Economic rationalism in Canberra. A nation-building state changes its mind. Cambridge: Cambridge University Press, 1991.

Pusey M. The impact of economic ideas on policies in Australia. In Argyrous G, Stilwell F, editors. Economics as a social system. Annandale NSW: Pluto Press, 1996.

Quinn JB. The strategy process: concepts , context and cases. Englewood Cliffs: Prentice Hall, 1988.

Raftery J. Health policy development in the 1980s and 1990s. In: Baum F, editor. Health for All: the South Australian experience. Adelaide: Wakefield Press, 1995.

Raftery J. The social and historical context. In: Baum F, editor. Health for all: the South Australian experience. Adelaide: Wakefield Press, 1995.

Rathwell T. Realities of Health for All by the year 2000. Soc Sci Med 1992; 35:541-547.

Rifkin SB, Walt G. Why health improves: defining the issues concerning comprehensive primary health care and selective primary health care. Soc Sci Med 1986; 23:559-566.

Roemer M. Systems of health care. New York: Springer Publishing, 1977.

Rosengren WR. Structure, policy and style: strategies of organisational control. In Brinkerhoff MB, Kunz PR, editors. Complex organisations and their environments. Dubuque, Iowa: WMC Brown Company Publishers, 1972.

Sabatier P, Mazmanian D. The conditions of effective implementation: a guide to accomplishing policy objectives. Policy Analysis 1979; 5: 481-504.

Saltman RB, Van Otter C. Public competition versus mixed markets: an analytic comparison. Hlth Policy 1989; 11:43-55.

Sanders W. The politics of daily life in Australian income security administration. Politics. 1985; 20:36-47.

Sardell A. Neighborhood health centres and community-based care: Federal policy from 1965 to 1982. Journal of Public Health Policy. 1983; 4: 484-503.

Saunders P. Towards a balanced vision: the role of social goals, social policies and social benchmarks. Social Policy Research Centre Report and Proceedings No. 116. Sydney: The University of New South Wales, 1994.

Sax S. Organisation and delivery of health care. In Gardner H, editor. The politics of health: the Australian experience. Melbourne: Churchill Livingstone, 1989.

Schatzman L, Strauss A. Field research: strategies for a natural sociology. Englewood Cliff NJ: Prentice Hall, 1973.

Schein EH. Organisational culture and leadership. San Francisco: Jossey-Bass, 1985.

Schon D. Beyond the stable state. London: Temple Smith, 1971.

Selznick P. Foundations of the theory of organisations. American Sociological Review 1948; 13:25-35. Cited in Blau PM. On the nature of organisations. New York: John Wiley & Sons, 1974.

Sherraden MS, Wallace SP. Innovation in Primary Care: Community Health Services in Mexico and the United States. Soc Sci Med. 1992; 35:1433-1443.

Silverman D. The theory of organisations: a sociological framework. London: Hienemann, 1970.

Six B, Eckes T. Gender Stereotypes: a representative design for analysing cognitive categorisation of men and women. In Forgas JP, Michael IJ, editors. Recent Advances in Social Psychology: an international perspective. Amsterdam, New York: North-Holland (Elsevier Science Publisher B.V.), 1989.

Smith DL, Bryant JH, Building the infrastructure for primary health care: an overview of integrated and vertical approaches. Soc Sci Med 1988; 26:909-917.

Soc Sci Med Editorial, The debate on selective and comprehensive PHC.1988; 26:877-878.

South Australian Community Health Research Unit (SACHRU). General Practice and Community Health Liaison Project 1991-95. Bedford Park: SACHRU, 1996.

South Australian Community Health Research Unit (SACHRU). Links between General Practitioners, Hospitals and Community Based Health Services. Bedford Park SA, SACHRU, 1994.

South Australian Health Commission (SAHC). A social health atlas of South Australia. South Australian Health Commission. Adelaide, 1990.

South Australian Health Commission (SAHC), Planning and Management Strategy MHSD, SAHC, 1993

South Australian Health Commission (SAHC). 1994-95 Annual Report. SAHC Adelaide,1995.

South Australian Health Commission (SAHC). Annual Report 1994-95. SAHC, 1995.

South Australian Health Commission (SAHC), Central Health Services Planning Unit, SAHC Booklets 1: A guide to the SAHC and its Area Planning Units. 1995.

South Australian Health Commission (SAHC). Central Health Services Planning Unit. Health Services in Adelaide's West: A profile (Booklet 5). 1995.

South Australian Health Commission. A social health atlas of South Australia. 2nd ed. Adelaide: South Australian Health Commission, 1996.

South Western Sydney Area Health Services (SWSAHS). Corporate Plan 1991-2001: Shaping a healthier future. SWSAHS, 1992.

South Western Sydney Area Health Services (SWSAHS) Health Promotion Unit. Health Promotion in South Western Sydney 1990-1993: Review. SWSAHS, 1993.

South Western Sydney Area Health Services (SWSAHS). Annual Report 1992-93. SWSAHS, 1993.

South Western Area Health Services (SWSAHS). Annual Report 1993-94. SWSAHS, 1994.

South Western Area Health Services (SWSAHS). Annual Report 1995-96. SWSAHS, 1996.

South Western Sydney Area Health Services (SWSAHS). Directions for promoting health in South Western Sydney: Strategic plan for promoting health 1996-2000. SWSAHS, 1995.

South Western Sydney Area Health Services (SWSAHS). Health Plan for Non English Speaking Background Communities in South Western Sydney: 1995-1998. SWSAHS 1995.

Steckler A, McLeroy K, Goodman R et al. Towards integrating qualitative and quantitative methods: an introduction. Health Education Quarterly 1992; 19:1-8.

Strauss AL, Corbin J. Basics of Qualitative Research: Grounded theory procedures and techniques. Newbury Park, Sage 1990.

Strauss AL. Qualitative analysis for the social scientist. Cambridge University Press, 1987.

Stretton H, Orchard L. Public goods, public enterprise, public choice: theoretical foundations of the contemporary attack on government. New York: St Martin's Press, 1994.

Sullivan E, Fahey M, Bauman A et al. Health in South Western Sydney: an epidemiological profile. Epidemiology Unit, SWSAHS, 1995.

Tarimo E, Fowkes FGR. Strengthening the backbone of primary health care. World Health Forum 1989; 10:74-9-79.

Terris M. The three world systems of medical care: trends and prospects. Am J Publ Hlth 1978; 68:1125-1131.

The National Health Strategy. The Australian Health Jigsaw: Integration of Health Care Delivery. National Health Strategy Issue Paper No. 1. Melbourne, 1991.

The Parks Community Health Service. Parks Health Observer. Annual Report 1994-95, Parks CHS, 1995.

Thomas S, Steven I, Browning C et al. Focus group in health research: a methodological review. Ann Rev Hlth Soc Sci 1992; 2:7-19.

Todd R, Sibthorp B. What divisions do. An analysis of Divisions' infrastructure activities for 1993-94. Canberra: Commonwealth Department of Human Services and Health and the National Centre for Epidemiology and Population Health. 1995. Quoted in Centre for General Practice Integration Studies. General Practice Integration: Literature Review. 1996.

Townsend P, Davidson N, editors. Inequalities in health: the Black Report. Harmondsworth: Penguin, 1982.

Turner BA. Some practical aspects of qualitative data analysis: one way of organising the cognitive processes associated with the generation of grounded theory. Quality and Quantity. 1981; 15:225-247.

Turner JC. Social Influence. Milton Keynes: Open University Press, 1991.

Uphoff NT. Political considerations in human development. In Knight PT, editor. Implementing programs for human development. Washington DC: World Bank, 1980.

Valdez RB, Giachello A, Rodriguez Trias H, Gomez P, de la Rocha C. Improving access to health care in Latino communities. Public Health Rep. 1993; 108: 534-9.

Van der Geest S, Speckmann JD, Streefland PH. Primary health care in a multi-level perspective: Towards a research agenda. Soc Sci Med 1990; 30:1025-1034.

Vaughan P, Mill A, Smith D. The importance of decentralised management. World Health Forum. 1984; 5: 27-29.

Vintila P. Markets, morals and manifestos. In Vintila P, Phillimore J, Newman P, editors. Markets, morals and manifestos. Fight back! and the politics of economic rationalism in the 1990s. Institute for Science and Technology Policy, Murdoch University: Perth, 1992.

Waldo D. The administrative state. New York: The Ronald Press, 1948.

Walker R. Interorganisational linkages as mediating structures in community health. Health Promotion International. 1992; 7:257-264.

Walsh JA, Warren KS. Selective primary health care: an interim strategy for disease control in developing countries. New Eng. J. Med. 1979; 301:967-974.

Warre RL. The interorganisational field as a focus for investigation. In Brinkerhoff MB, Kunz PR, editors. Complex organisations and their environments. Dubuque, Iowa: WMC Brown Company Publishers, 1972.

Webb A. Coordination: a problem in public sector management. Policy and Politics 1991; 19: 229-241.

Weber M. The theory of social and economic organisation. Glencoe; Free Press 1947.

Wellman B, Berkowitz SD, editors. Social structures: a network approach. Cambridge: Cambridge University Press, 1988.

Welton WE, Kantner TA, Katz SM. Developing tomorrow's integrated community health systems: a leadership challenge for public health and primary care. Milbank Quarterly. 1997; 75:261-288.

Whitehead M, Judge K, Hunter DJ et al. Tackling inequalities in health: the Australian experience. BMJ 1993; 306:783-787.

Wilenski P. Public power and public administration. Sydney: Hale & Iremonger, 1986.

Williams JE, Best DL. Sex stereotypes and inter-group relations. In Worchel S, Austin WG, editors. Psychology of inter-group relations. Chicago: Nelson-Hall Publishers, 1986.

Williams R. Key words: A vocabulary of culture and society. London: Fontana Press, 1983.

Williams W. The study of implementation: an overview. In Williams W, Elmore RF, Hall JS et al, editors. Studying implementation – methodological and administrative issues. Chatham, New Jersey: Chatham House Publishers, 1982.

Woelk GB. Primary health care in Zimbabwe: can it survive -- An exploration of the political and historical developments affecting the implementation of PHC. Soc. Sci. Med. 1994; 39:1027-1035.

Wolcott HF. Writing up qualitative research. Qualitative Research Methods Series 20. Newbury Park: Sage, 1990.

Woodward J. Industrial organisation: theory and practice. London: Oxford University Press, 1965.

World Bank. World Development Report. World Bank, Oxford University Press: 1983.

World Health Organisations (WHO). Alma Ata 1978: Primary Health Care. Health for All series No. 1. Geneva: WHO, 1978.

World Health Organisations (WHO). Formulating Strategies for Health for All by the year 2000. Health for All series No. 2. Geneva: WHO, 1979.

World Health Organisations (WHO). Primary health care in industrialised countries: report on a WHO meeting. Euro Reports and Studies No. 95. 1983.

World Health Organisations (WHO). Strengthening ministries of health for primary health care. Offset Publication No. 82. Geneva: WHO, 1984.

World Health Organisations (WHO). Glossary of terms used in the "Health for All" series No. 1-8. Geneva: WHO, 1984.

World Health Organisations (WHO). Eighth general program of work covering the period 1990-1995. Health for All series No. 10. Geneva: WHO, 1987.

World Health Organisations (WHO). Hospitals and health for all: report of an expert committee. Technical Report Series no 744. Geneva: WHO, 1987.

World Health Organisations (WHO). Integration of health care delivery. Report of a WHO Study Group. Technical Report Series 861. Geneva: WHO, 1996.

Wright RA. Community-Oriented Primary Care: the cornerstone of health care reform. JAMA 1993; 269:2544-2547.

Yeheskel HF. Human service organisation. Englewood Cliff NJ: Prentice Hall, 1983.

Young DW, Saltman RB. The hospital power equilibrium: an alternative approach to the cost containment dilemma. J Hlth Politics, Policy and Law, 1981: 6:391-418.