



NATIONAL RURAL
HEALTH
ALLIANCE INC.

Supporting Health Service Managers in Rural and Remote Australia

September 2004

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This Position Paper represents the agreed views of the National Rural Health Alliance, but not necessarily the full or particular views of all of its Member Bodies.

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Supporting Health Service Managers in Rural and Remote Australia

Introduction

Health service managers have sometimes been taken for granted in rural and remote health, despite the range of complexities and pressures they overcome on a daily basis. Such an approach is not appropriate, as they play key roles in determining the health and well-being of country people. No matter where the health service is or what it offers, good management increases its contribution to improved health outcomes. The publication of this first formal Paper by the Alliance on rural and remote health service managers aims to contribute to a better understanding of the value of their work.

Managers play the lead part in determining the quality of governance and the sustainability of a service, and the morale and effectiveness of its staff. Collectively, these characteristics make an important contribution to healthy organisations. This in turn helps with the retention of staff and the recruitment of future members to the team.

Some of the challenges faced by rural and remote health service managers are those faced by all health managers, such as dealing with structural changes from above and with ongoing pressures on organisational efficiency and effectiveness and, at times, viability.

Others (and these are the ones of particular interest to the Alliance) are the specific issues caused by the characteristics of rural and remote areas and their health services, such as greater personal visibility, potential conflicts of interest, and the relative difficulty of accessing training, professional development, mentoring and support.

This paper canvasses the key issues involved. It identifies some of the education, training and support options currently available and the gaps that need to be filled. It recommends ways in which the roles of health service managers in rural and remote areas can be better understood and their support needs addressed more effectively.

Who is a health service manager?

It has been estimated that 3% of the total health workforce are managers. Because of the small size of health teams in country areas it is very likely that a greater proportion of the rural and remote health workforce have managerial responsibilities.

Harris (2002) has defined a health service manager as someone who works for a health service organisation and who gets things done through other people. The manager is accountable to the organisation for the work of others, and is responsible for setting goals, allocating resources, creating opportunities for collaboration inside and outside the organisation, for looking outside the box, visioning, and for helping to empower staff and consumers. Overall the manager is a collaborator who organises and supports people to achieve the goals of an organisation.

Managers exist within a wide variety of mainstream and related health services, including Aboriginal Medical Services, aged care facilities, Divisions of General Practice, University Departments of Rural Health (UDRHs), Clinical Schools and private practices and clinics, as well as those in the public sector with Area Health Services, health service units, multipurpose services (MPSs) and hospitals. Those in the mainstream public health service have a weight of direct responsibility for the public not borne by, for example, the managers of academic units or Divisions.

Health service managers include some who spend all of their time ‘managing’, and clinician-managers (nurses, doctors, and allied health professionals) whose work is divided between management and clinical services. People in the second group have clinical (or caseload) and educative roles on top of their managerial responsibilities. Nurses occupy nearly 50 per cent of the health workforce and fill the majority of management positions in rural and remote areas.

Directors of Medical Services are playing an increasingly important role in many rural and regional hospitals. They are responsible for control of credentialing and privileging decisions for small to medium sized rural hospitals and interface between primary care and hospital based medical services. They also provide input into medical specialist and VMO service provision as well as policy direction at state health level.

For these Directors of Medical Services a postgraduate qualification in medical administration is available. This is something to be strongly encouraged, both as a quality control mechanism, and for building and managing relationships.

Full-time managers are found in middle and senior managers’ positions in the public health system and private hospitals. They manage individual units, facilities, hospitals, MPSs and Area Health Services. They include the managers of specialised services or units within larger organisations, such as finance departments and human resources sections, as well as the managers of aged care facilities, Aboriginal Medical Services, Divisions, UDRHs, Clinical Schools, religious organisations and general practices.

Clinician-managers work as managers of wards, medical services, large and small hospitals, community health services, allied health departments and multidisciplinary teams.

The background to health service management in Australia

Governments in developed nations worldwide are struggling to provide health care with available resources, and in the context of an ageing population, increasing demand, increased patient acuity in hospitals and aged care facilities, rapid throughput of patients, and escalating costs associated in part with medical technology. In the face of these pressures there has been a range of initiatives and reforms, with managers often in the forefront of their implementation. Such pressures can impact significantly upon their ability to perform effectively, and this is particularly the case in rural and remote areas where the pressure of workloads and an inadequate supply of health care professionals can negatively affect even the most committed manager.

Health service management has also been affected by trends towards the decentralisation of public services and greater market-oriented and fee-for-service payment systems. These have changed the fundamental nature of many health care organisations. Many procedures and facilities once provided by hospitals are now being provided out of hospital, and many acute hospitals, particularly in rural areas, have been transformed into multipurpose services providing some acute care, aged care and community health services.

Health service managers have had to adapt to such changes and also to the advent of 'new managerialism' (Baum 1996). A market model has brought about changes in the health sector that have often been quite inappropriate for rural and remote areas. Emerging technologies, increasing costs, rising consumer expectations and increased litigation have had dramatic effects on the management load. Decreasing length of stay in hospitals, increased ambulatory care and the increased burden of chronic diseases have also affected the roles of health managers in various health care settings and have implications for their training and professional development.

Performance criteria for managers are now more outcome-oriented, with a greater emphasis on population health, cost, activity and quality control. This orientation can be a real challenge to individual managers who have a natural inclination for processes or people, rather than outcomes. Information technology has improved only marginally in some areas, but in others sophisticated data analysis is possible on a range of performance-related criteria. With improved monitoring of organisations, managers are better able to measure their organisation's performance and compare it with that of other similar-sized facilities. There is increased work for managers in multi-agency service co-ordination, collaboration and inter-sectoral linkages.

Such changes in the roles of health service managers have altered their working relationships with clinicians, consumers and policy makers. Some clinician-managers have business managers providing advice and support but in many smaller rural and remote areas it is the manager - who is most often a nurse - who is called on to balance community, health professional and central office expectations. This is often a tough ask that can leave a manager feeling isolated within the community and within their professional networks.

Quite often the role of senior and middle level health service managers has expanded to include functions once performed by general managers. The responsibilities and job descriptions of senior and middle managers need to be clear so there is certainty about what is done and by whom.

These processes of change will continue. The background to health service management will be affected by:

- further globalisation of service standards and communication, at the same time as there is a continued push for localisation of management and participation;
- changing demands for service caused by the demographic, epidemiological and social situation in rural and remote areas;
- scientific and technological advances;
- workforce supply and structure, professional competencies, and the ethical and cultural issues associated with recruiting health care professionals from overseas;
- further shifts in the pattern of governance and funding of health care organisations;
- altered relationships among professionals, and between them and patients;

- new information and communications technologies (having a particular impact in remote settings); and
- increased litigation.

Although the situation varies between jurisdictions, in the rural areas of some States industrial agreements have been made whereby smaller facilities require a registered nurse as the health service manager. It is acknowledged that although nurses are the largest professional group involved in the delivery of health care services in rural and remote areas, these decisions have limited the management pathway opportunities for other managers. The NRHA would like to see management opportunities expanded for all health care professionals interested in management careers, and in particular the need for professional leadership training and support for nurses must be accommodated.

There is a demand from health professionals for career pathways that will allow them to achieve promotion within the sector and within disciplines, and for all disciplines to be able to compete for similar opportunities for promotion. Career progression provides benefits to clinician-managers who will gain some relief from the demands of heavy caseloads - and to patients through an increased supply of health professionals where the progression includes a new appointee.

Health service managers usually have responsibility for a complex multiprofessional workforce, and for open, unlimited demand for service. In other industries the workforce may be comprised largely of people from a single profession, or non-professionals, and the demand for service is finite or determined by price. In small health service organisations, there can be tension between the competing priorities and philosophies of different professional groups eg medicine, nursing, allied health.

In rural and remote areas more than anywhere else there is a need for good leadership that engages employees, key community leaders and other stakeholders. Whereas management is about explicit organisational goals and expectations, leadership fosters a positive code of behaviour or culture.

Many large health service organisations have in-house management development programs for their staff which can be articulated through to further management qualifications. However rural and remote services often have little or no such articulation or succession planning for their managers.

Some clinician-managers are appointed simply because no one else is available at the time. Rural facilities can either reap the short-term benefit of having skilled people with only a temporary rural commitment, or they may attract novice managers or those who cannot get a job in an urban area.

The education and training of health service managers

Historically non-clinical managers have usually been graduates with business, accountancy and IT qualifications, who have begun their careers in the health sector in a non-clinical area such as finance, IT or the general management of corporate services. This has enabled them to gain some familiarity with the health care system. They then progress through supervisory roles to manage larger services, units or facilities.

They may or may not have had further training in specific health service management, and may have undertaken a specific postgraduate study in health management from programs accredited by the Australian College of Health Service Executives (ACHSE). Others will have taken more general postgraduate studies in management, not specific to the health sector, to maximise the portability of their skills between various employment sectors.

In recent times it was more common for non-clinical managers to be recruited from other jurisdictions (eg the private sector, related industry environments, interstate or overseas) into senior health management positions, although this trend seems now to have peaked. Executive search firms report difficulty attracting qualified candidates for health service management positions, because they are perceived as being very demanding in relation to the compensation offered.

Contemporary health service managers should have graduate management training¹ to develop skills for leadership, team building, and oral and written communication (report writing etc). They require skill in human resource management, strategic management (eg to interpret demographic data for future planning), quality management, risk management, clinical governance, information, communication and technology management, contract management, financial management (to interpret financial statements, analyse casemix data), and in the development of strategies for community consultation and participation.

Given this very wide range of skill areas it is not surprising that a good clinician does not automatically and always make a good manager and leader. There are many examples of the Peter Principle in small centres – the phenomenon of an individual being promoted to one stage above their true capability, in order to fill a vacated management role. Health service organisations should be required to offer and insist on appropriate professional development, including through membership of the professional bodies².

Mentorship and good support systems for managers are essential. This may include the establishment of structured mentorship programs or on-line services for isolated managers to canvass issues and problems relating to industrial relations, human resources, clinical or public relations matters. Systems of rotation for relief, or a relief pool, can build the capacity of future managers and enable new appointees to make a smoother transition into vacant managerial positions.

¹ Many of those in senior management positions have postgraduate training in management. At least ten Australian universities offer postgraduate courses in health service management. Most of them are accredited by the ACHSE and most programs in health service management are affiliated with the Society for Health Administration in Education. Some of these programs offer their courses in distance education mode. Information about all of these courses is available at www.shape.org.au Unlike medicine and nursing, qualifications in health service management are not formally linked to award conditions or to increased remuneration.

Vocational health service management training programs are offered for graduates in NSW and Victoria through the respective State branches of the ACHSE. There is a health management training program specifically for Indigenous managers funded jointly by the Australian Government and the NSW Department of Health and run by the NSW Branch of ACHSE in collaboration with the NSW Aboriginal Health and Medical Research Council.

The Centre for Remote Health in Alice Springs, jointly owned and run by Flinders and Charles Darwin Universities, offers postgraduate courses in Remote Health Management.

² The ACHSE has a multidisciplinary membership because it is open to all health managers. For medical officers there is the Royal Australian College of Medical Administrators (RACMA). For nurses there is the Royal College of Nursing Australia. In NSW and ACT there is also the Institute of Nurse Executives which has members in rural parts of the State.

There also needs to be governance training for Boards and other committees overseeing health service organisations. Even the best manager cannot succeed if the Board is ineffective in its proper roles relating to policy, strategy and compliance or, worse still, if it becomes inappropriately involved in operational issues. This latter situation is a frequent cause of difficulties between a good manager and the Board. It is not uncommon for a senior manager to leave an organisation because of poor governance and a poor relationship with the Board.

Managers in a rural or remote setting

Managers in rural and remote settings face a number of issues that distinguish them from their metropolitan colleagues. As for other rural health professionals, they are isolated from peers and professional support and in their case it can affect the whole service and its professional team because of the leading role the manager plays in creating the environment in which others work.

Managers in smaller communities must gain the trust of the community themselves, whereas in major centres there is an executive team to share the load and help look after the community interface. As for other professionals, their work in a smaller community can be something of a 'goldfish bowl' existence. Face-to-face networks, teleconferencing, and the implementation of a buddy system can support rural health managers in handling this challenge.

There are positive aspects of being a rural manager, such as the immediacy of community support and the visibility of the role. Life in the country itself is of course the best reward for many people and something that is quite impossible to imitate in the major cities. The internet has helped to fill some of the communications and information gaps that used to exist.

Rural managers working their way up the ladder need well-honed skills in community consultation, managing community forums and relationships with the media. A well-informed staff and community are more likely to support new directions, especially if the decision making processes are transparent and inclusive. The modern management style that seems to work in metropolitan centres will not necessarily be successful in rural and remote areas where each community is unique. A high level of cultural awareness is essential if change - which is inevitable everywhere - is to be well managed.

Senior regional managers may prefer to work with local managers who will not challenge the status quo – but this may not be the best thing in the present environment. To improve health outcomes in rural and remote areas there is a constant need for innovation and enthusiasm, with no place for resignation in the face of perceived shortcomings of the system.

The CEO or Manager of a local rural or remote health service will face some or all of the following special challenges.³

³ The exact nature of some of these will vary according to whether the manager has permanence or a time-limited contract.

- They must implement at the local level policy that has been determined by a central office, and which may well impact on the viability of the local community (for example, bed closures or staff redundancies). In a rural centre the health facility is often the largest employer.
- From time to time there will be major changes in service direction, such as a change in role or service profile of the local hospital or health service, or the closure of a hospital.
- There may be budgetary overruns, which result in delayed payments to local businesses.
- Rural and remote managers often have to mix socially in a small community with staff and clinicians with whom there may be disagreements and whose performance they have to manage and appraise.
- They may have to deal with media that is more interested in ‘sensational’ or adverse news headlines than in the gradual development of services.
- They may be faced with governance issues concerning a Board whose members are not skilled in financial matters or quality and safety issues. This might include local aged care facilities.
- They may have to manage change in a situation in which community expectations for services are not sustainable.
- The local manager may have to deal with the situation in which ‘administrative savings’ have been used by the central authority as a reason to cut management positions, with the money saved not ending up in local clinical services.

Senior managers in rural areas face particular uncertainties because of frequent restructures in health services, or the demand to “perform in terms of the budget or move on”. Good managers can be adversely affected by changes in structures and/or governance that are completely beyond their control. A fixed term employment contract with no ongoing tenure provision leaves the displaced manager without an automatic fallback option.

This outcome often requires the complete separation of the manager from the community within which they live and work. Geographic factors associated with the next employment opportunity require the relocation of the manager, their spouse and children - with all the associated impacts that this has on the functioning of the family unit. The spouse’s employment, children’s educational needs and development, social and familial networks, community supports and housing are all put at risk, and there are also financial impacts associated with a forced relocation of the rural manager or executive.

Metropolitan managers are less likely to be forced to relocate on the basis of geographic considerations, having more employment opportunities available to them within commuting distance.

For example the formation of District Health Services in NSW saw many country CEOs displaced. About half of the 23 District General Manager positions were filled locally, the rest by interstate applicants. The subsequent restructure from 23 Districts to 8 Area Health Services displaced 15 senior executives, most of whom were on 3-5 year contracts with no tenure provisions. With no entitlement to redeployment within the location where they worked (or even within the NSW public sector), they either had to apply for any positions on offer at a lower classification within their location, or move house and family to secure an equivalent or better position. This climate of uncertainty continues with the current situation in NSW.

For these reasons, and because of the trend to short-term contracts for senior management positions, there are often few appropriate applicants for senior positions in country areas.

For Indigenous managers, there are other specific issues. They include the challenges of working between two cultures, such as responsibility directly to community as well as to the organisation; human resource issues around working with family and with other relationships; a perceived role as an activist/reformer within ‘the system’; and racism (Wakerman et al 2000).

Measuring a manager’s performance

The ultimate measure of performance for a health service is the advancement of population health and the alleviation of disability, pain and suffering. These are notoriously difficult to measure, given the complex causation of health and well-being and difficulties in measuring some of the inputs of a health service.

Other outcomes include the extent to which the work of the health service builds social capital, community connectedness and consumer participation – always a challenge in rural and remote areas that are imploding because of economic conditions. An alternative might be to measure the introduction of procedures, work practices and systems to ensure high quality care and a patient-centred approach. Also, targets can be established for throughput and access to services. In the private sector ultimate measures of performance also include ‘the budget bottom line’, which is relatively easy to bring to account.

More practicable is measurement according to the notion of excellence in service delivery to patients, clients, families and communities within the limits of available resources. This can be gauged by indicators of continuous improvement in quality, patient safety, efficiency, productivity and equity.

Finally, a health care organisation can be assessed in relation to organisational development. This is about building the organisation’s capacity to deliver services and programs in the future. It involves the planning and forecasting of needs and resources, and developing the personnel, finance, technologies, facilities, and systems that will be needed by the organisation to provide excellent services tomorrow.

Whatever elements are measured it is best if overall accreditation is against national or international standards. This provides the Board, staff and community with a clear guarantee that the service is working well and of a national best-practice standard.

Recommendations.

1. Health service managers should be recognised as an important professional group within the multidisciplinary team - nowhere more so than in rural and remote Australia. Quality managers are a prerequisite for bringing the best available health care to a rural or remote community within budget.
2. There should be a new national project to encourage and facilitate Indigenous people to become health service managers in both mainstream and Indigenous health care settings. Once in such positions, Indigenous health service managers need targeted and culturally-appropriate resources for support, ongoing professional development, mentoring and expanded career opportunities.

3. Health service management positions in rural and remote areas should be regarded as a specialist area of management and promoted as such by employers and professional organisations, so that career prospects for rural and remote health service managers are enhanced.
4. Private and public sector health employers, including Commonwealth and State Governments, should resource rural health service management positions appropriately and remunerate their incumbents at rates that are at least equivalent to positions in metropolitan health services. The employers should consider incentives and bonuses to compensate for the extra costs and difficulties of working in rural and remote areas, including through the provision of allowances to account for the costs of unavoidable relocation in cases where this occurs.
5. Opportunities should be provided for all career health service managers to experience rural aspects of health management and a general rural orientation.
6. Health systems should recognise the importance of providing career progression opportunities for managers in country areas. A range of strategies could facilitate this, including rotation postings in larger organisations as part of an operational professional development process, acknowledging the equivalence (to their metropolitan counterparts) of experience and skill development gained in working in a rural organisational environment, and encouraging progression through more complex organisational environments (whether metropolitan or rural).
7. Health service managers in rural and remote areas should be provided with support to attend further education and professional development with other rural clinicians, including in metropolitan areas and through video-conferencing, webstreaming and satellite broadcasts. This could include visiting fellow programs in which health management exponents are funded to provide workshops in rural and remote areas, scholarships for further tertiary education, mentoring schemes (which could include periods of work in city facilities – say 1-3 months at a time), and ongoing support for continuing professional development in the form of high grade IT access (eg for intranet contact with peers). Because so many managers in rural and remote areas are nurses, the need for leadership training and support for nurses must be accommodated.
8. A single on-line database should be compiled and maintained of resources available for the support and continuing professional development of health service managers in rural and remote areas. It should include networks, educational opportunities (including distance education), peer support activities, locum replacement and/or training and career pathways.
9. A scoping study should be undertaken to determine gaps in the rural health service management skill base, with a view to developing a post-graduate program that targets these areas. The gaps may relate to financial management, economic planning, legislation and common law, statistical analysis, epidemiology and sociology, behavioural management, organisational theory, or strategic planning methodologies.
10. There is a need for further collection of workforce data on health service management, and in particular in rural and remote areas.

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