

# Organisational governance structures in allied health services: A decade of change

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## Abstract

*A ten year review of developments in the organisation and management of allied health services in Australian acute care public hospitals reveals a steady transformation away from a medically managed universal model towards more complex and contested models of governance. This article revisits early observations about the reorganisation of allied health services and presents more recent research findings to guide managerial decision-making about restructuring the diverse disciplines that constitute allied health. A new organisational model "integrated decentralisation" is presented as an approach to managing allied health services which accommodates multiple stakeholder demands in the context of New Public Management (NPM) related reforms. The focus on the institutional level is complemented by examining developments in the profile and activity of allied health at the regional, state and national levels to present a more comprehensive picture of change over the decade of the 1990s.*

## Introduction

New Public Management policies of managerialism and marketisation which promote competition, the implementation of local interpretations of a purchaser-provider split, and service contestability have resulted in the restructuring of governance systems of public sector organisations (Harris 1999). Arising from this reform agenda, Australian public hospitals experienced sustained policy and financial pressures in the late 1980s and early 1990s which resulted in a wave of internal organisational restructuring and new inter-agency relationships (Boyce 1993a; National Health Strategy Unit 1991; National Health Strategy Unit 1993).

Whilst there were a wide variety of local drivers effecting the precise organisational restructuring prescriptions adopted by individual agencies, several common themes were evident. These included the recommendation that management and financial control be decentralised to clinical units and that services and resources should be organised around patients rather than providers (National Health Strategy Unit 1993). The organisational outcomes from the restructuring agenda of the early 1990s were seen in the emergence of new roles such as the medical clinician manager and the popularity of variations of clinical directorates, program management, product-line management and patient-focused care organisational models (Charns & Tewksbury 1993; Hunter 1996). These directions in organisational restructuring are still evident today in many Australian hospitals.

The allied health professions have operated largely in the shadow of NPM reforms, drawn along with change, but rarely the direct target of reformist objectives. The primary driver of change in the organisation of allied health services was the implementation of divisional structures composed of clinical units in public hospitals and the transformation of the role of the medical director in the late 1980s. Until this time medical directors (or their deputies) were the traditional and largely unchallenged operational supervisor-managers of allied health departments in public hospitals (Duckett, et al. 1981).

The devolution of managerial and financial decision-making towards formally structured internal clinical units created the new role of medical clinician manager and a range of shared medical and nursing governance models at the operational level. The traditional medical director role was frequently resituated to a non-operational corporate level position in many institutions. This shift inevitably raised the question, “who should manage allied health?” and heralded a previously unknown contestability about desirable institutional governance structures for allied health.

The purpose of this paper is to review developments over the past ten years in the restructuring of allied health services in public sector acute care hospitals and more broadly at the state and national levels. The paper reviews the findings of several previously published empirical and theoretical analyses, describes key features of a range of contemporary approaches and presents original data on current structural models in operation in Australia. The discussion of the utility of various governance models is embedded in the context of internal market reforms at the institutional level (internal service agreements and external contracts); an organisational scenario of continuing importance to allied health services and health care agencies. It is argued that there are two distinct domains in the governance structures of allied health services that require compatible structural outcomes if stakeholder needs are to be met: a resource management domain and a service delivery domain. The findings of the paper have implications for health service executives in terms of how they might structure allied health services in an operational and policy environment which increasingly stresses cost minimisation, greater provider accountability for service quality and cost and flexible client-centred oriented service delivery.

## **Researching Allied Health Organisation and Management**

This article draws on the author’s decade of research into the organisation and management of allied health professionals. The paper synthesises the research reported in Boyce (1993a, 1993b, 1996a, 1996b, 1996c, 1997, 1998) and three new projects being conducted in the context of internal market reforms, the emergence of enterprising professional behaviour and the development of “allied health” as a distinct organisational subculture (Boyce & Shepherd 2000; Boyce, et al. 2000; Rowe & Boyce 2000).

The data collection methodologies involved in the research program are case studies, interviews and analysis of institutional and public domain records. Approximately one hundred interviews have been conducted with senior allied health, medical, nursing and general management staff using a semi-structured framework. Nine Australian case studies (two longitudinal) based in metropolitan, rural and remote locations have been undertaken. This Australian work has been complemented by four international data collection periods in 1992, 1995, 1997 and 2000 to gain comparative data on new forms of organisation and the impact of internal market reforms on the health professions.

There are several challenges to conducting research on the organisation of allied health professionals (Boyce 1996a). Firstly, the international knowledge base on allied health organisation and management is widely dispersed in the journals of individual professional disciplines and the multi-disciplinary public health, public administration and organisational sociology fields of each country. Barriers to comparative analysis in an international context are significant because of differences in the membership of allied health, for example, American sources often include nursing and emergency / ambulance services as part of allied health (Institute of Medicine 1989). This is complicated by subtle, but sometimes significant, differences in the practices of each professional discipline when considered in a comparative cross-national context (Boyce 2000). In addition, the quality of the literature available for use as a secondary data source is often compromised. For example, institutional accounts of restructuring are often politicised selective deposits lacking in independent analysis.

Despite these general difficulties, researching allied health organisation in the acute-care sector offers particular advantages in terms of the data-rich and contested nature of inter-professional relations and power in a complex organisational setting. The acute-care hospital, as the site of intense organisational restructuring and the flagship environment of medical authority over allied health, is a research location of high analytical utility for studying changes in inter-professional and positional power. Prior work on the emergence of new forms of allied health organisation has demonstrated that the workplace is an under-appreciated source of influence on professional power. Specifically, institutional roles and access to decision-making forums are dictated by the

architecture of organisational structure in the workplace (Boyce 1996a; Boyce 1996b; Boyce 1996c; Hugman 1991; Øvretveit 1988; Øvretveit 1992).

In the following section of the paper, developments in the first wave of organisational restructuring in acute-care public sector allied health services from the late 1980's to the mid-1990s are briefly reviewed. This will be followed by a discussion of the second wave of restructuring from the mid-1990s to the late 1990s when more complex internal structures became apparent in the governance systems of allied health. These changes were due in large part to the implementation of internal purchaser-provider models in hospitals. The focus of this paper is on the acute care public sector however early experiences with innovative models occurred in the rural and non-acute care sectors at places such as the Queen Elizabeth Centre in Ballarat (Bauer 1985) and at Whyalla Health Service (Nihill 1992).

## First Wave Restructuring of Allied Health - late 1980s to mid 1990s

The first attempts to map the emergence of new models of Australian allied health organisation were presented by Boyce (1991) and Weeks (1991). Five general models, including three versions of the *division of allied health* were presented in Boyce (1991):

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

At the time these articles were published, there was only one known case of a fully implemented *unit dispersement* model operating for allied health services in a public sector acute care Australia hospital; the John Hunter Hospital in Newcastle. The model was vigorously resisted by allied health professional associations and unions (Australian Physiotherapy Association 1994; Huddy 1992; Public Service Association 1990). Their primary concern was the loss of management responsibility and control of a budget, factors which they argued would reduce their positional power, give control of their services to other professions with little knowledge of their services and further reduce already limited financial support for professional development, student training and service development.

The *division of allied health* model, particularly the freestanding version, was favoured by the professional associations and unions that had criticised the unit dispersement model as antithetical to core values espoused by the professions. Although several of the allied health professions saw the *division of allied health* model as a threat because the director of allied health position was open to competition from all allied health disciplines, it was regarded as less of a threat than the *unit dispersement* model (Boyce 1996a). The primary advantage of the divisional approach was the retention of profession management of professional resources and the ability to co-ordinate and develop organisational wide service priorities and systems, and the possibility of increased positional power in the organisation through the director of allied health's membership of the corporate executive (Australian Physiotherapy Association 1994). An influential and comprehensive study of the American allied health professions by the Institute of Medicine provided some support for the position adopted by Australian allied health professionals. The Institute's study noted the relationship between the lack of an "umbrella allied health administrator position to promote the interests and raise the level of visibility of the allied health workforce" and the ability of the diverse and fragmented allied health professions to "establish the

linkages to central administration” necessary for ameliorating various work related issues (Institute of Medicine 1989, p. 219).

Support amongst professionals for the *division of allied health* model in Australia was strengthened from British research and commentary that concluded adversely about the impact of *unit dispersement* approaches and more positively about the local equivalent of the divisional model in the context of the NHS reforms and the quasi-market. The British organisational equivalent, the Therapy Directorate, was associated with “business autonomy” a new form of professional autonomy which accrued from generating organisationally-valued revenues through internal and external contracts or service agreements (Cook 1994; Øvretveit 1992; Øvretveit 1994; Pringle 1996).

Although professionals and their associations and unions increasingly came to support the governance principles underpinning the *division of allied health* model, particularly the freestanding version, Chief Executive Officers of several influential hospitals publicly recorded their reservations about such approaches. Although there was little operational experience with fully implemented divisional or *unit dispersement* models, allied health professionals were labelled as “the most resistant group” to restructuring (Catchlove 1991, p. 86) whilst another predicted that the divisional model would only be a transitional step to decentralisation and *unit dispersement* (Scarf 1991).

Although there were no formal studies undertaken in the early 1990s to assess the influence of these models, or the extent to which they were established across the health sector, several secondary data sources give a partial picture of changes in the governance structures and status of allied health. Three events in the early 1990s suggest that the nature of allied health services organisation was experiencing a shift from its traditional focus on the individual professional discipline toward a focus on “allied health” as a distinct collective entity. Firstly in 1992, the Austin Hospital (Melbourne), which had been operating for three years with an appointed director of allied health and a division consisting of sixteen departments, hosted the 1st National Allied Health Services Conference. Over two hundred delegates attended the two-day conference. The conference program was devoted to allied health management issues such as comparative organisational structures, marketing, productivity measures and quality improvement. The program contained no discipline-specific clinical papers.

Secondly, the first national meeting of directors, co-ordinators and chairs of allied health was held in Melbourne in early 1993, following a call from a meeting of delegates at the national conference to investigate how the momentum for change in allied health services and growth in new organisational models could be sustained. Thirdly, a working group (National Allied Health Managers Group) was established in 1993 from the national directors meeting to develop discussion papers on how to progress allied health through the formation of a national peak association.

The minutes of the first national meeting of directors gives some data on the status of developments in terms of the *division of allied health* model of organisation. Thirty-three persons holding the title of director, co-ordinator or chair of allied health had been identified at the end of 1992 and were invited to the meeting. The personnel with these position titles were located in all states of Australia and in the ACT. Table 1 summarises key features presented by participants (n=19) at the national meeting of directors on the governance arrangements operating in their institution. Of the nineteen participants performing the role of head of the *division of allied health* only five had full-time funding of their position and a further six had part-time funding. Full budgetary responsibility for the management of the *division of allied health* had been instituted in seven of the nineteen sites. Membership of the hospital’s corporate executive, which included reporting directly to the CEO, was reported in six sites.

## Second Wave Restructuring of Allied Health - mid to late 1990s

By the mid 1990s several key events had occurred which produced a shift towards more sophisticated forms of internal restructuring within the allied health models of organisation. The most important driver of change was the introduction of local forms of the purchaser-provider split. Whereas casemix funding had little direct impact on the internal structural organisation of allied health profession services, the purchase-provider split, particularly the internal institutional form where service agreements or internal contracts were contemplated,

represented a significant change to the traditional funding environment of the annual allocated budget. The increasingly level of internal institutional complexity signalled a new wave of restructuring.

**Table 1. Organisational Features of Selected Divisions of Allied Health, 1993<sup>a, b</sup> (n= 19)**

Organisational Feature	Number of Sites
Divisional structures in place greater than two years (range 1-15 years)	10
Directors of Allied Health <sup>c</sup> with full budget responsibility for the Division	7
Directors of Allied Health reporting to a medical director	9
Directors of Allied Health with a position on the Executive, reporting to CEO	6
Directors of Allied Health with no funding for their position	6
Directors of Allied Health with part-time funding for their position	6
Directors of Allied Health with full funding for their position	5

Source: Minutes & research notes from inaugural meeting of directors, co-ordinators, chairpersons of allied health, January 29 1993, Austin Hospital, Melbourne.

<sup>a</sup> Data presented at the meeting showed 33 hospitals had implemented versions of a distinct allied health structure under the leadership of an allied health professional in a representative or appointed position.

<sup>b</sup> Data excluded from two sites involved in a one year trial of a division of allied health

<sup>c</sup> Other position titles included co-ordinator or chair of allied health

## Structural options for an internal purchaser-provider split

The internal purchaser-provider model typically constructed the clinical unit as the internal purchaser with the potential to assume the budget quantum that traditionally was allocated to the allied health disciplines. Theoretically, allied health services had access to several structural options in this scenario with allied health bearing a greater degree of financial risk in options 3 and 4 of those shown below:

- Option 1 Being re-located within the clinical unit structures (unit dispersement) with the loss of budget-holding role
- Option 2 Continuing to hold a budget and negotiating an internal service agreement with clinical units through “soft” service agreements designed to clarify mutual expectations, process flows and staffing arrangements with little systematic delineation of costs, volumes, performance benchmarking or penalties for non-performance
- Option 3 Zero based budgets for allied health services with revenues gained through negotiated internal contracts or formalised service agreements in which service costs, volumes, performance benchmarking or penalties for non-performance were specified.
- Option 4 Contestability through benchmarking against external providers or privatisation of the service.

The prospect of an internal purchaser-provider model renewed the attraction of the unit dispersement model of allied health organisation in sites where the development of costing systems of allied health services was rudimentary and where a classical medical model approach persisted. If the professionals were distributed amongst the clinical units (*unit dispersement*) then their budget allocations could simply be shifted to the clinical unit cost centre. In health care agencies where a *division of allied health* existed and *unit dispersement* was likely to be resisted, option 2 or 3 were typically recommended by allied health professionals to their executive management. The choice between options 2 and 3 was limited in the first instance by the availability of allied health information systems capable of supporting the more data-driven option 3 and by clinical unit manager's knowledge of allied health utilisation and cost profiles in their clinical unit.

In 1996 the Centre for Health Economics Research and Evaluation (CHERE) investigated a range of structural and funding options for allied health departments under pressure to engage in market-like transactions through clinical budgeting processes. The CHERE study, which focused on Westmead Hospital, reviewed six structural

options before recommending an internal purchaser model similar to option 2 above. They concluded this approach to be the “most appropriate funding arrangement for clinical and (therapeutic) service departments” for the hospital involved in the study (p. 24).

This growing trend towards the influence of internal purchaser-provider models for allied health was reflected in the conference program of the 2<sup>nd</sup> National Allied Health Service hosted by Central Sydney Area Health Services’ *division of allied health* in 1996. Conference papers were delivered on zero-based budgeting models (Bishop 1996), an evaluation of alternative internal funding and structural approaches (Haas 1996) and recommendations for developing a strategic framework for service agreements (Boyce 1996c). Altus & Bonnici (1997) also presented a comprehensive paper on a fully implemented internal purchaser-provider model for allied health services at the 1997 national conference of the Australian College of Health Service Executives. The 1998 3rd National Allied Health Services Conference also featured a session on “Restructuring Allied Health” that continued the focus on strategic responses to internal institutional restructuring.

## **Complexity, Flexibility and Further Restructuring: “Integrated Decentralisation”**

By the late 1990s a key challenge to the allied health professions was to create new approaches to organisation which preserved attributes valued by the professions, but which were capable of contributing to organisational objectives and customer (internal purchasers) needs in the context of market-like operational conditions. A more complex version of the *division of allied health* for sites engaged in internal service agreements and external contracts was proposed in Boyce (1996c) as a means of meeting multiple stakeholder needs. Called “*integrated decentralisation*”, the model was not dependent on the existence of an internal institutional quasi-market, but it was capable of accommodating such an approach in either of the operational modes described above as Option 2 and 3.

“*Integrated decentralisation*” supports individual professional discipline identities and profession-management by retaining distinct disciplinary-based management structures. However, the model also challenges allied health professionals to adapt to more collaborative practices and accept a loosening of the sovereignty of the professional discipline as the mainstay of organisation. This latter objective is achieved through an intra-divisional matrix, which is discussed more fully below. The internal matrix supports the professionally valued core principle of profession-management but also promotes responsiveness to the needs of clinical units through a team-based service delivery design.

The organisational design attempts to respond to issues raised by Abernethy & Stoelwinder (1995), Degeling et al (1998) and Anderson & McDaniel (2000) about ways of integrating professional cultures within complex organisations. Abernethy & Stoelwinder (1995) suggested that creating an organisational culture that supported professionally valued factors such as identity might be one pathway to achieving organisations goals. Degeling et al (1998) demonstrated that professional cultures are a limiting factor in health sector reform and need to be specifically addressed to achieve organisational change. Anderson & McDaniel (2000, p 90) argued that managerial approaches to limit and isolate professionals from each other as a means of restraining profession-centred behaviours would be counter-productive leading to protectionism.

Successful implementation of “*integrated decentralisation*” is predicted to require prior experience of a collective “allied health” philosophy and high levels of inter-professional trust. Although examples of “*integrated decentralisation*” in the health sector are small, each site that has adopted this approach had spent several years under a *division of allied health* before moving to the new model. There are no cases of a *classical medical* model or *unit dispersment* model proceeding to “*integrated decentralisation*” without prior experience as a *division of allied health*.



Key features of the “*integrated decentralisation*” model that will be discussed briefly in turn in the following sections of the paper include:

1. Restructuring into an internal matrix within the *division of allied health*.
2. Selling or negotiating “allied health packages of care” to the clinical units rather than individual discipline-based services.

## The internal matrix - different solutions for different organisational domains

A key shift in thinking about the organisation of allied health services arose from responding to the different governance requirements of managing professionals and delivering clinical services. In the internal matrix discrete professional management structures are retained but are overlain with an “allied health team” dimension to map the clinical units of the institution. The internal allied health structure represents an integrated approach to managing across the professions within the division but represents a decentralised approach to service delivery.

The two arms of the internal matrix deal with different, but equally important, domains of activity in complex organisations such as public hospitals. The professional structure leads *service management and development* of an organisational and clinical nature, whilst the “allied health teams” dimension is involved in service delivery. Another way of thinking of this is that one arm performs strategic level work of a developmental and managerial nature whilst the other arm has primarily an operational focus. The close integration of the two arms suggests that developmental initiatives could be efficiently operationalised into the service delivery domain.

As shown in figure 1 “*integrated decentralisation*” is composed of “allied health teams” which are organised to mirror the primary internal structure of the organisation’s clinical services and their approach to devolved clinical units, divisions or directorates. For example, if the institution were operating a paediatric clinical unit, then utilising the “*integrated decentralisation*” principles, the *division of allied health* would create an “allied health paediatric team” as the service delivery operational unit.

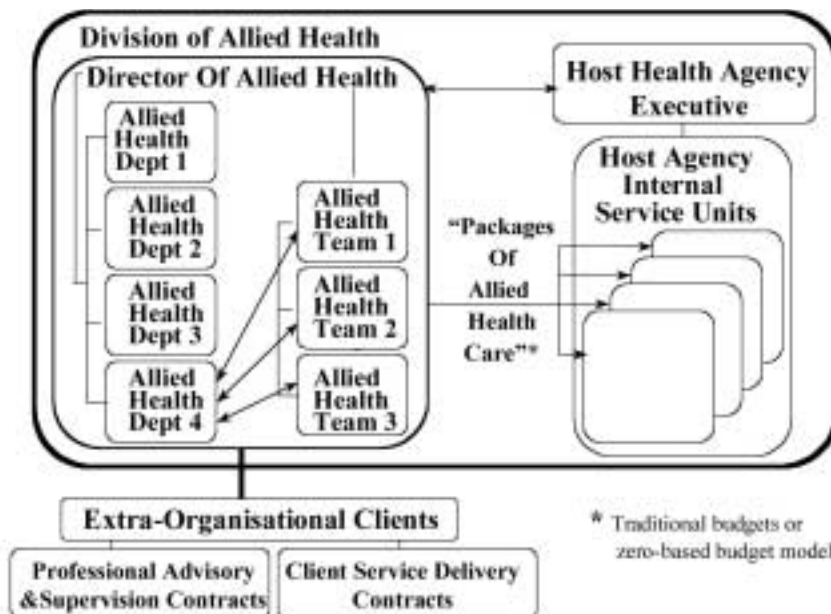


Figure 1. Integrated decentralisation: a model for allied health services

The model features a high degree of flexibility and complexity through the nesting of a distinct *service delivery model* within a matrix model of managing the human resource component (coexisting profession management structures and team management structures). In order to minimise managerial overheads it is proposed that in the first instance the roles of profession managers are reformulated to include responsibility for leading an “allied health team”; hence the need for pre-existing experience with collective “allied health” structures and a high degree of inter-professional trust.

Interview data from a case study site with more than five years experience operating a *division of allied health* before adopting the principles of “*integrated decentralisation*” showed that the profession managers were surprised by the amount of work that still needed to be devoted to profession management and developmental work. Their commitment to the model included moving the offices of the members of a team into the one location as well as moving the profession managers from individual offices into a shared open plan room.

R: I think because of the need to retain ah the professional structure as well as the allied health structure. It's almost doubled some people's work.

I: And the kind of work has it doubled, is that the profession management work?

R: Yeah, well no ... Um I think it's because we assumed that the professions stuff would bubble along by itself ... Um but as soon as there's change, then the profile you, that profession stuff still needs to happen um because each discipline has unique aspects to it that can only be managed by the senior in that discipline, so me as a manager of the [names an allied health team] I still had to still go back to the director of [names an allied health discipline] or [names an allied health discipline] or whatever to get ah to address certain things, and so we ended up doubling up on some things that otherwise would have only, only occupied one managers' role. So it, I I'm not saying it's a bad, you know like what's happened is bad, [but] I think we underestimated um ah, the work involved in supporting both those processes at once, or those structures at once. (Code 1-2-1 1999)

Although the inherent complexity of the “*integrated decentralisation*” model can be portrayed as an overhead, it also delivers flexibility because, unlike *unit dispersement*, professional resources can be moved between the teams to respond to unexpected service demands or staff absence because they are not “owned” by the clinical units.

## “Allied health packages of care”

Selling “allied health packages of care” as part of an internal purchaser-provider service delivery model was first discussed in Boyce (1993b). As a structural device, packages of care were perceived as a means of reducing the high transaction costs associated with each allied health discipline trying to negotiate a service agreement with the clinical units. Hence, “allied health packages of care” were viewed as a means of meeting the needs of clinical units for seamless allied health care on the basis of predictable service requirements for specific diagnostic types without the need for costly discipline-by-discipline transactions.

Research data from Australian case study sites at the leading edge of internal service agreements and external contracts for allied health services showed that “allied health packages of care” were being enforced as a mandatory transaction unit in some sites:

“I don't sell physiotherapy, people negotiate for me for allied health and I give them a package. So if you come to me and say; I don't want a package, what I want is physio, as has happened in [names location] ... And I have to say to them; I'm sorry we don't do that ... I've had some big fights with them about that, but we can't do it like that, we don't do it like that! They give us an allied health contract and I give them the allied health mix that is right for their patients ... so I can't negotiate for pieces of a team to be available to every patient. (Code 4-6-1 2000)

The results of a recent national telephone survey of hospitals to be discussed more fully in the last section of this paper also revealed a relationship between the organisational structure of allied health services and the utilisation of grouped (allied health) multi-disciplinary packages of care. The survey results showed that with one exception only sites organised as divisions of allied health with appointed directors utilised the “allied health



packages of care” approach. The exception was a hospital that had developed a sophisticated information system for allied health during the life of its *division of allied health* before being restructured in the mid 1990s back to a classical medical model following an amalgamation in the mid 1990s.

## Changing of the Guard: New Leaders and the New “Allied Health”

Although comprehensive data continued to be unavailable during the 1990s on the penetration of various organisational models for allied health throughout the health system, several secondary data sources give a partial picture of changes in governance structures and the general development of “allied health” in the health industry.

### Expanding the allied health leadership cohort

Firstly, Melbourne’s Austin Hospital and Newcastle’s John Hunter Hospital, the flag ship hospitals of the *division of allied health and unit dispersement* models respectively, were subjected to significant change in the mid 1990s that removed them from their influential positions of leading the debates about the shape of the new “allied health”.

The *division of allied health* and the director’s position at the Austin Hospital were not carried over into the amalgamation with the Heidelberg Repatriation Hospital. The new model most closely resembled a return to a *classical medical* model with a representative allied health position organised from the heads of the individual allied health disciplines. The John Hunter Hospital abandoned its *unit dispersement* model and established a traditional profession-management model in 1995 that most closely resembled a *classical medical* model with a chairperson of allied health representative position (Boyce 1996c; Robinson & Compton 1996). In 2000, a funded Area director of allied health position was established in the Hunter Area Health Service incorporating the John Hunter Hospital into a model that closely resembles that under which the Austin Hospital operated in the early 1990s.

The loss of leadership status of the Austin and the John Hunter hospitals was accompanied by a diffusion of influence across Australia to other sites operating a version of the *division of allied health* with a funded director’s position. These sites included, but were not limited to, the Royal Hobart Hospital, Canberra Hospital, Toowoomba Health Services, Whyalla Health Services, Queen Elizabeth Centre (Ballarat), Flinders Medical Centre, Adelaide Women’s and Children, Princess Margaret and King Edward Memorial Hospitals, Central Sydney Area Health Service, North Western Adelaide Health Service, and Princess Alexandra Hospital (Brisbane).

A further indicator of the continuity of change in allied health can be gleaned from secondary data associated with the 2<sup>nd</sup> and 3<sup>rd</sup> national allied health conferences held in 1996 and 1998. Attendance databases reveal that 16 and 22 people with the title director, manager, chair or co-ordinator of allied health registered for the conferences respectively showing that the demise of the model predicted in some quarters in the early 1990s had not occurred. Review of the conference programs again shows no discipline-based clinically oriented papers were delivered. The central focus continued to be on managerial issues with sessions on restructuring, marketing, best practice, health outcomes, innovative change, new service delivery models, benchmarking and evidence based practice. A 4<sup>th</sup> national allied health conference is to be conducted in 2001 in Perth.

Whilst the continuity in the national allied health conferences is an indicator in its own right of the shift from an exclusive focus on the individual professional discipline, the establishment of standing and ad hoc allied health groups at national, state and regional levels adds further evidence of the development of a collective “allied health” focus, at least in the domain of managerially-related issues. The evidence is less obvious in relation to clinically oriented issues but many of the developments in the conference papers cited above have used the collective “allied health” focus at the managerial level to drive changes towards more collaborative clinical practice.

## From allied health professions to “allied health”: Tribes and nations

Closely following the period of implementing new organisational models for allied health in Australian public hospitals in the early to mid 1990s there was a rise in targeted strategic activity by senior allied health professionals who organised under the banner or “allied health” at regional, state and national levels (Boyce 1997). This drive towards appropriating “allied health” as a professional, cultural and managerial vehicle was reflected in the emergence of new national groups such as the National Allied Health Managers Association, the National Allied Health Best Practice Consortium, the National Allied Health Benchmarking Consortium, and SARRAH (Services for Rural and Remote Allied Health) (Boyce 1997). Whilst the fortunes of the various groups have waxed and waned, often according to the continuity of a funding base, SARRAH has been extremely successful in building a sustainable membership and funding base and enjoys a high profile with government agencies.

Blayney & Fitz (1990, p. 8) have argued that the focus on the individual professions at the expense of the broader allied health grouping produces an unhelpful focus on “tribes rather than on nations”. Using the metaphor of tribes and nations, this period of transition in Australian allied health represents an appreciation of the politic of association as the means of attaining new influence. The attempts at nation building in terms of the impact on the established allied health tribes have not been without tension. A strategy has been to clearly delimit the terrains of influence with the new allied health associations avoiding the clinical domain that the individual associations regard as their core business sphere.

Part of the tension described above derives from the fact that the new groups are constituted by individuals rather than a federation or council of professions representative model through which the associations would be able to exert a high degree of control. Further, these new forms of association around “allied health” rather than individual professions potentially represent competitors in terms of developing relationships with government and policy makers. For example, the results of a survey of professional associations, relevant individuals and health care institutions (n= 134) about their attitudes to the formation of a National Allied Health Managers Association reported in Boyce (1997) showed that the national offices of allied health professional associations were the sector most likely to lack support for the proposal. The national association offices typically claimed that they already filled the role proposed by the new association. In contrast, these same association’s state-based offices were more likely to endorse the proposal on the grounds that the role was needed.

Australia does have a long-standing national allied health association formulated on a federation of professions model; the Australian Council of Allied Health Professions (ACAHP) (recently renamed the Health Professions Council of Australia (HPCA). Gardner & McCoppin (1995, p. 390) concluded that ACAHP had “never realised its potential as a powerful, peak organisation in allied health” despite it being the obvious forum for influence. Compared to the on-going influence and activity of SARRAH, Gardner and McCoppin’s observation of ACAHP would still hold today. Several states have seen the emergence of federated profession-based councils of allied health in the early to mid-1990s. These entities have had variable success in terms of their local influence however none had membership of ACAHP (or HCPA) because of the rigid nature of the membership charter of ACAHP and its restrictions to professions as the unit of membership. At a regional level allied health groupings have emerged along the lines of state government approaches to regions, area health boards, networks and districts. Workplaces and individuals rather than formal profession representatives have typically driven regional groupings.

The locus of power in sustaining this Australian “allied health” movement has primarily been the directors of allied health managing divisions of allied health (or their equivalent) in public hospitals. Their activities have seen the emergence of a national leadership cohort that was previously limited to a within-profession phenomenon. At the national and state levels the emergence of “allied health” has been somewhat variable with the exception of SARRAH, an organisation that had its genesis through the sponsoring efforts of the *division of allied health* at Toowoomba Health Services; again reinforcing the strength of the role of workplace based “allied health” in achieving change in the national landscape of allied health services.

In this section of the paper broader changes in the context of national developments have been reviewed to track the dimensions of change in public sector allied health in Australia in the decade of the 1990s. A critical

observation has been the mounting evidence of change in the relationship *between* allied health professions that has been argued elsewhere as representing a shift from the traditional understanding of allied health as “allied to medicine” toward a position of “allied to each other” (Boyce 1996a; Boyce 1998).

In the following section original data on the current state of governance structures for public sector acute care allied health services is presented from a recent national study. The results shed light on the outcome of predictions from the early 1990s about the extent of uptake of the governance structures discussed earlier in this article.

## Allied Health Governance Structures 2000

A national telephone survey of 114 public hospitals offering acute care services with more than 100 beds was conducted during late 1999 and early 2000. Hospitals were identified from the 1999 Hospital & Health Service Yearbook. Those which met the bed size criteria but which were identified as nursing homes, psychiatric, rehabilitation or other non-acute specialist sites or private hospitals were excluded from the survey database. Although the purpose of the survey was to investigate the activities of allied health professionals in internal service agreements and external contracts, specific questions were asked about organisational structure.

The data was collected by an experienced director of allied health with the expertise to pursue clarifying questions as an aide to classification. Data from 107 sites were included in the analysis representing a 94% participation rate. The occupational background of the 107 respondents who provided the data was as follows: 86% allied health professional, 2% nursing, 4% medicine and 9% administration.

The survey classified each organisation's allied health service governance structure as one of five structural options: *unit dispersement* model, *classical medical* model, matrix model, *division of allied health* model and other. The classification options have been described above with the exception of the matrix model which was defined as including two formal dimensions of organisational structure which in the context of this research could mean a formal *division of allied health* model coexisting with a *classical medical* model or a formal *division of allied health* model coexisting with a *quasi-unit dispersement model* (devolved clinical units) and so on. The crucial point of classification was that the multiple structural approaches were recognised as part of the formal organisation.

**Table 2 Australian Allied Health Organisational Governance Structures 2000**

Governance structure	Frequency	Total beds	% total beds
Unit Dispersement Model	6	1 239	3
Classical Medical Model	56 <sup>a</sup>	17 059	47
Division of Allied Health Model	37 <sup>b</sup>	13 118	37 (45) <sup>d</sup>
Matrix Model	6	3 831 <sup>c</sup>	11
Other <sup>e</sup>	2	869	2
TOTAL	107	35 936	100

Source: Original data

a Two sites indicated that they were about to be restructured into a unit dispersement model (without the support of the professional employees) and three sites indicated that they had approval to restructure into a division of allied health.

b Sites with an informal division of allied health consisting of a representative chair of allied health and no budgetary and managerial control of the allied health departments were classified as classical medical models.

c Four of the six organisations (2910 beds) classified as a matrix model include formal divisions of allied health with the equivalent of director positions. They were classified under the matrix model on the basis of the internal operational systems they described, however for some purposes they could be collapsed into the division of allied health model.

d When the bed numbers (2910) from the matrix model with a formal division of allied health (see above) are attributed to the division of allied health model the per cent of total beds rises to forty-five

e Two sites (509 beds and 180 beds) had an unusual hybrid governance model not able to be classified in terms of the four categories.

As shown in Table 2 the empirical evidence supports the speculations of the future importance of the *division of allied health* model in public hospitals at the time of its emergence in Australia ten years ago (Boyce 1991; Weeks 1991). The data shows that whilst the *classical medical* model continues to be important as a governance system with 47% of the total beds under survey, the *division of allied health* model accounts for 37% or 45% when adjusted to account for its presence in the matrix model. The unit dispersement model is relatively rare with only 6 sites identified. The 6 sites accounted for 3% of the total beds under survey. Two classical medical model sites indicated that they were to be restructured into a *unit dispersement* model without the support of the allied health professional employees. A further three sites indicated they had approval to implement a formal *division of allied health*.

There were trends in the data related to the size of the hospital and the utilisation of governance approach. The *division of allied health* model was more evenly distributed across most bed size categories (< 200; 201-400; 401-600; 601-800 and 801-1000) used in the survey analysis. In contrast, the majority of *classical medical* models were operating in hospitals less than 400 beds. The data showed:

- 5 of the 6 unit dispersement models have less than 200 beds
- 23 and 21 of the 56 classical medical models had less than 200 beds and between 201-400 beds respectively
- 4 of the 6 matrix models had more than 600 beds, and
- Of the 37 divisions of allied health models (excluding chairs - see note in table 2) 11 had less than 200 beds, 12 had between 201-400 beds, 11 had between 401-600 beds, 2 had between 601-800 beds and 1 was between 801-1000 beds.

The national telephone survey was designed to capture data on the uptake of internal market reforms by allied health professions in public hospitals using internal service agreements and external contracts as the markers of activity. Organisational governance structures such as the *division of allied health* were theoretically argued to have a higher degree of fit with the demands of internal marketisation strategies (Boyce 1998). Data derived from the national survey showed that no sites operating as a classical medical model or a *unit dispersement* model were engaged systematically in multi-disciplinary “allied health” external contracting or internal service agreements, although some individual allied health disciplines were able to demonstrate a small number of agreements or contracts (Boyce, Shepherd & Mickan 2000, p. 14).

## Conclusion

The Australian allied health professions have engaged in a decade of change particularly at the level of workplace governance systems. During this time traditional organisational approaches based on individualistic professional disciplines in subordinate organisational relationships with corporate level medical executive positions have been replaced with greater diversity in institutional arrangements.

The evidence presented shows that the expected dominance of the *unit dispersement* approach, and the consequential threats to profession interests that it was claimed to represent, have not come to pass. The *division of allied health* model has gained a central place in health services management in Australia as a viable model of organisation that is continuing to grow in number. The particular dynamics of the divisional model that leads to a more collaborative managerial focus on the “business of allied health” has driven clinical level operational reforms such as the internal matrix principles associated with the “*integrated decentralisation*” form of organisation.

“*Integrated decentralisation*” creates an internal allied health matrix which is premised on the recognition of the on-going importance of professionally managed services to sustaining professional identity, service management and development, together with a focus on customers (internal purchasers) through allied health service delivery teams. The internal matrix is an attempt to reconcile the complexity of integrating the management of diverse professionals on the one hand and delivering services to a range of clinical units with greater expectations of collaboration, accountability and service outcome on the other.

An outcome of the program of research discussed above is particularly relevant to health service executives and decisions made on organisational design. Removing profession-managed services through restructuring does not of itself remove what might be perceived as problematic profession-centred behaviour in organisations (Boyce 1996a, 1998). Somewhat counter-intuitively, the results of this research program suggest that supporting profession-managed services through a collective “allied health” framework can lead to a greater engagement of professionals with the organisation. Whilst this finding might not be generalisable to other health professions, in the case of allied health professions, nurturing a new *organisational* “allied health” identity that builds on the cultural capital of being “allied to each other” is partially responsible for the transition in allied health services that can be observed over the past decade.

Although the transition in allied health services is most profound at the workplace level, significant changes have also occurred at regional, state and national levels. These changes are delivering a greater voice for the interests of allied health in the crowded marketplace of the health sector. Rather than the reforms of New Public Management associated with marketisation, managerialism and restructuring representing a threat, they have provided opportunities for allied health professionals to create new structures, identities and futures.

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## Bibliography

- Abernethy MA & Stoelwinder JU 1995, ‘The role of professional control in the management of complex organisations’, *Accounting, Organizations and Society* vol 20, no 1, pp 1-17.
- Altus E & Bonnici J 1997, ‘Embracing change: allied health adopting a marketing approach’ paper presented at Australian College of Health Service Executives National Congress, Adelaide.
- Anderson RE & McDaniel RR Jr 2000, ‘Managing health care organizations: Where professionalism meets complexity science’, *Health Care Management Review*, vol 25, no 1, pp 83-92.
- Australian Physiotherapy Association 1994, *Position Statement and Discussion Paper on Hospital Restructuring*, Australian Physiotherapy Association, Melbourne.
- Bauer D 1985, ‘Paramedical organizations in focus’, *Contact, (Newsletter of the Victorian Health Professionals Association)*, vol 2, pp 8-9.
- Bishop M 1996, ‘Welcome to our nightmare? A zero base budgeting approach to allied health professional services’, *Proceedings of the 2nd National Allied Health Services Conference*, Division of Allied Health, Central Sydney Area Health Service, Sydney.
- Blayney KD & Fitz PA 1990, ‘The allied health professions: a critical resource in the future of health care, in *Perspectives on the Health Professions*, Pew Health Professions Programs, Duke University, Durham, NC, pp 5-21.
- Boyce RA 1991, ‘Hospital restructuring: The implications for allied health professions’, *Australian Health Review*, vol 14, no 2 pp 147-154.
- Boyce RA 1993a, *The Organisational Design of Hospitals — A Critical Review: A Report on the 1992 Australian College of Health Service Executives Overseas Study Award*, Australian College of Health Service Executives, North Ryde, Australia.
- Boyce RA 1993b, ‘Internal market reforms of health care systems and the allied health professions: an international perspective’, *International Journal of Health Planning and Management*, vol 8, pp 201-217.
- Boyce RA 1996a, ‘The Organisation of Allied Health Professions in Australian General Hospitals’, Unpublished PhD Thesis, Queensland University of Technology, Brisbane, Australia.

- Boyce RA 1996b, *The Management and Organisation of Rural Allied Health Services*, Graduate School of Management, University of Queensland, Brisbane, Australia.
- Boyce RA 1996c, 'Researching the organisation of allied health professions: Sorting fact from fiction' *Proceedings of the 2nd National Allied Health Conference, Division of Allied Health Central Sydney Area Health Service*, Division of Allied Health, Central Sydney Area Health Service, Sydney.
- Boyce RA 1997, 'Health sector reform and professional power, autonomy and culture: the case of the Australian allied health professions', in R Hugman, M Peelo & K Soothill (Eds) *Concepts of Care: Developments in Health and Social Welfare*, Arnold, London.
- Boyce RA 1998, 'The allied health professions', in M Clinton & D Scheiwe (Eds) *Management in the Australian Health Care Industry*, 2nd Edition, Longman, Melbourne.
- Boyce RA 2000, 'Allied Health' in an International Context: Problems of Description, Definition and Identity', Unpublished working paper, Graduate School of Management, University of Queensland, Australia.
- Boyce RA & Shepherd N 2000, 'Entrepreneurship as a dimension of professional culture', *Proceedings of the Annual Conference of the Australian Sociological Association*, Adelaide.
- Boyce RA, Shepherd N & Mickan S 2000, 'Restructuring professional culture: The impact of "enterprising" management ideologies and entrepreneurship on public sector professionals', paper presented to State, *Political Power and Professional Structures: New Patterns and New Challenges Conference of the International Sociology Association*, Lisbon, Portugal.
- Cook S 1994, 'The future of occupational therapy in health and social care markets: report of a professional workshop', *British Journal of Occupational Therapy*, vol 57 no 7, pp 284.
- Catchlove B 1991, 'Changing the Management Structure at the Royal Children's Hospital', *Australian Health Review* vol 14, pp 86-88.
- Charns MP & Tewksbury LJS 1993, *Collaborative Management in Health Care: Implementing the Integrative Organization*, Jossey-Bass, San Francisco.
- Degeling P, Kennedy J, Hill M, Carnegie M & Holt J 1998, *Hospital Reform and Professional Subcultures*, University of NSW, Sydney.
- Duckett SJ, Scarf CG, Schmiede AM & Weaver C J 1981, *The Organisation of Medical Staff in Australian Hospitals*, Longman Cheshire, Melbourne.
- Gardner H & McCoppin B 1995, 'Struggle for survival by health therapists, nurses and medical scientists', in H Gardner (ed) *The Politics of Health: The Australian Experience*, 2nd Edit, Churchill Livingstone, Melbourne.
- Haas M 1996, 'Theoretical perspectives on organisational restructuring in health care', *Proceedings of 2nd National Allied Health Services Conference*, Division of Allied Health, Central Sydney Area Health Service, Sydney.
- Haas M & Hall J 1996, 'Clinical budgeting for allied health: Some options and issues in a hospital setting', Discussion Paper No 30, Centre for Health Economics Research and Evaluation, Sydney.
- Harris P 1999, 'Changing patterns of governance: developments in Australian public hospitals and universities', *Policy Studies* vol 20, no 4 pp 255-272
- Huddy A 1992, 'Position Statement on Organisational Structures', Queensland Council of Allied Health Professions, Brisbane.
- Hugman R 1991, *Power in Caring Professions*, Macmillan, Basingstoke.
- Hunter DJ 1996, 'The changing roles of health care personnel in health and health care management', *Social Science and Medicine* vol 43, no 5 pp 799-808.
- Institute of Medicine 1989, *Allied Health Services: Avoiding Crises*, National Academy Press, Washington DC.
- National Health Strategy Unit 1991, *Hospital Services in Australia — Access and Financing*, National Health Strategy Unit, Melbourne.



National Health Strategy Unit 1993, *Health That Works: Reform and Best Practice in the Australian Health Industry*, National Health Strategy Unit, Melbourne.

Nihill M 1992, 'Recruitment and retention of allied health staff in the country - The Whyalla model', paper presented to *First National Allied Health Services Conference*, Melbourne, Australia.

Øvretveit JA 1988 'Professional Power and the State: A Study of Five Professions in State Welfare Agencies in the UK', unpublished PhD Thesis, Brunel University, United Kingdom.

Øvretveit JA 1992, *Therapy Services: Organisation, Management and Autonomy*, Harwood Academic Publishers, Chur, Switzerland.

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

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

Public Service Association 1990, *Allied Health Departments in Public Hospitals*, Public Service Association, Sydney.

Robinson M. & Compton J 1996, 'Decentralised management structures - the physiotherapy experience at John Hunter Hospital', *Australian Journal of Physiotherapy*, vol 42, no 4, pp 317-320.

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

Scarf CJ 1991, 'Clinical Management Structure: The Royal Prince Alfred Hospital Experience', *Australian Health Review*, vol 14, pp 83-85.

Weeks GR 1991, 'The allied health movement and changing organizational structures in hospitals: A pharmacy perspective', *Australian Journal of Hospital Pharmacy*, vol. 21, pp 359-367.