CASE STUDIES

# Clinicians as managers: Organisational change at the Illawarra Regional Hospital

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ABSTRACT

*In 1990 a decision was made to merge the Port Kembla (160 beds) and Wollongong (290 beds) Hospitals into the Illawarra Regional Hospital and to change the traditional functional management structure to one of product line institute management, with medical officers as part-time clinical directors. This transformation in health care management had been occurring in other sections of the Illawarra Area Health Service, with medical directors of programs and with allied health and nursing heads of departments throughout the system.*

*A survey was conducted among 22 clinician managers for their impressions of the 'new' management organisation. The respondents felt that the change had been a positive one and that it had particularly improved communication and accountability among clinicians.*

## Introduction

In 1991 the Australian National Health Strategy (1991, p 149) recommended

> altered internal organisational structures in hospitals for the clinical work force along divisional lines...this strategy would facilitate improved knowledge, responsibility and accountability amongst clinicians; and provide incentives for more cost-effective management.

Hospitals have traditionally been managed along what Mintzberg (in Rakich, Longest & Darr 1992) calls 'professional' bureaucratic lines – a director of medical services, a director of nursing services and a director of finance and administrative services reporting to a chief executive officer – with clinicians responsible for caring and managers for controlling (Degeling 1993). In Australia a number of hospitals in Melbourne and Sydney (Braithwaite 1993; Harris, Harris & Tapsell 1993; Hickie 1994) have now adopted 'product line' management structures similar to those of Johns Hopkins Hospital in Baltimore in the United States (Boyce 1993, Braithwaite 1993; Heyssel et al. 1984) and Guy's Hospital in London (Bernstein 1993; Braithwaite 1993; Burgoyne & Lorbiecki 1993; Chantler 1989; Lewis 1988; Sang 1993; Smith, Grabham & Chantler 1989), in which *patient-focused groups* are created and managed *across* 'functional' lines. The responsibility for decision-making is changed from the traditional matrix (Rakich, Longest & Darr 1992; Robbins 1991) to a structure in which clinical teams report to the general manager. The key element of the new structure is that the decision-making power of *budget responsibility* rests with directors of neurosciences, cancer services, surgery and so on rather than hospital directors of nursing, medical services and the like.

The Illawarra Area Health Service (IAHS) had begun this transformation in 1989 when it created area-wide programs in its structure, in psychiatric services, rehabilitation and geriatric services and community health services. Program directors (in this instance, all doctors) were given responsibility for their identified budgets across many different hospital and community centre settings and expected to plan, control, evaluate and serve within them.

By 1990 a decision had been made to merge the Port Kembla Hospital (160 beds) and the Wollongong Hospital (290 beds) to form the Illawarra Regional Hospital and to continue this clinical management model by creating an institute structure with clinician directors. The term 'institute' was chosen over 'division' because the IAHS already had divisions within its Medical Staff Council. The institutes were to be product line units within one hospital of the area health service and they were to be distinctive management entities. Positions for a director of nursing and medical superintendent for the Illawarra Regional Hospital were retained in 'staff' rather than 'line' management roles. The catalysts for this change were very similar to those in other settings in the United States and Australia (Braithwaite 1993): finance, competition, improvement in quality of certain products and clinical accountability.

As part of the evaluation of the impact of this change a survey was conducted in late 1994 among medical, nursing and allied health clinician managers in the IAHS and the Illawarra Regional Hospital to review their experiences and their impressions of management. The findings were also considered as part of a review of the clinician management structure of the hospital conducted over the next year.

## Illawarra Area Health Service

In early 1990 the IAHS was one of ten area health services in the New South Wales Department of Health. There were also 23 country districts. The IAHS was responsible for the health of 300 000 people along 200 kilometres of coastline south of Sydney. It managed nine hospitals of sizes ranging from 20 beds to 290 beds and numerous community health centres. The IAHS provided acute services, health promotion services, community health services, psychiatric services and aged care and rehabilitation services. The community health services included drug and alcohol support, mental health, dental services, diabetic education, sexual health and sexual assault services.

The budget for the IAHS was approximately $155 million and it could expect reductions of 1 to 2 per cent annually for the foreseeable future to bring it in line with the resource allocation formula for New South Wales. It had a high level of outflow to Sydney.

The IAHS was establishing close links with the universities of Wollongong and New South Wales for teaching and research collaboration in an attempt to raise the profile of the Illawarra area as a resource for those activities. The IAHS had established itself as a teaching area for postgraduate medicine, nursing, psychology and human movement science in conjunction with the Faculty of Health and Behavioural Sciences at Wollongong University. The area would need a hospital of 450 to 500 beds to attract the resources associated with being a teaching hospital.

## Illawarra Regional Hospital and clinician management

The reasons for the merger of the Port Kembla and Wollongong Hospitals were:

1. To create a referral (and possibly teaching) hospital in the northern

sector of the Illawarra by amalgamating Port Kembla and Wollongong Hospitals.

2. To reduce the waste associated with running two hospitals and test the hypotheses surrounding efficient bed-day numbers.
3. To achieve savings and redistribute resources from the northern sector to the Shoalhaven sector.
4. To reduce outflow from the Illawarra region by concentrating resources in one hospital rather than two.
5. To involve IAHS clinicians in more managerial decision-making in the belief that because they are most directly responsible for the costs of health care they are in the best position to describe ways of reducing waste.

Planning took place across a year, with a working party chaired by a clinician and a number of subcommittees with relevant stakeholders. In May 1991 the Illawarra Regional Hospital was formed with four clinical directorates, known as institutes, *each with its own budget* and a management structure of clinical director (medical practitioner), director of nursing and business manager. Technical and support services were separated. They all reported to the general manager. The four institutes were Surgery and Critical Care, Medicine and Diagnostics, Rehabilitation and Allied Health, and Maternal and Paediatric Services. The budget devolution continued down to department heads so, for example, the heads of Physiotherapy, Speech Pathology and Social Work also became responsible for their budgets. Interestingly, the four institutes were still a mixture of 'functional' and 'product' lines – surgeons, physicians and diagnosticians were still functionally grouped, as were allied health professionals; however, maternal services, critical care services and rehabilitation services with their multiple clinicians were grouped as product lines. The most significant change was the *devolution of budgets* and the *leadership by part-time doctors retaining clinical practices*. The management responsibilities were to include recruitment, plant purchase, maintenance costs and so on and a sophisticated system of cost centres was created.

The institute directors applied for their positions and were interviewed to be chosen. The changes for some were enormous. This report focuses on their opinions of that experience over three years, as well as those of other clinician managers in the IAHS and of allied health professionals in clinical management roles.

## Aims of the survey

1. To establish the management demands being made on clinician directors at the area health service and the Illawarra Regional Hospital level.
2. To determine their preparation for the changes.
3. To establish the effects on their relationships with their peers.
4. To compare their experiences with other clinical managers in the Illawarra Regional Hospital and the area health service.
5. To canvass their opinions on possible future changes.
6. To pilot a survey for establishing the effectiveness of this form of questioning for extension to other areas of the hospital (business managers, support services) to enhance the evaluation of the organisational change for strategic planning.

## Method

The survey focused on previous management experience, management skills, operational involvement, budgetary control and thoughts for future evolution of the organisational structure. The survey reflected impressions from the literature and used qualitative questions requiring marking on a scale of 1 to 10 as well as some open-ended questions. It was distributed in late 1994 to doctors who held or had held institute director positions in the Illawarra Regional Hospital in the previous three years, to area program directors and to senior allied health and nursing staff in the area and the hospital.

## Results

Twenty-five surveys were distributed and 20 were returned: nine doctors, one dentist, three pharmacists, two nurses, one physiotherapist, one occupational therapist, one speech pathologist, one social worker and one dietitian. Responses from the doctors and dentists were grouped for analysis and the allied health and nursing responses were grouped. Responses of the doctors and dentists will be described first.

There were two women and eight men in the first group, with an age range of 33–72 years (median 40 years). They had held their current

management roles as Illawarra Regional Hospital institute directors or area program directors (or in some instances both) for between 8 months and 5 years and had been specialists in their chosen clinical areas for between 3 and 35 years prior to being appointed. They maintained clinical loads varying between 10 hours and 40 hours per week. It was clear later in the questionnaire that those carrying the higher clinical loads complained most of lack of time for management tasks.

Only one doctor had formal management qualifications prior to appointment to the clinical management position under review, some had attended seminars prior to appointment and all had begun continuing education or formal training in management since appointment. None felt that the training had been a consideration in their appointment, nor did they feel it would it be necessary in the future; all were involved because of their own interest or because they felt it important for their institutes or programs. All believed that their clinical credibility/seniority was important to their appointments and although five of the ten felt that their management background may have had some bearing on their appointments, no-one believed it had been essential.

All had business manager support to varying degrees, three felt they would like more administrative support, and all thought it essential. The levels of business manager qualification varied – some had the expertise of a person with tertiary management qualification, one had support from a clerk with no formal training. Four also had nursing management support.

Five of those in the doctors' group felt that their level of budget responsibility was about right, five felt that they would like more responsibility. In those instances there was a call for more flexibility, for example, the capacity to retain savings or pursue creative alternatives in a business sense for accruing and retaining revenue, 'permission' to enter into enterprise agreements and capacity to plan for more than one year.

The group was asked to rate their need for particular management skills. They considered them to be in the following order of importance:

1. Communication
2. Ability to facilitate change
3. Negotiations with peers
4. Capacity for decision-making
5. Planning
6. Ability to be a team builder

7. Ability to recognise conflict
8. Capacity for creative thinking
9. Ability to be a team member
10. Writing skills
11. Budget skills
12. Negotiations on industrial issues
13. Awareness of occupational health and safety.

The three things most frequently cited as the most satisfying aspects of the clinician manager role were the ability to facilitate change, the capacity to influence the quality of care provided and the challenge of the 'new' role. The three most commonly reported unsatisfactory aspects of the role were lack of time available to do the job well, lack of responsiveness and support from 'above' and difficulties with negotiations with peers. Only a small number felt that training would help in their perceived problems, and all felt supported by other clinical managers.

Seven of the group felt that non-medical clinicians *could* do their jobs. There was strong opinion that a clinician brought the right mix of background and credibility. One commented that the job required clinical judgement and priority-setting, not a medical degree. Others commented that the person should retain a clinical load to avoid becoming a full-time bureaucrat. In spite of this support, only three would be happy for a medical administrator or nurse to be given their jobs. This was because they perceived that the full balance of issues might not be addressed, or that the person might lack the support of the doctors or lack complete understanding of the issues for the particular clinical area.

The three most commonly cited differences that clinician management structuring had made over the past three years were improved communication between clinicians and 'management'; a sense of ownership of the processes of the regional hospital rather than decision-making at a distance; and improved responsiveness by doctors (and dentists) to financial constraints.

The second group of respondents, the allied health professionals and nurses, were all department heads with varying levels of responsibility for their budgets.

They had an age range of 31–53 years, with a median age of 40 years. They had held their respective positions as heads for between six months and ten years. They held clinical loads that varied from zero to 20 hours per week (median 20 hours). Four held postgraduate management degrees.

All felt that their clinical expertise/seniority was important in their appointments but six of the ten believed that their management background/expertise was more important.

The management skills most valued were (in order):

1. Capacity for decision-making
2. Communication skills
3. Ability to be a team member
4. Capacity for creative thinking
5. Ability to recognise conflict
6. Planning skills
7. Ability to be a team builder
8. Ability to facilitate change
9. Writing skills
10. Budget skills
11. Awareness of occupational health and safety
12. Negotiations with peers
13. Negotiations on industrial issues.

All allied health professional heads and nursing directors had business manager support and felt it necessary. All felt that they would like more administrative support and most felt that they would like more responsibility for their budgets: to be more flexible, to be able to retain savings and to be able to plan for more than one year at a time.

The three most commonly cited reasons for satisfaction in their positions were developing staff in teamwork; being able to influence the quality of care provided; and setting direction and planning. The three most unsatisfactory aspects of their positions were lack of control over the budget and lack of budget to do things well; lack of time in juggling clinical with managerial loads; and problems with managing two sites.

There were few comments from this group about the effect of the institute structure on the Illawarra Regional Hospital, probably because they had retained their own 'functional' structure. The allied health departments stayed as distinct departments with career structures intact. For some the budgetary responsibilities were increased and some did comment on the problems associated with managing two-site departments. The corollary was the capacity for a bigger pool of staff for relief and rotation, and greater opportunity for communication with doctors.

## Discussion

The announcement of the plan to merge two hospitals and create a new management structure was met with significant anxiety in a number of stakeholders. The public associations (particularly the South Coast Labour Council) saw the beginning of the end for Port Kembla Hospital, the general staff saw job losses and the management staff in the traditional 'functional' system saw heartache as the merging of their functions meant career position casualties. The doctors had mixed feelings – there was interest in the concept of more clinician involvement in decision-making but scepticism that this was a real attempt to achieve this end.

There was much discontent amongst onlookers as to the management skills of clinicians, particularly doctors. It was perceived that generally doctors were used to being professionally autonomous, being 'customers' of the hospitals, and certainly not used to having their clinical decisions questioned with respect to cost. There was a perception that trained administrators had more management experience and expertise than the doctors becoming institute directors and there was a reluctance to entrust decision-making to them.

Previous experience with this structure (Bernstein 1993; Hickie 1994) suggests that most clinicians appointed to clinical director roles have no formal qualifications in management and that business manager support is a necessary component of the organisational restructure. The IAHS clinical directors generally fit this description and this was one cause for discontent, particularly among nursing administrators. It was interesting that the formal requirement for management expertise was more advanced among the allied health professionals than among the doctors. It should be noted that recruitment for heads of allied health departments is usually an open external process and that management qualifications are an essential criterion for appointment, whereas the doctor-director appointments in this instance were from among the ranks of existing medical appointees to the hospitals involved.

Both groups rated communication skills and decision-making highly. The doctor group noted negotiation with peers as important while the allied health professionals had this well down the list. The allied health professionals noted team membership as important while the doctors gave this less importance. This may well be due to interpretation of the concepts.

Industrial issues, occupational health and safety and budget skills were the least important skills for both groups and it is likely that this is because they relied on business managers for this expertise.

Interestingly, both groups would have liked more capacity to control the budget, in spite of this being one of the original aims of the change to the organisational structure. It was noted in the review conducted over 1995 that budgetary difficulties at the Illawarra Regional Hospital may have required the general manager of the hospital and the area executive to have become more involved in institute business decisions than would be desirable. In particular, it had not been possible to allow institutes to exercise full autonomy over their expenditure and savings.

Both groups enjoyed the challenges of managing, the doctors enjoying facilitation of change and capacity to influence quality and the allied health professionals enjoying managing their staff and being responsible for quality. The difficulties experienced by the doctors with peer criticism and lack of time for management responsibilities have been noted in the literature (Braithwaite 1993). The lack of support and responsiveness 'from above' may be unique to the Illawarra Regional Hospital. Both groups wanted more responsibility for their budgets but the allied health professionals more resoundingly so – their sense of frustration was related to how small their budgets were and their powerlessness to influence them. The other major complaint was the difficulty of managing two sites, a point not made by any of the doctors. It is possible that the allied health professionals as clinical managers were more operational than the doctors, whose role was more directive and strategic, as planned.

The clinical directors believed that good nursing, medical or allied health administrators could probably do their jobs. They did not believe that directing the product line structure necessarily required a medical degree but that there was certainly value in the director being a practising clinician of some discipline. In spite of this most felt that there was still a need in the political and financial climate of the Illawarra to retain a doctor as a director for a while.

There was also a need expressed for the position of part-time medical superintendent. Generally, the institute directors were not particularly interested in the day-to-day administrative issues such as medico-legal reporting, medical work force issues or junior resident medical officer recruitment and management.

For the larger institutes, however, time-consuming management left little time to be a credible manager and a credible clinician so the future may require some compromise to be made. The other dilemma faced by these clinicians had been the antagonism they had received from their peers who had expected advocacy and been affronted by accountability requirements.

In 1990–91 it cost approximately $70 million to run both the Port Kembla and Wollongong Hospitals; in 1993–94 it cost approximately $72 million to run the Illawarra Regional Hospital. These figures are not comparable because of wage increases and enhancements which have occurred. What is known, however, is that there were $2.5 million savings made in linen and pathology costs, as well as in nursing and medical officer staffing, much of which could be credited to the product structuring and attention to activities such as clinical pathways in particular institutes or wards.

Activity in the hospital increased. Between 1991–92 and 1993–94 there was a 25 per cent increase in admissions, a 52 per cent increase in day-only activity, a 7 per cent increase in non-inpatient occasions of service and a 24 per cent decrease in length of stay. There was no change in outflow from the area. Quality management activities based on feedback of casemix-based data changed the investigatory costs and reduced length of stay. Some of this change may have occurred regardless of structure but there was a sense among the clinicians that improved communications and accountability measures have contributed to the trends. There was a pervading belief that the experiment should continue because of the significant gains in ownership of decision-making that the formation of the institutes of the Illawarra Regional Hospital had created. It will be interesting to watch the evolution of this clinician management structuring in hospitals in Australia, particularly in light of recent criticism of the cost of creating this level of 'bureaucracy'.

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