

# **A case study in strategic change: Developing a strategic research program to address cardiovascular disease and related disorders in Aboriginal and Torres Strait Islander peoples and rural and remote settings**

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## **Abstract**

This paper presents an analysis of a strategic change process. It identifies and reviews the critical factors that impact on, and need to be considered in order to successfully initiate and implement change.

The problem was the narrow focus and priorities of a well-established research program. We undertook a stringent process to refocus the program to the areas of greatest need. The paper provides information on the process undertaken to achieve the change and other factors that impacted. The outcome has been considered successful in the first instance. However the long-term picture may not be as positive. Reviewing and presenting the process and influential factors provides the reader with the opportunity to compare this scenario with their own experience and thereby develop their own change strategies.

## **The need for strategic change**

Strategic change, or change that enables an organisation to address priorities through a dynamic and appropriate response to a changing environment, is essential for sound organisational growth and development. Successful change is predicated on sound planning and clear processes that take into consideration, and advantage of, external and internal forces (Stoner, Yetton, Craig & Johnston, 1994). However, it is far from easy to achieve, and there are frequent failures (Braithwaite et al, 2002).

This paper presents a description and analysis of a qualified success story of achieving significant strategic change within the National Heart Foundation (NHF), and using a financial commitment from NHF to negotiate a collaborative research funding arrangement with the Commonwealth Department of Health and Aged Care (DHAC). This has resulted in a substantial increase in funding for priority and strategic research in cardiovascular disease (CVD) and related disorders in Aboriginal peoples and Torres Strait Islanders and rural and remote populations.

Early in 1998 the NHF initiated a priority program for Aboriginal peoples, Torres Strait Islanders and rural and remote populations. Shortly after the commencement of the program, the Rural, Remote, Aboriginal and Torres Strait Islanders Advisory Committee (RRAAC) was convened to provide strategic direction and advice. This committee comprises academics, health service providers and representatives from government and non-government organisations. RRAAC has expertise in public health, epidemiology, clinical care, health services, policy development and planning for Aboriginal peoples and Torres Strait Islanders and rural and remote settings and has been active in planning for strategic health care and research in CVD in these areas. RRAAC and the Program Director were strong internal forces that impacted on the success of achieving strategic change that involved a significant shift in the allocation of internal and external funding.

In the past 40 years the NHF has provided \$79 million for research. This is equivalent to \$138 million at 1999 dollar values. The NHF Business Plan 1999 states that "... peer reviewed basic [scientific] and clinical research and individual funding of Research Fellows, Scholars and travel grants continues as a crucial aspect of the Foundation's work. Priority areas include clinical research, public health and epidemiology, behavioural research, and research among socially disadvantaged groups including Indigenous populations."

Despite this prioritisation, Professor Andrew Tonkin, NHF Director of Medical and Scientific Affairs stated in 2000 that "... we are advancing rapidly in basic scientific research [but] by contrast public health research and social research have been relatively neglected. A process was developed to address this deficit particularly in research into CVD in Aboriginal peoples and Torres Strait Islanders and rural and remote populations" (NHF, 2000). Professor Tonkin was responsible for the changes in prioritisation and focusing managerial policy toward Aboriginal and Torres Strait Islander Health. He was therefore a powerful internal force in this change process.

## **Process of strategic change: reviewing research and identifying priorities**

A combination of internal forces through organisational change and external forces through changes in government policy, and a major review of research by Wills in 1998, influenced the shift towards a NHF strategic research program into CVD in Aboriginal and Torres Strait Islander peoples and rural and remote populations. These factors combined with three major activities in the change process. These were the promulgation of a discussion paper on research priorities developed by RRAAC; a workshop in Townsville to progress implementation of the DHAC National Health Priority Area report on Cardiovascular Health; and a workshop in Alice Springs to determine strategic research priorities for CVD in Aboriginal peoples, Torres Strait Islanders and in rural and remote settings.

The NHF reviewed its general research program in 1998. To inform this process, RRAAC developed an options/discussion paper. The paper provided the opportunity to promote key issues identified by Wills (1998). These included priority and strategic research, and evaluation and dissemination research as an alternative to investigator driven, fundamental and clinical research (Wills, 1998). The latter paradigm had predominated in the NHF research program since inception (Field, 1999). This paper was circulated widely, both internally and externally. Whilst the NHF's response to the document indicated that the points raised would be considered in the development of the generic NHF research program, no immediate action was taken. This cautious response is to be anticipated when significant change is proposed.

Secondly, RRAAC was progressing the recommendations of the DHAC National Health Priority Area report on Cardiovascular Health that related to heart disease in Aboriginal peoples and Torres Strait Islanders and rural and remote populations. Almost 100 participants, including representatives of the National Aboriginal Community Controlled Health Organisation (NACCHO), DHAC, Divisions of GPs, clinicians, non-government organisations and relevant academic institutions, attended a workshop in Townsville in October 1999. Participants developed a detailed action plan to implement the report's recommendations.

Finally, a process was implemented to determine strategic research priorities for CVD in Aboriginal peoples and Torres Strait Islanders and rural and remote settings. The research planning group included representatives of the NHF, the Centre for Remote Health (Flinders University and Northern Territory University), the South Australian Centre for Rural and Remote Health, NACCHO, Edith Cowan University, the University of Melbourne and Monash University. This planning group commissioned literature reviews to determine the state

of knowledge of CVD in Aboriginal peoples and Torres Strait Islanders and rural and remote settings. The information was presented to a workshop held in Alice Springs in November 1999.

This workshop was co-hosted by the NHF Rural, Remote, Aboriginal and Torres Strait Islander Program and the Centre for Remote Health, Alice Springs. It brought together over 40 key researchers, community representatives, policy makers and health practitioners. Information from the Townsville workshop was also used at this workshop.

The task of the workshop was to consider the needs of rural and remote non-Indigenous populations, as well as rural, remote and urban Indigenous populations, and to identify gaps in knowledge and research priorities that would contribute to an improvement in health outcomes related to CVD.

The major findings of these activities were that research in this area has been predominantly descriptive, with few intervention studies, evaluation or dissemination research. There was also a dearth of public health, sociological or behavioural research. Differing research foci and findings were identified for Indigenous and non-Indigenous Australians.

### **Rural and remote non-Indigenous populations**

Whether there is a difference in the cardiovascular health of rural and remote populations compared with urban populations, when Aboriginal and Torres Strait Islander people are considered separately, remains unclear. Evidence presented by some of descriptive studies is that there is no significant difference (Wilkinson, 1999; Australian Institute of Health and Welfare, 1998).

However, this conclusion is based on highly aggregated data. There is regional evidence that people living in rural and remote areas have poorer health status, including higher rates of CVD, and reduced access to services compared with their metropolitan counterparts (Fragar, Gray, Franklin & Petrauskas 1997; Harper, 1998; Sexton & Sexton, 2000). Hospitalisation rates are higher, and lengths of stay longer in the rural and remote areas compared with the city (Huy Dinh Vu, Heller, Lim & D'Este, 2000). It has also been demonstrated that hospital mortality in non-metropolitan hospitals is higher than in metropolitan hospitals, after adjusting for severity of disease (Heller, O'Connell, D'Este, Lim & Fletcher, 2000). The authors of this study propose that this may be partly explained by the difference in treatment regimens between rural and urban settings. Another study demonstrates that the rate of access to procedures is comparatively poorer in rural and remote areas (Department of Health and Aged Care and Australian Institute of Health and Welfare, 1998).

These findings suggest that there are significant inequalities in health status, treatment, access and outcomes. Further investigation is needed in order to provide comparable regional information that can be used to make informed decisions.

### **Aboriginal peoples and Torres Strait Islanders**

The review served to confirm that CVD continues to be the highest cause of mortality in Indigenous and non-Indigenous populations. Across all age groups Aboriginal peoples and Torres Strait Islanders are known to die from CVD at twice the rate of other populations (Thomson, 2000). Thomson also found that in the 25-45 year age group, the mortality rates are up to 15 times higher. The higher rate of CVD in Indigenous populations is further compounded by rates of diabetes that are up to 16 times higher than in non-Indigenous populations (Australian Institute of Health and Welfare, 1999). Finally Thomson concluded that the vast majority of studies were descriptive. The review indicated that very few interventional studies had been undertaken.

### **Identified research priorities**

As a result of this process, the following research priority areas were identified at the Alice Springs workshop (Field, Wakerman & Nash, 2000):

- Interventions aimed at risk factors for CVD and the associated cluster of risk factors (poor nutrition, sedentary lifestyle, and tobacco) for non-communicable disease (eg, diabetes, renal, hypertension, stroke, some cancers)
- Food supply issues
- Strategies to enhance community control and participation in all processes including health services and also individual power and control over the environment, health risk factors and disease

- Models of health care
- Addressing social and economic inequalities
- Improved information relating to epidemiology, access, quality and data collection
- Building shared cultural understanding

The workshop participants concluded that research projects are required that address or identify epidemiological and demographic regional variations including morbidity, mortality, treatment, risk factors, follow up and migratory patterns; barriers to access and management issues, including health service systems and structures; and various interventions focusing on risk factors and treatment to be trialled and evaluated using appropriate methodology.

Behavioural and sociological research was also supported as a priority. Workshop participants called for funding bodies to alter their criteria and review processes in order to ensure that there is appropriate peer review by social and behavioural scientists specifically to support these categories of proposals.

## Results of the strategic change process

Based on this evidence, the NHF Cardiovascular Health Advisory Committee (CVHAC) supported the RRAAC recommendations that \$275 000 be allocated from the NHF research budget to support appropriate research, and study grants, for research in rural, remote and Aboriginal and Torres Strait Islander populations.

These funds were to be used for competitive research grants within the priority areas and specified criteria to a maximum level of \$250 000, and for scholarships or grants for Aboriginal and Torres Strait Islander students to study in priority areas. The value of the scholarships or grants was to be matched by the hosting/supervising academic organisation (with a total from NHF of \$25 000). Following this decision, processes were to be commenced in the year 2000 for projects and study programs in 2001. It was intended that the funding be recurrent and the amount reviewed annually in line with other NHF budget procedures (Field, 1999).

The Population Health Division and the Office of Aboriginal and Torres Strait Islander Health of the then Commonwealth Department of Health and Aged Care (DHAC) was approached and agreed to match the NHF funds. That is, there was \$250 000 allocated by the NHF and \$250 000 from DHAC, totalling \$500 000. The \$25,000 sought for scholarships was not provided.

An ongoing expert committee developed appropriate assessment criteria and called for submissions, and considered how the program should be link with the NHF mainstream research program. Criteria were based on the National Health of Medical Research Council (NHMRC) criteria for research in Aboriginal and Torres Strait Islander populations and consistent with the findings of the Alice Springs workshop. The criteria emphasized the need for research to be action-focused, to show clear community benefit, sustainability, community involvement, and transferability.

Whilst a number of research projects have now been funded and have commenced under this program, its future is uncertain and is currently under review by a committee of both internal (NHF) and external members. This committee will consider the initial process of calling for, reviewing and decision making for funding of proposals. No funding has been allocated for 2002/2003 due at least in part to unspent funds from the original allocation.

This is an example of a change process that was very thorough and utilized many positive internal and external forces including lobbying and advocacy. The review process that is currently under way is essential for finding a way forward and can be considered another step in the change process which is not complete until the program is integrated into the core research program with funds allocated and spent according to the criteria.

## Conclusion

This paper outlines an example of an effective process of strategic change within an organisation that has resulted in the allocation of resources to an area of the highest research priority. The strength of the process has included collaboration of a spectrum of interests: academics, a non-government organisation, Aboriginal organisations and the DHAC. Timing and utilization of internal and external forces to strengthen the case were

also of utmost importance in this process. Another strength was related to the effective gathering of evidence and persistent advocacy based on available evidence.

Persistence is a key factor as initial failure to act is common when significant strategic and cultural change promoted within an organisation. The funding allocated was 'one-off'. Sustainability of the program depends on the result of the current review.

## References

- Australian Institute of Health and Welfare 1998, *Australia's Health 1998: The Sixth Biennial Health Report of the Australian Institute of Health and Welfare*, Australian Institute of Health and Welfare, Canberra, ACT.
- Australian Institute of Health and Welfare and Heart Foundation of Australia 1999, *Heart Stroke and Vascular Disease Australian facts*, AIHW, Canberra.
- Braithwaite J, Hindle D, Iedema R, & Westbrook JI 2002, Introducing soft systems methodology plus (SSM+): why we need it and what it can contribute, *Australian Health Review*, vol 25 no 1.
- Department of Health and Aged Care and Australian Institute of Health and Welfare 1998, National Health Priority Areas Report. Cardiovascular Health. *A report on heart, stroke and vascular disease: Summary*, AIHW Cat No PHE 12, pp 13-14.
- Field P 1999, Developing a strategic approach to research in Cardiovascular Disease (CVD) in Rural and Remote Settings, and Aboriginal and Torres Strait Islander Populations (unpublished), NHF, ACT.
- Field P, Wakeman J & Nash K 2000, Report of the *Workshop to Review Current Research and Determine Future Research Priorities for Cardiovascular Disease in Rural and Remote Settings, and in Aboriginal and Torres Strait Islander People*. National Heart Foundation & the Centre for Remote Health, Alice Springs, NT.
- Fragar LJ, Gray EJ, Franklin RJ & Petrauskas V 1997, *A Picture of Health? A Preliminary Report of the Health of Country Australian*, Australian Agricultural Health Unit, Moree, NSW.
- Harper C 1998, *Ischaemic Heart Disease in Central Queensland*. Central Public Health Unit Network, Rockhampton, Queensland.
- Heller R, O'Connell R, D'Este K, Lim L & Fletcher P 2000, Stated and actual management of acute myocardial infarction among different specialties, *Med J Aust*, March 6, 172(5), pp208-12.
- Huy Dinh Vu, Heller R, Lim L & D'Este K 2000, Mortality after acute myocardial infarction is lower in Metropolitan Regions than in Non-Metropolitan regions, *J Epidemiology Community Health*, Aug; 54 (8), pp590-95.
- National Heart Foundation of Australia 2000, Business Plan, ACT.
- Sexton PT & Sexton TLH 2000, excess coronary mortality among Australian men and women living outside the capital city statistical divisions, *MJA* 172, pp370-374.
- Stoner J, Yetton P, Craig J, Johnston 1994, Management, Prentice Hall, Australia.
- Thomson N 2000, Review of the state of knowledge of cardiovascular disease among Aboriginal and Torres Strait Islander populations IN Field P Wakeman J & Nash K, *Report of the Workshop to Review Current Research and Determine Future Research Priorities for Cardiovascular Disease in Rural and Remote Settings, and in Aboriginal and Torres Strait Islander People*. National Heart Foundation & the Centre for Remote Health, Alice Springs, NT.
- Wilkinson D 1999, Review of Research in Cardiovascular Disease in non-Indigenous Rural and Remote Populations. IN Field P Wakeman J & Nash K, *Report of the Workshop to Review Current Research and Determine Future Research Priorities for Cardiovascular Disease in Rural and Remote Settings, and in Aboriginal and Torres Strait Islander People*. National Heart Foundation & the Centre for Remote Health, Alice Springs, NT.
- Wills P 1998 *The Virtuous Cycle. Working together for health and medical research. Health and medical research strategic review*. Commonwealth of Australia: ISBN 1 86496 066 3, Department of Health and Aged Care, Canberra, ACT.