

Experiencing “change” from within: situating the transition to primary health care in a remote Australian context

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Abstract

The transition to primary health care (PHC) is often described in an idealised manner, which either ignores or obscures the experiences associated with its implementation at the local level. By adopting an anthropological perspective, this article highlights some of these experiences and the context within which they occur for one health care organisation in remote Western Australia. It specifically focuses on problems associated with economic rationalism, managerialism, and the inherently fragmented character of health service organisations. Such issues must be allowed to inform idealised PHC models in order to make them more applicable and attuned to local needs and realities.

Primary health care and the culture of change

Much emphasis is placed on “change” within health care in Australia today. When it comes to service delivery, most authors and/or researchers preface their discussion by emphasising “great change”, an “environment of change”, or a “culture of change.” It is interesting to note that their discussions are not necessarily conditioned by or in any way based on technological imperatives or scientific advancements related to biomedicine. Change as it pertains to the Australian health care system is increasingly discussed in terms of organisational and systemic issues rooted in the transition from acute care activities to a primary health care (PHC) model. This transition sustains and is sustained by a wide variety of strategies such as best practice guidelines, evidence-based medicine, and various management strategies related to organisational efficiency designed to facilitate and rationalise the entire process.

The transition to PHC and its accompanying changes are routinely discussed in an idealised manner while experiences associated with implementation at the local level receive less attention. While specific activities are cited and discussed, they tend to be couched in managerial jargon that obscures as much as it explains the experiential nature of change and the confrontation between structural level initiatives and the individuals most affected by them. In this sense, the boundary between what actually happens and what “should” happen becomes blurred as ideological rhetoric becomes an unproblematic means by which change in the local context is described. The current paper highlights these issues by focusing on one remote health service in Western Australia – the Murchison Health Service (MHS) – and its efforts to implement a PHC approach. In doing so, it demonstrates the practical value of an anthropological perspective and its ability to provide a critical framework for the structural-local interface and the ideological-experiential dichotomy associated with the transition to PHC.

Primary health care in Australia and the anthropological perspective

There is little doubt that PHC has powerful global sponsors, particularly the World Health Organization (WHO) and UNICEF, who were the driving forces behind its fundamental principles as outlined in the Declaration of Alma Ata (WHO 1978) and the Ottawa Charter for Health Promotion (WHO 1986). At its essence, PHC is a public health strategy based on the assumption that people's basic needs must be met in order to create substantial health improvements (Keleher 2001). It entails a broad prevention-oriented, population-based approach to both health and health care delivery by drawing attention to structural disadvantage and the social and economic determinants of disease. It focuses in part on identifying and addressing community needs (Fuller et al. 2001), establishing formal and informal linkages between and among health and non-health related services (Walker and Mitchell 1995; Robinson 1999; Harvey 2001), community participation and empowerment (MacDougall 2001; Aldrich and Mooney 2001), and health promotion (Keleher 2001). Its overall aim is to move health care from the "traditional", clinically bounded world of acute medicine as rooted in individualistic, curative, and reactive health care practices to the wider, community-based world of primary health care as defined by social, preventative, and initiatory action.

As a means of fostering the organisational shift towards PHC in Australia, the Commonwealth Government has established a number of accreditation measures and incentives to encourage and assist individual health care services to achieve "best practice". Best practice guidelines place a clear emphasis on health outcomes (rather than outputs such as patient contacts), which creates a strong and mutually reinforcing link between best practice accreditation and PHC via the need to define and address community needs (Podger 1996; Gale 1997). The significance of community needs, in turn, creates further connections between PHC, best practice guidelines, and the growing call for "evidence-based medicine" (see for example McDonald and Smith 2001), particularly the identification and prioritisation of specific health problems and associated target groups within the community. In order to benefit from such information and apply it to a PHC approach, health care professionals are assumed to have access to, actively seek out, and correctly interpret relevant information as a means of changing their behaviour and organisational structure (Weller and Veale 1999). It has become apparent however that such information, even when accessible, does not necessarily translate into the desired change at the local level (Gale 1997; Healy et al. 1998; McDonald and Smith 2001).

The gap between concept and practice associated with PHC and PHC-related strategies underpins the growing emphasis on quality management and organisational process. The overriding objective of this work is to incorporate business ideals, ethics, and strategies into the health care sector as a means of achieving desired changes and outcomes. Various issues have risen to prominence in this respect, such as improving the flow of communication within the health service organisation (Horsley 1996; Harber and Ashkanasy 1998), the importance of teamwork (Mickan and Rodger 2000a; 2000b), leadership (Hartley 1996), benchmarking (Waixel and Laidlaw 1996), attention to managerial styles and change management (Southon 1996; Beattie 2000; Badrick and Preston 2001) and market analysis (Clarke 1999). Underlying each of these strategies is an assumption regarding the inherent value of market ideology and private sector values, which are often framed in a generalised manner as the "business idea" (Barker and Anderson 2001) or simply "organisational culture" (Bloor 1999). Health services are implored to become more reflective and foster a "customer" and/or "client" perspective through an ongoing process of self-monitoring, accountability, and attention to quality of care measures. In the end, the private business sector is unquestioningly accepted as a model by which health services can bridge the gap between concept and practice and implement a PHC approach.

It is interesting to note that the gap between concept (or the ideal) and practice (or what actually happens "on the ground") is also a central area of inquiry for anthropology. The discipline has long focused on the dialogue between structural level processes and individual experience. The context within which this dialogue occurs (and partially produces) is an important means by which to understand how different aspects of idealised changes are implemented, resisted, fall to the wayside, or subjected to redefinition with potentially unintended consequences. An important part of this context involves the ways in which individuals align and realign themselves to various groups with respect to their stance towards a particular aspect of the change process. When the transition to PHC is viewed as a dialogue in this manner it is possible to critically examine it from various perspectives. It also demonstrates that changes to the health sector do not operate in isolation but within an overall community context. In the end, adopting a critical anthropological perspective is a particularly valuable means of framing the implementation of a PHC approach that (ironically) may obscure local-level issues and the experience of actually "doing" it.

Research background and methodology

Data collection coincided with the initial push on the part of the MHS to initiate a PHC approach, which began in July 2001. Data collection was one component of a formal working partnership between the MHS and the Combined Universities Centre for Rural Health (CUCRH). As a full-time staff member at CUCRH, I have been involved in the development and implementation of a “research/evaluation program” associated with the transition to a PHC approach by the MHS. This program, which is ongoing, is part of a broad range of partnership activities between the two organisations including professional development activities, Aboriginal health worker training and development, undergraduate and postgraduate research projects, and a series of joint and adjunct appointments and shared funding programs. It is important to highlight this context since the largest and most valuable part of data collection involved field notes resulting from participant observation and extensive informal discussions with MHS staff. Other data collection methods included semi-structured interviews with individual staff members, attendance at monthly site meetings and various strategic planning workshops, and a wide variety of written documents pertaining to the health service and the Murchison Region.

Data analysis can be very broadly summarised as a three-step process. The first step involved identifying and defining the barriers to change as experienced/perceived by various individuals and the ways in which these interacted with the perception and construction of different “groups” within the health service. The second step involved situating this process in terms of organisational issues and broader structural forces/pressures. The third and final step involved a critical examination of the basic principles associated with PHC in terms of the dialogue between individual/group experience and broader, structural forces.

Economic rationalism and the State: engendering a hostile environment “from above”

When one speaks of the implementation of a PHC approach at the local level, particularly in rural and remote Australia, it is necessary to highlight a context that is becoming increasingly defined by economic rationalism. Both the Commonwealth and the State government of Western Australia have adopted a wide range of policies that are firmly rooted in the principles of economic rationalism (Duckett 1984; Rees 1994; Melleuish 1997; Tonts and Jones 1997; Beeson and Firth 1998; Van Eyk et al 2001). These policies have a large impact on rural and remote regions in general while simultaneously acting as a dominant structural force within the health care sector. This dual impact is important and particularly evident in the Murchison Region.

At a regional level, rationalist policies and cost-cutting exercises underpin shortages in service delivery, which results in the loss of key organizations (for example, the region operates without a single bank or pharmacy) and creates dependency on external sources via the need to contract out. Moreover, the absence of a wholesale sector combined with supply costs continually drives up prices in the local retail sector and feeds the lack of diversification in the regional workforce. The latter is reflected in regional unemployment and job-unreadiness rates, which are among the highest in Australia. The lack of key services and economic opportunities also sustains a deeply rooted pattern of marginalisation (the region is the third most disadvantaged in WA according to the 1996 Australian Bureau of Statistic’s “Index of Relative Socio-Economic Disadvantage”). Escalating demands from the State Government (particularly in the areas of environmental regulation, public safety, and community development) coincide with the loss of amenities and both public and private services. In this context, regional economic development easily deteriorates into inter-shire competition. A case in point is the competition between Mt. Magnet and Meekatherra for sub-regional HQs of State and Federal agencies, as is the constant dispute between the Shires over roading priorities.

The mining industry particularly exemplifies the negative consequences of rationalism and cost control for the Murchison community. Despite being the main source of employment in the region, mining activities are subject to global economic pressures and are for all intents and purposes part of the metropolitan economy. For instance, workers are supplied in-house with goods secured from wholesalers in Perth (the level of discounting required for goods is not available from the local infrastructure). Surplus items can then be marked up when retailed to local consumers. The region has the highest proportion of fly-in/fly-out mining staff in WA (approximately 70%; Boots

2001), which creates little if any opportunity or incentive to invest in the local economy. The lack of opportunities or incentive for local investment and community development is reinforced by the fact that overseas interests now control the gold industry, which accounts for the largest and most profitable mining activities in the Murchison. Furthermore, developments in the mining industry land leases system cause the local shires to lose tens of thousands of dollars and contribute to land shortages for commercial and residential development. For example, in 1999/2000 Mt Magnet Shire lost approximately \$40,000 in rates because of mining leases being handed back. Other Shires, in particular Meekatharra, have suffered losses on an even greater scale. Western Australia's Mining Act reinforces these patterns by restricting the rights and powers of local interests.

The negative consequences of economic rationalism exacerbate demographic trends and problems associated with community wellbeing. The average annual growth rate of the four regional shires that make up the Murchison are each negative and significantly lower than State or Regional rates (Mid West Development Commission 2000). In fact, the three lowest growth rates by shire in the Mid West Region of WA are part of the Murchison (Cue, Mount Magnet, and Sandstone). The region's towns are dominated by the closed shops and empty buildings of defunct agencies and failed businesses. The shrinking and transient nature of the population, together with the fly-in fly-out phenomenon and the vast distances between towns, continually undermines social networks and community cohesiveness. In this context, "lifestyle diseases" and their consequences such as alcohol-related disorders and assaults are among the highest in WA (Boots 2001).

Economic rationalism has a parallel impact on the MHS by creating an uncertain and hostile environment. For example, rationalist policies directly informed the decision by the Health Department of Western Australia to reduce the number of country health services in WA from more than 20 to 6. The reduction, which had been pending for some time, has effectively limited the position of General Manager (GM) for the MHS to a series of 3-month contract extensions. This individual has been particularly important since he developed and has been the driving force behind what is widely applauded as one of the best PHC plans in the State. Subsequently, PHC itself has been under continuous threat by the restructuring process, particularly since it is in the early stages of implementation (a feature of most if not all PHC approaches) when its success is more likely to depend on the efforts of a handful of local health administrators and key community stakeholders such as MHS board members (whose positions are also under continuous threat by the restructuring process). Staff were employed to implement a PHC approach despite continuous and widespread uncertainties regarding its very survival.

Restructuring and cost-cutting incentives have an equally negative impact on the current annual budget of MHS, which has yet to be finalised by the State. The result has been a time-consuming and difficult "hit and miss" process whereby local administrators have been forced to submit their budgets on a monthly basis. In addition, the State has not given the MHS certain monies promised to it and continually threatens to reclaim that which it has (based on certain time restrictions). While the effects of funding uncertainties were initially felt by MHS administrators, they have also passed on to health staff who have been compelled to learn and implement the long-range goals and broad strategies of PHC with fewer resources and in the midst of rolling monthly budgets that are neither adequate nor guaranteed.

It is important to note here that the transition to a PHC approach by the MHS would not have been possible unless local initiative was supported by Commonwealth funding. Most health services do not have this type of Commonwealth funding, an absence of which makes it difficult if not impossible to transition to a PHC approach since State funds are required simply to keep the service afloat. For the MHS, State funding has decreased in real terms and even Commonwealth funding has been subjected to a degree of uncertainty and frustration since much of it has not materialized at the local level.

One irony associated with the dual impact of rationalist policies on the Murchison Region and MHS is that as staff move forward with a PHC model emphasising the structural determinants of health, they increasingly confront the consequences of regional exploitation and underdevelopment associated with and/or exacerbated by rationalist policies and processes. This confrontation reinforces the importance of a PHC model and justifies the change process. However, the parallel impact of the very same forces within the health care system contributes to an uncertain and hostile environment and creates fundamental barriers to effective and systematic implementation. The resulting level of frustration with external policies and direction and sense of disempowerment easily undermines staff morale and contributes to the problems associated with recruitment and retention of quality staff.

Managerialism and the construction of primary health care

As PHC is actively promoted and fostered, it is continually merged with managerial philosophy, which reflects the increasing power and authority of administrators in health organisations. This process is evident within the MHS, where information and organisational change flow outward from a handful of senior administrators. These changes are underpinned by a series of core philosophical values that were defined (perhaps not surprisingly) during a strategic planning meeting via exercise materials borrowed from a business course. Subsequently, there has been a merger of PHC and such fundamental business themes as “customer focus”, “teamwork”, “communication”, “leadership”, “efficiency” and “cutting out the waste.” In fact, the language of business is continuously employed to define and legitimate the changes associated with a PHC model. For example, staff work together in “business units” as a means of better targeting the needs of specific “customer groups.” They are also asked to consider the most effective means to “market” themselves and their health service. These changes go hand in hand with organisational restructuring, the most notable aspect of which is the identification of a clear hierarchy of “line managers” that oversee the work of individual business units. Some outcomes associated with the transition to PHC – at least in the early stages – are not defined by health parameters per se but in terms of “process” (for example communication and networking). The relatively sudden emergence during staff meetings of such issues as risk management, quality assurance and internal auditing processes (all of which are reinforced via accreditation requirements) further underscore the relationship between managerial philosophy and PHC.

An important consequence of the merger of managerial philosophy and PHC within the MHS involves the intensification of an internal, reflexive focus. Staff are continually asked to reflect upon and change their daily activities as well as their entire outlook on health care. The necessity of internal reflection is reinforced by senior administrators through continual reference to the region’s poor showing in terms of health indicators, which are among the worst in Western Australia. Against this backdrop, staff have been asked to stop doing what they “traditionally” do and alter their normal patterns of behaviour. They have been asked to be more “culturally aware”, open to new ideas and perspectives, and rebuked in various ways with an interventionist type of approach. In fact, a “change management facilitator” was brought in from Perth as a means of “dealing with difficult personalities” and those amongst staff whom administrators viewed as hampering the process. When several older and more “entrenched” staff quit their positions in the early stages, administrators constructed this in a positive light and as a visible manifestation of a move away from tradition. Together, these actions create an intensely self-reflexive, inward-looking environment that carries with it the assumption that staff and their relations with one another are to blame for the region’s poor health.

While MHS administrators construct and promote PHC for staff by merging it with a reflexive managerialism, they also do so in terms of a notably external orientation. Thus, staff are implored to “go out into the community” and repeatedly told to “get to know the community.” To this end, individuals have been physically relocated (both temporarily or permanently) as a means of fostering such interaction and breaking down old patterns of behaviour. Administrators once again draw upon the poor health status of the region but now as a means of reinforcing the idea that staff have very little knowledge of their own communities. At one point, staff sat through a presentation entitled “Know the customers” delivered by an individual with an accounting background who had only recently arrived in the region for the first time (from Perth) to begin work as the risk manager. The presentation itself constructed the community in terms of a barrage of regional statistical, demographic, and epidemiological information that undermined the relevance of staffs’ professional and personal experiences in the area. Epidemiological information is continually used as a means of profiling the community and as one that fits neatly with managerialism’s emphasis on efficiency and streamlining (i.e., via a prioritised hierarchy of risk factors/groups associated with each business unit’s strategic plan). In addition to undermining knowledge associated with staff experience, the process misleadingly equates community need/perspectives with epidemiological notions of risk and threatens full community participation and interaction.

As the immediate context associated with clinical outcomes is replaced with the long-term management of epidemiological risk factors, health outcomes are pushed into the distant future. Subsequently, staff are asked to concentrate on intermediate outcomes that are only indirectly associated with health such as organisational management, process, networking, and envisioning what a health service based on prevention “might look like.”

In this way, the inward-looking focus of managerialism and its construction of staff ignorance reinforces and is reinforced by its external focus on the community as a collection of epidemiological risk factors and long-term management strategies.

The concept-practice dichotomy and the fragmented organisation

The strong connection between managerial philosophy and the transition to PHC within the MHS sustains the division between senior administrators and health practitioner staff. Staff tend to view the conceptual models and language associated with managerialist philosophy as too abstract and in direct contradiction to the experiential, on-the-ground knowledge associated with years of clinical practice. They take exception to the implication that they do not know the communities within which they live and work on a daily basis. This concept-practice dichotomy is clearly evident during monthly site meetings where the managerialist focus of senior administrators conflicts with staff talk regarding the day-to-day problems and pragmatics associated with work activities and service delivery. Staff are less likely to regurgitate the language and rhetoric of managerialism (hence PHC) and more apt to focus on such things as petty cash problems, the use of health service cars, ageing and decrepit facilities, pharmaceutical supply issues, community dependency and the limited personal time in the small town setting, inter-personal issues, difficulties with the Health Direct phone service, and the ongoing problems of recruitment and retention. Senior administrators are clearly frustrated with having to deal with these issues and downplay many as “petty” and “little niggly things.” However, they are not only important to staff but have become a sounding board to question the often abstract focus of PHC as embedded in managerialist philosophy. Thus, staff negate many changes as a top-down imposition of “theory” and “academic type stuff” because they do not change their daily realities and directly address these issues. In comparison to these types of complaints, which have come to dominate site meetings, administrators’ attempts to prompt staff into discussions regarding PHC are often met with an awkward silence. When staff do discuss such activities, they often do away with its managerialist content and qualify their remarks by defining it as “stuff we should be doing anyway.”

While the concept-practice dichotomy highlights the most fundamental division (that between health administrators and health practitioners), the MHS is clearly defined by multiple, crosscutting divisions that have additional implications for the implementation of a PHC approach. These are summarised below.

General practitioners vs. nurses: As employees of either the Royal Flying Doctor Service (RFDS) or the Australian Medical Association (AMA), general practitioners are not under direct supervision of MHS administrators. They are widely acknowledged as “different” and show little incentive or interest in “doing” PHC. It is clear that their daily routines and activities have not been affected. In fact, only one of the four general practitioners working within the region has attended local PHC meetings and/or workshops during which she claimed it was “business as usual.” Of course, such indifference is fostered by professional autonomy and State patronage. As a result, MHS employees and the nurses in particular bear the brunt of any changes.

Permanent nurses vs. agency nurses: Like most remote health services, the MHS relies heavily on agency nurses hired on short-term contracts (usually 3 months). Agency nurses are simply not around long enough to become familiar with the changes and involved as productive members of the PHC approach (thus, no attempt is made to do so). There is also no economic incentive to become permanent staff since they are paid more than most permanent nurses. These factors contribute to a widespread view of them as “outsiders” and “foreigners.” Subsequently, changes and pressures associated with a PHC approach tend to be shouldered by the permanent nurses in particular.

Preventative activities vs. curative activities: Many nurses have difficulties managing time spent performing preventative activities as opposed to their clinically based, curative duties. The problem is made worse by the fact that prevention-oriented activities are regionally focused and population-based (via notions of risk) and require extensive amounts of travel and commitment in towns where individuals have comparatively little work experience. The regional focus of prevention activities further undermines the experiential authority and local knowledge that nurses have acquired in their particular towns. While their coverage is more diffuse, they are less visible and active within the specific town where they have gained respect. Individuals were clearly frustrated with having to pass on calls from the community to other people. They were also uncertain and hesitant with respect to their more active role in less familiar towns.

Aboriginal vs. white staff: There is an obvious division between Aboriginal staff (mostly health workers) and white staff (nurses and general practitioners). Aboriginal staff are underrepresented at meetings and workshops regarding PHC and several attempts at meetings amongst themselves failed due to lack of attendance. While there are efforts to increase the power and representation of Aboriginal staff within the MHS, it is difficult to do so when there is little precedent from which to work. Aboriginal staff express a desire to get things done but are uncertain regarding the expectations placed upon them and are particularly inclined to feel that change has been imposed from above. Subsequently, there is a degree of hesitancy among Aboriginal staff and a feeling that commitment to the change process will result in their being labelled as “sell-outs” amongst their peers.

Regional location: Often rural and remote regions are defined in a homogenous manner, particularly if they are juxtaposed in generalised ways with urban areas. The views of MHS staff provide a counterpoint to these generalisations because they are based on a spatial hierarchy within the region. More specifically, staff in towns like Cue and Sandstone feel marginalized and less supported in direct comparison to Meekatherra, which they view as dominating the health agenda (and associated bureaucracy).

Residential time, age, and urban-rural divisions: Additional divisions between MHS staff are defined in terms of time spent in the community, age, and whether or not individuals have recently arrived from Perth or other major urban centres. Older staff who have lived in the region for longer periods of time are often classified as “traditionalists” and resistant to change by younger staff, who view themselves as more informed, motivated and as advocates for change. Because several of the latter have also recently arrived from Perth these differences tend to overlap with meanings rooted in a broad rural-urban dichotomy. Such meanings are so readily “available” that staff utilise them quite frequently and in an almost unconscious fashion. Whether true or not, they polarise staff by becoming synonymous with other differences. For example, several key administrators are younger and recent arrivals while a number of nurses are older and long-term residents of the region.

The fragmented character of the MHS and the meanings that continually produce and are produced by those divisions contribute to and justify the internal, reflexive focus associated with managerialist philosophy. As such, it tends to obscure external forces and issues associated with economic rationalism. As staff concerns continually draw from and focus on meanings associated with internal strife, personal conflicts, role confusion, and professional identity, attention is drawn away from the State and economic restructuring and towards the local cultural realm. For a similar discussion regarding the effects of managerialist strategies in Australian health care, see Mahoney (2000). Problems associated with the implementation of a PHC approach are internalised and displaced to such a degree that the economic context is either ignored (for example, the obligations of the mining industry to the local community) or dismissed with a mixture of resignation and fatalism (for example, staff attitudes towards the Health Department). Meanwhile, the rationalising and restructuring practices stemming from top-down economic imperatives contribute to the fragmented nature of the MHS and the health problems that it seeks to address.

Conclusion

Accounting for change in Australia’s health care system involves both the development and implementation of an ideal. The ideal as represented by PHC may become part of the local reality in remote regions like the Murchison but it will never fully explain it. Adopting a broader anthropological perspective highlights this relatively obvious yet neglected fact and makes clear that the process of local implementation must be allowed to inform the development of idealised models as much as it is informed by them. As the MHS case illustrates, doing so will highlight important issues such as the marginalisation associated with rationalist policies at both the regional and organisational level, the effects of managerialism together with its internal focus on staff quality and merger of epidemiological risk with economic efficiency, and the inherently fragmented character of health care organisations and the clash between conceptual knowledge and practical experience.

When local circumstances are allowed to inform the ideal of PHC, then the reality of living and working in rural and remote regions of Australia becomes a powerful means to critically examine the broader context that idealised, top-down models almost inherently obscure. By themselves, the basic principles of PHC are good, but when they are implemented within a context of continued resource depletion and economic rationalism,

those principles are twisted into a false discourse of self-responsibility that acts to displace blame from the macro-political and economic realm to the local social and cultural realm of the organisation and community. The health problems that a PHC approach highlight stem from economic marginalisation and neo-liberal politics and will never be successfully addressed by a reorganisation of the health care industry alone. Ironically, any attempt to do so transforms PHC into a curative, band-aid approach for the consequences of globalisation.

As a final note, the role of the GMs in the WA health care system should be fully supported rather than undermined and cut back by the reduction of health regions. They are important individuals who represent the entry point for the implementation of a PHC approach. It is important, however, that PHC be stripped of the managerialism that currently informs it by allowing for much greater input from staff and community members. The former will address the concept-practice dichotomy within the organisation and the latter can be used to supplement and inform epidemiological risk with the actual voice(s) of the community. In this way, the GM becomes an advocate for local interests rather than an agent of top-down, economic imperatives.

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