

# Celebrating success—visionary leadership recognising “fit for health” in the delivery of rural and remote primary health care services

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## Abstract

An ageing population and increasing demands and costs for acute health care have placed health reform on the agenda. The rising burden on the health system resulting from largely preventable chronic disease is changing the focus from acute care to multidisciplinary team-based primary health care. Access to such primary health care is difficult in rural and remote areas. Much of the responsibility for the delivery of services is placed on local organisations, including state funded health facilities. These organisations are often reliant on centrally distributed funding. However, health policies created centrally in capital cities or Canberra, with uniform guidelines for allocation of funds have variable implementation and impact in different geographic regions. The North and West Queensland Primary Health Care Association is one such organisational group.

A Masters by Research study being conducted at the University of Tasmania is examining the role of visionary leadership, an organisation's culture and commitment to community and consumers in the provision of primary health care services. The study seeks to generate in-depth understanding about the drivers for a Division of General Practice, an organisation set up to support GPs, has become a major provider of allied health services in its region. Through a document review and participant interviews characteristics which have enabled this organisation to become a leader in the delivery of primary health care services have been identified. These findings will inform the development of a model for health service organisations with potential for national rollout. The case study is used to present examples of visionary leadership and organisational culture that led to major organisational development for the Division in keeping with its vision to deliver primary health care excellence.

Evidence is provided of a governance structure used by the organisation that enables management by place. Place management allows for local level regional variation in the delivery of programs, a consultative and research framework that positions the community and consumer centrally and a goal to fill gaps in health services. The structure has resulted in the organisation becoming a major allied health service provider in its region. The research findings show that the organisation's activity and function is driven through an understanding of rural and remote context and in meeting community needs.

The research findings are applicable for individuals and organisations delivering primary health care services, irrespective of their particular employment characteristics. There is particular relevance for those outside metropolitan regions, where an understanding of rural and remote context as it impacts on an organisation's ability to deliver services across its population base is essential for successful outcomes. It has implications for policy makers and funders of health services in determining allocation of funding and the implementation of health policy to provide a positive impact on health outcomes, particularly in rural and remote communities.

## Background

Australians typically have better health and high quality care compared to some other nations (Australian Institute of Health and Welfare, 2008, Duckett, 2008, Podger, 2006). An ageing population and increasing demands and costs for acute health care have placed health reform on the agenda. The rising costs to deliver that health care as a proportion of gross domestic product has risen in the last 10 years and will continue to grow if the health system does not undergo reform. Australia, in 2005-06, spent 9% of GDP on health services (Australian Institute of Health and Welfare, 2008). The increasing burden on the health system resulting from largely preventable chronic disease is changing the focus from acute care to multidisciplinary team-based primary health care. These drivers are well reflected in policy developments relating to chronic disease (National Health Priority Action Council (NHPAC), 2006) and changes to the Medical Benefits Schedule in the late 1990s and 2004.

Workforce shortages have been identified across all the clinical health professions Australian Institute of Health and Welfare workforce reports (Australian Institute of Health and Welfare, 2008, Lowe and O'Kane, 2004) identify that, other than nursing workforce, for the medical and much of the allied health workforce there are less per 100,000 population in rural and remote areas compared with metropolitan areas. Whilst there is some variation across the professions, shortages affect community access to multidisciplinary health services.

Through the 1990s federal government policy focused on the recruitment and retention of the rural and remote medical workforce. In the mid 1990s the Divisions of General Practice Program was implemented to support general practitioners (GPs) and the links between GPs, communities and other health service providers. The Divisions form a network that covers Australia geographically, and focus on supporting the delivery of primary health care services (Department of Health and Ageing, 2004).

Although most Australians' health and wellbeing is amongst the worlds' best, it is now known that populations in rural and remote areas have a poorer health status (Australian Institute of Health and Welfare, 2008). These populations generally experience a shorter life expectancy and higher rates of chronic disease and associated risk factors than metropolitan based counterparts (pg 62). The poorer health status of rural and remote Australia and the need for a targeted approach was identified in the 1990's with the implementation of the National Rural Health Strategy (Australian Health Ministers Conference, 1994), and the Regional Health Strategy in 2000. The later incorporates Regional Health Services (RHS) enabling communities with populations of less than 5000 to provide services that are generally not readily available in those areas (Australian Government, 2000).

Access to primary health care is difficult in rural and remote areas. Much of the responsibility for the delivery of services is placed on local organisations, including state funded health facilities. Organisations are often reliant on centrally distributed funding. However, health policies created centrally in capital cities or Canberra, with uniform guidelines for allocation of funds have variable implementation and impact in different geographic regions. The North and West Queensland Primary Health Care Association (NWQPHC) is one such organisational group, a member of the Australia wide Divisions of General Practice network, and the focus of this research study. A case study of this organisation aimed to examine how the Division has utilised existing programs for the delivery of primary health care services to rural and remote communities to become a major allied health service provider. It sought to determine the influence of visionary leadership on the development and implementation of effective primary health policy programs.

## Method

The case study design was used to focus in-depth on how an organisation in rural and remote Australia was implementing primary health care policy. This type of design allows the researcher to study the interactions between the players and processes that are part of the case and to understand the complexity and the context in which the case operates (Stake, 1995, Kumar, 2005, Jones, 2006, Yin, 2003).

The NWQPHC case was selected as an example of an organisation that was directly implementing federal government primary health care programs which targeted improved access to primary health care services delivered by a range of health professionals

The NWQPHC covers an area of North and West Queensland with a geographic area three times the size of Victoria. The organisation was selected because of the availability of published material relating to the development and implementation of the North West Queensland Allied Health Service (NWQAHS). Utilising a hub and spoke model the RHS funded program delivers multidisciplinary allied health services, with a focus on primary health care, into rural and remote communities from the Gulf of Carpentaria in the north to Longreach in the South. Following approval from the Social Science Human Research Ethics Committee of the University of Tasmania and the Research Committee and Board of the NWQPHC, access was granted to a range of published and unpublished documents relating to the operation of the Division from 2000 to 2004.

Document content analysis using NVivo and Excel was undertaken to determine the history, sequence and processes relating to activity of the Division at a time of active change and growth. From the documents a range of stakeholder groups with an interest in the activities of the Division were identified. These included staff, members, customers, other service providers and funders.

With the assistance of a third party recruiter, eleven people from across the stakeholder groups agreed to an in-depth individual interview relating to their involvement in and recollection of Divisional activity from 2000-04, some of which continues to the current time. Interviews were digitally recorded, transcribed verbatim and returned to each of the participants to allow for any amendments prior to analysis of the contents. Using NVivo, the interview transcripts were coded. Major themes were developed by grouping codes.

## Findings

The document analysis revealed that other significant activities were impacting on the operation of the organisation. These other activities affected the geographic size and consumer base of the organisation, its governance structure and its name.

### The changes

Change started with the move to become a health service provider with the development and implementation of the NWQAHS. Through consultation as part of the organisation's strategic planning with members and other service providers a major gap in allied health services in the region was identified. The potential solution, identified by the leaders of the organisation, was for the Division itself to become an allied health service provider.

As the allied health service was being implemented, the neighbouring Central West Queensland Rural Division of General Practice (CWQRDGP), already receiving administration support from NWQRHS, was becoming increasingly unsustainable. The CWQRDGP underwent a process of examining options for their

future which ultimately resulted in an amalgamation between the two divisions in 2003. The amalgamation, the second major change for the NWQPHC was of interest in the study as it increased both the membership and the geographic size of the Division. In the lead up to the amalgamation, the NQRDGP reviewed and adopted a new constitution and began operating under a new name, North and West Queensland Primary Health Care Association. The operating name, the third change for the Division, became the official name of the new organisation with the formalisation of the merger. The Division was the second in Australia to change its name to reflect the focus on primary health care and the broader health care team.

The fourth significant change for the organisation related to the managing of programs and staff, and the support for members across the widely diverse geographic region. A change in the method of managing staff and programs from the coastal located head office to management **based on place** was implemented. The place model recognises the geographic regions of east coast, northwest and central west. It enables the development of local solutions for local issues for both health service delivery and the support of staff and members.

### Leadership

The organisation's CEO was readily identified by interview participants as a visionary thinker, leader and 'big picture man' (Interview with staff member). He is the spokesperson for the organisation and is accredited with the ability to seek opportunity to expand and enhance the services delivered by the Division. By so doing, the sustainability (survival) of the organisation is ensured. However, all participants agree that the CEO **does not** operate alone.

Leaders have been identified at all levels of the organisations and throughout its geographic region. These leaders have been supported and provided with training to build their skills and provided with opportunity to participate in the strategic planning of the organisation (Leadership training workshops, manual). The place management model has enabled the organisation an opportunity create a management structure to incorporate senior and middle management leadership positions. The structure ensures both clinical leadership (team managers) and organisational leadership and management (financial, GP support, health service delivery) is covered.

The CEO, supported by the Board, takes a partnership approach and works with funding providers as members of the team ("fundors are not adversaries" CEO). Potential rivals to service delivery or funding are identified and collaborative partnerships are set up to enhance services through memorandum of understanding (Queensland Health) and co-location (Royal Flying Doctor Service, Longreach). Education and training for members and staff is supported through collaborations with James Cook University and other training providers. Networks of influence are built through the encouragement for Board members and senior staff to participate on external committees, attend and present at conferences, meet and liaise with others involved in rural and remote health.

### Vision

The organisation's vision "Primary Health Care Excellence in North and West Queensland" is clearly articulated through publications. It can be argued that the move to health service provision is evidence of the adherence to this vision in both word and manner.

### Change management

Together, the major changes experienced by the organisation are indicative of a change management process in action. A change management process was implemented for each of the identified changes with has had major impact on the function of the organisation. For three of the four changes investigated,

a change management agent was employed through the contracting of a consultant. The consultant's role was to research the identified issue, gathering relevant data in relation to the issue through a process of literature review and consultation with those involved through community forums, workshops, interview and correspondence. From the data the consultant was able to present reports to the board and members of the organisation/s stating their options for solution to the issue. Those involved in the processes were kept informed of progress. This was particularly evident in relation to the communities that would be serviced by the NWQAHS.

Whilst the change to place management did not involve the contracting of an external consultant, the organisation's CEO followed a similar process of collecting evidence through literature and consultation and presentation of the case to the Board and membership for approval. With all events investigated the implementation incorporated a comprehensive evaluation of impact which involved the collection of data from all involved and ongoing consultation.

Key to the consultation process was the involvement of the end users of the service, the consumer. The involvement of consumers is fundamental to the approach taken by the organisation in that the consumer and the community in which the organisation operates is the focus of the vision, not the membership of the organisation.

The result is a Division of General Practice that in 2009 employs over 70 allied health staff delivering multidisciplinary primary health care services throughout the Division's geographic area. Place management has enabled regional variation and adaptation in the implementation of health services funded by primary health care programs, and localised support for GPs. Leaders and managers of the organisation, supported by training and a team approach, are located in each of the regions, enhancing access to community and consumers for consultation on services provided.

## Discussion

Both the nature of the leadership and the culture of the organisation are important in enabling major structural change.

Many of the changes to the organisation can be attributed to effective leadership. The literature relating to organisational culture discusses the importance of the organisation's leadership in the setting of the culture and vision (Carroll and Edmondson, 2002, O'Connor and Fiol, 2006, Gardner, 1999, Helms and Stern, 2001, Higgins, 1995). To undertake fundamental changes within an organisation altering the nature or direction of the organisation requires a shift in the culture of an organisation which is often difficult and resistant to change. Visioning, setting the future direction of the organisation is the responsibility of the management, built through effective team work (Kakabadse, 2001). The use of a change agent, an organisation development agent, in this case the hiring of consultants and researchers to develop options and facilitate consultation is a recognised aspect of organisational development (DuBrow, Woche, 2001).

The culture of the organisation comprises both overt and tacit components. Overt cultural components are expressed in the action and conduct of the staff, publications, written expression of vision and values and visible presence provided by website and physical structures. However, this overt culture is the tip of the cultural iceberg. The tacit components, those underlying assumptions and beliefs that drive the way in which those people internal and external to the organisation operate and relate to each other, have a significant impact on the organisation's activities and its ability to adapt to changes in existing conditions or to meet new opportunities.

Four characteristics of the culture of the organisation appear to have major significance:

- A **clear vision** of what the organisation is striving to achieve. The organisation has a clearly articulated vision which focuses attention on improving health outcomes in the community it serves. It strives for 'primary health care excellence' (North and West Queensland Primary Health Care, 2003). Enacting the vision is as a result of direction from the leadership. How the vision is articulated and understood by others who interact with the organisation is seen in the nature of the activities undertaken by the organisation and the manner in which those directly involved, the staff and board, relate. The **strategic** direction and management of the organisation is regularly reviewed by the leadership, driven by the CEO and the Board.
- Evidence based practice and a focus on **research and evaluation**. This characteristic is both overtly and tacitly part of organisational culture, driven executive staff members. Interview participants identified that they were part of the organisation's data collection systems. This may be through consultation with the communities whilst delivering a health service in their area, meeting with the membership, undertaking a more formal process of survey and interview as part of the strategic planning process or evaluation of a health service program or participating in a community forum. The division employs research officers, consultants and project officers whose role it is to analyse data and produce reports and publications. Reports are used to enhance, modify and expand services. In particular they are able to be used in discussions with the funders of services with a view to influencing how health programs that result from policy development may be implemented. When issues are identified (e.g. from participant interviews: management issues relating to the allied health service, issues relating to management positions in the place management model) the continued cycle of change management is put into place to address the issue and implement the solution, a characteristic of a learning organisation and a focus on service improvement. That funding proposals submitted to the Department of Health and Ageing for the implementation of new programs have such a strong evidence base, and that the Division is able to negotiate from an evidence base, is a very strong characteristic clearly evident from the organisation's continued growth to become a significant health service provider in north-western Queensland. The collection and analysis of data as an ongoing daily process within the organisation, and the dissemination of results through conference presentation and publication has enabled the organisation to have a key role in adding to the evidence base for rural health, primary health care, and multidisciplinary care.
- The identification that it is the end-user, the **consumer** and the improvement of health outcomes that is the core function of the organisation. For similar organisations within the divisions' network, it may be considered that the core function of the organisation is the delivery of programs that support the member—the GP—and by focusing on the GP, the health of the community will be improved. This organisation has reversed the order and by focusing on the health needs of the community has been able to negotiate and introduce programs which have impact not only on the community but on the membership, the GPs. The importance of consumer involvement is evidenced from the consultation process undertaken in the setting up of the allied health service where the consultant met with community members in each of the communities to which services were going to be provided. The strength of the consumer involvement and the method of consultation enabled the organisation to negotiate a higher level of funding for the delivery of the service. Rather than adapting the service to a level of funding initially offered by the Department, a higher level was agreed to in order to ensure acceptance by the community as to the level of service able to be offered. The holding of consumer forums where consumers from the various communities are supported to attend a meeting held with staff and members is also a feature of the organisation and it has long had a full voting position on its board for a member of the community.
- The establishment and maintenance of **relationships** between internal and external stakeholders. The relationships that have been developed between the identified leaders of the organisation, in particular

those with responsibility for developing and adhering to the vision and those who interact with the organisation both internally and externally is fundamental to its operation. These relationships appear to be built on trust and respect and on consistency of action and belief. This appears to be recognition that more can be achieved by working together than working apart, accentuating the positives rather than the negatives of a collaborative partnership.

The identified leader uses his position and vision to bring those involved with the organisation along as part of the team. Working relationships to establish teams exist at multiple levels between staff, the board, the consumers, other service providers in the region and funding bodies. Relationships built on trust and respect is fundamental to the operation. The leader has driven a culture which enables the identification of skills and talents in staff employed by the division and set up systems to enable the training of these staff as leaders in their areas. This recognises the importance of appointing staff that are able to fit in with the culture of the organisation. Within this organisation, this has required staff that is adaptable and able to cope with periods of rapid change.

An important aspect of being a visionary leader is to identify gaps in your skills and to build a management team which fills the gaps in those skills required for success in sustaining and growing an organisation. That this has been done within the Division is evidenced by the changes in the management structure over the last 10 years, building a significant executive level team. The structure has undergone a number of changes relating to the ongoing evaluation of its effectiveness. Together the team ensures that the organisation meets the contractual requirements of programs funded under the various health policy options. The leadership is able to address issue arising out of the ongoing evaluation and consultation. Stakeholders are kept informed. Options for increasing the sustainability and expanding the operation of the organisation are researched and developed with a view to implementation.

## Conclusion

The study is generating in-depth and meaningful findings about why a Division of General Practice, an organisation set up to support GPs, has become a major provider of allied health services in its region. The research, involving a document review and participant interviews has identified characteristics which have enabled this organisation to become a leader in the delivery of primary health care services and a model with potential for national rollout. The leadership provided by a man of vision, supported by other leaders at all levels of the organisation and the organisational culture have led to major organisational development for the Division which is in keeping with its clearly articulated vision. The findings of the study supports that of an evaluation of rural and remote primary health care services (Wakeman, Humphreys, 2006) and successful organisations (Flower, 2002). These studies identify leadership, workforce structure and support, governance, relationships, and community participation as key aspects of support. The next step is to use the findings to inform the development of a model that could potentially be used for future rural primary health care policy development and implementation.

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## Presenter

**Shelagh Lowe** has a background in physiotherapy. She has lived and worked on the east coast of Tasmania since 1985. Shelagh has been an advocate for rural and remote allied health services and the allied health workforce since 1997, through involvement with various organisations, including the Australian Physiotherapy Association, Allied Health Professions Australia, and the National Rural Health Alliance. She was the inaugural Executive Officer for Services for Australian Rural and Remote Allied Health (SARRAH), and now holds the position of Manager, Policy and Programs with SARRAH. Shelagh is also a rural allied health academic at the University Department of Rural Health—Tasmania.