'Designing Better Health Care in the South': A case study of unsuccessful transformational change in public sector health service reform

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This article presents a case study of a project known as 'Designing Better Health Care in the South' that attempted to transform four separately incorporated health services in southern Adelaide into a single regional health service. The project's efforts are examined using Kotter's (1996) model of the preconditions for transformational change in organisations and the areas in which it met or failed to meet these preconditions are analysed, using results from an evaluation that was commenced during the course of the attempted reform. The article provides valuable insights into an attempted major change by four public sector health organisations and the facilitators and barriers to such change. It also examines the way in which forces beyond the control of individual public sector agencies can significantly impact on attempts to implement organisational change in response to an identified need. This case study offers a rare glimpse into the micro detail of health care reform processes that are so widespread in contemporary health services but which are rarely systematically evaluated.

This article reports on the evaluation of a project that sought to take four separately incorporated health units in the southern metropolitan region of Adelaide (three hospitals and one community based home care service) and transform them into a regional health service that shared resources and carried out regionally based planning and service delivery. In undertaking this change, the agencies formed a project group known as 'Designing Better Health Care in the South' (DBHCS) whose task it was to consult with stakeholders and develop a model for implementation. In the process, the project followed many of the steps outlined by Kotter (1995; 1996) as being necessary to achieve transformational change. However, before the process could be completed, several factors, including a major shift in the external policy context intervened, leading ultimately to the disbandment of the project and its aims. The evaluation effort commissioned for the project continued despite these changes and was able to record these processes, subsequent efforts at promoting health care reform and the reaction of stakeholders to them over a three year period: 1998–2001. In doing so, the evaluation has provided valuable insights into an attempted major reform by four diverse organisations and the facilitators and barriers to such reform. Reform implies that instituted changes will be an improvement and will 'make or become better by the removal of faults and errors' (Oxford Encyclopaedic English Dictionary 1991). This article also examines the way in which forces beyond the control of individual public sector agencies can significantly affect attempts to implement organisational change in response to an identified need. It offers a rare glimpse into the micro detail of health care reform processes that are so widespread in contemporary health services but which are rarely systematically evaluated.

Literature review

To date, most studies of organisational change of a 'transformational' nature have focused upon the private, corporate sector (Ferlie *et al*. 1996). It has been suggested that successful change is much more difficult for the public sector for a

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number of reasons including the fact that such organisations have to answer to a range of stakeholders, not just shareholders. The rationale for change is also more difficult to articulate in a sector where demand for services usually exceeds the resources available (Becker *et al.* 1998). Also, the political context into which such changes are introduced has a significant impact. While areas such as health care are key targets for reform (Southon 1996), changes proposed are often vulnerable to shifts in the political context (Becker 1998) and they rarely deliver all that is promised by those who promote them (Ferlie 1997). Lastly, the arrival of new leaders into the public sector, often as the result of electoral cycles, frequently results in organisational changes. These changes are introduced as a means of establishing a new leader's managerial style, often at the expense of repudiating previous organisational directions (Becker 1998). Continuous changes of this kind can lead to high anxiety and low morale among non-managerial staff (Southon 1996).

According to Ferlie *et al.* (1996) a large number of the changes instigated in western health systems in the 1980s were top-down initiatives that had variable impacts. In addition, there was relatively little analysis of what measures contributed to the success (or failure) of various efforts undertaken in health system reform (Pollitt 1995; Southon 1996; Klein 1998). One article examining the failed attempt at health system reform in the USA in the mid 1990s (Mechanic 1996) found that the lack of a simple, understandable vision of change that utilised existing structures and demonstrated clear, incremental gains, led to the downfall of this reform effort. A shift in the political context also meant momentum for change was lost (Mechanic 1996).

Reviewing the 10 years of multiple health system reforms in New Zealand, Ashton (2001) stated that the lessons learned from this process included the need for: clear goals and strategies to achieve them; early and frequent consultation with stakeholders; establishing trust with stakeholders and using opinion leaders to help promote change, and that substantial reform takes time and structures should be evaluated for their effectiveness before they are reformed or replaced.

Klein (1998) stated that another problem is that research and evaluation rarely take place concurrently with changes in policy and this makes the development of an evidence base for health policy decisions very difficult. Moreover, there is little systematic evaluation and analysis of agency level organisational change efforts either internationally or in Australian health care systems (Pollitt 1997).

Transformational change of organisations has been defined as radical and wide ranging changes made to an organisations' mission, culture and structure in order to meet changing environmental conditions (Dunphy and Stace 1990). Two types of transformational change have been identified — modular and corporate, according to the scale and depth of change. 'Modular' change alters some structures while 'corporate' change tackles all structures including making changes to power and status of individuals within the organisation (Dunphy and Stace 1990). The reform attempted by DBHCS, the case study that forms the basis of this article, falls into the modular rather than corporate model.

The article will draw chiefly upon the work of Kotter (1995; 1996) that provides a framework through which to view organisational change. The requirements he outlines for transformational change are as follows:

- An agreement among staff and managers that change is needed
- A powerful coalition of leaders to drive the change
- A simple statement of goals and vision for change that is easily and widely communicated
- 'Small wins' along the way toward the final goal
- The willingness to confront and overcome barriers to change
- Consolidating the improvements by ensuring that progress is not linked to the presence of key people
- Institutionalising new approaches through checking that the changes have permeated the organisations culture (Kotter 1995; Kotter 1996).

The DBHCS project team followed many of these principles in their pursuit of lasting organisational change but alterations in the external political and policy context beyond

their immediate control led to the dismantling of their efforts. In analysing this attempted change process, we are endeavouring to add to the literature in this field and to provide some reflections on the nature of change efforts in the health care sector and the forces that influence them.

Methods

The methods used to evaluate DBHCS included the following:

- Document analysis of minutes of meetings, newsletters produced by the project, correspondence and agency Annual Reports (1994–2000)
- Project reports
- Phone interviews carried out between March and April 1999, with key people involved in the project. The purpose of these interviews was to discuss the evolution and changing nature of DBHCS and seek their views on the project, the importance and achievability of its objectives and factors that supported and inhibited collaboration between the partner agencies. 36 people were approached to be interviewed and a total of 29 took part. Participants included past members of the DBHCS Steering Committee and other key stakeholders.

Further details of the methodology are available elsewhere (van Eyk and Baum 2003; van Eyk, *et al*. 2001).

Background to the project

The case study area in the southern metropolitan area of Adelaide has a population of just over 300,000. The demographic profile of the region is mixed, with a higher number of young families and people on low incomes living in the outer southern area and a higher number of people aged over 60 years in the inner southern area.

The four agencies jointly investigating ways to increase interagency collaboration were:

- a 430 bed acute care teaching hospital which is combined with a university medical school and has administrative responsibility for a number of community based health care agencies;
- a domiciliary care and rehabilitation service providing home and community-based health and supportive care for aged and disabled people and their carers;
- a 270 bed veterans' hospital that provides acute care and rehabilitation services for war veterans and war widows as well as some community patients (which is also a university teaching hospital); and
- an integrated health service which incorporates a community hospital and a number of community health services for the outer southern metropolitan area.

From the mid 1970s, these agencies have discussed and developed strategies in an effort to increase collaboration and service coordination in order to improve health service provision and health outcomes for consumers, as well as to manage the increasing financial and service demand pressures that are being experienced throughout the Australian public health system. However, in South Australia there are also significant barriers to cross-agency collaboration that exist in the structural arrangements of health services. Since the 1970s, health services have been organised under a Health Commission with an Act that allows these services to be separately incorporated. This means they have their own Boards of Management, funding arrangements and financial and information systems. In times of constrained resources, this structure encouraged agencies to adopt a 'silo mentality' focussing on their own concerns rather than collaborating with other services to provide coordinated services to their common clients.

A history of collaboration and regionalisation

In South Australia in the early 1990s, the State government department responsible for health, the SA Health Commission, had pursued a policy of regionalisation for health service policy and planning. This was evidenced by its setting up of regional health advisory panels, involving both providers and consumers and regional health planning units. It also showed a

willingness to experiment with new models of service delivery in health care through its sponsorship of two Coordinated Care Trials (1997–2000) and funding of experimental health projects through a Primary Health Care Innovations Program. In such a climate, health care agencies were encouraged to find new and more efficient ways of providing services, with the dual aim of reducing or stabilising costs.

However, the financial collapse of the South Australian State Bank and the findings of a review undertaken by the Audit Commission in 1994 resulted in large cuts to public sector expenditure with a corresponding effect on health services. At the national and international level, health care technology, consumer demand and expectations for the best possible services resulted in increasing costs.

The origins of Designing Better Health Care in the South

It was against this background that the major southern Adelaide health care agencies met at a strategic planning conference in November 1994 and resolved to pursue an integrated regional health service that would promote the idea of a 'teaching region' and develop a framework for linking clinical services across the south. As a result of this conference, a group of key leaders from the four agencies outlined above and other stakeholders, including the local Division of General Practice, staff from community health services and the University School of Medicine, began meeting regularly to discuss ways in which these outcomes could be achieved. This forum was known as the Southern Region Liaison Forum.

In 1995, this forum released a 'Statement of Intent' that made clear the four key agencies' commitment to pursuing region-based health service provision and co-operative planning:

> We have affirmed a commitment to:… develop a broad regional culture as opposed to an individual organizational view with regard to health service planning, delivery teaching and research… (Statement of Intent 1995).

The group released a discussion paper entitled 'Toward a Regional Health Service in the South' in December 1995. This paper acknowledged that only three of the agencies were in a position to commit fully to integrated service provision as the veteran's hospital was obliged to remain freestanding for three years following its recent transfer from a Commonwealth to a State-funded service. The paper offered rationales for integration and suggested safeguards. The final page of the paper contained an endorsement by the three agency Boards committing them in principle to pursuing the development of a regional health service, while the Board of the veteran's hospital gave endorsement to participation in the planning and consultation process.

The aim of the initiative that was proposed by the four agencies was to improve their integration and collaboration in order to enhance the way that services were provided to people in their catchment area. The initiative also aimed to achieve operational efficiencies to help the agencies cope with reduced funding relative to demand and to help them to use their resources more effectively. The SA Minister of Health endorsed the paper and appointed a QC to chair the Steering Committee that would oversee the process

The Board Chairpersons and Chief Executive Officers (CEOs) of each of the four agencies signed a 'Memorandum of Understanding' at a ceremony on the 19th of April, 1996 in which they agreed to '*planning, designing and implementing a regional health service model*' using the Steering Committee to develop and consult on the planned service. The Steering Committee was made up of representatives of each agency, consumers and the SA Health Commission. Funding was supplied both by the agencies and the SA Health Commission for the appointment of a Project Manager to drive the project and implement the decisions taken by the committees. The committee chose the name 'Designing Better Health Care in the South' (DBHCS) for the project. This name was meant to reflect the objective of the project rather than the structural solution in forming a regional health service. It also emphasised the evolutionary and consultative nature of the planning process. The project did not begin with a firm pre-set model for a regional service but rather had the desire to explore various options in consultation with all relevant stakeholders. A CEOs group consisting of the four agency CEOs, staff and consumer representatives also began meeting at this time. Their role was to implement the actions recommended by the DBHCS Steering Committee.

The importance of evaluating this proposed change was suggested by the major teaching hospital CEO, especially in light of the literature suggesting that health care reforms are largely unevaluated (Pollitt 1995; Ferlie *et al.* 1996). As a result of her suggestion, an application for funding for an evaluation of DBHCS was made to the ARC SPIRT (Australian Research Council, Strategic Partnerships with Industry, Research and Training) fund in late 1997. This application was successful and the evaluation commenced with the appointment of a Senior Research Associate in July 1998. However, as will be shown later, by this time there had been significant contextual changes that were to impact heavily on both the project and its evaluation.

Designing Better Health Care in the South — an attempt at transformational change

The active phase of DBHCS commenced with the appointment of the Project Manager in October 1996. She immediately began compiling a communications strategy in order to disseminate the aims of the project and its vision as widely as possible to staff and other stakeholders affected by the proposed regional health service. She sought multiple methods and opportunities to communicate the vision to as many different groups as possible. For example, articles were placed in staff newsletters; all the Boards of Management were addressed, as were many staff meetings. Other agencies not involved directly in the proposed change but who were considered interested parties were consulted and their support sought. Key medical personnel and union officials were also briefed.

A series of focus groups were then conducted to '*explore the perceptions of the need for change in response to problems of effective service delivery*' (Minutes of the Steering Committee meeting, 19/11/96) across the region. These were designed to encourage participants to take a regional focus on issues and examine the ways in which a regional approach could be applied to service planning and delivery. A total of 71 people attended the four focus groups, incorporating 41 employees of the four agencies, 21 people from outside organisations and nine consumers. The participants were described as enthusiastic about the potential for working in a regionally integrated fashion.

The focus groups commenced with a briefing from the Project Manager on the aims of DBHCS and the need for change from the current model of working within agency boundaries to one where people worked across organisations in the region. The groups were then asked to identify the potential benefits and disadvantages of this new model. In undertaking this exercise, the project was giving stakeholders a chance to try the model out theoretically and to apply it to their current concerns. In this way they could envisage how a regional health service might benefit their patients and themselves. In undertaking this, the Project Manager and the steering committee were both confirming the need for change to the current structures and providing an opportunity for staff to both give input on the vision and examine ways of putting it into practice

Following the focus groups, a 'trial' of a regional approach to health service planning was proposed. The Project Manager and CEOs' group called for Expressions of Interest from groups of staff to try regional service planning using criteria set down by the committee. They proposed to fund four to six proposals for regional planning exercises, all of which needed to include things such as a primary health care approach to their issue, opportunities for staff participation, building upon existing networks and fostering inter-disciplinary and inter-agency collaboration. Four projects: rehabilitation and aged care, emergency services, cardiac services and primary health care were run for a total of four months using funding provided by the project and the reports were forwarded to the Steering Committee. Again, the experience of formulating and running these projects allowed staff from all the agencies to be involved in activities that were aligned with the vision of regional planning and service delivery and demonstrated some of its potential benefits and challenges.

Formation of the Department of Human Services (DHS)

In October 1997 a state election was held in South Australia. The incumbent government

was returned with a significantly reduced majority and changes in ministerial portfolios followed. The most significant change was the amalgamation of the SA Health Commission with the Departments of Housing and Family and Community Services into one 'mega-Department' known as the Department of Human Services (DHS). A new Minister was to oversee the portfolio and a new Chief Executive was appointed. In the months that followed, a number of senior Executives of the SA Health Commission who had supported regionalisation of health services left their positions. The new Department announced its intention to focus upon the integration of the three previously separate areas with the aim of more efficient and effective service planning and provision. However, the implications of this new direction were not spelled out for some months until new Executive appointments had been made.

Meanwhile in DBHCS, after receiving the results of the regional planning trials, the CEOs' group met in November 1997 to develop the final proposed model for the regional health service. The outcome and the proposed model were presented at the next Steering Committee meeting and the draft recommendations for the new organisational structure were debated. The CEOs proposed that the four organisations should be dissolved and reconstituted under one body with a single board and CEO with the current CEOs being re-titled as General Managers. The new body would then adopt a program approach to service provision rather than the current institutional focus. An interim report detailing these recommendations and the events that led up to them was written by the Project Manager and released in December 1997. This report was presented to the Steering Committee for comment and endorsement of the recommendations. It was acknowledged at this meeting that the formation of the Department of Human Services may require an assessment of its impact on the project in the final report.

Impact of the interim proposal for a Regional Health Service under one Board of Management

The interim report was distributed widely among stakeholders during early 1998 and reaction sought. The feedback was mixed.

The war veteran community reacted negatively to the proposal for a regional health service, fearing it would reduce their access to the veteran's hospital and fail to account for their special needs. This reaction may or may not have been exacerbated by the fact that the Chair of the hospital Board did not attend any of the Steering Committee meetings.

A private company undertook consultations with service providers and consumers, including the veterans, regarding the recommendations. There were concerns raised about the ability of the smaller agencies to have a voice in the new structure, about extra management being added at the expense of services and about reduced local access to services (Oz>Train Report March 1998).

Overall, the concerns related mainly to the proposed structure of the regional health service rather than the objectives of coordinated planning and provision.

In early February, the four CEOs and the Project Manager met with the new Chief Executive of DHS. Her response to the report was described as being that:

> …while encouraging contact at regional level, she indicated that the evolutionary phase of the new department should not stand in the way of the Steering Committee's activities, (CEOs Group Minutes 10/02/98).

There was also consultation with the regional managers of the SA Housing Trust and Family and Youth services, parts of the new Department, who were supportive of the proposal.

In light of the concerns expressed by some groups regarding the structure of the proposed regional health service, the final report of the project (released in April 1998) revised the model to one of a 'loose federation'. This meant that each agency would retain its separate status but agree to a joint Regional Board that would oversee the development of regional health programs. There was no response to the report from DHS at this stage apart from an email response from the Chief Executive of DHS to the Senior Research Associate undertaking the evaluation, stating that she was

> …a strong supporter of the type of integrated approaches being pursued in the South. A structural approach is not necessarily the best way to pursue it — but the general

project approach is extremely good (28/04/98).

This proposal was eventually ratified by the four Boards of Management and presented to DHS and the Minister for Human Services in July 1998. Having delivered the report, the Steering Committee was disbanded with implementation being left in the hands of the four CEOs and the Project Manager via a new coordinating committee.

Correspondence records that the four agency CEOs met with the Chief Executive of DHS on the 26th of July and that the Chief Executive reportedly supported the proposals contained in the Final Report but suggested some changes including that the new coordinating committee should not have the words 'council' (suggesting structural change) or 'health' (in line with the new broader focus of DHS) in its title.

It was not until some months later that it became unequivocally clear to the four partner agencies that regionalisation was no longer a part of State health policy and that integration of health, housing and welfare services had become the Department's primary objective, along with an increased centralisation of decision making in service policy and planning. These new directions were indicated by a number of factors. First, the hospitals and community based services now reported to different executive structures within DHS. This reporting structure was outlined at a hospital facilities workshop held by the Department in July 1998 and was followed by a proposal for a metropolitan wide 'region' for hospital services in September 1999. The proposal contained no reference to the previous work on interagency collaboration and joint planning done by Designing Better Health Care in the South. It was also made clear via correspondence and in meetings that planning and policy must come from the Department rather than through collaboration with each other. While interagency collaboration was mentioned as part of the new Department's rhetoric, the four CEOs were actively discouraged from meeting outside the Department's auspices. Another significant occurrence was the resignation of the major teaching hospital CEO in November 1998. As a result of her departure, DBHCS lost one of its most powerful and important advocates.

The shift to a non-structural model and the demise of DBHCS

In spite of these changes, the four CEOs, including the new CEO of the teaching hospital, continued to meet as the Southern Network Coordinating Committee (SNCC) until mid-1999. Their focus was now on a new series of collaborative projects and on providing oversight to the evaluation.

A change to DBHCS was forced by the resignation of the Project Manager in May 1999. A temporary Project Manager was engaged and her first task was to speak with Executives in DHS about the way in which DBHCS was regarded and what its possible future role could be. She reported to the next meeting of the CEOs that DHS had reiterated that all hospital policy was to be determined centrally and that regions other than a whole-of-metropolitan one, were not part of DHS policy. She also reported that the implications of this were that the titles 'Designing Better Health Care in the South' and 'Southern Network Coordinating Committee' (SNCC) were now considerably out of favour with DHS (and the veteran community in the case of DBHCS). Her proposal was therefore:

- That they should complete the current collaborative projects before the end of 1999
- That they should work with DHS to implement the recently initiated Metropolitan Clinical Services Plan for hospitals
- The SNCC be disbanded owing to a lack of support from DHS for this forum
- That the evaluation should continue.

The committee agreed to these proposals. The remaining vestiges of DBHCS were now the regional projects and the evaluation. The regional projects continued until the end of 1999 and were written up as a part of the evaluation. The evaluation itself was reframed as a project documenting and analysing health care reform efforts in southern Adelaide, the levels of interagency collaboration between the four partner agencies and the effect of changes on staff and managers involved. It changed its name to the 'Health Care Reform in Southern Adelaide Evaluation' Project in light of this alteration in direction. The four CEOs continued to contribute to the evaluation project committee until early 2000 when another key

CEO left. At this time the division of hospitals from community services reporting structures in DHS meant that the four CEOs no longer met at joint forums organised centrally. Their concerns became of necessity, much more focussed on their own agencies and there was a sense that continuing to pursue regional concerns was detrimental to this. Only the CEO from the veteran's hospital was able to continue his involvement in the evaluation project committee, through to the end of 2001.

Designing Better Health Care in the South and the stages of transformational change

The changes proposed under the DBHCS project were wide-ranging and significant enough to be classified as being transformational, albeit of a 'modular' rather than 'corporate' kind (Dunphy and Stace 1990). It is therefore possible to review the efforts undertaken by the DBHCS project team and the Project Manager in particular, as corresponding to the pre-conditions identified by Kotter (1995, 1996) for such organisational change. In identifying a need for significant change, the health agency managers that met at the 1994 Strategic Planning conference and subsequently at the Southern Region Liaison Forum identified the growth in demand for health services, along with a reduction of funding following the recommendations of the SA Audit Commission Report. The health agency leadership was aware that these trends were likely to continue and believed the current SA Health Commission emphasis on regional service planning and provision offered a potential direction for change. The initial meetings of the DBHCS CEOs also recognised that substantial change needed broad agreement from a range of stakeholders including health service staff, Health Commission staff and policy makers, unions and consumers. As a result, all these groups were invited to have a role on the Steering Committee and were a part of the extensive consultation process.

The next pre-condition, that of having a powerful guiding coalition behind the change (Kotter 1996) was also fulfilled by the wide representation on the Steering Committee and the ongoing commitment shown to the process by the four CEOs. In the phone interviews, many respondents identified the support of the CEOs as being one of the most critical factors in getting DBHCS as far as they did. Specifically the respondents commented on the important role the four CEOs played in promoting the changed agenda. They felt the working relationship and level of trust between the CEOs was unusual in an essentially competitive environment and a key factor in the success of the project to that point. It was also felt that the CEOs gave a concrete demonstration of their commitment to the regional health service concept by pursuing a model that would effectively see them agreeing to share resources and sacrifice total autonomy of their agency in favour of joint management. The CEOs became opinion leaders for the organisations and were important in explaining and modeling the proposed changes (Ashton 2001). It was only when they were no longer able to meet regularly due to the changes in reporting structures that this commitment to cross-agency collaboration was of necessity, diminished.

The Southern Region Liaison Forum's Statement of Intent also represented a brief and easily communicated vision for change (Kotter 1996) that was the basis for the DBHCS project. However, it was sufficiently broad to allow the structural details to be worked out by process of negotiation with stakeholders. This avoided the problems associated with having opponents arguing over the details rather than the overall goal and vision (Mechanic 1996). The Project Manager for DBHCS made significant efforts to communicate the vision and aims of the project to many stakeholders on multiple occasions, thereby fulfilling Kotter's (1996) requirement for wide-ranging and frequent promotion of the vision.

Another vision-promoting effort came from the use of the regional planning trials and the later regional coordination projects. By offering health agency staff the opportunity to participate in these exercises, the DBHCS project team were encouraging individuals to apply the vision to their specific area of work and see how they could operate within a collaborative regional framework. This process also allowed them to 'win over' people who may have been sceptical about how the regional health service proposal may work. These funded projects also provided a form of 'small wins' for some staff in the four agencies, another of the pre-conditions (Kotter 1996).

A case can be made that DBHCS almost achieved two of the three final pre-conditions for transformational change — overcoming barriers and consolidating improvements (Kotter 1996). The significance of the project getting four separately incorporated agencies and their boards to agree to the regional health service proposal cannot be overstated. This was the most significant initial barrier for the project. The next barrier was the formation of DHS in late 1997, just as DBHCS had developed their interim model for the regional health service. The reaction to the interim report by veterans and others led to the reformulation of the proposal to that of a 'loose federation' model. Later, following the lead of DHS, the project moved away from structural change and focussed on collaboration across services. The DBHCS project also managed to survive the departure of two agency CEOs in its early period and, initially, it appeared, the Project Manager and the teaching hospital CEO in early 1999. This fact would suggest that the project was not overly dependant on the presence of key individuals for its survival (Kotter 1996).

So what went wrong?

Continuing the analysis of DBHCS within the Kotter (1995) transformational change framework, where did it fail? There are several factors that caused significant damage to the regional health service proposal. The most obvious of these was the change in policy direction following the formation of DHS in late 1997. This was an event that occurred outside the control of the project and an example of the way in which public sector agencies are subject to change caused by the political context within which they operate (Ferlie *et al*.1996). Also, as Becker (1998) has identified, the new leaders appointed to DHS after the election, were keen to pursue a different direction — integration of the three departments and centralised control of health service policy rather than regional coordination. Despite the best efforts of the DBHCS team to respond and shift the project to fit within these changed conditions, they were, in the eyes of DHS, unable to bridge the gap. This meant they lost the high level support they had enjoyed from the previous policy-makers. Under such circumstances, the project could not survive.

Phone interview respondents identified the lack of support from the DHS hierarchy as the most significant barrier to the success of DBHCS. Some believed that DHS had viewed the project as an attempt to build a regional power base that would interfere with their determination to centralise all decision making. Others suggested that DHS did not trust the hospitals to look beyond their own needs and interests to provide the full spectrum of care to patients. There was also the suspicion that even the support provided initially by the SA Health Commission was driven by a desire for cost savings rather than improved service provision. It was clear that most participants were unaware of the reasons for the change in policy direction and some incorrectly blamed the CEOs for backing away from the project. Others referred to the perceived lack of clarity in DHS policy directions and the sense that the health system had been subject to too many changes in direction.

With the benefit of hindsight, another barrier not adequately addressed was the non-attendance of the Chair of the veteran's hospital at any of the Steering Committee meetings. The failure to win his support for the project may have contributed to the adverse reaction of many veterans to the Interim Report. Also, results from the phone interviews suggested that in spite of the Project Manager's best efforts, some staff had significant reservations about the proposed model and did not believe that it would have succeeded. This anxiety and opposition was felt to be based upon fear of the unknown and concern by those in the smaller agencies that the teaching hospital would dominate the new structure by virtue of its size and resource base. This was an echo of the concerns expressed earlier in the stakeholder focus groups carried out after the release of the Interim Report. Many staff felt that they had not been kept informed about the progress of the project. This is largely a reflection of how difficult it is to communicate with large numbers of workers operating in an often stressful and information overloaded environment. The uncertain policy environment made it difficult for the CEOs to report back on the lack of response to their proposal by DHS.

Finally, the departure of the largest teaching hospital CEO did have a significant effect as she had been a powerful advocate for the project

and her replacement focussed on fulfilling the directions of the DHS. It is likely that the proposed changes were not firmly established enough to survive this turnover, along with all the other changes.

Conclusion

In proposing to transform four separately incorporated health units into one regional health service, the DBHCS project was a bold initiative. It began with favourable policy conditions, high level support and fulfilled many of the pre-conditions for successful transformational change identified by Kotter (1995). However, a number of factors, including the inability of the project to convince all the key stakeholders to support it and lack of information leading to uncertainty among staff about how the new structure would affect them, had a negative impact on the push for change. The most significant factor was a policy shift to centralisation and integration of health, housing and community services in one Department, meaning the project fell out of favour and was unable to proceed. The demise of this project not only demonstrates how critical strong, high level support is to achieve transformational change but also reinforces the inherently political nature of public sector change and its vulnerability to external policy shifts that occur beyond the control of the local Executives. Although the evaluation of DBHCS did not commence until the implications of the new regime were becoming evident, it was well placed to document the changes that occurred and to obtain feedback from the key players before they dispersed. This has enabled some learning to be drawn from a project that was ultimately unsuccessful and reduces the chance that similar mistakes will be made in the future.

In February 2002, a new government was elected in South Australia and new Executives, including a new Chief Executive, were appointed to key positions within the Department of Human Services. One of the first initiatives announced by the new government was a wide-ranging Generational Review of the health system in South Australia. This review was conducted over 12 months and consulted widely with policy makers, practitioners and consumers. One of the key findings of the review was confirmation that changes to the way in which health services are governed is needed to overcome their lack of integration. The final report recommended the dissolution of individual metropolitan health boards and the introduction of three metropolitan regions: northern, southern and central, built around population numbers and the location of key institutions including hospitals and other health services. The report also stated:

> During consultations, the Generational Health Review was given a clear message that change is expected and a regional governance model would be broadly supported. Stakeholders were seeking arrangements that provide an appropriate balance between central decision making and local responsiveness… (Final Report of the South Australian Generational Health Review, April 2003).

In response, the state government stated:

> We will establish a Regional Health Structure — to build better accountability, improve services and build our capacity for health services to work as an integrated system of care. (First Steps Forward — South Australian Health Reform, June 2003).

In December, 2003, the Acting Premier, the Hon Kevin Foley, announced that the Department of Human Services would be split into two departments: Health and Social Justice (incorporating Housing, Community Services and others). The reason given for this split was 'to give greater strength and focus to their real priorities of implementing the Generational Health Review and dealing with child protection…It is our belief that in its current form, the Department of Human Services is too big and unwieldy' (Media Release, 16/12/03). Plans for the formation of two metropolitan regional health services are proceeding and the boards of each of these are due to be announced in the near future. The similarities between the regional health service model now being adopted following the Generational Health Review and that proposed by DBHCS, six years earlier, are notable. In the government's response to the latest move toward regionalisation, there is a new window of opportunity for change, and a new sense of urgency about reforming the health care system in order to provide quality care for consumers. The indications are that this

proposal for change will enjoy more success and support than its predecessor. In documenting the processes that occurred prior to this latest incarnation of regionalisation, including the failures of a previous reform attempt, the evaluation of DBHCS may help to inform change efforts and to ensure that history is not repeated.

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