A comparative analysis of entrepreneurial approaches within public healthcare organisations

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This article examines the development of two distinct models of organising allied health professionals within two public sector health service organisations in Australia. The first case illustrated a mode of organising that facilitated a culture that focused on asset protection and whose external orientation was threat oriented because its disparate multiple identities operated as a fractured, fragmented and competitive set of profession disciplines. In this milieu, there was no evidence of entrepreneurial approaches being used. In contrast, the second case study illustrated a mode of organising that facilitated an entrepreneurial culture that focused on asset growth and an external orientation that was opportunity oriented because of the evolution of a strong superordinate allied health identity that operated as a single united health services stakeholder. This evolution was coupled with the emergence of a corporate boardroom model of management that is consonant with Savage et al. (1997) IDS/N model of management. Once this structure and strategy were in place, corporate entrepreneurship became the modus operandi. Consequently, because the case study was a situation where corporate entrepreneurship existed in the public sector, it was possible to compare the factors that stimulate corporate entrepreneurship in Sadler’s (2000) study with factors that were observed in our study.

Health systems have experienced significant organisational change in recent decades (Ham 1997; Bigelow and Arndt 2000). The impetus for this change has emerged from a number of environmental triggers within the sector, such as constrained budgetary environments, increased demand for health services and increasing levels of professionalisation and specialisation. There is also general agreement that the New Public Management (NPM) policies of managerialism and marketisation have had widespread influence on both public and private health sector agencies in industrialised Western countries (Hood 1995). In addition to institutional and sector-level effects, significant impacts from NPM policies have also occurred at the workforce level. These changes are reflected in the growing body of work looking at the shifting nature of professional work (Ferlie et al. 1996; Broadbent et al. 1997; Leicht and Fennell 1997; Exworthy and Halford 1998; Malin 2000). Hood (1995) urged against the assumption of a universalist outcome thesis for NPM, arguing that the effects of NPM were dependent on the specific underlying geopolitical arrangements of the implementing nation-state. In this paper we present the findings from an Australian comparative case study to add to the body of international literature exploring the effects of NPM reform agendas on professionals.
New Public Management: The Australian healthcare context

A raft of NPM-related policy changes within Australian industry has typically promoted the separation of purchasers and providers, performance management systems, restructuring of public sector governance systems and appeals for more business-like practices in publicly funded institutions (Hancock 1999; Harris 1999). Specific health sector strategies include evidence-based medicine, population commissioning (pooling health funds and allocating funds to local communities to manage priorities), casemix funding methodologies and the restructuring of patients into clients/consumers. These policy and financial drivers have resulted in a wave of organisation restructuring and new inter-agency relationships (Keating 2000; Leeder 2000; National Health Strategy Unit 1991, 1993).

This changing policy environment has encouraged some health services to explore alternative approaches to both established governance structures and internal modes of organising. Within this context health professions with a traditional focus on clinical care have been forced to engage with issues related to the organisational domain of their practice and service delivery. Similarly to other international experiences reported in the literature, the Australian health professions, particularly medicine and nursing, have responded to the changing institutional context by reorganising. Typical patterns of reorganisation have included the adoption of devolved clinical unit structures, assuming clinical director roles and implementing shared governance models (Degeling et al. 2001; Fournier 2000; Kitchener 2000; Llewellyn 2001; Thorne 2002). In this article we move beyond the focus on medicine and nursing to examine the experiences of other healthcare professions. This objective is accomplished through a comparative study of two public sector health organisations subject to identical government reform agendas, including the effects of managerialism and marketisation. These concepts were coined in the 1984 White Paper, Budget Reform (McKenna 1996). This White Paper included the terms managerialism and marketisation that all levels of government in Australia are still endeavouring to internalise and implement. The term marketisation refers to the ability of public and not-for-profit organisations to operate within a competitive ‘market’ environment similar to that of the private sector. Marketisation processes such as purchaser–provider arrangements appropriated the language and practices of the private sector buyer–seller relationships. Managerialism is a concept that is based on the belief that the management of public sector services is primarily concerned with the management of scarce resources, or ‘doing more
with less’ (Yeatman 1991). The intent to implement fundamental change in public sector identity is captured in terms such as privatisation, contracting out, corporatisation and the ‘contract state’.

The cases were selected for the specific research reported in this article because they were the sites with the longest involvement in the research program (approximately six years at 2000) and as such their ‘deep structure’ and historical context was well known to the researchers. In addition, both sites also met the criteria associated with different organisational forms that are discussed in more detail below. It is important to note that in the early 1990s when the sites initially became involved in the research program they were organised in a largely identical form. Each allied health department was managed by a member of their profession who reported to a corporate-level medical director within an overarching division of medicine. This organisational form was the universal structural configuration for allied health professions in Australian public sector hospitals until the early 1990s. For the purposes of our research program we have labelled this organising mode as a traditional model: the classical medical model (Boyce 1991). The classical medical model of organising allied health professions also serves the role of a reference model against which emergent structural forms can be interrogated.

Since the 1990s, when a wave of restructuring occurred in Australian public hospitals, two new organising modes for the allied health professions have emerged. Although there are small local variations in the implementation of the new approaches, as general types they can be summarised as follows. First, there is the division of allied health in which individual professional departments are retained as management units but with a move away from medical management to form their own self-managing allied health division. The most striking change is the establishment of a non-medical director of allied health role that has membership of the hospital executive. Second, there is the unit dispersement model, a close relative of the patient-focused care approach popularised internationally by management consulting firms. In a unit dispersement approach the allied health profession departments are eliminated and the staff are assigned to, and managed by, medical clinical units according to their area of specialty practice. There may be some advisory leadership role for a senior member of the professions; however, this is not a managerial role.

The reduced dominance of the previously universal classical medical model was reported in a recent national survey (Boyce 2001). The survey was conducted on all Australian general hospitals in the public sector with 100 or more beds. A participation rate of 94 per cent was achieved and data was collected on 107 hospitals. The results showed that by the year 2000 the classical medical model accounted for 52 per cent of the sites (n = 56). Divisions of allied health were in situ at 35 per cent of locations (n = 37), but accounted for close to 45 per cent of the total beds in the survey (35,936), reflecting the presence of the model at larger hospitals. The unit dispersement model was present at 6 per cent of sites (n = 6). The remaining 7 per cent of sites (n = 8) were distributed across three other minor variants.

There are now several reports in the literature describing the formation of divisions of allied health and the organisational development processes undertaken to achieve successfully functioning units (Astley 2000; Dawson 2001; Law and Boyce 2003; Wake-Dyster 2001). This small body of literature is based on individual case study methodology and is limited in scope to a structure and practice perspective. In the current article we present data from a comparative case study approach to show how a sustainable allied health subculture was developed in one setting, and the constraints and difficulties encountered in trying to achieve a shift towards a similar allied health identity in another setting.

The evolution of an allied health subculture is not well understood. Evidence of a shift in professional identity from one of ‘allied to medicine’ to ‘allied to each other’ was a key finding in an analysis of a decade of reforms within and between Australian allied health professions (Boyce 2001). However, this work was located at the health system level and not at the workplace level, which is the focus of the current article. Using a comparative case study approach we are able to show that the form of structural organisation in the workplace
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(division of allied health) is an important factor in building and sustaining a collective allied health identity.

The other key difference in the two settings was the use of entrepreneurial corporate metaphors and processes as an inter-professional regulatory management approach. A key element in the ability of allied health professionals to operate in this novel corporate entrepreneurial manner was the establishment of a single allied health stakeholder entity underpinned by a unified identity. Appeals to public sector health professionals to adopt behaviours more like those in the private sector were not uncommon in the 1990s as part of NPM reforms (Aldridge 1996; Boyce and Shepherd 2000). In this article we explore how public sector health professionals operating in an environment favouring enterprising business-like conduct were able to translate these appeals into a mode of organising a multi-professional division.

The novelty of the corporate entrepreneurship approach in a public sector hospital’s professional workforce motivated our further study into investigating whether the factors reported in the literature that stimulate corporate entrepreneurship in the private sector might also operate in a public health services organisation.

In order to understand the conditions that stimulate corporate entrepreneurship in public sector health service settings we reviewed the literature to identify factors accepted as influential. We were particularly interested in looking at factors accepted as valid in the private sector that the literature suggested were not important in the public sector and examining them in the context of our research setting, that is, the health industry. To accomplish this objective we drew on Sadler’s (2000) review of corporate entrepreneurship in the public sector as a primary source. In the following section of the article we provide an overview of the literature on corporate entrepreneurship and examine the concept of professional identity more fully before describing the research method and case study sites in more detail.

Corporate entrepreneurship in the public sector

The private sector literature suggests that there are numerous organisational factors that facilitate a tendency toward entrepreneurship (Jennings 1994; Slevin and Covin 1990). Unlike the private sector entrepreneurship literature, there is little published material that addresses those ‘structures, systems or cultures’ that stimulate/constrain corporate entrepreneurship in the public sector (Sadler 2000). An exception is a recently reported study, relevant to the current research, in which 24 such factors were identified Sadler (2000). Sadler’s (2000) study of 322 publicly owned Australian urban water businesses found that 15 of these private sector factors facilitate a tendency towards entrepreneurship in the public sector.

We will focus on four of the factors unsupported or not tested in Sadler’s (2000) study. These unsupported or untested factors are: (1) consistent objectives; (2) few bureaucratic processes — little red tape; (3) decision-making by staff with specialised training; and (4) innovative role model and mentors. In one of the case studies we report on, these four entrepreneurship-stimulating factors worked hand in glove with the evolution of a single stakeholder entity to promote corporate entrepreneurship.

The nature of stakeholder relationships within allied health

The literature regarding stakeholders and multiple identities provides some insights into how the allied health professions in a public health services organisation positioned themselves as a single stakeholder entity that adopted a corporate boardroom governance structure and culture. In the following sections we briefly review the literature on stakeholders and multiple identities, showing how they apply in our contextual setting of health professions and the public sector organisations they inhabit.

A broad definition of stakeholder, as applied in this study, is any group or individual who can affect or is affected by achievement of the organisation’s objectives (Freeman 1999). Kochan and Rubinstein (2000) cite four conditions for stakeholder entities to emerge which can be applied to our research setting. First, leadership values are open to the evolution of a distinct allied health subculture in health services. Second, employees provide critical knowledge assets to the organisation and have a legitimate claim on ‘property right’ for putting their assets at risk,
equivalent to the property rights granted to financial investors. And fourth, employees, as a would-be stakeholder of an organisation, amass sufficient power to challenge the privileged position that other investors and agents achieve in the organisation.

Most studies of stakeholder relationships have focused on a macro- or meso-level of analysis. In contrast, we explore stakeholder identification and salience at the micro-level of analysis. In particular, we focus on the stakeholder relationships within and between allied health professions at two public sector health services organisations. At one of these organisations, the term ‘integrated delivery system/network’ (IDS/N) (Savage et al. 1997) is introduced as a way of describing an innovative governance structure and internal mode of organising that was responsive to internal and external stakeholder needs. A key principle of an IDS/N is the alignment of incentives to encourage cooperation rather than adversarial relationships between a portfolio of healthcare stakeholders (Savage et al. 1997). Figure 1 is a highly simplified stakeholder map from the perspective of an allied health IDS/N in the Australian context.

It reflects some of the complexity of stakeholder networks that can influence allied health in both its day-to-day operations and at the strategic planning level. For example, the direction (positive or negative) and strength of an allied health IDS/N’s relationship with specific stakeholders can influence other relationships in the portfolio of healthcare industry stakeholders. In the short term, the complex dynamics that result from the current configuration of relationships the IDS/N develops with these other healthcare stakeholders influences day-to-day operations. At a strategic level, configuration of relationships influences planning decisions. The outside concentric circle in Figure 1 lists major external stakeholders. The hatched rectangular box that transcends the IDS/N and the internal and external stakeholders represents the allied health governing board of the IDS/N. The board is ‘the glue that binds the IDS/N together’ (Savage et al. 1997). One of the case studies outlined in this paper, through a corporate entrepreneurship strategy, successfully applied a corporate board governance structure to meet the needs of all of its myriad stakeholders, even

![Figure 1 Allied health stakeholders](image-url)
though many of these stakeholders’ individual needs conflicted or competed with each other.

**Relationship between multiple profession identities and allied health identity**

Each of the two health services in this research is a multiple identity organisation (Albert and Whetten 1985). For example, in relation to allied health, there are different collectives, namely the professions, which have unique sub-identities even if the allied health entity as a whole works hard to maintain a singular, common identity for its external constituencies. At best, management of multiple identities can result in a significant competitive edge because it enhances response capacity through creativity and learning (Eccles et al. 1992; Nkomo and Cox 1996; Fiol 1994). However, multiple identities can also lead to organisational inaction or vacillation (Pratt and Foreman 2000) or intraorganisational conflict (Golden-Biddle and Roa 1997; Pratt and Rafaeli 1997). In addition, they can cause ambivalence and thus have significant effects on the strategic management of an organisation.

When a specific profession identity is strong, it can be clearly articulated, it captures the imagination of organisational members and is robust in that as a profession it can independently take action capable of accomplishing short-term goals (Barney et al. 1998). If more than one profession is high on all three characteristics, then conflict is likely. Conflict resolution is more likely if a strong superordinate identity such as ‘allied health’ captures the imagination of the disparate profession identities, is articulated in a way that encompasses the subgroups and is also robust (Barney et al. 1998).

**Research design**

The findings reported in this article are part of a 10-year research program investigating the health professions and public sector reforms such as organisational restructuring, managerialism and marketisation. Over the life of the program, 100 semi-structured interviews have been conducted with senior allied health, medical, nursing and general management staff. Nine case studies (two longitudinal) based in metropolitan, rural and remote locations have also been undertaken (Boyce 2001).

The case study sites for the current investigation, Provincial Health Services and Coastal Health Services, have participated in several data collection phases over this 10-year research period.

In this paper we are drawing on interviews with 13 allied health profession managers from the two study sites. A semi-structured interview protocol was developed following the procedural guidelines recommended by Yin (1994). The protocol was based on a propositional model of allied health organisational subculture developed from Boyce (1996). Questions focused on the following topics: intra-profession stability; resource environment; profession interests; critical mass of participants; level of organisational support for allied health; medical management environment; structural support; leadership; emergence of allied health associations; support of profession associations and unions; identity; and ambiguity.

Each interview was tape recorded, transcribed and returned to each interviewee for clarifying amendments. The corrected transcripts were then coded using the qualitative data analysis package NUD*IST NVivo to aid analysis of coded data through indexing themes and illustrative extracts. Qualitative data management and analysis techniques recommended by Miles and Huberman (1994) were utilised throughout the research to achieve conceptual grouping around the themes of an individualistic, threat-oriented, arbitration model of management in the stakeholder-oriented case environment at Coastal Health Services and a collective, opportunity-oriented, boardroom model of management in the IDS/N-oriented case environment at Provincial Health Services.

**Coastal Health Services**

Coastal Health Services have approximately 500 registered beds providing acute and tertiary healthcare services. The allied health professionals were organised at the macro-level within a classical medical model with each discipline structured as a profession hierarchy managed.
by a member of the profession reporting to a corporate-level medical executive position. The profession managers were accountable for the management of financial and human resources and were accountable to an executive-level medical manager. This medical manager represented the interests of all allied health professionals and the medical profession on top-level management committees. The service delivery approach involved each allied health profession independently allocating professionals from their discipline to geographically separate areas of the health services organisation where they provided services to various medical clinical units. The professionals were not, however, managed by those medical clinical units.

Coastal Health Services had an allied health subculture with competing visions and an arbitration-type model of management. Less than one-third of the profession managers had postgraduate business degrees. Interviewees identified with both an allied health identity and a profession identity. However, they identified more strongly with their profession identity. Allied health professionals were extremely individualist. As a result, management perceived the allied health professions as individualist, competitive and non-influential stakeholders in the health services organisation rather than as a united and influential superordinate allied health stakeholder entity. There was no single allied health representative with legitimate leadership over the multiple profession disciplines. Divisive work practices and competing visions were frequently described in interviews. Further, there was much evidence of attempted dispute resolution and arbitration between threat-oriented, individual stakeholders over limited resources. The external orientation of these stakeholders was both individualistic and threat oriented. For example, individual allied health professionals frequently breached formal governance structures in their own self-interests to secure resources and/or jobs, as indicated by the broken arrows in Figure 2.

In summary, the way in which Coastal Health Services organised its internal environment was underpinned by an emphasis on asset protection by individual profession managers who perceived themselves as individual stakeholders with scant influence, competing for rapidly shrinking assets.

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**Figure 2** Organisational structures at Coastal Health Services

Unbroken arrows represent formal (espoused) governance structures
Broken arrows represent informal (observed) governance structures
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Provincial Health Services

The Provincial Health Services is a 280-bed facility providing acute healthcare services to a rural district in Australia. Like the preceding case study, it is considered to be one of the top 10 hospitals in its state based on activity and expenditure. In addition to the provision of direct acute care, the Provincial Health Services provide specialist consultative services to some smaller health services in surrounding districts.

In the late 1980s, allied health professionals in this health services’ district were organised traditionally as a classical medical model. Each profession had its own department with a senior clinician providing management expertise as well as managing a full clinical caseload. The senior clinician of each profession would report directly to a corporate-level medical director. The chief executive officer at the time was reported to have expressed concern that the ‘paramedical professions’ were ‘out of control’ and needed ‘stronger’ management. As a result the traditional classical organisational model was restructured in 1992. The new structure was a division of allied health, under the leadership of a director of allied health. The director was a member of the health services executive management team. This position gave allied health professionals their own voice at the most senior levels for the first time. All interviewees in this case had postgraduate business qualifications at the time of this study. The director of allied health held both professional qualifications and a postgraduate qualification in business. The director successfully encouraged all discipline managers to pursue postgraduate business qualifications by the time of this study.

A further restructuring within the division of allied health occurred in 1997. This internal restructuring, which was instigated directly by the allied health professionals, involved the formation of several allied health resource teams. Decisions about which allied health professionals to allocate to a specific client were made at an executive level by the director of allied health and his or her management team. The restructure also involved the physical relocation of all discipline managers into a single, open-plan workspace. This new workspace was designed to maximise interpersonal contact and to enhance knowledge creation/utilisation (Nonaka and Takeuchi 1995; Nonaka and Konno 1998).

Under the new model, the internal configuration of the division of allied health involved a complex matrix arrangement. It maintained traditional professional hierarchies for each discipline but introduced a new dimension by simultaneously integrating these hierarchies with the allied health resource team service delivery structure. This structure is shown in Figure 3. The service delivery team structure mirrored the organisational structure of the medical clinical units in this health services organisation. In the Australian context, organising allied health professionals in this form of internal matrix has been classified as an integrated decentralisation model (Boyce 2001). The underlying organising principles of the internal matrix structure address many of the concerns raised by Anderson and McDaniel (2001) about the need for complex adaptive systems in managing the health professional workforce. An integrated decentralisation structure for allied health professions had a facilitating role in developing new interdisciplinary work practices at Provincial Health Services that were considered ‘best practice’ examples by other organisations.

The restructured division of allied health is loosely and informally run as a ‘corporate entity’. Discipline managers take on a role as board members and the director of allied health is chairman of the board. This model ensures that each allied health manager is accountable to his or her peers and that the division of allied health takes responsibility for all its business processes and internal and external relationships. According to the then director of allied health, this arrangement is beneficial for senior management of the organisation as well.

I think senior management wants there to be an allied health identity... They are very keen to have an allied health point of contact so that they’re not dealing with competing demands from five different professions, but that allied health works as an entity and puts its priorities as an entity.

The staff from within the division of allied health provides a wide range of services to the
health services as a whole, the community and a range of outreach and visiting services across the rural district it serves. Within the new corporatised and brokerage model, the division was able to negotiate service agreements with a number of other government and non-government agencies. The agreements were with the Department of Education, private physiotherapy service providers and the division of general practice. Also at this time, a large number of research, services and development grants were attracted to the organisation through the division of allied health. Between the years 1993 and 1999 $5.2 million in service, research and development grants had been obtained by the division of allied health, most recently an $80,000 grant from the women’s health policy unit. In addition, staff within allied health were encouraged to ‘work smarter together’, dividing the labour across and between profession disciplines in the most efficient manner. One senior allied health professional commented on her flexibility to divide the labour:

…like [name] is the word person, I’m the number person, we’re meant to be managers and do monthly reports for our two teams. We’ve decided that I’ll do all the figures for all of them and she will do all the word stuff for all of them.

Strategically, the superordinate allied health entity is influential when negotiating service agreements with these other stakeholders. Analysis of institutional documents and interview data shows that the division of allied health’s decision to move toward an integrated decentralisation model based on an internal matrix of profession hierarchies and teams was developed to overcome a number of functional barriers to the efficient provision of scarce allied health services to purchasers and consumers. Profession leaders had a dual role of managing their respective disciplines and also provided functional leadership across the whole division of allied health. Five functional areas included two roles as managers of allied health resource teams and one each for research and development, information management/technology and professional development/standards. At an operational level, the mix of both profession hierarchies and multidisciplinary teams (the integrated management model) minimised internal competition and maximised external opportunity for extra funding in negotiating with the hospital.

The model, as enumerated in divisional planning documents and espoused by interviewees, is based on a number of principles. First, allied health professional resources must be closely linked to budget holder priorities for service, which in turn are linked to both major corporate policy direction and communities’ health needs. Second, allied health professional disciplines’ individual developmental needs and processes are strengthened. Third, allied health professional services are increasingly patient and team focused. Fourth, allied health professional clinical services are price competitive, giving the very best value for money.

Overlying these principles were a number of internal and external ‘drivers’ of change, emphasising the need to work smarter. Considerable resources were being spent in supporting communication and information flow to six different profession-specific managers. Previously, repetitive and routine management tasks were replicated by all five profession-specific managers. The time spent in the duties of filing, developing reports, in-service education and generic procedural skills was increasing. This was considered a major waste of high-level and expensive managers’ time, while other important but not as pressing issues such as research and development were being given less than optimal time during work hours.

The introduction of an automated networked information system designed to support and integrate allied health professional practice and data collection allowed for a major reduction in managing information by paper and provided many opportunities for efficiency.

With major changes across the organisation, the division of allied health was also being increasingly requested to become involved in projects and organisational priorities outside the traditional scope of practice. Some of these ‘projects’ included hospital information management systems development, human resource management reforms, workplace health and safety reforms and institutional accreditation. The following extract reflects this development at Provincial Health Services:

We [allied health] form alliances with whoever or whatever systems are required
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in order to fulfil whatever it is we want to do… it’s very much a systems approach, the idea being that we are part of like a multiplicity of systems and depending on what needs to be achieved, we ally ourselves with that part of the system (doc1, 3–7).

The emergence of entrepreneurial approaches to organising

The combination of governance system, structure and culture at Provincial Health Services is atypical of traditional health services organisations. The integrated decentralisation model on which Provincial Health Services’ allied health division is based is a new approach in Australia. A recent national study of governance structures in the acute-care public hospital sector showed that the model had been implemented in fewer than 10 of the 107 sites surveyed (Boyce 2001). However, those sites that had committed to the model were large hospitals with leadership status in terms of innovative practice approaches.

Discussion of these case studies draws on the work of Sadler (2000) and others to help explain how and why one allied health service successfully developed entrepreneurial modes of organising in contrast to the other which did not. Our key focus here is to discuss how corporate entrepreneurial approaches emerged within a public sector context. The manner in which Provincial Health Services organised its internal environment was underpinned by an emphasis on asset growth by the director of allied health and his team of discipline managers. They perceived themselves as an IDS/N in the business of allied health services delivery. Roles were formalised within a corporate board management model. The external orientation of allied health was a single collective stakeholder entity that was opportunity oriented.

We will now discuss both case studies in relation to the nature of Sadler’s (2000) four factors which are purported to be the major facilitators of corporate entrepreneurial activity within a public sector context.

Diminished bureaucratic processes

One of the key facilitators of entrepreneurial approaches at Provincial Health Services was the development of a singular superordinate allied health identity, which had the effect of minimising red tape. In turn, this assisted
Provincial Health Services in developing a strong sense of shared vision of the direction, mission and philosophy of the service. A corporate model of management was employed to achieve their shared objectives. The management team consisted of discipline leaders and the director of the allied health division, the latter taking a leading director’s role at allied health business meetings. Relationships at this management level appeared to be based more on trust and reciprocity than on explicit notions of power and legitimacy. The following extract of an interview with the then director of the allied health division captures the spirit of the management team’s approach to decision-making.

Everybody has an equal say … I like to manage by consensus … at times we have to play the board room rules so the overall majority win … once outside of this [meeting] we will become allied health professionals … we will not show dissent outside this room (doc 6,10).

Externally, this approach resulted in allied health being perceived as an organised, single, united influential stakeholder (Mitchell et al. 1997).

**Consistent objectives**

A key long-term objective within Provincial Health Services was the achievement and sustenance of a stable resource environment. This developed through the evolution of both a mode of organising that focused internally on asset growth, and an external orientation that was opportunity oriented. This consistent objective guided allied health in their evolution as a single collective stakeholder entity that facilitated consistent objectives through an IDS/N governance structure.

**Innovative role model and mentors**

Our study of Provincial Health Services suggested that the leadership values of the director of allied health coupled with a stable resource environment had implications for training, professional development and mentoring. On the one hand, at Provincial Health Services, the mode of organising resulted in a higher level of intra-profession stability than at Coastal Health Services because of agreed inter-professional protocols to reduce tension. There was also a more stable resource environment at Provincial Health Services because their organisational model styled on entrepreneurial governance permitted the professions to collectively focus on asset growth as part of proactively seeking alternative sources of revenue both within the organisation and externally. In contrast, at Coastal Health Services the allied health professions focused on asset protection and defending threats to their discipline’s resource base.

The steadying influences of intra-profession stability and a stable resource environment actively managed by the board was one of the major reasons for a more harmonious workplace climate. Thus, this environment was more conducive to staff training, professional development and mentoring than the Coastal Health Services work environment, where many of the professions seemed fractured and fragmented and the resource environment was markedly less stable despite both host health services operating in an identical public sector environment.

In contrast, Coastal Health Services had an allied health subculture with competing visions and an arbitration-type model of management. Allied health professions were extremely individualist focusing on defining and defending their unique, distinct discipline-based identity. As a result, individual non-influential stakeholders prevailed rather than a united allied health stakeholder entity. There was no single allied health representative with legitimate leadership over the professions. The following interview extract from Coastal Health Services succinctly articulates this situation:

So much energy just goes into survival. You know, what the hell are we arguing about? There’s no way you want to go out and hurt anybody else, any more than anyone else, [but] it’s like family turning against family. I just can’t get away from the feeling that, for me personally that is so unproductive (doc 3,63).

**Decision-making efficacy and quality**

Provincial Health Services was characterised by a high level of postgraduate business qualifications among discipline managers/board
members in addition to their clinico-profession qualifications. While all such staff at Provincial Health Services possessed management qualifications or were enrolled in a formal program, only one of the equivalent positions at Coastal Health Services had management qualifications. It was an explicit policy of the division of allied health at Provincial Health Services that senior health professionals gain formal managerial qualifications. This policy reflected the cultural value that was placed on such expertise and explains in part the willingness of staff to engage with managerialist reforms. As a result of their distinctive approach to management and consensus, they developed and actively supported formal protocols that contributed to the effectiveness of management-related decision-making within allied health. Significant examples of the quality of the decision-making include the development of skills and expertise that resulted in the evolution of an IDS/N governance structure, the introduction of an internal matrix structure and the introduction of sophisticated automated systems.

Comparative findings regarding the four factors that stimulate corporate entrepreneurship are summarised in Table1.

**Implications for governance in the new public sector**

The implications of the structures within which allied health is organised are salient in these two cases. Allied health demonstrated at Provincial Health Services that it is possible to evolve a strong superordinate identity within the integrated decentralisation model. As a result, they were able to achieve high status as an influential stakeholder in their organisation. In contrast, with a classical medical model at Coastal Health Services, the tyranny of competing visions and a low-trust environment meant that allied health was constrained in its ability to gain influence and garner resources.

The implications of different structures for other health services are also clear. Like Provincial Health Services, they too must learn to be more flexible in the ways they ‘do business’ with the allied health community. One example of this flexibility was the inclusion of allied health middle managers on decision-making health services-wide committees where their management expertise was highly valued and contributed to more systemic decision-making. Another example is the flexibility that

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<th>Table 1   Comparison of factors stimulating corporate entrepreneurship in the private sector with Sadler (2000) and the health services case studies</th>
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<td><strong>Private sector corporate entrepreneurship stimulating factors</strong></td>
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<td>Innovative role model and mentors</td>
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<td>Few bureaucratic processes — little red tape</td>
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Provincial Health Services displayed in encouraging the development of partnerships between allied health and external funding sources drawn from both government and non-government agencies. These are just two examples of the positive outcomes that resulted from the evolution of a strong allied health profession community operating within an IDS/N mode of organising.

This study adds to a growing body of literature that looks at systemic ways of dealing with the influence of marketisation, managerialism and NPM upon health services within the Australian context and elsewhere (Keating 2000; Harris 1999). The impact of these changes has led allied health services to review and transform both their clinical and administrative practice (Boyce 2001). However, different health professions and the organisations they inhabit have responded to these changes in disparate ways. It is not surprising then to find that allied health will develop a variety of approaches to organising in response to both internal and environmental pressure to engage in organisational transformation.

While Australia is yet to move to a managed care environment, budgetary pressure for interdisciplinary teams to operate more efficiently is strong (Schofield and Amodeo 1999). Given that allied health already work within an interdisciplinary framework, the pressure to ensure increased efficient and effective output throughout will grow substantially (Boyce 1998). This means that allied health professions will need to look for more innovative ways of organising internal management structures as well as service delivery approaches.

**Future trends for organising health services**

It needs to be recognised that the unique histories of these cases and the attitudes of leaders within these health services may have facilitated or constrained the development of disparate approaches to organising allied health. Therefore, these case studies must be considered in light of this context. These two cases are not meant to be representative in the sense of being generalisable to the wider population of sites. Rather, they are critical cases that reflect the organising principles and entrepreneurial possibilities and limitations of each of the discrete models from which they are drawn.

Future trends within allied health indicate that there will be significant pressure placed upon health services worldwide to further align professional education with healthcare priorities. New forms of organising health services in general and allied health in particular will have a direct impact on this alignment. Future research will need to consider the implications of these changes and the impact this may have upon the status of allied health within the broader healthcare system. This includes the effect of stakeholders, salience and identification within allied health and the challenges this creates when working within a decentralised structure.

**Conclusion**

In conclusion, the transformation of health services in Australia and elsewhere is characterised by the introduction of new forms of organising. This trend has been exacerbated by a healthcare environment that is fraught with environmental uncertainty and turbulence. Individual health services are constantly faced with trying to integrate professional groupings and structures that have traditionally been in competition with each other. In order to be more responsive to both internal and external stakeholders, stakeholders within the healthcare environment need to develop structures and ways of organising that maximise entrepreneurship, innovation and both human and systemic resources.

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